

**SENATE AMENDMENT ,
TO SENATE SUBSTITUTE AMENDMENT 1,
TO 2007 SENATE BILL 40**

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

2 **1.** Page 5, line 6: before “or 279” insert “260.”.

3 **2.** Page 5, line 6: after that line insert:

4 “**SECTION 8h.** 13.48 (13) (a) of the statutes is amended to read:

5 13.48 **(13)** (a) Except as provided in par. (b) or (c), every building, structure or
6 facility that is constructed for the benefit of or use of the state, any state agency,
7 board, commission or department, the University of Wisconsin Hospitals and Clinics
8 Authority, the Fox River Navigational System Authority, the Healthy Wisconsin
9 Authority, or any local professional baseball park district created under subch. III
10 of ch. 229 if the construction is undertaken by the department of administration on
11 behalf of the district, shall be in compliance with all applicable state laws, rules,
12 codes and regulations but the construction is not subject to the ordinances or

1 regulations of the municipality in which the construction takes place except zoning,
2 including without limitation because of enumeration ordinances or regulations
3 relating to materials used, permits, supervision of construction or installation,
4 payment of permit fees, or other restrictions.”.

5 **3.** Page 7, line 20: before “or 279” insert “260.”.

6 **4.** Page 15, line 8: after that line insert:

7 “**SECTION 17yd.** 13.94 (1) (dj) of the statutes is created to read:

8 13.94 (1) (dj) Annually, conduct a financial audit of the Healthy Wisconsin Plan
9 under ch. 260 and file copies of each audit report under this paragraph with the
10 distributees specified in par. (b).

11 **SECTION 17yh.** 13.94 (1s) (c) 5. of the statutes is created to read:

12 13.94 (1s) (c) 5. The Healthy Wisconsin Authority for the cost of the audit under
13 sub. (1) (dj).”.

14 **5.** Page 16, line 19: after “Authority.” insert “the Healthy Wisconsin
15 Authority.”.

16 **6.** Page 25, line 6: before “and 279” insert “260.”.

17 **7.** Page 25, line 11: before “and 279” insert “260.”.

18 **8.** Page 25, line 17: before “and 279” insert “260.”.

19 **9.** Page 25, line 19: after that line insert:

20 “**SECTION 71d.** 16.004 (7d) of the statutes is created to read:

21 16.004 (7d) CONTAINMENT OF HEALTH CARE COSTS. In consultation with the board
22 of the Healthy Wisconsin Authority, the secretary shall establish, by rule, a program
23 to contain health care costs in this state during any year in which the board

1 determines that health care costs increase at a rate exceeding the national average
2 of medical inflation, as defined in s. 260.01 (4).

3 **SECTION 71L.** 16.004 (7h) of the statutes is created to read:

4 **16.004 (7h)** EMPLOYER ASSESSMENTS TO THE HEALTHY WISCONSIN TRUST FUND.
5 The secretary shall establish a methodology for allocating employer assessments
6 among state agencies to pay the Healthy Wisconsin trust fund for the operation and
7 funding of the Healthy Wisconsin Plan under ch. 260. State agencies shall pay, from
8 appropriations used to fund fringe benefit costs of state employees, to the Healthy
9 Wisconsin trust fund amounts determined by the secretary.”.

10 **10.** Page 26, line 2: after “Remediation Authority.” insert “the Healthy
11 Wisconsin Authority.”.

12 **11.** Page 26, line 22: before “or 279” insert “260.”.

13 **12.** Page 29, line 18: before “or 279” insert “260.”.

14 **13.** Page 29, line 18: after that line insert:

15 “**SECTION 80h.** 16.417 (1) (a) of the statutes is amended to read:

16 16.417 (1) (a) “Agency” means an office, department, independent agency,
17 institution of higher education, association, society, or other body in state
18 government created or authorized to be created by the constitution or any law, that
19 is entitled to expend moneys appropriated by law, including the legislature and the
20 courts, but not including an authority or the body created under subch. III of ch. 149
21 or under ch. 260.”.

22 **14.** Page 30, line 11: before “or 279” insert “260.”.

23 **15.** Page 34, line 9: before “or 279” insert “260.”.

24 **16.** Page 34, line 19: before “or 279” insert “260.”.

1 **17.** Page 35, line 18: before “or 279” insert “260.”.

2 **18.** Page 38, line 5: before “or 279” insert “260.”.

3 **19.** Page 42, line 1: after “Authority.” insert “the Healthy Wisconsin
4 Authority.”.

5 **20.** Page 42, line 13: after “Authority.” insert “the Healthy Wisconsin
6 Authority.”.

7 **21.** Page 43, line 7: after “Authority.” insert “the Healthy Wisconsin
8 Authority.”.

9 **22.** Page 43, line 15: after “Authority.” insert “the Healthy Wisconsin
10 Authority.”.

11 **23.** Page 43, line 22: after “Remediation Authority.” insert “the Healthy
12 Wisconsin Authority.”.

13 **24.** Page 44, line 10: after “Authority.” insert “the Healthy Wisconsin
14 Authority.”.

15 **25.** Page 44, line 18: after “Authority.” insert “the Healthy Wisconsin
16 Authority.”.

17 **26.** Page 44, line 22: after “Authority.” insert “the Healthy Wisconsin
18 Authority.”.

19 **27.** Page 45, line 6: after “Authority.” insert “the Healthy Wisconsin
20 Authority.”.

21 **28.** Page 45, line 11: after “Remediation Authority.” insert “the Healthy
22 Wisconsin Authority.”.

1 **29.** Page 45, line 16: after “Authority.” insert “the Healthy Wisconsin
2 Authority.”.

3 **30.** Page 45, line 20: after “Remediation Authority.” insert “the Healthy
4 Wisconsin Authority.”.

5 **31.** Page 48, line 7: before “or 279” insert “260.”.

6 **32.** Page 48, line 23: before “or 279” insert “260.”.

7 **33.** Page 274, line 1: before that line insert:

8 “(4m) HEALTHY WISCONSIN PLAN

9 (s) Healthy Wisconsin Authority SEG S –0– –0–”.

10 **34.** Page 396, line 12: after that line insert:

11 “**SECTION 573h.** 20.855 (4m) of the statutes is created to read:

12 20.855 **(4m)** HEALTHY WISCONSIN PLAN. (s) *Healthy Wisconsin Authority.* From
13 the Healthy Wisconsin trust fund, a sum sufficient to pay the Healthy Wisconsin
14 Authority for the operation and funding of the Healthy Wisconsin Plan under ch.
15 260.”.

16 **35.** Page 436, line 20: after that line insert:

17 “**SECTION 678h.** 25.17 (1) (ge) of the statutes is created to read:

18 25.17 **(1)** (ge) Healthy Wisconsin trust fund (s. 25.775).”.

19 **36.** Page 440, line 14: after that line insert:

20 “**SECTION 698h.** 25.775 of the statutes is created to read:

21 **25.775 Healthy Wisconsin trust fund. (1)** There is established a separate,
22 nonlapsible trust fund designated as the Healthy Wisconsin trust fund, consisting
23 of all moneys appropriated or transferred to or deposited in the fund.”.

1 **37.** Page 485, line 17: after that line insert:

2 “**SECTION 765cb.** 40.05 (4) (a) 4. of the statutes is created to read:

3 40.05 **(4)** (a) 4. This paragraph does not apply to any insured employee or
4 retired insured employee who receives health care coverage under the Healthy
5 Wisconsin Plan under ch. 260.

6 **SECTION 765db.** 40.05 (4) (ag) (intro.) of the statutes is amended to read:

7 40.05 **(4)** (ag) (intro.) Beginning on January 1, 2004, except as otherwise
8 provided in accordance with a collective bargaining agreement under subch. I or V
9 of ch. 111 or s. 230.12 or 233.10, the employer shall pay for its currently employed
10 insured employees who are not covered under the Healthy Wisconsin Plan under ch.
11 260:

12 **SECTION 765eb.** 40.05 (4) (ar) of the statutes is repealed.

13 **SECTION 765fb.** 40.05 (4) (b) of the statutes is amended to read:

14 40.05 **(4)** (b) Except as provided under pars. (bc) and (bp), accumulated unused
15 sick leave under ss. 13.121 (4), 36.30, 230.35 (2), 233.10, and 757.02 (5) and subch.
16 I or V of ch. 111 of any eligible employee shall, at the time of death, upon qualifying
17 for an immediate annuity or for a lump sum payment under s. 40.25 (1) or upon
18 termination of creditable service and qualifying as an eligible employee under s.
19 40.02 (25) (b) 6. or 10., be converted, at the employee’s highest basic pay rate he or
20 she received while employed by the state, to credits for payment of health insurance
21 premiums on behalf of the employee or the employee’s surviving insured dependents.
22 Any supplemental compensation that is paid to a state employee who is classified
23 under the state classified civil service as a teacher, teacher supervisor, or education
24 director for the employee’s completion of educational courses that have been

1 approved by the employee's employer is considered as part of the employee's basic
2 pay for purposes of this paragraph. The full premium for any eligible employee who
3 is insured at the time of retirement, or for the surviving insured dependents of an
4 eligible employee who is deceased, shall be deducted from the credits until the credits
5 are exhausted and paid from the account under s. 40.04 (10), and then deducted from
6 annuity payments, if the annuity is sufficient. The department shall provide for the
7 direct payment of premiums by the insured to the insurer if the premium to be
8 withheld exceeds the annuity payment. Upon conversion of an employee's unused
9 sick leave to credits under this paragraph or par. (bf), the employee or, if the employee
10 is deceased, the employee's surviving insured dependents may initiate deductions
11 from those credits or may elect to delay initiation of deductions from those credits,
12 but only if the employee or surviving insured dependents are covered by a
13 comparable health insurance plan or policy during the period beginning on the date
14 of the conversion and ending on the date on which the employee or surviving insured
15 dependents later elect to initiate deductions from those credits. If an employee or an
16 employee's surviving insured dependents elect to delay initiation of deductions from
17 those credits, an employee or the employee's surviving insured dependents may only
18 later elect to initiate deductions from those credits during the annual enrollment
19 period under par. (be). A health insurance plan or policy is considered comparable
20 if it provides hospital and medical benefits that are substantially equivalent to the
21 ~~standard health insurance plan established under s. 40.52 (1)~~ benefits provided
22 under the Healthy Wisconsin Plan under ch. 260.

23 **SECTION 765gb.** 40.05 (4) (be) of the statutes is amended to read:

24 40.05 (4) (be) The department shall establish an annual enrollment period
25 during which an employee or, if the employee is deceased, an employee's surviving

1 insured dependents may elect to initiate or delay continuation of deductions from the
2 employee's sick leave credits under par. (b). An employee or surviving insured
3 dependent may elect to continue or delay continuation of such deductions any
4 number of times. If an employee or surviving insured dependent has initiated the
5 deductions but later elects to delay continuation of the deductions, the employee or
6 surviving insured dependent must be covered by a comparable health insurance plan
7 or policy during the period beginning on the date on which the employee or surviving
8 insured dependent delays continuation of the deductions and ending on the date on
9 which the employee or surviving insured dependent later elects to continue the
10 deductions. A health insurance plan or policy is considered comparable if it provides
11 hospital and medical benefits that are substantially equivalent to ~~the standard~~
12 ~~health insurance plan established under s. 40.52 (1)~~ benefits provided under the
13 Healthy Wisconsin Plan under ch. 260.

14 **SECTION 765hb.** 40.05 (4g) (d) of the statutes is created to read:

15 40.05 **(4g)** (d) This subsection shall not apply to an eligible employee who is
16 receiving health care coverage under the Healthy Wisconsin Plan under ch. 260
17 while on active duty in the U.S. armed forces.

18 **SECTION 765ib.** 40.51 (1) of the statutes is amended to read:

19 40.51 **(1)** The procedures and provisions pertaining to enrollment, premium
20 transmitted and coverage of eligible employees for health care benefits shall be
21 established by contract or rule except as otherwise specifically provided by this
22 chapter. Notwithstanding subs. (6) and (7), an eligible employee who is covered
23 under the Healthy Wisconsin Plan under ch. 260 may not receive coverage under this
24 subchapter for any coverage provided the employee under ch. 260.

25 **SECTION 765jb.** 40.51 (2) of the statutes is amended to read:

1 40.51 **(2)** Except as provided in subs. (10), (10m), (11) and (16), any eligible
2 employee may become covered by group health insurance benefits under this
3 subchapter by electing coverage within 30 days of being hired, to be effective as of
4 the first day of the month which begins on or after the date the application is received
5 by the employer, or by electing coverage prior to becoming eligible for any employer
6 contribution towards the premium cost as provided in s. 40.05 (4) (a) to be effective
7 upon becoming eligible for employer contributions. ~~An eligible employee who is not~~
8 ~~insured, but who is eligible for an employer contribution under s. 40.05 (4) (ag) 1.,~~
9 ~~may elect coverage prior to becoming eligible for an employer contribution under s.~~
10 ~~40.05 (4) (ag) 2., with the coverage to be effective upon becoming eligible for the~~
11 ~~increase in the employer contribution.~~ Any employee who does not so elect at one of
12 these times, or who subsequently cancels the insurance, shall not thereafter become
13 insured unless the employee furnishes evidence of insurability satisfactory to the
14 insurer, at the employee's own expense or obtains coverage subject to contractual
15 waiting periods. The method to be used shall be specified in the health insurance
16 contract.

17 **SECTION 765kb.** 40.51 (6) of the statutes is renumbered 40.51 (6) (a) and
18 amended to read:

19 40.51 **(6)** (a) This state shall offer to all of its eligible employees described in
20 subs. (10), (10m), and (16) at least 2 insured or uninsured health care coverage plans
21 providing substantially equivalent hospital and medical benefits, including a health
22 maintenance organization or a preferred provider plan, if those health care plans are
23 ~~determined by the group insurance board to be available in the area of the place of~~
24 ~~employment and are approved by the group insurance board.~~ The group insurance
25 board shall place each of the plans into one of 3 tiers established in accordance with

1 standards adopted by the group insurance board. The tiers shall be separated
2 according to the employee's share of premium costs.

3 **SECTION 765Lb.** 40.51 (6) (b) of the statutes is created to read:

4 40.51 (6) (b) The state may offer to its employees coverage for health care
5 benefits not provided to the employees under the Healthy Wisconsin Plan under ch.
6 260.

7 **SECTION 765nb.** 40.51 (7) of the statutes is amended to read:

8 40.51 (7) Any employer, other than the state, may offer to all of its employees
9 ~~a health care coverage plan~~ coverage for health care benefits not provided to the
10 employees under the Healthy Wisconsin Plan under ch. 260 through a program
11 offered by the group insurance board. Notwithstanding sub. (2) and ss. 40.05 (4) and
12 40.52 (1), the department may by rule establish different eligibility standards or
13 contribution requirements for such employees and employers and may by rule limit
14 the categories of employers, other than the state, which may be included as
15 participating employers under this subchapter.

16 **SECTION 765pb.** 40.51 (8) of the statutes is amended to read:

17 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
18 (a) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to
19 (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3)
20 to (6), 632.895 (5m) and (8) to (14),₁ and 632.896.

21 **SECTION 765qb.** 40.51 (8m) of the statutes is amended to read:

22 40.51 (8m) Every health care coverage plan offered by the group insurance
23 board under ~~sub. (6) (b) and (7)~~ subs. (6) (b) and (7) shall comply with ss. 631.89, 631.90, 631.93 (2),
24 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835,
25 632.85, 632.853, 632.855,₁ and ~~632.895 (11) to (14)~~ 632.87 (3) to (6).

1 **SECTION 765rb.** 40.52 (1) (intro.) of the statutes is amended to read:

2 40.52 (1) (intro.) The group insurance board shall establish by contract a
3 standard health insurance plan in which all insured employees shall participate
4 except as otherwise provided in this chapter. ~~The Except as provided in sub. (1m),~~
5 the standard plan shall provide:

6 **SECTION 765sb.** 40.52 (1m) of the statutes is created to read:

7 40.52 (1m) The standard health insurance plan described under sub. (1) shall
8 not provide employees any health care coverage that the employees receive under the
9 Healthy Wisconsin Plan under ch. 260.

10 **SECTION 765tb.** 40.52 (2) of the statutes is amended to read:

11 40.52 (2) Health insurance benefits under this subchapter shall be integrated,
12 with exceptions determined appropriate by the group insurance board, with benefits
13 under federal plans for hospital and health care for the aged and disabled and with
14 benefits provided under the Healthy Wisconsin Plan under ch. 260. Exclusions and
15 limitations with respect to benefits and different rates may be established for
16 persons eligible under federal plans for hospital and health care for the aged and
17 disabled in recognition of the utilization by persons within the age limits eligible
18 under the federal program and for employees who receive benefits under the Healthy
19 Wisconsin Plan under ch. 260. The plan may include special provisions for spouses
20 and other dependents covered under a plan established under this subchapter where
21 one spouse is eligible under federal plans for hospital and health care for the aged
22 or under the Healthy Wisconsin Plan under ch. 260 but the others are not eligible
23 because of age or other reasons. As part of the integration, the department may, out
24 of premiums collected under s. 40.05 (4), pay premiums for the federal health
25 insurance.

1 **SECTION 765ub.** 40.98 (2) (a) 1. of the statutes is amended to read:

2 40.98 **(2)** (a) 1. The department shall design an actuarially sound health care
3 coverage program for employers that includes more than one group health care
4 coverage plan and that provides coverage beginning not later than January 1, 2001.
5 The health care coverage program shall be known as the “Private Employer Health
6 Care Purchasing Alliance”. In designing the health care coverage program, the
7 department shall consult with the office of the commissioner of insurance and may
8 consult with the departments of commerce and health and family services. The
9 health care coverage program may not be implemented until it is approved by the
10 board. The health care coverage program shall not provide employees any health
11 care coverage that the employees receive under the Healthy Wisconsin Plan under
12 ch. 260.”.

13 **38.** Page 750, line 18: after that line insert:

14 “**SECTION 1608h.** 49.473 (2) (c) of the statutes is amended to read:

15 49.473 **(2)** (c) The woman is not covered under the Healthy Wisconsin Plan
16 under ch. 260 and is not eligible for any other health care coverage that qualifies as
17 creditable coverage in 42 USC 300gg (c), excluding the coverage specified in 42 USC
18 300gg (c) (1) (F).”.

19 **39.** Page 762, line 18: after that line insert:

20 “**SECTION 1641r.** 49.665 (5) (ag) of the statutes is repealed.”.

21 **40.** Page 763, line 2: after that line insert:

22 “**SECTION 1645d.** 49.68 (3) (d) 1. of the statutes is amended to read:

23 49.68 **(3)** (d) 1. No aid may be granted under this subsection ~~unless~~ if the
24 recipient has ~~no other form of~~ aid available from the federal medicare Medicare

1 program, from private health, accident, sickness, medical, ~~and~~ or hospital insurance
2 coverage, or from other health care coverage specified by rule under s. 49.687 (1m),
3 excluding the Healthy Wisconsin Plan under ch. 260. If insufficient aid is available
4 from other sources and if the recipient has paid an amount equal to the annual
5 ~~medicare~~ Medicare deductible amount specified in subd. 2., the state shall pay the
6 difference in cost to a qualified recipient. If at any time sufficient federal or private
7 insurance aid or other health care coverage becomes available during the treatment
8 period, state aid under this subsection shall be terminated or appropriately reduced.
9 Any patient who is eligible for the federal ~~medicare~~ Medicare program shall register
10 and pay the premium for ~~medicare~~ Medicare medical insurance coverage where
11 permitted, and shall pay an amount equal to the annual ~~medicare~~ Medicare
12 deductible amounts required under 42 USC 1395e and 1395L (b), prior to becoming
13 eligible for state aid under this subsection.

14 **SECTION 1645h.** 49.683 (3) of the statutes is amended to read:

15 49.683 (3) No payment shall be made under this section for any portion of
16 medical care costs that are payable under any state, federal, or other health care
17 coverage program, including a health care coverage program specified by rule under
18 s. 49.687 (1m), or under any grant, contract, or other contractual arrangement, but
19 excluding the Healthy Wisconsin Plan under ch. 260.

20 **SECTION 1645p.** 49.685 (6) (b) of the statutes is amended to read:

21 49.685 (6) (b) Reimbursement shall not be made under this section for any
22 blood products or supplies that are not purchased from or provided by a
23 comprehensive hemophilia treatment center, or a source approved by the treatment
24 center. Reimbursement shall not be made under this section for any portion of the
25 costs of blood products or supplies that are payable under any other state, federal,

1 or other health care coverage program under which the person is covered, including
2 a health care coverage program specified by rule under s. 49.687 (1m), or under any
3 grant, contract, or other contractual arrangement, but excluding the Healthy
4 Wisconsin Plan under ch. 260.”.

5 **41.** Page 763, line 21: after that line insert:

6 “**SECTION 1649r.** 49.687 (1m) (d) of the statutes is created to read:

7 49.687 **(1m)** (d) Notwithstanding the health care programs for which a person
8 must apply that are specified by the department by rule under pars. (a) and (b), a
9 person is not ineligible to receive benefits under s. 49.68, 49.683, or 49.685 by reason
10 of being eligible for or covered under the Healthy Wisconsin Plan under ch. 260.”.

11 **42.** Page 823, line 9: after that line insert:

12 “**SECTION 1846h.** 59.52 (11) (c) of the statutes is amended to read:

13 59.52 **(11)** (c) *Employee insurance.* Provide for individual or group hospital,
14 surgical and life insurance for county officers and employees and for payment of
15 premiums for county officers and employees. A county may elect to provide health
16 care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to its
17 officers and employees and a county with at least 100 employees may elect to provide
18 health care benefits not provided under the Healthy Wisconsin Plan under ch. 260
19 on a self-insured basis to its officers and employees. A county and one or more cities,
20 villages, towns, or other counties that together have at least 100 employees may
21 jointly provide health care benefits not provided under the Healthy Wisconsin Plan
22 under ch. 260 to their officers and employees on a self-insured basis. Counties that
23 elect to provide health care benefits not provided under the Healthy Wisconsin Plan

1 under ch. 260 on a self-insured basis to their officers and employees shall be subject
2 to the requirements set forth under s. 120.13 (2) (c) to (e) and (g).”.

3 **43.** Page 827, line 3: after that line insert:

4 “**SECTION 1858h.** 60.23 (25) of the statutes is amended to read:

5 **60.23 (25)** SELF-INSURED HEALTH PLANS. Provide health care benefits not
6 provided under the Healthy Wisconsin Plan under ch. 260 to its officers and
7 employees on a self-insured basis, subject to s. 66.0137 (4).”.

8 **44.** Page 832, line 12: after that line insert:

9 “**SECTION 1873j.** 62.61 of the statutes is renumbered 62.61 (1) (intro.) and
10 amended to read:

11 **62.61 (1)** (intro.) The common council of a 1st class city may, by ordinance or
12 resolution, provide do any of the following:

13 (a) Provide for, including the payment of premiums of, general hospital,
14 surgical and group insurance for ~~both active and~~ retired city officers and city
15 employees and their respective dependents in private companies, ~~or may, by~~
16 ~~ordinance or resolution, elect.~~

17 (c) Elect to offer to all of its employees a health care coverage plan through a
18 program offered by the group insurance board under ch. 40. Municipalities ~~which~~
19 that elect to participate under s. 40.51 (7) are subject to the applicable sections of ch.
20 40 instead of this section.

21 **(2)** Contracts for insurance under this section may be entered into for active
22 officers and employees separately from contracts for retired officers and employees.
23 Appropriations may be made for the purpose of financing insurance under this
24 section. Moneys accruing to a fund to finance insurance under this section, by

1 investment or otherwise, may not be diverted for any other purpose than those for
2 which the fund was set up or to defray management expenses of the fund or to
3 partially pay premiums to reduce costs to the city or to persons covered by the
4 insurance, or both.

5 **SECTION 1873k.** 62.61 (1) (b) of the statutes is created to read:

6 62.61 (1) (b) Subject to s. 260.37, provide for, including the payment of
7 premiums of, group health insurance for active city officers and city employees and
8 their respective dependents.”.

9 **45.** Page 832, line 17: after that line insert:

10 “**SECTION 1874h.** 66.0137 (4) of the statutes is amended to read:

11 66.0137 (4) SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or
12 a village provides health care benefits not provided under the Healthy Wisconsin
13 Plan under ch. 260 under its home rule power, or if a town provides health care
14 benefits not provided under the Healthy Wisconsin Plan under ch. 260, to its officers
15 and employees on a self-insured basis, the self-insured plan shall comply with ss.
16 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
17 632.85, 632.853, 632.855, 632.87 (4), ~~(5), and (6), 632.895 (9) to (14), 632.896,~~ and
18 767.513 (4).

19 **SECTION 1874n.** 66.0137 (4m) (b) of the statutes is amended to read:

20 66.0137 (4m) (b) A political subdivision and one or more other political
21 subdivisions, that together have at least 100 employees, may jointly provide health
22 care benefits not provided under the Healthy Wisconsin Plan under ch. 260 to their
23 officers and employees on a self insured self-insured basis.

24 **SECTION 1874t.** 66.0137 (5) of the statutes is amended to read:

1 66.0137 (5) HOSPITAL, ACCIDENT, AND LIFE INSURANCE. The Subject to s. 260.37,
2 the state or a local governmental unit may provide for the payment of premiums for
3 ~~hospital, surgical and other~~ health and accident insurance and life insurance for
4 employees and officers and their spouses and dependent children. A local
5 governmental unit may also provide for the payment of premiums for hospital and
6 surgical care for its retired employees. In addition, a local governmental unit may,
7 by ordinance or resolution, elect to offer to all of its employees a health care coverage
8 plan through a program offered by the group insurance board under ch. 40. A local
9 governmental unit that elects to participate under s. 40.51 (7) is subject to the
10 applicable sections of ch. 40 instead of this subsection.”.

11 **46.** Page 844, line 14: after that line insert:

12 “**SECTION 1934c.** 70.11 (41p) of the statutes is created to read:

13 70.11 (41p) HEALTHY WISCONSIN AUTHORITY. All property owned by the Healthy
14 Wisconsin Authority, provided that use of the property is primarily related to the
15 purposes of the authority.”.

16 **47.** Page 923, line 2: after that line insert:

17 “**SECTION 2021p.** 71.26 (1) (be) of the statutes is amended to read:

18 71.26 (1) (be) *Certain authorities.* Income of the University of Wisconsin
19 Hospitals and Clinics Authority, of the Health Insurance Risk-Sharing Plan
20 Authority, ~~and of the Healthy Wisconsin Authority,~~ of the Fox River Navigational
21 System Authority, and of the Wisconsin Aerospace Authority.”.

22 **48.** Page 1128, line 25: after that line insert:

23 “**SECTION 2356d.** 77.54 (9a) (a) of the statutes is amended to read:

1 77.54 **(9a)** (a) This state or any agency thereof, the University of Wisconsin
2 Hospitals and Clinics Authority, the Wisconsin Aerospace Authority, the Health
3 Insurance Risk–Sharing Plan Authority, the Healthy Wisconsin Authority, and the
4 Fox River Navigational System Authority.”.

5 **49.** Page 1210, line 10: after that line insert:

6 “**SECTION 2606p.** 100.45 (1) (dm) of the statutes is amended to read:

7 100.45 **(1)** (dm) “State agency” means any office, department, agency,
8 institution of higher education, association, society or other body in state
9 government created or authorized to be created by the constitution or any law which
10 is entitled to expend moneys appropriated by law, including the legislature and the
11 courts, the Wisconsin Housing and Economic Development Authority, the Bradley
12 Center Sports and Entertainment Corporation, the University of Wisconsin
13 Hospitals and Clinics Authority, the Wisconsin Health and Educational Facilities
14 Authority, the Wisconsin Aerospace Authority, ~~and~~ the Fox River Navigational
15 System Authority, and the Healthy Wisconsin Authority.”.

16 **50.** Page 1223, line 12: after that line insert:

17 “**SECTION 2651p.** 109.075 (9) of the statutes is created to read:

18 109.075 **(9)** This section does not apply to an employer that ceases providing
19 health care benefits to its employees because the employees are covered under the
20 Healthy Wisconsin Plan under ch. 260.”.

21 **51.** Page 1228, line 9: after that line insert:

22 “**SECTION 2664d.** 111.70 (1) (dm) of the statutes is amended to read:

23 111.70 **(1)** (dm) “Economic issue” means salaries, overtime pay, sick leave,
24 payments in lieu of sick leave usage, vacations, clothing allowances in excess of the

1 actual cost of clothing, length-of-service credit, continuing education credit, shift
2 premium pay, longevity pay, extra duty pay, performance bonuses, health insurance
3 coverage of benefits not provided under the Healthy Wisconsin Plan under ch. 260,
4 life insurance, dental insurance, disability insurance, vision insurance, long-term
5 care insurance, worker’s compensation and unemployment insurance, social
6 security benefits, vacation pay, holiday pay, lead worker pay, temporary assignment
7 pay, retirement contributions, supplemental retirement benefits, severance or other
8 separation pay, hazardous duty pay, certification or license payment, limitations on
9 layoffs that create a new or increased financial liability on the employer and
10 contracting or subcontracting of work that would otherwise be performed by
11 municipal employees in the collective bargaining unit with which there is a labor
12 dispute.”.

13 **52.** Page 1228, line 17: after that line insert:

14 “**SECTION 2677.** 111.70 (4) (cm) 8s. of the statutes is amended to read:

15 111.70 **(4)** (cm) 8s. ‘Forms for determining costs.’ The commission shall
16 prescribe forms for calculating the total increased cost to the municipal employer of
17 compensation and fringe benefits provided to school district professional employees.
18 The cost shall be determined based upon the total cost of compensation and fringe
19 benefits provided to school district professional employees who are represented by
20 a labor organization on the 90th day before expiration of any previous collective
21 bargaining agreement between the parties, or who were so represented if the
22 effective date is retroactive, or the 90th day prior to commencement of negotiations
23 if there is no previous collective bargaining agreement between the parties, without
24 regard to any change in the number, rank or qualifications of the school district

1 professional employees. For purposes of such determinations, any cost increase that
2 is incurred on any day other than the beginning of the 12-month period commencing
3 with the effective date of the agreement or any succeeding 12-month period
4 commencing on the anniversary of that effective date shall be calculated as if the cost
5 increase were incurred as of the beginning of the 12-month period beginning on the
6 effective date or anniversary of the effective date in which the cost increase is
7 incurred. For the purpose of determining if a municipal employer has maintained
8 current fringe benefits under sub. (1) (nc) 1. a., the commission shall consider the
9 municipal employer to have maintained its health care coverage benefit if the
10 municipal employer provides health care coverage to its school district professional
11 employees through the Healthy Wisconsin Plan under ch. 260 and supplements that
12 coverage, if necessary, to produce a health care coverage benefit that is actuarially
13 equivalent to the health care coverage benefit in place before the school district
14 professional employees become covered under the Healthy Wisconsin Plan under ch.
15 260. If a dispute arises concerning the municipal employer's determination of
16 actuarial equivalence or what supplemental benefits are sufficient to achieve
17 actuarial equivalence, the dispute shall be resolved by a neutral person who is
18 designated by the commission. In each collective bargaining unit to which subd. 5s.
19 applies, the municipal employer shall transmit to the commission and the labor
20 organization a completed form for calculating the total increased cost to the
21 municipal employer of compensation and fringe benefits provided to the school
22 district professional employees covered by the agreement as soon as possible after
23 the effective date of the agreement.

24 **SECTION 2680j.** 111.91 (2) (pt) of the statutes is created to read:

HEALTHY WISCONSIN PLAN

260.01 Definitions. In this chapter, except as otherwise provided:

(1) “Authority” means the Healthy Wisconsin Authority.

(2) “Board” means the board of trustees of the authority.

(3) “Health care network” means a provider–driven, coordinated group of health care providers comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment.

(4) “Medical inflation” means changes in the consumer price index for all consumers, U.S. city average, for the medical care group, including medical care commodities and medical care services, as determined by the U.S. department of labor.

(5) “Plan” means the Healthy Wisconsin Plan.

(6) “Primary care provider” means a health care provider who is identified as the key professional responsible for coordinating all medical care for a given participant, including referral to a specialist. “Primary care provider” includes general practice physicians, family practitioners, internists, pediatricians, obstetricians and gynecologists, advanced practice nurses, certified nurse midwives, and physician assistants. “Primary care provider” may also include a specialist who is treating a person with a chronic medical condition or special health care needs for which regular treatment by a specialist is medically necessary or a specialist who is treating a disabled person.

260.05 Creation and organization of authority. (1) CREATION AND MEMBERSHIP OF BOARD. There is created a public body corporate and politic to be

1 known as the “Healthy Wisconsin Authority.” The nonvoting members of the board
2 shall consist of the secretary of employee trust funds and 4 representatives from the
3 advisory committee under s. 260.49 who are health care personnel and
4 administrators, selected by the advisory committee. The secretary of employee trust
5 funds shall serve as the initial chairperson of the board until such time as the board
6 elects a chairperson from its voting membership. The board shall also consist of the
7 following voting members, nominated by the governor and with the advice and
8 consent of the senate appointed, for staggered 6–year terms:

9 (a) Four members selected from a list of names submitted by statewide labor
10 or union coalitions. One of these members shall be a public employee.

11 (b) Four members selected from a list of names submitted by statewide
12 business and employer organizations. One of these members shall be a public
13 employer.

14 (c) One member selected from a list of names submitted by statewide public
15 school teacher labor organizations.

16 (d) One member selected from a list of names submitted by statewide small
17 business organizations.

18 (e) Two members who are farmers, selected from a list of names submitted by
19 statewide general farm organizations.

20 (f) One member who is a self–employed person.

21 (g) Three members selected from a list of names submitted by statewide health
22 care consumer organizations.

23 **(2) TERMS OF OFFICE; VACANCIES; QUORUM; BUSINESS.** (a) The terms of all members
24 of the board shall expire on July 1.

1 (b) Each member of the board shall hold office until a successor is appointed
2 and qualified unless the member vacates or is removed from his or her office. A
3 member who serves as a result of holding another office or position vacates his or her
4 office as a member when he or she vacates the other office or position. A member who
5 ceases to qualify for office vacates his or her office. A vacancy on the board shall be
6 filled in the same manner as the original appointment to the board for the remainder
7 of the unexpired term, if any.

8 (c) A majority of the members of the board constitutes a quorum for the purpose
9 of conducting its business and exercising its powers and for all other purposes,
10 notwithstanding the existence of any vacancies. Action may be taken by the board
11 upon a vote of a majority of the members present. Meetings of the members of the
12 board may be held anywhere within or without the state.

13 **(3) BOARD MEMBER RESPONSIBILITY AS TRUSTEE.** Each member of the board shall
14 be responsible for taking care that the highest level of independence and judgment
15 is exercised at all times in administering the plan and overseeing the individuals and
16 organizations selected to implement the plan.

17 **(4) DUTIES.** The board shall:

18 (a) Establish and administer a health care system in this state that ensures
19 that all eligible persons have access to high quality, timely, and affordable health
20 care. In establishing and administering the health care system, except as otherwise
21 provided by law, the board shall seek to attain all of the following goals:

22 1. Every resident of this state shall have access to affordable, comprehensive
23 health care services.

24 2. Health care reform shall maintain and improve choice of health care
25 providers and high quality health care services in this state.

1 3. Health care reform shall implement cost containment strategies that retain
2 and assure affordable coverage for all residents of this state.

3 (b) Establish, fund, and manage the plan as provided in this chapter.

4 (c) Appoint an executive director, who shall serve at the pleasure of the board.
5 The board may delegate to one or more of its members or its executive director any
6 powers and duties the board considers proper. The executive director shall receive
7 such compensation as may be determined by the board.

8 (d) Provide for mechanisms to enroll every eligible resident in this state under
9 the plan. Contracts entered into by the board with providers shall include provisions
10 to enroll all eligible persons at the point of service, and outreach programs to assure
11 every eligible person becomes enrolled in the plan.

12 (e) Create a program for consumer protection and a process to resolve disputes
13 with providers.

14 (f) Establish an independent and binding appeals process for resolving
15 disputes over eligibility and other determinations made by the board. Any person
16 who is adversely affected by a board eligibility determination or any other
17 determination is entitled to judicial review of the determination.

18 (g) Submit an annual report on its activities to the governor and chief clerk of
19 each house of the legislature, for distribution under s. 13.172 (2).

20 (h) Contract for annual, independent, program evaluations and financial
21 audits that measure the extent to which the plan is achieving the goals under par.

22 (a) 1. to 3. The board may not enter into a contract with the same auditor for more
23 than 6 years.

24 (i) Accept bids from health care networks in accordance with the criteria set out
25 in s. 260.30, or make payments to fee-for-service providers in accordance with s.

1 260.30. The board shall consult with the department of employee trust funds in
2 determining the most effective and efficient way of purchasing health care benefits.

3 (j) Audit health care networks and providers to determine if their services meet
4 the plan objectives and criteria under this chapter.

5 (5) POWERS. The board shall have all the powers necessary or convenient to
6 carry out the purposes and provisions of this chapter. In addition to all other powers
7 granted the board under this chapter, the board may:

8 (a) Adopt, amend, and repeal bylaws and policies and procedures for the
9 regulation of its affairs and the conduct of its business.

10 (b) Have a seal and alter the seal at pleasure.

11 (c) Maintain an office.

12 (d) Sue and be sued.

13 (e) Accept gifts, grants, loans, or other contributions from private or public
14 sources.

15 (f) Establish the authority's annual budget and monitor the fiscal management
16 of the authority.

17 (g) Execute contracts and other instruments, including contracts for any
18 professional services required for the authority.

19 (h) Employ any officers, agents, and employees that it may require and
20 determine their qualifications and compensation.

21 (i) Procure liability insurance.

22 (j) Contract for studies on issues, as identified by the board or by the advisory
23 committee under s. 260.49, that relate to the plan.

24 (k) Borrow money, as necessary on a short-term basis, to address cash flow
25 issues.

1 (L) Compel witnesses to attend meetings and to testify upon any necessary
2 matter concerning the plan.

3 **260.10 Eligibility. (1) COVERED PERSONS.** Except as provided in subs. (2) to
4 (5) and subject to sub. (6), a person is eligible to participate in the plan if the person
5 satisfies all of the following criteria:

6 (a) The person has maintained his or her place of permanent abode, as defined
7 by the board, in this state for at least 12 months.

8 (b) The person maintains a substantial presence in this state, as defined by the
9 board.

10 (c) The person is under 65 years of age.

11 (d) The person is not eligible for health care coverage from the federal
12 government or a foreign government, is not an inmate of a penal facility, as defined
13 in s. 19.32 (1e), and is not placed or confined in, or committed to, an institution for
14 the mentally ill or developmentally disabled.

15 (e) Unless a waiver requested under sub. (6) (b) has been granted and is in
16 effect, the person is not eligible for Medical Assistance under subch. IV of ch. 49 or
17 for health care coverage under the Badger Care health care program under s. 49.665.

18 **(2) GAINFULLY EMPLOYED.** If a person and the members of the person's
19 immediate family do not meet the criteria under sub. (1) (a) and (b), but do meet the
20 criteria under sub. (1) (c) to (e) and the person is gainfully employed in this state, as
21 defined by the board, the person and the members of the person's immediate family
22 are eligible to participate in the plan.

23 **(3) DEPENDENT CHILDREN.** If a child under age 18 resides with his or her parent
24 in this state but the parent does not yet meet the residency requirement under sub.

1 (1) (a), the child is eligible to participate in the plan regardless of the length of time
2 the child has resided in this state.

3 (4) PREGNANT WOMEN. A pregnant woman who resides in this state who does
4 not yet meet the residency requirement under sub. (1) (a) is eligible to participate in
5 the plan regardless of the length of time the pregnant woman has resided in this
6 state.

7 (5) COLLECTIVE BARGAINING AGREEMENT. A person who is eligible to participate
8 in the plan under sub. (1), (2), (3), or (4) and who receives health care coverage under
9 a collective bargaining agreement that is in effect on January 1, 2009, is not eligible
10 to participate in the plan until the day on which the collective bargaining agreement
11 expires or the day on which the collective bargaining agreement is extended,
12 modified, or renewed.

13 (6) WAIVER REQUEST. (a) In this subsection, “department” means the
14 department of health and family services.

15 (b) 1. The department shall develop a request for a waiver from the secretary
16 of the federal department of health and human services to provide coverage under
17 the plan to individuals who are eligible for Medical Assistance under subch. IV of ch.
18 49 in the low-income families category, as determined by the department, and to
19 individuals who are eligible for health care coverage under the Badger Care health
20 care program under s. 49.665. The waiver request shall be written so as to allow the
21 use of federal financial participation to fund, to the maximum extent possible, health
22 care coverage under the plan for the individuals specified in this subdivision.

23 2. The department shall, not later than July 1, 2008, submit the waiver request
24 developed under subd. 1. to a special legislative committee that shall be comprised
25 of the members of the joint committee on finance and the members of the standing

1 committees of the senate and the assembly with subject matter jurisdiction over
2 health issues. The special legislative committee shall have 60 days to review and
3 comment to the department on the waiver request.

4 (c) Except as required under par. (b), the department may develop waiver
5 requests to the appropriate federal agencies to permit funds from federal health care
6 services programs to be used for health care coverage for persons under the plan.

7 **(7) DEFINITIONS OF TERMS.** For purposes of this chapter, the board shall define
8 all of the following terms:

9 (a) Place of permanent abode.

10 (b) Substantial presence this state. In defining “substantial presence in this
11 state,” the board shall consider such factors as the amount of time per year that an
12 individual is actually present in the state and the amount of taxes that an individual
13 pays in this state, except that, if the individual attends school outside of this state
14 and is under 23 years of age, the factors shall include the amount of time that the
15 individual’s parent or guardian is actually present in the state and the amount of
16 taxes that the individual’s parent or guardian pays in this state, and if the individual
17 is in active service with the U.S. armed forces outside of this state, the factors shall
18 include the amount of time that the individual’s parent, guardian, or spouse is
19 actually present in the state and the amount of taxes that the individual’s parent,
20 guardian, or spouse pays in this state.

21 (c) Immediate family.

22 (d) Gainfully employed. The definition shall include employment by persons
23 who are self-employed and persons who work on farms.

24 **260.12 Office of outreach, enrollment, and advocacy. (1) ESTABLISHMENT.**

25 The board shall establish an office of outreach, enrollment, and advocacy. The office

1 shall contract with nonprofit organizations to perform the outreach, enrollment, and
2 advocacy functions specified in this section, and to review the health care payment
3 and services records of persons who are participating, or who are eligible to
4 participate, in the plan and who have provided the office with informed consent for
5 the review. The office may not contract with any organization under this subsection
6 that provides services under the plan or that has any other conflict of interest, as
7 described in sub. (3).

8 **(2) DUTIES.** The office of outreach, enrollment, and advocacy shall do all of the
9 following:

10 (a) Engage in aggressive outreach to enroll eligible persons and participants
11 in their choice of health care coverage under the plan.

12 (b) Assist eligible persons in choosing health care coverage by examining cost,
13 quality, and geographic coverage information regarding their choice of available
14 networks or providers.

15 (c) Inform plan participants of the role they can play in holding down health
16 care costs by taking advantage of preventive care, enrolling in chronic disease
17 management programs if appropriate, responsibly utilizing medical services, and
18 engaging in healthy lifestyles. The office shall inform participants of networks or
19 workplaces where healthy lifestyle incentives are in place.

20 (d) At the direction of the board, establish a process for resolving disputes with
21 providers.

22 (e) Act as an advocate for plan participants having questions, difficulties, or
23 complaints about their health care services or coverage, including investigating and
24 attempting to resolve the complaint. Investigation should include, when

1 appropriate, consulting with the health care advisory committee under s. 260.49
2 regarding best practice guidelines.

3 (f) If a participant's complaint cannot be successfully resolved, inform the
4 participant of any legal or other means of recourse for his or her complaint. If the
5 complaint involves a dispute over eligibility or other determinations made by the
6 board, the participant shall be directed to the appeals process for board decisions.

7 (g) Provide information to the public, agencies, legislators, and others
8 regarding problems and concerns of plan participants and, in consultation with the
9 health care advisory committee under s. 260.49, make recommendations for
10 resolving those problems and concerns.

11 (h) Ensure that plan participants have timely access to the services provided
12 by the office.

13 **(3) CONFLICT OF INTEREST LIMITATION.** The office and its employees and
14 contractors shall not have any conflict of interest relating to the performance of their
15 duties. There is a conflict of interest if, with respect to the office's director, employees,
16 or contractors, or a person affiliated with the office's director, employees, or
17 contractors, any of the following exists:

18 (a) Direct involvement in the licensing, certification, or accreditation of a
19 health care facility, health insurer, or health care provider.

20 (b) Direct ownership interest or investment interest in a health care facility,
21 health insurer, or health care provider.

22 (c) Employment by, or participation in, the management of a health care
23 facility, health insurer, or health care provider.

1 (d) Receipt of, or having the right to receive, directly or indirectly, remuneration
2 under a compensation arrangement with a health care facility, health insurer, or
3 health care provider.

4 **260.15 Benefits. (1) GENERALLY.** The board shall establish a health care plan
5 that will take effect on January 1, 2009. The plan shall provide the same benefits
6 as those that were in effect as of January 1, 2007, under the state employee health
7 plan under s. 40.51 (6). The board may adjust the plan benefits to provide additional
8 cost-effective treatment options if there is evidence-based research that the options
9 are likely to reduce health care costs, avoid health risks, or result in better health
10 outcomes.

11 **(2) ADDITIONAL BENEFITS.** In addition to the benefit requirements under sub.
12 (1), the plan shall provide coverage for mental health services and alcohol or other
13 drug abuse treatment to the same extent as the plan covers treatment for physical
14 conditions and coverage for preventive dental care for children up to 18 years of age.

15 **260.20 Cost sharing. (1) NO COST SHARING.** The plan shall cover the following
16 preventive services without any cost-sharing requirement:

17 (a) Prenatal care for pregnant women.

18 (b) Well-baby care.

19 (c) Medically appropriate examinations and immunizations for children up to
20 18 years of age.

21 (d) Medically appropriate gynecological exams, Papanicolaou tests, and
22 mammograms.

23 (e) Medically appropriate regular medical examinations for adults, as
24 determined by best practices.

25 (f) Medically appropriate colonoscopies.

1 (g) Preventive dental care for children up to 18 years of age.

2 (h) Other preventive services or procedures, as determined by the board, for
3 which there is scientific evidence that exemption from cost sharing is likely to reduce
4 health care costs or avoid health risks.

5 (i) Chronic care services, provided that the participant receiving the services
6 is participating in, and complying with, a chronic disease management program as
7 defined by the board.

8 **(2) DEDUCTIBLES.** (a) *Maximum amounts and who must pay.* 1. Subject to subd.
9 2., during any year, a participant who is 18 years of age or older on January 1 of that
10 year shall pay a deductible of \$300, which shall apply to all covered services and
11 articles.

12 2. During any year, a family consisting of 2 or more participants who are 18
13 years of age or older on January 1 of that year shall pay a deductible of \$600, which
14 shall apply to all covered services and articles.

15 3. During any year, a participant who is under 18 years of age on January 1 of
16 that year shall not be required to pay a deductible.

17 4. Except for copayments and coinsurance, the plan shall provide a participant
18 with full coverage for all covered services and articles after the participant has
19 received covered services and articles totaling the applicable deductible amount
20 under this paragraph, regardless of whether the participant has paid the deductible
21 amount.

22 (b) *Provider requirements.* 1. A provider that provides to a participant a
23 covered service or article to which a deductible applies shall charge for the service
24 or article the payment rate established by the board under s. 260.30 (7) (b) 1. if the
25 participant's coverage is under the fee-for-service option under s. 260.30 (2) (a) or

1 the applicable network rate for the service or article, as determined by the board, if
2 the participant's coverage is under the health care network option under s. 260.30
3 (2) (b). Except as provided in subd. 3., a provider of a covered service or article to
4 which a deductible applies shall accept as payment in full for the covered service or
5 article the payment rate specified in this subdivision and may not bill a participant
6 who receives the service or article for any amount by which the charge for the service
7 or article is reduced under this subdivision.

8 2. Except for prescription drugs, a provider may not refuse to provide to a
9 participant a covered service or article to which a deductible applies on the basis that
10 the participant does not pay, or has not paid, any applicable deductible amount
11 before the service or article is provided.

12 3. A provider may not charge any interest, penalty, or late fee on any deductible
13 amount owed by a participant unless the deductible amount owed is at least 6
14 months past due and the provider has provided the participant with notice of the
15 interest, penalty, or late fee at least 90 days before the interest, penalty, or late fee
16 payment is due. Interest may not exceed 1 percent per month, and any penalty or
17 late fee may not exceed the provider's reasonable cost of administering the unpaid
18 bill.

19 (c) *Adjustments by board.* Notwithstanding par. (a) 1. and 2., the board may
20 adjust the deductible amounts specified in par. (a) 1. and 2., but only to reduce those
21 amounts.

22 **(3) COPAYMENTS AND COINSURANCE.** (a) *General copayments.* During any year,
23 a participant who is 18 years of age or older on January 1 of that year shall pay a
24 copayment of \$20 for medical, hospital, and related health care services, as
25 determined by the board.

1 (b) *Specialist provider services without referral.* A participant, regardless of
2 age, who receives health care services from a specialist provider without a referral
3 from his or her primary care provider under the plan shall be required to pay 25
4 percent of the cost of the services provided.

5 (c) *Inappropriate emergency room use.* Notwithstanding par. (a), a participant
6 who is 18 years of age or older shall pay a copayment of \$60 for inappropriate
7 emergency room use, as determined by the board.

8 (d) *Prescription drugs.* 1. All participants, regardless of age, shall pay \$5 for
9 each prescription of a generic drug that is on the formulary determined by the board.

10 2. All participants, regardless of age, shall pay \$15 for each prescription of a
11 brand-name drug that is on the formulary determined by the board.

12 3. All participants, regardless of age, shall pay \$40 for each prescription of a
13 brand-name drug that is not on the formulary determined by the board.

14 4. Notwithstanding subs. 1. to 3., no participant shall pay more for a
15 prescription drug than the actual cost of the prescription drug plus the negotiated
16 dispensing fee.

17 (e) *Adjustments by board.* Notwithstanding pars. (a) to (d), the board may
18 adjust the copayment and coinsurance amounts specified in pars. (a) to (d).

19 **(4) MAXIMUM AMOUNTS.** Notwithstanding the deductible, coinsurance, and
20 copayment amounts in subs. (2) and (3), all of the following apply:

21 (a) Subject to par. (b), a participant who is 18 years of age or older on January
22 1 of a year may not be required to pay more than \$2,000 during that year in total cost
23 sharing under subs. (2) and (3).

24 (b) A family consisting of 2 or more participants may not be required to pay
25 more than \$3,000 during a year in total cost sharing under subs. (2) and (3).

1 **260.30 Service areas; selection and payment of health care providers**
2 **and health care networks. (1)** ESTABLISHMENT OF AREAS WHERE SERVICES WILL BE
3 PROVIDED. The board may establish areas in the state, which may be counties,
4 multicounty regions, or other areas, for the purpose of receiving bids from health care
5 networks. These areas shall be established so as to maximize the level and quality
6 of competition among health care networks or to increase the number of provider
7 choices available to eligible persons and participants in the areas.

8 **(2)** OPTIONS AVAILABLE IN EACH AREA. In each area designated by the board under
9 sub. (1), the board shall offer both of the following options for delivery of health care
10 services under the plan:

11 (a) An option, known as the “fee-for-service option,” under which participants
12 must choose a primary care provider, may be referred by the primary care provider
13 to any medical specialist, and may be admitted by the primary care provider or
14 specialist to any hospital or other facility, for the purpose of receiving the benefits
15 provided under this chapter. Under this option, the board, with the assistance of one
16 or more administrators chosen by a competitive bidding process and with whom the
17 board has contracted, shall pay directly, at the provider payment rates established
18 by the board under sub. (7) (b) 1., for all health care services and articles that are
19 covered under the plan.

20 (b) An option under which one or more health care networks that meet the
21 qualifying criteria in sub. (4) and are certified under sub. (5) provide health care
22 services to participants. The board is required to offer this option in each area
23 designated by the board to the extent that qualifying health care networks exist in
24 the area.

1 **(3) SOLICITATION OF BIDS FROM HEALTH CARE NETWORKS.** The board shall annually
2 solicit sealed risk-adjusted premium bids from competing health care networks for
3 the purpose of offering health care coverage to participants. The board shall request
4 each bidder to submit information pertaining to whether the bidder is a qualifying
5 health care network, as described in sub. (4).

6 **(4) QUALIFYING HEALTH CARE NETWORKS.** A health care network is qualifying if
7 it does all of the following:

8 (a) Demonstrates to the satisfaction of the board that the fixed monthly
9 risk-adjusted amount that it bids to provide participants with the health care
10 benefits specified in this chapter reasonably reflects its estimated actual costs for
11 providing participants with such benefits in light of its underlying efficiency as a
12 network, and has not been artificially underbid for the predatory purpose of gaining
13 market share.

14 (b) Will spend at least 92 percent of the revenue it receives under this chapter
15 on one of the following:

16 1. Payments to health care providers in order to provide the health care benefits
17 specified in this chapter to participants who choose the health care network.

18 2. Investments that the health care network has reasonably determined will
19 improve the overall quality or lower the overall cost of patient care.

20 (c) Ensures all of the following:

21 1. That participants living in an area that a health care network serves shall
22 not be required to drive more than 30 minutes, or, in a metropolitan area served by
23 mass transit, spend more than 60 minutes using mass transit facilities, in order to
24 reach the offices of at least 2 primary care providers, as defined by the board.

1 2. That physicians, physician assistants, nurses, clinics, hospitals, and other
2 health care providers and facilities, including providers and facilities that specialize
3 in mental health services and alcohol or other drug abuse treatment, are
4 conveniently available, as defined by the board, to participants living in every part
5 of the area that the health care network serves.

6 (d) Ensures that participants have access, 24 hours a day, 7 days a week, to a
7 toll-free hotline and help desk that is staffed by persons who live in the area and who
8 have been fully trained to communicate the benefits provided under this chapter and
9 the choices of providers that participants have in using the health care network.

10 (e) Ensures that each participant who chooses the health care network selects
11 a primary care provider who is responsible for overseeing all of the participant's care.

12 (f) Will provide each participant with medically appropriate and high-quality
13 health care, including mental health services and alcohol or other drug abuse
14 treatment, in a highly coordinated manner.

15 (g) Emphasizes, in its policies and operations, the promotion of healthy
16 lifestyles; preventive care, including early identification of and response to high-risk
17 individuals and groups, early identification of and response to health disorders,
18 disease management, including chronic care management, and best practices,
19 including the appropriate use of primary care, medical specialists, medications, and
20 hospital emergency rooms; and the utilization of continuous quality improvement
21 standards and practices that are generally accepted in the medical field.

22 (h) Has developed and is implementing a program, including providing
23 incentives to providers when appropriate, to promote health care quality, increase
24 the transparency of health care cost and quality information, ensure the

1 confidentiality of medical information, and advance the appropriate use of
2 technology.

3 (i) Has entered into shared service agreements with out-of-network medical
4 specialists, hospitals, and other facilities, including medical centers of excellence in
5 the state, through which participants can obtain, at no additional expense to
6 participants beyond the normally required level of cost sharing, the services of
7 out-of-network providers that the network's primary care physicians selected by
8 participants have determined is necessary to ensure medically appropriate and
9 high-quality health care, to facilitate the best outcome, or, without reducing the
10 quality of care, to lower costs.

11 (j) Has in place a comprehensive, shared, electronic patient records and
12 treatment tracking system and an electronic provider payment system.

13 (k) Has adopted and implemented a strong policy to safeguard against conflicts
14 of interest.

15 (L) Has been organized by physicians or other health care providers, a
16 cooperative, or an entity whose mission includes improving the quality and lowering
17 the cost of health care, including the avoidance of unnecessary operating and capital
18 costs arising from inappropriate utilization or inefficient delivery of health care
19 services, unwarranted duplication of services and infrastructure, or creation of
20 excess capacity.

21 (m) Agrees to enroll and provide the benefits specified in this chapter to all
22 participants who choose the network, regardless of the participant's age, sex, race,
23 religion, national origin, sexual orientation, health status, marital status, disability
24 status, or employment status, except that a health care network may do one of the
25 following:

1 1. Limit the number of new enrollees it accepts if the health care network
2 certifies to the board that accepting more than a specified number of enrollees would
3 make it impossible to provide all enrollees with the benefits specified in this chapter
4 at the level of quality that the network is committed to maintaining, provided that
5 the health care network uses a random method for deciding which new enrollees it
6 accepts.

7 2. Limit the participants that it serves to a specific affinity group, such as
8 farmers or teachers, that the health care network has certified to the board, provided
9 that the limitation does not involve discrimination based on any of the factors
10 described in this paragraph and has neither been created for the purpose, nor will
11 have the effect, of screening out higher-risk enrollees. This subdivision applies only
12 to affinity groups that are in existence as of December 31, 2007.

13 **(5) CERTIFICATION OF HEALTH CARE NETWORKS AND CLASSIFICATION OF BIDS.** (a) The
14 board shall review the bids submitted under sub. (3), the information submitted by
15 bidders pertaining to whether the bidders are qualifying health care networks, and
16 other evidence provided to the board as to whether a particular bidder is a qualifying
17 health care network.

18 (b) Based on the information about bidder qualification submitted or otherwise
19 provided under par. (a), the board shall certify which health care networks are
20 qualifying health care networks.

21 (c) With respect to all health care networks that the board certifies under par.
22 (b), the board shall open the submitted, sealed bids at a predetermined time. The
23 board shall classify the certified health care networks according to price and quality
24 measures after comparing their risk-adjusted per-month bids and assessing their
25 quality. The board shall classify the network that bid the lowest price as the

1 lowest-cost network, and shall classify as a low-cost network any network that has
2 bid a price that is close to the price bid by the lowest-cost network. Any other
3 network shall be classified as a higher-cost network.

4 **(6) OPEN ENROLLMENT.** The board shall provide an annual open enrollment
5 period during which each participant may select a certified health care network from
6 among those offered, or a fee-for-service option. Coverage shall be effective on the
7 following January 1. A participant who does not select a certified health care
8 network or the fee-for-service option will be assigned randomly to one of the
9 networks that have been classified under sub. (5) as having submitted the lowest or
10 a low bid and as performing well on quality measures, or to the fee-for-service option
11 if that is the lowest-cost option. A participant who selects the fee-for-service option
12 or a certified health care network that has been classified as a higher-cost network,
13 but who fails to pay the additional payment under sub. (7) (a) 2., shall be assigned
14 randomly to one of the networks that has been classified under sub. (5) as the
15 lowest-cost network or as a low-cost network and as performing well on quality
16 measures, or to the fee-for-service option if that is the lowest-cost option.

17 **(7) PAYMENTS TO NETWORKS AND PROVIDERS.** (a) *Payments to health care*
18 *networks.* 1. On behalf of each participant who selects or has been assigned to a
19 certified health care network that has been classified under sub. (5) (c) as the
20 lowest-cost network or a low-cost network and as performing well on quality
21 measures, the board shall pay monthly to the health care network the full
22 risk-adjusted per-member per-month amount that was bid by the network. The
23 dollar amount shall be actuarially adjusted for the participant based on age, sex, and
24 other appropriate risk factors determined by the board. A participant who selects

1 or is assigned to the lowest-cost network or a low-cost network shall not be required
2 to pay any additional amount to the network.

3 2. If a participant chooses instead to enroll in a certified health care network
4 that has been classified under sub. (5) (c) as a higher-cost network, the board shall
5 pay monthly to the chosen health care network an amount equal to the bid submitted
6 by the network that the board classified under sub. (5) (c) as the lowest-cost network
7 and as having performed well on quality measures. The dollar amount shall be
8 actuarially adjusted for the participant based on age, sex, and other appropriate risk
9 factors determined by the board. A participant who chooses to enroll in a higher-cost
10 network shall be required to pay monthly, in addition to the amount paid by the
11 board, an additional payment sufficient to ensure that the chosen network receives
12 the full price bid by that network.

13 3. The board may retain a percentage of the dollar amounts established for each
14 participant under subds. 1. and 2. to pay to certified health care networks that have
15 incurred disproportionate risk not fully compensated for by the actuarial adjustment
16 in the amount established for each eligible person. Any payment to a certified health
17 care network under this subdivision shall reflect the disproportionate risk incurred
18 by the health care network.

19 (b) *Payments to fee-for-service providers.* 1. The board shall establish provider
20 payment rates that will be paid to providers of covered services and articles that are
21 provided to participants who choose the fee-for-service option under sub. (2) (a). The
22 payment rates shall be fair and adequate to ensure that this state is able to retain
23 the highest quality of medical practitioners. The board shall limit increases in the
24 provider payment rate for each service or article such that any increase in per person
25 spending under the plan does not exceed the national rate of medical inflation.

1 2. Except for deductibles, copayments, coinsurance, and any other cost sharing
2 required or authorized under the plan, a provider of a covered service or article shall
3 accept as payment in full for the covered service or article the payment rate
4 determined under subd. 1. and may not bill a participant who receives the service or
5 article for any amount by which the charge for the service or article is reduced under
6 subd. 1.

7 3. The board, with the assistance of its actuarial consultants, shall establish
8 the monthly risk-adjusted cost of the fee-for-service option offered to participants
9 under sub. (2) (a). The board shall classify the fee-for-service option in the same
10 manner that the board classifies certified health care networks under sub. (5) (c).

11 4. If the board has determined under sub. (5) (c) that there is at least one
12 certified low-cost health care network in an area, which may be the lowest-cost
13 health care network, and if the fee-for-service option offered in that area has been
14 classified as a higher-cost choice under subd. 3., the cost to a participant enrolling
15 in the fee-for-service option shall be determined as follows:

16 a. If there are available to the participant 3 or more certified health care
17 networks classified under sub. (5) (c) as low-cost networks, or as the lowest-cost
18 network and 2 or more low-cost networks, the participant shall pay the difference
19 between the cost of the lowest-cost health care network and the monthly
20 risk-adjusted cost established under subd. 3. for the fee-for-service option, except
21 that the amount paid may not exceed \$100 per month for an individual, or \$200 per
22 month for a family, as adjusted for medical inflation.

23 b. If there are available to the participant 2 certified health care networks
24 classified under sub. (5) (c) as low-cost networks, or as the lowest-cost network and
25 one low-cost network, the participant shall pay the difference between the cost of the

1 lowest-cost health care network and the monthly risk-adjusted cost established
2 under subd. 3. for the fee-for-service option, except that the amount paid may not
3 exceed \$65 per month for an individual, or \$125 per month for a family, as adjusted
4 for medical inflation.

5 c. If there is available to the participant only one certified health care network
6 classified under sub. (5) (c) as a low-cost network, or as the lowest-cost network, the
7 person shall pay the difference between the cost of the lowest-cost health care
8 network and the monthly risk-adjusted cost established under subd. 3. for the
9 fee-for-service option, except that the amount paid may not exceed \$25 per month
10 for an individual, and \$50 per month for a family, as adjusted for medical inflation.

11 6. If the board has determined, under sub. (5) (c), that there is no certified
12 lowest-cost health care network or low-cost health care network in the area, there
13 shall be no extra cost to the participant enrolling in the fee-for-service option.

14 **(8) INCENTIVE PAYMENTS TO FEE-FOR-SERVICE PROVIDERS.** Health care providers
15 and facilities providing services under the fee-for-service option under sub. (2) (a)
16 shall be encouraged to collaborate with each other through financial incentives
17 established by the board. Providers shall work with facilities to pool infrastructure
18 and resources; to implement the use of best practices and quality measures; and to
19 establish organized processes that will result in high-quality, low-cost medical care.
20 The board shall establish an incentive payment system to providers and facilities
21 that comply with this subsection, in accordance with criteria established by the
22 board.

23 **(9) PHARMACY BENEFIT.** Except for prescription drugs to which a deductible
24 applies, the board shall assume the risk for, and pay directly for, prescription drugs
25 provided to participants. In implementing this requirement, the board shall

1 replicate the prescription drug buying system developed by the group insurance
2 board for prescription drug coverage under the state employee health plan under s.
3 40.51 (6), unless the board determines that another approach would be more
4 cost-effective. The board may join the prescription drug purchasing arrangement
5 under this chapter with similar arrangements or programs in other states to form
6 a multistate purchasing group to negotiate with prescription drug manufacturers
7 and distributors for reduced prescription drug prices, or to contract with a 3rd party,
8 such as a private pharmacy benefits manager, to negotiate with prescription drug
9 manufacturers and distributors for reduced prescription drug prices.

10 **260.35 Subrogation.** The board and authority are entitled to the right of
11 subrogation for reimbursement to the extent that a participant may recover
12 reimbursement for health care services and items in an action or claim against any
13 3rd party.

14 **260.37 Employer-provided health care benefits.** Nothing in this chapter
15 prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying
16 all or part of any cost sharing under s. 260.20 or 260.30, or from providing any health
17 care benefits not provided under the plan, for any of the employer's employees.

18 **260.40 Assessments, individuals and businesses. (1) DEFINITIONS.** In this
19 section:

20 (a) "Department" means the department of revenue.

21 (b) "Dependent" means a spouse, an unmarried child under the age of 19 years,
22 an unmarried child who is a full-time student under the age of 21 years and who is
23 financially dependent upon the parent, or an unmarried child of any age who is
24 medically certified as disabled and who is dependent upon the parent.

1 (c) “Eligible individual” means an individual who is eligible to participate in
2 the plan, other than an employee or a self–employed individual.

3 (d) “Employee” means an individual who has an employer.

4 (e) “Employer” means a person who is required under the Internal Revenue
5 Code to file form 941.

6 (f) “Medical inflation” means the percentage change between the U.S.
7 consumer price index for all urban consumers, U.S. city average, for the medical care
8 group only, including medical care commodities and medical care services, for the
9 month of August of the previous year and the U.S. consumer price index for all urban
10 consumers, U.S. city average, for the medical care group only, including medical care
11 commodities and medical care services, for the month of August 2007, as determined
12 by the U.S. department of labor.

13 (g) “Poverty line” means the federal poverty line, as defined under 42 USC 9902
14 (2), for a family the size of the individual’s family.

15 (h) “Self–employed individual” means an individual who is required under the
16 Internal Revenue Code to file schedule SE.

17 (i) “Social security wages” means:

18 1. For purposes of sub. (2) (a), the amount of wages, as defined in section 3121
19 (a) of the Internal Revenue Code, paid to an employee by an employer in a taxable
20 year, up to a maximum amount that is equal to the social security wage base.

21 2. For purposes of sub. (2) (b), the amount of net earnings from
22 self–employment, as defined in section 1402 (a) of the Internal Revenue Code,
23 received by an individual in a taxable year, up to a maximum amount that is equal
24 to the social security wage base.

1 3. For purposes of sub. (3), the amount of wages, as defined in section 3121 (a)
2 of the Internal Revenue Code, paid by an employer in a taxable year with respect to
3 employment, as defined in section 3121 (b) of the Internal Revenue Code, up to a
4 maximum amount that is equal to the social security wage base multiplied by the
5 number of the employer's employees.

6 **(2) INDIVIDUALS.** Subject to sub. (4), the board shall calculate the following
7 assessments, based on its anticipated revenue needs:

8 (a) For an employee who is under the age of 65, a percent of social security
9 wages that is at least 2 percent and not more than 4 percent, subject to the following:

10 1. If the employee has no dependents and his or her social security wages are
11 150 percent or less of the poverty line, the employee may not be assessed.

12 2. If the employee has no dependents and his or her social security wages are
13 more than 150 percent and 200 percent or less of the poverty line the assessment
14 shall be in an amount, as determined by the board on a sliding scale based on the
15 employee's social security wages, that is between zero percent and 4 percent of the
16 employee's social security wages.

17 3. If the employee has one or more dependents, or is a single individual who is
18 pregnant, and the employee's social security wages are more than 150 percent and
19 300 percent or less of the poverty line the assessment shall be in an amount, as
20 determined by the board on a sliding scale based on the employee's social security
21 wages, that is between zero percent and 4 percent of the employee's social security
22 wages.

23 (b) For a self-employed individual who is under the age of 65, a percent of social
24 security wages that is at least 9 percent and not more than 10 percent.

1 (c) For an eligible individual who has no social security wages under sub. (1)
2 (i) 1. or 2. or, from an employer, under sub. (1) (i) 3., 10 percent of federal adjusted
3 gross income, up to the maximum amount of income that is subject to social security
4 tax.

5 **(3) EMPLOYERS.** Subject to sub. (4), the board shall calculate an assessment,
6 based on its anticipated revenue needs, that is a percent of aggregate social security
7 wages that is at least 9 percent and not more than 12 percent.

8 **(4) COLLECTION AND CALCULATION OF ASSESSMENTS.** (a) For taxable years
9 beginning after December 31, 2008, the department shall impose on, and collect
10 from, individuals the assessment amounts that the board calculates under sub. (2),
11 either through an assessment that is collected as part of the income tax under subch.
12 I of ch. 71, or through another method devised by the department. For taxable years
13 beginning after December 31, 2008, the department shall impose on, and collect
14 from, employers the assessment amounts that the board calculates under sub. (3),
15 either through an assessment that is collected as part of the tax under subch. IV of
16 ch. 71, or through another method devised by the department. Section 71.80 (1) (c),
17 as it applies to ch. 71, applies to the department's imposition and collection of
18 assessments under this section.

19 (b) The amounts that the department collects under par. (a) shall be deposited
20 into the Healthy Wisconsin trust fund under s. 25.775.

21 (c) The board may annually increase or decrease the amounts that may be
22 assessed under subs. (2) and (3). No annual increase under this paragraph may
23 exceed the percentage increase for medical inflation unless a greater increase is
24 provided for by law.

1 **260.49 Advisory committee. (1) DUTIES.** The board shall establish a health
2 care advisory committee to advise the board on all of the following:

3 (a) Matters related to promoting healthier lifestyles.

4 (b) Promoting health care quality.

5 (c) Increasing the transparency of health care cost and quality information.

6 (d) Preventive care.

7 (e) Early identification of health disorders.

8 (f) Disease management.

9 (g) The appropriate use of primary care, medical specialists, prescription
10 drugs, and hospital emergency rooms.

11 (h) Confidentiality of medical information.

12 (i) The appropriate use of technology.

13 (j) Benefit design.

14 (k) The availability of physicians, hospitals, and other providers.

15 (L) Reducing health care costs.

16 (m) Any other subject assigned to it by the board.

17 (n) Any other subject determined appropriate by the committee.

18 **(2) MEMBERSHIP.** The board shall appoint as members of the committee all of
19 the following individuals:

20 (a) At least one member designated by the Wisconsin Medical Society, Inc.

21 (b) At least one member designated by the Wisconsin Academy of Family
22 Physicians.

23 (c) At least one member designated by the Wisconsin Hospital Association, Inc.

1 (d) One member designated by the president of the Board of Regents of the
2 University of Wisconsin System who is knowledgeable in the field of medicine and
3 public health.

4 (e) One member designated by the president of the Medical College of
5 Wisconsin.

6 (f) Two members designated by the Wisconsin Nurses Association, the
7 Wisconsin Federation of Nurses and Health Professionals, and the Service
8 Employees International Union.

9 (g) One member designated by the Wisconsin Dental Association.

10 (h) One member designated by statewide organizations interested in mental
11 health issues.

12 (i) One member representing health care administrators.

13 (j) Other members representing health care professionals.”.

14 **57.** Page 1353, line 13: after that line insert:

15 “**SECTION 3085c.** 285.59 (1) (b) of the statutes is amended to read:

16 285.59 (1) (b) “State agency” means any office, department, agency, institution
17 of higher education, association, society, or other body in state government created
18 or authorized to be created by the constitution or any law ~~which~~ that is entitled to
19 expend moneys appropriated by law, including the legislature and the courts, the
20 Wisconsin Housing and Economic Development Authority, the Bradley Center
21 Sports and Entertainment Corporation, the University of Wisconsin Hospitals and
22 Clinics Authority, the Fox River Navigational System Authority, the Wisconsin
23 Aerospace Authority, ~~and~~ the Wisconsin Health and Educational Facilities
24 Authority, and the Healthy Wisconsin Authority.”.

1 **58.** Page 1497, line 21: after that line insert:

2 “**SECTION 3660d.** 609.01 (7) of the statutes is repealed.

3 **SECTION 3660h.** 609.10 of the statutes is repealed.

4 **SECTION 3660p.** 609.20 (1m) (c) of the statutes is repealed.

5 **SECTION 3660t.** 609.20 (1m) (d) of the statutes is repealed.”.

6 **59.** Page 1499, line 25: after that line insert:

7 “**SECTION 3665c.** 628.36 (4) (a) (intro.) of the statutes is amended to read:

8 628.36 **(4)** (a) (intro.) The commissioner shall provide information and
9 assistance to ~~the department of employee trust funds,~~ employers and their
10 employees, providers of health care services, and members of the public, as provided
11 in par. (b), for the following purposes:

12 **SECTION 3665g.** 628.36 (4) (b) 1. of the statutes is repealed.

13 **SECTION 3665n.** 628.36 (4) (b) 2. of the statutes is repealed.

14 **SECTION 3665t.** 628.36 (4) (b) 3. of the statutes is repealed.”.

15 **60.** Page 1504, line 8: after that line insert:

16 “**SECTION 3680b.** 632.87 (5) of the statutes is amended to read:

17 632.87 **(5)** No insurer ~~or self-insured school district, city or village~~ may, under
18 a policy, plan, or contract covering gynecological services or procedures, exclude or
19 refuse to provide coverage for Papanicolaou tests, pelvic examinations, or associated
20 laboratory fees when the test or examination is performed by a licensed nurse
21 practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse
22 practitioner’s professional license, if the policy, plan, or contract includes coverage
23 for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the
24 test or examination is performed by a physician.

1 **SECTION 3687d.** 632.895 (8) (f) 4. of the statutes is created to read:

2 632.895 **(8)** (f) 4. A disability insurance policy providing only health care
3 benefits not provided under the Healthy Wisconsin Plan under ch. 260.

4 **SECTION 3687f.** 632.895 (9) (d) 4. of the statutes is created to read:

5 632.895 **(9)** (d) 4. A disability insurance policy providing only health care
6 benefits not provided under the Healthy Wisconsin Plan under ch. 260.

7 **SECTION 3687h.** 632.895 (10) (a) of the statutes is amended to read:

8 632.895 **(10)** (a) Except as provided in par. (b), every disability insurance policy
9 ~~and every health care benefits plan provided on a self-insured basis by a county~~
10 ~~board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political~~
11 ~~subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district~~
12 ~~under s. 120.13 (2)~~ shall provide coverage for blood lead tests for children under 6
13 years of age, which shall be conducted in accordance with any recommended lead
14 screening methods and intervals contained in any rules promulgated by the
15 department of health and family services under s. 254.158.

16 **SECTION 3687j.** 632.895 (10) (b) 6. of the statutes is created to read:

17 632.895 **(10)** (b) 6. A disability insurance policy providing only health care
18 benefits not provided under the Healthy Wisconsin Plan under ch. 260.

19 **SECTION 3687L.** 632.895 (11) (a) (intro.) of the statutes is amended to read:

20 632.895 **(11)** (a) (intro.) Except as provided in par. (e), every disability
21 insurance policy, ~~and every self-insured health plan of the state or a county, city,~~
22 ~~village, town or school district,~~ that provides coverage of any diagnostic or surgical
23 procedure involving a bone, joint, muscle, or tissue shall provide coverage for
24 diagnostic procedures and medically necessary surgical or nonsurgical treatment for
25 the correction of temporomandibular disorders if all of the following apply:

1 **SECTION 3687n.** 632.895 (11) (c) 1. of the statutes is amended to read:

2 632.895 (11) (c) 1. The coverage required under this subsection may be subject
3 to any limitations, exclusions, or cost-sharing provisions that apply generally under
4 the disability insurance policy ~~or self-insured health plan.~~

5 **SECTION 3687p.** 632.895 (11) (d) of the statutes is amended to read:

6 632.895 (11) (d) Notwithstanding par. (c) 1., an insurer ~~or a self-insured health~~
7 ~~plan of the state or a county, city, village, town or school district~~ may require that an
8 insured obtain prior authorization for any medically necessary surgical or
9 nonsurgical treatment for the correction of temporomandibular disorders.

10 **SECTION 3687r.** 632.895 (11) (e) 3. of the statutes is created to read:

11 632.895 (11) (e) 3. A disability insurance policy providing only health care
12 benefits not provided under the Healthy Wisconsin Plan under ch. 260.

13 **SECTION 3687t.** 632.895 (14) (b) of the statutes is amended to read:

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

19 **SECTION 3687v.** 632.895 (14) (d) 7. of the statutes is created to read:

20 632.895 (14) (d) 7. A disability insurance policy providing only health care
21 benefits not provided under the Healthy Wisconsin Plan under ch. 260.”.

22 **61.** Page 1644, line 14: after that line insert:

23 “(4c) HEALTHY WISCONSIN PLAN.

1 (a) *Legislative findings.* In establishing the Healthy Wisconsin Plan under
2 chapter 260 of the statutes, as created by this act, the legislature finds all of the
3 following:

4 1. ‘Costs.’ Health care costs in Wisconsin are rising at an unsustainable rate
5 making the need for comprehensive reform urgent. Rising costs are seriously
6 threatening the ability of Wisconsin businesses to globally compete; farms to thrive;
7 government to provide needed services; schools to educate; and local citizens to form
8 new and successful business ventures. Some indicators of rising costs are the
9 following:

10 a. Total health care spending in Wisconsin in 2007 is projected to be \$42.3
11 billion, and is projected to grow 82 percent, to \$76.9 billion, in the next decade.

12 b. The cost of employer–provided health care in Wisconsin increased by 9.3
13 percent in 2006, averaging \$9,516 per employee. This figure is 26 percent more than
14 the national average.

15 c. Employee premium contributions and out–of–pocket costs are rising faster
16 than wages.

17 d. Rising costs have led to a decline in employer–provided health benefits. In
18 1979, 73 percent of private–sector Wisconsin workers had employer–based health
19 insurance coverage; however, only 57 percent received health benefits in 2004.

20 e. At least one–half of all personal bankruptcies in the United States are the
21 result of medical expenses. Over 75.7 percent of this group had insurance at the
22 onset of illness. In 2004, there were 13,454 medical bankruptcies in Wisconsin
23 affecting 37,360 people.

24 f. The costs of health services provided to individuals who are unable to pay are
25 shifted to others. Of the \$22 billion charged by hospitals in 2005, \$736,000,000 was

1 not collected. Those who bear the burden of this cost shift have an increasingly
2 difficult time paying their own health care costs.

3 2. ‘Access.’ There is a large and increasing number of people who have no health
4 insurance or who are underinsured. For this growing population, health care is
5 unaffordable and, most often, not received in the most timely and effective manner.
6 Some indicators of lack of access to health care are as follows:

7 a. Over one 500,000 Wisconsin residents were uninsured at any given point
8 during 2007.

9 b. Over 65 percent of the uninsured in Wisconsin are employed.

10 c. The uninsured are less likely to seek care and, thus, have poorer health
11 outcomes compared to the insured population.

12 d. In 2007, total spending on the uninsured in Wisconsin is projected to reach
13 over \$1,000,000,000. About 23.2 percent of this amount will be in the form of
14 uncompensated care; 21.7 percent will be provided through public programs; and
15 37.5 percent will be paid by the uninsured individuals.

16 3. ‘Inequity.’ The health care system contains inequities. Some indicators of
17 inequity are as follows:

18 a. Wisconsin businesses are competing on an uneven playing field. The
19 majority of Wisconsin businesses that do insure their workers are subsidizing those
20 businesses that are not paying their fair share for health care.

21 b. Our current system forces the sick and the aging to pay far higher premiums
22 than the healthy and those covered under group plans, rather than spreading the
23 risk across the broadest pool possible.

24 c. The uninsured face medical charges by hospitals, doctors, and other health
25 care providers that are 2.5 times what public and private health insurers pay.

1 4. ‘Inefficiency.’ Wisconsin does not have a clearly defined, integrated health
2 care system. Our health care system is complex, fragmented, and disease–focused
3 rather than health–focused, resulting in massive inefficiencies and placing
4 inordinate administrative burdens on health care professionals. Some indicators of
5 inefficiency are as follows:

6 a. Health care financing is accomplished through a patchwork of public
7 programs, private sector employer–sponsored self–insurance, commercial
8 insurance, and individual payers. The most recent study for Wisconsin estimates
9 that about 27 cents of every health care dollar is spent on marketing, overhead, and
10 administration, leaving only 73 cents left to deliver medical care.

11 b. This fragmentation and misaligned financial incentives lead, in some
12 instances, to excessive or inadequate care and create barriers to coordination and
13 accountability among health care professionals, payers, and patients.

14 c. The Institute of Medicine estimates that between 30 cents and 40 cents of
15 every health care dollar is spent on costs of poor quality — overuse, underuse,
16 misuse, duplication, system failures, unnecessary repetition, poor communication,
17 and inefficiency. Included in this inefficiency are an unacceptable number of adverse
18 events attributable to medical errors. Patients receive appropriate care based on
19 known “best practices” only about one–half of the time.

20 d. The best care results from the conscientious, explicit, and judicious use of
21 current best evidence and knowledge of patient values by well–trained, experienced
22 clinicians.

23 5. ‘Limitations on reform.’ Federal laws and programs, such as Medicaid,
24 Medicare, Tri–Care, and Champus, constrain Wisconsin’s ability to establish
25 immediately a fully integrated health care system.

1 6. ‘Wisconsin as a laboratory for the nation.’ Wisconsin is in a unique position
2 to successfully implement major health care reform. Many providers are already
3 organized into comprehensive delivery systems and have launched innovative pilot
4 programs to improve both the quality and efficiency of their care. Wisconsin is at the
5 forefront in developing systems for health information transparency. Organizations
6 such as the Wisconsin Collaborative for Healthcare Quality, Wisconsin Health
7 Information Organization, and the Wisconsin Hospital Association have launched
8 ambitious projects to provide data on quality, safety, and pricing.

9 (b) *Initial terms of Healthy Wisconsin Authority board.* Notwithstanding the
10 lengths of terms of the members of the board of the Healthy Wisconsin Authority
11 specified in section 260.05 (1) of the statutes, as created by this act, the initial
12 members shall be appointed for the following terms:

13 1. One member each from section 260.05 (1) (a), (b), and (g) of the statutes, as
14 created by this act, for terms that expire on July 1, 2009.

15 2. One member each from section 260.05 (1) (a), (b), and (e) of the statutes, as
16 created by this act, for terms that expire on July 1, 2010.

17 3. One member each from section 260.05 (1) (c), (e), and (g) of the statutes, as
18 created by this act, for terms that expire on July 1, 2011.

19 4. One member each from section 260.05 (1) (d), (f), and (g) of the statutes, as
20 created by this act, for terms that expire on July 1, 2012.

21 5. One member each from section 260.05 (1) (a) and (b) of the statutes, as
22 created by this act, for terms that expire on July 1, 2013.

23 6. One member each from section 260.05 (1) (a) and (b) of the statutes, as
24 created by this act, for terms that expire on July 1, 2014.

1 (c) *Provisional appointments.* Notwithstanding the requirement for senate
2 confirmation of the appointment of the members of the board of the Healthy
3 Wisconsin Authority under section 260.05 (1) of the statutes, as created by this act,
4 the initial members may be provisionally appointed by the governor, subject to
5 confirmation by the senate. Any such appointment shall be in full force until acted
6 upon by the senate, and when confirmed by the senate shall continue for the
7 remainder of the term, or until a successor is chosen and qualifies. A provisional
8 appointee may exercise all of the powers and duties of the office to which such person
9 is appointed during the time in which the appointee qualifies. Any appointment
10 made under this subsection that is withdrawn or rejected by the senate shall lapse.
11 When a provisional appointment lapses, a vacancy occurs. Whenever a new
12 legislature is organized, any appointments then pending before the senate shall be
13 referred by the president to the appropriate standing committee of the newly
14 organized senate.

15 (d) *Property tax credit.* If with respect to levies imposed for 2009, any taxing
16 jurisdiction, as defined in section 74.01 (7) of the statutes, reduces the costs of
17 providing health care coverage to its employees as a result of providing that coverage
18 under the Healthy Wisconsin Plan under chapter 260 of the statutes, as created by
19 this act, together with any supplemental coverage needed to ensure that the health
20 care coverage provided to employees of the taxing jurisdiction is actuarially
21 equivalent to the coverage they received in 2008, the taxing jurisdiction shall
22 distribute at least 50 percent of the savings to the property taxpayers in the taxing
23 jurisdiction as a reduction in the property tax assessments as of January 1, 2009.
24 The reduction shall be calculated based on the equalized value of the property, as

1 determined under section 70.57 of the statutes, and shall reduce the property taxes
2 otherwise payable in that year.”.

3 **62.** Page 1688, line 13: after that line insert:

4 “(4c) HEALTHY WISCONSIN PLAN. The treatment of sections 13.94 (1) (dj) and (1s)
5 (c) 5., 16.004 (7d) and (7h), 40.05 (4) (a) 4., (ag) (intro.), (ar), (b), and (be) and (4g) (d),
6 40.51 (1), (2), (7), (8), and (8m), 40.52 (1) (intro.), (1m), and (2), 40.98 (2) (a) 1., 49.473
7 (2) (c), 49.665 (5) (ag), 49.68 (3) (d) 1., 49.683 (3), 49.685 (6) (b), 49.687 (1m) (d), 59.52
8 (11) (c), 60.23 (25), 66.0137 (4), (4m) (b), and (5), 109.075 (9), 111.70 (1) (dm) and (4)
9 (cm) 8s., 111.91 (2) (pt), 120.13 (2) (b) and (g), 149.12 (2) (em), 609.01 (7), 609.10,
10 609.20 (1m) (c) and (d), 628.36 (4) (a) (intro.) and (b) 1., 2., and 3., 632.87 (5), and
11 632.895 (8) (f) 4., (9) (d) 4., (10) (a) and (b) 6., (11) (a) (intro.), (c) 1., (d), and (e) 3., and
12 (14) (b) and (d) 7. of the statutes, the renumbering and amendment of sections 40.51
13 (6) and 62.61 of the statutes, and the creation of sections 40.51 (6) (b) and 62.61 (1)
14 (b) of the statutes take effect on January 1, 2009.”.

15

(END)