State of Wisconsin
2013 - 2014 LEGISLATURE

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LRB-1145/2
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2013 SENATE BILL 38

February 20, 2013 – Introduced by Senators ERPENBACH, RISSER, CARPENTER, T. CULLEN, HANSEN, HARRIS, JAUCH, C. LARSON, LASSA, LEHMAN, MILLER, SHILLING, TAYLOR, VINEHOUT and WIRCH, cosponsored by Representatives RICHARDS, PASCH, C. TAYLOR, BARCA, BARNES, BERCEAU, BERNARD SCHABER, BEWLEY, BILLINGS, CLARK, DANOU, DOYLE, GENRICH, GOYKE, HEBL, HESSELBEIN, HINTZ, HULSEY, JOHNSON, JORGENSEN, KAHL, KESSLER, KOLSTE, MASON, MILROY, OHNSTAD, POPE, RIEMER, RINGHAND, SARGENT, SHANKLAND, SINICKI, SMITH, VRUWINK, WACHS, WRIGHT, YOUNG, ZAMARRIPA and ZEPNICK. Referred to Committee on Health and Human Services.

AN ACT ***to repeal*** 20.435 (4) (h), 49.45 (23), 49.471 (11g) (c), 49.67, 149.12 (2) (f) 2. g., 227.01 (13) (ur) and 227.42 (7); ***to amend*** 20.435 (4) (hm), 20.435 (4) (jw), 25.77 (2), 49.45 (59) (b), 49.471 (11) (intro.) and 49.686 (3) (d); and ***to create*** 49.471 (1) (cr), 49.471 (4) (b) 5., 49.471 (4m) and 49.471 (11g) of the statutes; **relating to:** Medical Assistance for certain adults who are not currently eligible for traditional Medicaid or BadgerCare Plus.

Analysis by the Legislative Reference Bureau

Currently, the Department of Health Services (DHS) administers the Medical Assistance (MA) program, which is a joint federal and state program that provides health services to individuals who have limited resources. Some services are provided through programs that operate under a waiver of federal Medicaid laws, including services provided through the BadgerCare Plus (BC+) and BadgerCare Plus Core (BC+ Core) programs. Under current law, BC+ provides health and medical services to eligible recipients and has a standard plan with a larger set of benefits and a Benchmark plan with fewer benefits. Recipients of standard BC+ benefits may be required to pay certain copayments for services and, with some exceptions, to pay premiums. Recipients of BC+ under the Benchmark plan have increased copayments and coinsurance for certain services, and certain recipients under the Benchmark plan may be charged higher premiums compared to certain recipients under the standard plan.

Under current law, unless DHS has a policy that conflicts with current state law eligibility requirements, the following individuals, among others, are eligible for benefits under the BC+ standard plan: a pregnant women whose family income does not exceed 200 percent of the federal poverty line (FPL); a child meeting certain criteria whose family income does not exceed 200 percent of the FPL; a child meeting certain criteria whose family income exceeds 150 percent of the FPL but the difference between the actual family income and 150 percent of the FPL is expended on behalf of a member of the child's family or the child for certain medical or health reasons; a parent or caretaker relative of a child whose family income does not exceed 200 percent of the FPL; and an individual who qualifies for a transitional extension of MA benefits even though his or her income increases above the poverty line. The following individuals, among others, are eligible for benefits under the BC+ Benchmark plan, under current law: a pregnant woman whose family income exceeds 200 percent, but does not exceed 300 percent, of the FPL; a pregnant woman and everyone in her family if her family income exceeds 300 percent of the FPL but the difference between her actual family income and 300 percent of the FPL is expended for any family member's or her medical or health care; a child whose family income exceeds 200 percent, but does not exceed 300 percent, of the FPL; and a parent or caretaker of a child whose income includes self–employment income but does not exceed 200 percent of the FPL after depreciation is deducted.

Under current law, DHS also administers BC+ Core, which provides basic primary and preventive care to eligible individuals. Adults who are under age 65, who have family incomes that do not exceed 200 percent of the FPL, and who are not otherwise eligible for MA, including BC+, are eligible for benefits under BC+ Core, unless DHS has a policy that conflicts with current state law eligibility requirements.

DHS also currently administers the BadgerCare Plus Basic (BC+ Basic) plan, which is not an MA program but is funded by premiums paid by plan participants. To be eligible for the BC+ Basic plan, an individual must be on the waiting list for BC+ Core. BC+ Basic provides health care benefits that do not exceed those benefits provided by BC+ Core. Under current law, BC+ Basic terminates on January 1, 2014.

Currently, beginning on January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) requires states that participate in the Medicaid program to offer medical assistance benefits to adults who are under 65 years of age, are not pregnant, are not entitled to Medicare benefits, are not otherwise eligible for Medicaid, and have an income, as calculated under a specified method, that does not exceed 133 percent of the FPL (expansion population). PPACA requires the state to provide benefits to the expansion population that meet the standards of benchmark coverage as defined in PPACA. The federal Department of Health and Human Services (federal DHHS) pays a matching rate, known as the federal medical assistance percentage or FMAP, to states that participate in the Medicaid program. PPACA creates enhanced FMAPs, which are rates that are higher than the typical matching rate, for states to cover newly eligible individuals in the expansion population and for states that already covered certain individuals in the expansion population to cover the entire expansion population. The United States Supreme

Court decision, in *National Federation of Independent Business v. Sebelius*, 567 U.S. ___, 132 S. Ct. 2566 (2012), makes coverage of the expansion population by states optional instead of mandatory.

This bill makes adults who are under 65 years of age, who are not pregnant, who are not otherwise eligible for MA under the state's traditional MA program or BC+, and whose income, as determined under federal law, do not exceed 133 percent of the FPL (Wisconsin expansion population) eligible for the BC+ Benchmark plan beginning January 1, 2014. The bill also eliminates BC+ Core and the language regarding BC+ Basic.

The bill requires that, if the benefits under the BC+ Benchmark plan are not sufficient to qualify DHS to obtain an enhanced FMAP, DHS must provide coverage that complies with PPACA in order to qualify for an enhanced FMAP. Additionally, if the federal DHHS prohibits charging a copayment or premium to the Wisconsin expansion population in order to qualify for an enhanced FMAP, DHS may not charge copayments or premiums that disqualify DHS from obtaining an enhanced FMAP.

For further information see the ***state*** 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) (h) of the statutes is repealed.

SECTION 2. 20.435 (4) (hm) of the statutes is amended to read:

20.435 **(4)** (hm) *BadgerCare Plus Basic Plan; benefits and administration.* All moneys received from premiums under s. 49.67 (4)<u>, 2011 stats.</u>, to pay for the provision of services under the BadgerCare Plus Basic Plan under s. 49.67<u>, 2011 stats.,</u> and for administration of the plan.

SECTION 3. 20.435 (4) (jw) of the statutes is amended to read:

20.435 **(4)** (jw) *BadgerCare Plus, hospital assessment, and pharmacy benefits purchasing pool administrative costs.* All moneys received from payment of enrollment fees under the program under s. 49.45 (23)<u>, 2011 stats.</u>, all moneys transferred under s. 50.38 (9), all moneys transferred from the appropriation account under par. (jz), and 10 percent of all moneys received from penalty assessments under s. 49.471 (9) (c), for administration of the program under s. 49.45 (23)<u>, 2011</u>

stats., to provide a portion of the state share of administrative costs for the BadgerCare Plus Medical Assistance program under s. 49.471, for administration of the hospital assessment under s. 50.38, and to administer a contract with an entity to operate the pharmacy benefits purchasing pool under s. 146.45.

SECTION 4. 25.77 (2) of the statutes is amended to read:

25.77 **(2)** All public funds that are related to payments under s. 49.45 and that are transferred or certified under 42 CFR 433.51 (b) and used as the nonfederal and federal share of Medical Assistance funding, except funds that are deposited into the appropriation accounts under s. 20.435 (4) ~~(h),~~ (kx)~~,~~ or (ky).

SECTION 5. 49.45 (23) of the statutes is repealed.

SECTION 6. 49.45 (59) (b) of the statutes is amended to read:

49.45 **(59)** (b) Health maintenance organizations shall pay all of the moneys they receive under par. (a) to eligible hospitals, as defined in s. 50.38 (1), within 15 days after receiving the moneys. The department shall specify in contracts with health maintenance organizations to provide medical assistance a method that health maintenance organizations shall use to allocate the amounts received under par. (a) among eligible hospitals based on the number of discharges from inpatient stays and the number of outpatient visits for which the health maintenance organization paid such a hospital in the previous month for enrollees who are recipients of medical assistance~~, except enrollees who receive medical assistance under s. 49.45 (23)~~. Payments under this paragraph shall be in addition to any amount that a health maintenance organization is required by agreement between the health maintenance organization and a hospital to pay the hospital for providing services to the health maintenance organization's enrollees.

SECTION 7. 49.471 (1) (cr) of the statutes is created to read:

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

SECTION 8. 49.471 (4) (b) 5. of the statutes is created to read:

49.471 **(4)** (b) 5. Subject to sub. (4m), an adult who is under 65 years of age; who is not pregnant; who is not otherwise eligible for Medical Assistance under par. (a) or (b) 1. to 4. or s. 49.46 (1); and whose income, as determined under the method described in 42 USC 1396a (e) (14), does not exceed 133 percent of the poverty line for a family the size of the individual's family.

SECTION 9. 49.471 (4m) of the statutes is created to read:

49.471 **(4m)** MEDICAID EXPANSION. For services provided to individuals described under sub. (4) (b) 5., the department shall comply with all federal requirements to qualify for the highest available enhanced federal medical assistance percentage. The department shall submit any amendment to the state medical assistance plan, request for a waiver of federal Medicaid law, or other approval required by the federal government to provide services to the individuals described under sub. (4) (b) 5. and qualify for the highest available enhanced federal medical assistance percentage.

SECTION 10. 49.471 (11) (intro.) of the statutes is amended to read:

49.471 **(11)** BENCHMARK PLAN BENEFITS AND COPAYMENTS. (intro.) ~~Recipients~~ Subject to sub. (11g), recipients who are not eligible for the benefits described in s. 49.46 (2) (a) and (b) shall have coverage of the following benefits and pay the following copayments:

SECTION 11. 49.471 (11g) of the statutes is created to read:

49.471 **(11g)** MEDICAID EXPANSION BENCHMARK COVERAGE. (a) If, to obtain an enhanced federal medical assistance percentage, the federal department of health

and human services prohibits charging of a copayment or premium to an individual described under sub (4) (b) 5., the department may not charge the copayments described under sub. (11) or a premium that would disqualify the department from obtaining an enhanced federal medical assistance percentage.

(b) If the federal department of health and human services determines that the benefits provided under sub. (11) are not sufficient to qualify the department to obtain an enhanced federal medical assistance percentage for benefits provided to individuals described under sub. (4) (b) 5., the department shall provide any benchmark coverage or benchmark equivalent coverage that complies with 42 USC 1396u–7 to qualify to obtain the highest available enhanced federal medical assistance percentage.

(c) Notwithstanding sub. (13), the department may not create a policy under s. 49.45 (2m) (c) that affects the eligibility or benefits of the individuals described under sub. (4) (b) 5. such that the department fails to obtain an enhanced federal medical assistance percentage.

SECTION 12. 49.471 (11g) (c) of the statutes, as created by 2013 Wisconsin Act .... (this act), is repealed.

SECTION 13. 49.67 of the statutes is repealed.

SECTION 14. 49.686 (3) (d) of the statutes is amended to read:

49.686 **(3)** (d) Has applied for coverage under and has been denied eligibility for medical assistance within 12 months prior to application for reimbursement under sub. (2). This paragraph does not apply to an individual who is eligible for benefits under ~~the demonstration project for childless adults under s. 49.45 (23) or to an individual who is eligible for benefits under~~ BadgerCare Plus under s. 49.471 (11).

SECTION 15. 149.12 (2) (f) 2. g. of the statutes is repealed.

SECTION 16. 227.01 (13) (ur) of the statutes is repealed.

SECTION 17. 227.42 (7) of the statutes is repealed.

SECTION 18. Effective dates. This act takes effect on January 1, 2014, except as follows:

(1) The repeal of section 49.471 (11g) (c) of the statutes takes effect on January 1, 2015.

(END)