State of Wisconsin
2017 - 2018 LEGISLATURE

LRBb0824/1
ALL:all

ASSEMBLY AMENDMENT 8,

TO ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO ASSEMBLY BILL 64

September 13, 2017 – Offered by Representatives SUBECK, C. TAYLOR, ANDERSON, HEBL, BARCA, BERCEAU, BILLINGS, BOWEN, BROSTOFF, CONSIDINE, CROWLEY, DOYLE, FIELDS, GENRICH, GOYKE, HESSELBEIN, HINTZ, KESSLER, KOLSTE, MASON, MEYERS, MILROY, OHNSTAD, POPE, RIEMER, SARGENT, SHANKLAND, SINICKI, SPREITZER, STUCK, VRUWINK, WACHS, YOUNG, ZAMARRIPA and ZEPNICK.

At the locations indicated, amend the substitute amendment as follows:

1. Page 11, line 1: before that line insert:

"**SECTION 8r.** 13.94 (1) (nm) of the statutes is created to read:

13.94 **(1)** (nm) No later than February 1, 2021, prepare a financial and performance evaluation audit of the nonemergency medical transportation program for Medical Assistance recipients including a comparison of services provided under an alternative arrangement made under 2017 Wisconsin Act .... (this act), section 9120 (5p), to services provided under a contract other than the alternative arrangement.".

2. Page 173, line 16: increase the dollar amount for fiscal year 2017–18 by $239,800 and increase the dollar amount for fiscal year 2018–19 by $239,800 for the

purpose of increasing the funding for emergency medical services training and certification aids.

3. Page 179, line 2: decrease the dollar amount for fiscal year 2017–18 by $98,900,000 and decrease the dollar amount for fiscal year 2018–19 by $187,400,000 for the purpose of providing Medical Assistance to certain adults with family incomes up to 133 percent of the federal poverty line.

4. Page 179, line 2: increase the dollar amount for fiscal year 2017–18 by $72,836,000 and increase the dollar amount for fiscal year 2018–19 by $156,124,700 for the purpose of increasing reimbursement rates for certain providers of Medical Assistance services as described under SECTION 9120 (7g) of this act.

5. Page 179, line 2: increase the dollar amount for fiscal year 2017–18 by $7,459,500 and increase the dollar amount for fiscal year 2018–19 by $15,961,700 for the purpose of increasing reimbursement rates for certain providers of Medical Assistance nursing homes as described under SECTION 9120 (5v) of this act.

6. Page 179, line 2: increase the dollar amount for fiscal year 2017–18 by $13,262,515 and increase the dollar amount for fiscal year 2018–19 by $28,318,166 for the purpose of increasing reimbursement rates for certain providers of Medical Assistance personal care services as described under SECTION 9120 (5t) of this act.

7. Page 424, line 21: after that line insert:

"**SECTION 709n.** 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853,

632.855, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 709p. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.728, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, and 632.895 (11) to (17).".

8. Page 424, line 21: after that line insert:

"**SECTION 709p.** 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, and 632.895 ~~(11)~~ (8) and (10) to (17).".

9. Page 424, line 21: after that line insert:

"**SECTION 709n.** 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.87 (3) to (6), 632.883, 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 709p. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,

632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.883, 632.885, 632.89, and 632.895 (11) to (17).".

10. Page 518, line 19: after that line insert:

"**SECTION 925t.** 49.45 (9d) of the statutes is created to read:

49.45 **(9d)** FAMILY PLANNING SERVICES; PRIVATE PROVIDERS. (a) In this subsection:

1. "Family planning" has the meaning given s. 253.07 (1) (a).

2. "Federal funding prohibition" means an enacted federal law, a regulation, or an executive order or action that prohibits federal moneys from being paid by the state to a provider under the Medicaid program because of the scope of services offered by the provider or the scope of services for which the provider offers referrals.

3. "Nonpublic family planning provider" means an entity other than a public entity or governmental unit that is a provider of services for family planning under the Medical Assistance program under this subchapter on December 31, 2016.

(b) If a nonpublic family planning provider becomes subject to a federal funding prohibition, the department shall do all of the following:

1. Ensure that enrollees in the Medical Assistance program under this subchapter are allowed access to the nonpublic family planning provider to the same extent as before the federal funding prohibition.

2. Reimburse the nonpublic family planning provider for services provided to Medical Assistance enrollees under this subchapter for services for family planning that are covered under the Medical Assistance program.

3. Maintain requirements for the nonpublic family planning provider to receive state payments under this subchapter that are the same requirements as before the federal funding prohibition.

(c) The department may not limit the scope of services for which a nonpublic family planning provider may offer a referral in order to receive reimbursement under par. (b) 2.".

11. Page 521, line 19: after that line insert:

"**SECTION 926w.** 49.45 (23) (a) of the statutes is amended to read:

49.45 **(23)** (a) The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide health care coverage to adults who are under the age of 65, who have family incomes not to exceed ~~100~~ 133 percent of the poverty line ~~before application of the 5 percent income disregard under 42 CFR 435.603 (d)~~, except as provided in s. 49.471 (4g), and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq.".

12. Page 531, line 15: after that line insert:

"**SECTION 933p.** 49.471 (1) (cr) of the statutes is created to read:

49.471 **(1)** (cr) "Enhanced federal medical assistance percentage" means a federal medical assistance percentage described under 42 USC 1396d (y) or (z).

SECTION 933r. 49.471 (4) (a) 4. b. of the statutes is amended to read:

49.471 **(4)** (a) 4. b. ~~The~~ Except as provided in sub. (4g), the individual's family income does not exceed ~~100~~ 133 percent of the poverty line ~~before application of the 5 percent income disregard under 42 CFR 435.603 (d)~~.

SECTION 933t. 49.471 (4g) of the statutes is created to read:

49.471 **(4g)** MEDICAID EXPANSION; FEDERAL MEDICAL ASSISTANCE PERCENTAGE. (a) For services provided to individuals described under sub. (4) (a) 4. and s. 49.45 (23),

the department shall comply with all federal requirements to qualify for the highest available enhanced federal medical assistance percentage. The department shall submit any amendment to the state medical assistance plan, request for a waiver of federal Medicaid law, or other approval request required by the federal government to provide services to the individuals described under sub. (4) (a) 4. and s. 49.45 (23) and qualify for the highest available enhanced federal medical assistance percentage.

(b) If the department does not qualify for an enhanced federal medical assistance percentage, or if the enhanced federal medical assistance percentage obtained by the department is lower than printed in federal law as of July 1, 2013, for individuals eligible under sub. (4) (a) 4. or s. 49.45 (23), the department shall submit to the joint committee on finance a fiscal analysis comparing the cost to maintain coverage for adults who are not pregnant and not elderly with family incomes up to 133 percent of the poverty line to the cost of limiting eligibility to those adults with family incomes up to 100 percent of the poverty line. The department may reduce income eligibility for adults who are not pregnant and not elderly from family incomes of up to 133 percent of the poverty line to family incomes of up to 100 percent of the poverty line only if this reduction in income eligibility levels is approved by the joint committee on finance.".

13. Page 531, line 15: after that line insert:

"**SECTION 933t.** 49.471 (4m) of the statutes is created to read:

49.471 **(4m)** PURCHASE OPTIONS FOR BADGERCARE PLUS AND THE ASSISTANCE FOR CHILDLESS ADULTS DEMONSTRATION PROJECT. (a) 1. The department shall, if required, request a waiver from or submit amendments to the state Medical Assistance plan

to the secretary of the federal department of health and human services to establish a program that allows individuals with income above the maximum income eligibility limit applicable under this section or the assistance for childless adults demonstration project under s. 49.45 (23), and who otherwise meet the eligibility requirements under this section or under s. 49.45 (23), the option of purchasing coverage through this section or through the demonstration project under s. 49.45 (23) instead of purchasing an individual health plan through private insurance. The department shall also include a request for any federal waiver or state Medical Assistance plan amendments necessary to allow an option for small businesses to purchase coverage for their employees under this section as part of the small business health options program through an exchange under 42 USC 18031.

2. The department shall seek any federal waiver and state Medical Assistance plan amendments necessary to allow individuals who qualify under subd. 1. to use advanced tax credits and cost–sharing credits, if eligible, to purchase one of the options described under subd. 1.

(b) 1. The department shall coordinate the administration of the purchase options under this subsection with the programs under this section and s. 49.45 (23) to maximize efficiency and improve the continuity of care, consistent with the requirements of this section and s. 49.45 (23). The department shall seek to implement mechanisms to ensure the long–term financial sustainability of the programs under this section and s. 49.45 (23). These mechanisms must address issues related to minimizing adverse selection, the state financial risk and contribution, and negative impacts to premiums in the individual and group insurance markets.

2. The purchase option program shall include, at a minimum, all of the following attributes:

a. Establishment of an annual per enrollee premium rate similar to the average rate paid by the state to managed care plan contractors.

b. Establishment of a benefit set equal to the benefits covered under this section and s. 49.45 (23).

c. Annual enrollment that is limited to the same annual open enrollment periods established for the programs under this section and s. 49.45 (23).

d. The ability for the department to adjust the purchase option's actuarial value to a value no lower than 87 percent.

e. Reimbursement mechanisms for addressing potential increased costs to the programs under this section and s. 49.45 (23).

(c) By March 1, 2018, the department of health services shall submit a report to the appropriate standing committee in each house of the legislature under s. 13.172 (3) that provides information on the status of the request for a federal waiver and the results from actuarial and economic analyses that are necessary for a waiver proposal.

(d) If any necessary waiver or amendments to the state plan described under par. (a) 1. are approved, the department shall implement the program. If the department is authorized to implement the program, and if any waiver or state plan amendment described under par. (a) 2. is necessary and is approved, or if the department determines neither a waiver nor state plan amendment is necessary, the department shall allow the purchase options described under par. (a) 2.".

14. Page 563, line 2: after that line insert:

"**SECTION 983a.** 66.0137 (4) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).".

15. Page 563, line 2: after that line insert:

"**SECTION 983a.** 66.0137 (4) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

16. Page 563, line 2: after that line insert:

"**SECTION 983a.** 66.0137 (4) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis,

the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).".

17. Page 831, line 3: after that line insert:

"**SECTION 1624k.** 120.13 (2) (g) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.728, 632.746 (1), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).".

18. Page 831, line 3: after that line insert:

"**SECTION 1624k.** 120.13 (2) (g) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.885, 632.89, 632.895 ~~(9)~~ (8) to (17), 632.896, and 767.513 (4).".

19. Page 831, line 3: after that line insert:

"**SECTION 1624k.** 120.13 (2) (g) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),

632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4) to (6), 632.883, 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).".

20. Page 857, line 18: after that line insert:

"**SECTION 1691am.** 185.983 (1) (intro.) of the statutes, as affected by 2017 Wisconsin Act 30, is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 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, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.728, 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:".

21. Page 857, line 18: after that line insert:

"**SECTION 1691am.** 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 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, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (2) to (6), 632.883, 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:".

22. Page 876, line 22: after that line insert:

"**SECTION 1791df.** 253.07 (title) of the statutes is amended to read:

253.07 (title) **Women's health block grant; state family planning funds.**

SECTION 1791dh. 253.07 (6) of the statutes is created to read:

253.07 **(6)** STATE-FUNDED FAMILY PLANNING PROGRAM. (a) In this subsection:

1. "Federal funding prohibition" means an enacted federal law, a regulation, or an executive order or action that prohibits federal moneys from being paid by the state to or directly to a provider under Title X of the federal Public Health Service Act, 42 USC 300 to 300a–6, because of the scope of services offered by the provider or the scope of services for which the provider offers referrals.

2. "Nonpublic family planning provider" means an entity other than a public entity or governmental unit that is a provider of services for family planning and that is eligible to apply for grant funding under Title X of the federal Public Health Service Act, 42 USC 300 to 300a–6, on December 31, 2016.

(b) Notwithstanding sub. (5), if a nonpublic family planning provider becomes subject to a federal funding prohibition, the department shall establish a state–funded family planning program to ensure continuity of family planning services in the state and distribute state funds to any nonpublic family planning providers that are subject to a federal funding prohibition to be used to provide family planning services.".

23. Page 925, line 14: after that line insert:

"**SECTION 2218s.** 625.02 (1) of the statutes is renumbered 625.02 (1m).

SECTION 2218t. 625.02 (1j) of the statutes is created to read:

625.02 **(1j)** "Health insurance" has the meaning given in s. 632.745 (12).

SECTION 2218u. 625.03 (1m) (intro.) of the statutes is amended to read:

625.03 **(1m)** (intro.) ~~This~~ Except as specifically provided otherwise in this chapter, this chapter applies to all kinds and lines of direct insurance written on risks or operations in this state by any insurer authorized to do business in this state, except:

SECTION 2218v. 625.13 (1) of the statutes is amended to read:

625.13 **(1)** FILING PROCEDURE. Except as provided in sub. (2) and s. 625.25 (2) (a), every authorized insurer and every rate service organization licensed under s. 625.31 which has been designated by any insurer for the filing of rates under s. 625.15 (2) shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in this state within 30 days after they become effective.

SECTION 2218w. 625.15 (2) of the statutes is amended to read:

625.15 **(2)** RATE FILING. An insurer may discharge its obligation under s. 625.13 (1) or 625.25 (2) (a) by giving notice to the commissioner that it uses rates and supplementary rate information prepared by a designated rate service organization, with such information about modifications thereof as is necessary fully to inform the commissioner. The insurer's rates or proposed rates and supplementary rate information shall be those filed from time to time by the rate service organization, including any amendments or proposed amendments thereto as filed, subject, however, to the modifications filed by the insurer.

SECTION 2218x. 625.21 (1) of the statutes is amended to read:

625.21 **(1)** RULE INSTITUTING DELAYED EFFECT. If the commissioner finds that competition is not an effective regulator of the rates charged or that a substantial number of companies are competing irresponsibly through the rates charged, or that there are widespread violations of this chapter, in any kind or line of insurance or

subdivision thereof or in any rating class or rating territory, he or she may promulgate a rule requiring that in the kind or line of insurance or subdivision thereof or rating class or rating territory comprehended by the finding any subsequent changes in the rates or supplementary rate information be filed with the commissioner at least 15 days before they become effective. The commissioner may extend the waiting period for not to exceed 15 additional days by written notice to the filer before the first 15–day period expires. This subsection does not apply to health insurance, which is subject to s. 625.25 (2) (a).

SECTION 2218y. 625.22 (1) of the statutes is amended to read:

625.22 **(1)** ORDER IN EVENT OF VIOLATION. If the commissioner finds after a hearing that a rate or proposed rate is not in compliance with s. 625.11, the commissioner shall order that its use be discontinued, or that it may not be used, for any policy issued or renewed after a date specified in the order.

SECTION 2218z. 625.22 (3) of the statutes is amended to read:

625.22 **(3)** APPROVAL OF SUBSTITUTED RATE. ~~Within~~ Except for rates for health insurance, which is subject to s. 625.25 (2) (a), within one year after the effective date of an order under sub. (1), no rate promulgated to replace a disapproved one may be used until it has been filed with the commissioner and not disapproved within 30 days thereafter.

SECTION 2219b. 625.23 of the statutes is amended to read:

625.23 Special restrictions on individual insurers. The commissioner may by order require that a particular insurer file any or all of its rates and supplementary rate information 15 days prior to their effective date, if and to the extent that he or she finds, after a hearing, that the protection of the interests of its insureds and the public in this state requires closer supervision of its rates because

of the insurer's financial condition or rating practices. The commissioner may extend the waiting period for any filing for not to exceed 15 additional days by written notice to the insurer before the first 15–day period expires. A filing not disapproved before the expiration of the waiting period shall be deemed to meet the requirements of this chapter, subject to the possibility of subsequent disapproval under s. 625.22. This section does not apply to an insurer with respect to rates for health insurance, which is subject to s. 625.25 (2) (a).

SECTION 2219c. 625.25 of the statutes is created to read:

625.25 Rates for health insurance. (1) DEFINITIONS. In this section:

(a) "Group health benefit plan" has the meaning given in s. 632.745 (9).

(b) "Health benefit plan" has the meaning given in s. 632.745 (11).

(c) "Insurer" has the meaning given in s. 632.745 (15).

(d) "Large group market" has the meaning given in s. 632.745 (17).

(e) "Small group market" has the meaning given in s. 632.745 (26).

(2) FILING OF RATES; HEARING. (a) Every insurer, and every rate service organization licensed under s. 625.31 that has been designated by any insurer for the filing of rates under s. 625.15 (2), shall file with the commissioner all proposed rates and supplementary rate information, and all proposed changes and amendments to rates and supplementary rate information, for use in this state for any health benefit plan offered by the insurer before the proposed rates or changes to rates become effective. An insurer may not use a proposed rate or change to a rate until it has been filed with and approved by the commissioner. Unless the commissioner holds a hearing on the proposed rate or change to a rate, a proposed rate or change to a rate is approved if the commissioner does not disapprove the proposed rate or change within 30 days after filing, or within a 30–day extension of that period ordered by the

commissioner prior to the expiration of the first 30 days. The requirement under this paragraph applies with respect to rates and changes to rates for all health benefit plans, including individual health benefit plans, group health benefit plans offered in the small group market, and group health benefit plans offered in the large group market, that have not gone into effect by the effective date of this paragraph .... [LRB inserts date].

(b) If any proposed change to a rate filed under par. (a) increases the existing rate by more than 10 percent of that rate, the commissioner shall hold a public hearing before approving or disapproving the proposed change to the rate.

(c) The commissioner may disapprove a proposed rate or change to a rate filed under par. (a) that the commissioner determines is not justified based on underlying medical costs.

(3) PUBLICATION OF INCREASES, NEGOTIATED RATES. (a) The commissioner shall publish on the office's Internet site, in a format that is readily understandable by members of the public, all rate changes filed under sub. (2) (a) that increase an existing rate by any amount and that are approved.

(b) If the commissioner approves a rate increase after holding a hearing under sub. (2) (b) and the insurer justified the rate increase based on increased medical costs, the commissioner shall publish on the office's Internet site, in a format that is readily understandable by members of the public, the discounted payment rates the insurer has negotiated with each of the insurer's provider networks.

(4) NOTICE OF RATE INCREASE TO INSUREDS. If the commissioner approves a rate increase filed under sub. (2) (a), the insurer shall provide notice of the rate increase to each insured under the health benefit plan at least 60 days before the rate increase goes into effect.".

24. Page 925, line 14: after that line insert:

"**SECTION 2218u.** 609.713 of the statutes is created to read:

609.713 Essential health benefits. Defined network plans and preferred provider plans are subject to s. 632.895 (14m).

SECTION 2218y. 632.895 (14m) of the statutes is created to read:

632.895 **(14m)** ESSENTIAL HEALTH BENEFITS. (a) In this subsection, "self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) On a date specified by the commissioner, by rule, every disability insurance policy and every self–insured health plan shall provide coverage for essential health benefits as determined by the commissioner, by rule, subject to par. (c).

(c) In determining the essential health benefits for which coverage is required under par. (b), the commissioner shall do all of the following:

1. Include benefits, items, and services in, at least, all of the following categories:

a. Ambulatory patient services.

b. Emergency services.

c. Hospitalization.

d. Maternity and newborn care.

e. Mental health and substance use disorder services, including behavioral health treatment.

f. Prescription drugs.

g. Rehabilitative and habilitative services and devices.

h. Laboratory services.

i. Preventive and wellness services and chronic disease management.

j. Pediatric services, including oral and vision care.

2. Conduct a survey of employer–sponsored coverage to determine benefits typically covered by employers and ensure that the scope of essential health benefits for which coverage is required under this subsection is equal to the scope of benefits covered under a typical disability insurance policy offered by an employer to its employees.

3. Ensure that essential health benefits reflect a balance among the categories described in subd. 1. such that benefits are not unduly weighted toward one category.

4. Ensure that essential health benefit coverage is provided with no or limited cost–sharing requirements.

5. Require that disability insurance policies and self–insured health plans do not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.

6. Establish essential health benefits in a way that takes account of the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

7. Ensure that essential health benefits established under this subsection not be subject to a coverage denial based on an insured's or plan participant's age, expected length of life, present or predicted disability, degree of dependency on medical care, or quality of life.

8. Require that disability insurance policies and self–insured health plans cover emergency department services that are essential health benefits without imposing any requirement to obtain prior authorization for those services and without limiting coverage for services provided by an emergency services provider

that is not in the provider network of a policy or plan in a way that is more restrictive than requirements or limitations that apply to emergency services provided by a provider that is in the provider network of the policy or plan.

9. Require a disability insurance policy or self–insured health plan to apply to emergency department services that are essential health benefits provided by an emergency department provider that is not in the provider network of the policy or plan the same copayment amount or coinsurance rate that applies if those services are provided by a provider that is in the provider network of the policy or plan.

(d) The commissioner shall periodically update, by rule, the essential health benefits under this subsection to address any gaps in access to coverage.

(e) If an essential health benefit is also subject to mandated coverage elsewhere under this section and the coverage requirements are not identical, the disability insurance policy or self–insured health plan shall provide coverage under whichever subsection provides the insured or plan participant with more comprehensive coverage of the medical condition, item, or service.

(f) Nothing in this subsection or rules promulgated under this subsection prohibits a disability insurance policy or a self–insured health plan from providing benefits in excess of the essential health benefit coverage required under this subsection.".

25. Page 925, line 14: after that line insert:

"**SECTION 2218t.** 609.847 of the statutes is created to read:

609.847 Preexisting condition discrimination prohibited. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.728.

SECTION 2218w. 625.12 (1) (a) of the statutes is amended to read:

625.12 **(1)** (a) Past and prospective loss and expense experience within and outside of this state, except as provided in s. 632.728.

SECTION 2218y. 625.12 (1) (e) of the statutes is amended to read:

625.12 **(1)** (e) Subject to ~~s.~~ ss. 632.365 and 632.728, all other relevant factors, including the judgment of technical personnel.

SECTION 2219b. 625.12 (2) of the statutes is amended to read:

625.12 **(2)** CLASSIFICATION. ~~Risks~~ Except as provided in s. 632.728, risks may be classified in any reasonable way for the establishment of rates and minimum premiums, except that no classifications may be based on race, color, creed or national origin, and classifications in automobile insurance may not be based on physical condition or developmental disability as defined in s. 51.01 (5). Subject to ~~s.~~ ss. 632.365 and 632.728, rates thus produced may be modified for individual risks in accordance with rating plans or schedules that establish reasonable standards for measuring probable variations in hazards, expenses, or both. Rates may also be modified for individual risks under s. 625.13 (2).

SECTION 2219d. 625.15 (1) of the statutes is amended to read:

625.15 **(1)** RATE MAKING. ~~An~~ Except as provided in s. 632.728, an insurer may itself establish rates and supplementary rate information for one or more market segments based on the factors in s. 625.12 and, if the rates are for motor vehicle liability insurance, subject to s. 632.365, or the insurer may use rates and supplementary rate information prepared by a rate service organization, with average expense factors determined by the rate service organization or with such modification for its own expense and loss experience as the credibility of that experience allows.

SECTION 2219f. 628.34 (3) (a) of the statutes is amended to read:

628.34 **(3)** (a) No insurer may unfairly discriminate among policyholders by charging different premiums or by offering different terms of coverage except on the basis of classifications related to the nature and the degree of the risk covered or the expenses involved, subject to ss. 632.365, 632.728, 632.746 and 632.748. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, blanket or franchise policy, and terms are not unfairly discriminatory merely because they are more favorable than in a similar individual policy.

SECTION 2219h. 632.728 of the statutes is created to read:

632.728 Premiums and cost-sharing discrimination prohibited for preexisiting conditions. (1) DEFINITION. In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) PROHIBITION. For the purpose of setting rates or premiums for coverage under a group or individual disability insurance policy or a self–insured health plan and for the purpose of setting any deductibles, copayments, or coinsurance under a group or individual disability insurance policy or a self–insured health plan, the policy or plan may not consider whether an individual, including a dependent, who would be covered under the plan has a preexisting condition.

SECTION 2219j. 632.746 (1) (a) of the statutes is renumbered 632.746 (1) and amended to read:

632.746 **(1)** ~~Subject to subs. (2) and (3), an~~ An insurer that offers a group health benefit plan may~~, with respect to a participant or beneficiary under the plan,~~ not impose a preexisting condition exclusion ~~only if the exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which~~

~~medical advice, diagnosis, care or treatment was recommended or received within the 6–month period ending on the participant's or beneficiary's enrollment date under the plan~~ on a participant or beneficiary under the plan.

SECTION 2219n. 632.746 (1) (b) of the statutes is repealed.

SECTION 2219p. 632.746 (2) (a) of the statutes is amended to read:

632.746 **(2)** (a) An insurer offering a group health benefit plan may not treat genetic information as a preexisting condition under sub. (1) ~~without a diagnosis of a condition related to the information~~.

SECTION 2219r. 632.746 (2) (c), (d) and (e) of the statutes are repealed.

SECTION 2219t. 632.746 (3) (a) of the statutes is repealed.

SECTION 2219v. 632.746 (3) (d) 1. of the statutes is renumbered 632.746 (3) (d).

SECTION 2219x. 632.746 (3) (d) 2. and 3. of the statutes are repealed.

SECTION 2219z. 632.746 (5) of the statutes is repealed.

SECTION 2220b. 632.746 (8) (a) (intro.) of the statutes is amended to read:

632.746 **(8)** (a) (intro.) A health maintenance organization that offers a group health benefit plan ~~and that does not impose any preexisting condition exclusion under sub. (1)~~ with respect to a particular coverage option may impose an affiliation period for that coverage option, but only if all of the following apply:

SECTION 2220d. 632.76 (2) (a) and (ac) 1. and 2. of the statutes are amended to read:

632.76 **(2)** (a) No claim for loss incurred or disability commencing after 2 years from the date of issue of the policy may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of loss. This paragraph does not apply to a group health benefit

plan, as defined in s. 632.745 (9), which is subject to s. 632.746, a disability insurance policy, as defined in s. 632.895 (1) (a), or a self–insured health plan, as defined in s. 632.85 (1) (c).

(ac) 1. ~~Notwithstanding par. (a), no~~ No claim or loss incurred or disability commencing ~~after 12 months from the date of issue of~~ under an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage~~, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss~~.

2. ~~Except as provided in subd. 3., an~~ An individual disability insurance policy, as defined in s. 632.895 (1) (a), ~~other than a short–term policy subject to s. 632.7495 (4) and (5),~~ may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received ~~within 12 months before the effective date of coverage~~.

SECTION 2220f. 632.76 (2) (ac) 3. of the statutes is repealed.

SECTION 1. 632.795 (4) (a) of the statutes is amended to read:

632.795 **(4)** (a) An insurer subject to sub. (2) shall provide coverage under the same policy form and for the same premium as it originally offered in the most recent enrollment period, subject only to the medical underwriting used in that enrollment period. Unless otherwise prescribed by rule, the insurer may apply deductibles, ~~preexisting condition limitations,~~ waiting periods, or other limits only to the extent that they would have been applicable had coverage been extended at the time of the most recent enrollment period and with credit for the satisfaction or partial satisfaction of similar provisions under the liquidated insurer's policy or plan. The

insurer may exclude coverage of claims that are payable by a solvent insurer under insolvency coverage required by the commissioner or by the insurance regulator of another jurisdiction. Coverage shall be effective on the date that the liquidated insurer's coverage terminates.

SECTION 2220h. 632.897 (11) (a) of the statutes is amended to read:

632.897 **(11)** (a) Notwithstanding subs. (2) to (10), the commissioner may promulgate rules establishing standards requiring insurers to provide continuation of coverage for any individual covered at any time under a group policy who is a terminated insured or an eligible individual under any federal program that provides for a federal premium subsidy for individuals covered under continuation of coverage under a group policy, including rules governing election or extension of election periods, notice, rates, premiums, premium payment, ~~application of preexisting condition exclusions,~~ election of alternative coverage, and status as an eligible individual, as defined in s. 149.10 (2t), 2011 stats.".

26. Page 925, line 14: after that line insert:

"**SECTION 2218t.** 609.896 of the statutes is created to read:

609.896 Preventive services. Defined network plans and preferred provider plans are subject to s. 632.895 (13m).

SECTION 2218w. 632.895 (8) (d) of the statutes is amended to read:

632.895 **(8)** (d) Coverage is required under this subsection despite whether the woman shows any symptoms of breast cancer. Except as provided in pars. (b), (c)~~,~~ and (e), coverage under this subsection may only be subject to exclusions and limitations, including ~~deductibles, copayments and~~ restrictions on excessive charges, that are applied to other radiological examinations covered under the disability insurance

policy. Coverage under this subsection may not be subject to any deductibles, copayments, or coinsurance.

SECTION 2219b. 632.895 (13m) of the statutes is created to read:

632.895 **(13m)** PREVENTIVE SERVICES. (a) In this section, "self–insured health plan" has the meaning given in s. 632.85 (1) (c).

(b) Every disability insurance policy and every self–insured health plan shall provide coverage for all of the following preventive services:

1. Mammography in accordance with sub. (8).

2. Genetic breast cancer screening and counseling and preventive medication for adult women at high risk for breast cancer.

3. Papanicolaou test for cancer screening for women 21 years of age or older with an intact cervix.

4. Human papillomavirus testing for women who have attained the age of 30 years but have not attained the age of 66 years.

5. Colorectal cancer screening in accordance with sub. (16m).

6. Annual tomography for lung cancer screening for adults who have attained the age of 55 years but have not attained the age of 80 years and who have health histories demonstrating a risk for lung cancer.

7. Skin cancer screening for individuals who have attained the age of 10 years but have not attained the age of 22 years.

8. Counseling for skin cancer prevention for adults who have attained the age of 18 years but have not attained the age of 25 years.

9. Abdominal aortic aneurysm screening for men who have attained the age of 65 years but have not attained the age of 75 years and who have ever smoked.

10. Hypertension screening for adults and blood pressure testing for adults, for children under the age of 3 years who are at high risk for hypertension, and for children 3 years of age or older.

11. Lipid disorder screening for minors 2 years of age or older, high risk women 20 years of age or older, men age 20 years of age or older at high risk for lipid disorders, and all men 35 years of age or older.

12. Aspirin therapy for cardiovascular health for adults who have attained the age of 55 years but have not attained the age of 80 years and for men who have attained the age of 45 years but have not attained the age of 55 years.

13. Behavioral counseling for cardiovascular health for adults who are overweight or obese and who have risk factors for cardiovascular disease.

14. Type II diabetes screening for adults with elevated blood pressure.

15. Depression screening for minors 11 years of age or older and for adults when follow–up supports are available.

16. Hepatitis B screening for minors at high risk for infection and adults at high risk for infection.

17. Hepatitis C screening for adults at high risk for infection and one time hepatitis C screening for adults born in 1945 to 1965.

18. Obesity screening and management for all minors and adults with a body mass index indicating obesity, counseling and behavioral interventions for obese minors who are 6 years of age or older, and referral for intervention for obesity for adults with a body mass index of 30 kilograms per square meter or higher.

19. Osteoporosis screening for all women 65 years of age or older and for women at high risk for osteoporosis under the age of 65 years.

20. Immunizations in accordance with sub. (14).

21. Anemia screening for individuals 6 months of age or older and iron supplements for individuals at high risk for anemia and who have attained the age of 6 months but have not attained the age of 12 months.

22. Fluoride varnish for prevention of tooth decay for minors at the age of eruption of their primary teeth.

23. Fluoride supplements for prevention of tooth decay for minors 6 months of age or older who do not have fluoride in their water source.

24. Gonorrhea prophylaxis treatment for newborns.

25. Health history and physical exams for prenatal visits and for minors.

26. Length and weight measurements for newborns and height and weight measurements for minors.

27. Head circumference and weight for length measurements for newborns and minors who have not attained the age of 3 years.

28. Body mass index for minors 2 years of age or older.

29. Blood pressure measurements for minors 3 years of age or older and a blood pressure risk assessment at birth.

30. Risk assessment and referral for oral health issues for minors who have attained the age of 6 months but have not attained the age of 7 years.

31. Blood screening for newborns and minors who have not attained age 2 months.

32. Screening for critical congenital health defect for newborns.

33. Lead screenings in accordance with sub. (10).

34. Metabolic and hemoglobin screening and screening for phenylketonuria, sickle cell anemia, and congenital hypothyroidism for minors including newborns.

35. Tuberculin skin test based on risk assessment for minors one month of age or older.

36. Tobacco counseling and cessation interventions for individuals who are 5 years of age or older.

37. Vision and hearing screening and assessment for minors including newborns.

38. Sexually transmitted infection and human immunodeficiency virus counseling for sexually active minors.

39. Risk assessment for sexually transmitted infection for minors who are 10 years of age or older and screening for sexually transmitted infection for minors who are 16 years of age or older.

40. Alcohol misuse screening and counseling for minors 11 years of age or older.

41. Autism screening for minors who have attained the age of 18 months but have not attained the age of 25 months.

42. Developmental screening and surveillance for minors including newborns.

43. Psychosocial and behavioral assessment for minors including newborns.

44. Alcohol misuse screening and counseling for pregnant adults and a risk assessment for all adults.

45. Fall prevention and counseling and preventive medication for fall prevention for community-dwelling adults 65 years of age or older.

46. Screening and counseling for intimate partner violence for adult women.

47. Well-woman visits for women who have attained the age of 18 years but have not attained the age of 65 years and well-woman visits for recommended preventive services, preconception care, and prenatal care.

48. Counseling on, consultations with a trained provider on, and equipment rental for breastfeeding for pregnant and lactating women.

49. Folic acid supplement for adult women with reproductive capacity.

50. Iron deficiency anemia screening for pregnant and lactating women.

51. Preeclampsia preventive medicine for pregnant adult women at high risk for preeclampsia.

52. Low–dose aspirin after 12 weeks of gestation for pregnant women at high risk for miscarriage, preeclampsia, or clotting disorders.

53. Screenings for hepatitis B and bacteriuria for pregnant women.

54. Screening for gonorrhea for pregnant and sexually active females 24 years of age or younger and females older than 24 years of age who are at risk for infection.

55. Screening for chlamydia for pregnant and sexually active females 24 years of age and younger and females older than 24 years of age who are at risk for infection.

56. Screening for syphilis for pregnant women and adults who are at high risk for infection.

57. Human immunodeficiency virus screening for adults who have attained the age of 15 years but have not attained the age of 66 years and individuals at high risk of infection who are younger than 15 years of age or older than 65 years of age.

58. All contraceptives and services in accordance with sub. (17).

59. Any services not already specified under this paragraph having an A or B rating in current recommendations from the U.S. Preventive Services Task Force.

60. Any preventive services not already specified under this paragraph that are recommended by the federal health resources and services administration's Bright Futures project.

61. Any immunizations, not already specified under sub. (14), that are recommended and determined to be for routine use by the Advisory Committee on Immunization Practices.

(c) Subject to par. (d), no disability insurance policy and no self–insured health plan may subject the coverage of any of the preventive services under par. (b) to any deductibles, copayments, or coinsurance under the policy or plan.

(d) 1. If an office visit and a preventive service specified under par. (b) are billed separately by the health care provider, the disability insurance policy or self–insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit but not on the preventive service.

2. If the primary reason for an office visit is not to obtain a preventive service, the disability insurance policy or self–insured health plan may apply deductibles to and impose copayments or coinsurance on the office visit.

3. If a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self–insured health plan's network of providers, the policy or plan may apply deductibles to and impose copayments or coinsurance on the office visit and the preventive service. If a preventive service specified under par. (b) is provided by a health care provider that is outside the disability insurance policy's or self–insured health plan's network of providers because there is no available health care provider in the policy's or plan's network of providers that provides the preventive service, the policy or plan may not apply deductibles to or impose copayments or coinsurance on preventive service.

4. If multiple well–woman visits described under par. (b) 47. are required to fulfill all necessary preventive services and are in accordance with clinical recommendations, the disability insurance policy or self–insured health plan may

not apply a deductible or impose a copayment or coinsurance to any of those well–woman visits.

SECTION 2219d. 632.895 (14) (a) 1. i. and j. of the statutes are amended to read:

632.895 **(14)** (a) 1. i. Hepatitis A and B.

j. Varicella and herpes zoster.

SECTION 2219f. 632.895 (14) (a) 1. k. to o. of the statutes are created to read:

632.895 **(14)** (a) 1. k. Human papillomavirus.

L. Meningococcal meningitis.

m. Pneumococcal pneumonia.

n. Influenza.

o. Rotavirus.

SECTION 2219h. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, ~~that provides coverage for a dependent of the insured~~ shall provide coverage of appropriate and necessary immunizations~~, from birth to the age of 6 years,~~ for an insured or plan participant, including a dependent ~~who is a child~~ of the insured or plan participant.

SECTION 2219j. 632.895 (14) (c) of the statutes is amended to read:

632.895 **(14)** (c) The coverage required under par. (b) may not be subject to any deductibles, copayments, or coinsurance under the policy or plan. ~~This paragraph applies to a defined network plan, as defined in s. 609.01 (1b), only with respect to appropriate and necessary immunizations provided by providers participating, as defined in s. 609.01 (3m), in the plan.~~

SECTION 2219m. 632.895 (14) (d) 3. of the statutes is amended to read:

632.895 **(14)** (d) 3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3)~~, or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b)~~.

SECTION 2219p. 632.895 (16m) (b) of the statutes is amended to read:

632.895 **(16m)** (b) The coverage required under this subsection may be subject to any limitations~~,~~ or exclusions~~, or cost-sharing provisions~~ that apply generally under the disability insurance policy or self-insured health plan. The coverage required under this subsection may not be subject to any deductibles, copayments, or coinsurance.

SECTION 2219r. 632.895 (17) (b) 2. of the statutes is amended to read:

632.895 **(17)** (b) 2. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, ~~if covered for any other drug benefits under the policy or plan~~ sterilization procedures, and patient education and counseling for all females with reproductive capacity.

SECTION 2219t. 632.895 (17) (c) of the statutes is amended to read:

632.895 **(17)** (c) Coverage under par. (b) may be subject only to the exclusions~~,~~ and limitations~~, or cost-sharing provisions~~ that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self-insured health plan. A disability insurance policy or self-insured health plan may not apply a deductible or impose a copayment or coinsurance to at least one of each type of contraceptive method approved by the federal food and drug administration for which coverage is required under this subsection. The disability insurance policy or self-insured health plan may apply reasonable medical management to a method of contraception

to limit coverage under this subsection that is provided without being subject to a deductible, copayment, or coinsurance to prescription drugs without a brand name. The disability insurance policy or self–insured health plan may apply a deductible or impose a copayment or coinsurance for coverage of a contraceptive that is prescribed for a medical need if the services for the medical need would otherwise be subject to a deductible, copayment, or coinsurance.".

27. Page 925, line 14: after that line insert:

"**SECTION 2218s.** 609.845 of the statutes is created to read:

609.845 Lifetime and annual limits. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.883.

SECTION 2218x. 632.883 of the statutes is created to read:

632.883 Lifetime and annual limits. (1) No group or individual disability insurance policy, as defined in s. 632.895 (1) (a), and no self–insured health plan, as defined in s. 632.745 (24), may impose a lifetime limit on the dollar value of benefits provided under the policy or plan.

(2) No group or individual disability insurance policy, as defined in s. 632.895 (1) (a), and no self–insured health plan, as defined in s. 632.745 (24), may impose an annual limit on the dollar value of benefits under the policy or plan.".

28. Page 1015, line 10: after that line insert:

"(5r) EXTENSION OF PRESCRIPTION DRUG ASSISTANCE FOR ELDERLY. The department of health services shall request from the federal secretary of health and human services any waiver of federal medicaid laws necessary to permit the department of health services to continue administering the program under section 49.688 of the

statutes for 4 years from the date the waiver under this subsection is granted. The department shall implement any waiver received under this subsection.".

29. Page 1015, line 10: after that line insert:

"(5p) MEDICAL ASSISTANCE NONEMERGENCY MEDICAL TRANSPORTATION.

(b) The department of health services shall, to the extent permitted by the contract, modify the contract that is in effect on the effective date of this paragraph for the arrangement and reimbursement of nonemergency medical transportation services to recipients of Medical Assistance under subchapter IV of chapter 49 of the statutes to exclude recipients of Medical Assistance residing in Buffalo, Eau Claire, Jefferson, Kenosha, Milwaukee, Ozaukee, Pepin, Racine, Rock, Trempealeau, Walworth, Washington, and Waukesha counties from that contract unless the county chooses to remain under the original contract.

(c) If the department of health services modifies the contract under paragraph (b), the department of health services shall make alternative arrangements with counties, health maintenance organizations, or transportation providers to provide nonemergency medical transportation services to Medical Assistance recipients who reside in the counties specified in paragraph (b), except any county that chooses to remain under the original contract, no later than January 1, 2019. The department of health services shall include in any contract for alternative arrangements under this paragraph a requirement that the nonemergency medical transportation provider submit to the department of health services information substantially similar to the information required under the original contract including trip log data, summary information on all calls for services and contacts with Medical Assistance recipients, encounter data based on Centers for Medicare and Medicaid

Services 1500 claim form data, network provider information, accident and moving violation reports, vehicle reports, complaint summary reports, telecommunications system reports, annual fiscal audit reports, and daily reports including numbers of trips, canceled trips, denied trips, and complaints.".

30. Page 1015, line 10: after that line insert:

"(5t) INCREASING MEDICAL ASSISTANCE REIMBURSEMENT RATES FOR PERSONAL CARE SERVICES. The department of health services shall increase the reimbursement rates 15 percent under the Medical Assistance program for the 2017–18 biennium for personal care services providers and shall increase the reimbursement rates 15 percent under the Medical Assistance program for the 2018–19 biennium for personal care services providers.

(5v) INCREASING MEDICAL ASSISTANCE REIMBURSEMENT RATES FOR NURSING HOMES. The department of health services shall increase the reimbursement rates 5 percent under the Medical Assistance program for the 2017–18 biennium for nursing homes and shall increase the reimbursement rates 5 percent under the Medical Assistance program for the 2018–19 biennium for nursing homes.".

31. Page 1016, line 20: after that line insert:

"(7g) INCREASING MEDICAL ASSISTANCE REIMBURSEMENT RATES. The department of health services shall increase the reimbursement rates 12 percent under the Medical Assistance program for dates of service on and after January 1, 2017, for noninstitutional providers who are not personal care services providers, hospitals, nursing homes, or providers of services for which reimbursement is made on a basis other than a maximum fee schedule.".

32. Page 1065, line 18: after that line insert:

"(1e) PREEXISTING CONDITIONS.

(d) For policies and plans containing inconsistent provisions, the treatment of sections 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2. and 3., (5), and (8) (a) (intro.), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), and 632.897 (11) (a) of the statutes first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in paragraph (e).

(e) For policies or plans that are affected by a collective bargaining agreement containing inconsistent provisions, the treatment of sections 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2. and 3., (5), and (8) (a) (intro.), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), and 632.897 (11) (a) of the statutes first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.".

33. Page 1065, line 18: after that line insert:

"(1d) PREVENTIVE SERVICES.

(f) For policies and plans containing inconsistent provisions, the treatment of sections 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 609.896, 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (16m) (b), and (17) (b) 2. and (c) of the statutes first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in paragraph (g).

(g) For policies and plans that are affected by a collective bargaining agreement containing inconsistent provisions, the treatment of sections 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 609.896, 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (16m) (b), and (17) (b) 2. and (c) of the statutes first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.".

34. Page 1065, line 18: after that line insert:

"(1f) LIFETIME AND ANNUAL LIMITS.

(h) For policies and plans containing provisions inconsistent with this act, the treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.845, and 632.883 of the statutes first applies to policy or plan years beginning on January 1 of the year following the year in which this paragraph takes effect, except as provided in paragraph (i).

(i) For policies or plans that are affected by a collective bargaining agreement containing provisions inconsistent with this act, the treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.845, and 632.883 of the statutes first applies to policy or plan years beginning on the effective date of this paragraph or on the day on which the collective bargaining agreement is newly established, extended, modified, or renewed, whichever is later.".

35. Page 1080, line 17: after that line insert:

"(7g) MEDICAID EXPANSION. The treatment of sections 49.45 (23) (a) and 49.471 (1) (cr), (4) (a) 4. b., and (4g) of the statutes take effect on January 1, 2018, or on the day after publication, whichever is later.".

36. Page 1080, line 24: after that line insert:

"(2e) PREEXISTING CONDITIONS. This act 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.847, 625.12 (1) (a) and (e) and (2), 625.15 (1), 628.34 (3) (a), 632.728, 632.746 (1) (a) and (b), (2) (a), (c), (d), and (e), (3) (a) and (d) 1., 2. and 3., (5), and (8) (a) (intro.), 632.76 (2) (a) and (ac) 1., 2., and 3., 632.795 (4) (a), and 632.897 (11) (a) of the statutes and SECTION 9324 (1e) take effect on the first day of the 4th month beginning after publication.".

37. Page 1080, line 24: after that line insert:

"(2d) PREVENTIVE SERVICES. The treatment of sections 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 609.896, 632.895 (8) (d), (13m), (14) (a) 1. i., j., and k. to o., (b), (c), and (d) 3., (16m) (b), and (17) (b) 2. and (c) of the statutes and SECTION 9324 (1d) of this act takes effect on the first day of the 4th month beginning after publication.".

38. Page 1080, line 24: after that line insert:

"(2f) LIFETIME AND ANNUAL LIMITS. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.983 (1) (intro.), 609.845, and 632.883 of the statutes and SECTION 9324 (1f) of this act take effect on the first day of the 4th month beginning after publication.".

39. At the appropriate places, insert all of the following:

"**SECTION 1ab.** 1.12 (1) (b) of the statutes is amended to read:

1.12 **(1)** (b) "State agency" means an office, department, agency, institution of higher education, the legislature, a legislative service agency, the courts, a judicial branch agency, an association, society, or other body in state government that is created or authorized to be created by the constitution or by law, for which

appropriations are made by law, excluding the Badger Health Benefit Authority and the Wisconsin Economic Development Corporation.

SECTION 1ac. 13.172 (1) of the statutes is amended to read:

13.172 **(1)** In this section, "agency" means an office, department, agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, and any authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 238, or 279.

SECTION 1ad. 13.62 (2) of the statutes is amended to read:

13.62 **(2)** "Agency" means any board, commission, department, office, society, institution of higher education, council, or committee in the state government, or any authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 232, 233, 234, 237, 238, or 279, except that the term does not include a council or committee of the legislature.

SECTION 1ae. 13.94 (1) (dj) of the statutes is created to read:

13.94 **(1)** (dj) At least once every 2 years, perform a financial audit and performance evaluation audit of any health benefit plan exchange under subch. II of ch. 636 and an audit of the Badger Health Benefit Authority's policies and management practices and file copies of each audit report under this paragraph with the distributees specified in par. (b).

SECTION 1af. 13.94 (1s) (c) 9. of the statutes is created to read:

13.94 **(1s)** (c) 9. The Badger Health Benefit Authority for the cost of the audit under sub. (1) (dj).

SECTION 1ag. 13.95 (intro.) of the statutes is amended to read:

13.95 Legislative fiscal bureau. (intro.) There is created a bureau to be known as the "Legislative Fiscal Bureau" headed by a director. The fiscal bureau shall be strictly nonpartisan and shall at all times observe the confidential nature of the research requests received by it; however, with the prior approval of the requester in each instance, the bureau may duplicate the results of its research for distribution. Subject to s. 230.35 (4) (a) and (f), the director or the director's designated employees shall at all times, with or without notice, have access to all state agencies, the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, and the Fox River Navigational System Authority, and to any books, records, or other documents maintained by such agencies or authorities and relating to their expenditures, revenues, operations, and structure.

SECTION 1ah. 16.002 (2) of the statutes is amended to read:

16.002 **(2)** "Departments" means constitutional offices, departments, and independent agencies and includes all societies, associations, and other agencies of state government for which appropriations are made by law, but not including authorities created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 232, 233, 234, 237, 238, or 279.

SECTION 1aj. 16.004 (4) of the statutes is amended to read:

16.004 **(4)** FREEDOM OF ACCESS. The secretary and such employees of the department as the secretary designates may enter into the offices of state agencies and authorities created under subch. II of ch. 114 and subch. III of ch. 636 and under chs. 231, 233, 234, 237, 238, and 279, and may examine their books and accounts and

any other matter that in the secretary's judgment should be examined and may interrogate the agency's employees publicly or privately relative thereto.

SECTION 1ak. 16.004 (5) of the statutes is amended to read:

16.004 **(5)** AGENCIES AND EMPLOYEES TO COOPERATE. All state agencies and authorities created under subch. II of ch. 114 and subch. III of ch. 636 and under chs. 231, 233, 234, 237, 238, and 279, and their officers and employees, shall cooperate with the secretary and shall comply with every request of the secretary relating to his or her functions.

SECTION 1am. 16.004 (12) (a) of the statutes is amended to read:

16.004 **(12)** (a) In this subsection, "state agency" means an association, authority, board, department, commission, independent agency, institution, office, society, or other body in state government created or authorized to be created by the constitution or any law, including the legislature, the office of the governor, and the courts, but excluding the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, the Badger Health Benefit Authority, and the Fox River Navigational System Authority.

SECTION 1an. 16.045 (1) (a) of the statutes is amended to read:

16.045 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 232, 233, 234, 237, 238, or 279.

SECTION 1ap. 16.15 (1) (ab) of the statutes is amended to read:

16.15 **(1)** (ab) "Authority" has the meaning given under s. 16.70 (2), but excludes the University of Wisconsin Hospitals and Clinics Authority, the Lower Fox River Remediation Authority, ~~and~~ the Wisconsin Economic Development Corporation, and the Badger Health Benefit Authority.

SECTION 1aq. 16.41 (4) of the statutes is amended to read:

16.41 **(4)** In this section, "authority" means a body created under subch. II of ch. 114 or subch. III of ch. 636 or under ch. 231, 233, 234, 237, 238, or 279.

SECTION 1ar. 16.417 (1) (a) of the statutes is amended to read:

16.417 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority or the body created under subch. III of ch. 636.

SECTION 1as. 16.52 (7) of the statutes is amended to read:

16.52 **(7)** PETTY CASH ACCOUNT. With the approval of the secretary, each agency that is authorized to maintain a contingent fund under s. 20.920 may establish a petty cash account from its contingent fund. The procedure for operation and maintenance of petty cash accounts and the character of expenditures therefrom shall be prescribed by the secretary. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 237, 238, or 279.

SECTION 1at. 16.528 (1) (a) of the statutes is amended to read:

16.528 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 237, 238, or 279.

SECTION 1au. 16.53 (2) of the statutes is amended to read:

16.53 **(2)** IMPROPER INVOICES. If an agency receives an improperly completed invoice, the agency shall notify the sender of the invoice within 10 working days after it receives the invoice of the reason it is improperly completed. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 237, 238, or 279.

SECTION 1av. 16.54 (9) (a) 1. of the statutes is amended to read:

16.54 **(9)** (a) 1. "Agency" means an office, department, independent agency, institution of higher education, association, society or other body in state government created or authorized to be created by the constitution or any law, which is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 237, 238, or 279.

SECTION 1aw. 16.70 (2) of the statutes is amended to read:

16.70 **(2)** "Authority" means a body created under subch. II of ch. 114 or subch. III of ch. 636 or under ch. 231, 232, 233, 234, 237, or 279.

SECTION 1ax. 16.72 (2) (e) (intro.) of the statutes is amended to read:

16.72 **(2)** (e) (intro.) In writing the specifications under this subsection, the department and any other designated purchasing agent under s. 16.71 (1) shall incorporate requirements for the purchase of products made from recycled materials and recovered materials if their use is technically and economically feasible. Each authority other than the University of Wisconsin Hospitals and Clinics Authority ~~and,~~ the Lower Fox River Remediation Authority, and the Badger Health Benefit Authority, in writing specifications for purchasing by the authority, shall incorporate requirements for the purchase of products made from recycled materials and recovered materials if their use is technically and economically feasible. The specifications shall include requirements for the purchase of the following materials:

SECTION 1ay. 16.72 (2) (f) of the statutes is amended to read:

16.72 **(2)** (f) In writing specifications under this subsection, the department, any other designated purchasing agent under s. 16.71 (1), and each authority other than the University of Wisconsin Hospitals and Clinics Authority ~~and,~~ the Lower Fox River Remediation Authority, and the Badger Health Benefit Authority shall incorporate requirements relating to the recyclability and ultimate disposition of products and, wherever possible, shall write the specifications so as to minimize the amount of solid waste generated by the state, consistent with the priorities established under s. 287.05 (12). All specifications under this subsection shall discourage the purchase of single–use, disposable products and require, whenever practical, the purchase of multiple–use, durable products.

SECTION 1az. 16.75 (1m) of the statutes is amended to read:

16.75 **(1m)** The department shall award each order or contract for materials, supplies or equipment on the basis of life cycle cost estimates, whenever such action is appropriate. Each authority other than the University of Wisconsin Hospitals and Clinics Authority, the Lower Fox River Remediation Authority, ~~and~~ the Wisconsin Aerospace Authority, and the Badger Health Benefit Authority shall award each order or contract for materials, supplies or equipment on the basis of life cycle cost estimates, whenever such action is appropriate. The terms, conditions and evaluation criteria to be applied shall be incorporated in the solicitation of bids or proposals. The life cycle cost formula may include, but is not limited to, the applicable costs of energy efficiency, acquisition and conversion, money, transportation, warehousing and distribution, training, operation and maintenance and disposition or resale. The department shall prepare documents containing technical guidance for the development and use of life cycle cost estimates, and shall make the documents available to local governmental units.

SECTION 1ba. 16.75 (8) (am) of the statutes is amended to read:

16.75 **(8)** (am) The department, any other designated purchasing agent under s. 16.71 (1), any agency making purchases under s. 16.74, and each authority other than the University of Wisconsin Hospitals and Clinics Authority ~~and,~~ the Lower Fox River Remediation Authority, and the Badger Health Benefit Authority shall, to the extent practicable, make purchasing selections using specifications developed under s. 16.72 (2) (e) to maximize the purchase of materials utilizing recycled materials and recovered materials.

SECTION 1bb. 16.75 (8) (bm) of the statutes is amended to read:

16.75 **(8)** (bm) Each agency and authority other than the University of Wisconsin Hospitals and Clinics Authority ~~and,~~ the Lower Fox River Remediation

Authority, and the Badger Health Benefit Authority shall ensure that the average recycled or recovered content of all paper purchased by the agency or authority measured as a proportion, by weight, of the fiber content of paper products purchased in a fiscal year, is not less than 40 percent of all purchased paper.

SECTION 1bc. 16.75 (9) of the statutes is amended to read:

16.75 **(9)** The department, any other designated purchasing agent under s. 16.71 (1), any agency making purchases under s. 16.74, and any authority other than the University of Wisconsin Hospitals and Clinics Authority ~~and~~, the Lower Fox River Remediation Authority, and the Badger Health Benefit Authority shall, to the extent practicable, make purchasing selections using specifications prepared under s. 16.72 (2) (f).

SECTION 1bd. 16.765 (1) of the statutes is amended to read:

16.765 **(1)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, and the Bradley Center Sports and Entertainment Corporation shall include in all contracts executed by them a provision obligating the contractor not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01 (5), sexual orientation as defined in s. 111.32 (13m), or national origin and, except with respect to sexual orientation, obligating the contractor to take affirmative action to ensure equal employment opportunities.

SECTION 1be. 16.765 (2) of the statutes is amended to read:

16.765 **(2)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, and the Bradley Center Sports and Entertainment Corporation shall include the following provision in every contract executed by them: "In connection with the performance of work under this contract, the contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the contractor further agrees to take affirmative action to ensure equal employment opportunities. The contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause".

Section 1bf. 16.765 (4) of the statutes is amended to read:

16.765 **(4)** Contracting agencies, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, and the Bradley Center Sports and Entertainment Corporation shall take appropriate action to revise the standard government contract forms under this section.

Section 1bg. 16.765 (5) of the statutes is amended to read:

16.765 **(5)** The head of each contracting agency and the boards of directors of the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, and the Bradley Center Sports and Entertainment Corporation shall be primarily responsible for obtaining compliance by any contractor with the nondiscrimination and affirmative action provisions prescribed by this section, according to procedures recommended by the department. The department shall make recommendations to the contracting agencies and the boards of directors of the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, and the Bradley Center Sports and Entertainment Corporation for improving and making more effective the nondiscrimination and affirmative action provisions of contracts. The department shall promulgate such rules as may be necessary for the performance of its functions under this section.

Section 1bh. 16.765 (6) of the statutes is amended to read:

16.765 **(6)** The department may receive complaints of alleged violations of the nondiscrimination provisions of such contracts. The department shall investigate and determine whether a violation of this section has occurred. The department may delegate this authority to the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or

the Bradley Center Sports and Entertainment Corporation for processing in accordance with the department's procedures.

SECTION 1bk. 16.765 (7) (intro.) of the statutes is amended to read:

16.765 **(7)** (intro.) When a violation of this section has been determined by the department, the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation, the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation shall:

SECTION 1bm. 16.765 (7) (d) of the statutes is amended to read:

16.765 **(7)** (d) Direct the violating party to take immediate steps to prevent further violations of this section and to report its corrective action to the contracting agency, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation.

SECTION 1bn. 16.765 (8) of the statutes is amended to read:

16.765 **(8)** If further violations of this section are committed during the term of the contract, the contracting agency, the Fox River Navigational System Authority,

the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation may permit the violating party to complete the contract, after complying with this section, but thereafter the contracting agency, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation shall request the department to place the name of the party on the ineligible list for state contracts, or the contracting agency, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, the Badger Health Benefit Authority, the Lower Fox River Remediation Authority, the Wisconsin Economic Development Corporation, or the Bradley Center Sports and Entertainment Corporation may terminate the contract without liability for the uncompleted portion or any materials or services purchased or paid for by the contracting party for use in completing the contract.

SECTION 1bp. 16.85 (2) of the statutes is amended to read:

16.85 **(2)** To furnish engineering, architectural, project management, and other building construction services whenever requisitions therefor are presented to the department by any agency. The department may deposit moneys received from the provision of these services in the account under s. 20.505 (1) (kc) or in the general fund as general purpose revenue — earned. In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, which is entitled to expend moneys appropriated by law,

including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 233, 234, 237, 238, or 279.

SECTION 1bq. 16.865 (8) of the statutes is amended to read:

16.865 **(8)** Annually in each fiscal year, allocate as a charge to each agency a proportionate share of the estimated costs attributable to programs administered by the agency to be paid from the appropriation under s. 20.505 (2) (k). The department may charge premiums to agencies to finance costs under this subsection and pay the costs from the appropriation on an actual basis. The department shall deposit all collections under this subsection in the appropriation account under s. 20.505 (2) (k). Costs assessed under this subsection may include judgments, investigative and adjustment fees, data processing and staff support costs, program administration costs, litigation costs, and the cost of insurance contracts under sub. (5). In this subsection, "agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority created in subch. II of ch. 114 or subch. III of ch. 636 or in ch. 231, 232, 233, 234, 237, 238, or 279.

SECTION 1br. 25.50 (1) (d) of the statutes is amended to read:

25.50 **(1)** (d) "Local government" means any county, town, village, city, power district, sewerage district, drainage district, town sanitary district, public inland lake protection and rehabilitation district, local professional baseball park district created under subch. III of ch. 229, long–term care district under s. 46.2895, local professional football stadium district created under subch. IV of ch. 229, local cultural arts district created under subch. V of ch. 229, public library system, school

district or technical college district in this state, any commission, committee, board or officer of any governmental subdivision of this state, any court of this state, other than the court of appeals or the supreme court, or any authority created under s. 114.61, 231.02, 233.02, ~~or~~ 234.02, or 636.70.

SECTION 1bs. 40.02 (54) (n) of the statutes is created to read:

40.02 **(54)** (n) The Badger Health Benefit Authority.

SECTION 1bt. 49.45 (2) (a) 3. of the statutes is amended to read:

49.45 **(2)** (a) 3. ~~Determine~~ Subject to s. 636.30 (1) (o), determine the eligibility of persons for medical assistance, rehabilitative, and social services under ss. 49.46, 49.468, 49.47, and 49.471 and rules and policies adopted by the department and may, under a contract under s. 49.78 (2), delegate all, or any portion, of this function to the county department under s. 46.215, 46.22, or 46.23 or a tribal governing body.

SECTION 1bu. 70.11 (41c) of the statutes is created to read:

70.11 **(41c)** BADGER HEALTH BENEFIT AUTHORITY. All property owned by the Badger Health Benefit Authority, provided that the use of the property is primarily related to the purposes of the authority.

SECTION 1bv. 71.26 (1) (be) of the statutes is amended to read:

71.26 **(1)** (be) *Certain authorities.* Income of the University of Wisconsin Hospitals and Clinics Authority, of the Badger Health Benefit Authority, of the Fox River Navigational System Authority, of the Wisconsin Economic Development Corporation, and of the Wisconsin Aerospace Authority.

SECTION 1bw. 77.54 (9a) (a) of the statutes is amended to read:

77.54 **(9a)** (a) This state or any agency thereof, the University of Wisconsin Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Badger

Health Benefit Authority, the Wisconsin Economic Development Corporation, and the Fox River Navigational System Authority.

SECTION 1bx. 101.055 (2) (a) of the statutes is amended to read:

101.055 **(2)** (a) "Agency" means an office, department, independent agency, authority, institution, association, society, or other body in state government created or authorized to be created by the constitution or any law, and includes the legislature and the courts, but excludes the Badger Health Benefit Authority.

SECTION 1bxa. 230.03 (3) of the statutes is amended to read:

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

SECTION 1by. 230.80 (4) of the statutes is amended to read:

230.80 **(4)** "Governmental unit" means any association, authority, board, commission, department, independent agency, institution, office, society, or other body in state government created or authorized to be created by the constitution or any law, including the legislature, the office of the governor, and the courts, but excluding the Badger Health Benefit Authority. "Governmental unit" does not mean

any political subdivision of the state or body within one or more political subdivisions that is created by law or by action of one or more political subdivisions.

SECTION 1bz. 230.90 (1) (c) of the statutes is amended to read:

230.90 **(1)** (c) "Governmental unit" means any association, authority, board, commission, department, independent agency, institution, office, society or other body in state government created or authorized to be created by the constitution or any law, including the legislature, the office of the governor and the courts. "Governmental unit" does not mean the University of Wisconsin Hospitals and Clinics Authority, the Badger Health Benefit Authority, or any political subdivision of the state or body within one or more political subdivisions which is created by law or by action of one or more political subdivisions.

SECTION 1ca. 635.18 (1) of the statutes is amended to read:

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

SECTION 1cb. Chapter 636 of the statutes is created to read:

CHAPTER 636

HEALTH BENEFIT PLAN EXCHANGE

SUBCHAPTER I

GENERAL PROVISIONS

636.01 Definitions. In this chapter:

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

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

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

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

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

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

2. Coverage issued as a supplement to liability insurance.

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

4. Worker's compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit–only insurance.

7. Coverage for on–site medical clinics.

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

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

1. Limited scope dental or vision benefits.

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

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

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

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

(5) "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health

maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

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

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

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

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

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

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

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

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

(b) The individual resides in this state.

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

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

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

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

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

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

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

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

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

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

5. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and that would cease to be a small employer by reason of an increase in the number of its employees shall continue to

be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

SUBCHAPTER II

OPERATION OF EXCHANGE

636.25 General matters. (1) The authority shall establish and operate a Wisconsin Health Benefit Exchange and shall make qualified health plans, with effective dates on or before January 1, 2018, available to qualified individuals and qualified employers.

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

(b) The authority shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832 (c) (2) (A) of the Internal Revenue Code through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302 (b) (1) (J) of the federal act.

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

(4) The authority may enter into information–sharing agreements with federal and state agencies and entities operating exchanges in other states to carry out its responsibilities under this chapter, provided that such agreements include adequate

protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and rules and regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section

36B of the Internal Revenue Code and any cost–sharing reduction under section 1402 of the federal act.

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

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

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

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

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

3. Facilitate enrollment in qualified health plans.

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under 42 USC 300gg–93, or to any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or determination under that plan or coverage.

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

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

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

2. That an individual who is incarcerated in a correctional facility, but scheduled to be released from incarceration in the near future, is enrolled prior to release, through the exchange and effective upon the date of his or her release, in Medical Assistance, a qualified health plan, or some other form of minimum essential coverage on the date of his or her release from incarceration.

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

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

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

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

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

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

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

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

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

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

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

4. The department of health services.

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

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

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

2. Fully cooperate with any investigation conducted by the secretary under the secretary's authority under the federal act and allow the secretary, in coordination

with the inspector general of the federal department of health and human services, to do all of the following:

a. Investigate the affairs of the authority.

b. Examine the properties and records of the authority.

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

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

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

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

(b) Establish risk adjustment mechanisms for the exchange.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

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

f. Data on rating practices.

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

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

i. Other information as determined appropriate by the secretary.

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

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

(4) The authority may not exempt any health carrier seeking certification of a health benefit plan as a qualified health plan, regardless of the type or size of the health carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures equitable treatment of all health carriers participating in the exchange.

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

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

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

act and such other dental benefits as the authority or the secretary may specify by regulation.

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

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

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

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

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

(a) Complies with the provisions of this chapter.

(b) Promotes positive health outcomes.

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

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

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

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

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

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

636.46 Rules; application form. (1) The commissioner may promulgate rules to implement the provisions of this chapter. Rules promulgated under this

section may not conflict with or prevent the application of regulations promulgated by the secretary under the federal act.

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

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

SUBCHAPTER III

BADGER HEALTH BENEFIT AUTHORITY

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

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

(b) A health economist.

(c) An employee benefits specialist.

(d) A representative of small employers.

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

(f) A representative of organized labor.

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

(2) No member of the board appointed under sub. (1) (a) to (g) may be a health care provider, as defined in s. 146.81 (1) (a) to (hp); an employee of a health care provider, as defined in s. 146.81 (1) (i) to (p); an employee of an insurer that is authorized to do business in the state; or an insurance intermediary.

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

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

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

(6) The board shall appoint an executive director who shall not be a member of the board and who shall serve at the pleasure of the board. The executive director shall receive compensation commensurate with the duties of the office, as determined by the board. The executive director shall serve as secretary of the authority and shall keep a record of the proceedings of the authority and shall be

custodian of all books, documents, and papers filed with the authority, the minute book or journal of the authority, and its official seal. The executive director or other person may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates. The executive director shall have all of the following duties:

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

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

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

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

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

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

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

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

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

(a) Progress toward the goals of the exchange.

(b) The operations and administration of the exchange.

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

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

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

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

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

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

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

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

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

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

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

(5) Incur debt.

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

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

(8) Procure liability insurance.

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

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

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

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

date of the last insertion of the notice or at least 7 days after the date of posting on the Internet.

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

(c) For purposes of clarification, the authority may discuss the requirements of the proposed contract with any person who submits a bid or proposal and shall permit any offerer to revise his or her bid or proposal to ensure its responsiveness to those requirements.

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

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

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

authority shall state in writing the reason for the award and shall place the statement in the contract file.

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

636.78 Political activities. (1) No employee of the authority may directly or indirectly solicit or receive subscriptions or contributions for any partisan political party or any political purpose while engaged in his or her official duties as an employee. No employee of the authority may engage in any form of political activity calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office while engaged in his or her official duties as an employee or engage in any political activity while not engaged in his or her official duties as an employee to such an extent that the person's efficiency during working hours will be impaired or that he or she will be tardy or absent from work. Any violation of this section is adequate grounds for dismissal.

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

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

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

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

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

(3) An individual required to file shall file with the ethics commission a statement of economic interests meeting each of the requirements of s. 19.44 (1) no later than 21 days following the date he or she assumes a position on the board or the position of executive director if the individual required to file has not previously filed a statement of economic interests with the ethics commission during that year. The information on the statement shall be current as per the date he or she assumes the position.

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

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

(6) (a) Any person who violates this section may be required to forfeit not more than $500 for each violation. If the court determines that the accused has realized economic gain as a result of the violation, the court may, in addition, order the accused to forfeit the amount gained as a result of the violation. The attorney general, when so requested by the ethics commission, shall institute proceedings to recover any forfeiture incurred under this subsection that is not paid by the person against whom it is assessed.

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

636.82 Conflict of interest prohibited; exception. (1) Except in accordance with the ethics commission's advice under s. 19.46 (2) (a) and except as otherwise provided in sub. (2), a member of the board and the executive director may not do any of the following:

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

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

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

(3) (a) Any person who violates this section may be required to forfeit not more than $5,000 for each violation. If the court determines that the accused has realized economic gain as a result of the violation, the court may, in addition, order the accused to forfeit the amount gained as a result of the violation. The attorney general, when so requested by the ethics commission, shall institute proceedings to recover any forfeiture incurred under this subsection that is not paid by the person against whom it is assessed.

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

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

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

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

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

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

SECTION 9424. Effective dates; Insurance.

(1) HEALTH BENEFIT EXCHANGE. The treatment of section 635.18 (1) of the statutes takes effect on January 1, 2018.".

(END)