State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–4473/1
DAK/PJK/MDK:ALL:ch/jf

2003 ASSEMBLY BILL 995

March 11, 2004 – Introduced by Representatives WASSERMAN, MILLER, MOLEPSKE, VRUWINK, KREUSER, SHERMAN, SHILLING, HEBL, TAYLOR, POPE-ROBERTS, CULLEN, SCHOOFF, SINICKI, BERCEAU, STASKUNAS, HUBER and RICHARDS. Referred to Committee on Health.

AN ACT ***to repeal*** 49.46 (1) (L), S456.04 (4) and 628.36 (2m) (e) 4.; ***to renumber*** 46.277 (1m) (a), 49.45 (6v), 456.04 (1), 456.04 (2), 456.04 (3), 628.36 (2m) (a) 1., 628.36 (2m) (a) 2., 628.36 (2m) (a) 3. and 895.48 (1m); ***to renumber and amend*** 49.47 (4) (h), 51.30 (4) (b) 13., 100.31 (1) (a), 100.31 (1) (b), 146.89 (1), 456.04 (intro.) (except 456.04 (title)), 456.08 and 628.36 (1); ***to consolidate, renumber and amend*** 628.36 (2m) (a) (intro.) and 2m.; ***to amend*** 20.435 (4) (b), 20.435 (7) (bd), 46.277 (1), 46.277 (2) (intro.), 46.277 (3) (a), 46.277 (3) (b) 1., 46.277 (3) (b) 2., 46.277 (4) (a), 46.277 (4) (b), 46.277 (5) (g), 46.277 (5g) (a), 49.46 (1) (a) 1., 49.46 (1) (a) 1g., 49.46 (1) (a) 1m., 49.46 (1) (a) 6., 49.46 (1) (a) 9., 49.46 (1) (a) 10., 49.46 (1) (a) 11., 49.46 (1) (a) 12., 49.46 (1) (e), 49.47 (4) (am) 1., 49.47 (4) (am) 2., 49.47 (4) (c) 1., 49.47 (4) (c) 3., 49.665 (4) (a) 1., 100.31 (title), 100.31 (1) (c), 100.31 (2), 100.31 (4), 146.89 (2) (a), 146.89 (2) (c), 146.89 (2) (d), 146.89 (3) (b) (intro.), 146.89 (3) (c), 146.89 (3) (d) (intro.), 441.07 (1) (d), 448.015 (4), 448.04 (1) (a), 450.10 (1) (a) (intro.), 450.11 (1), 456.02 (intro.), 456.02 (1),

456.02 (2), 456.02 (3), 456.02 (4), 456.02 (5), 456.02 (6), 456.02 (7), 456.09 (1) (c), 609.22 (2), 609.32 (2) (a), 628.36 (2) (a) (intro.), 628.36 (2) (b) 3., 628.36 (2) (b) 4., 628.36 (2m) (e) 1., 628.36 (2m) (e) 2., 628.36 (2m) (e) 3., 628.36 (3), 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; ***to repeal and recreate*** 628.36 (2m) (title); and ***to create*** 46.03 (44), 46.277 (1m) (ag), 46.277 (4) (c), 49.45 (6ur), 49.45 (53), 49.46 (1) (ar), 49.47 (4) (cg) 3., 49.665 (4) (d), 49.688 (4r), 100.31 (1) (ae), 100.31 (1) (as), 100.31 (2r), 146.385, 146.89 (1) (d), 146.89 (1) (g), 146.89 (1) (h), 146.89 (3m), 441.16 (3m), 448.035, 450.11 (1g), 456.04 (1m) (d), 456.04 (1m) (e), 456.04 (2m), 456.08 (1), (2), (3) and (4), 456.12, 628.36 (1c) (intro.), 628.36 (2) (b) 4m., 632.89 (1) (am), 632.89 (1) (b), 632.89 (2) (f), 632.89 (6) and (7) and 895.48 (1m) (b) of the statutes; **relating to:** treating property taxes as a deduction to annual household income for purposes of determining eligibility and deductible amounts under the prescription drug assistance program for the elderly; exempting amounts claimed for depreciation for purposes of calculating farm and self–employment income under the Medical Assistance and Badger Care health care programs; requiring Medical Assistance incentive payments to hospitals that establish a physician order entry record system; prescriptions for antibiotic drugs for treatment of chlamydia, gonorrhea, or trichomonas; the requirements for examinations for nursing home administrator licenses and for reciprocal nursing home administrator licenses and creating an exemption from such requirements; provision of home and community–based services under a community integration program to persons relocated from facilities; discrimination in prescription drug prices; health care provider service rates and insurer health care services reimbursement rates; expanding the Volunteer Health Care

Provider Program to include provision of services to students from 4–year–old kindergarten to grade 6 in public elementary schools, charter schools, and private schools that participate in the Milwaukee Parental Choice Program; allowing any provider to participate in a health care plan under the terms of the plan, requiring an annual period for providers to elect to participate in health care plans, and requiring notice to a provider of the reason for exclusion from a health care plan; treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems; increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems; an exception to confidentiality requirements for treatment records; granting rule–making authority; and requiring the exercise of rule–making authority.

Analysis by the Legislative Reference Bureau

Under current law, elderly persons may purchase prescription drugs at reduced amounts under a program commonly known as "Senior Care." A person is eligible for Senior Care if he or she is a state resident, is at least 65 years of age, is not a medical assistance (MA) recipient or does not receive prescription drug coverage as an MA recipient, and his or her annual household income, as determined by the Department of Health and Family Services (DHFS), does not exceed 240 percent of the federal poverty line. A person must pay an annual $30 fee to enroll in Senior Care. An enrollee pays the "program payment rate" for prescription drugs (105 percent of the MA prescription drug payment rate plus a dispensing fee) until the enrollee has met an annual deductible, if applicable, and thereafter pays only a copayment of $5 for generic prescription drugs and a copayment of $15 for nongeneric prescription drugs. A person whose annual household income is 160 percent or less of the federal poverty line pays no deductible; if the person's annual household income is more than 160 percent but not more than 200 percent of the federal poverty line, the deductible is $500; and if the person's annual household income exceeds 200 percent of the federal poverty line, the deductible is $850. Other persons who meet all of the requirements except the income limitation are also eligible to purchase prescription drugs for the $5 and $15 copayment amounts for the time remaining in a 12–month period after spending the difference between their annual household

income and 240 percent of the federal poverty line by paying for prescription drugs at the retail price and satisfying the $850 deductible by purchasing prescription drugs at the program payment rate.

This bill requires that in determining a person's annual household income for purposes of Senior Care eligibility, DHFS must deduct the amount that the person paid in property taxes on his or her primary residence in the previous 12 months. DHFS must also use the annual household income adjusted for property taxes to determine the appropriate deductible amount for persons who are enrolled in Senior Care.

Currently, DHFS administers the MA and Badger Care health care (BadgerCare) programs.

Under part of the MA program, DHFS provides health care services and benefits to individuals who meet the requirements under one of the following MA eligibility categories:

1. *AFDC–MA.* Under this category, an individual who meets the nonfinancial and financial requirements for the federal Aid to Families with Dependent Children (AFDC) program that were in effect on July 16, 1996, without regard to the individual's assets, is eligible to receive MA. The AFDC program was replaced with the federal Temporary Assistance for Needy Families (TANF) program on July 16, 1996. Generally, individuals who qualify under the AFDC–MA category are certain children under 19 years of age, their caretaker relatives, and pregnant women in the eighth or ninth month of pregnancy.

2. *AFDC–related MA.* This category includes certain children under the age of 19, their caretaker relatives, and pregnant women throughout the entire pregnancy who meet the income requirements of the AFDC program that were in effect on July, 16, 1996, without regard to assets, but who would not have received an AFDC payment. Also eligible under this category are children under the age of 18 and pregnant women whose incomes do not exceed 133.33 percent of the maximum payment under the AFDC program, and whose assets do not exceed certain asset limits.

3. *Healthy Start.* This category includes children between the ages of six and 19 whose incomes do not exceed 100 percent of the federal poverty line, children under the age of six and pregnant women whose incomes do not exceed 133.33 percent of the federal poverty line, and children under the age of six and pregnant women whose incomes do not exceed 185 percent of the federal poverty line.

The BadgerCare program provides health care coverage to eligible low–income children who do not reside with a parent and to eligible low–income families. A child or family is generally considered low–income if the child's or family's income does not exceed 185 percent of the poverty line.

Currently, in calculating an individual's income for the MA or BadgerCare program, if the individual has farm or self–employment income, DHFS calculates the amount of that income by adding the amount that the individual claimed for depreciation to the amount of the individual's net taxable income.

This bill prohibits DHFS from adding any amounts claimed for depreciation to an individual's net taxable farm or self–employment income for purposes of

determining whether an individual meets the income limits for the MA program under the AFDC–MA, AFDC–related MA, or Healthy Start eligibility categories or for the BadgerCare program.

Beginning on January 1, 2005, or the day after publication of this bill as an act, whichever is later, this bill requires that, for each hospital that establishes and maintains a physician order entry record system for medical services, DHFS annually make an incentive MA payment that equals 1 percent of the MA reimbursement to the hospital for the previous fiscal year. The hospital must establish the physician order entry record system by January 1, 2007.

This bill allows a physician, physician assistant, or advanced practice nurse to prescribe to a patient an antibiotic drug as a course of therapy for the treatment of chlamydia, gonorrhea, or trichomonas for use by a person with whom the patient has had sexual intercourse if the patient states that the person is not allergic to the drug. Such a prescription may be made for no more than two people in one year with whom the patient has had sexual intercourse. In addition, the prescription order must state that the patient is responsible for paying for the antibiotic drug that is prescribed for the person with whom the patient has had sexual intercourse. Also, such a prescription may not be made for a controlled substance.

A physician, physician assistant, or advanced practice nurse who makes such a prescription may provide the patient with written information specified in rules promulgated by DHFS. The information must include information about sexually transmitted diseases and their treatment and about the risk of drug allergies. In addition, the physician, physician assistant, or advanced practice nurse may request that the patient provide the written information to the person with whom he or she has had sexual intercourse.

This bill makes changes to current law regarding the following: 1) the requirements for a nursing home administrator license; 2) the requirements for a reciprocal nursing home administrator license that apply to persons licensed in other states; and 3) the requirement to be licensed as a nursing home administrator.

Under current law, a person must satisfy certain education requirements before he or she is allowed to take the examination for a nursing home administrator license. Specifically, he or she must complete a regular course of study, equivalent specialized courses, or a program of study that is considered adequate academic preparation for nursing home administration by the Nursing Home Administrator Examining Board. In addition, the examining board is required to develop and enforce standards regarding the supervised practical experience that is required for a person to be licensed as a nursing home administrator. A person may satisfy the supervised practical experience requirements before or after taking the examination.

This bill changes the requirements that a person must satisfy before taking the nursing home administrator examination. Under the bill, except as discussed below, a person must satisfy certain education and supervised practical experience requirements before he or she can take the examination. Regarding education, the bill requires, except as discussed below, a person to have either: 1) a bachelor's, master's, or doctoral degree with a health care administration or long–term care

major; or 2) a bachelor's degree and completion of a specialized course in nursing home administration. The bill directs the Nursing Home Administrator Examining Board to promulgate rules establishing the supervised practical experience requirements. The rules must require a person to complete at least 2,000 hours in an internship, administrator–in–training program, or other structured program before he or she can take the examination. The 2,000 hours must be completed in any consecutive three–year period within the five–year period immediately preceding the date of application for the examination.

The bill creates an exception to the above requirements that apply to a person who was enrolled, at any time within the two–year period before the bill's general effective date, in a course of study that the Nursing Home Administrator Examining Board had considered adequate preparation at that time. The bill allows such a person to take the examination if he or she completes the course no later than two years after the bill's general effective date and if the person satisfies, no later than the same deadline, practical experience requirements specified in the bill.

Under current law, a person who has a nursing home administrator license in another state is eligible for a reciprocal nursing home administrator license if he or she satisfies certain requirements, including submitting satisfactory evidence of the person's qualifications to the Nursing Home Administrator Examining Board. This bill specifies the qualifications that a person must have to be eligible for a reciprocal license. Under the bill, an applicant for such a license must have a bachelor's degree or be certified as a nursing home administrator by the American College of Health Care Administrators and must have practiced as a nursing home administrator in good standing for at least 2,000 hours in any consecutive three–year period within the five–year period immediately preceding the date of application for the reciprocal license. Also, the applicant must not have an arrest or conviction record the circumstances of which substantially relate to nursing home administration. In addition, the person must pass an examination relating to state and federal laws governing the practice of nursing home administration.

Finally, current law prohibits a person from practicing as a nursing home administrator unless he or she is licensed by the Nursing Home Administrative Examining Board. This bill creates an exception for a person who acts in the capacity of an administrator of a nursing home operated by adherents of a church or religious denomination which subscribes to the act of healing by prayer and the principles of which do not include medical treatment. However, the exemption applies only if the person does not use any title implying that he or she is a nursing home administrator.

Currently, the DHFS administers a Community Integration Program (commonly known as "CIP II"), under which MA moneys are paid to counties to provide home and community–based services, under a waiver of federal Medicaid laws, to elderly and physically disabled persons who meet the level of care requirements for MA–reimbursed nursing home care or are relocated from facilities. DHFS must establish a uniform daily rate for CIP II and reimburse counties up to that rate for each person enrolled in CIP II. Under 2003 Wisconsin Act 33 (the biennial budget act), DHFS may provide enhanced reimbursement for CIP II services for a person who is relocated to the community from a nursing home by a

county after July 16, 2003, if the nursing home bed used by the person is delicensed upon the person's relocation.

This bill authorizes DHFS to provide CIP II funding for home and community–based services to an MA–eligible person who relocates from a facility to the community. Reimbursement is not conditioned on delicensure of a nursing home bed upon the person's relocation. The funding begins on the date of the relocation and ends on the date that the person discontinues program participation or no longer meets the level of care requirements for MA reimbursement in a nursing home. Funding in the aggregate for these relocated persons may not exceed the total MA costs for the persons if served in nursing homes. DHFS may provide an enhanced reimbursement rate for the services. The total number of persons who may participate in this particular aspect of CIP II is not restricted by limitations on numbers participating in the remainder of CIP II.

The bill changes a prohibition under current law against price discrimination that applies to a seller who trades in prescription drugs for resale. Under current law, the prohibition applies to a seller who sells prescription drugs directly to consumers. Under the bill, the prohibition applies to a seller who sells to a "dispenser," which the bill defines as a person who delivers a prescription drug to an ultimate user for outpatient use, including an insurer that issues certain types of managed health care plans. Also included under the definition of "dispenser" is a hospital that directly or indirectly bills a patient for prescription drugs.

The prohibition on price discrimination under current law applies to prescription drugs on a list of therapeutically equivalent drugs published by the federal Food and Drug Administration (FDA). This bill provides that the prohibition applies to drugs included in the most current version of either of the following: 1) the FDA list; or 2) another publication specified in rules promulgated by the Department of Agriculture, Trade and Consumer Protection that identifies drug products approved on the basis of safety and effectiveness by the FDA under the federal Food, Drug, and Cosmetic Act.

This bill requires DHFS annually by April 1 to make available, on the DHFS website and, upon request, by mail, the current MA fee schedule for services of health care providers (as defined in the bill). The bill requires health care providers, annually by April 15, to provide to DHFS a statement of the providers' rates for health care services for the following May 1 to April 30. Health care providers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS. The rates must be stated in a form, as determined by DHFS, that may include statement as a percentage of the MA fee schedule. In addition, health care providers, annually beginning on May 1, must post their rates on an Internet website, if the health care provider has such a website, and take reasonable steps to ensure that their health care services consumers are aware that rate information is available and are informed about how to obtain the information. Any increase in a health care provider's rates is chargeable only after the health care provider has notified DHFS and, if the health care provider has a website, has posted information on the website about the rate increase.

The bill requires insurers, annually by April 15, to provide to DHFS and to the insurers' insureds a statement of the insurers' rates of reimbursement for health care provider services for the following May 1 to April 30, stated as a percentage of the MA fee schedule. Insurers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS.

DHFS may make available, on the DHFS website and, upon request, by mail, the health care provider rate and insurer reimbursement rate information, including increases, provided to DHFS. DHFS is also authorized to contract for the receipt and posting of this information and the current MA fee schedule for health care provider services, in accordance with DHFS request–for–proposal procedures.

Under current law, if the Department of Administration (DOA) has approved a joint application of a health care provider and a nonprofit agency, the health care provider acting within the scope of his or her licensure or certification may provide, without charge to low–income, uninsured persons at the agency, diagnostic tests, health education, office visits, patient advocacy, prescriptions, information about available health care resources, referrals to health care specialists, and, for dentists, simple tooth extractions and necessary related suturing. The health care provider, for the provision of these services, is a state agent of DHFS; as such, for a civil action arising out of an act committed in the lawful course of the health care provider's duties, certain time limitations for filing the action apply, legal counsel is provided to the health care provider, judgments against the health care provider are paid by the state, and amounts recoverable are capped at $250,000.

This bill expands the Volunteer Health Care Provider Program to authorize provision of services, without charge, from four–year–old kindergarten to grade six in a public elementary school, a charter school, or a private school participating in the Milwaukee Parental Choice Program (MPCP), if DOA approves the joint application of a health care provider and a school board or the governing body of a charter school or a private school participating in MPCP. After providing to the school board or relevant governing body proof of satisfactory completion of any relevant competency requirements, the volunteer health care provider may provide without charge to students from four–year–old kindergarten to grade six of the school, regardless of income, diagnostic tests; health education; information about available health care resources; office visits; patient advocacy; referrals to health care specialists; first aid for illness or injury; in compliance with the written instructions of a pupil's parent or guardian, the administration of any drug, other than a contraceptive drug, that may lawfully be sold over the counter; health screenings; any other health care services designated by the Department of Public Instruction (DPI); and, for dentists, simple tooth extractions and necessary related suturing. However, the volunteer health care provider may not provide emergency medical services, hospitalization, or surgery, except as designated by DPI by rule, and may not provide abortion referrals, contraceptives, or pregnancy tests.

Under current law, a health care plan must allow any provider to participate in the plan under the terms of the plan. However, this requirement does not apply to health maintenance organizations, limited service health organizations, or preferred provider plans, each of which is a health care plan that requires, or

provides incentives for, its enrollees to obtain health care services from providers participating in the plan. "Participating" is defined as being under contract to provide health care services, items, or supplies to plan enrollees.

This bill requires any health care plan, including a health maintenance organization, limited service health organization, or preferred provider plan, to allow any provider to participate in the plan under the terms of the plan. The requirement only applies to a health maintenance organization, limited service health organization, or preferred provider plan, however, if the provider is located in the geographic service area of the plan. The bill also requires a health care plan that excludes a provider from participation in the plan to give the provider written notice of the reason for the exclusion.

Also under current law, a health maintenance organization, limited service health organization, or preferred provider plan that covers pharmaceutical services provided by one or more pharmacists who are not full–time salaried employees or partners of the organization or plan must provide an annual 30–day period during which any pharmacist may elect to participate in the organization or plan under its terms as a selected provider for at least one year. This bill expands that requirement. Under the bill, a health maintenance organization, limited service health organization, or preferred provider plan that covers health care services that are provided by one or more health care professionals who are not full–time salaried employees or partners of the organization or plan is required to provide an annual 30–day period during which any health care professional who provides those health care services and who is located in the geographic service area of the organization or plan may elect to participate in the organization or plan under its terms as a selected provider for at least one year.

Under current law, a group health insurance policy that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital

services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill specifies that the minimum coverage limits required for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems do not include costs incurred for prescription drugs and diagnostic testing. Diagnostic testing is defined in the bill as procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems. DHFS is authorized to specify, by rule, the diagnostic testing procedures that are not included under the coverage limits.

The bill provides that, if an insurer pays less than the amount that a provider charges, the required minimum coverage limits apply to the amount actually paid by the insurer rather than to the amount charged by the provider.

The bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted. Inpatient services must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $16,800 minus the applicable cost sharing or, if there is no cost sharing under the policy, $15,100 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $4,600 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,100 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $16,800, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on

the increase in the federal cost–of–living for medical coverage "indexed" since the enactment of the current coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost–sharing	$7,000*	1985	$16,800*
No cost–sharing	$6,300	1985	$15,100
Outpatient			
Cost–sharing	$2,000*	1992	$ 3,100*
No cost–sharing	$1,800	1992	$ 2,800
Transitional			
Cost–sharing	$3,000*	1992	$ 4,600*
No cost–sharing	$2,700	1992	$ 4,100
All services	$7,000	1985	$16,800

*Minus cost–sharing

The bill also requires the DHFS to annually report to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

Under current law, the treatment records of an individual who is treated for mental illness, developmental disabilities, alcoholism, or drug dependence must remain confidential, are privileged to the individual, and may be released only with the individual's informed written consent. However, numerous exceptions apply that permit the release of treatment records without informed written consent. One of the exceptions permits the release of information contained in a treatment record as to whether or not an individual is a patient at an inpatient facility; and the information may be released to the individual's parents, children, or spouse, to a law enforcement officer who is seeking to determine if the individual is on unauthorized absence from the facility, and to mental health professionals who are providing treatment to the individual.

This bill changes that exception to *require* that notice be provided as to whether or not an individual is a patient at an inpatient facility and, if no longer a patient, the facility to which the individual was transferred or other place, if known, at which the individual is located. This information must be released to the individual's siblings, as well as the individual's parents, children, or spouse, or to a law enforcement officer or mental health professional. However, the bill prohibits the release of the information to the individual's parents, children, siblings, or spouse if the individual has specifically named the person and requested that the information be withheld from him or her.

This bill also requires the DHFS fiscal intermediary for MA to maintain a separate unit for the processing of MA claims for dental services provided under MA.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 20.435 (4) (b) of the statutes is amended to read:

20.435 **(4)** (b) *Medical assistance program benefits.* Biennially, the amounts in the schedule to provide the state share of medical assistance program benefits administered under s. 49.45, to provide medical assistance program benefits administered under s. 49.45 that are not also provided under par. (o), to fund the pilot project under s. 46.27 (9) and (10), to provide the facility payments under 1999 Wisconsin Act 9, section 9123 (9m), to fund services provided by resource centers under s. 46.283 and for services under the family care benefit under s. 46.284 (5). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation under sub. (7) (kb) funds in the amount of and for the purposes specified in s. 46.485. Notwithstanding ss. 20.001 (3) (b) and 20.002 (1), the department may credit or deposit into this appropriation and may transfer between fiscal years funds that it transfers from the appropriation under sub. (7) (kb) for the purposes specified in s. 46.485 (3r). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation account under sub. (7) (bd) funds in the amount and for the purposes specified in s. 49.45 ~~(6v)~~ (6L).

SECTION 2. 20.435 (7) (bd) of the statutes is amended to read:

20.435 **(7)** (bd) *Community options program; pilot projects; family care benefit.* The amounts in the schedule for assessments, case planning, services, administration and risk reserve escrow accounts under s. 46.27, for pilot projects

under s. 46.271 (1), to fund services provided by resource centers under s. 46.283 (5), for services under the family care benefit under s. 46.284 (5) and for the payment of premiums under s. 49.472 (5). If the department transfers funds to this appropriation from the appropriation account under sub. (4) (b), the amounts in the schedule for the fiscal year for which the transfer is made are increased by the amount of the transfer for the purposes specified in s. 49.45 ~~(6v)~~ (6L). Notwithstanding ss. 20.001 (3) (a) and 20.002 (1), the department may under this paragraph transfer moneys between fiscal years. Except for moneys authorized for transfer under this appropriation or under s. 46.27 (7) (fm) or (g), all moneys under this appropriation that are allocated under s. 46.27 and are not spent or encumbered by counties or by the department by December 31 of each year shall lapse to the general fund on the succeeding January 1 unless transferred to the next calendar year by the joint committee on finance.

SECTION 3. 46.03 (44) of the statutes is created to read:

46.03 **(44)** SEXUALLY TRANSMITTED DISEASE TREATMENT INFORMATION. Promulgate a rule specifying the information that a physician, physician assistant, or advanced practice nurse prescriber may provide, in writing, to a patient under s. 448.035 (3) and encourage physicians, physician assistants, and advanced practice nurse prescribers to provide such information to a patient under s. 448.035 (3). The information shall consist of information about sexually transmitted diseases and their treatment and about the risk of drug allergies. The information shall also include a statement advising a person with questions about the information to contact his or her physician or local health department, as defined in s. 250.01 (4).

SECTION 4. 46.277 (1) of the statutes is amended to read:

46.277 **(1)** LEGISLATIVE INTENT. The intent of the program under this section is to provide home or community–based care to serve in a noninstitutional community setting a person who meets eligibility requirements under 42 USC 1396n (c) and is relocated from an institution other than a state center for the developmentally disabled or meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, except that the number of persons who receive home or community–based care under this section is not intended, other than under sub. (4) (c), to exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department. The intent of the program is also that counties use all existing services for providing care under this section, including those services currently provided by counties.

SECTION 5. 46.277 (1m) (a) of the statutes is renumbered 46.277 (1m) (ak).

SECTION 6. 46.277 (1m) (ag) of the statutes is created to read:

46.277 **(1m)** (ag) "Delicensed" means deducted from the number of beds stated on a facility's license, as specified under s. 50.03 (4) (e).

SECTION 7. 46.277 (2) (intro.) of the statutes is amended to read:

46.277 **(2)** DEPARTMENTAL POWERS AND DUTIES. (intro.) The department may request a waiver from the secretary of the federal department of health and human services, under 42 USC 1396n (c), authorizing the department to serve medical assistance recipients, who meet the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, in their communities by providing home or community–based services as part of medical assistance. ~~The~~ Except under sub. (4) (c), the number of persons for whom the waiver is requested may not exceed the number of nursing home beds that are delicensed

as part of a plan submitted by the facility and approved by the department. If the department requests a waiver, it shall include all assurances required under 42 USC 1396n (c) (2) in its request. If the department receives this waiver, it may request one or more 3–year extensions of the waiver under 42 USC 1396n (c) and shall perform the following duties:

SECTION 8. 46.277 (3) (a) of the statutes is amended to read:

46.277 **(3)** (a) Sections 46.27 (3) (b) and 46.275 (3) (a) and (c) to (e) apply to county participation in this program, except that services provided in the program shall substitute for care provided a person in a skilled nursing facility or intermediate care facility who meets the level of care requirements for medical assistance reimbursement to that facility rather than for care provided at a state center for the developmentally disabled. ~~The~~ Except in sub. (4) (c), the number of persons who receive services provided by the program under this paragraph may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

SECTION 9. 46.277 (3) (b) 1. of the statutes is amended to read:

46.277 **(3)** (b) 1. ~~If~~ Except under sub. (4) (c), if the provision of services under this section results in a decrease in the statewide nursing home bed limit under s. 150.31 (3), the facility affected by the decrease shall submit a plan for delicensing all or part of the facility that is approved by the department.

SECTION 10. 46.277 (3) (b) 2. of the statutes is amended to read:

46.277 **(3)** (b) 2. Each county department participating in the program shall provide home or community–based care to persons eligible under this section, except that the number of persons who receive home or community–based care under this

section may not exceed, other than under sub. (4) (c), the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

SECTION 11. 46.277 (4) (a) of the statutes is amended to read:

46.277 **(4)** (a) Any medical assistance recipient who meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility is eligible to participate in the program, except that the number of participants may not exceed, other than under par. (c), the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department. Such a recipient may apply, or any person may apply on behalf of such a recipient, for participation in the program. Section 46.275 (4) (b) applies to participation in the program.

SECTION 12. 46.277 (4) (b) of the statutes is amended to read:

46.277 **(4)** (b) To the extent authorized under 42 USC 1396n and except under par. (c), if a person discontinues participation in the program, a medical assistance recipient may participate in the program in place of the participant who discontinues if that recipient meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility, except that the number of participants may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

SECTION 13. 46.277 (4) (c) of the statutes is created to read:

46.277 **(4)** (c) The department may, under this paragraph, provide funding under this section for services for a medical assistance recipient who relocates from

a facility to the community, beginning on the date of the relocation and ending on the date that the individual discontinues participation in the program or no longer meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility. Funding for medical assistance costs for individuals relocated under this paragraph may not exceed, in the aggregate, total medical assistance costs for the individuals if served in facilities. The total number of individuals who may participate in the program under this paragraph is not restricted by any otherwise applicable limitation on the number of individuals who may participate in the program under this section.

SECTION 14. 46.277 (5) (g) of the statutes, as created by 2003 Wisconsin Act 33, is amended to read:

46.277 **(5)** (g) The department may provide enhanced reimbursement for services provided under this section to an individual who is relocated to the community from a nursing home by a county department on or after July 26, 2003, if the nursing home bed that was used by the individual is delicensed upon relocation of the individual or if the individual is relocated under sub. (4) (c). The department shall develop and utilize a formula to determine the enhanced reimbursement rate.

SECTION 15. 46.277 (5g) (a) of the statutes is amended to read:

46.277 **(5g)** (a) ~~The~~ Except under sub. (4) (c), the number of persons served under this section may not exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department.

SECTION 16. 49.45 (6ur) of the statutes is created to read:

49.45 **(6ur)** PHYSICIAN ORDER ENTRY RECORD SYSTEM; INCENTIVE PAYMENTS. From the appropriation accounts under s. 20.435 (4) (b) and (o), the department shall

annually make an incentive payment to each hospital that establishes, by January 1, 2007, and thereafter continues to maintain a physician order entry record system for provided medical services that, at a minimum, include pharmacy, laboratory, ultrasonography, and radiology services. The incentive payment shall equal 1% of the Medical Assistance reimbursement to the hospital for the previous fiscal year.

SECTION 17. 49.45 (6v) of the statutes is renumbered 49.45 (6L).

SECTION 18. 49.45 (53) of the statutes is created to read:

49.45 **(53)** FISCAL INTERMEDIARY; DENTAL FORMS. The department's fiscal intermediary shall maintain a separate unit for the processing of claims for dental services received under this section.

SECTION 19. 49.46 (1) (a) 1. of the statutes is amended to read:

49.46 **(1)** (a) 1. Notwithstanding s. 49.19 (20), any individual who, without regard to the individual's resources and subject to par. (ar), would qualify for a grant of aid to families with dependent children under s. 49.19.

SECTION 20. 49.46 (1) (a) 1g. of the statutes is amended to read:

49.46 **(1)** (a) 1g. Notwithstanding s. 49.19 (20), any individual who, without regard to the individual's resources and subject to par. (ar), would qualify for a grant of aid to families with dependent children but who would not receive the aid solely because of the application of s. 49.19 (11) (a) 7.

SECTION 21. 49.46 (1) (a) 1m. of the statutes is amended to read:

49.46 **(1)** (a) 1m. Any pregnant woman whose income, determined in accordance with par. (ar), does not exceed the standard of need under s. 49.19 (11) and whose pregnancy is medically verified. Eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls.

SECTION 22. 49.46 (1) (a) 6. of the statutes is amended to read:

49.46 **(1)** (a) 6. Any person not described in pars. (c) to (e) who, without regard to the individual's resources and subject to par. (ar), would be considered, under federal law, to be receiving aid to families with dependent children for the purpose of determining eligibility for medical assistance.

SECTION 23. 49.46 (1) (a) 9. of the statutes is amended to read:

49.46 **(1)** (a) 9. Any pregnant woman not described under subd. 1., 1g., or 1m. whose family income, determined in accordance with par. (ar), does not exceed 133% of the poverty line for a family the size of the woman's family.

SECTION 24. 49.46 (1) (a) 10. of the statutes is amended to read:

49.46 **(1)** (a) 10. Any child not described under subd. 1. or 1g. who is under 6 years of age and whose family income, determined in accordance with par. (ar), does not exceed 133% of the poverty line for a family the size of the child's family.

SECTION 25. 49.46 (1) (a) 11. of the statutes is amended to read:

49.46 **(1)** (a) 11. If a waiver under s. 49.665 is granted and in effect, any child not described under subd. 1. or 1g. who has attained the age of 6 but has not attained the age of 19 and whose family income, determined in accordance with par. (ar), does not exceed 100% of the poverty line for a family the size of the child's family. If a waiver under s. 49.665 is not granted or in effect, any child not described in subd. 1. or 1g. who was born after September 30,1983, who has attained the age of 6 but has not attained the age of 19 and whose family income, determined in accordance with par. (ar), does not exceed 100% of the poverty line for a family the size of the child's family.

SECTION 26. 49.46 (1) (a) 12. of the statutes is amended to read:

49.46 **(1)** (a) 12. Any child not described under subd. 1. or 1g. who is under 19 years of age and whose income, determined in accordance with par. (ar), does not exceed the standard of need under s. 49.19 (11).

SECTION 27. 49.46 (1) (ar) of the statutes is created to read:

49.46 **(1)** (ar) 1. Except as provided in subd. 2. and except to the extent that the determination is inconsistent with 42 USC 1396a (a) (17), for purposes of determining under par. (a) 1., 1g., or 6. whether an individual would qualify for a grant of aid to families with dependent children under s. 49.19 or would be considered, under federal law, to be receiving aid to families with dependent children, or of determining whether an individual meets the income limits under par. (a) 1m., 9., 10., 11., or 12., "income" includes income that would be included in determining eligibility for aid to families with dependent children under s. 49.19 and excludes income that would be excluded in determining eligibility for aid to families with dependent children under s. 49.19.

2. Notwithstanding s. 49.19 (5), for purposes of determining under par. (a) 1., 1g., or 6. whether an individual would qualify for a grant of aid to families with dependent children under s. 49.19 or would be considered, under federal law, to be receiving aid to families with dependent children, or of determining whether an individual meets the income limits under par. (a) 1m., 9., 10., 11., or 12., (am), or (e), the department shall exclude from the calculation of farm or self–employment income any amounts claimed for depreciation for income tax purposes.

SECTION 28. 49.46 (1) (e) of the statutes is amended to read:

49.46 **(1)** (e) If an application under s. 49.47 (3) shows that the ~~individual~~ individual's income, determined in accordance with par. (ar), meets the income limits under s. 49.19, or that the individual meets the income and resource requirements

under federal Title XVI or s. 49.77, or ~~that the individual~~ is an essential person, an accommodated person, or a patient in a public medical institution, the individual shall be granted the benefits enumerated under sub. (2) whether or not the individual requests or receives a grant of any of such aids.

SECTION 29. 49.46 (1) (L) of the statutes is repealed.

SECTION 30. 49.47 (4) (am) 1. of the statutes is amended to read:

49.47 **(4)** (am) 1. A pregnant woman whose family income, determined in accordance with par. (cg), does not exceed 155% of the poverty line for a family the size of the woman's family, except that, if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the woman's family in each state fiscal year after the 1994–95 state fiscal year.

SECTION 31. 49.47 (4) (am) 2. of the statutes is amended to read:

49.47 **(4)** (am) 2. A child who is under 6 years of age and whose family income, determined in accordance with par. (cg), does not exceed 155% of the poverty line for a family the size of the child's family, except that, if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the child's family in each state fiscal year after the 1994–95 state fiscal year.

SECTION 32. 49.47 (4) (c) 1. of the statutes is amended to read:

49.47 **(4)** (c) 1. Except as provided in par. (am) and as limited by subd. 3., eligibility exists if income, determined in accordance with par. (cg), does not exceed 133 1/3% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available

under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.77, whichever is higher. ~~In this subdivision~~

(cg) 1. Except as provided in subd. 3., for purposes of determining whether an individual's income meets the income requirements under par. (c), "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled under 42 USC 1381 to 1385~~. "Income" does not include~~ and excludes earned or unearned income ~~which~~ that would be excluded in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

SECTION 33. 49.47 (4) (c) 3. of the statutes is amended to read:

49.47 **(4)** (c) 3. Except as provided in par. (am), no person is eligible for medical assistance under this section if the person's income, determined in accordance with par. (cg), exceeds the maximum income levels that the U.S. department of health and human services sets for federal financial participation under 42 USC 1396b (f).

SECTION 34. 49.47 (4) (cg) 3. of the statutes is created to read:

49.47 **(4)** (cg) 3. Notwithstanding s. 49.19 (5), for purposes of determining whether an individual under par. (ag) or (am) is eligible for medical assistance, the department shall exclude from the calculation of farm or self–employment income any amounts claimed for depreciation for income tax purposes.

SECTION 35. 49.47 (4) (h) of the statutes is renumbered 49.47 (4) (cg) 2. and amended to read:

49.47 **(4)** (cg) 2. ~~For the~~ Except as provided in subd. 3., for purposes of determining whether an individual meets the income limits under par. (am), "income" includes income that would be ~~used~~ included in determining eligibility for

aid to families with dependent children under s. 49.19 and excludes income that would be excluded in determining eligibility for aid to families with dependent children under s. 49.19.

SECTION 36. 49.665 (4) (a) 1. of the statutes is amended to read:

49.665 **(4)** (a) 1. The family's income does not exceed 185% of the poverty line, except as provided in par. (at) and except that a family that is already receiving health care coverage under this section may have an income that does not exceed 200% of the poverty line. ~~The~~ Subject to par. (d), the department shall establish by rule the criteria to be used to determine income.

SECTION 37. 49.665 (4) (d) of the statutes is created to read:

49.665 **(4)** (d) For purposes of determining a family's or child's income under this section, the department shall exclude from the calculation of farm or self–employment income any amounts claimed for depreciation for income tax purposes.

SECTION 38. 49.688 (4r) of the statutes is created to read:

49.688 **(4r)** In determining a person's annual household income under sub. (2) (a) 4. and (b) for purposes of determining eligibility for prescription drug assistance and under sub. (3) (b) 1. and 2. a. for purposes of establishing the required deductible amount, the department shall deduct the amount of property taxes that the person or any member of his or her household paid on the person's primary residence in the 12–month period before the department makes an eligibility determination under sub. (4).

SECTION 39. 51.30 (4) (b) 13. of the statutes is renumbered 51.30 (4) (cm) and amended to read:

51.30 **(4)** (cm) *Required access to records.* ~~To the parents, children~~ Notwithstanding par. (a), treatment records of an individual shall be released without informed written consent, except as restricted under par. (c), to the parent, child, sibling, or spouse of an individual who is or was a patient at an inpatient facility~~,~~; to a law enforcement officer who is seeking to determine whether an individual is on unauthorized absence from the facility~~,~~; and to mental health professionals who are providing treatment to the individual at the time that the information is released to others. Information released under this ~~subdivision~~ paragraph is limited to notice as to whether or not an individual is a patient at the inpatient facility and, if the individual is no longer a patient at the inpatient facility, the facility or other place, if known, at which the individual is located. This paragraph does not apply to an individual's parent, child, sibling, or spouse from whom the individual has specifically requested that the information under this paragraph be withheld.

SECTION 40. 100.31 (title) of the statutes is amended to read:

100.31 (title) ~~**Unfair discrimination in**~~ **Prescription drug pricing.**

SECTION 41. 100.31 (1) (a) of the statutes is renumbered 100.31 (1) (bm) and amended to read:

100.31 **(1)** (bm) ~~"Drug"~~ "Prescription drug" means any substance subject to 21 USC 353 (b).

SECTION 42. 100.31 (1) (ae) of the statutes is created to read:

100.31 **(1)** (ae) "Consumer" means a person for whom a prescription drug is prescribed.

SECTION 43. 100.31 (1) (as) of the statutes is created to read:

100.31 **(1)** (as) "Federal drug list" means the "Approved Drug Products with Therapeutic Equivalence Evaluations" published by the federal food and drug administration, or other publication specified in rules promulgated by the department under sub. (2r).

SECTION 44. 100.31 (1) (b) of the statutes is renumbered 100.31 (1) (am) and amended to read:

100.31 **(1)** (am) ~~"Purchaser"~~ "Dispenser" means any person who engages ~~primarily~~ in ~~selling~~ dispensing, as defined in s. 450.01 (7), prescription drugs ~~directly~~ to consumers for outpatient use. "Dispenser" includes a hospital that directly or indirectly bills patients for prescription drugs, or an insurer that issues a defined network plan, as defined in s. 609.01 (1b), and that provides prescription drugs or prescription drug coverage to the enrollees of the plan.

SECTION 45. 100.31 (1) (c) of the statutes is amended to read:

100.31 **(1)** (c) "Seller" means any person who trades in prescription drugs for resale to ~~purchasers~~ dispensers in this state.

SECTION 46. 100.31 (2) of the statutes is amended to read:

100.31 **(2)** PRICE DISCRIMINATION PROHIBITED. Every seller shall offer prescription drugs from the most current federal drug list ~~of therapeutically equivalent drugs published by the federal food and drug administration~~ to every ~~purchaser~~ dispenser in this state, with all rights and privileges offered or accorded by the seller to the most favored ~~purchaser~~ dispenser, including purchase prices for similar volume purchases, rebates, free merchandise, samples, and similar trade concessions. Nothing in this subsection prohibits the giving of a discount for volume purchases.

SECTION 47. 100.31 (2r) of the statutes is created to read:

100.31 **(2r)** RULES. The department may promulgate rules that, for purposes of sub. (1) (as), specify a publication that identifies drug products approved on the basis of safety and effectiveness by the federal food and drug administration under the federal Food, Drug, and Cosmetic Act.

SECTION 48. 100.31 (4) of the statutes is amended to read:

100.31 **(4)** PENALTIES. For any violation of this section, the department or a district attorney may commence an action on behalf of the state to recover a forfeiture of not less than $100 nor more than $10,000 for each offense. Each delivery of a prescription drug sold to a ~~purchaser~~ dispenser at a price in violation of this section and each separate day in violation of an injunction issued under this section is a separate offense.

SECTION 49. 146.385 of the statutes is created to read:

146.385 Health care provider service rate charges; limitations. (1) In this section:

(a) "Health care provider" means any of the following that receives income from the provision of health care or mental health services, items, or supplies in this state:

1. An individual who is licensed, registered, permitted, or certified by the department of health and family services or by the department of regulation and licensing to provide health care or mental health services, items, or supplies.

2. A partnership, corporation, or limited liability company of individuals specified in subd. 1.

3. A facility or agency that provides health care or mental health services, items, or supplies.

(b) "Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health care plans, as defined in s. 628.36 (2) (a) 1., covering individuals in this state.

(2) (a) By April 1 annually, the department shall make available on the department's website, in a form that is downloadable, and, upon request, by mail, the current Medical Assistance fee schedule for health care services of health care providers.

(b) The department may make available on the department's website, in a form that is downloadable, and, upon request, by mail, all of the following:

1. The current insurer rates of health care providers provided to the department under sub. (3) (a), including any rate increases about which the department is informed under sub. (3 (a).

2. The current rates of reimbursement for health care services of health care providers provided to the department under sub. (5), including any rate increases about which the department is informed under sub. (5).

(c) The department may contract for the receipt of information under sub. (3) (a) or (5) and for the posting of the information under par. (a) or (b), in accordance with the department's request–for–proposal procedures.

(3) (a) By April 15 annually, a health care provider shall provide to the department, on a form provided by the department, a statement of the provider's rates for health care services for the period from the following May 1 to April 30. If during this period the health care provider increases any of the rates from the amount stated, the health care provider shall so inform the department, on a form provided by the department. The rates shall be stated in a form determined by the department that may include statement as a percentage of the Medical Assistance

fee schedule for services of providers, as specified by the department under sub. (2) (a).

(b) Beginning on May 1 annually, a health care provider shall, with respect to the provider's rates for the period from that date to April 30 of the following year, do all of the following:

1. If the health care provider has an Internet website, post the rates, including any rate increases, on the website, in a form that is downloadable.

2. Take reasonable steps to ensure that health care consumers of services of the health care provider are aware that information on the provider's rates for health care services is available and are informed about the means by which the rate information may be obtained.

(4) Any increase in a rate for the health care service of a health care provider is chargeable only after the health care provider has, under sub. (3) (a), informed the department of the increase and has, if applicable, posted the rate increase under sub. (3) (b) 1.

(5) By April 15 annually, an insurer shall provide to the department, on a form provided by the department, and to the insurer's insureds a statement of the insurer's rates of reimbursement for health care services of health care providers for the period from the following May 1 to April 30. If during this period the insurer increases any of the rates of reimbursement from the amount stated, the insurer shall so inform the department, on a form provided by the department. The rates of reimbursement shall be stated as a percentage of the Medical Assistance fee schedule for health care services of health care providers, as specified by the department under sub. (2) (a).

SECTION 50. 146.89 (1) of the statutes is renumbered 146.89 (1) (intro.) and amended to read:

146.89 **(1)** (intro.) In this section~~, "volunteer:~~

(r) "Volunteer health care provider" means an individual who is licensed as a physician under ch. 448, dentist under ch. 447, registered nurse, practical nurse, or nurse–midwife under ch. 441, optometrist under ch. 449, or physician assistant under ch. 448 or certified as a dietitian under subch. V of ch. 448 and who receives no income from the practice of that health care profession or who receives no income from the practice of that health care profession when providing services at the nonprofit agency or school specified under sub. (3).

SECTION 51. 146.89 (1) (d) of the statutes is created to read:

146.89 **(1)** (d) "Governing body" means the governing body of any of the following:

1. A charter school, as defined in s. 115.001 (1).

2. A private school, as defined in s. 115.001 (3r), that participates in the Milwaukee Parental Choice Program under s. 119.23.

SECTION 52. 146.89 (1) (g) of the statutes is created to read:

146.89 **(1)** (g) "School" means any of the following:

1. A public elementary school.

2. A charter school, as defined in s. 115.001 (1).

3. A private school, as defined in s. 115.001 (3r), that participates in the Milwaukee Parental Choice Program under s. 119.23

SECTION 53. 146.89 (1) (h) of the statutes is created to read:

146.89 **(1)** (h) "School board" has the meaning given in s. 115.001 (7).

SECTION 54. 146.89 (2) (a) of the statutes is amended to read:

146.89 **(2)** (a) A volunteer health care provider may participate under this section only if he or she submits a joint application with a nonprofit agency, school board, or governing body to the department of administration and that department approves the application. If the volunteer health care provider submits a joint application with a school board or governing body, the application shall include a statement by the school board or governing body that certifies that the volunteer health care provider has received materials that specify school board or governing body policies concerning the provision of health care services to students and has agreed to comply with the policies. The department of administration shall provide application forms for use under this paragraph.

SECTION 55. 146.89 (2) (c) of the statutes is amended to read:

146.89 **(2)** (c) The department of administration shall notify the volunteer health care provider and the nonprofit agency, school board, or governing body of the department's decision to approve or disapprove the application.

SECTION 56. 146.89 (2) (d) of the statutes is amended to read:

146.89 **(2)** (d) Approval of an application of a volunteer health care provider is valid for one year. If a volunteer health care provider wishes to renew approval, he or she shall submit a joint renewal application with a nonprofit agency, school board, or governing body to the department of administration. The department of administration shall provide renewal application forms that are developed by the department of health and family services and that include questions about the activities that the individual has undertaken as a volunteer health care provider in the previous 12 months.

SECTION 57. 146.89 (3) (b) (intro.) of the statutes is amended to read:

146.89 **(3)** (b) (intro.) ~~The~~ Under this section, the nonprofit agency may provide the following health care services:

SECTION 58. 146.89 (3) (c) of the statutes is amended to read:

146.89 **(3)** (c) ~~The~~ Under this section, the nonprofit agency may not provide emergency medical services, hospitalization, or surgery, except as provided in par. (b) 8.

SECTION 59. 146.89 (3) (d) (intro.) of the statutes is amended to read:

146.89 **(3)** (d) (intro.) ~~The~~ Under this section, the nonprofit agency shall provide health care services primarily to low–income persons who are uninsured and who are not recipients of any of the following:

SECTION 60. 146.89 (3m) of the statutes is created to read:

146.89 **(3m)** All of the following apply to a volunteer health care provider whose joint application with a school board or relevant governing body is approved under sub. (2):

(a) Before providing health care services in a school, the volunteer health care provider shall provide to the school board or relevant governing body proof of satisfactory completion of any competency requirements that are relevant to the volunteer health care provider, as specified by the department of public instruction by rule.

(b) Under this section, the volunteer health care provider may provide only to students from 4–year–old kindergarten to grade 6 the following health care services:

1. Except as specified in par. (c), the health care services specified in sub. (3) (b) 1. to 5., 7., and 8.

2. First aid for illness or injury.

3. Except as specified in par. (c), the administration of drugs, as specified in s. 118.29 (2) (a) 1. to 3.

4. Health screenings.

5. Any other health care services designated by the department of public instruction by rule.

(c) Under this section, the volunteer health care provider may not provide any of the following:

1. Emergency medical services.

2. Hospitalization.

3. Surgery, except as provided in par. (b) 2. and 5.

4. A referral for abortion, as defined in s. 48.375.

5. A contraceptive article, as defined in s. 450.155 (1) (a).

6. A pregnancy test.

(d) Any health care services provided under par. (b) shall be provided without charge at the school and shall be available to all students from 4–year–old kindergarten to grade 6 regardless of income.

SECTION 61. 441.07 (1) (d) of the statutes is amended to read:

441.07 **(1)** (d) Misconduct or unprofessional conduct. In this paragraph, "misconduct" and "unprofessional conduct" do not include the prescribing of an antibiotic drug as described in s. 448.035.

SECTION 62. 441.16 (3m) of the statutes is created to read:

441.16 **(3m)** An advanced practice nurse who is certified under sub. (2) may prescribe an antibiotic drug as described in s. 448.035.

SECTION 63. 448.015 (4) of the statutes is amended to read:

448.015 **(4)** "Unprofessional conduct" means those acts or attempted acts of commission or omission defined as unprofessional conduct by the board under the authority delegated to the board by s. 15.08 (5) (b) and any act by a physician or physician assistant in violation of ch. 450 or 961. "Unprofessional conduct" does not include the prescribing of an antibiotic drug as described in s. 448.035.

SECTION 64. 448.035 of the statutes is created to read:

448.035 Prescribing certain antibiotic drugs. (1) In this section:

(a) "Advanced practice nurse prescriber" means a nurse who is certified under s. 441.16 (2).

(b) "Antibiotic drug" means an antibiotic drug recommended for treatment of chlamydia, gonorrhea, or trichomonas in the most current guidelines for the treatment of sexually transmitted diseases of the federal centers for disease control.

(2) Notwithstanding the requirements of s. 448.30, a physician, physician assistant, or advanced practice nurse prescriber may prescribe an antibiotic drug as a course of therapy for treatment of chlamydia, gonorrhea, or trichomonas to a patient for use by a person with whom the patient has had sexual intercourse if the patient states to the physician, physician assistant, or advanced practice nurse prescriber that the person is not allergic to the drug. The prescription order is required to include the name and address of the patient, a statement that indicates that the patient should ask the person with whom the patient has had sexual intercourse whether that person is allergic to the drug, and a statement that indicates that the drug should not be taken by a person who is allergic to the drug. The prescription order is not required to include the name and address of the person with whom the patient has had sexual intercourse. The prescription order shall state that the patient is responsible for paying for the antibiotic drug that is prescribed for

the person with whom the patient has had sexual intercourse. This subsection does not apply to the prescribing of a substance listed in the schedules in ss. 961.14, 961.16, 961.18, 961.20, and 961.22 or substances added by the controlled substances board acting under s. 961.11 (1). A physician, physician assistant, or advanced practice nurse prescriber may not issue prescriptions under this subsection for more than 2 persons in one year with whom a particular patient has had sexual intercourse.

(3) At the time of issuing the prescription under sub. (2), the physician, physician assistant, or advanced practice nurse prescriber may provide the patient, in writing, with information specified by the department of health and family services under s. 46.03 (44) and request that the patient give the information to the person with whom the patient has had sexual intercourse.

SECTION 65. 448.04 (1) (a) of the statutes is amended to read:

448.04 **(1)** (a) *License to practice medicine and surgery.* A person holding a license to practice medicine and surgery may practice as defined in s. 448.01 (9) and as provided in s. 448.035.

SECTION 66. 450.10 (1) (a) (intro.) of the statutes is amended to read:

450.10 **(1)** (a) (intro.) In this subsection, "unprofessional conduct" includes any of the following, but ~~is not limited to~~ does not include the dispensing of an antibiotic drug as described in s. 450.11 (1g):

SECTION 67. 450.11 (1) of the statutes is amended to read:

450.11 **(1)** DISPENSING. No person may dispense any prescribed drug or device except upon the prescription order of a practitioner. All prescription orders shall specify the date of issue, ~~the name and address of the patient,~~ the name and address of the practitioner, the name and quantity of the drug product or device prescribed,

directions for the use of the drug product or device and, if the order is written by the practitioner, the signature of the practitioner. Except as provided in s. 448.035 (2), all prescription orders shall also specify the name and address of the patient. Any oral prescription order shall be immediately reduced to writing by the pharmacist and filed according to sub. (2).

SECTION 68. 450.11 (1g) of the statutes is created to read:

450.11 **(1g)** DISPENSING CERTAIN ANTIBIOTIC DRUGS. (a) In this subsection, "antibiotic drug" has the meaning given in s. 448.035 (1) (b).

(b) A pharmacist may, upon the prescription order of a practitioner, as specified in s. 448.035, and under all other requirements of sub. (1), dispense an antibiotic drug as a course of therapy for treatment of chlamydia, gonorrhea, or trichomonas to a patient for use by a person with whom the patient has had sexual intercourse. A pharmacist may dispense an antibiotic drug under this paragraph without providing a consultation to the person with whom the patient has had sexual intercourse.

(c) A patient specified in par. (b) is responsible for paying for an antibiotic drug that is dispensed under par. (b). Any insurance claim submitted by a pharmacist for an antibiotic drug dispensed under this subsection shall specify that the antibiotic drug was dispensed for use by a person other than the patient.

SECTION 69. 456.02 (intro.) of the statutes is amended to read:

456.02 Duties. (intro.) The examining board shall do all of the following:

SECTION 70. 456.02 (1) of the statutes is amended to read:

456.02 **(1)** Develop, impose and enforce standards ~~which must be met by individuals~~ that an individual is required to meet in order to receive a license as a nursing home administrator~~, which~~. The standards shall be designed to ~~insure~~

ensure that a nursing home ~~administrators will be individuals who are~~ administrator is of good character ~~and are,~~ is otherwise suitable, and ~~who~~, by training or experience in the field of institutional administration, ~~are~~ is qualified to serve as a nursing home ~~administrators;~~ administrator.

SECTION 71. 456.02 (2) of the statutes is amended to read:

456.02 **(2)** Develop and apply appropriate techniques, including examinations and investigations, for determining whether an individual meets ~~such~~ the standards~~;~~ under sub. (1).

SECTION 72. 456.02 (3) of the statutes is amended to read:

456.02 **(3)** Issue ~~licenses to individuals~~ a license to an individual determined, after the application of ~~such~~ the techniques under sub. (2), to meet ~~such~~ the standards under sub. (1), and revoke or suspend ~~licenses~~ a license previously granted by the examining board ~~in any case where~~ if the individual holding ~~any such~~ the license is determined substantially to have failed to conform to the requirements of ~~such~~ the standards~~;~~.

SECTION 73. 456.02 (4) of the statutes is amended to read:

456.02 **(4)** Establish and carry out procedures designed to ~~insure~~ ensure that individuals licensed as nursing home administrators will~~, during any period that they serve as such,~~ comply with the requirements of ~~such~~ the standards~~;~~ under sub. (1).

SECTION 74. 456.02 (5) of the statutes is amended to read:

456.02 **(5)** Subject to the rules promulgated under s. 440.03 (1), receive, investigate, and take appropriate action with respect to, any charge or complaint filed with the examining board to the effect that any individual licensed as a nursing

home administrator has failed to comply with the requirements of ~~such~~ the standards~~;~~ under sub. (1).

SECTION 75. 456.02 (6) of the statutes is amended to read:

456.02 **(6)** In cooperation with other agencies and appropriate organizations, conduct a continuing study of the practice of nursing home administration within the state with a view to the improvement of the standards imposed for the licensing of ~~such~~ nursing home administrators and of procedures and methods for the enforcement of ~~such~~ the standards under sub. (1) with respect to nursing home administrators ~~of nursing homes~~ who have been licensed ~~as such;~~ under this chapter.

SECTION 76. 456.02 (7) of the statutes is amended to read:

456.02 **(7)** ~~Develop and enforce standards for the~~ Promulgate rules establishing supervised practical experience ~~to be required~~ requirements that, except as provided in s. 456.04 (2m), an individual shall satisfy before being allowed to take an examination for licensure~~; and~~ as a nursing home administrator. Except as provided in s. 456.04 (2m), the rules shall require the individual to complete at least 2,000 hours in any consecutive 3–year period within the 5–year period immediately preceding the date of application for examination in an internship, administrator–in–training program, or any other structured program approved by the examining board.

SECTION 77. 456.04 (intro.) (except 456.04 (title)) of the statutes is renumbered 456.04 (1m) (intro.) and amended to read:

456.04 **(1m)** (intro.) ~~The~~ Except as provided in sub. (2m), the examining board shall allow any person to take the examination for licensure as a nursing home administrator who satisfies all of the following requirements:

SECTION 78. 456.04 (1) of the statutes is renumbered 456.04 (1m) (a).

SECTION 79. 456.04 (1m) (d) of the statutes is created to read:

456.04 **(1m)** (d) Has one of the following:

1. A bachelor's, master's, or doctoral degree with a major in health care administration or long–term care from an accredited college or university.

2. A bachelor's degree in any field from an accredited college or university and completion of a specialized course that the examining board determines is adequate preparation for nursing home administration.

SECTION 80. 456.04 (1m) (e) of the statutes is created to read:

456.04 **(1m)** (e) Satisfies the supervised practical experience requirements specified in the rules promulgated under s. 456.02 (7).

SECTION 81. 456.04 (2) of the statutes is renumbered 456.04 (1m) (b).

SECTION 82. 456.04 (2m) of the statutes is created to read:

456.04 **(2m)** The examining board shall allow a person to take the examination for licensure as a nursing home administrator if he or she satisfies the requirements specified in sub. (1m) (a), (b), and (c) and all of the following are satisfied:

(a) The person was enrolled, at any time within the 2–year period before the effective date of this paragraph .... [revisor inserts date], in a regular course of study or equivalent specialized courses or a program of study that the examining board considered adequate academic preparation for nursing home administration under s. 456.04 (4), 2001 stats.

(b) No later than 2 years after the effective date of this paragraph .... [revisor inserts date], the person completes the regular course of study, specialized courses, or program of study specified in par. (a).

(c) If the person was enrolled, at any time within the 2–year period before the effective date of this paragraph .... [revisor inserts date], in specialized courses or a

program of study specified in par. (a), the person completes, no later than 2 years after the effective date of this paragraph .... [revisor inserts date], one year of supervised practical experience as specified in rules promulgated by the examining board.

(d) If the person was enrolled, at any time within the 2–year period before the effective date of this paragraph .... [revisor inserts date], in a regular course of study specified in par. (a), the person completes, no later than 2 years after the effective date of this paragraph .... [revisor inserts date], a supervised clinical practicum as specified in rules promulgated by the examining board.

SECTION 83. 456.04 (3) of the statutes is renumbered 456.04 (1m) (c).

SECTION 84. 456.04 (4) of the statutes is repealed.

SECTION 85. 456.08 of the statutes is renumbered 456.08 (intro.) and amended to read:

456.08 Reciprocity. (intro.) The examining board may grant a nursing home administrator license under this chapter to ~~a person~~ an applicant who holds a current nursing home administrator license issued by the proper authorities of any other state or licensing jurisdiction, upon payment of the fee specified in s. 440.05 (2) and upon submission of ~~satisfactory evidence of the person's qualifications.~~ evidence satisfactory to the examining board that the applicant satisfies each of the following:

SECTION 86. 456.08 (1), (2), (3) and (4) of the statutes are created to read:

456.08 **(1)** The applicant has a bachelor's degree in any field or holds a current certification as a nursing home administrator granted by the American College of Health Care Administrators.

(2) The applicant has practiced as a nursing home administrator in good standing for at least 2,000 hours in any consecutive 3–year period within the 5–year period immediately preceding the date of application.

(3) Subject to ss. 111.321, 111.322, and 111.335, the applicant does not have an arrest or conviction record.

(4) The applicant has passed an examination approved by the examining board relating to state and federal laws governing the practice of nursing home administration.

SECTION 87. 456.09 (1) (c) of the statutes is amended to read:

456.09 **(1)** (c) ~~Practice~~ Except as provided in s. 456.12, practice as a nursing home administrator or use in connection with his or her name any title or designation tending to imply that the person is a nursing home administrator unless duly licensed and registered to so practice under this chapter; or

SECTION 88. 456.12 of the statutes is created to read:

456.12 Exemption. This chapter does not apply to a person who acts in the capacity of an administrator of a nursing home operated by adherents of a church or religious denomination which subscribes to the act of healing by prayer and the principles of which do not include medical treatment, if the person does not use in connection with his or her name any title or designation tending to imply that the person is a nursing home administrator.

SECTION 89. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are, to the extent consistent with s. 628.36 (2) (b) 3. and (2m), accessible and qualified.

SECTION 90. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A defined network plan shall develop, consistent with s. 628.36 (2) (b) 3. and (2m), a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish, to the extent consistent with s. 628.36 (2) (b) 3. and (2m), minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 91. 628.36 (1) of the statutes is renumbered 628.36 (1m) and amended to read:

628.36 **(1m)** PAYMENT METHODS. Any corporation operating a voluntary health care plan may pay health care professionals on a salary, per patient, or fee–for–service basis to provide health care to policyholders or beneficiaries of the corporation.

SECTION 92. 628.36 (1c) (intro.) of the statutes is created to read:

628.36 **(1c)** DEFINITIONS. (intro.) In this section:

SECTION 93. 628.36 (2) (a) (intro.) of the statutes is amended to read:

628.36 **(2)** (a) (intro.) In this ~~section~~ subsection:

SECTION 94. 628.36 (2) (b) 3. of the statutes is amended to read:

628.36 **(2)** (b) 3. Except as provided in ~~subd.~~ subds. 4. and 4m., and subject to sub. (2m) (e), no provider may be denied the opportunity to participate in a health care plan~~, other than a health maintenance organization, a limited service health organization or a preferred provider plan,~~ under the terms of the plan.

SECTION 95. 628.36 (2) (b) 4. of the statutes is amended to read:

628.36 **(2)** (b) 4. Any health care plan may exclude a provider from participation in the health care plan for cause related to the practice of his or her profession. A health care plan that excludes a provider from participation shall advise the provider in writing of the reason for the exclusion.

SECTION 96. 628.36 (2) (b) 4m. of the statutes is created to read:

628.36 **(2)** (b) 4m. Subdivision 3. applies to a health maintenance organization, limited service health organization, or preferred provider plan only with respect to a provider located in the geographic service area of the health maintenance organization, limited service health organization, or preferred provider plan.

SECTION 97. 628.36 (2m) (title) of the statutes is repealed and recreated to read:

628.36 **(2m)** (title) ANNUAL PARTICIPATION ELECTION PERIOD.

SECTION 98. 628.36 (2m) (a) (intro.) and 2m. of the statutes are consolidated, renumbered 628.36 (2m) (ac) and amended to read:

628.36 **(2m)** (ac) In this subsection~~: 2m. "Pharmaceutical~~, "health care services" do not include the administration of a drug product or device or vaccine under s. 450.035.

SECTION 99. 628.36 (2m) (a) 1. of the statutes is renumbered 628.36 (1c) (a).

SECTION 100. 628.36 (2m) (a) 2. of the statutes is renumbered 628.36 (1c) (b).

SECTION 101. 628.36 (2m) (a) 3. of the statutes is renumbered 628.36 (1c) (c).

SECTION 102. 628.36 (2m) (e) 1. of the statutes is amended to read:

628.36 **(2m)** (e) 1. A health maintenance organization, limited service health organization, or preferred provider plan that provides coverage of ~~pharmaceutical~~ health care services ~~when~~ that are performed by one or more ~~pharmacists~~ health care professionals who are selected by the organization or plan but who are not full–time

salaried employees or partners of the organization or plan shall provide an annual period of at least 30 days during which any ~~pharmacist registered under ch. 450~~ health care professional who provides those health care services, who has been granted a credential, as defined in s. 440.01 (2) (a), to practice in this state, and who is located in the geographic service area of the organization or plan may elect to participate in the health maintenance organization, limited service health organization, or preferred provider plan under its terms as a selected provider for at least one year.

SECTION 103. 628.36 (2m) (e) 2. of the statutes is amended to read:

628.36 **(2m)** (e) 2. Except as provided in subd. 3., subd. 1. applies to health maintenance organizations ~~on and after May 10, 1984. Except as provided in subd. 4., subd. 1. applies to~~, limited service health organizations, and preferred provider plans on or after ~~April 28, 1990~~ the effective date of this subdivision .... [revisor inserts date].

SECTION 104. 628.36 (2m) (e) 3. of the statutes is amended to read:

628.36 **(2m)** (e) 3. If compliance with the requirements of subd. 1. during the period specified in subd. 2. would impair any provision of a contract between a health maintenance organization, limited service health organization, or preferred provider plan and any other person, and if the contract provision was in existence prior to ~~May 10, 1984~~ the effective date of this subdivision .... [revisor inserts date], then immediately after the expiration of all such contract provisions the health maintenance organization, limited service health organization, or preferred provider plan shall comply with the requirements of subd. 1.

SECTION 105. 628.36 (2m) (e) 4. of the statutes is repealed.

SECTION 106. 628.36 (3) of the statutes is amended to read:

628.36 **(3)** EXEMPTION BY RULE. By rule the commissioner may exempt from the application of any part of subs. ~~(1)~~ (1m) to (2m) plans ~~which~~ that provide innovative approaches to the delivery of health care or ~~which~~ that are designed to contain health care costs, and ~~which~~ that cannot operate successfully consistent with all of the provisions in subs. ~~(1)~~ (1m) to (2m). The commissioner may promulgate such a rule only if on a finding that the interests of the public require such plans as an experiment, to supply health care services that are not otherwise available in adequate quantity or quality, or to contain health care costs. The promulgated rule shall be as narrow as is compatible with the success of the plans.

SECTION 107. 632.89 (1) (am) of the statutes is created to read:

632.89 **(1)** (am) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

SECTION 108. 632.89 (1) (b) of the statutes is created to read:

632.89 **(1)** (b) "Diagnostic testing" means procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems.

SECTION 109. 632.89 (2) (b) 1. of the statutes is amended to read:

632.89 **(2)** (b) 1. Except as provided in subd. 2., if a group or blanket disability insurance policy issued by an insurer provides coverage of inpatient hospital treatment or outpatient treatment or both, the policy shall provide coverage in every policy year as provided in pars. (c) to (dm), as appropriate, except that the total coverage under the policy for a policy year need not exceed ~~$7,000~~ $16,800 or the equivalent benefits measured in services rendered.

SECTION 110. 632.89 (2) (c) 2. b. of the statutes is amended to read:

632.89 **(2)** (c) 2. b. ~~Seven thousand~~ Sixteen thousand eight hundred dollars minus any applicable cost sharing at the level charged under the policy for inpatient hospital services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$6,300~~ $15,100 in equivalent benefits measured in services rendered.

SECTION 111. 632.89 (2) (d) 2. of the statutes is amended to read:

632.89 **(2)** (d) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$2,000~~ $3,100 minus any applicable cost sharing at the level charged under the policy for outpatient services or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$1,800~~ $2,800 in equivalent benefits measured in services rendered.

SECTION 112. 632.89 (2) (dm) 2. of the statutes is amended to read:

632.89 **(2)** (dm) 2. Except as provided in par. (b), a policy under subd. 1. shall provide coverage in every policy year for not less than ~~$3,000~~ $4,600 minus any applicable cost sharing at the level charged under the policy for transitional treatment arrangements or the equivalent benefits measured in services rendered or, if the policy does not use cost sharing, ~~$2,700~~ $4,100 in equivalent benefits measured in services rendered.

SECTION 113. 632.89 (2) (f) of the statutes is created to read:

632.89 **(2)** (f) *Report on coverage limits.* The department of health and family services shall report annually to the governor and the legislature on revising the coverage limits specified in this subsection based on the change in the consumer price index for medical costs.

SECTION 114. 632.89 (6) and (7) of the statutes are created to read:

632.89 **(6)** PRESCRIPTION DRUGS AND DIAGNOSTIC TESTING. (a) The coverage amounts specified in sub. (2) shall not include costs incurred for prescription drugs or diagnostic testing.

(b) The department of health and family services may specify, by rule, the diagnostic testing procedures to which par. (a) applies.

(7) TREATMENT OF COSTS. The coverage amounts specified in sub. (2) apply to actual payments or reimbursements made by an insurer if the payment or reimbursement amounts are less than the amounts charged by a provider.

SECTION 115. 895.48 (1m) of the statutes, as affected by 2003 Wisconsin Act 33, is renumbered 895.48 (1m) (a).

SECTION 116. 895.48 (1m) (b) of the statutes is created to read:

895.48 **(1m)** (b) This subsection does not apply to health care services provided by a volunteer health care provider under s. 146.89.

SECTION 117. Nonstatutory provisions.

(1) The department of health and family services shall submit in proposed form the rules required under section 46.03 (44) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 7th month beginning after the effective date of this subsection.

SECTION 118. Initial applicability.

(1) The treatment of section 49.688 (4r) of the statutes first applies to eligibility determinations made and deductible amounts paid on the effective date of this subsection.

(2) If an insurance policy that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 632.89 (6) or (7) of the statutes, the treatment of section 632.89 (6) or (7) of the statutes, whichever

is inconsistent, first applies to that insurance policy on the date on which it is renewed.

(3) The treatment of sections 632.89 (1) (am) and (2) (b) 1., (c) 2. b., (d) 2., (dm) 2., and (f) of the statutes first applies to a policy issued, renewed, or modified on the first day of the 13th month beginning after publication.

(4) The treatment of sections 146.89 (2) (a), (c), and (d), (3) (b) (intro.), (c), and (d) (intro.), and (3m) and 895.48 (1m) of the statutes, the renumbering and amendment of section 146.89 (1) of the statutes, and the creation of section 146.89 (1) (d), (g), and (h) and 895.48 (1m) (b) of the statutes first applies to applications submitted under section 146.89 (2) (a) of the statutes, as affected by this act, on the effective date of this subsection.

(5) The renumbering and amendment of section 456.08 of the statutes and the creation of section 456.08 (1), (2), (3), and (4) of the statutes first apply to applications received on the effective date of this subsection.

(6) The treatment of sections 49.46 (1) (a) 1., 1g., 1m., 6., 9., 10., 11., and 12., (ar), (e), and (L), 49.47 (4) (am) 1. and 2., (c) 1. and 3., (cg) 3., and (h), and 49.665 (4) (a) 1. and (d) of the statutes first applies to eligibility determinations for the Medical Assistance and Badger Care health care programs that are made on the effective date of this subsection.

SECTION 119. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of section 49.688 (4r) of the statutes and SECTION 118 (1) of this act take effect on the first day of the 2nd month beginning after publication.

(2) The treatment of sections 20.435 (4) (b) and (7) (bd), 49.45 (6ur) and 49.45 (6v) of the statutes takes effect on takes effect on January 1, 2005, or on the day after publication, whichever is later.

(3) The treatment of sections 100.31 (title), (1) (a), (ae), (as), (b), and (c), (2), (2r), and (4) of the statutes takes effect on the first day of the 3rd month beginning after publication.

(4) The treatment of sections 46.03 (44), 441.07 (1) (d), 441.16 (3m), 448.015 (4), 448.035, 448.04 (1) (a), 450.10 (1) (a) (intro.), and 450.11 (1) and (1g) of the statutes takes effect on the first day of the 13th month beginning after publication.

(5) The treatment of sections 456.02 (intro.), (1), (2), (3), (4), (5), and (6), 456.04 (intro.), (1), (1m) (d) and (e), (2), (2m), (3), and (4), 456.08 (1), (2), (3), and (4), 456.09 (1) (c), and 456.12 of the statutes and the renumbering and amendment of section 456.08 of the statutes take effect on the first day of the 7th month beginning after publication.

(END)