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Date of enactment: **April 27, 1992**
1991 Assembly Bill 655 Date of publication*: **May 11, 1992**

# 1991 WISCONSIN ACT 250

AN ACT ***to repeal*** 635.02 (4); ***to renumber and amend*** 619.12 (2) (e); ***to amend*** 150.03, 150.11 (1), 150.11 (5), 150.13, 185.983 (1) (intro.), 600.01 (2) (b), 613.03 (3), 628.36 (2) (b) 1, 3 and 5, 631.01 (4), 632.89 (2) (b) (title) and 1, 632.89 (2) (c) 2. b., 632.89 (2) (d) 2, 635.02 (2), 635.02 (6), 635.05 (1) and (2) (intro.) and (a) 1 to 3, 635.07 (1) (intro.), (2) and (3), 635.09, 635.11 (intro.) and (1), 635.13 and 635.15; ***to repeal and recreate*** subchapter III of chapter 150 and 635.02 (7); and ***to create*** 15.195 (10), 15.197 (10), 15.735, 36.11 (25), 38.04 (24), 49.45 (34), (35) and (35m), 50.02 (6), 115.28 (37), 146.905, 150.01 (4m), (6m), (6r) and (12m), subchapter IV of chapter 150, subchapter V of chapter 150, subchapter VI of chapter 150, subchapter VII of chapter 150, 153.05 (4m), 153.48, 185.983 (1g), 230.08 (2) (mp), 619.12 (2) (e) 2. and 3., 619.123, 632.70, 632.725, 632.89 (1) (f), 632.89 (2) (dm), 632.89 (4), 635.02 (1c), 635.02 (3c), (3f), (3j) and (3m), 635.02 (5m), 635.02 (6m), 635.02 (8), 635.17, 635.18 and subchapter II of chapter 635 of the statutes; and ***to affect*** 1983 Wisconsin Act 27, section 2020 (17), **relating to:** medical assistance manuals, training and computer system; directing the board of regents of the university of Wisconsin system, the board of vocational, technical and adult education and the state superintendent of public instruction to promote public awareness of, access to and training of health professionals; establishing a Wisconsin cost containment commission and a cost containment council; establishing capital expenditure review for hospitals; requiring public hearings for certain hospital rate increases; establishing regulation of certain cooperative agreements under issuance of certificates of public advantage; limiting certain expenditures for, and numbers of, approved hospital beds; requiring investigation of the concept of regulating rural medical centers; requiring public review prior to initiation of certain health care projects; limiting certain expenditures for conversions to, and numbers of, psychiatric and chemical dependency beds; prohibiting health care provider fee reductions to individuals with health insurance; insurance coverage of transitional services for the treatment of nervous or mental disorders or alcoholism or other drug abuse; creating a task force on health cost containment; insurance coverage of transitional treatment arrangements for the treatment of nervous or mental disorders or alcoholism or other drug abuse; standardization of health care billing and health insurance claim forms; establishment of a uniform statewide patient identification system; the development of a funding plan for family practice residency programs; establishing a health insurance plan for employes of small employers and creating a board to develop and oversee the plan; establishing certain standards for insurers for underwriting and the treatment of preexisting conditions for small employer health insurance; establishing fair marketing standards for small employer health insurance; providing exemptions from emergency rule procedures; and granting rule–making authority.

***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

**SECTION 1.** 15.195 (10) of the statutes is created to read:

15.195 **(10)** WISCONSIN COST CONTAINMENT COMMISSION. There is created a Wisconsin cost containment commission, which is attached to the department of health and social services under s. 15.03. No member of the commission may have a financial interest in a hospi-

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tal, as defined in s. 50.33 (2). Any member who voluntarily assumes a financial interest in a hospital shall vacate the office. Any member who involuntarily assumes a financial interest in a hospital shall divest himself or herself of the interest within a reasonable time or shall vacate the office.

**SECTION 2.** 15.197 (10) of the statutes is created to read:

15.197 **(10)** COST CONTAINMENT COUNCIL. There is created a cost containment council. The council shall consist of 11 members appointed for 4–year terms, who shall represent a balance of economic, provider, scientific, government and consumer viewpoints. No more than 3 members may be state employes. The following members shall be appointed from the following groups of nominees:

(a) Three members nominated by the Wisconsin hospital association.

(b) One member nominated by the state medical society of Wisconsin. This member shall be a physician, as defined in s. 448.01 (5).

(c) One member nominated by the largest service insurance corporation licensed under ch. 613. Determination of size under this paragraph is based on premium volume, as reported in the most recent Wisconsin insurance commissioner's report on business.

(d) One member nominated by the Wisconsin association of life and health insurers.

(e) One member nominated by the Wisconsin nurses association. This member shall be a registered nurse licensed under s. 441.06.

**SECTION 3.** 15.735 of the statutes is created to read:

**15.735 Same; attached boards.** **(1)** SMALL EMPLOYER INSURANCE BOARD. There is created a small employer insurance board which is attached to the office of the commissioner of insurance under s. 15.03. The board shall consist of 11 members. Notwithstanding s. 15.07 (2) (intro.), one member shall be the commissioner of insurance, or his or her designee, who shall be a nonvoting member and who shall serve permanently as chairperson of the board. The other 10 members shall be nominated by the governor, and with the advice and consent of the senate appointed, for 3–year terms. Five members shall represent employers that are eligible to participate in the plan under subch. II of ch. 635, and 5 members shall represent employes of employers that are eligible to participate in the plan under subch. II of ch. 635.

**SECTION 4.** 36.11 (25) of the statutes is created to read:

36.11 **(25)** TRAINING OF HEALTH PROFESSIONALS. The board shall promote public awareness of, access to and training of health professionals for rural and underserved urban areas.

**SECTION 5.** 38.04 (24) of the statutes is created to read:

38.04 **(24)** TRAINING OF HEALTH PROFESSIONALS. The board shall promote public awareness of, access to and training of health professionals for rural and underserved urban areas.

**SECTION 6.** 49.45 (34), (35) and (35m) of the statutes are created to read:

49.45 **(34)** MEDICAL ASSISTANCE MANUAL. The department shall prepare a medical assistance manual that is clear, comprehensive and consistent with ss. 49.43 to 49.47 and 42 USC 1396a to 1396u and shall, no later than July 1, 1992, provide the manual to counties for use by county employes who administer the medical assistance program.

**(35)** TRAINING FOR NONPROFIT ORGANIZATIONS. The department shall provide training to employes and volunteers of private nonprofit organizations concerning medical assistance eligibility under s. 49.47 of persons whose incomes exceed the levels under s. 49.47 (4) (am) and (c) 1. before consideration, under s. 49.47 (4) (c) 2., of the level of those persons' medical expenses.

**(35m)** COMPUTER SYSTEM REDESIGN. The department shall ensure that any redesign or replacement of the computer network that is used by counties on the effective date of this subsection .... [revisor inserts date], to determine eligibility for medical assistance includes the capability of determining eligibility for medical assistance under s. 49.47 (4) (c) 2.

**SECTION 7.** 50.02 (6) of the statutes is created to read:

50.02 **(6)** REGULATION OF RURAL MEDICAL CENTERS. The department shall investigate the concept of regulating a new category of health care providers, known as rural medical centers.

**SECTION 8.** 115.28 (37) of the statutes is created to read:

115.28 **(37)** TRAINING OF HEALTH PROFESSIONALS. Promote public awareness of, access to and training of health professionals for rural and underserved urban areas.

**SECTION 9.** 146.905 of the statutes is created to read:

**146.905 Reduction in fees prohibited.** **(1)** Except as provided in sub. (2), a health care provider, as defined in s. 146.81 (1), or a pharmacist licensed under ch. 450, that provides a service or a product to an individual with coverage under a disability insurance policy, as defined in s. 632.895 (1) (a), may not reduce or eliminate or offer to reduce or eliminate coinsurance or a deductible required under the terms of the disability insurance policy.

**(2)** Subsection (1) does not apply if payment of the total fee would impose an undue financial hardship on the individual receiving the service or product.

**SECTION 10.** 150.01 (4m), (6m), (6r) and (12m) of the statutes are created to read:

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150.01 **(4m)** "Approved bed capacity" means the bed count collected and verified by the department and by a hospital.

**(6m)** "Capital expenditure limit" means the maximum amount of capital expenditures that may be approved under subch. III.

**(6r)** "Commission" means the Wisconsin cost containment commission.

**(12m)** "Innovative medical technology" means equipment or procedures that are potentially useful for diagnostic or therapeutic purposes and that introduce new technology in the diagnosis and treatment of illness.

**SECTION 11.** 150.03 of the statutes is amended to read:

**150.03 Rule making; forms.** The department shall adopt rules and set standards to administer ~~this chapter~~ subchs. I and II. The department shall create the forms to be used and timetables to be followed under subchs. I and II in applying for an approval and in applying for the renewal or modification of an approval. The department shall issue a statement of the applicable rules and procedures to be followed in reviewing an application under subchs. I and II with each application form.

**SECTION 12.** 150.11 (1) of the statutes is amended to read:

150.11 **(1)** The department may refuse to issue or renew, under s. 50.03, any license for a nursing home, and may withhold, suspend or revoke, under s. 50.35, any approval for a hospital, that fails to comply with this chapter.

**SECTION 13.** 150.11 (5) of the statutes is amended to read:

150.11 **(5)** The department may reject the application for approval of a project operated by any person who has repeatedly been subject to the penalties specified in this section or may impose restrictions as part of its approval to ensure compliance with ~~this chapter~~ subchs. I, II and III.

**SECTION 14.** 150.13 of the statutes is amended to read:

**150.13 Fees.** Any person applying for approval under ~~this chapter~~ subch. I or II shall pay an application fee equal to 0.37% of the estimated project cost, but not less than $1,850 and not more than $37,000. No application is complete without payment of the correct fee.

**SECTION 15.** Subchapter III of chapter 150 of the statutes is repealed and recreated to read:

**CHAPTER 150**

SUBCHAPTER III

CAPITAL EXPENDITURE REVIEW PROGRAM

**150.61 Applicability.** Beginning July 1, 1993, no person may do any of the following without first obtaining the commission's approval:

**(1)** Except as provided in s. 150.613, obligate for a capital expenditure, by or on behalf of a hospital, that exceeds $1,000,000. The cost of the studies, surveys, plans and other activities essential to the proposed capital expenditure shall be included in determining the value of the capital expenditure. Any donation of equipment or facilities that, if acquired directly, would be subject to review under this subchapter is a capital expenditure. Any transfer of equipment or facilities for less than fair market value that, if transferred at fair market value, would be subject to review under this subchapter is a capital expenditure.

**(2)** Implement services new to the hospital that exceed $500,000 in a 12–month period, including an organ transplant program, burn center, neonatal intensive care program, cardiac program or air transport services, implement other services or programs specified by the commission by rule or, after June 30, 1996, add psychiatric or chemical dependency beds.

**(3)** Obligate for an expenditure, by or on behalf of a hospital, independent practitioner, partnership, unincorporated medical group or service corporation as defined in s. 180.1901 (2), that exceeds $500,000 for clinical medical equipment.

**(4)** Purchase or otherwise acquire a hospital.

**(5)** Construct or operate an ambulatory surgery center or a home health agency.

**150.613 Exemptions from capital expenditure review. (1)** Section 150.61 does not apply if a person has, prior to July 1, 1993, entered into a legally enforceable contract, promise or agreement with another to do any of the activities specified in s. 150.61 (1) to (5).

**(2)** A person may obligate for a capital expenditure, by or on behalf of a hospital, without obtaining the approval of the commission if the expenditure is for heating, air conditioning, ventilation, electrical systems, energy conservation, telecommunications, computer systems or nonsurgical outpatient services, unless any of the above is a constituent of another project reviewable under s. 150.61 or unless expenditures for any of the above would exceed 20% of a hospital's gross annual patient revenue for its last fiscal year.

**150.63 Innovative medical technology exemption. (1)** In this section:

(a) "Clinical trial" means clinical research conducted under approved protocols in compliance with federal requirements applicable to investigations involving human subjects, including the requirement for an informed consent advising the patient clearly of the risks associated with participating in the clinical development and evaluation project.

(b) "Innovative medical technology" means equipment or procedures that are potentially useful for diagnostic or therapeutic purposes and that introduce new technology in the diagnosis and treatment of illness.

**(2)** The commission may grant an exemption from the requirements of approval under this subchapter for the research, development and evaluation of innovative medical technology, the development of the clinical

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applications of this technology or the research, development and evaluation of a major enhancement to existing medical technology if all of the following occur:

(a) The commission receives an application for an exemption from a person intending to undertake a capital expenditure in excess of $500,000 or intending to undertake a substantial change in a health service.

(b) Prior to applying for an exemption, preliminary animal studies or preliminary clinical investigation establishes that the innovative medical technology or major enhancement to existing medical technology has a reasonable probability of advancing clinical diagnosis or therapy.

(c) In the development and evaluation of the clinical applications the applicant undertakes scientifically sound studies to determine clinical efficacy, safety, cost–effectiveness and appropriate utilization levels in a clinical setting.

(d) The clinical trials, evaluation or research are conducted according to scientifically sound protocols subject to peer review and approval in accord with the requirements applicable to investigations and clinical evaluation involving human subjects.

(e) The innovative medical technology is being installed to conduct necessary research, development and evaluation.

(f) The applicant does not include any recovery of capital expenses incurred as part of an exemption under this section in its expense and revenue budget for purposes of rate setting, until the applicant receives the approval of the federal food and drug administration and of the commission under this subchapter for general medical use. The applicant may recover operating expenses only after all of the following occur:

1. Approval by the federal food and drug administration for safety and efficacy.

2. A 3rd party agrees to pay for these expenses.

**(3)** The commission may not grant more than 2 exemptions for any particular type of innovative medical technology or for any particular major enhancement to existing medical technology.

**150.64 Public hearing requirement. (1)** Any person intending to undertake a project or activity subject to this subchapter shall cause to be published a class 1 notice under ch. 985 in the official newspaper designated under s. 985.04 or 985.05 or, if none exists, in a newspaper likely to give notice in the area of the proposed project or activity. The notice shall describe the proposed project or activity and describe the time and place for the public hearing required under sub. (2).

**(2)** No sooner than 30 days after the date of publication of the notice under sub. (1), the person shall conduct a public hearing on the proposed project or activity. The hearing shall be on the expected impact of the proposed project or activity on health care costs, the expected improvement, if any, in the local health care delivery system, and any other issue related to the proposed project or activity. Management staff, if any, of the person seeking to undertake the project or activity and, if possible, at least 3 members of the governing board of a not–for–profit health care provider, if any, seeking to undertake the project or activity shall attend the public hearing to review public testimony. The person seeking to undertake the project or activity shall record accurate minutes of the meeting, shall include copies of the minutes and any written testimony presented at the hearing in an application concerning the project or activity that is submitted under s. 150.67 and shall submit the application within 10 days after the date of the public hearing.

**150.65 Notification requirement.** Any person intending to undertake a project subject to this subchapter shall notify the commission in writing of this intent at least 30 days prior to submitting an application for review. Any application expires unless the commission declares it complete within one year after the date the applicant notifies the commission of its intent to undertake the project.

**150.67 Review requirements. (1)** The commission's review of an application begins on the date it receives a completed application. On or before the 20th day of the month following receipt of a completed application, the commission shall send a notice of receipt of a completed application to the applicant and shall publish a class 2 notice under ch. 985 containing this information in a daily newspaper with general circulation in the area where the proposed project would be located.

**(2)** The commission may group applications for the same or similar types of facilities, services or applications that are proposed, for concurrent review. The commission shall base its review under this subsection on a comparative analysis of these applications, using the criteria specified in s. 150.69 and a ranking of its priorities. The applicant has the burden of proving, by a preponderance of the evidence, that each of the criteria specified in s. 150.69 has been met or does not apply to the project. The commission shall, by rule, establish its review requirements under this subsection.

**150.69 Review criteria.** The commission shall use the following criteria in reviewing each application under this subchapter, plus any additional criteria it develops by rule. The commission shall consider cost containment as its first priority in applying these criteria, and shall consider the recommendations and comments of affected parties. The commission may not approve any project under this subchapter unless the applicant demonstrates:

**(1)** The project is consistent with the state health services plan under s. 150.82.

**(2)** A need for the project, as determined by current and projected utilization.

**(3)** The project would efficiently and economically use resources, including financing for capital investment

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and operating expenses, when measured against alternative uses of resources.

**(4)** Sufficient cash reserves and cash flow to pay operating and capital costs.

**(5)** Increases in operating and capital costs resulting from the project are reasonable, including the direct charge to the consumer, the applicant's projected request for rate increases under ch. 52 and the charges to be paid by medical assistance and by disability insurers. The commission shall determine the effect on these rates of the applicant's project for review under this subsection.

**(6)** Financing is available at market rates.

**(7)** Health care personnel are available and would be effectively used.

**(8)** Proposed construction costs are consistent with industry averages.

**(9)** Any proposed addition of area and construction or renovation alternatives are cost–effective.

**(10)** The project is consistent with efficiency standards and criteria.

**(11)** The applicant is participating in a utilization review program that is applicable to a statistical sampling of all hospital patients regardless of payment source, that requires public disclosure of all review data in a form useful to the commission but protects the identities of individual patients and health care professionals and that is conducted by persons who are free of any substantial conflict of interest.

**(12)** The applicant has prepared a plan acceptable to the commission for the provision of health care to indigents.

**150.71 Review process. (1)** The commission shall hold a public meeting upon the request of an affected party to review projects seeking approval, at which all affected parties may present testimony. The commission may consider projects seeking approval that are within a related area at joint public meetings. The commission shall keep minutes or other record of testimony presented at the public meeting.

**(2)** The commission shall issue an initial finding to approve or reject the project within 75 days after the date it publishes its notice under s. 150.67 (1), unless all applicants consent to an extension of this period. The commission may not require substantial modification of any project as a condition of approval without the applicant's consent. The commission may extend by 60 days the review cycle of all projects being reviewed concurrently under s. 150.67 (2), if it finds that completing the reviews within 75 days after the date it publishes its notice under s. 150.67 (1) is not practicable due to the volume of applications received. The commission shall submit its decision to the applicant. Unless the applicant makes a timely request for a hearing under sub. (3), the commission's initial finding under this subsection is its final action.

**(3)** (a) Any applicant whose project is rejected may request a public hearing to review the commission's initial finding under sub. (2), if the request is submitted in writing within 10 days after the commission's decision, or may initiate a hearing under s. 227.42. The commission shall commence the hearing under sub. (2) within 30 days after receiving a timely request, unless all parties consent to an extension of this period.

(b) Except as provided in s. 227.42, ss. 227.43 to 227.50 do not apply to hearings under this subsection. The commission shall promulgate rules to establish:

1. Procedures for scheduling hearings under this subsection.

2. Procedures for conducting hearings under this subsection, including methods of presenting arguments, cross–examination of witnesses and submission of exhibits.

3. Procedures following the completion of a hearing under this subsection, including the establishment of time limits for issuance of a decision.

4. Standards relating to ex parte communication in hearings under this subsection.

5. Procedures for reconsideration and rehearing.

(c) The commission shall issue all decisions in writing.

(d) Each applicant at any hearing under this subsection has the burden of proving, by clear and convincing evidence, that the commission's initial finding was contrary to the weight of the evidence on the record when considered as a whole, arbitrary and capricious or contrary to law.

**150.73 Judicial review.** Any applicant adversely affected by a decision of the commission under s. 150.71 (3) may petition for judicial review of the decision under s. 227.52. The scope of judicial review shall be as provided in s. 227.57 and the record before the reviewing court shall consist of:

**(1)** The application and all supporting material received prior to the commission's initial finding under s. 150.71 (2).

**(2)** The record of the public meeting under s. 150.71 (1).

**(3)** The commission's analysis of the project and its compliance with the criteria specified in s. 150.69.

**(4)** The record of the hearing held under s. 150.71 (3).

**(5)** The commission's decision and analysis issued under s. 150.71 (2) or (3) (c).

**150.75 Validity and contents of an approval. (1)** An approval is valid for one year from the date of issuance. The commission may grant a single extension of up to 6 months.

**(2)** The commission shall specify the maximum expenditure that may be obligated for a project.

**(3)** Each approval shall include the proposed timetable for implementing and completing the project and, for

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the 3–year period following completion of the project, the project's depreciation and interest schedule, staff required for the project, the proposed per diem rate needed to pay capital costs and the proposed per diem rate needed to pay operating costs.

**150.76 Rate approval.** Rate reimbursement to cover the cost of the project established for medical assistance under s. 49.45 (3) (e) may not exceed the rates proposed in the approval under s. 150.75 (3) by more than 5% during the 3–year period following completion of the project. This section does not apply if the hospital demonstrates to the satisfaction of the commission that the excess was due to conditions beyond its control.

**150.77 Capital budget reporting.** Each hospital shall annually, by January 1, beginning January 1, 1993, report to the commission a proposed capital budget for the 5–year period that begins with July 1, 1993. This budget shall specify all anticipated capital expenditures subject to this subchapter and anticipated application dates, if any. This requirement does not apply to purchase or other acquisitions of a hospital under s. 150.61 (4). No application from a hospital under s. 150.65 to approve a project is complete until the commission receives this information.

**150.78 Rule making.** The commission shall promulgate all of the following rules:

**(1)** Establishing review requirements under s. 150.67 (2).

**(2)** Establishing procedures and standards under s. 150.71 (3) (b).

**(3)** Establishing a method for defining an acute care service area under s. 150.82 (2).

**150.80 Cost containment council.** The cost containment council shall:

**(1)** Advise the commission on matters relating to implementing this chapter, to containing hospital costs and to maintaining the quality of health care.

**(2)** Review and comment on proposed commission rules prior to the date that the commission proposes its rules in final draft form. The council shall complete its review and submit its comments to the commission within time limits specified by the commission. The commission shall transmit the written majority and minority comments, if any, of the council to the presiding officer of each house of the legislature under s. 227.19 (2).

**(3)** Periodically issue reports concerning:

(a) The performance of the commission and its operations.

(b) The degree to which general relief under s. 49.02, medical assistance under ss. 49.43 to 49.499 and medicare under 42 USC 1395 to 1395ccc do not pay rates equal to the rates paid by nongovernment payers. Reports under this paragraph shall be issued annually and shall discuss these effects on both a statewide and individual hospital basis.

(c) The policy implications to hospitals and nongovernment payers of discounts granted to nongovernment payers. Reports under this paragraph shall be issued annually.

**(4)** Develop, review and recommend to the commission for adoption under s. 150.82 a state health services plan that includes a description of the hospital system in this state; identifies health care needs and surpluses with respect to existing health care services, facilities and equipment; and meets other requirements of the plan that are specified in s. 150.82.

**(6)** Prepare written minutes of each of its meetings.

**150.81 Enforcement. (1)** No person may recover through charges or rates any depreciation, interest or principal payments or any operating expenses associated with a project subject to this subchapter that does not have the commission's approval.

**(2)** (a) If a project whose cost falls below the minimum threshold specified in s. 150.61 (1), (2) or (3) incurs costs exceeding the threshold, the person who operates the project shall submit an application for the commission's approval under s. 150.61.

(b) If a project that has received the commission's approval incurs a cost overrun, the person who operates the project shall submit another application for the commission's approval under s. 150.61.

**(3)** The commission's approval of any project is revoked if the capital expenditures specified in the approval have not been obligated, if financing in an amount sufficient to complete the project has not been obtained or if substantial and continuing progress has not been undertaken within the period specified in the approval. In addition, the commission's approval of any project is revoked if the person who operates a project misses any other deadlines specified in the approval and fails to make a good faith effort to meet these deadlines.

**(4)** The commission may reject the application for approval of a project operated by any person who has repeatedly been subject to the penalties specified in this section or may impose restrictions as part of its approval to ensure compliance with this subchapter.

**150.82 State health services plan. (1)** The commission shall adopt a state health services plan, based on recommendations of the cost containment council made under s. 150.80 (4) and using information provided by the office of health care information, at least once every 3 years that includes a description of the hospital system in the state and identifies health care needs and surpluses with respect to existing health care services, facilities and equipment and other components the commission finds useful.

**(2)** The commission may not accept any application for a project under this subchapter for the addition of hospital beds that would exceed the number of beds described by the state health services plan for the acute care service area where the project would be located. The

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commission shall establish its method for defining an acute care service area by rule.

**SECTION 16.** Subchapter IV of chapter 150 of the statutes is created to read:

**CHAPTER 150**

SUBCHAPTER IV

HEALTH CARE COOPERATIVE AGREEMENTS

**150.84 Definitions.** In this subchapter:

**(1)** "Cooperative agreement" means an agreement between 2 health care providers or among more than 2 health care providers for the sharing, allocation or referral of patients; or the sharing or allocation of personnel, instructional programs, support services and facilities, medical, diagnostic or laboratory facilities or procedures or other services customarily offered by health care providers.

**(2)** "Health care facility" means a facility, as defined in s. 647.01 (4), or any hospital, nursing home, community–based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the department under s. 49.14, 49.16, 49.171, 50.02, 50.03, 50.35, 51.08, 51.09, 58.06, 149.01 or 149.02 or a facility under s. 45.365, 51.05, 51.06 or 149.06 or ch. 142.

**(3)** "Health care provider" means any person licensed, registered, permitted or certified by the department or by the department of regulation and licensing to provide health care services in this state.

**(4)** "Health maintenance organization" has the meaning given in s. 609.01 (2).

**(5)** "Preferred provider plan" has the meaning given in s. 609.01 (4).

**150.85 Certificate of public advantage. (1)** AUTHORITY. A health care provider may negotiate and voluntarily enter into a cooperative agreement with another health care provider in this state. The requirements of ch. 133 apply to the negotiations and cooperative agreement unless the parties to the agreement hold a certificate of public advantage for the agreement that is issued by the department and is in effect under this section.

**(2)** APPLICATION. Parties to a cooperative agreement may file an application with the department for a certificate of public advantage governing the cooperative agreement. The application shall include a signed, written copy of the cooperative agreement, and shall describe the nature and scope of the cooperation contemplated under the agreement and any consideration that passes to a party under the agreement.

**(3)** PROCEDURE FOR DEPARTMENT REVIEW. (a) The department shall review and approve or deny the application in accordance with the standards set forth in sub. (4) within 30 days after receiving the application. Unless the department issues a denial of the certificate of public advantage, the application is approved.

(b) If the department denies the application for a certificate of public advantage, the department shall issue the denial to the applicants in writing, including a statement of the basis for the denial and notice of the opportunity for a hearing under s. 227.44. If the applicant desires to contest the denial of an application, it shall, within 10 days after receipt of the notice of denial, send a written request for hearing under s. 227.44 to the division of hearings and appeals in the department of administration and so notify the department of health and social services.

**(4)** STANDARDS FOR CERTIFICATION. (a) The department shall issue a certificate of public advantage for a cooperative agreement if it determines all of the following:

1. That the benefits likely to result from the agreement substantially outweigh any disadvantages attributable to a reduction in competition likely to result.

2. That any reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.

(b) In order to determine that the criterion under par. (a) 1. is met, the department shall find that at least one of the following is likely to result from the cooperative agreement:

1. The quality of health care provided to residents of the state will be enhanced.

2. A hospital, if any, and health care facilities that customarily serve the communities in the area likely affected by the cooperative agreement will be preserved.

3. Services provided by the parties to the cooperative agreement will gain cost efficiency.

4. The utilization of health care resources and equipment in the area likely affected by the cooperative agreement will improve.

5. Duplication of health care resources in the area likely affected by the cooperative agreement will be avoided.

(c) In order to determine that the criterion under par. (a) 2. is met, the department shall consider all of the following:

1. The likely adverse impact, if any, on the ability of health maintenance organizations, preferred provider plans, persons performing utilization review or other health care payers to negotiate optimal payment and service arrangements with hospitals and other health care providers.

2. Whether any reduction in competition among physicians, allied health professionals or other health care providers is likely to result directly or indirectly from the cooperative agreement.

3. Whether any arrangements that are less restrictive as to competition could likely achieve substantially the same benefits or a more favorable balance of benefits over disadvantages than that likely to be achieved from reducing competition.

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**(5)** CERTIFICATE REVOCATION. (a) If the department determines that the benefits resulting from or likely to result from a cooperative agreement under a certificate of public advantage no longer outweigh any disadvantages attributable to any actual or potential reduction in competition resulting from the agreement, the department may revoke the certificate of public advantage governing the agreement and, if revoked, shall so notify the holders of the certificate. A holder of a certificate of public advantage whose certificate is revoked by the department may contest the revocation by sending a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1), within 10 days after receipt of the notice of revocation.

(b) If a party to a cooperative agreement that is issued a certificate of public advantage terminates its participation in the agreement, the party shall file a notice of termination with the department within 30 days after the termination takes effect. If all parties to the cooperative agreement terminate their participation in the agreement, the department shall revoke the certificate of public advantage for the agreement.

**(6)** RECORD KEEPING. The department shall maintain a file of all cooperative agreements for which certificates of public advantage are issued and that remain in effect.

**150.86 Judicial review.** A denial by the department under s. 150.85 (3) (b) of an application for a certificate of public advantage and a revocation by the department under s. 150.85 (5) (a) of a certificate of public advantage is subject to judicial review under ch. 227.

**SECTION 17.** Subchapter V of chapter 150 of the statutes is created to read:

**CHAPTER 150**

SUBCHAPTER V

HOSPITAL RATE INCREASES

**150.90 Definitions.** In this subchapter:

**(1)** "Consumer price index" has the meaning given in s. 16.004 (8) (e) 1.

**(2)** Notwithstanding s. 150.01 (12), "hospital" has the meaning given in s. 50.33 (2), except that "hospital" does not include a center for the developmentally disabled as defined in s. 51.01 (3).

**(3)** "Rates" means individual charges of a hospital for the services that it provides.

**150.91 Public hearing.** No hospital may increase its rates or charge any payer an amount exceeding its rates that are in effect on the effective date of this section .... [revisor inserts date], unless the hospital first does all of the following:

**(1)** Causes to be published a class 1 notice under ch. 985 in the official newspaper designated under s. 985.04 or 985.05 or, if none exists, in a newspaper likely to give notice in the area where the hospital is located. The notice shall describe the proposed rate change and the time and place for the public hearing required under sub. (2).

**(2)** No sooner than 30 days after the date of publication of the notice under sub. (1), conducts a public hearing on the proposed rate change. The hearing shall be on the expected impact of the proposed rate change on health care costs, the expected improvement, if any, in the local health care delivery system, and any other issue related to the proposed rate change. Management staff, if any, of the hospital proposing the rate change and, if possible, at least 3 members of the governing board of any not–for–profit hospital proposing the rate change shall attend the public hearing to review public testimony. The hospital shall record accurate minutes of the meeting and shall provide copies of the minutes and any written testimony presented at the hearing to the office of health care information within 10 days after the date of the public hearing.

**150.92 Exemption.** This subchapter does not apply to a hospital that proposes to increase its rates during the course of the hospital's fiscal year by any amount or amounts that, in the aggregate, do not exceed the percentage amount that is the percentage difference between the consumer price index reported for the 12–month period ending on December 31 of the preceding year and the consumer price index reported for the 12–month period ending on December 31 of the year prior to the preceding year.

**SECTION 18.** Subchapter VI of chapter 150 of the statutes is created to read:

**CHAPTER 150**

SUBCHAPTER VI

MORATORIUM ON CONSTRUCTION
OF HOSPITAL BEDS

**150.93 Moratorium on construction of hospital beds.** **(1)** The maximum number of beds of approved hospitals in this state that may be approved by the department for occupancy is 22,516.

**(2)** Except as provided in sub. (3), before July 1, 1996, no person may obligate for a capital expenditure or implement services, by or on behalf of a hospital, to increase the approved bed capacity of a hospital unless the person has, prior to the effective date of this subsection .... [revisor inserts date], entered into a legally enforceable contract, promise or agreement with another to so obligate or implement.

**(3)** A person may obligate for a capital expenditure, by or on behalf of a hospital, to renovate or replace on the same site existing approved beds of the hospital or to make new construction, if the renovation, replacement or new construction does not increase the approved bed capacity of the hospital, except that obligation for such a capital expenditure that exceeds $1,000,000 is subject to subch. III.

**(4)** No person may transfer approved beds of a hospital to a facility that is associated with the hospital.

**SECTION 19.** Subchapter VII of chapter 150 of the statutes is created to read:

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**CHAPTER 150**
SUBCHAPTER VII
PSYCHIATRIC OR CHEMICAL DEPENDENCY
BED LIMITATIONS

**150.94 Definition.** In this subchapter, notwithstanding s. 150.01 (12), "hospital" has the meaning given in s. 50.33 (2).

**150.95 Moratorium.** Before July 1, 1996, no person may obligate for a capital expenditure by or on behalf of a hospital, to add to the number of the licensed psychiatric or chemical dependency beds of the hospital that the department determines exist on the effective date of this section .... [revisor inserts date], or to establish a new hospital with psychiatric or chemical dependency beds. Before July 1, 1996, no person may convert existing hospital beds approved for occupancy to licensed psychiatric or chemical dependency beds of the hospital.

**SECTION 20.** 153.05 (4m) of the statutes is created to read:

153.05 **(4m)** The office shall provide the Wisconsin cost containment commission with information necessary for performance of duties of the Wisconsin cost containment commission under s. 150.82 (1) and as requested of the office by the Wisconsin cost containment commission.

**SECTION 21.** 153.48 of the statutes is created to read:

**153.48 Uniform accounting system.** For each fiscal year of a hospital that begins after June 30, 1993, the hospital shall use a uniform accounting system that is developed by the office and specified in rules promulgated by the department.

**SECTION 22.** 185.983 (1) (intro.) of the statutes, as affected by 1989 Wisconsin Act 336 and 1991 Wisconsin Act 39, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.93, 632.775, 632.79, 632.795, 632.87 (2m), (3) and (5), 632.895 (5) and (9) and 632.896, subch. II of ch. 619 and chs. 609, 630, 635, 645 and 646, but the sponsoring association shall:

**SECTION 23.** 185.983 (1g) of the statutes is created to read:

185.983 **(1g)** A cooperative association that is a small employer insurer, as defined in s. 635.02 (8), is subject to the health insurance mandates, as defined in s. 601.423 (1), to the same extent as any other small employer insurer, as defined in s. 635.02 (8).

**SECTION 24.** 230.08 (2) (mp) of the statutes is created to read:

230.08 **(2)** (mp) One staff director of the Wisconsin cost containment commission, created under s. 15.195 (10).

**SECTION 25.** 600.01 (2) (b) of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ch. 633 or 635.

**SECTION 26.** 613.03 (3) of the statutes is amended to read:

613.03 **(3)** APPLICABILITY OF INSURANCE LAWS. Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to subch. II of ch. 619 and ss. 610.01, 610.11, 610.21, 610.23 and 610.24 and chs. 600, 601, 609, 617, 620, 623, 625, 627, 628, 631, 632, 635 and 645 and to no other insurance laws.

**SECTION 27.** 619.12 (2) (e) of the statutes, as created by 1991 Wisconsin Act 39, is renumbered 619.12 (2) (e) 1. and amended to read:

619.12 **(2)** (e) 1. ~~No~~ Except as provided in subd. 2, no person who is eligible for health care benefits provided by an employer on a self–insured basis or through health insurance is eligible for coverage under the plan.

**SECTION 28.** 619.12 (2) (e) 2. and 3. of the statutes are created to read:

619.12 **(2)** (e) 2. Subdivision 1 does not apply to a person who is eligible for health care benefits under the small employer health insurance plan under subch. II of ch. 635 if all of the following apply:

a. The person is certified in writing by a physician licensed under ch. 448 to have a severe and chronic or long–lasting physical or mental illness or disability.

b. The board determines that the coverage under the small employer health insurance plan under subch. II of ch. 635 is not substantially equivalent to or greater than the coverage under the plan.

c. The board finds that the person is eligible for coverage under the plan after a review process, determined by the commissioner by rule under s. 619.123, that evaluates and approves the certification by the physician that the person has a severe and chronic or long–lasting physical or mental illness or disability.

3. The requirements under sub. (1) (a) to (d) do not apply to a person who is found eligible for coverage under the plan by the board under subd. 2.

**SECTION 29.** 619.123 of the statutes is created to read:

**619.123 Rules for review of physician certification.** The commissioner shall promulgate rules that establish the procedure to be used by the board under s. 619.12 (2) (e) 2. c. The rules shall provide for an insurer that would be affected by the decision of the board to participate in the review process to contest or support the physician's certification.

**SECTION 30.** 628.36 (2) (b) 1., 3. and 5. of the statutes are amended to read:

628.36 **(2)** (b) 1. Except for health maintenance organizations, preferred provider plans ~~and~~, limited service health organizations and the small employer health insurance plan under subch. II of ch. 635, no health care plan may prevent any person covered under the plan from choosing freely among providers who have agreed to par-

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ticipate in the plan and abide by its terms, except by requiring the person covered to select primary providers to be used when reasonably possible.

3. Except as provided in subd. 4, no provider may be denied the opportunity to participate in a health care plan, other than a health maintenance organization, a limited service health organization ~~or~~, a preferred provider plan or the small employer health insurance plan under subch. II of ch. 635, under the terms of the plan.

5. ~~All~~ Except for the small employer health insurance plan under subch. II of ch. 635 to the extent determined by the small employer insurance board under s. 635.23 (1) (b), all health care plans, including health maintenance organizations, limited service health organizations and preferred provider plans are subject to s. 632.87 (3).

**SECTION 31.** 631.01 (4) of the statutes is amended to read:

631.01 **(4)** GROUP POLICIES AND ANNUITIES FOR ELEEMOSYNARY INSTITUTIONS. This chapter ~~and~~, ch. 632 and the health insurance mandates under ch. 632 that apply to the plan under subch. II of ch. 635 do not apply to group policies or annuities provided on a basis as uniform nationally as state statutes permit to educational, scientific research, religious or charitable institutions organized without profit to any person, for the benefit of employes of such institutions. The commissioner may by order subject such contracts issued by a particular insurer to this chapter ~~or~~, ch. 632 or the health insurance mandates under ch. 632 that apply to the plan under subch. II of ch. 635 or any portion of ~~either~~ those provisions upon a finding, after a hearing, that the interests of Wisconsin insureds or creditors or the public of this state so require.

**SECTION 32.** 632.70 of the statutes is created to read:

**632.70 Exemption for plan under ch. 635.** The health insurance mandates, as defined in s. 601.423 (1), that are provided under this subchapter apply to the small employer health insurance plan under subch. II of ch. 635 only to the extent determined by the small employer insurance board under s. 635.23 (1) (b).

**SECTION 33.** 632.725 of the statutes is created to read:

**632.725 Standardization of health care billing and insurance claim forms. (1)** DEFINITION. In this section, "health care provider" has the meaning given in s. 146.81 (1).

**(2)** RULES FOR STANDARDIZATION OF FORMS. The commissioner, in consultation with the department of health and social services, shall, by rule, do all of the following:

(a) Establish a standardized billing format for health care services and require that a health care provider that provides health care services in this state use, by July 1, 1993, the standardized format for all printed billing forms.

(b) Establish a standardized claim format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed claim forms.

(c) Establish a standardized explanation of benefits format for health care insurance benefits and require that an insurer that provides health care coverage to one or more residents of this state use, by July 1, 1993, the standardized format for all printed forms that contain an explanation of benefits. The rule shall also require that benefits be explained in easily understood language.

(d) Establish a uniform statewide patient identification system in which each individual who receives health care services in this state is assigned an identification number. The standardized billing format established under par. (a) and the standardized claim format established under par. (b) shall provide for the designation of an individual's patient identification number.

**(3)** PROPOSALS FOR LEGISLATION. The commissioner shall develop proposals for legislation for the use of the patient identification system established under sub. (2) (d) and for the implementation of the proposed uses, including any proposals for safeguarding patient confidentiality.

**SECTION 34.** 632.89 (1) (f) of the statutes is created to read:

632.89 **(1)** (f) "Transitional treatment arrangements" means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services, and that are specified by the commissioner by rule under sub. (4).

**SECTION 35.** 632.89 (2) (b) (title) and 1 of the statutes are amended to read:

632.89 **(2)** (b) (title) *Minimum coverage of inpatient hospital, outpatient and transitional treatment arrangements.* 1. Except as provided in subd. 2, if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital ~~services and~~ treatment or outpatient ~~services~~ treatment or both, the policy shall provide coverage in every policy year as provided in pars. (c) ~~and (d)~~ to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed $7,000 or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the equivalent benefits measured in services rendered.

**SECTION 36.** 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. The first $7,000 minus a copayment of up to 10% ~~unless~~ for inpatient hospital services or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), ~~in which case~~ the first $6,300 or the equivalent benefits measured in services rendered.

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**SECTION 37.** 632.89 (2) (d) 2. of the statutes is amended to read:

632.89 **(2)** (d) 2. Except as provided in par. (b), a policy under subd. 1 shall provide coverage in every policy year for not less than the first ~~$1,000~~ $2,000 minus a copayment of up to 10% for outpatient services ~~unless~~ or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), ~~in which case~~ the first ~~$900~~ $1,800 or the equivalent benefits measured in services rendered.

**SECTION 38.** 632.89 (2) (dm) of the statutes is created to read:

632.89 **(2)** (dm) *Minimum coverage of transitional treatment arrangements.* 1. If a group or blanket disability insurance policy issued by an insurer provides coverage of any inpatient hospital treatment or any outpatient treatment, the policy shall provide coverage for transitional treatment arrangements for the treatment of conditions under par. (a) 1 as provided in subd. 2.

2. Except as provided in par. (b), a policy under subd. 1 shall provide coverage in every policy year for not less than the first $3,000 minus a copayment of up to 10% for transitional treatment arrangements or, if the coverage is provided by a health maintenance organization, as defined in s. 609.01 (2), the first $2,700 or the equivalent benefits measured in services rendered.

**SECTION 39.** 632.89 (4) of the statutes is created to read:

632.89 **(4)** SPECIFY TRANSITIONAL TREATMENT ARRANGEMENTS BY RULE. The commissioner shall specify by rule the services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems, including but not limited to day hospitalization, that are covered under sub. (2) (dm).

**SECTION 40.** 635.02 (1c) of the statutes is created to read:

635.02 **(1c)** "Basic health benefit plan" means the small employer health insurance plan under subch. II.

**SECTION 41.** 635.02 (2) of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

635.02 **(2)** "Case characteristics" means the demographic, actuarially based characteristics of the employes of a small employer, and the employer, if covered, such as age, sex, geographic location and occupation, used by ~~an~~ a small employer insurer to determine premium rates for a small employer. "Case characteristics" does not include loss or claim history, health status, duration of coverage or other factors related to claim experience.

**SECTION 42.** 635.02 (3c), (3f), (3j) and (3m) of the statutes are created to read:

635.02 **(3c)** "Dependent" means a spouse, an unmarried child under the age of 19 years, an unmarried child who is a full–time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

**(3f)** "Eligible employe" means an employe who works on a full–time basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and an independent contractor if the sole proprietor, business owner, partner or independent contractor is included as an employe under a health benefit plan of a small employer, but the term does not include an employe who works on a part–time, temporary or substitute basis.

**(3j)** "Established geographic service area" means a geographic area within which a small employer insurer provides coverage and that has been approved by the commissioner.

**(3m)** "Health benefit plan" means any hospital or medical policy or certificate. "Health benefit plan" does not include accident–only, credit, dental, vision, medicare supplement, long–term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or other insurance exempted by rule of the commissioner.

**SECTION 43.** 635.02 (4) of the statutes, as created by 1991 Wisconsin Act 39, is repealed.

**SECTION 44.** 635.02 (5m) of the statutes is created to read:

635.02 **(5m)** "Qualifying coverage" means benefits or coverage provided under any of the following:

(a) Medicare or medicaid.

(b) An employer–based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a basic health benefit plan.

(c) An individual health insurance policy that provides benefits similar to or exceeding benefits provided under a basic health benefit plan, if the policy has been in effect for at least one year.

**SECTION 45.** 635.02 (6) of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

635.02 **(6)** "Rating period" means the period, determined by ~~an~~ a small employer insurer, during which a premium rate established by the small employer insurer remains in effect.

**SECTION 46.** 635.02 (6m) of the statutes is created to read:

635.02 **(6m)** "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on obtaining services or articles from health care providers that have contracted with the small employer insurer to provide health care services or articles to covered individuals.

**SECTION 47.** 635.02 (7) of the statutes, as created by 1991 Wisconsin Act 39, is repealed and recreated to read:

635.02 **(7)** "Small employer" means any of the following:

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(a) An individual, firm, corporation, partnership or association that is actively engaged in a business enterprise in this state, including a farm business, and that employs in this state not fewer than 2 nor more than 25 eligible employes. In determining the number of eligible employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(b) A village or town that provides or that is eligible under s. 635.25 (1) to provide coverage to its eligible employes under a basic health benefit plan.

**SECTION 48.** 635.02 (8) of the statutes is created to read:

635.02 **(8)** "Small employer insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers group health benefit plans covering eligible employes of one or more small employers in this state, or that sells 3 or more individual health benefit plans to a small employer, covering eligible employes of the small employer. The term includes a health maintenance organization, as defined in s. 609.01 (2), a preferred provider plan, as defined in s. 609.01 (4), and an insurer operating as a cooperative association organized under ss. 185.981 to 185.985, but does not include a limited service health organization, as defined in s. 609.01 (3).

**SECTION 49.** 635.05 (1) and (2) (intro.) and (a) 1. to 3. of the statutes, as created by 1991 Wisconsin Act 39, are amended to read:

635.05 **(1)** Establishing restrictions on premium rates that ~~an~~ a small employer insurer may charge a small employer such that the premium rates charged to small employers with similar case characteristics for the same or similar benefit design characteristics do not vary from the midpoint rate for those small employers by more than 35% of that midpoint rate.

**(2)** (intro.) Establishing restrictions on increases in premium rates that ~~an~~ a small employer insurer may charge a small employer such that:

(a) 1. The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period, or the percentage change in the base premium rate in the case of a class of business for which the small employer insurer is not issuing new policies.

2. An adjustment, not to exceed 15% per year, adjusted proportionally for rating periods of less than one year, for such rating factors as claim experience, health status and duration of coverage, determined in accordance with the small employer insurer's rate manual or rating procedures.

3. An adjustment for a change in case characteristics or in benefit design characteristics, determined in accordance with the small employer insurer's rate manual or rating procedures.

**SECTION 50.** 635.07 (1) (intro.), (2) and (3) of the statutes, as affected by 1991 Wisconsin Act 39, are amended to read:

635.07 **(1)** (intro.) Notwithstanding s. 631.36 (2) to (4m), a plan or policy subject to this ~~chapter~~ subchapter may not be canceled by an insurer before the expiration of the agreed term, and shall be renewable to the employer and all employes and dependents eligible under the terms of the plan or policy at the expiration of the agreed term at the option of the small employer, except for any of the following reasons:

**(2)** Notwithstanding sub. (1), ~~an~~ a small employer insurer may elect not to renew a health insurance plan or policy subject to this ~~chapter~~ subchapter if the small employer insurer complies with all of the following:

(a) The small employer insurer ceases to renew all plans or policies subject to this ~~chapter~~ subchapter that are issued to all other small employers in the same class of business.

(b) The small employer insurer provides notice to all affected small employers and to the commissioner in each state in which an affected insured individual resides not later than one year before termination of coverage.

(c) The small employer insurer does not establish a new class of business earlier than 5 years after the nonrenewal of the plans or policies.

(d) The small employer insurer does not transfer or otherwise provide coverage to a small employer from the nonrenewed class of business unless the small employer insurer offers to transfer or provide coverage to all affected small employers from the nonrenewed class of business without regard to case characteristics, claim experience, health status or duration of coverage.

**(3)** This section does not apply to a plan or policy subject to this ~~chapter~~ subchapter if the small employer insurer that issued the policy is in liquidation.

**SECTION 51.** 635.09 of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

**635.09 Prohibited denial of coverage.** No small employer insurer may refuse to provide coverage for employes of a small employer solely on the basis of the occupation of the employes or the type of business in which the small employer is engaged.

**SECTION 52.** 635.11 (intro.) and (1) of the statutes, as created by 1991 Wisconsin Act 39, are amended to read:

**635.11 Disclosure of rating factors and renewability provisions.** (intro.) Before the sale of a plan or policy subject to this ~~chapter, an~~ subchapter, a small employer an insurer shall disclose to a small employer all of the following:

**(1)** The small employer insurer's right to increase premium rates and the factors limiting the amount of increase.

**SECTION 53.** 635.13 of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

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**635.13 Annual certification of compliance. (1)** RECORDS. ~~An~~ A small employer insurer shall maintain at its principal place of business complete and detailed records relating to its rating methods and practices and its renewal underwriting methods and practices, and shall make the records available to the commissioner and the small employer insurance board upon request.

**(2)** CERTIFICATION. ~~An~~ A small employer insurer shall file with the commissioner on or before May 1 annually an actuarial opinion by a member of the American academy of actuaries certifying all of the following:

(a) That the small employer insurer is in compliance with the rate provisions of s. 635.05.

(b) That the small employer insurer's rating methods are based on generally accepted and sound actuarial principles, policies and procedures.

(c) That the opinion is based on the actuary's examination of the small employer insurer's records and a review of the small employer insurer's actuarial assumptions and statistical methods used in setting rates and procedures used in implementing rating plans.

**SECTION 54.** 635.15 of the statutes, as created by 1991 Wisconsin Act 39, is amended to read:

**635.15 Temporary suspension of rate regulation.** The commissioner may suspend the operation of all or any part of s. 635.05 with respect to one or more small employers for one or more rating periods upon the written request of ~~an~~ a small employer insurer and a finding by the commissioner that the suspension is necessary in light of the financial condition of the small employer insurer or that the suspension would enhance the efficiency and fairness of the small employer health insurance market.

**SECTION 55.** 635.17 of the statutes is created to read:

**635.17 Coverage requirements for small employer plans. (1)** UNDERWRITING, PORTABILITY AND PREEXISTING CONDITIONS. (a) A health benefit plan subject to this subchapter may not deny, exclude or limit benefits for a covered individual for losses incurred more than 12 months after the effective date of the individual's coverage due to a preexisting condition. Such a health benefit plan may not define a preexisting condition more restrictively than any of the following:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage.

2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of coverage.

3. A pregnancy existing on the effective date of coverage.

(b) 1. A health benefit plan subject to this subchapter shall waive any period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period that an individual was previously covered by qualifying coverage that provided benefits with respect to such services, if the qualifying coverage was continuous to a date not less than 30 days before the effective date of the new coverage.

2. Subdivision 1 does not prohibit the application of a waiting period to all new enrollees under the health benefit plan; however, a waiting period may not be counted when determining whether the qualifying coverage was continuous to a date not less than 30 days before the effective date of the new coverage. For the purpose of subd. 1, the new coverage shall be considered effective as of the date that it would be effective but for the waiting period.

3. Until the first day of the 13th month beginning after the effective date of this subdivision .... [revisor inserts date], subd. 1 does not apply to a health benefit plan that is not a basic health benefit plan if the previous qualifying coverage was a basic health benefit plan.

**(2)** MINIMUM PARTICIPATION OF EMPLOYES. (a) Except as provided in par. (d), requirements used by a small employer insurer in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employes and minimum employer contributions, shall be applied uniformly among all small employers that apply for or receive coverage from the small employer insurer and that have the same number of eligible employes.

(b) A small employer insurer may vary its minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(c) 1. Except as provided in subd. 2, in applying minimum participation requirements with respect to a small employer, a small employer insurer may not count eligible employes or their dependents who have other coverage that is qualifying coverage in determining whether the applicable percentage of participation is met.

2. If a small employer has 10 or fewer eligible employes, a small employer insurer may count eligible employes or their dependents who have coverage under another health benefit plan sponsored by that small employer in applying minimum participation requirements to determine whether the applicable percentage of participation is met.

(d) A small employer insurer may not increase a requirement for minimum employe participation or a requirement for minimum employer contribution that applies to a small employer after the small employer has been accepted for coverage.

**(3)** PROHIBITED COVERAGE PRACTICES. (a) If a small employer insurer offers coverage to a small employer, the small employer insurer shall offer coverage to all of the eligible employes of the small employer and their dependents. A small employer insurer may not offer coverage to only certain individuals in a small employer group or

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to only part of the group, except for an eligible employe who has not yet satisfied an applicable waiting period, if any.

(b) A small employer insurer may not modify a health benefit plan with respect to a small employer or an eligible employe or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

SECTION 56. 635.18 of the statutes is created to read:

**635.18 Fair marketing standards. (1)** Every small employer insurer shall actively market health benefit plan coverage, including basic health benefit plans, to small employers in the state. If a small employer insurer denies coverage to a small employer under a health benefit plan that is not a basic health benefit plan on the basis of the health status or claims experience of the small employer or its eligible employes on their dependents, the small employer insurer shall offer the small employer the opportunity to purchase a basic health benefit plan.

**(2)** (a) Except as provided in par. (b), a small employer insurer or an intermediary may not, directly or indirectly, do any of the following:

1. Discourage a small employer from applying, or direct a small employer not to apply, for coverage with the small employer insurer because of the health status, claims experience, industry, occupation or geographic location of the small employer.

2. Encourage or direct a small employer to seek coverage from another insurer because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) Paragraph (a) does not prohibit a small employer insurer or an intermediary from providing a small employer with information about an established geographic service area or a restricted network provision of the small employer insurer.

**(3)** (a) Except as provided in par. (b), a small employer insurer may not, directly or indirectly, enter into any contract, agreement or arrangement with an intermediary that provides for or results in compensation to an intermediary for the sale of a health benefit plan that varies according to the health status, claims experience, industry, occupation or geographic location of the small employer or eligible employes or dependents.

(b) Payment of compensation on the basis of percentage of premium is not a violation of par. (a) if the percentage does not vary based on the health status, claims experience, industry, occupation or geographic area of the small employer or eligible employes or dependents.

(c) A small employer insurer shall provide reasonable compensation to an intermediary, if any, for the sale of a basic health benefit plan.

**(4)** A small employer insurer may not terminate, fail to renew or limit its contract or agreement of representation with an intermediary for any reason related to the health status, claims experience, occupation or geographic location of the small employers or eligible employes or their dependents placed by the intermediary with the small employer insurer.

**(5)** A small employer insurer or an intermediary may not induce or otherwise encourage a small employer to separate or otherwise exclude an employe from health coverage or benefits provided in connection with the employe's employment.

**(6)** Denial by a small employer insurer of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

**(7)** A 3rd–party administrator that enters into a contract, agreement or other arrangement with a small employer insurer to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state is subject to this subchapter as if it were a small employer insurer.

**(8)** The commissioner may by rule establish additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

SECTION 57. Subchapter II of chapter 635 of the statutes is created to read:

**CHAPTER 635**

SUBCHAPTER II

SMALL EMPLOYER

HEALTH INSURANCE PLAN

**635.20 Definitions.** In this subchapter:

**(1)** "Basic benefits" means the minimum benefits established by the plan board under ss. 635.21 and 635.23 (1) (a), and includes all health insurance mandates to the extent determined by the plan board under s. 635.23 (1) (b).

**(1c)** "Dependent" has the meaning given in s. 635.02 (3c).

**(1m)** "Eligible employe" has the meaning given in s. 635.02 (3f).

**(2)** "Eligible employer" means an employer that satisfies the requirements of s. 635.25 (1).

**(5)** "Health care provider" has the meaning given in s. 146.81 (1).

**(5m)** "Health insurance mandate" has the meaning given in s. 601.423 (1).

**(10)** "Plan" means the health insurance plan for individuals employed by small employers that is created under s. 635.21 and that consists of a policy under this subchapter containing the basic benefits.

**(11)** "Plan board" means the small employer insurance board.

**(12)** "Small employer" means any of the following:

(a) An individual, firm, corporation, partnership or association that is actively engaged in a business enterprise in this state, including a farm business, and that employs in this state not fewer than 2 nor more than 25 eligible employes. In determining the number of eligible

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employes, employers that are affiliated, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(b) A village or town that employs not fewer than 2 nor more than 10 eligible employes and that has not provided health insurance coverage to its eligible employes at any time during the past 12 months.

**(13)** "Small employer insurer" has the meaning given in s. 635.02 (8).

**635.21 Establishment of plan.** There is established a plan of health insurance coverage for individuals employed by small employers. The plan board shall formulate, supervise and modify the plan as needed, and shall promulgate rules regarding the establishment and administration of the plan.

**635.23 Duties of plan board. (1)** The plan board shall:

(a) By rule determine the basic benefits that small employer insurers may offer to eligible employers for providing coverage to eligible employes and their dependents.

(b) By rule establish the extent to which the plan shall comply with the health insurance mandates, without elimination of any of those mandates.

(c) By rule formulate minimum benefit standards for policies providing the basic benefits.

(d) By rule establish employer eligibility requirements for participation in the plan.

(dm) By rule establish deductibles, copayment and maximum payment requirements for policies providing the basic benefits.

(dp) By rule determine whether employers participating in the plan may impose a probationary or waiting period on employes who become eligible for coverage after the commencement of the employer's coverage. The plan board may not allow for a probationary or waiting period that exceeds 90 days.

(dr) By rule determine enrollment periods, if any, for employer or employe coverage under the plan.

(e) Annually submit a report to the chief clerk of each house of the legislature, for distribution under s. 13.172 (3) to the appropriate standing committees, summarizing the activities of the plan board and the operation of the plan in the preceding year, and including but not limited to all of the following:

1. The number of small employers participating in the plan.

2. The number of employes and dependents participating in the plan.

3. An evaluation of the plan's operation and effectiveness.

**(1m)** The plan board may by rule establish plan features in addition to those specified in sub. (1).

**(1r)** All aspects of the composition and operation of the plan that are established by the plan board shall be established by rule.

**(2)** All rules promulgated by the plan board are subject to approval by the commissioner.

**(3)** All final decisions of the plan board under this section concerning the formulation, supervision and modification of the plan shall be adopted by a vote of not less than 8 members of the plan board's current voting membership.

**(4)** In the formulation of the plan, for the purpose of cost containment the plan board shall encourage the use, to the extent possible, of the services of health care providers other than physicians. The plan board shall report any recommendations on ways to encourage the use of the services of health care providers other than physicians to the chief clerk of each house of the legislature for distribution under s. 13.172 (3) to the standing committees with jurisdiction over health insurance.

**(5)** The plan board may submit any recommendations for legislation to improve the plan to the chief clerk of each house of the legislature for distribution under s. 13.172 (3) to the standing committees with jurisdiction over health insurance.

**635.25 Eligibility for participation in plan. (1)** EMPLOYERS. (a) To be eligible to participate in the plan by purchasing a policy under this subchapter containing the basic benefits, an employer:

1. Must be a small employer; and

2. Must comply with any other eligibility requirements specified by the plan board.

(b) Except as provided in ss. 645.43 and 646.35, an employer that purchases a policy under this subchapter containing the basic benefits and that ceases to be eligible to participate in the plan during a policy period shall retain coverage under the plan to the end of the policy period.

**(1m)** Notwithstanding sub. (1), an employer is not eligible to participate in the plan if all of the individuals to be covered under the plan may be covered by a single policy providing individual or family coverage.

**(2)** EMPLOYES AND DEPENDENTS. (a) All eligible employes of an eligible employer that participates in the plan are eligible for coverage under the plan, subject to the policy terms.

(b) Any dependent of an eligible employe who is covered under the plan is eligible for coverage under the plan, subject to the policy terms.

**635.254 Employer premium contribution. (1)** An employer that participates in the plan shall pay a premium contribution of not less than 50% of the premium rate on behalf of an eligible employe with individual coverage and not less than 40% of the premium rate on behalf of an eligible employe with family coverage.

**(2)** An employer under sub. (1) shall withhold from the earnings of an employe with coverage under the plan the amount of premium not contributed by the employer under sub. (1).

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**(3)** For an eligible employe who obtains coverage under the health insurance risk sharing plan under s. 619.12 (2) (e) 2., an employer under sub. (1) shall pay a premium contribution to the health insurance risk sharing plan that is equal to the amount that the employer would pay on behalf of the employe for coverage under the plan under this subchapter.

**635.26 Guaranteed issue. (1)** (a) Except as provided in subs. (2m) to (4), a small employer insurer shall provide coverage under the plan, regardless of health status or claims experience, to an eligible employer and to all of its eligible employes and their dependents if all of the following apply:

1. The employer agrees to pay the premium required for coverage under the plan.

2. The employer agrees to comply with all other plan provisions that apply generally to a policyholder or an insured without regard to health status or claims experience.

(b) Except as provided in subs. (2m) to (4), a small employer insurer shall provide coverage under the plan, regardless of health status or claims experience, to an eligible employe who becomes eligible for coverage after the commencement of the employer's coverage, and to the eligible employe's dependents, if all of the following apply:

1. The employe applies for coverage under the plan before the expiration of any applicable enrollment period, if any, required under the plan.

2. The employer agrees to pay the premium required for coverage of the employe under the plan.

**(1m)** A small employer insurer shall be in compliance with sub. (1) if it issues a policy that complies with the plan and the minimum benefit standards determined by the plan board under s. 635.23 (1) (c) but that includes only the basic benefits.

**(1s)** Nothing in sub. (1) prohibits a small employer insurer that provides coverage under sub. (1) from imposing preexisting condition provisions, waiting period requirements, or other provisions or requirements related to health status or claims experience, that are permitted or required under the plan.

**(2)** A small employer insurer that provides coverage under sub. (1) may impose payment security provisions reasonably related to the risk covered.

**(2m)** Nothing in sub. (1) requires a small employer insurer to issue coverage that the small employer insurer is not authorized to issue under its bylaws, charter or certificate of incorporation or authority.

**(3)** Subsection (1) does not apply to a small employer insurer if the commissioner determines that any of the following applies:

(a) It is inequitable to apply sub. (1) to the small employer insurer due to its disproportionate share of groups with high claims experience.

(b) It is in the public interest to exempt the small employer insurer from the requirement under sub. (1) because the small employer insurer is in financially hazardous condition.

**(4)** A small employer insurer that offers health insurance coverage exclusively to a single category or limited categories of eligible employers is required to comply with sub. (1) only as to that single category or those limited categories of eligible employers.

**(6)** The commissioner may adopt rules that are reasonably necessary to accomplish the purpose of this section.

**635.272 Payments to health care providers. (1)** CONTRACTING HEALTH CARE PROVIDERS. A health care provider that contracts with a small employer insurer to provide services to individuals with coverage under the plan shall accept amounts payable under the contract for the basic benefits as payment in full for those services.

**(2)** SELECTED PROVIDERS. Nothing in sub. (1) supersedes s. 609.05.

**635.28 Liability of state and plan board.** Neither the state nor the plan board is liable for any obligation arising under the plan. Plan board members are immune from civil liability for acts or omissions while performing their duties under this subchapter.

**635.29 Exemption from required coverage.** The health insurance mandates apply to the plan under this subchapter only to the extent determined by the plan board under s. 635.23 (1) (b).

**635.31 Chapters 600 to 655 applicable.** Except as otherwise provided in this subchapter, the plan shall comply with and be administered in compliance with chs. 600 to 655.

**SECTION 58.** 1983 Wisconsin Act 27, section 2020 (17), as last affected by 1985 Wisconsin Act 120, is repealed.

**SECTION 9101. Nonstatutory provisions; administration.**

(1) FAMILY PRACTICE RESIDENCY PROGRAMS FUNDING.

(a) For the first budget that is compiled under section 16.43 of the statutes after the effective date of this subsection, the department of administration shall submit to the secretary of administration a funding plan to provide financial assistance for the development and operation of the family practice residency programs of the medical college of Wisconsin, inc., the university of Wisconsin–Madison and the St. Francis family practice residency program in La Crosse. The plan shall include a funding mechanism that provides a funding level for each family practice residency program that is as equitable as possible and which is consistent with the overall objective of increasing the number of family practice physicians who practice in this state.

(b) In the funding plan under paragraph (a), the department of administration shall specify possible fund-

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ing sources and include its recommendation for legislation that will implement the funding plan and the amounts recommended from each funding source to provide financial assistance for the family practice residency programs.

**SECTION 9125. Nonstatutory provisions; health and social services.**

(1) COST CONTAINMENT.

(a) *Initial membership on the commission.* Notwithstanding the length of terms of commission members specified in section 15.06 (1) (a) of the statutes, of the initial members of the Wisconsin cost containment commission under section 15.195 (10) of the statutes, as created by this act, one member shall be appointed for a term that expires on March 1, 1994, one member shall be appointed for a term that expires on March 1, 1996, and one member shall be appointed for a term that expires on March 1, 1998. All commissioners shall be appointed prior to initial promulgation of the commission's rules.

(b) *Initial membership on the council.* Notwithstanding the length of terms specified in section 15.197 (10) (intro.) of the statutes, as created by this act, of the initial members of the cost containment council under section 15.197 (10) of the statutes as created by this act, 4 members shall be appointed for terms that expire on July 1, 1994, 4 members shall be appointed for terms that expire on July 1, 1996, and 3 members shall be appointed for terms that expire on July 1, 1998.

(c) *Rule making.* By January 1, 1993, the Wisconsin cost containment commission shall submit to the legislative council staff under section 227.15 (1) of the statutes its proposed rules for implementing subchapter III of chapter 150 of the statutes, as created by this act. These rules may not take effect before July 1, 1993.

(2) STUDY ON DIRECT CONTRACTING. The department of health and social services shall analyze and evaluate the feasibility of directly contracting with individual health care providers for the provision of services under the medical assistance program and shall report its findings and recommendations to the chief clerk of each house of the legislature, for distribution in the manner provided under section 13.172 (2) of the statutes, by March 1, 1993.

(3) PROJECT REVIEW.

(a) *Definitions.* In this subsection:

1. "Ambulatory surgery center" has the meaning given under 42 CFR 416.2.

2. "Board" means the board on health care information under section 15.195 (6) of the statutes.

3. "Department" means the department of health and social services.

(b) *Applicability.* After September 30, 1992, and before July 1, 1993, no person may do any of the following without first complying with paragraph (e):

1. Except as provided in paragraph (c), obligate for a capital expenditure, by or on behalf of a hospital, that exceeds $1,000,000, including the renovation or replacement on the same site of existing approved beds of a hospital or new construction. The cost of the studies, surveys, plans and other activities essential to the proposed capital expenditure shall be included in determining the value of the capital expenditure. Any donation of equipment or facilities that, if acquired directly, would be subject to review under this subsection is a capital expenditure. Any transfer of equipment or facilities for less than fair market value that, if transferred at fair market value, would be subject to review under this subsection is a capital expenditure.

2. Implement services new to the hospital that exceed $500,000 in a 12–month period, including an organ transplant program, burn center, neonatal intensive care program, cardiac program or air transport services or implement other services or programs specified by the department by rule.

3. Obligate for an expenditure, by or on behalf of a hospital, independent practitioner, partnership, unincorporated medical group or service corporation as defined in section 180.1901 (2) of the statutes, that exceeds $500,000 for clinical medical equipment.

4. Purchase or otherwise acquire a hospital.

5. Construct or operate an ambulatory surgery center or a home health agency.

(c) *Exemptions.*

1. Paragraph (b) does not apply if a person has, prior to October 1, 1992, entered into a legally enforceable contract, promise or agreement with another to do any of the activities specified in paragraph (a) 1. to 5.

2. A person may obligate for a capital expenditure, by or on behalf of a hospital, without complying with paragraph (e) if the expenditure is for heating, air conditioning, ventilation, electrical systems, energy conservation, telecommunications, computer systems or nonsurgical outpatient services, unless any of the above is a constituent of another project reviewable under this subsection or unless expenditures for any of the above would exceed 20% of a hospital's gross annual patient revenue for its last fiscal year.

(d) *Innovative medical technology exemption.*

1. In this paragraph:

a. "Clinical trial" means clinical research conducted under approved protocols in compliance with federal requirements applicable to investigations involving human subjects, including the requirement for an informed consent advising the patient clearly of the risks associated with participating in the clinical development and evaluation project.

b. "Innovative medical technology" means equipment or procedures that are potentially useful for diagnostic or therapeutic purposes and that introduce new technology in the diagnosis and treatment of illness.

2. A person is exempted from complying with paragraph (e) for the research, development and evaluation of

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innovative medical technology, the development of the clinical applications of this technology or the research, development and evaluation of a major enhancement to existing medical technology if all of the following occur:

a. A person intending to undertake a capital expenditure in excess of $500,000 or intending to undertake a substantial change in a health service so notifies the board.

b. Preliminary animal studies or preliminary clinical investigation establishes that the innovative medical technology or major enhancement to existing medical technology has a reasonable probability of advancing clinical diagnosis or therapy.

c. In the development and evaluation of the clinical applications the person undertakes scientifically sound studies to determine clinical efficacy, safety, cost–effectiveness and appropriate utilization levels in a clinical setting.

d. The clinical trials, evaluation or research are conducted according to scientifically sound protocols subject to peer review and approval in accord with the requirements applicable to investigations and clinical evaluation involving human subjects.

e. The innovative medical technology is being installed to conduct necessary research, development and evaluation.

f. The person does not include any recovery of capital expenses incurred as part of an exemption under this paragraph in its expense and revenue budget for purposes of rate setting, until the person receives the approval of the federal food and drug administration for general medical use. The person may recover operating expenses only after the federal food and drug administration approves for safety and efficacy and a 3rd party agrees to pay for these expenses.

3. A person may not have more than 2 exemptions for any particular type of innovative medical technology or for any particular major enhancement to existing medical technology.

(e) *Health care project analysis.*

1. Before making a binding legal or financial commitment, a person who seeks to undertake a project or activity governed by paragraph (b) or rules promulgated under paragraph (b) shall prepare a health care project analysis, submit a copy to the board and comply with all requirements of this section.

2. The department shall promulgate rules that specify information required to be included in a health care project analysis under subdivision 1.

3. The person preparing the health care project analysis under subdivision 1 shall do all of the following:

a. File the analysis with the office of health care information.

b. Cause to be published a class 1 notice under chapter 985 of the statutes in the official newspaper designated under section 985.04 or 985.05 of the statutes or, if none exists, in a newspaper likely to give notice in the area of the proposed project or activity. The notice shall describe the proposed project or activity, summarize the contents of the health care project analysis and describe where copies of the analysis may be reviewed and the time and place for the public hearing required under subdivision 3. c.

c. No sooner than 30 days after the date of publication of the notice under subdivision 3. b., conduct a public hearing on the proposed project or activity. The hearing shall be on the completeness and accuracy of the health care project analysis, the expected impact of the proposed project or activity on health care costs, the expected improvement, if any, in the local health care delivery system, and any other issue related to the proposed project or activity. Management staff, if any, of the person seeking to undertake the project or activity and, if possible, at least 3 members of the governing board of a not–for–profit health care provider, if any, seeking to undertake the project or activity shall attend the public hearing to review public testimony. The person seeking to undertake the project or activity shall record accurate minutes of the meeting and shall provide copies of the minutes and any written testimony presented at the hearing to the office of health care information and the board within 10 days after the date of the public hearing.

4. The board shall distribute copies of each health care project analysis filed under subdivision 3. a. to the county clerk, to the clerk of the city, village or town, if any, in which the person proposes to undertake the project or activity, to the main public library, if any, of the city, village or town in which the proposed project or activity will be undertaken and to a business or labor coalition, if any, located in the county of the proposed project that has notified the board of its interest in receiving a copy of a health care project analysis. The board shall provide any other person who requests the health care project analyses with a copy at a reasonable cost.

(f) *Enforcement.*

1. If the department issues a written finding and order that a person has violated this subsection, the department may disallow the person reimbursement under medical assistance, to the extent provided by federal law, for services rendered by the person in a facility, under a program or by use of equipment that is subject to this subsection. The order of disallowance shall continue to be in full force and effect for 36 months after the violation of this subsection first occurs or until the person is in compliance with this subsection, whichever is first. Issuance by the department of a written finding and order under this subsection is subject to chapter 227 of the statutes.

2. The department of justice shall enforce this subsection and all orders issued and rules promulgated under this subsection. The circuit court for any county in which a violation has occurred in whole or in part or for Dane county has jurisdiction to enforce this subsection or

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orders issued or rules promulgated under this subsection by injunction or other appropriate relief.

(g) *Rule–making.* The board shall review and approve all proposed rules that are prepared by the department for promulgation to implement this subsection.

(h) *Sunset.* This subsection does not apply after June 30, 1993.

(4) RULES ON PROJECT REVIEW.

(a) The department of health and social services shall submit proposed rules required under subsection (3) to the legislative council staff for review under section 227.15 (1) of the statutes no later than October 1, 1992.

(b) Using the procedure under section 227.24 of the statutes, the department of health and social services shall promulgate rules required under subsection (3) for the period prior to the effective date of the rules submitted under paragraph (a), but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a) and (2) (b) of the statutes, the department need not provide evidence of the necessity of preservation of the public peace, health, safety or welfare in promulgating the rules under this paragraph.

(5) OFFICE OF HEALTH CARE INFORMATION STUDY. The office of health care information shall study and, by July 1, 1993, shall submit to the chief clerk of each house of the legislature for distribution to the legislature in the manner provided under section 13.172 (2) of the statutes, a report concerning all of the following:

(a) Whether a discount on charges for hospital services would likely increase the affordability and availability of health care insurance for small groups, and, if so, a recommended amount of discount.

(b) Methods to collect and present health plan outcomes and costs.

(6) RULES ON UNIFORM ACCOUNTING FOR HOSPITALS. The department of health and social services shall submit proposed rules required under section 153.48 of the statutes, as created by this act, to the legislative council staff for review under section 227.15 (1) of the statutes no later than January 1, 1993.

**SECTION 9130. Nonstatutory provisions; insurance.**

(1) INITIAL TERMS OF SMALL EMPLOYER INSURANCE BOARD MEMBERS. Notwithstanding section 15.735 (1) of the statutes, as created by this act, the initial appointed members of the small employer insurance board shall be appointed for the following terms:

(a) Three members, one of whom represents employers and 2 of whom represent employes, for terms expiring on May 1, 1993.

(b) Four members, 2 of whom represent employers and 2 of whom represent employes, for terms expiring on May 1, 1994.

(c) Three members, 2 of whom represent employers and one of whom represents employes, for terms expiring on May 1, 1995.

(2) STUDIES BY COMMISSIONER.

(a) The commissioner of insurance shall study all of the following issues:

1. The effect of guaranteed issue on the desirability or the necessity of reinsurance for the small employer health insurance plan under subchapter II of chapter 635 of the statutes, as created by this act.

2. The availability of private reinsurance for health care coverage of small groups.

3. Options for mandatory assessment of insurers for the purpose of reinsuring the small employer health insurance plan.

4. Whether nondomestic insurers underreport the health insurance premiums that they write in this state.

5. The effects and desirability of probationary or waiting period portability for the small employer health insurance plan and for other small group health insurance coverage.

(b) On or before January 8, 1993, the commissioner shall submit the results of the studies and any recommendations to the chief clerk of each house of the legislature for distribution in the manner provided under section 13.172 (3) of the statutes to the standing committees with jurisdiction over health insurance.

(3) RULE DEADLINES.

(a) *Basic benefits plan.*

1. The small employer insurance board shall submit the proposed rules under section 635.23 (1) and (1m) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 7th month beginning after publication.

2. The small employer insurance board may not submit the notices and reports for the proposed rules under section 635.23 (1) and (1m) of the statutes, as created by this act, to the presiding officer of either house of the legislature under section 227.19 (2) of the statutes before January 8, 1993.

(b) *Health insurance risk sharing plan.* The commissioner of insurance shall submit the proposed rules required under section 619.123 of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 5th month beginning after publication.

(c) *Health care billing and insurance claim forms.* The commissioner of insurance shall submit the proposed rules required under section 632.725 (2) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than January 4, 1993.

(d) *Transitional treatment arrangements.* The commissioner of insurance shall submit the proposed rules

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required under section 632.89 (4) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 4th month beginning after the effective date of this subsection.

(4) PROPOSED LEGISLATION DEADLINE. The commissioner shall submit, on or before January 4, 1993, proposals for legislation under section 632.725 (3) of the statutes, as created by this act, to the chief clerk of each house of the legislature for distribution in the manner provided under section 13.172 (3) of the statutes to the standing committees with jurisdiction over health insurance.

**SECTION 9136. Nonstatutory provisions; legislature.**

(1) TASK FORCE ON HEALTH COST CONTAINMENT.

(a) There is created a special committee to be known as the task force on health cost containment, consisting of all of the following:

1. The secretary of health and social services, or his or her designee.

2. The commissioner of insurance, or his or her designee.

3. The speaker, majority leader and minority leader of the assembly or their designees.

4. The president, majority leader and minority leader of the senate or their designees.

(b) The task force on health cost containment shall, by majority vote, elect a chairperson from among its members and establish the operating procedures of the task force.

(c) The task force on health cost containment may call upon any state agency or officer for the facilities and data of the agency or officer, and those agencies shall cooperate with the task force to the fullest extent possible.

(d) By January 1, 1993, the task force on health cost containment shall submit, to the presiding officer of each house of the legislature and to the governor a report on all of the following:

1. Establishing health care practice protocols, adherence to which would create a legal presumption against liability for malpractice, for appropriate treatment and use of technology and nonphysician health care providers.

2. Creating additional incentives for the use of nonphysician health care providers in circumstances in which this use could reduce health care costs or increase the availability of health care services.

3. Controlling health care costs, including requiring state regulation of individual or group health care provider charges or requiring state approval of a comprehensive health care budget providing for and limiting charges of all health care providers.

4. The feasibility of authorizing the operation of a public employe health buying consortium in this state, under which the state, counties, cities, villages, towns and school districts would join to negotiate, with providers of health care services, discount rates for volume purchases of health care services.

5. The desirability and the effects of pooling small groups in the state, or organizing private or public purchasers of health insurance or plans under a few regional brokers or sponsors, in order to maximize market forces to obtain reduced–cost health care coverage.

6. The desirability of reinsurance, or coverage for catastrophic losses, as well as alternative methods of providing this coverage, including government and market programs, for health care coverage of small groups.

7. The possibility, and the policy ramifications, of eliminating the ability of one or 2 health plans or providers to dominate a single market.

(e) The task force on health cost containment terminates upon submittal of the report as required under paragraph (d).

**SECTION 9330. Initial applicability; insurance.**

(1) COVERAGE OF TRANSITIONAL TREATMENT ARRANGEMENTS. The treatment of section 632.89 (2) (b) 1. and (dm) of the statutes first applies to policies issued or renewed on the effective date of this subsection.

(2) MINIMUM BENEFITS FOR OUTPATIENT SERVICES. The treatment of section 632.89 (2) (d) 2. of the statutes first applies to policies issued or renewed on the effective date of this subsection.

(3) UNDERWRITING. The treatment of section 635.17 of the statutes first applies to health benefit plans issued or renewed on the effective date of this subsection.

(4) FAIR MARKETING. The treatment of section 635.18 (3), (4) and (7) of the statutes first applies to contracts, agreements or arrangements entered into or renewed on the effective date of this subsection.

**SECTION 9400. Effective dates. This act takes effect on the day after publication, except as follows:**

(1) COVERAGE OF TRANSITIONAL TREATMENT ARRANGEMENTS. The treatment of section 632.89 (2) (b) 1. and (dm) of the statutes and SECTION 9330 (1) of this act take effect on the first day of the 6th month beginning after publication.

(2) HEALTH INSURANCE RISK SHARING PLAN. The treatment of section 619.12 (2) (e) of the statutes and the creation of section 619.12 (2) (e) 2. and 3. of the statutes take effect on the first day of the 10th month beginning after publication.