635.18 **(1)** ~~Every~~ Any small employer insurer ~~shall~~ may actively market health benefit plan coverage to small employers in the state.

SECTION 49. Chapter 636 of the statutes is created to read:

CHAPTER 636

HEALTH BENEFIT PLAN EXCHANGE

SUBCHAPTER I

GENERAL PROVISIONS

636.01 Definitions. In this chapter:

(1) "Authority" means the Badger Health Benefit Authority.

(2) "Educated health care consumer" means an individual who is knowledgeable about the health care system and who has background or experience in making informed decisions regarding health, medical, and scientific matters.

(3) "Federal act" means the federal Patient Protection and Affordable Care Act (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), and any amendments to, or regulations or guidance issued under, those acts.

(4) (a) Except as provided in pars. (b) to (e), "health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) "Health benefit plan" does not include any of the following:

1. Coverage only for accident, or disability income insurance, or any combination of those.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Worker's compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit–only insurance.

7. Coverage for on–site medical clinics.

8. Other similar insurance coverage, specified in federal regulations issued under P.L. 104–191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include any of the following benefits if they are provided under a separate policy, certificate, or contract of insurance or otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits.

2. Benefits for long–term care, nursing home care, home health care, community–based care, or any combination of those.

3. Other similar, limited benefits specified in federal regulations issued under P.L. 104–191.

(d) "Health benefit plan" does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

(e) "Health benefit plan" does not include any of the following if offered as a separate policy, certificate, or contract of insurance:

1. Medicare supplemental health insurance as defined under section 1882 (g) (1) of the federal Social Security Act.

2. Coverage supplemental to the coverage provided under 10 USC ch. 55 (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

3. Similar supplemental coverage provided to coverage under a group health plan.

(5) "Health carrier" or "carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(5m) "Minimum essential coverage" has the meaning given in 26 USC 5000A (f) (1).

(6) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with s. 636.42 (5).

(7) "Qualified employer" means a small employer that elects to make its full–time employees eligible for one or more qualified health plans offered through the SHOP Exchange and, at the option of the employer, some or all of its part–time employees, provided that the employer satisfies any of the following:

(a) The employer has its principal place of business in this state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.

(b) The employer elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

(8) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311 (c) of the federal act and s. 636.42.

(9) "Qualified individual" means an individual, including a minor, who satisfies all of the following:

(a) The individual is seeking to enroll in a qualified health plan offered to individuals through the exchange under subch. II.

(b) The individual resides in this state.

(c) At the time of enrollment, the individual is not incarcerated in a correctional facility, other than incarceration pending the disposition of charges.

(d) The individual is, and is reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(10) "Secretary" means the secretary of the federal department of health and human services.

(11) "SHOP Exchange" means a small business health options program established under s. 636.30 (1) (q).

(12) (a) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

(b) For purposes of this subsection, all of the following apply:

1. All persons treated as a single employer under section 414 (b), (c), (m), or (o) of the Internal Revenue Code shall be treated as a single employer.

2. An employer and any predecessor employer shall be treated as a single employer.

3. All employees shall be counted, including part–time employees and employees who are not eligible for coverage through the employer.

4. If an employer was not in existence during the entire preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that it is reasonably expected that employer will employ on business days in the current calendar year.

5. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and that would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

SUBCHAPTER II

OPERATION OF EXCHANGE

636.25 General matters. (1) The authority shall establish and operate a Wisconsin Health Benefit Exchange and shall make qualified health plans, with effective dates on or before January 1, 2014, available to qualified individuals and qualified employers.

(2) (a) The authority may not make available any health benefit plan that is not a qualified health plan.

(b) The authority shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832 (c) (2) (A) of

the Internal Revenue Code through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302 (b) (1) (J) of the federal act.

(3) Neither the authority nor a carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer–sponsored coverage has become affordable under the standards of section 36B (c) (2) (C) of the Internal Revenue Code.

(4) The authority may enter into information–sharing agreements with federal and state agencies and entities operating exchanges in other states to carry out its responsibilities under this chapter, provided that such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and rules and regulations.

636.30 Exchange duties and powers. (1) In addition to all other duties imposed under this chapter, the authority shall do all of the following relating to the exchange:

(a) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311 (c) of the federal act and s. 636.42, of health benefit plans as qualified health plans.

(b) Provide for the operation of a toll–free telephone hotline to respond to requests for assistance.

(c) Provide for enrollment periods, as provided under section 1311 (c) (6) of the federal act.

(d) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

(e) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311 (c) (3) of the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302 (d) (2) (A) of the federal act.

(f) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Service Act (42 USC 300gg–15).

(g) Establish quality improvement standards for health benefit plans offered through the exchange.

(h) Establish a system for enrolling eligible groups and individuals, using a standard application form developed by the commissioner under s. 636.46 (2).

(i) Establish procedures for collecting premiums and remitting premium payments and providing enrollment information to health carriers.

(j) Establish, in consultation with the commissioner, the method for determining the amount of the surcharge under s. 636.45 (1) and establish the procedure for imposing and collecting the surcharge.

(k) Establish a plan for publicizing the exchange and the eligibility requirements and enrollment procedures.

(L) Establish and operate a service center to provide information to small employers, individuals, enrollees, and insurance intermediaries about the exchange.

(m) Establish a mechanism for regular communication and cooperation with insurance intermediaries.

(n) Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the authority.

(o) In accordance with section 1413 of the federal act, inform individuals of eligibility requirements for Medical Assistance under subch. IV of ch. 49 or any other applicable state or local public program and if, through screening of the application by the authority, the authority determines that any individual is eligible for any such program, assist that individual to enroll in that program.

(p) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code and any cost–sharing reduction under section 1402 of the federal act.

(q) Establish a SHOP Exchange through which qualified employers may access health care coverage for their employees and which shall enable any qualified employer to specify the level of coverage at which its employees may enroll in any qualified health plan offered through the SHOP Exchange.

(r) Perform duties required of the authority by the secretary or the federal secretary of the treasury related to determining eligibility for premium tax credits, reduced cost–sharing, or individual responsibility requirement exemptions.

(s) Select entities, which may include insurance intermediaries, that are qualified to serve as navigators in accordance with section 1311 (i) of the federal act and standards developed by the secretary, and award grants to enable navigators to do all of the following:

1. Conduct public education activities to raise awareness of the availability of qualified health plans.

2. Distribute fair and impartial information concerning enrollment in qualified health plans and concerning the availability of premium tax credits under section 36B of the Internal Revenue Code and cost–sharing reductions under section 1402 of the federal act.

3. Facilitate enrollment in qualified health plans.

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the federal Public Health Service Act (42 USC 300gg–93), or to any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health benefit plan, coverage, or determination under that plan or coverage.

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

(t) Assist in the coordination of any necessary administrative operations between the department of corrections and the department of health services to ensure all of the following:

1. That an individual, upon placement in a correctional facility, is disenrolled for the duration of his or her incarceration from any health care coverage in which he or she is enrolled.

2. That an individual who is incarcerated in a correctional facility, but scheduled to be released from incarceration in the near future, is enrolled prior to release, through the exchange and effective upon the date of his or her release, in

Medical Assistance, a qualified health plan, or some other form of minimum essential coverage on the date of his or her release from incarceration.

(u) For those persons whose alcohol or other drug abuse or mental health treatment is not covered by a federally administered program, coordinate the relationships among the Medical Assistance program, the exchange, and the county departments under s. 51.42 or 51.437 to provide outpatient and inpatient mental health and alcohol or other drug abuse treatment with all of the following goals for the coordination:

1. Maximizing coverage and improving access through the exchange for outpatient and inpatient treatment of mental illness and alcohol or other drug abuse.

2. Improving the quality of treatment for persons with alcohol or other drug dependence or a mental illness.

3. Fully integrating the treatment for physical conditions, alcohol or other drug abuse, and mental illness.

4. Reducing the cost of the county departments under ss. 51.42 and 51.437 to taxpayers by avoiding unnecessary overlap between the improved coverage of alcohol or other drug abuse treatment or mental illness treatment by health plans offered through the exchange and the services provided by county departments under s. 51.42 or 51.437.

(v) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(w) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the federal act, and collect the amount credited from the offering employer.

(x) Consult with stakeholders relevant to carrying out the activities required under this chapter, including any of the following:

1. Educated health care consumers who are enrollees in qualified health plans.

2. Individuals and entities with experience in facilitating enrollment in qualified health plans.

3. Representatives of small businesses and self–employed individuals.

4. The department of health services.

5. Advocates for enrolling hard–to–reach populations.

(y) Meet all of the following financial integrity requirements:

1. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the secretary, the governor, the commissioner, and the legislature a report concerning such accountings.

2. Fully cooperate with any investigation conducted by the secretary under the secretary's authority under the federal act and allow the secretary, in coordination with the inspector general of the federal department of health and human services, to do all of the following:

a. Investigate the affairs of the authority.

b. Examine the properties and records of the authority.

c. Require periodic reports in relation to the activities undertaken by the authority.

3. In carrying out its activities under this chapter, not use any funds intended for the administrative and operational expenses of the authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications, except that this subdivision does not prohibit the authority from advocating, as part of administering the exchange, for

policies that the authority determines are in the best interest of the exchange or of individuals and employees receiving coverage through the exchange.

(2) The authority may do all of the following relating to the exchange:

(a) Contract with a 3rd–party administrator for the provision of services on behalf of the exchange.

(b) Establish risk adjustment mechanisms for the exchange.

(c) Enter into agreements with or establish sub–exchanges.

(d) Create any other exchange, or component of the exchange, that is provided for under federal law.

(3) The authority shall seek grants to the fullest extent to which it is eligible, including amounts under section 1311 (a) (1) and (4) of the federal act, or other funding from the federal or state government for which it may be eligible and from private foundations for the purpose of the exchange.

636.42 Health benefit plan certification. (1) The authority may certify a health benefit plan as a qualified health plan if all of the following are true:

(a) The plan provides the essential health benefits package described in section 1302 (a) of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in sub. (5), if all of the following are satisfied:

1. The authority has determined that at least one qualified dental plan is available to supplement the plan's coverage.

2. The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the authority, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange.

(b) The premium rates and contract language have been filed with and not disapproved by the commissioner.

(c) The plan provides at least a bronze level of coverage, as determined under s. 636.30 (1) (e), unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage.

(d) The plan's cost–sharing requirements do not exceed the limits established under section 1302 (c) (1) of the federal act and, if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302 (c) (2) of the federal act.

(e) The health carrier offering the plan satisfies all of the following:

1. Is licensed and in good standing to offer health insurance coverage in this state.

2. Offers at least one qualified health plan in the silver level and at least one qualified health plan in the gold level through each component of the exchange in which the carrier participates. In this subdivision, "component" refers to the SHOP Exchange and the exchange for individual coverage.

3. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered directly from the carrier or through an insurance intermediary.

4. Does not charge any cancellation fees or penalties in violation of s. 636.25 (3).

5. Complies with the regulations developed by the secretary under section 1311 (d) of the federal act and such other requirements as the authority may establish.

(f) The plan meets the requirements of certification as required by any rules promulgated under s. 636.46 (1) and by the secretary under section 1311 (c) of the federal act, including minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance.

(g) The authority determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(2) The authority shall not exclude a health benefit plan for any of the following reasons or in any of the following ways:

(a) On the basis that the plan is a fee–for–service plan.

(b) Through the imposition of premium price controls by the authority.

(c) On the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the authority determines are inappropriate or too costly.

(3) The authority shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to do all of the following:

(a) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet Web site. The authority shall take this information, along with the information and the recommendations provided to the authority by the commissioner under section 2794 (b) of the federal Public Health Service Act (42 USC 300gg–94 (b)), into consideration when determining whether to allow the carrier to make the plan available through the authority exchange

(b) 1. Make available to the public, in the format described in subd. 2., and submit to the authority, the secretary, and the commissioner, accurate and timely disclosure of all of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost–sharing and payments with respect to any out–of–network coverage.

h. Information on enrollee and participant rights under title I of the federal act.

i. Other information as determined appropriate by the secretary.

2. The information required in subd. 1. shall be provided in plain language, as that term is defined in section 1311 (e) (3) (B) of the federal act.

(c) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost–sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(4) The authority ~~shall~~ may not exempt any health carrier seeking certification of a health benefit plan as a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of

this section in a manner that assures equitable treatment of all health carriers participating in the exchange.

(5) (a) The provisions of this chapter that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with pars. (b), (c), and (d) or by regulations adopted by the authority.

(b) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(c) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary under section 1302 (b) (1) (J) of the federal act and such other dental benefits as the authority or the secretary may specify by regulation.

(d) Carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

636.43 Insurer requirements. (1) Any health carrier that is authorized to do business in this state in one or more lines of insurance that includes health insurance may offer health benefit plans through the exchange. After the exchange becomes operational, no health carrier may offer or issue a health benefit plan in this state to an individual or to a small employer except through the exchange.

(2) For the purpose of determining premiums, a carrier may pool together all individuals and employees who have coverage under all of the qualified health plans issued by the carrier through the exchange.

(3) A carrier that offers qualified health plans through the exchange shall establish a toll–free hotline for providing information to enrollees and other individuals and shall furnish such reasonable reports as the authority determines necessary for the administration of the exchange.

(4) The authority may audit any carrier that provides coverage under a qualified health plan through the exchange for the purpose of ensuring that the carrier is providing covered individuals with the benefits provided for under this subchapter in a manner that does all of the following:

(a) Complies with the provisions of this chapter.

(b) Promotes positive health outcomes.

(c) Advances value–based and evidence–based medical practices.

(d) Avoids unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess care delivery capacity.

(e) Holds down the growth of health care costs.

636.44 Intermediaries. An insurance intermediary that enrolls a qualified individual in a qualified health plan through the exchange shall be paid a commission by the carrier offering the qualified health plan. An insurance intermediary that enrolls the employees of a qualified employer in one or more qualified health plans through the exchange shall be paid a commission by each carrier offering a qualified health plan selected by an employee of the qualified employer. The authority shall determine the commission amounts that must be paid

to intermediaries under this section after considering information provided to the commissioner under s. 628.81 with respect to health insurance.

636.45 Funding; publication of costs. (1) For payment of administrative expenses, the authority may impose a surcharge on each health carrier offering qualified health plans through the exchange. The surcharge shall be based on the carrier's total premium or flat dollar amount per enrollee collected through the exchange.

(2) The authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the authority, and the administrative costs of the authority, on an Internet Web site to educate consumers on such costs. This information shall include information on moneys lost to waste, fraud, and abuse.

636.46 Rules; application form. (1) The commissioner may promulgate rules to implement the provisions of this chapter. Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the secretary under the federal act.

(2) The commissioner shall develop a standard application form for use in the exchange.

636.48 Relation to other laws. Nothing in this chapter, and no action taken by the authority under this chapter, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules promulgated and orders issued by the commissioner.

SUBCHAPTER III

BADGER HEALTH BENEFIT AUTHORITY

636.70 Creation and organization of authority. **(1)** There is created a public body corporate and politic to be known as the "Badger Health Benefit Authority." The board of directors of the authority shall consist of the commissioner, or his or her designee; the secretary of employee trust funds, or his or her designee; the person who is appointed by the secretary of health services to be the director of the Medical Assistance program, or his or her designee; the executive director, or his or her designee, of the Health Insurance Risk–Sharing Plan Authority, if that organization exists; the executive director, or his or her designee, of the Wisconsin Collaborative for Healthcare Quality, if that organization exists; the executive director, or his or her designee, of the the Wisconsin Health Information Organization, if that organization exists; and all of the following members, who shall be nominated by the governor, and with the advice and consent of the senate appointed for 3–year terms except as provided in sub. (2):

(a) A member in good standing of the American Academy of Actuaries.

(b) A health economist.

(c) An employee benefits specialist.

(d) A representative of small employers.

(e) A representative of an organization that represents consumer interests.

(f) A representative of organized labor.

(g) An individual with experience in health care administration.

(2) No member of the board appointed under sub. (1) (a) to (g) may be a health care provider, as defined in s. 146.81 (1) (a) to (hp); an employee of a health care

provider, as defined in s. 146.81 (1) (i) to (p); an employee of an insurer that is authorized to do business in the state; or an insurance intermediary.

(3) A vacancy on the board shall be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

(4) A member of the board shall receive no compensation for services under this chapter but shall be reimbursed for actual and necessary expenses, including travel expenses, incurred in the discharge of the member's duties under this chapter.

(5) The commissioner or the commissioner's designee shall be the chairperson of the board. Seven members of the board constitute a quorum for the purpose of conducting the business and exercising the powers of the authority, notwithstanding the existence of any vacancy. The board may take action upon a vote of a majority of the members present, unless the bylaws of the authority require a larger number.

(6) The board shall appoint an executive director who shall not be a member of the board and who shall serve at the pleasure of the board. The executive director shall receive compensation commensurate with the duties of the office, as determined by the board. The executive director shall serve as secretary of the authority and shall keep a record of the proceedings of the authority and shall be custodian of all books, documents, and papers filed with the authority, the minute book or journal of the authority, and its official seal. The executive director or other person may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates. The executive director shall have all of the following duties:

(a) Supervising the administrative affairs and the general management and operation of the authority.

(b) Planning, directing, coordinating, and executing administrative functions in conformity with the policies and directives of the board.

(c) Employing professional and clerical staff, as necessary.

(d) Reporting to the board on all operations under his or her control and supervision.

(e) Preparing an annual budget and managing the administrative expenses of the authority.

(f) Undertaking any activities necessary to implement the powers and duties set forth in this chapter.

636.72 Authority duties. In addition to all other duties imposed under this chapter, the authority shall do all of the following:

(1) Establish its annual budget and monitor its fiscal management.

(2) No later than two years after an exchange under subch. II begins operation, and annually thereafter, submit a report to the legislature under s. 13.172 (2) and to the governor on the operation of any exchange under subch. II, including a review of all of the following:

(a) Progress toward the goals of the exchange.

(b) The operations and administration of the exchange.

(c) The types of health insurance plans available to eligible individuals and groups and the percentage of the total exchange enrollees served by each plan.

(d) Surveys and reports on the insurers' experiences with different plans, including aggregated data on enrollees, claims, statistics, complaint data, and enrollee satisfaction data.

(e) Significant observations regarding utilization and adoption of the exchange.

(3) Annually submit to the governor and the legislative audit bureau a statement of its activities and financial condition.

(4) Approve the use of any trademarks, seals, or logos by participating insurers and small employers.

(5) Comply with the requirements of s. 16.413 as if the authority is a state agency.

636.74 Authority powers. The authority has all of the powers necessary or convenient to carry out its duties under this chapter, except that it may not acquire or hold title to real estate or issue bonds. In addition, the authority may do any of the following:

(1) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.

(2) Have a seal and alter the seal at pleasure; have perpetual existence; and maintain an office.

(3) Hire employees, define their duties, and fix their rate of compensation.

(4) Delegate by resolution to one or more of its members any powers and duties that it considers proper.

(5) Incur debt.

(6) Appoint any technical or professional advisory committee that the authority finds necessary to assist the authority in exercising its duties and powers. If the authority appoints a committee, the authority shall define the duties of the committee and provide reimbursement for the expenses of the committee.

(7) Accept gifts, grants, loans, or other contributions from private or public sources.

(8) Procure liability insurance.

(9) Sue and be sued in its own name and plead and be impleaded.

(10) Execute contracts and other instruments, including contracts for professional or technical services required for the authority or the operation of an exchange under subch. II.

636.76 Contracting for professional services. (1) Whenever contracting for professional services, the authority shall solicit competitive sealed bids or competitive sealed proposals, whichever is appropriate. Each request for competitive sealed proposals shall state the relative importance of price and other evaluation factors.

(2) (a) When the estimated cost exceeds $25,000, the authority may invite competitive sealed bids or proposals by publishing a class 2 notice under ch. 985 or by posting notice on the Internet at a site determined or approved by the authority. The notice shall describe the contractual services to be purchased, the intent to make the procurement by solicitation of bids or proposals, any requirement for surety, and the date the bids or proposals will be opened, which shall be at least 7 days after the date of the last insertion of the notice or at least 7 days after the date of posting on the Internet.

(b) When the estimated cost is $25,000 or less, the authority may award the contract in accordance with simplified procedures established by the authority for such transactions.

(c) For purposes of clarification, the authority may discuss the requirements of the proposed contract with any person who submits a bid or proposal and shall

permit any offerer to revise his or her bid or proposal to ensure its responsiveness to those requirements.

(3) (a) The authority shall determine which bids or proposals are reasonably likely to be awarded the contract and shall provide each offerer of such a bid or proposal a fair and equal opportunity to discuss the bid or proposal. The authority may negotiate with each offerer in order to obtain terms that are advantageous to the authority. Prior to the award of the contract, any offerer may revise his or her bid or proposal. The authority shall keep a written record of all meetings, conferences, oral presentations, discussions, negotiations, and evaluations of bids or proposals under this section.

(b) In opening, discussing, and negotiating bids or proposals, the authority may not disclose any information that would reveal the terms of a competing bid or proposal.

(4) (a) After receiving each offerer's best and final offer, the authority shall determine which proposal is most advantageous and shall award the contract to the person who offered it. The authority's determination shall be based only on price and the other evaluation factors specified in the request for bids or proposals. The authority shall state in writing the reason for the award and shall place the statement in the contract file.

(b) Following the award of the contract, the authority shall prepare a register of all bids or proposals.

636.78 Political activities. (1) No employee of the authority may directly or indirectly solicit or receive subscriptions or contributions for any partisan political party or any political purpose while engaged in his or her official duties as an employee. No employee of the authority may engage in any form of political activity

calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office while engaged in his or her official duties as an employee or engage in any political activity while not engaged in his or her official duties as an employee to such an extent that the person's efficiency during working hours will be impaired or that he or she will be tardy or absent from work. Any violation of this section is adequate grounds for dismissal.

(2) If an employee of the authority declares an intention to run for partisan political office, the employee shall be placed on a leave of absence for the duration of the election campaign and if elected shall no longer be employed by the authority on assuming the duties and responsibilities of such office.

(3) An employee of the authority may be granted, by the executive director, a leave of absence to participate in partisan political campaigning.

(4) Persons on leave of absence under sub. (2) or (3) shall not be subject to the restrictions of sub. (1), except as they apply to the solicitation of assistance, subscription, or support from any other employee in the authority.

636.80 Financial disclosure. (1) In this section, "individual required to file" means a person who is a member of the board of the authority or the executive director of the authority.

(2) Each individual who in January of any year is an individual required to file shall file with the government accountability board no later than April 30 of that year a statement of economic interests meeting each of the requirements of s. 19.44 (1). The information contained on the statement shall be current as of December 31 of the preceding year.

(3) An individual required to file shall file with the government accountability board a statement of economic interests meeting each of the requirements of s. 19.44

(1) no later than 21 days following the date he or she assumes a position on the board or the position of executive director if the individual required to file has not previously filed a statement of economic interests with the government accountability board during that year. The information on the statement shall be current as per the date he or she assumes the position.

(4) If an individual required to file fails to make a timely filing, the government accountability board shall promptly provide notice of the delinquency to the secretary of administration, and to the executive director of the authority, or the chairperson of the board if the executive director's filing is untimely. Upon such notification, both the secretary of administration and the executive director, or chairperson, shall withhold all payments for compensation, reimbursement of expenses, and other obligations to the individual until the government accountability board notifies those to whom notice of the delinquency was provided that the individual has complied with this section.

(5) On its own motion or at the request of any individual required to file a statement of economic interests, the government accountability board may extend the time for filing or waive any filing requirement if the government accountability board determines that the literal application of the filing requirements of this subchapter would work an unreasonable hardship on that individual or that the extension of the time for filing or waiver is in the public interest. The government accountability board shall set forth in writing as a matter of public record its reason for the extension or waiver.

(6) (a) Any person who violates this section may be required to forfeit not more than $500 for each violation. If the court determines that the accused has realized economic gain as a result of the violation, the court may, in addition, order the

accused to forfeit the amount gained as a result of the violation. The attorney general, when so requested by the government accountability board, shall institute proceedings to recover any forfeiture incurred under this subsection that is not paid by the person against whom it is assessed.

(b) Any person who intentionally violates this section shall be fined not less than $100 nor more than $5,000 or imprisoned not more than one year in the county jail or both.

636.82 Conflict of interest prohibited; exception. **(1)** Except in accordance with the government accountability board's advice under s. 5.05 (6a) and except as otherwise provided in sub. (2), a member of the board and the executive director may not do any of the following:

(a) Take any official action substantially affecting a matter in which the board member or executive director, a member of his or her immediate family, or an organization with which the board member or director is associated has a substantial financial interest.

(b) Use his or her office or position in a way that produces or assists in the production of a substantial benefit, direct or indirect, for the board member or executive director, one or more members of his or her immediate family either separately or together, or an organization with which the board member or executive director is associated.

(2) This section does not prohibit a board member or the executive director from taking any action concerning the lawful payment of salaries or employee benefits or reimbursement of actual and necessary expenses.

(3) (a) Any person who violates this section may be required to forfeit not more than $5,000 for each violation. If the court determines that the accused has realized

economic gain as a result of the violation, the court may, in addition, order the accused to forfeit the amount gained as a result of the violation. The attorney general, when so requested by the government accountability board, shall institute proceedings to recover any forfeiture incurred under this subsection that is not paid by the person against whom it is assessed.

(b) Any person who intentionally violates this section shall be fined not less than $100 nor more than $5,000 or imprisoned not more than one year in the county jail or both.

636.84 Liability; expenses; limitations. **(1)** Neither the state, nor any political subdivision of the state, nor any officer, employee, or agent of the state or a political subdivision who is acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

(2) All of the expenses incurred by the authority in exercising its duties and powers under this chapter shall be payable only from funds of the authority.

(3) A cause of action may arise against and civil liability may be imposed on the authority for its acts or omissions or for any act or omission of a member of the board, the executive director, or an employee of the authority in the performance of his or her powers and duties under this chapter.

(4) A cause of action may not arise against and civil liability may not be imposed on a member of the board, the executive director, or an employee of the authority for any act or omission in the performance of his or her powers and duties under this chapter, unless the person asserting liability proves that the act or omission constitutes willful misconduct or intentional violation of the law. The member of the board, executive director, or employee who performed the act or omission that formed the basis of liability shall be jointly liable with the authority if that board member,

executive director, or employee fails to cooperate with the authority in defense of the claim and if the failure to cooperate affects the defense of the action.

(5) The amount recoverable by any person for any damages, injuries, or death in any civil action or civil proceeding against the authority, including any such action or proceeding based on contribution or indemnification, shall not exceed $100,000.

SECTION 50. Effective dates. This act takes effect on the day after publication, except as follows: July 1, 2013

(1) The repeal and recreation of section 16.417 (1) (a) 230.03 (3) of the statutes takes effect on January 1, 2012, or on the day after publication, whichever is later.

(2) The treatment of section 635.18 (1) of the statutes takes effect on January 1, 2014.

(END)

INSERT 23–6

SECTION 1. 230.03 (3) of the statutes, as affected by 2011 Wisconsin Act 32 and 2013 Wisconsin Act ....(this act), is repealed and recreated to read:

230.03 **(3)** "Agency" means any board, commission, committee, council, or department in state government or a unit thereof created by the constitution or statutes if such board, commission, committee, council, department, unit, or the head thereof, is authorized to appoint subordinate staff by the constitution or statute, except the Board of Regents of the University of Wisconsin System, a legislative or judicial board, commission, committee, council, department, or unit thereof or an authority created under subch. II of ch. 114, subch. III of ch. 149, or subch. III of ch. 636 or under ch. 231, 232, 233, 234, 237, 238, or 279. "Agency" does not mean any local unit of government or body within one or more local units of government that is created by law or by action of one or more local units of government.

NOTE: NOTE: Sub. (3) is shown as affected by 2011 Wis. Acts 10 and 229 and as merged by the legislative reference bureau under s. 13.92 (2) (i). Sub. (3) is affected by 2011 Wis. Acts 10, 32, and 229 and merged by the legislative reference bureau under s. 13.92 (2) (i) effective 7–1–13 to read:NOTE:

(3) "Agency" means any board, commission, committee, council, or department in state government or a unit thereof created by the constitution or statutes if such board, commission, committee, council, department, unit, or the head thereof, is authorized to appoint subordinate staff by the constitution or statute, except the Board of Regents of the University of Wisconsin System, a legislative or judicial board, commission, committee, council, department, or unit thereof or an authority created under subch. II of ch. 114 or subch. III of ch. 149 or under ch. 231, 232, 233, 234, 237, 238, or 279. "Agency" does not mean any local unit of government or body within one or more local units of government that is created by law or by action of one or more local units of government.

History: 1971 c. 270; 1973 c. 333; 1977 c. 196 ss. 24, 100; 1977 c. 418; 1981 c. 20, 26; 1983 a. 27 ss. 1604, 2200 (15); 1983 a. 409, 453, 538; 1987 a. 32; 1989 a. 31; 1991 a. 101, 147; 1993 a. 16, 254; 1995 a. 27, 255; 1997 a. 27; 1999 a. 65, 87; 2001 a. 16, 103; 2003 a. 33 ss. 2385 to 2387s, 9160; 2005 a. 22, 74, 335, 393; 2007 a. 20, 97; 2009 a. 28; 2011 a. 7, 10, 32, 229; s. 13.92 (2) (i); s. 35.17 correction in (14) (intro.).

(END INSERT 23–6)

Parisi, Lori

From: Nilsestuen, Joel
Sent: Friday, February 08, 2013 3:29 PM
To: LRB.Legal
Subject: Draft Review: LRB -1262/1 Topic: Badger Health Benefit Authority and health insurance exchanges

Please Jacket LRB -1262/1 for the SENATE.