Sixty-first
Legislative Assembly
of North Dakota

SENATE BILL NO.

Introduced by

Senator Mathern

A BILL for an Act

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. 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, physicians 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.

SECTION 2. Creation and organization of authority.

1. Creation and Membership of Board. There is created a public body corporate and political to be known as the Healthy Wisconsin Authority." The nonvoting members of the board shall consist of the secretary of employee trust funds and four representatives from the advisory committee under s. 260.49 who are health care personnel and administrators, selected by the advisory committee. The secretary of employee trust funds shall serve as the initial chairperson of the board until such time as the board elects a chairperson from its voting membership. The board shall also consist of the following voting members, nominated by the governor and with the advice and consent of the senate appointed, for staggered six-year terms:
   a. Four members selected from a list of names submitted by statewide labor union coalitions. One of these members shall be a public employee.
   b. Four members selected from a list of names submitted by statewide business and employer organizations. One of these members shall be a public employer.
   c. One member selected from a list of names submitted by statewide public school teacher labor organizations.
   d. One member selected from a list of names submitted by statewide small business organizations.
   e. Two members who are farmers, selected from a list of names submitted by statewide general farm organizations.
   f. One member who is a self-employed person.
   g. Three members selected from a list of names submitted by statewide health care consumer organizations.
2. Terms of office - Vacancies - Quorum - Business.
   a. The terms of all members of the board shall expire on July first.

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

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

3. Board member responsibility as trustee. Each member of the board shall be responsible for taking care that the highest level of independence and judgement is exercised at all times in administering the plan and overseeing the individual and organizations selected to implement the plan.

4. Duties. The board shall:

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

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

(2) Health care reform shall maintain an improve choice of health care providers and high quality care services in this state.

(3) Health care reform shall implement and improve choice of health care providers and high quality health care services in this state.

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

c. Appoint an executive director, who shall serve at the pleasure of the board. The board may delegate to one or more of its members or its executive

director any powers and duties the board considers proper. The executive director shall receive such compensation as may be determined by the board.

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

e. Create a program for consumer protection and a process to resolve disputes with providers.

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

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

h. Contract for annual, independent, program evaluations and financial audits that measure the extent to which the plan is achieving the goals under paragraph (1)1. to 3. The board may not enter into a contract with the same auditor for more than six years.

i. Accept bids from health care networks in accordance with the criteria set out in s.260.30, or make payments for fee for service providers in accordance with s.260.30. The board shall consult with the department of employee trust funds in determining the most effective and efficient way of purchasing health care benefits.

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

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

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

b. Have a seal and alter the seal at pleasure.

c. Maintain an office.

d. Sue and be sued.

e. Accept gifts, grants, loans, or other contributions from private or public sources.

f. Establish the authority's annual budget and monitor the fiscal management of the authority.

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

h. Employ any officers, agents, and employees that it may required and determine their qualifications and compensation.

i. Procure liability insurance.

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

k. Borrow money, as necessary on a short-term basis, to address cashflow issues.

l. Compel witnesses to attend meetings and to testify upon an necessary matter concerning the plan.

SECTION 3. Eligibility

1. Covered persons. Except as provided in subsections (2) to (5) and subject to subsection (6), a person is eligible to participate in the plan if the person satisfies all of the following criteria:

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

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

c. The person is under sixty-five years of age.

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

e. Unless a waiver requested under subsection (6)(b) has been granted and is in effect, the person is not eligible for Medical Assistance under subchapter IV of Chapter 49 or for health care coverage under the Badger Care health care program under section 49.665.

2. Gainfully employed. If a person and the members of the person's immediate family do not meet the criteria under subsection (1)(a) and (b), but do meet the criteria under subsection (1)(c) to (e) and the person is gainfully employed in this state, as defined by the board, the person and the members of the person's immediate family are eligible to participate in the plan.

3. Dependent children. If a child under age eighteen resides with his or her parent in this state but the parent does not yet meet the residency requirement under subsection (1)(a), the child is eligible to participate in the plan regardless of the length of time the child has resided in this state.

4. Pregnant women. A pregnant woman who resides in this state who does not yet meet the residency requirement under subsection (1)(a) is eligible to participate in the plan regardless of the length of time the pregnant woman has resided in this state.

5. Collective bargaining agreement. A person who is eligible to participate in the plan under subsection (1), (2), (3), or (4) and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2009, is not eligible to participate in the plan until the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed.

6. Waiver request.

a. In this subsection, "department" means the department of health and family services.

b. (1) The department shall develop a request for a waiver from the secretary of the federal department of health and human services to provide coverage under this plan to individuals who are eligible for Medical Assistance under subchapter IV of chapter 49 in the low-income families category, as determined by the department, and to individuals

who are eligible for health care coverage under the Badger Care health care program under s.49.665. The waiver request shall be written so as to allow the use of federal financial participation to fund, to the maximum extent possible, health care coverage under the plan for the individuals specified in this subdivision.

(2) The department shall, not later than July 1, 2008, submit the waiver request developed under subdivision 1 to a special legislative committee that shall be comprised of the members of the joint committee on finance and the members of the standing committees of the senate and the assembly with subject matter jurisdiction over health issues. The special legislative committee shall have sixty days to review and comment to the department on the waiver request.

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

7. Definitions of terms. For purposes of this chapter, the board shall define all of the following term:

a. Place of permanent abode.

b. Substantial presence this state. In defining "substantial present in this state," the board shall consider such factors as the amount of time per year that an individual is actually present in the state and the amount of taxes that an individual pays in this state, except that, if the individual attends school outside of this state and is under twenty three years of age, the factors shall include the amount of time that the individual's parent or guardian is actually present in the state and the amount of taxes that the individual's parent or guardian pays in this state, the factors shall include the amount of time that the individual's parent, guardian, or spouse is actually present in the state and the amount of taxes that the individual's parent, guardian, or spouse pays in this state.

c. Immediate family.

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

SECTION 4. Office of outreach, enrollment, and advocacy.

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

2. Duties. The office of outreach, enrollment, and advocacy shall do all of the following:

   a. Engage in aggressive outreach to enroll eligible persons and participants in their choice of health are coverage under the plan.

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

   c. Informant plan participants of the roll they can play in holding down health care costs by taking advantage of preventive care, enrolling in chronic disease management programs, if appropriate, responsibility utilizing medical services, and engaging in healthy lifestyles. The office shall inform participants of networks or workplaces where healthy lifestyle incentives are in place.

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

   e. Act as a advocate for plan participants having questions, difficulties, or complaints about their health care services or coverage, including investigating and attempting to resolve the complaint. Investigation should include, when appropriate, consulting with the health care advisory committee under section 260.49 regarding best practice guidelines.

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

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

h. Ensure that plan participants have timely access to the services provided by the office.

3. Conflict of interest limitation. The office and its employees and contractors shall not have any conflict of interest relating to the performance of their duties. There is a conflict of interest if, with respect to the office's director, employees, or contractors, or a person affiliated with the office's director, employees, or contractors, any of the following exists:

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

b. Direct ownership interest or investment interest in a health care facility, health insurer, or health care provider.

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

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

SECTION 5. Benefits.

1. Generally. The board shall establish a health care plan that will take effect on January 1, 2009. The plan shall provide the same benefits as those that were in effect as of January 1, 2007, under the state employee health plan under section 40.51(6). The board may adjust the plan benefits to provide additional cost-effective treatment options if there is evidence-based research that the

options are likely to reduce health are costs, avoid health risks, or result in better health outcomes.

2. Additional benefits. In addition to the benefit requirements under subsection (1), the plan shall provide coverage for mental health services and alcohol or other drug abuse treatment to the same extent as the plan covers treatment for physical conditions and coverage for preventative dental care for children up to eighteen years of age.

SECTION 6. Cost-sharing.

1. No cost-sharing. The plan shall cover the following preventative services without any cost-sharing requirement:
   a. Prenatal care for pregnant women.
   b. Well-baby care.
   c. Medically appropriate examinations and immunizations for children up to eighteen years of age.
   d. Medically appropriate gynecological exams, Papanicolaou tests, and mammograms.
   e. Medically appropriate regular medical examinations for adults, as determined by best practices.
   f. Medically appropriate colonoscopies.
   g. Preventive dental care for children up to eighteen years of age.
   h. Other preventive services or procedures, as determined by the board, for which there is scientific evidence that exemption from cost-sharing is likely to reduce health care costs or avoid health risks.
   i. Chronic care services, provided that the participant receiving the services is participating in, and complying with, a chronic disease management program as defined by the board.
2. Deductibles.
   a. Maximum amounts and who must pay.
      (1) Subject to subdivision 2, during any year, an participant who is eighteen years of age or older on January first of that year shall pay a deductible

of three-hundred dollars, which shall apply to all covered services and articles.

(2) During any year, a family consisting of two or more participants who are eighteen years of age or older on January first of that year shall pay a deductible of six-hundred dollars, which shall apply to all covered services and articles.

(3) During any year, a participant who is under eighteen years of age on January first of that year shall not be required to pay a deductible.

(4) Except for copayments and coinsurance, the plan shall provide a participant with full coverage for all covered services ad articles after the participant has received covered services and articles totaling the applicable deductible amount under this paragraph, regardless of whether the participant has pad the deductible amount.

b. Provider requirements.

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

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

(3) A provider may not charge any interest, penalty, or late fee on deductible amount owed by a participant unless the deductible amount owed is at last six months past due and the provider has provided the participant with notice of the interest, penalty, or late fee at least ninety days before the interest, penalty, or late fee payment is due. Interest may not exceed one percent per month, and any penalty or late fee may not exceed the provider's reasonable cost of administering the unpaid bill.

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

3. Copayments and coinsurance.

a. General copayments. During any year, a participant who is eighteen years of age or older on January first of that year shall pay a copayment of twenty dollars for medical, hospital, and related health care services, as determined by the board.

b. Specialist provider services without referral. A participant, regardless of age, who receives health care services from a specialist provider without a referral from his or her primary care provider under the plan shall be required to pay twenty-five percent of the cost of the services provider.

c. Inappropriate emergency room use. Notwithstanding paragraph (1), a participant who is eighteen years of age or older shall pay a copayment of sixty dollars for inappropriate emergency room use, as determined by the board.

d. Prescription drugs.

(1) All participants, regardless of age, shall pay five dollars for each prescription of a generic drug that is one the formulary determined by the board.

(2) All participants, regardless of age, shall pay fifteen dollars for each prescription of a brand-name drug that is on the formulary determined by the board.

(3) All participants, regardless of age, shall pay forty dollars for each prescription of a brand-name drug that is not on the formulary determined by the board.

(4) Notwithstanding subdivisions 1 to 3, no participant shall pay more for a prescription drug than the actual cost of the prescription drug plus the negotiated dispensing fee.

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

4. Maximum amounts. Notwithstanding the deductible, coinsurance, and copayment amounts in subsections (2) and (3), all of the following apply:

a. Subject to paragraph (b), a participant who is eighteen years of age or older on January first of a year may not be required to pay more than two-thousand dollars during that year in total cost-sharing under subsections (2) and (3).

b. A family consisting of two or more participants may not be required to pay more than three-thousand dollars a year in total cost-sharing under subsections (2) and (3).

SECTION 7. Service areas - Selection and payment of health care providers and health care networks.

1. Establishment of areas where services will be provided. The board may establish areas in the state, which may be counties, multicounty regions, or other areas, for the purpose of receiving bids from health care networks. These areas shall be established so as to maximize the level and quality of competition among health care networks or to increase the number of provider choices available to eligible persons and participants in the areas.

2. Options available in each area. In each area designated by the board under subsection (1), the board shall offer both of the following options for delivery of health care services under the plan:

a. An option, known as for "fee-for-service option," under which participants must choose a primary care provider, may be referred by the primary care provider to any medical specialist, and may be admitted by the primary care

provider or specialist to any hospital or other facility, for the purpose of receiving the benefits provided under this chapter. Under this option, the board, with the assistance of one or more administrators chosen by a competitive bidding process and with whom the board has constructed, shall pay directly, at the provider payment rates established by the board under subsection (7)(b)1, for all health care services and articles that are covered under the plan.

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

3. Solicitation of bids from health care networks. The board shall annually solicit sealed risk-adjusted premium bids from competing health care networks for the purpose of offering health care coverage to participants. The board shall request each bidder to submit information pertaining to whether the bidder is qualifying health care network, as described in subsection (4).

4. Qualifying health care networks. A health care network is qualifying if it does all of the following:

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

b. Will spend at least ninety-two percent of the revenue it receives under this chapter on one of the following:

(1) Payments to health care providers in order to provide the health care benefit specified in this chapter to participants who choose the health care network.

(2) Investments that the health care network has reasonably determined will improve the overall qualifying or lower the overall cost of patient care.

c. Ensures all of the following:

(1) That participants living in an area that a health care network serves shall not be required to drive more than thirty minutes, or, in a metropolitan area served by mass transit, spend more than sixty minutes using mass transit facilities, in order to reach the offices of at least two primary care providers, as defined by the board.

(2) That physicians, physician assistants, nurses, clinics, 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, are conveniently available, as defined by the board, to participate living in every part of the area that the health care network serves.

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

e. Ensures that each participant who chooses the health care networks selects a primary care provider who is responsible for overseeing all of the participant's care.

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

g. Emphasize, in its policies and operations, the promotion of healthy lifestyles; preventive care, including early identification of and response to high-risk individuals and groups, early identification of an response to health disorders, disease management, including chronic care management, and best practices, including the appropriate use of primary care, medical specialists,

medications, and hospital emergency rooms; and the utilization of continuous quality improvement standards and practices that are generally accepted in the medical field.

h. Has developed and is implementing a program, including providing incentives to providers when appropriate, to promote health care quality, increase the transparency of health care cost and quality information, ensure the confidentiality of medical information, and advance the appropriate use of technology.

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

j. has in place a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system.

k. Has adopted and implemented a strong policy to safeguard against conflicts of interest.

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

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

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

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

5. Certification of health care networks and classifications of bids.

a. The board shall review the bids submitted under subsection (3), the information submitted by bidders pertaining to whether the bidders are qualifying health care networks, and other evidence provided to the board as to whether a particular bidder is a qualifying health care network.

b. Based on the information about bidder qualifications submitted or otherwise provided under paragraph (a), the board shall certify which health care networks are qualifying health care networks.

c. With respect to all health care networks that are board certified under paragraph (b), the board shall open the submitted, sealed bids at a predetermined time. The board shall classify the certified health care networks according to price and quality measures after comparing their risk-adjusted per month bids and assessing their quality. The board shall classify the network that bid the lowest price as the lowest cost network, and shall classify as a low-cost network any network that has bid a price that is close to the price bid by the lowest cost network. Any other network shall be classified as a higher cost network.

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

7. Payments to networks and providers.

a. Payments to health care networks.

(1) On behalf of each participant who selects or has been assigned to a certified health care network that has been classified under subsection (5)(c) as the lowest cost network or a low-cost network and as performing well on quality measures, the board shall pay monthly to the health care network the full risk-adjusted per member, per month amount that was bid by the network. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who selects or is assigned to a lowest cost network or a low-cost network shall not be required to pay any additional amount to the network.

(2) If a participant chooses instead to enroll in a certified health care network that has been classified under subsection (5)(c) as a higher cost network, the board shall pay monthly to the chosen health care network an amount equal to the bid submitted by the network that he board classified under subsection (5)(c) as the lowest cost network and

as having performed well on quality measures. The dollar amount shall be actuarially adjusted for the participant based on a age, sex, and other appropriate risk factors determined by the board. A participant who chooses to enroll in a higher cost network shall be required to pay monthly, in addition to the amount paid by the board, an additional payment sufficient to ensure that the chosen network receives the full price bid by that network.

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

b. Payments to fee-for-service providers.

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

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

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

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

(a) If there are available to the participant three or more certified health care networks classified under subdivision (5)(c) as low-cost networks, or as the lowest cost network and two or more low-cost networks, the participant shall pay the difference between the cost of the lowest cost health care network and the monthly risk-adjusted cost established under subdivision 3 for the fee-for-service option, except that the amount paid may not exceed one-hundred dollars per month for an individual, or two-hundred dollars per month for a family, as adjusted for medical inflation.

(b) If there are available to the participant two certified health care networks classified under subsection (5)(c) as low-cost networks, or as the lowest cost network and one low-cost network, the participant shall pay the difference between the cost of the lowest cost health care network and the monthly risk-adjusted cost established under subdivision 3 for the fee-for service option, except that the amount paid may not exceed sixty five dollars per month for an individual, or one hundred twenty five dollars per month for a family, as adjusted for medical inflation.

(c) If there is available to the participant only one certified health care network classified under subsection (5)(c) as a low-cost network, or as the lowest cost network, the person shall pay the difference between the cost of the lowest cost health care network and the monthly risk-adjusted cost established under subdivision 3 for the fee-for-service option, except that the amount paid may not exceed twenty-five dollars per month for an individual, and fifty dollars per month for a family, as adjusted for medical inflation.

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

8. Incentive payments to fee-for-service providers. Health care providers and facilities providing service under the fee-for-service option under subsection (2)(a) shall be encouraged to collaborate with each other through financial incentives established by the board. Providers shall work with facilities to pool infrastructure and resources; to implement the use of the best practices and quality measures; and to establish organized processes that will result in high-quality, low-cost medical care. The board shall establish an incentive payment system to providers and facilities that comply with this subsection, in accordance with criteria established by the board.

9. Pharmacy benefits. Except for prescription drugs to which a deductible applies, the board shall assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, the board shall replicate the prescription drug buying system developed by the group insurance board for prescription drug coverage under the state employee health plan under s.40.51(6) unless the board determines that another approach would be more cost-effective. The board may join the prescription drug purchasing arrangement under this chapter with similar arrangements or programs in other states to form a multistate purchasing group to negotiate with prescription drug manufacturers and

distributors for reduced prescription drug prices, or to contract with a third-party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

SECTION 8. Subrogation. The board and authority are entitled to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim against any third-party.

SECTION 9. Employer-provided health care benefits. Nothing in this chapter prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying all or part of any cost-sharing under s.260.20 or 260.30, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

SECTION 10. Assessments, individuals and businesses.

1. Definitions. In this section:

a. "Department" means the department of revenue.

b. "Dependent" means a spouse, an unmarried child under the age of nineteen years of age, an unmarried child who is a full-time student under the age of twenty-one and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

c. "Eligible individual" means an individual who is eligible to participate in the plan, other than an employee or a self-employed individual.

d. "Employee" means an individual who has an employer.

e. "Employee" means a person who is required under the Internal Revenue COde to file form 941.

f. "Medical inflation" means the percentage change between the United States consumer price index for all urban consumers, United States city average, for the medical care group only, including medical care commodities and medical care services, for the month of August of the previous year and the United States consumer price index for all urban consumers, United States city average, for the medical care services, for the month of August 2007, as determined by the United States department of labor.

g. "Poverty line" means the federal poverty line, as defined under 42 U.S.C 9902(2), for a family the size of the individual's family.

h. "Self-employed individual" means an individual who is required under the Internal Revenue Code to file schedule SE.

i "Social security wages" means:

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

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

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

2. Individuals. Subject to subsection (4), the board shall calculate the following assessments, based on its anticipated revenue needs:

a. For an employee who is under the age of sixty-five, a percent of social security wages that is at least two percent and not more than four percent, subject to the following:

(1) If the employee has social security wages that are one-hundred fifty percent or less of the poverty line, the employee may not be assessed.

(2) If the employee has no dependents and his or her social security wages are more than one hundred fifty percent and two-hundred percent or less of the poverty line the assessment shall be in an amount, as determined by the board on a sliding scale based on the employee's

social security wages, that is between zero and four percent of the employee's social security wages.

(3) If the employee has one or more dependents, or is a single individual who is pregnant, and the employee's social security wages are more than one-hundred fifty percent and three-hundred percent or less of the poverty line the assessment shall be in an amount, as determined by the board on a sliding scale based on the employee's social security wages, that is between zero and four percent of the employee's social security wages.

b. For a self-employed individual who is under the age of sixty-five, a percent of social security wages that is at least nine percent and not more than ten percent.

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

3. Employers. Subject to subsection (4), the board shall calculate an assessment, based on its anticipated revenue needs, that is a percent of aggregate social security wages that is at least nine percent and not more than twelve percent.

4. Collection and calculation of assessments.

a. For taxable years beginning December 31, 2008, the department shall impose on, and collect from, individuals the assessment amounts that the board calculates under subsection (2), either through an assessment that is collected as part of the income tax under subchapter I of chapter 71, or through another method devised by the department. For taxable years, beginning after December 31, 2008, the department shall impose on, and collect from, employers the assessment amounts that the board calculates under subsection (3), either through an assessment that is collected as part of the tax under subchapter IV of chapter 71, or through an assessment that is collected as part of the tax under subchapter IV of chapter 71, or through another method devised by the department. Section 71.80(1)(c), as it applies

to chapter 71, applies to the department's imposition and collection of assessments under this section.

b. The amounts that the department collects under paragraph (a) shall be deposited into the Health Wisconsin trust fund under s.255.775.

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

SECTION 11. Advisory committee

1. Duties. The board shall establish a health care advisory committee to advise the board on all of the following:

a. Matters related to promoting healthier lifestyles.

b. Promoting health care quality.

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

d. Preventive care.

e. Early identification of health disorders.

f. Disease management.

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

h. Confidentiality of medical information.

j. Benefit design.

k. The availability of physicians, hospitals, and other providers.

l. Reducing health care costs.

m. Any other subject assigned to it by the board.

n. Any other subject determined appropriate by the committee.

2. Membership. The board shall appoint as members of the committee all of the following individuals:

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

b. At least one member designated by the Wisconsin Academy of Family Physicians.

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

d. One member designated by the president of the Board of Regents of the University of Wisconsin System who is knowledgable in the field of medicine and public health.

e. One member designated by the president of the Medical College of Wisconsin.

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

g. One member designated by the Wisconsin Dental Association.

h. One member designated by statewide organizations interested in mental health issues.

i. One member representing health care administrators.

j. Other members representing health care professionals.