03-021 HFS 102

Clearinghouse Rule 03-021

PROPOSED ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING AND CREATING RULES

The Wisconsin Department of Health and Family Services proposes an order to amend ss. HFS 102.01 (5) (e) and (6), 102.04 (3) (c), 103.01 (1) (a), 103.03 (1) (title) and (a), (8) and (9), 103.08 (1), 103.11 (title) and (1) (intro) and 104.02 (7), and to create ss. HFS 101.03 (63m), 103.03 (1) (i), 103.04 (10) and (11), 103.08 (6), 103.089, 103.11 (3) and 107.21 (4), relating to the Department's operation of the Family Planning Demonstration Project.

Analysis Prepared by the Department of Health and Family Services

Section 49.45 (24r) of the Wisconsin statutes, which took effect on October 14, 1997, directed the Department to request a federal waiver of certain requirements of the federal Medicaid Program to permit the Department to implement the Family Planning Demonstration Project not later than July 1, 1998, or the effective date of the waiver, whichever date was later. On June 25, 1999, the Department submitted a request for a waiver of federal law to the Centers for Medicare and Medicaid Services (CMS), the agency within the United States Department of Health and Human Services that controls states' use of Medicaid funds. On June 14, 2002, the Centers for Medicaid and Medicare granted the waiver, effective January 1, 2003. The waiver allows the state to expand Medicaid services by providing coverage of family planning services for females of child-bearing age who would not otherwise be eligible for Medicaid coverage. Under the waiver, a woman of child-bearing age whose income does not exceed 185% of the federal poverty line will be eligible for most of the family planning services currently available under Medicaid, as described in s. HFS 107.21.

Upon approval of the waiver in 2002, the Department began developing policies for the project and subsequently administrative rules, which were necessary and had to be in effect before the program began. The Department issued an emergency rulemaking order containing identical rules on January 30, 2003. The rules took effect on January 31, 2003. In promulgating the rules on an emergency basis, the Department has been able to provide health care coverage already authorized by CMS as quickly as possible to women currently not receiving family planning services and unable to pay for them.

Through this expansion of coverage, implemented initially by emergency rules and permanently through this rulemaking order, the Department hopes to reduce the number of unwanted pregnancies in Wisconsin.

The Department's authority to amend and create these rules is found under ss. 49.45 (10) and 227.11 (2), Stats. The rules interpret s. 49.45 (24r), Stats.

SECTION 1. HFS 101.03 (63m) is created to read:

HFS 101.03 (63m) "Family planning demonstration project" means the medical assistance waiver program approved by the federal centers for medicare and medicaid services to provide family planning services to women of child-bearing age who are not otherwise eligible for and receiving medical assistance benefits which would include family planning services.

SECTION 2. HFS 102.01 (5) (e) and (6) are amended to read:

HFS 102.01 (5) (e) When a ~~child~~person is under the age of 18 and is a parent or is pregnant, but is not married and is not under the care of a relative as specified in s. 49.19 (1) (a), Stats., the agency shall determine individually the eligibility of the ~~child~~person. When a person applies solely for benefits under the family planning demonstration project, the department shall determine the eligibility of the person without regard to the person's parent or parents.

(6) PROVIDING CORRECT AND TRUTHFUL INFORMATION. The applicant, recipient, or person described in sub. (7) who is acting on behalf of the applicant or recipient is responsible for providing to the agency, the department or the department's delegated agent, full, correct and truthful information necessary for eligibility determination or redetermination and for disclosing assets which the agency determines may affect the applicant's or recipient's eligibility, including but not limited to health insurance policies or other health care plans and claims or courses of action against other parties on the part of the applicant or recipient. Changes in income, assets or other circumstances which may affect eligibility shall be reported to the agency within 10 days of the change, except that changes in household income will not have to be reported for persons receiving benefits under the family planning demonstration project.

SECTION 3. HFS 102.04 (3) (c) is amended to read:

HFS 102.04 (3) (c) Within 12 months after the date initial eligibility is determined for AFDC-related persons and persons eligible for BadgerCare or for the family planning demonstration project;

SECTION 4. HFS 103.01 (1) (a) is amended to read:

HFS 103.01 Introduction. (1) PERSONS ELIGIBLE. (a) Eligibility for medical assistance (MA) shall be determined pursuant to ss. 49.45 (24r), 49.455, 49.46 (1), 49.47 (4), 49.472 and 49.665, Stats., and this chapter, except that MA shall be provided without eligibility determination to persons receiving SSI or those persons who would currently be eligible under the AFDC program that was in place on July 16, 1996 in this state pursuant to s. 49.19, Stats.

SECTION 5. HFS 103.03 (1) (title) and (a) are amended to read:

HFS 103.03 (1) AFDC-RELATEDNESS, SSI-RELATEDNESS, ~~OR~~ BADGERCARE ELIGIBILITY OR FAMILY PLANNING WAIVER. (a) *Requirement.* To be non-financially eligible for MA, an applicant shall be AFDC-related, SSI-related or meet the non-financial requirements under par. (f) for BadgerCare, or par. (i) for the family planning demonstration project for as long as the waiver is in effect.

SECTION 6. HFS 103.03 (1) (i) is created to read:

HFS 103.03 (1) (i) *Family planning demonstration project non-financial eligibility.* To be non-financially eligible for the family planning demonstration project, a person shall:

1. Be a woman at least 15 years old and no older than 44 years.

2. Not be receiving Medicaid, unless the person is eligible for medical assistance under s. 49.46 (1) (a) 15. or 49.468, Stats.

3. Meet the other non-financial criteria in subs. (2) through (7).

4. Cooperate with providing information to assist in pursuing third parties who may be liable to pay for services covered under medical assistance as required under 42 CFR 433.147, except for persons receiving medical assistance benefits only under the family planning demonstration project.

SECTION 7. HFS 103.03 (8) and (9) are amended to read:

HFS 103.03 (8) NOT AN INELIGIBLE CARETAKER RELATIVE. A caretaker relative enumerated in s. 49.19 (1) (a), Stats., with whom a dependent child as defined in s. 49.19 (1) (a), Stats., is living when the income and resources of the MA group or fiscal test group exceed the limitations of ss. 49.19 and 49.77, Stats., or title XVI of the social security act of 1935, as amended, is not eligible unless the caretaker relative is SSI-related in accordance with sub. (1) (c), ~~or~~ is a woman who is medically verified to be pregnant, or is eligible for services under the family planning demonstration project under s. 49.45 (24r), Stats.

(9) NOT A STRIKER. A person on strike is not eligible. When the striker is a caretaker relative, all members of the MA group who are 18 years of age or older shall be ineligible except that if the member of the MA group who is on strike is medically verified as pregnant or, if the MA group includes a medically verified pregnant woman, the pregnant woman continues to be eligible during her pregnancy and through the month in which the 60th day following the end of pregnancy falls or is eligible for services under the family planning demonstration project under s. 49.45 (24r), Stats. In this subsection, "striker" means anyone who on the last day of the month is involved in a strike or a concerted effort with other employees to stop work, including a stoppage of work due to the expiration of a collective bargaining agreement, or any concerted slowdown or other concerted interruption of operations by employees.

SECTION 8. HFS 103.04 (10) and (11) are created to read:

HFS 103.04 (10) FAMILY PLANNING DEMONSTRATION PROJECT. (a) A person that meets the requirements of s. HFS 103.03 (1) (i) and (2) to (7) and the income limits of par. (b) or (c) or the criteria under par. (d) is eligible for the family planning services demonstration project.

(b) The income for a family planning demonstration project fiscal test group may be no greater than 185% of the poverty line for a family the size of the group.

(c) The income for a family planning demonstration project family fiscal unit may be no greater than an amount based on 185% of the poverty line for a family the size of the family fiscal unit, or a prorated amount based on criteria in sub. (11) (e).

(d) Women who lose eligibility for medical assistance within 90 days of the end of their pregnancy are financially eligible for the family planning demonstration project for the 12 calendar months following the end of their eligibility for pregnancy-related medical assistance regardless of their income.

(11) FAMILY PLANNING DEMONSTRATION PROJECT BUDGETING PROCEDURES. (a) *Initial and subsequent determination*. To determine whether a person meets the income limits in sub. (10), the net income of the members of the fiscal test group described in par. (b) will first be compared to the income limit in sub. (10) (b). If the net income of the fiscal test group exceeds the limit, the net income of the family fiscal unit described in par. (c) will also be compared to the income limit in sub. (10) (c).

(b) *Family planning demonstration project fiscal test group*. Except for SSI recipients, the following shall be included in the fiscal test group:

1. The applicant.

2. The applicant's spouse who resides in the home with the applicant.

3. Natural or adoptive children under age 18 of the applicant who reside in the home with the applicant.

4. A fetus the applicant or a child specified in subd. 3. has been medically verified as carrying.

(c) *Family planning demonstration project family fiscal unit*. The family fiscal unit shall include all of the following:

1. The applicant.

2. The applicant's spouse who is residing in the home with the applicant, unless the spouse is an SSI recipient.

3. A fetus the applicant has been medically verified as carrying.

(d) *Inclusion of net income*. After applying the income disregards and deductions found in s. HFS 103.07 (2) and (3) to the gross income, the net income of anyone included in the fiscal test group in par. (b) or in the family fiscal unit in par. (c) will be included when determining the financial eligibility of the applicant after applying the income disregards and deductions found in s. HFS 103.07 (2) and (3) to the gross income.

(e) *Family fiscal unit budgeting procedures*. 1. The amount of the applicant's net income determined in par. (d) counted in determining financial eligibility for the family planning demonstration project shall be divided by the number of persons living in the home for whom the applicant is financially responsible in accordance with s. 49.90 (1m), Stats., including the applicant.

2. The amount of net income determined in par. (d) of an applicant's spouse, who is in the family fiscal unit, counted in determining the financial eligibility of the applicant shall be divided by the number of persons living in the home for whom the spouse is financially responsible in accordance with s. 49.90 (1m), Stats., including the spouse.

3. Financial eligibility is determined using the following process:

a. Start with the amount that is 185% of the poverty line for a family the size of the applicant's family fiscal unit.

b. Multiply the amount in subd. 3. a. by the total of the number of fetuses in par. (c) 3. plus one.

c. Divide the amount in subd. 3. b. by the total number in the family fiscal unit. The result is the income limit for this family fiscal unit.

d. The total of the income amounts derived from subds. 1. and 2. shall be less than or equal to the income limit from subd. 3. c., for the applicant to be considered to have met the income limit in sub. (10) (c).

SECTION 9. HFS 103.08 (1) is amended to read:

HFS 103.08 Beginning of eligibility. (1) DATE. Except as provided in subs. (2) to ~~(5)~~(6), eligibility shall begin on the date on which all eligibility requirements were met, but no earlier than the first day of the month 3 months prior to the month of application. Retroactive eligibility ~~of up to 3 months~~for any of the 3 previous months may occur even though the applicant is found ineligible in the month of application.

SECTION 10. HFS 103.08 (6) is created to read:

HFS 103.08 (6) FAMILY PLANNING DEMONSTRATION PROJECT. Eligibility for the family planning demonstration project shall begin on the first day of the month in which all eligibility requirements are met, but no earlier than the first day of the month of application.

SECTION 11. HFS 103.089 is created to read:

HFS 103.089 Conditions for continuation of eligibility under family planning demonstration project. (1) Changes in income or in the size of the fiscal test group or family fiscal unit that result in the income exceeding the project's income limit shall not affect the recipient's eligibility for the remainder of the 12-month certification period.

(2) Notwithstanding sub. (1), eligibility for the family planning demonstration project shall terminate when the recipient no longer meets the non-financial eligibility requirements under s. HFS 103.03 (1) (i).

(3) When eligibility is reviewed at the end of the 12-month certification period, the recipient shall meet the requirements under s. HFS 103.04 (10) for eligibility under the family planning demonstration project to continue.

SECTION 12. HFS 103.11 (title) and (1) (intro) are amended to read:

~~HFS 103.11 Presumptive eligibility for pregnant women.~~ (1) REQUIREMENTS. Pregnant women may be determined presumptively eligible for MA on the basis of verification of pregnancy and preliminary information about family income. Women also may be determined presumptively eligible under the family planning demonstration project. That determination shall be made by providers designated by the department who are qualified in accordance with this section. A provider qualified to make determinations of presumptive eligibility for pregnant women shall meet the following requirements:

SECTION 13. HFS 103.11 (3) is created to read:

HFS 103.11 (3) PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING DEMONSTRATION PROJECT. (a) Women may become eligible for the family planning demonstration project initially through presumptive eligibility determined by a certified MA provider who the department determines to be qualified and is any of the following:

1. A service provider under sub. (1) (b).

2. A family planning clinic or agency under s. HFS 105.36.

(b) A qualified provider shall determine presumptive eligibility on the basis of preliminary information that:

1. The woman is 15 years of age or older and under age 45.

2. The woman is a Wisconsin resident.

3. The woman is a citizen of the U.S.

4. The woman is not a recipient of presumptive eligibility under this subsection during the 12 months preceding the date of application.

5. The woman is not otherwise receiving MA.

6. The woman's family income meets the applicable income limits.

(c) A woman may qualify for no more than one period of presumptive eligibility under this subsection per 12-month period. The presumptive eligibility period will extend from the date a qualified provider determines presumptive eligibility to the last day of the second calendar month following the date the provider makes the determination.

(d) The provider shall inform the woman, in writing, of the determination of presumptive eligibility and that if she fails to file an application for MA eligibility with the agency in the county in which the woman resides by the last day of the second calendar month following the month of the presumptive eligibility determination, her presumptive eligibility will end no later than that day.

(e) In the event that the provider determines that a woman is not presumptively eligible, the provider shall inform her that she may file an application for MA eligibility at the agency in the county in which she resides.

SECTION 14. HFS 104.02 (7) is amended to read:

HFS 104.02 (7) FINANCIAL RESPONSIBILITY OF SPOUSE OR RESPONSIBLE RELATIVE. Within the limitations provided by s. 49.90, Stats., and this chapter, the spouse of an applicant of any age or the parent of an applicant under 18 years of age, except for the parent of an applicant under 18 years of age when that applicant is eligible for services under the family planning demonstration project, shall be charged with the cost of medical services before MA payments shall be made. However, eligibility may not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the agency determines that a responsible relative is able to contribute without undue hardship to self or immediate family but refuses to contribute, the agency shall exhaust all available administrative procedures to obtain that relative's contribution. If the responsible relative fails to contribute support after the agency notifies the relative of the obligation to do so, the agency shall notify the district attorney in order to commence legal action against that relative.

SECTION 15. HFS 107.21 (4) is created to read:

HFS 107.21 (4) SERVICES UNDER THE FAMILY PLANNING DEMONSTRATION PROJECT. (a) Except as provided in par. (b), the services identified in this section are covered for

persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats., to the same extent and subject to the same conditions and limitations as specified in this section.

(b) A laboratory and other other diagnostic service under s. HFS 107.21 (1) (c) is covered for persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats., only if the primary purpose of the office visit is contraceptive management.

(c) The following services not otherwise identified under this section are covered for persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats.:

1. Specialized motor vehicle services, as described in and subject to the restrictions under s. HFS 107.23 (1) (c).

2. Common carrier transportation services, as described in and subject to the restrictions under s. HFS 107.23 (1) (d).

3. Other than for the treatment of acquired immune deficiency syndrome, contraceptives and prescription drugs for sexually-transmitted diseases under s. HFS 107.10 (1).

4. The intramuscular injection of an antibiotic.

Note: Recipients of benefits under both the family planning demonstration project and the tuberculosis services benefit may receive medications, procedures, services and supplies relating to tuberculosis treatment.

The rule shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22 (2), Stats.

Wisconsin Department of Health
and Family Services

Dated:

By: _____
Helene Nelson
Secretary

SEAL:

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Fiscal Estimate — 2001 Session

☒ Original ☐ Updated	LRB Number	Amendment Number if Applicable
☐ Corrected ☐ Supplemental	Bill Number	Administrative Rule Number HFS 101 to 104 and 107

Subject

Family planning waiver.

Fiscal Effect

State: ☐ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☒ Increase Costs — May be possible to absorb within agency's budget. ☒ Yes ☐ No

☐ Decrease Costs

Local: ☒ No Local Government Costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others ☐ School Districts ☐ WTCS Districts

Fund Sources Affected: ☒ GPR ☒ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations: 20.435(4)(b) and 20.435(4)(o)

Assumptions Used in Arriving at Fiscal Estimate

The administrative rule would allow the implementation of a Medicaid expansion of family planning services to single women aged 15 to 44 that have annual incomes below 185% of the federal poverty level. As directed by statute, the Department applied and received federal approval for this expansion of MA eligibility.

Currently, Medicaid and BadgerCare cover women below 185% of the federal poverty level who are either pregnant or have children. However, low-income women without children are not eligible for Medicaid or BadgerCare. Low-income women who do not qualify for these programs are unlikely to have either employer-provided insurance coverage, or sufficient personal funds to purchase family planning and reproductive health services in the private sector. They are therefore at a higher risk of unintended pregnancy. If a woman with an income below 185% federal poverty level becomes pregnant, Medicaid or BadgerCare would pay for birth costs, first year costs of the child, and other costs for the child and mother.

The family planning waiver is a five-year demonstration project that will provide family planning services and ancillary family planning services, on a fee-for-service basis, to any woman between the ages of 15 and 44 whose family income does not exceed 185% of the federal poverty level. Funding for the family planning services will be funded 90% FED and 10% GPR. Funding for covered ancillary family planning services will be funded at the Medicaid matching rate.

By preventing unintended pregnancies and therefore preventing low-income women from becoming eligible for Medicaid or BadgerCare, the cost to Medicaid and BadgerCare is reduced. In the first three years years of operation, it is projected that the cost of providing the family planning services will exceed the savings. However, over the five-year period, allowing low-income women access to family planing services, will save BadgerCare and Medicaid $8,897,500 AF ($1,557,100 GPR). The net cost is $742,100 AF ($129,900 GPR) in FY03; $1,638,100 AF ($286,700 GPR) in FY04; and $1,786,000 AF ($312,500 GPR) in FY05. Projected costs for FY04 and FY05 were included in the Departments's 03-05 biennial budget request for the MA Benefits Re-estimate item. It is estimated that enrollment at the end of the five year demonstration period will reach approximately 47,000 women.

Long-Range Fiscal Implications

Over a five year period the family planning waiver program is projected to save the Wisconsin Medicaid program $8,897,500.

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Authorized Signature	Telephone No.	Date (mm/dd/ccyy)
		01/30/03

TESTIMONY ON THE ADMINISTRATIVE RULE

My name is Jeffrey Jones, I am a physician infectious diseases specialist with a Ph.D. in Microbiology, a Professor of Medicine at UW Medical School and Chief of Staff at the VA Hospital in Madison. For the past 8 years, I have volunteered to talk to teens about STD's, giving a strong abstinence message, and having reached at least 25,000 teens. I come to you today as Vice President of the Wisconsin Physicians Resource Council and a member of the Physicians Consortium, two groups interested in providing medical information important to the family.

I come to testify against the rule and in favor of restriction of the provision of contraceptives to minors. In particular I find the lack of any provision for parental consent to be a very troubling feature of this rule.

Many say the problem confronting us with 15-19 year old teens today are the twin epidemics of out of wedlock pregnancy and STD's. In fact these are outcomes of the real problem, which is enhanced sexual activity among teens. Americans are in love with technology. Unfortunately, until the late 1980's to early 1990's, we have attempted to fix a behavioral problem with technical bandaides, and it did not work.

This problem is overwhelmingly due to what teens see the adults in their lives telling them with respect to sexual activity. This has to do with the messages advertising and news media, parents, medical professionals, public officials, and public policy give them about what the limits of sexual activity should be.

With the licensing of the oral contraceptive in 1960, opinion makers began to say that sex could be recreational. In the late 1960's and early1970's, the youth protest against the Vietnam War and Roe vs. Wade fostered a focus upon individual autonomy rather than social responsibility among baby boomers, which soon found its way into public policy and was an overpowering stimulus to heightened sexual activity in teens that produced the twin outcomes of unwanted pregnancies and STD's. The rise in unwed births rose precipitously after 1960, and reflects a sea change in sexual behavior.

For example, Klick and Stratmann of George Mason University showed a steady increase in rates of gonorrhea and other STD's associated with legalization of abortion; moreover, the rate of rise of gonorrhea was significantly higher in states that were early legalizers. Public policy does influence choices people make with respect to the decision to be sexually active.

Title X funding for contraceptive services increased dramatically between 1972 and 1980. In spite of this teen birth rate increased 16% while abortion rates soared. Through the early 1980's the main impact of Title X was on birth prevention as opposed to pregnancy prevention.

In the early 1980's, AIDS became a reality. This vitalized the abstinence movement in the United States. Among those interested in teen contraception, there was a shift away from oral contraceptives towards condoms. Yet we know that condoms have a high failure rate in pregnancy prevention for teens. The overall effect of encouraging condom reliance for sexually active teens was a decrease in contraceptive efficacy as oral contraceptives were used less. News for use of the condom in preventing spread of STD's also was not good. By 2001, a NIH consensus panel concluded that for 8 STD's examined, the consistent condom use was highly effective in preventing spread of 1 and a half—HIV and gonorrhea in males. For other STD's the published data was muddy, and for HPV, the cause of cervical cancer, it was difficult to argue the condom provided any meaningful protection. We have become much less sanguine about the benefits of condoms for teens.

In 1991, teen pregnancy rates peaked and then had begun a decline by 1995. In 1999, I was coauthor of a Physicians Consortium analysis showing that the decline was due principally to decreased sexual activity among teens. We concluded that the birth rate among unwed sexually experienced teens was actually increasing, and increased promotion of the condom might actually be contributing to this change.

Alan Guttmacher Institute published a rejoinder to this, saying that it was increased use of implantable/injectable contraception and condom use which was related to the decreased pregnancy rate and that this plus increased condom use accounted for 75% of the decrease in pregnancy rates. They did not describe the precise methodology used in reaching this conclusion and their paper was reviewed only internally by Guttmacher staff. The Guttmacher rejoinder ignored the decrease in oral contraceptive use and the decreased contraceptive efficacy of the condom, the predominant form of contraception being used by teens. Available data show that at most, about 7% of sexually active teens were using injectables or implantables by 1995, which would not impact enough to explain the fall in pregnancy when one looks at the decline in oral contraceptive use and the increase condom use.

This month, Mohn , Tingle, and Finger published an externally peer reviewed article in Adolescent and Family Health [2003, 3(1): 39-47], concluding that between 1991 and 1995 the increase in the proportion of teen girls who did not have sex the previous year accounted for 51.3% of the decline in overall birth rate to 15-19 yr old girls while the decrease in birthrate to those teens who were married contributed 43 percent of the decline in the overall birthrate to 15-19 yr old girls. A decrease in the proportion of teen girls who were married contributed 57.4% of the decline in overall birthrate. Birthrate to sexually active single girls actually increased, contributing a negative 47.3 percent to the change in birthrate to all teen girls between 1991 and 1995. Two thirds of the decrease in teen pregnancy rates of single girls was attributable to abstinence

In other words, given proper encouragement, teens can refrain from having sex. Between 1991 and 2001, the number of high school students in Wisconsin who had sexual intercourse fell from 47 to 39%. With 41,000 teens, this 8% decline meant 3,280 teens removed from the risk pool for pregnancy or STD's.

PROBLEMS WITH PROVISION OF CONTRACEPTIVE SERVICES TO MINORS

There are those who believe we must open the gates wide to the provision of contraceptive services to unwed teens. The main problem with this approach is that it ignores the difficulties teens have in making use of contraceptives and potential long term consequences.

- Multiple studies show that for teens, consistent, correct use 100% of the time simply does not occur. Studies of interventions either show some improvement in use of the condom at last intercourse, seldom exceeding 60%, or minimum effects. Condom fatigue is a real problem among experienced teens, particularly those with serial partners.
- Multiple studies have shown that for an unwed 15-19 yr old choosing the condom for contraception, the likelihood of pregnancy during the first year of this behavior is roughly 1 in 6.
- As was noted above, the efficacy of the condom in preventing the transmission of the largest STD epidemics affecting teens, Chlamydia and HPV, have been grossly overrated. The biology of these infections and the inherent difficulties teens have with compliance combine to make it very unlike the condom will make an impact. In fact we know that the relative risk for HPV among condom users exceeds 100% in some studies because of the increased number of sexual partners. Chlamydia is the leading preventable cause of female sterility in the United States and HPV is the cause of cervical cancer.
- It is argued that access to family planning will allow girls to get access to injectables or implantables, thus assuring effective contraception. But this argument ignores important facts. First, use of these drugs will virtually guarantee very low condom use, so that any protection offered here against STD's, and HIV in particular will be lost. Second, there may be long term consequences from use of these hormonal agents. For example, depo-medroxyprogesterone produced bone density loss in adolescents, which required nearly 30 months to return to normal. A recent review of 28 studies involving 12,500 women in Lancet (2003;361:1159-1167) showed that use of oral contraceptives increased risk for cervical cancer developing after HPV infection and the risk increased with the total duration of use.
- Surveys of teens are cited where teens state they would be less likely to seek contraceptive services if parental notification occurred. A basic assumption here is that teens would be sexually active anyway and they are being denied contraception. This argument is a hard sell, given the availability of condoms for sale in pharmacies and grocery stores. Those citing such surveys ignore other survey results regarding teen intentions. For example Schuster et al. (Fam

Planning Perspectives 1998; 30:67-72) found teens agreeing at a level of nearly 4 (on a 5 point scale) that "having condoms with you makes it more likely that you will decide to have vaginal intercourse." The teens also agreed substantially with the statement, "people my age should not be having vaginal intercourse."

THE NEGATIVE IMPACTS OF LACK OF PARENTAL CONSENT

At a minimum, I think that parental consent for contraceptive services is needed for the following reasons:

- Parental notification and consent will stimulate parents to engage teens about the advisability of not being sexually active. It would provide an opportunity for health care workers to work with parents in encouraging teens not to be sexually active. It would assure that more complete information about the limitations of all contraceptive approaches would be provided to teens and their families.

- Parental advice regarding teen sexual activity remains a potent means of shaping teen sexual behavior. The HARMS study of 1997 (Resnick et al., JAMA 1997;278:823) studied factors predicting presence or absence of sexual activity in 12,118 adolescents. Factors were corrected for race and socioeconomics. It found that parent-family connectedness, parental disapproval of adolescent sex, and parental disapproval of adolescent contraception were highly correlated with postponement of sexual activity. This fits with what we know about prevention of alcohol, drug, and tobacco abuse by teens. Ellen et al. (Sexually Transmitted Diseases 2001; 28: 533-534) found delay in onset of intercourse for girls from families with reported "moral-religious emphasis" and with more "direct parental monitoring." Making contraceptive services available to teens without a possibility of parental involvement removes this potent family influence from the picture.

- Other evidence points towards parental involvement in influencing sexual behavior among teens. Abortion rates in states with parental consent laws are a surrogate for this. Abortion rates in states with consent laws declined an average of 55% between 1990 and 1999, rates for notice law states declined 31%, and 18% in no law states.

- Nearly 40 years into the twin outcome epidemics of pregnancy and STD's in teens one can still assert that the biggest impact on diminishing pregnancy rates in unwed teens has been through abstinence.

- There is no good evidence that school based clinics produce meaningful changes in percentages of teens engaging in sex or in truly consistent condom use. One can site studies by Kirby of St Paul, MN schools from 1971-1986 (Fam Plan Perspect 1992; 25:12-16), and of Philadelphia schools in late 1980's (Furstenberg et al. Fam Plan Perspect 1997; 29:123).

- Paton recently reported a British study in Journal of Health Economics (2002;21:27-45) indicating that when a cohort of teens with universal access to family planning was compared with a cohort where access was restricted, there was no evidence that provision of family planning reduces either underage conception or abortion rates. Their models projected that an increased decision to have sex by teens associated with provision of family planning appeared to cancel any benefits obtained.

- Averett et al. (American Journal of Public Health 2002; 92:1773-1778) reported that girls in areas with greater family planning services were more likely to use contraception to some extent, but neighborhood environment was a stronger influence over sexual behavior than any government policy they studied.

- Resnick recently reported (March 2003) that 71% of parents surveyed over 1,000 parents in Minnesota and Wisconsin believed a mandatory parental notification policy, including a 5-day delay for access to contraception was reasonable. 2/3rds were unaware teens can give consent for STD treatment or contraception without parental involvement. Parents commented they thought changing laws would have positive consequences—namely teens would decide not to have sex.

SUMMARY

The history of the sexual revolution in the United States shows that teens will set limits to sexual behavior based upon the messages and standards they are given by responsible adults. Unfortunately, the messages they received from the mid-1960's through the end of the 1980's floated prepominantly towards a permissive one. The stimuli provided by society, including public policy, which see sex as inevitable among teens and foster access to contraceptives without input from the family have and will heighten sexual activity among teens if not reined in. Permissiveness carries over into what happens when a teen encounters a physician or nurse practitioner. Without some brake assuring family involvement, the conversation will inevitably turn to use of a technology. This will be the course of least resistance for a practitioner and it will give the inevitable message that the teen should go ahead and be sexually active.

Chapter HFS 103

ELIGIBILITY

Note: Chapter HSS 103 as it existed on February 28, 1986, was repealed and a new chapter HSS 103 was created effective March 1, 1986. Chapter HSS 103 was renumbered Chapter HFS 103 under s. 13.93, Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, January, 1997, No. 493.

HFS 103.01 Introduction. (1) PERSONS ELIGIBLE. (a) Eligibility for medical assistance shall be determined pursuant to ss. 49.455, 49.46 (1), 49.47 (4) and 49.472, Stats., and this chapter, except that medical assistance shall be provided without eligibility determination to persons receiving SSI or those persons who would currently be eligible under the AFDC program that was in place on July 16, 1996 in this state pursuant to s. 49.19, Stats.

(b) Presumptive eligibility for pregnant women shall be determined under s. 49.465, Stats., and this chapter.

(2) SINGULAR ENROLLMENT. No person may be certified eligible in more than one MA case.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; renum. (1) to be (1) (a) and cr. (1) (b), Register, February, 1988, No. 386, eff. 3–1–88; am. (1) (a), Register, March, 1993, No. 447, eff. 4–1–93; emerg. am. (1) (a), eff. 7–1–99; am. (1) (a), Register, March, 2000, No. 531, eff. 4–1–00; am. (1) (a), Register, November, 2000, No. 539, eff. 12–1–00.

HFS 103.03 Non–financial conditions for eligibility. In order to be eligible for MA, a person shall meet both non–financial conditions for eligibility in this section and financial conditions for eligibility under s. HFS 103.04. The non–financial conditions for eligibility are:

(1) AFDC–RELATEDNESS, SSI–RELATEDNESS OR BADGERCARE ELIGIBILITY. (a) *Requirement.* To be non–financially eligible for MA, an applicant shall be AFDC–related, SSI–related or meet the non–financial requirements under par. (f) for BadgerCare.

(b) *AFDC–related persons.* In this subsection, "AFDC–related" means a person who meets one of the following conditions:

1. The person is pregnant and meets the conditions specified in s. 49.46 (1) (a) 1m. or 9., 49.465 or 49.47 (4) (ag) 2. or (am) 1., Stats.;

2. The person is a dependent child as defined in s. 49.19 (1) (a), Stats., or is a child who meets the conditions specified in s. 49.46 (1) (a) 10. or 49.47 (4) (a) 1. or (am) 2., Stats.;

3. The person is a caretaker relative; or

4. The person is a foster child under 19 years of age living in a foster home licensed under s. 48.62, Stats., or a group home licensed under s. 48.625, Stats., or is a child in an adoption assistance placement under s. 48.975, Stats.

(c) *SSI–related persons.* In this subsection, "SSI–related person" means a person who meets one of the following conditions:

1. The person is age 65 or over; or

2. The person is blind or disabled.

(d) *Verification of blindness or disability.* Except as provided under par. (e), the blindness or disability claimed under par. (c) 2. shall be verified in one of the following ways:

1. By presentation of a current old age and survivors disability insurance (OASDI) disability award notice;

2. By presentation of a current medicare card indicating blindness or disability; or

3. By receipt of a disability determination made by the department's bureau of social security disability insurance, along with current medical reports.

(e) *Presumption of disability in an emergency.* 1. Under emergency circumstances, a person may be presumed disabled for purposes of demonstrating SSI–relatedness and be eligible for MA without the verification required under par. (d).

2. When an emergency need for MA exists, the department shall make a preliminary disability determination within 7 days of the date a completed disability determination form is received.

3. An emergency need for MA shall exist when the applicant is:

a. A patient in a hospital;

b. Seriously impaired and the attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months;

c. In need of long–term care and the nursing home will not admit the applicant until MA benefits are in effect; or

d. Unable to return home from a nursing home unless in–home service or equipment is available and this cannot be obtained without MA benefits.

Note: Copies of the disability determination form may be obtained from the county or tribal income maintenance agency.

(f) *BadgerCare eligibility.* To be non–financially eligible for BadgerCare, a person shall meet all of the following conditions:

1. The person is under age 19, a custodial parent living with his or her child who is under age 19 or the spouse of a custodial parent if the spouse resides with the custodial parent's child who is under the age of 19.

2. The person does not have health insurance coverage and has not been covered at any time in the previous 3 calendar months. The 3 calendar month period does not apply if the coverage ended for a good cause reason. A good cause reason is any of the following:

a. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employment ended for a reason other than voluntary termination, except for cases in which the voluntary termination was a result of the incapacitation of the subscriber.

b. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber changed to a new employer who does not offer family coverage.

c. The person was covered by a group health insurance plan that was provided by a subscriber through his or her employer, and the subscriber's employer discontinued health plan coverage for all employees.

d. COBRA continuation coverage was exhausted in accordance with 29 CFR 2590.701–2(4).

e. The person was covered by insurance that has ended due to the death or change in marital status of the subscriber.

f. Any other reason determined by the department to be a good cause reason.

3. The person does not have access to family coverage under a group health insurance plan offered by an employer for which the employer pays 80% of the cost, excluding any deductibles or co–payments that may be required under the plan, or to a state employee health plan through any of the following:

a. The person's employer.

b. The employer of the person's spouse when the spouse is residing with the person.

c. The employer of the person's parent, step–parent or other caretaker relative residing with the person, when the person is under 19 years of age.

4. Except as provided in subd. 5., the applicant for BadgerCare did not at any time in the 18 months immediately preceding application for BadgerCare have access to employer–subsidized health care coverage, or a state employee's health plan. The applicant is ineligible for BadgerCare the first day of the month that the employer's plan would have provided coverage for the recipient if the family had been enrolled in the plan. The applicant remains ineligible for each month that coverage would have been available up to 18 months from the month the failure to enroll in the plan occurred. The insurance the applicant had access to shall have been available only through one of the following:

a. The person's employer.

b. The employer of the person's spouse when the spouse is residing with the person.

c. The employer of the person's parent, step–parent or other caretaker relative residing with the person, when the person is under 19 years of age.

5. The 18 month period in subd. 4. does not apply if one of the following statements is true about access to employer–subsidized health care coverage:

a. The employment ended.

b. The person's employer discontinued health care coverage for all employees.

c. A member or members of the family were eligible for other health insurance coverage or MA at the time the employee failed to enroll in the employer–subsidized health care coverage and no member of the group was eligible for BadgerCare at that time.

d. The person was covered by insurance that has ended due to the death or change in marital status of the subscriber.

e. Any other reason determined by the department to be a good cause reason.

6. The person is not eligible for MA under AFDC–related or SSI–related criteria in this chapter.

7. A person required to pay a premium under s. HFS 103.085(1) has made the first payment.

8. A person has not chosen to receive AFDC–related or SSI–related MA through a spend–down, as described in s. HFS 103.08 (2) (a), or has chosen to end a spend–down period at any time prior to the date at which the expenditure or obligation of excess income has been achieved.

(g) *Medicaid purchase plan non–financial eligibility.* To be non–financially eligible for the medicaid purchase plan a person shall meet the conditions described in par. (c) for SSI–related persons and shall be age 18 or older and the person shall meet any of the following conditions:

1. a. The person shall be employed.

b. The person shall be enrolled in a department–certified health and employment counseling program.

c. The health of the person participating in the medicaid purchase plan for at least 6 months shall have deteriorated to the point that he or she is unable to participate under subd. 1. a. or b. and the county agency has waived the requirement for a period up to 6 calendar months. The county agency may waive the requirement if the person is hospitalized, injured or suffers any other health setback. The county agency may waive the requirement as long as it had not granted a waiver of the requirement twice within the 36 months immediately preceding the current waiver request. The waiver periods shall be non–consecutive. The person shall supply proof of health difficulties. In addition to the discretion the county agency has to grant a waiver, the department may grant a temporary waiver of the work requirement upon a showing of good cause.

2. The person meets SSI–related non–financial eligibility requirements under par. (c) as verified under par. (d) and s. 49.472 (3) (c), Stats.

3. The applicant meets the eligibility requirements described in s. HFS 103.087.

(h) *Medicaid purchase plan health and employment counseling eligibility.* 1. Initial eligibility. To be eligible for the health and employment counseling program within the medicaid purchase plan, a person shall complete an employment plan.

a. The employment plan shall be reviewed by a screening agency and approved by the department before the person receives approval from the department as a participant.

b. The screening agency shall refer the person to community resources as appropriate to meet all employment plan requirements. The screening agency may assist the person in completing the written employment plan or providing any other services required under the plan.

c. A notice of participation status shall be sent by the department to the person, the screener and the appropriate county or tribal economic support office.

2. Period of eligibility. a. A person may participate in a health and employment counseling program for a period of up to nine consecutive calendar months and for any allowable periods of extension described under subd. 3.

b. Upon completion of a period of eligibility, a person shall be ineligible for a health and employment counseling program for a period of 6 consecutive calendar months. Following the 6–month period, a person may begin a new period of eligibility, but a given person may only use 2 periods of eligibility within a period of 5 consecutive calendar years.

c. Participation in a health and employment counseling program approved by the department meets the eligibility requirement in par. (g) 1. b.

3. Extending eligibility. a. If a person is not employed at the end of the period of eligibility, the person may request an extended period of eligibility from the department. The extended period of eligibility shall be valid for a period of three consecutive calendar months.

b. The extended period of eligibility shall be approved by the department.

c. The person may not request more than one extension of eligibility per period of eligibility.

d. After participation in a health and employment counseling [program] ends, a person may continue to receive services from an agency that also provides screening services, in accordance with the agency's rules.

4. Retroactive eligibility. a. A person may request retroactive participation in a health and employment counseling program for a period of up to three months if the person demonstrates he or she met all eligibility requirements of the employment plan during those months.

b. Any retroactive months of eligibility requested by the person shall count toward the period of eligibility as described in this paragraph.

c. The department shall approve requested months of retroactive eligibility.

(2) CITIZENSHIP. U.S. citizenship shall be a requirement for eligibility for MA, except that an alien lawfully admitted for permanent residency may be eligible, including an alien lawfully present in the United States as a result of s. 203 (a) 7. (8. USC 1153), 207 (c) (8. USC 1157), 208 (8 USC 1158) or 212 (d) 5 (8 USC 1182) of the immigration and nationality act, an alien granted lawful temporary resident status under s. 245A (8 USC 1255a), 210 (8 USC 1160) or 210A (8 USC 1161) of the immigration and nationality act or an alien otherwise permanently residing in the United States under color of law within the meaning of 42 CFR 435.408. An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law may not receive medical assistance benefits except as provided under 8 USC 1255a (h) (3) or 42. USC 1396b (v).

(3) WISCONSIN RESIDENCE. (a) *Definitions.* In this subsection:

1. "Incapable of indicating intent" means:

a. The individual's IQ is 49 or less, or the individual has a mental age of 7 or less, based on tests acceptable to the department;

b. The individual is found legally incompetent under guardianship statutes; or

c. Medical documentation or other documentation acceptable to the department supports a finding that the individual is incapable of indicating intent.

2. "Intent to reside" means that a person intends that Wisconsin is the person's place of residence and that the person intends to maintain the residence indefinitely.

3. "Physical presence" means living in Wisconsin.

(b) *Physical presence and intention.* An eligible person shall be a Wisconsin resident, as determined under 42 CFR 435.403. Residence shall be based on physical presence, except as provided in an interstate agreement, and on the person's intent to maintain Wisconsin residence indefinitely, except as otherwise provided in pars. (c) to (g).

(c) *Migrant farm workers.* A migrant farm worker who is living in Wisconsin and who entered with a job commitment or to seek employment shall be considered a resident so long as there is no medical assistance being received from another state. In this paragraph, "migrant farm worker" means any person whose primary employment in Wisconsin is in the agricultural field or cannery work, is authorized to work in the United States, who is not immediate family by blood or marriage of the employer, and routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment. Members of the migrant farm worker's family who live with the worker in Wisconsin shall also be considered Wisconsin residents.

(d) *Non–institutionalized persons.* The residence of a person under age 21 shall be determined in accordance with the rules governing residence under the AFDC program except that non–institutionalized persons under age 21 whose MA eligibility is based on blindness or disability are residents if they are physically present in Wisconsin.

(e) *Institutionalized persons.* 1. For any institutionalized person who is under age 21, or who is age 21 or older and became incapable of indicating intent before age 21, the state of residence is that of:

a. The parents or the legal guardian, if one has been appointed, and parental rights have terminated at the time of placement in an institution; or

b. The parent applying for MA on behalf of the applicant if the parent resides in another state and there is no appointed legal guardian.

2. Institutionalized persons over age 21 are Wisconsin residents when they are physically present with the intent to reside in Wisconsin except that persons who become incapable of indicating intent at or after age 21 are residents of the state in which they are physically present.

(f) *Out–of–state institutional placements.* When a state arranges for a person to be placed in an institution located in another state, the state making the placement is the state of residence irrespective of the person's indicated intent or ability to indicate intent.

(g) *Establishment of residence.* Once established, residence is retained until superseded by a new place of residence.

(4) FURNISHING OF A SOCIAL SECURITY NUMBER. (a) All individuals for whom MA benefits are requested shall have a social security number and shall furnish the number to the agency, except an individual who is one of the following:

1. An alien who is requesting medical assistance only for emergency services; or

2. A child who is eligible for medical assistance under 42 USC 1396a (e) (4). During the time that the child is eligible under 42 USC 1396a (e) (4), the agency shall use the mother's social security number.

(b) If an applicant does not have a social security number, application for the number shall be made by or on behalf of the applicant to the federal social security administration. If there is a refusal to furnish a number or apply for a number, the person for whom there is a refusal is not eligible for MA. The department may not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's social security number.

(5) ASSIGNMENT OF MEDICAL SUPPORT. The parent or caretaker relative of a dependent child enumerated in s. 49.19 (1) (a), Stats., shall be deemed to have assigned all rights to medical support to the state as provided in s. 49.45 (19) (a), Stats. If there is a refusal to make the assignment, the person who refuses is not eligible for MA.

(6) NOT A PERSON DETAINED BY LEGAL PROCESS. A person detained by legal process is not eligible for MA benefits. For purposes of this subsection, "detained by legal process" means incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, and delinquent acts. A person who returns to the court after observation, is found not guilty of a law violation by reason of mental deficiency and is subsequently committed to a mental institution shall not be considered detained by legal process.

(7) NOT A PERSON RESIDING IN AN INSTITUTION FOR MENTAL DISEASES. A person 21 to 64 years of age who resides in an institution for mental diseases (IMD) is not eligible for MA benefits, unless the person is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident of the IMD since then. An IMD resident 21 to 64 years of age may be eligible for MA benefits while on convalescent leave from the IMD.

(8) NOT AN INELIGIBLE CARETAKER RELATIVE. A caretaker relative enumerated in s. 49.19 (1) (a), Stats., with whom a dependent child as defined in s. 49.19 (1) (a), Stats., is living when the income and resources of the MA group or fiscal test group exceed the limitations of ss. 49.19 and 49.77, Stats., or title XVI of the social security act of 1935, as amended, is not eligible unless the caretaker relative is SSI–related in accordance with sub. (1) (c), or is a woman who is medically verified to be pregnant.

(9) NOT A STRIKER. A person on strike is not eligible. When the striker is a caretaker relative, all members of the MA group who are 18 years of age or older shall be ineligible except that if the member of the MA group who is on strike is medically verified pregnant or, if the MA group includes a medically verified pregnant woman, the pregnant woman continues to be eligible during her pregnancy and through the month in which the 60th day following the end of pregnancy falls. In this subsection, "striker" means anyone who on the last day of the month is involved in a

strike or a concerted effort with other employees to stop work, including a stoppage of work due to the expiration of a collective bargaining agreement, or any concerted slowdown or other concerted interruption of operations by employees.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; am. (1) (b) 1., Register, February, 1988, No. 386, eff. 3–1–88; emerg. r. and recr. (7), eff. 8–1–88; r. and recr. (7), Register, December, 1988, No. 396, eff. 1–1–89; emerg. am. (7), eff. 6–1–89; am. (7), Register, February, 1990, No. 410, eff. 3–1–90; am. (1) (b) 1., 2. and 4, (2), (3) (b) and (9), r. and recr. (4), Register, March, 1993, No. 447, eff. 4–1–93; emerg. am. (1) (a) and (b) 3., eff. 7–1–99; am. (1) (a) and (b) 3. and cr. (1) (f), Register, March, 2000, No. 531, eff. 4–1–00; cr. (1) (g) and (h), Register, November, 2000, No. 539, eff. 12–1–00; **correction in (1) (b) 1. made under s. 13.93 (2m) (b) 7., Stats.**

HFS 103.04 Asset and income limits. The nonexempt assets and budgetable income of the MA group or, when applicable, the fiscal test group, shall be compared to the following asset and income limits established in this section to determine the eligibility of the MA group:

(1) CATEGORICALLY NEEDY. (a) The MA group or fiscal test group shall first be tested against the categorically needy standard. Persons who meet the non–financial eligibility conditions and who meet the income and asset standards specified in this subsection shall be determined eligible as categorically needy in accordance with s. 49.46 (1) (e), Stats., and shall receive MA benefits in accordance with s. 49.46 (2), Stats., and chs. HFS 101 to 108.

(b) The AFDC–related categorically needy income standard for MA applicants shall be the appropriate AFDC assistance standard as specified in s. 49.19 (11) (a) 1., Stats., except that persons who are ineligible to receive AFDC solely because of the application of s. 49.19 (11) (a) 6., Stats., which specifies that payments that are not whole dollar amounts shall be rounded down to the nearest whole dollar, shall receive MA as categorically needy. The AFDC–related categorically needy asset standard shall be the same as that set out in s. 49.19 (4), Stats.

(c) The SSI–related categorically needy income standard shall be the maximum SSI payment including state supplement that a single person or a couple, as appropriate, could receive in Wisconsin under s. 49.77, Stats., or federal title XVI of the social security act of 1935, as amended. The SSI–related categorically needy asset standard shall be the same as specified in section 1613 of title XVI of the social security act of 1935, as amended.

(2) MEDICALLY NEEDY. If the MA group or fiscal test group is not eligible as categorically needy, the medically needy standard shall be applied. Persons who meet non–financial conditions for eligibility and meet the income and assets criteria set forth in s. 49.47 (4) (b) and (c), Stats., and this chapter, except for AFDC–related adult caretakers who are not blind, disabled or age 65 or older, shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. HFS 101 through 108.

(3) EXCESS INCOME CASES. (a) In this subsection, "spend–down period" means the period during which excess income may be expended or obligations to expend excess income may be incurred for the purpose of obtaining AFDC–related or SSI–related MA eligibility, as described under s. HFS 103.08 (2) (a).

(b) When an SSI–related or AFDC–related fiscal test group is found ineligible as medically needy and excess income is the only reason, the group may expend or incur obligations to expend the excess income above the appropriate medically needy income limit pursuant to s. 49.47 (4) (c) 2. and 3., Stats., and this chapter. If after incurred medical expenses are deducted, the remaining income is equal to or less than the income limit, the MA group shall be determined medically needy and shall receive MA benefits in accordance with s. 49.47 (6), Stats., and chs. HFS 101 to 108 for the balance of the spend–down period.

(c) Health insurance premiums actually incurred or paid, plus any medical service recognized by state law received by a member of the MA or fiscal test group shall be counted toward fulfilling the excess income expenditure or incurrence requirement when the service is prescribed or provided by a medical practitioner who is licensed by Wisconsin or another state and if either or both of the following conditions are met:

1. The service is received during the spend–down period; or

2. The expense was incurred prior to the spend–down period and a fiscal test group member is still legally responsible for the debt and is consistently making payments, in which case the payments made during the spend–down period shall be counted.

(d) No medical costs that are incurred and are to be paid or have been paid by a person other than the applicant or members of the fiscal test group may be counted toward fulfilling the excess income expenditure or incurrence requirement. No expense for which a third party is liable, including but not limited to medicare, private health insurance, or a court–ordered medical support obligation, may be used to meet the expenditure of excess income requirement.

(4) SPECIAL FINANCIAL STANDARDS FOR INSTITUTIONALIZED PERSONS. The categorically needy and medically needy asset standards shall be the same for institutionalized persons as for non–institutionalized persons, except that in determining initial eligibility under s. HFS 103.075 for an institutionalized individual with a community spouse the asset standard shall be the regular SSI–related MA group size one asset standard as provided under s. 49.47 (4) (b) 3g., Stats., plus the community spouse resource allowance as provided under s. 49.455 (6) (b), Stats. The eligibility standards against which an institutionalized person's income is tested shall be the following:

(a) *Categorically needy standard.* The categorically needy standard for an institutionalized person shall be an amount equal to 3 times the federal share of the SSI payment for one person living in that person's own home.

(b) *Medically needy standard.* An institutionalized person shall be determined medically needy in accordance with requirements under 42 CFR 435.1007.

(5) IRREGULAR CASES. (a) *Mixture of AFDC and SSI–relatedness.* When there is a mixture in an MA group of AFDC–relatedness and SSI–relatedness, AFDC–related financial eligibility procedures shall be used except when no minor child is in the home, in which case SSI–related procedures shall be used.

(b) *Fiscal test groups in which some are receiving AFDC and some are applying for MA only.* 1. If some members of the fiscal test group are receiving AFDC and some are not, the eligibility of the non–AFDC recipients shall be determined by comparing the assets of the entire fiscal test group to the appropriate asset standard and by comparing the income of the non–AFDC members or, if appropriate, the fiscal test group, to the appropriate share of the total family income standard.

2. For purposes of this paragraph, the family consists of parents and all children, including AFDC recipients, in the household for whom either spouse is legally responsible, except that the family does not include SSI recipients and children who do not have a legally responsible parent in the home.

(c) *SSI–related child when family is ineligible.* A blind or disabled child in a family found financially ineligible for AFDC–related MA may have his or her eligibility determined individually according to SSI–related financial procedures for child–only cases specified in s. HFS 103.05.

(d) *Non–legally responsible relative (NLRR) case.* 1. If SSI–related adults are caring for a minor child for whom they are not legally responsible, the adults shall have their financial eligibility determined according to AFDC–related procedures, except that their eligibility may be determined according to SSI–related financial procedures if they are found ineligible for AFDC–related MA because of earned income or if they elect to be processed as SSI–related.

2. The income and assets of a child residing with an NLRR shall be measured against the AFDC–related standard for one person, except that when the NLRR child is blind or disabled eligibil-

ity shall be determined according to SSI–related financial procedures.

3. If the child is found financially ineligible, the eligibility of the NLRR caretaker relative shall be determined by measuring that relative's income and assets against AFDC–related eligibility standards.

(e) *Child residing in a licensed foster or group home.* For a child who lives in a foster or group home licensed under chs. HFS 56 or 57, only the child's own income and assets shall be used when determining the child's financial eligibility. The child's income and assets shall be measured against the AFDC–related income and asset standards for one person.

(6) BADGERCARE. (a) A group that meets the requirements of s. HFS 103.03 (1) (f) and (2) to (9) and the income limits in this subsection or in s. HFS 103.085 (6) is eligible for BadgerCare.

(b) For all applicant BadgerCare fiscal test groups, the income limit is 185% of the poverty line, or a lower percentage of the poverty line established by the department in accordance with s. 49.665 (4) (at), Stats.

(7) SPECIAL BADGERCARE BUDGETING PROCEDURES. (a) *BadgerCare group.* The following persons who reside in the home with the primary person shall be included in the BadgerCare group if otherwise non–financially eligible and applying for BadgerCare:

1. The primary person.

2. The primary person's spouse.

3. A natural or adoptive child under age 19 of the primary person.

4. A parent of a child under subd. 3.

5. The spouse of a parent under subd. 4.

6. The natural or adoptive child of the primary person's child under subd. 3.

7. The spouse of the child in subd. 3., if that child is a parent.

(b) *BadgerCare fiscal test group.* 1. The income of the following persons shall be included when determining the eligibility of the BadgerCare group:

a. Any person listed in par. (a).

b. Except for SSI recipients, any person residing with members of the BadgerCare group who is legally responsible for any member.

2. Except for SSI recipients, the needs of the following persons shall be used to determine the eligibility of the BadgerCare group:

a. Any person listed in par. (a).

b. Children under age 19 of the primary person who are eligible for AFDC–related or SSI–related MA.

c. Any person residing with members of the BadgerCare group, and who is legally responsible for any member.

(c) *Non–legally responsible relative (NLRR) case.* The income of a minor child residing with an NLRR caretaker shall be measured against the BadgerCare income limits for one person.

(d) *18 year old case.* An 18 year old who resides with his or her parent or parents may have his or her BadgerCare eligibility determined either with the parent or parents or separately.

(8) MEDICAID PURCHASE PLAN FINANCIAL ELIGIBILITY CRITERIA. (a) A person who meets the requirements of s. HFS 103.03 (1) (g) and (2) to (9) and the income and asset limits described in this subsection is eligible for the medicaid purchase plan.

(b) The person's total net family income is less than 250% of the federal poverty line as determined by the person's family size. Net income is calculated using the standard SSI disregards and exemptions. The income disregards are the following:

1. Sixty–five dollars and one–half of the family's remaining earned income. If the family does not have any unearned income, $85 and one–half of the family's remaining earned income.

2. Twenty dollars of any unearned income.

3. Impairment–related work expenses.

(c) The person has non–exempt assets less than the asset limit described under s. 49.472 (3) (b), Stats.

(d) If the person leaves the medicaid purchase plan and subsequently re–enrolls in the program, the person's independence account and any interest, gains, or dividends from that account are disregarded for purposes of subsequent eligibility determinations.

(9) SPECIAL MEDICAID PURCHASE PLAN BUDGETING PROCEDURES. (a) *Medicaid purchase plan group.* Any of the following persons who reside in the home with the applicant or recipient shall be included in determining the family size of the person applying for the medicaid purchase plan, with this family size used in calculating the person's financial eligibility under this section:

1. The applicant.

2. The applicant's spouse.

3. Any dependent child of the applicant as described in s. 49.141, Stats.

(b) *Medicaid purchase plan fiscal test group.* The income of any person listed in par. (a) 1. or 2. shall be included when determining financial eligibility of the applicant.

(c) *Medicaid purchase plan coverage.* 1. Medical assistance under the medicaid purchase plan applies to the applicant or recipient only.

2. The monthly premium for the medicaid purchase plan is calculated using only the income of the applicant or recipient.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; am. (4) (intro.), Register, March, 1993, No. 447, eff. 4–1–93; correction in (1) (a) made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520; emerg. am. (3) (a), eff. 7–1–99; am. (3) (a) and cr. (6) and (7), Register, March, 2000, No. 531, eff. 4–1–00; cr. (8) and (9), Register, November, 2000, No. 539, eff. 12–1–00; **correction in (5) (e) made under s. 13.93 (2m) (b) 7., Stats.**

HFS 103.05 Determining assets and income in child–only cases. (1) MEANING OF CHILD–ONLY CASE. A child–only case exists when:

(a) A family has been determined financially ineligible for AFDC–related MA only and there is a child in the family who is SSI–related but not receiving SSI payments;

(b) A step–parent family requests MA exclusively for a stepchild;

(c) A step–parent family refuses or is determined ineligible for AFDC;

(d) A step–parent family is determined financially ineligible for MA only; or

(e) A step–parent family is determined ineligible for MA because a caretaker relative is a striker.

(2) ESTABLISHING CHILD–ONLY MA GROUPS. In child–only cases, the child or children of each legal parent shall form their own MA group and shall be tested for financial eligibility with the children's own income and assets, if any, plus the income and assets deemed to the children of this group according to subs. (3) and (4).

(3) DEEMING OF PARENTAL ASSETS. (a) All of the legal parent's nonexempt assets shall be deemed to the child in 3–generation and stepparent cases.

(b) In cases of an SSI–related child where 2 parents are in the home, parental assets in excess of the SSI asset limit for 2 persons shall be deemed to the blind or disabled child. Where there is one parent, parental assets in excess of the SSI asset limit for one person shall be deemed to the blind or disabled child in accordance with 42 CFR 435.845.

(4) DEEMING OF PARENTAL INCOME. (a) *To the third–generation child.* All of the net income of the second–generation minor parent shall be deemed to the third–generation child.

(b) *To the stepchild.* The income deemed to the stepchild shall be the remainder of the total of the net income of the legal parent

minus the categorically needy income standard based on the number of ineligible family members.

(c) *To the SSI–related child.* The amount of parental monthly income deemed to the SSI–related child shall be determined according to the procedure set out in this paragraph. The department shall adjust the monthly amounts in accordance with changes in the SSI program. Beginning with unearned income, parental monthly gross income shall be deemed to each ineligible child to bring the child's income up to an amount equal to one–half the maximum federal share of the SSI benefit paid to a single individual living in his or her own household. The remaining parental income shall be deemed to the SSI–related child as follows:

1. When the only type of parental income remaining is unearned, $20 shall be subtracted. Then, where there are 2 parents, an amount equal to the maximum federal share of the SSI benefit paid to a couple living in their own household shall be subtracted, and where there is one parent, an amount equal to the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI–related child as unearned income.

2. When the only type of parental income remaining is earned, $85 shall be subtracted. Then, where there are 2 parents, an amount equal to 3 times the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted, and where there is one parent, an amount equal to 2 times the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI–related child as unearned income.

3. When parental income remaining is a mix of unearned and earned, $20 shall be subtracted using unearned income first. From any remaining earned income, $65 shall be subtracted and then one–half of the remainder. When there are 2 parents, an additional amount equal to the maximum federal share of the SSI benefit paid to a couple living in their own household shall be subtracted, and when there is one parent, an additional amount equal to the maximum federal share of the SSI benefit paid to an individual living in his or her own household shall be subtracted. The remaining income shall be considered available to the SSI–related child as unearned income.

(5) INCOME LIMITS FOR CHILD–ONLY MA GROUPS. (a) In third–generation and stepchild cases, each MA group shall be tested against an income standard consisting of a proportionate share of the AFDC–related standard for the appropriate family size. For purposes of this paragraph, "family" means parents and all children in the household for whom either spouse is legally responsible, including the third–generation, but not SSI recipients or NLRR children. If the stepchild or third–generation child is ineligible for MA because of excess income, the applicant may elect either a family spend–down period or a child–only spend–down period to gain MA eligibility.

(b) The eligibility of an SSI–related child shall be determined by testing against the SSI–related income standard for one person.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86.

HFS 103.06 Assets. (1) SPECIAL SITUATIONS OF INSTITUTIONALIZED PERSONS. (a) In determining the eligibility of an institutionalized person, only the assets actually available to that person shall be considered.

(b) The homestead property of an institutionalized person is not counted as an asset if:

1. The institutionalized person's home is currently occupied by the institutionalized person's spouse or a dependent relative. In this subdivision,"dependent relative" means a son, daughter, grandson, granddaughter, stepson, stepdaughter, in–law, mother, father, stepmother, stepfather, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, halfsister, halfbrother, niece, nephew or cousin who is financially, medically or otherwise dependent on the institutionalized person;

2. The institutionalized person intends to return to the home and the anticipated absence from the home, as verified by a physician, is less than 12 months; or

3. The anticipated absence of the institutionalized person from the home is for more than 12 months but there is a realistic expectation, as verified by a physician, that the person will return to the home. That expectation shall include a determination of the availability of home health care services which would enable the recipient to live at home.

(c) If none of the conditions under par. (b) is met, the property is no longer the principal residence and becomes non–homestead property.

(d) When income that has been protected for institutionalized recipients accumulates to the point that the asset limit is exceeded, MA eligibility shall terminate. Eligibility may not be reinstated until the assets are below the limit at which time a new application shall be required.

(e) To maintain continuous MA eligibility the recipient may apply assets as a refund of MA benefits to the department. In no instance may refunds exceed benefits received.

(2) MOTOR VEHICLES. (a) In this section:

1. "Motor vehicle" means a passenger car or other motor vehicle used to provide transportation of persons or goods and which is owned by a person in the MA or fiscal test group.

2. "Equity value" means the fair market value minus any encumbrances which are legal debts.

3. "Fair market value" means the wholesale value shown in a standard guide on motor vehicle values or the value as estimated by a reliable expert.

(b) For persons whose eligibility is being determined according to AFDC categorically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned, up to $1,500 of equity value is exempt; and

2. If more than one vehicle is owned, up to $1,500 of equity value of the vehicle with the greatest equity value is exempt. The equity value of the vehicle with the greatest equity value in excess of $1,500 and the equity value of any other vehicle is counted as an asset.

(bm) For persons whose eligibility is being determined according to AFDC medically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned, it is exempt from consideration as an asset regardless of value;

2. If more than one vehicle is owned, a second vehicle is exempt from consideration as an asset if the agency determines that it is necessary for the purpose of employment or to obtain medical care; and

3. The equity value of any nonexempt vehicle owned by the applicant is counted as an asset.

(c) For persons whose eligibility is being determined according to SSI categorically needy or medically needy financial standards, the following conditions shall apply:

1. If one vehicle is owned it is exempt if it meets one of the following conditions:

a. It is necessary for employment;

b. It is necessary for medical treatment of a specific or regular medical problem;

c. It is modified for operation by or transportation of a handicapped person; or

d. It is necessary because of climate, terrain, distance or similar factors to provide transportation to perform essential daily activities.

2. If no automobile is exempt under subd. 1., one automobile is not counted as an asset to the extent that its current fair market value does not exceed $4,500. Fair market value in excess of $4,500 counts toward the asset limit.

3. If more than one vehicle is owned, the equity value of the nonexempt vehicle is counted as an asset.

(3) JOINT ACCOUNTS AND JOINTLY HELD PROPERTY. (a) *Joint accounts.* A joint account shall be deemed available to each person whose name is on the account or listed as an owner. The value of a joint savings or checking account shall be determined as follows in determining eligibility for MA:

1. For persons who receive MA who are not age 65 or over, or not blind or disabled, the division of a joint account shall be determined according to applicable federal law; and

2. For persons who receive MA who are age 65 or over or who are blind or disabled, joint accounts shall be divided as follows:

a. If both owners of the joint account receive MA, equal shares of the joint account shall be included for the purpose of determining MA eligibility; and

b. If only one owner of the joint account receives MA, the full amount of the joint account shall be included for the purpose of determining MA eligibility.

(b) *Jointly held property.* If the applicant or recipient is a joint owner of property with a person who refuses to sell the property and who is not a legally responsible relative of the applicant or recipient, the property shall not be considered available to the applicant or recipient and may not be counted as an asset. If the property is available to the applicant or recipient, it shall be divided equally between the joint owners.

(4) HOMESTEAD PROPERTY. (a) A home owned and lived in by an applicant or recipient is an exempt asset.

(b) Net proceeds from the sale of homestead property shall be treated as assets as follows:

1. For AFDC–related MA the proceeds are considered available assets in the month of receipt and, if retained, in any of the following months; and

2. For SSI–related MA the proceeds are disregarded if they are placed in an escrow account and used to purchase another home within 3 months. After 3 months the proceeds are considered available.

(5) NON–HOMESTEAD REAL PROPERTY. (a) If the equity value of the non–homestead property together with all other assets does not exceed the asset limit, the person may retain the property and be eligible for MA.

(b) If the value of non–homestead property together with the value of the other assets exceeds the asset limit, the non–homestead property need not be counted as an asset if it produces a reasonable amount of income. In this paragraph, "reasonable amount of income"means a fair return considering the value and marketability of the property.

(c) If the total value of non–homestead property and non–exempt assets exceeds the asset limit, the person who owns the non–homestead property shall list the property for sale with a licensed realtor at a price which the realtor certifies as appropriate. If the property is listed for sale, it may not be counted as an asset. When the property is sold, the net proceeds shall be counted as an asset.

(6) LIFE ESTATE. The applicant or recipient may hold a life estate without affecting eligibility for MA. If the property or the life estate is sold, any proceeds received by the applicant or recipient shall be considered assets. In this subsection, "life estate" means a claim or interest a person has in a homestead or other property, the duration of the interest being limited to the life of the party holding it with that party being entitled to the use of the property including the income from the property in his or her lifetime.

(7) TRUSTS. (a) Trust funds shall be considered available assets, except that:

1. Trust funds payable to a beneficiary only upon order of a court shall not be considered available assets if the trustee or other person interested in the trust first applied to the court for an order allowing use of part or all of the trust fund to meet the needs of the beneficiary and the court denied such application;

2. Trust funds held in a trust which meets the requirements of s. 701.06, Stats., shall not be considered available assets unless the settlor is legally obligated to support the beneficiary;

3. For SSI–related MA applicants and recipients, the pertinent SSI standards on the treatment of trusts as resources shall apply; and

4. For AFDC–related applicants and recipients, the pertinent AFDC standards on the treatment of trusts as resources shall apply.

(8) PERSONAL PROPERTY. Household and personal effects of reasonable value, considering the number of members in the fiscal test group, shall be exempt.

(9) LOANS. Money received on loan shall be exempt unless it is available for current living expenses, in which case the money shall be treated as an asset even if a repayment schedule exists.

(10) LIFE INSURANCE POLICIES. The cash value of a life insurance policy shall be considered an asset, except that for SSI–related persons it is an asset only when the total face value of all policies owned by the person exceeds $1,500. In this subsection, "cash value" means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it, and"face value" means the dollar amount of the policy which is payable on death.

(11) LUMP SUM PAYMENTS. All lump sum payments, unless specifically exempted by federal statute or regulation, shall be treated as assets instead of income. In this subsection, "lump sum payment"means a nonrecurring payment such as retroactive social security benefits, income tax refunds, and retroactive unemployment benefits.

(12) WORK–RELATED ITEMS. Work–related items essential to the employment or self–employment of a household member, except motor vehicles, are exempt from being counted as assets. For business or farm operations, internal revenue service (IRS) returns shall be used to determine whether or not the operation is profitable or moving toward becoming profitable. If the operation is not profitable or becoming profitable, all assets related to the operation shall be counted in the determination of eligibility.

(13) SPECIAL EXEMPT ASSETS FOR BLIND OR DISABLED PERSONS. The following assets shall be exempted in determining the eligibility of blind or disabled persons:

(a) Assets essential to the continuing operation of the person's trade or business;

(b) Income–producing property; and

(c) Funds conserved for a departmentally approved plan for self–support of a blind or disabled person. The conserved funds shall be segregated from other funds. Interest earned on conserved funds is exempt so long as the conserved funds do not exceed the provision of the approved plan.

(14) LAND CONTRACTS. (a) The applicant or recipient shall obtain a written estimate of the fair market value of a land contract from a source active in the market for land contracts in Wisconsin.

(b) If the applicant's or recipient's vendor interest in a land contract exceeds the medically needy asset limit under s. 49.47 (4) (b), Stats., the applicant or recipient shall offer the land contract for sale. The applicant's or recipient's vendor interest in a land contract shall be counted as an available asset unless he or she provides written documentation from a source active in the market for land contracts in Wisconsin proving that his or her interest in the land contract cannot be sold.

(15) INDEPENDENCE ACCOUNTS. (a) *Account provisions.* 1. Contributions to any of the recipient's registered independence

accounts are subject to the rules described in this section and to any policies of the respective financial institution governing the account.

2. All contributions to the recipient's independence account or accounts, including interest, dividends, or other gains from the principal, shall be treated as an exempt asset for the purpose of calculating eligibility for the medicaid purchase plan.

3. The purpose of an independence account is to allow the recipient to purchase any items or services that may aid in his or her pursuit of personal or financial independence.

4. The medicaid purchase plan recipient shall be the sole owner of any account registered as an independence account.

5. Retirement or pension accounts registered as independence accounts are not required to remain as separate holdings from the recipient's other non–exempt retirement or pension assets.

6. The county agency shall monitor the recipient's independence account as described in the medicaid review period for the medicaid purchase plan. The review process shall include verifying all contributions to the recipient's independence account with the financial institution holding the recipient's account.

7. The sum total a medical assistance recipient deposits in all independence accounts may not exceed an amount equal to 50% of the recipient's gross earned income for the medicaid review period. If a recipient's contributions to his or her independence accounts total more than an amount equal to 50% of his or her gross earned income within the medicaid review period, an amount equal to one–twelfth of the contributions greater than an amount equal to 50% of gross earned income shall be added to the recipient's monthly premium payment under s. HFS 103.087 for the next 12 months of eligibility.

(b) *Independence account registration.* 1. A person shall register each independence account with the county agency. A person shall re–register the independence account with the county agency if the financial institution or other information for the independence account changes.

2. A medicaid purchase plan recipient shall complete an account registration form to register the account as an independence account.

3. The applicant or recipient shall report any changes in personal or financial status that may affect his or her eligibility for medical assistance to the county agency as described in s. HFS 104.02 (6).

4. For all registered independence accounts that are not retirement or pension accounts, the date of account creation may be no earlier than the date a medicaid purchase plan recipient is determined eligible for medical assistance under this section. For all registered independence accounts that are not retirement or pension accounts, the funds in the independence account shall be held separate from a recipient's non–exempt assets.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; am. (1) (d), r. and recr. (1) (e), Register, January, 1987, No. 373, eff. 2–1–87; am. (6), cr. (14), Register, July, 1989, No. 403, eff. 8–1–89; am. (2) (b), cr. (2) (bm), r. and recr. (2) (c), Register, December, 1990, No. 420, eff. 1–1–91; am. (1) (b) 1., r. and recr. (4) (b), Register, March, 1993, No. 447, eff. 4–1–93; cr. (15), Register, November, 2000, No. 539, eff. 12–1–00.

HFS 103.063 Divestment prior to August 9, 1989.

(1) APPLICABILITY. This section applies to all applicants for MA and recipients of MA who disposed of a resource at less than fair market value prior to August 9, 1989 and to all inter–spousal transfers occurring before October 1, 1989. Section HFS 103.065 applies to all institutionalized applicants and recipients who divest on or after August 9, 1989, except for inter–spousal transfers occurring before October 1, 1989.

(1m) PURPOSE. This section implements s. 49.45 (17), 1987 Stats., which makes an applicant for or recipient of MA ineligible when the applicant or recipient disposed of a resource at less than fair market value within 2 years before or at any time after his or her most recent application for MA or any review of eligibility for MA. Section 49.45 (17) (d), 1987 Stats., is specifically concerned with an applicant for or recipient of MA who resides as an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF) or inpatient psychiatric facility and who disposed of homestead property at any time during or after the 2 year period prior to the date of the most recent application or any review of eligibility.

(2) DIVESTMENT OF NON–HOMESTEAD PROPERTY. (a) *Amount of divestment.* For any person who disposed of a resource, except a homestead or other exempt resource, at less than fair market value within 2 years before or at any time after his or her most recent application for MA, or any review of eligibility, the agency shall determine the amount of the divestment in the following manner:

1. If the compensation received is less than net market value, the difference between the compensation received and the net market value is the divested amount and shall be considered an asset.

2. If the divested amount plus other nonexempt assets are equal to or less than the appropriate assets limit, the divestment shall not be considered a bar to eligibility.

3. If the divested amount plus the other nonexempt assets are greater than the appropriate assets limit, the excess over this limit shall be the amount of divestment to be expended for maintenance needs and medical care.

(b) *Divestment as a barrier to eligibility.* 1. Divestment by any person within 2 years before or at any time after his or her most recent application for MA or any review of eligibility shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2. and 3. and par. (c).

2. To rebut the presumption that divestment was made in contemplation of seeking aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that at the time of divesting the applicant had provided for future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s. 49.47 (4) (b) 3., Stats.

4. Division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments is not divestment.

(c) *Removing divestment as a barrier to eligibility.* 1. Divestment is no longer a barrier to MA eligibility for persons who are determined to have divested non–homestead property:

a. If the divested amount is $12,000 or less, when the sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient or when 2 years have elapsed since the date of divestment, whichever occurs first; or,

b. If the divested amount exceeds $12,000, when the entire sum of the divestment has been expended for maintenance needs and medical care of the applicant or recipient.

2. The amount expended for maintenance needs and medical care of the applicant or recipient shall be calculated monthly, as follows:

a. For a non–institutionalized person, the expended amount is the medical care expenses for the person plus the appropriate medically needy income limit for either AFDC or SSI, depending upon which program the person would be eligible for under MA, were it not for the divestment; and

b. For a person institutionalized in a SNF, ICF or inpatient psychiatric facility, the expended amount is the total cost of the institutional care.

(3) DIVESTMENT OF HOMESTEAD PROPERTY. (a) *Applicability.* Divestment by any person of his or her homestead property is a

barrier to eligibility only if he or she is a resident of an SNF, ICF or inpatient psychiatric facility.

(b) *Amount of divestment.* A person who is a resident of an SNF, ICF or inpatient psychiatric facility who disposed of his or her homestead for less than fair market value on or after July 2, 1983, but within 2 years before or at any time after his or her most recent application for MA or any review of his or her eligibility for MA, shall have the amount of divestment determined in the same manner as in sub. (2) (a).

(c) *Divestment as a barrier to eligibility.* 1. Divestment of a homestead by any person residing as an inpatient in an SNF, ICF or inpatient psychiatric facility within 2 years prior to the date of his or her most recent application for MA or any review of his or her eligibility for MA, shall, unless shown to the contrary, be presumed to have been made in contemplation of receiving MA. Divestment bars eligibility for MA except as provided in subds. 2. and 3. and par. (d).

2. To rebut the presumption that divestment was made in contemplation of receiving aid, the applicant shall furnish convincing evidence to establish that the transaction was exclusively for some other purpose. For example, the applicant may rebut the presumption that the divestment was done in contemplation of receiving aid by showing by convincing evidence that, at the time of divesting, the applicant had provided for his or her future maintenance needs and medical care.

3. Divestment shall only be considered a barrier to eligibility when the net market value of all the resources disposed of exceeds the medically needy asset levels in s. 49.47 (4) (b) 3., Stats.

4. Divestment does not occur in cases of division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments.

(d) *Removing divestment as a barrier to eligibility.* 1. Divestment of a homestead is no longer a barrier to eligibility for institutionalized persons:

a. If the amount of divestment to be expended for maintenance needs and medical care is less than the average MA expenditures for 24 months of care in an SNF, when the entire amount of the divestment is expended for this care, or 2 years has elapsed since the date of the divestment, whichever occurs first; or

b. If the amount of divestment to be expended for maintenance needs and medical care is greater than the average MA expenditure for 24 months of care in an SNF, when the entire amount of the divestment has been expended.

2. Expended amounts shall be determined, as long as the person is institutionalized, by using the average monthly MA expenditure, statewide, for care provided in an SNF.

3. An individual who is an inpatient in a SNF, ICF or inpatient psychiatric facility who has been determined to have divested a homestead, may be found eligible if:

a. It is shown to the satisfaction of the department that the individual can reasonably be expected to be discharged from the medical institution and return to that homestead;

b. The title to the homestead was transferred to the individual's spouse or child who is under age 21 or is blind or totally and permanently disabled according to a determination made by the department's bureau of social security disability insurance;

c. It is shown to the satisfaction of the department that the individual intended to dispose of the homestead either at fair market value or for other valuable consideration; or

d. It is determined by the department that the denial of eligibility would work undue hardship on the individual.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; renum. from HSS 103.02 and am., cr. (1), Register, April, 1990, No. 412, eff. 5–1–90.

HFS 103.065 Divestment on or after August 9, 1989.

(1) APPLICABILITY. This section applies to all institutionalized applicants for and recipients of MA who dispose of resources at less than fair market value on or after August 9, 1989, except for inter–spousal transfers occurring before October 1, 1989, and to all institutionalized applicants for and recipients of MA whose spouse disposes of resources at less than fair market value on or after July 1, 1990. Section HFS 103.063 applies to all applicants and recipients who divested before August 9, 1989 and to inter–spousal transfers occurring before October 1, 1989.

(2) PURPOSE. This section implements s. 49.453, Stats., which provides for a period of restricted MA coverage when an individual who is institutionalized or becomes institutionalized, or the individual's spouse, disposes of resources at less than fair market value.

(3) DEFINITIONS. In this section:

(a) "Annuity" means a written contract under which, in return for payment of a premium or premiums, an individual or individuals have the right to receive fixed, periodic payments for life or up to a fixed point in time.

(b) "Community spouse" means a person who is legally married as recognized under state law to an institutionalized individual but is not himself or herself an institutionalized individual.

(c) "Expected value of the benefit" means the amount that an irrevocable annuity will pay to a primary annuitant or to joint annuitants during his or her expected lifetime.

(d) "Institutionalized individual" means an applicant or recipient who is an inpatient in an SNF or ICF, an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in an SNF or ICF, or receiving home and community–based care MA services under ss. 49.46 and 49.47, Stats.

(e) "Joint annuitants" means the institutionalized individual and his or her spouse named as the payees under an annuity.

(f) "Medical assistance" or "MA" means payment for services provided to a resident of an SNF or ICF under s. HFS 107.09 (2) and (4) (a), payment to a medical institution as defined under 42 CFR 435.1009 for care based on a level of care provided in an SNF or ICF, or payment for services provided under a home and community–based care waiver program authorized under 42 USC 1396n (c).

(g) "Medical assistance card services" means the services covered under ch. HFS 107, except for services reimbursed as institutional care, as defined by s. HFS 107.09 (2) and (4) (a), services received in an SNF or ICF or a medical institution and services reimbursed under a home and community–based care waiver program authorized under 42 USC 1396n (c).

(h) "MA eligibility handbook" means the medical assistance program handbook issued by the department's division of economic support for use by agencies in determining eligibility for MA.

(i) "Primary annuitant" means the first individual, which may be either the institutionalized individual or his or her spouse, to receive payment from an annuity.

(j) "Resource" has the meaning given in 42 USC 1382b, except that the home, as defined in s. HFS 101.03 (75), is a nonexempt resource.

(4) DIVESTMENT. (a) *Divestment resulting in ineligibility.* An institutionalized individual or someone acting on behalf of that individual who disposes of resources at less than fair market value within 30 months immediately before or at any time after the individual becomes institutionalized if the individual is receiving MA on the date he or she becomes institutionalized or, if the individual is not receiving MA on that date, within 30 months immediately before or at any time after the date the individual applies for MA while institutionalized, shall be determined to have divested. A divestment results in ineligibility for MA for the institutionalized individual unless made to an exempt party under par. (b) or (c) or when one of the circumstances in par. (d) exist. An institutionalized individual may also be determined ineligible for MA if his or

her spouse disposes of resources at less than fair market value on or after July 1, 1990. In this paragraph, "receiving" means entitled to receive as well as actually receiving, in the same way that "recipient" as defined in s. HFS 101.03 (150) means a person who is entitled to receive benefits under MA as defined under s. HFS 101.03 (95).

Note: The department advises that when the transfer for less than fair market value has been made by the spouse of the institutionalized applicant or recipient, the determination of whether or not the transfer will be treated as a divestment will be made pursuant to both the divestment provisions under s. 49.453, Stats., and the spousal impoverishment prevention provisions under s. 49.455, Stats.

(am) *Transfer of resources within same month.* In determining the amount of the divestment to be satisfied, the agency shall consider all transfers by either the institutionalized individual or his or her community spouse at less than fair market value that occur within a calendar month as one divestment.

(at) *Transfer of resources to an irrevocable annuity on or after October 1, 1993.* 1. Whenever an institutionalized individual or his or her spouse, or another person acting on behalf of the institutionalized individual or his or her spouse, transfers funds on or after October 1, 1993, to an irrevocable annuity in an amount that exceeds the expected value of the benefit, the institutionalized individual or his or her spouse shall be determined to have divested.

2. The agency shall determine the amount of the divestment under subd. 1. by:

a. Determining the life expectancy of the primary annuitant or joint annuitants using the life expectancy tables included in the MA eligibility handbook. Table I shows the age at which the male or female institutionalized individual chose the settlement option for annuitization, life expectancy for an individual of that age, and estimated remaining years of life based on the age at which the institutionalized individual chose the settlement option. Table II shows the ages at which both the male and female joint annuitants chose the settlement option for annuitization, life expectancy for each individual of that individual's age, and estimated remaining years of life based on the ages at which the joint annuitants chose this settlement option; and

b. Adding together the amount of all the payments from the irrevocable annuity scheduled to be made after the month in which the primary annuitant's age or joint annuitants' ages exceed the estimated remaining years of life. The divested amount is the sum of all the payments to be made from the irrevocable annuity after the month in which the primary annuitant's age or joint annuitants' ages exceed the estimated remaining years of life.

Note: For a copy of the life expectancy tables included in the MA eligibility handbook, write the Bureau of Welfare Initiatives, Division of Economic Support, P.O. Box 7935, Madison, WI 53707.

3. If the agency receives a physician's statement which states that the primary annuitant or joint annuitant had a diagnosed medical condition which would shorten his or her life expectancy and that the medical condition was diagnosed before the institutionalized individual, his or her spouse, or someone acting on behalf of the institutionalized individual or his or her spouse transferred funds to an irrevocable annuity, the agency shall determine the expected value of the benefits based upon the physician's statement instead of using a life expectancy table as provided under subd. 2.

(b) *Permitted divestment to an exempt party — homestead property.* Transfer of homestead property at less than fair market value is not divestment resulting in ineligibility under this section if the individual transferred title to the homestead property to:

1. The spouse of the institutionalized individual on or after October 1, 1989;

2. A child of the institutionalized individual who is under age 21 or who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c;

3. A sibling of the institutionalized individual who has an equity interest in the homestead and who was residing in the institutionalized individual's home for at least one year immediately before the date the individual became an institutionalized individual. In this subdivision, "equity interest" means ownership interest in a homestead by one or more persons who pay or have paid all or a portion of mortgage or land contract payments, expenses for upkeep and repair or payment of real estate taxes. The institutionalized individual shall provide documentation to verify the sibling's equity interest in the homestead; or

4. The child, other than a child described in subd. 2., of the institutionalized individual who was residing in the institutionalized individual's home for a period of at least 2 years immediately before the date the individual became an institutionalized individual and who provided care to the institutionalized individual which permitted him or her to reside at home rather than in an SNF, ICF or medical institution which receives payment based on a level of care provided in an SNF or ICF. The institutionalized individual shall provide a notarized statement to the agency from his or her physician or another person or persons who have personal knowledge of the living circumstances of the institutionalized individual stating that the individual was able to remain in his or her home because of the care provided by the child. A notarized statement only from the child does not satisfy the requirements of this subdivision.

(c) *Permitted divestment on or after August 9, 1989, but before July 1, 1990, to an exempt party — non–homestead property.* For transfers that occurred on or after August 9, 1989, but before July 1, 1990, transfer of a non–homestead resource at less than fair market value is not divestment resulting in ineligibility under this section if the individual transferred the resource to one of the following individuals:

1. Beginning October 1, 1989, to the community spouse or to another individual for the sole benefit of the community spouse after the individual became an institutionalized individual;

2. To a minor or adult child of the institutionalized individual who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c; or

3. Beginning October 1, 1989, to the individual's spouse or to another person for the sole benefit of the individual's spouse before the individual became an institutionalized individual. Such a transfer is not considered divestment resulting in ineligibility for as long as the individual's spouse does not transfer the resource to another person other than his or her spouse at less than fair market value. The individual's spouse shall report any transfer of the resource to the agency within 10 days after the transfer is made as required under s. 49.455, Stats. Failure of the institutionalized individual's spouse to report the transfer may be fraud under s. 49.49 (1) (a) 3., Stats.

(cm) *Permitted divestment on or after July 1, 1990, to an exempt party — non–homestead property.* Transfer of a non–homestead resource at less than fair market value on or after July 1, 1990, is not divestment resulting in ineligibility under this section to the extent that the resource was transferred:

1. To or from the individual's spouse or to another individual for the sole benefit of the spouse; or

2. To a minor or adult child of the institutionalized individual who meets the SSI definition of total and permanent disability or blindness under 42 USC 1382c.

(d) *Circumstances under which divestment is not a barrier to eligibility.* An institutionalized individual who has been determined to have made a prohibited divestment under this section shall be found ineligible for MA as defined under s. HFS 101.03 (95) unless:

1. The transfer of property occurred as the result of a division of resources as part of a divorce or separation action, the loss of a resource due to foreclosure or the repossession of a resource due to failure to meet payments; or

2. It is shown to the satisfaction of the department that one of the following occurred:

a. The individual intended to dispose of the resource either at fair market value or for other valuable consideration;

b. The resource was transferred exclusively for some purpose other than to become eligible for MA;

c. The ownership of the divested property was returned to the individual who originally disposed of it; or

d. The denial or termination of eligibility would work an undue hardship. In this subparagraph, "undue hardship" means that a serious impairment to the institutionalized individual's immediate health status exists.

(5) DETERMINING THE PERIOD OF INELIGIBILITY. An institutionalized individual who has made a prohibited divestment under this section resulting in ineligibility or whose spouse has made a divestment under this section resulting in ineligibility on or after July 1, 1990, as determined by the agency, without a condition under sub. (4) (d) existing, shall be ineligible for MA as defined in this section for, beginning with the month of divestment, the lesser of:

(a) Thirty months; or

(b) The number of months obtained by dividing the total uncompensated value of the transferred resources by the statewide average monthly cost to a private pay patient in an SNF at the time of application. In this paragraph, "total uncompensated value of the transferred resource" means the difference between the compensation received for the resource and the fair market value of the resource less any outstanding loans, mortgages or other encumbrances on the resource.

(6) AGENCY RESPONSIBILITIES. (a) The agency shall determine if an applicant or recipient who is ineligible for MA under this section is eligible for MA card services. The applicant or recipient's income eligibility shall be determined using the standards under s. HFS 103.04 (4).

(b) The agency shall monitor retention of assets by the non–institutionalized spouse for those transfers that occur on or after October 1, 1989, but before July 1, 1990, under sub. (4) (c) 3. at each application or review of eligibility for the institutionalized spouse.

History: Cr. Register, March, 1990, No. 412, eff. 5–1–90; am. (1), (2), (4) (a) and (c) (intro.), (5) (intro.) and (6) (b), cr. (4) (cm), Register, May, 1991, No. 425, eff. 6–1–91; am. (2), (3) (a) and (4) (a), cr. (4) (am), Register, March, 1993, No. 447, eff. 4–1–93; emerg. renum. (3) (a) to (e) to be (3) (b), (d), (f), (g) and (j), cr. (4) (at), eff. 1–1–94; renum. (3) (a) to (e) to be (3) (b), (d), (f), (g) and (j), cr. (4) (at), Register, August, 1994, No. 464, eff. 9–1–94; **corrections in (2) and (4) (c) 3. made under s. 13.93 (2m) (b) 7., Stats., Register February 2002 No. 554.**

HFS 103.07 Income. (1) SPECIAL SITUATIONS OF INSTITUTIONALIZED PERSONS. (a) *Support received by institutionalized persons.* 1. Any financial support or contribution received by an institutionalized person shall be considered available when determining the eligibility of that person for MA.

2. The income and assets of the parents of children under age 18 who reside in institutions shall be evaluated by the department to determine whether, pursuant to s. 46.10 (14), Stats., collections may be made from one or both parents. If the child is residing in an institution not specified in s. 46.10 (14), Stats., but the institution is approved to receive MA payments, the parental liability shall be the same as that provided in s. 46.10 (14), Stats., and collected in the same manner.

3. The agency shall decide if the spouse of an institutionalized applicant or recipient should be referred for support action under s. 49.90, Stats. When deciding whether to refer for support action, the agency shall consider the spouse's basic essential needs and present and future expenses. In no case may support from the spouse of an institutionalized applicant or recipient be pursued when the spouse's assets, not counting homestead property and a motor vehicle, or, if applicable, not counting assets excluded under s. HFS 103.075 (5) (b) 2., are less than the amount provided under s. 49.47 (4) (b) 3g., Stats., or, if applicable, the spousal asset share under s. 49.455 (6) (b), Stats., and when the spouse's income is less than the spousal monthly income allowance under s. 49.455 (4) (b), Stats.

(b) *Allocation of institutionalized person's income to dependents outside the institution.* Except as provided under s. HFS 103.075 (6), no allocation may be made from an institutionalized applicant's or recipient's income to a spouse who is eligible for SSI but who refuses to obtain SSI. Except as provided under s. HFS 103.075 (6), no allocation may be made to a spouse or to minor children under the spouse's care if the spouse or any of the children are receiving AFDC or SSI. Otherwise, allocations shall be made as follows:

1. If the spouse is caring for a minor child for whom either the institutionalized person or the spouse is legally responsible, the AFDC assistance standard plus expenses that would be allowed under s. HFS 103.04 (3) shall be used to determine the need of the spouse and children. If their total net income is less than their need, income of the institutionalized person shall be allocated in an amount sufficient to bring the spouse's and children's income up to their monthly need. In this subdivision, "total net income" means income equal to unearned income plus net earned income, and "net earned income" means income equal to gross earned income minus work–related expenses according to requirements of AFDC. Income disregards of the AFDC program under 45 CFR 233.20 (a) shall be used as appropriate in computing income.

2. If the spouse is not caring for a minor child, the SSI payment level for one person living in that person's own household shall be used to determine the spouse's monthly need. The spouse's earned income shall be netted by subtracting the work–related expenses according to sub. (3) and $20. from earned or unearned income or both. If the spouse's net income is less than the spouse's monthly need, income of the institutionalized person may be allocated in an amount sufficient to bring the spouse's income up to monthly need. Income disregards of the SSI program under 20 CFR 416.1112 and 416.1124 shall be used as appropriate in computing income.

3. The following amounts shall be excluded when computing the income of the spouse and children under subd. 1. or the spouse alone under subd. 2.:

a. All earnings of a child less than 14 years old, or less than 18 years old when the child is a full–time student;

b. All earnings of a child less than 18 years old who attends school part–time and is employed fewer than 30 hours a week;

c. Any portion of any grant, scholarship or fellowship used to pay the costs of tuition, fees, books and transportation to and from classes;

d. Amounts received for foster care or subsidized adoption;

e. The bonus value of food stamps and the value of foods donated by the federal department of agriculture;

f. Home produce grown for personal consumption; and

g. Income actually set aside for the post–high school education of a child who is a junior or senior in high school.

(c) *When both spouses are institutionalized and there is an application for MA.* When both spouses are institutionalized, the following shall apply:

1. If one spouse applies for MA, the total income of both spouses may be combined to ascertain if their combined income is less than total need, provided that the spouse not applying has income exceeding that spouse's needs and is willing to make that income available;

2. If the combined income of both spouses is less than total need, separate determinations shall be made to see if either spouse has excess income. Any excess may be allocated to the other spouse. Either one or both of the spouses may be eligible depending on income allocation; and

3. If the combined income of both spouses exceeds total need, separate determinations shall be made. Only the actual amount of

income made available from one spouse to the other may be used in determining the eligibility of the other spouse. If the spouse refuses to make a reasonable amount available, the agency shall review the case under par. (a) 3. to determine if legal action for support should be taken pursuant to s. 49.90, Stats.

(d) *Computing income available towards cost of care.* Institutionalized recipients of MA who are determined eligible under s. HFS 103.06 and this section shall apply their available income toward the cost of their care after deducting the income disregards in this paragraph. In this paragraph, "available income" means any remaining income after the following reductions are made:

1. A personal needs allowance, as provided under s. 49.45 (7) (a), Stats., and

2. If employed, the first $65 and one–half of the remainder of gross earnings;

3. The cost of health insurance;

4. Necessary medical or remedial care recognized under state law but not covered by MA;

5. The actual amount paid by the institutionalized person for support of a person for whom the institutionalized person is legally responsible but not to exceed the appropriate AFDC assistance standard unless the institutionalized person is paying court–ordered support in an amount greater than the AFDC assistance standard in s. 49.19 (11) (a) 1., Stats.; and

6. The monthly cost of maintaining a home when the conditions of s. HFS 103.06 (1) (b) 3. are met, but not to exceed the SSI payment level for one person living in that person's own household.

(2) SPECIAL TYPES OF INCOME. (a) *Farm and self–employment income.* Farm and self–employment income used in MA calculations shall be determined by adding back into the net earnings the following: depreciation, personal business and entertainment expenses, personal transportation, purchases of capital equipment, and payments on the principal of loans. The total shall be divided by 12 to get monthly earnings. If no tax return has been filed, the individual shall complete a 1040 form of the internal revenue service (IRS) to determine net earnings or loss, or to anticipate, in case of relatively new businesses, net earnings as required by the IRS. If the latest income tax return does not accurately reflect the household's actual circumstances because the household has experienced a substantial increase or decrease in business, the agency shall calculate the self–employment income based on anticipated earnings. Agencies shall determine whether it is necessary to use anticipated earnings on a case–by–case basis and shall document the reasons for the determination in the case record.

(b) *Contractual employment income.* Income received on other than an hourly or piecework basis from employment performed under a contract which is renewable on an annual basis shall be averaged over a 12–month period. Persons receiving this income shall be considered to receive compensation for the entire 12–month period even though actual compensation may only be received for part of the year.

Note: For example, if school teachers are paid 9 months a year, the wages they receive are to be averaged over a 12–month period.

(c) *In–kind benefits.* Predictable in–kind benefits received regularly and in return for a service or product delivered shall be treated as earned income in MA calculations. The value of the in–kind income is determined by using the prevailing wage rate in the local community for the type of work performed, but not less than the minimum wage for that type of work.

(d) *Income from providing room and board.* Net profit from room and board shall be treated as earned income in MA calculations. Net profit is determined by deducting the following expenses of providing room and board from the gross room and board income received:

1. Roomer only – $15.00;

2. Boarder only – current food stamp allotment for one; and

3. Roomer and boarder – current food stamp allotment for one plus $15.00.

(e) *Income from rentals.* When the owner reports rental income to the IRS as self–employment income, the procedures set forth in par. (a) shall be followed in MA calculations. If the owner does not report rental income to the IRS as self–employment income, net rental income shall be determined as follows:

1. When the owner is not an occupant, net rental income is the rental income minus the mortgage payment and verifiable operational costs;

2. When the owner receives rental income from a duplex or multiple rental unit building and the owner resides in one of the units, net rental income shall be computed according to the following method:

a. Add the interest portion of the mortgage and other verifiable operational costs common to the entire operation;

b. Multiply the number of rental units by the total in subd. 2. a.;

c. Divide the result in subd. 2. b. by the total number of units;

d. Add the result in subd. 2. c. to any operational costs paid by the owner that are unique to any rental unit; and

e. Subtract the result in subd. 2. d. from the total rent payments. The result is net rental income.

(f) *Income of SSI child's parents.* Income of a disabled child's parents shall not be considered when determining the child's eligibility for MA if the child meets the conditions stated in 42 USC 1396a (e) (3).

(g) *Income disregards.* Income disregards of the AFDC program under 45 CFR 233.20 (a) and of the SSI program under 20 CFR 416.1112 and 416.1124 shall be used as appropriate.

(h) *Income from land contracts.* Income received from a land contract shall be counted as unearned income. If the income is received on a monthly basis, it shall be included as monthly income. Payments received on less than a monthly basis shall be prorated to a monthly amount over the period between payments. Any expenses that the applicant or recipient is required to pay under the terms of the land contract shall be deducted from the gross income received from the land contract.

(i) *Interest income.* 1. Interest income shall be counted as unearned income when:

a. It is received on a regular basis; and

b. It exceeds $20.00 per month. Amounts of $20.00 or less are considered inconsequential income and are disregarded.

2. The interest shall be counted as income in the month in which it is received. Interest income that is received less often than monthly shall be prorated over the period the payment covers.

(3) DEDUCTIONS FROM EARNED INCOME. (a) *Work–related deduction.* If an individual is employed, $90 shall be deducted from the individual's earned income when determining MA eligibility.

(b) *Dependent care deductions.* When employment cannot be maintained without dependent care for a child or incapacitated adult in the MA or fiscal test group, the following deductions shall be applied:

1. The actual cost of care but not more than $175 each month for each dependent child age 2 or over or incapacitated adult; and

2. The actual cost of care but not more than $200 each month for each dependent child under age 2.

(c) *Special deductions for employed blind persons.* Transportation expenses incurred in getting to and from work, expenses related to job performance and expenses related to improving job ability such as training meant to improve employability and increase earning power shall be deducted from the earned income of blind persons.

Note: Examples of expenses related to job performance are a reader, translation of material into braille, the cost and upkeep of a seeing eye dog for a blind person, and the cost of a prosthesis.

(4) DEDUCTION FROM ANY INCOME FOR SUPPORT TO AN INSTITUTIONALIZED PERSON. If a person in the MA group has legal responsibility for a person residing in an institution where the cost of care cannot be covered by MA, any income actually made available by the MA group toward the institutional cost of care shall be deducted from the MA group's income.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; cr. (2) (h), Register, July, 1989, No. 403, eff. 8–1–89; emerg. r. and recr. (3) (a) and (b), eff. 10–2–89; r. and recr. (3) (a) and (b), Register, March, 1990, No. 411, eff. 4–1–90; am. (1) (a) 3., (b) (intro.), (c) 3. and (d) (intro.), r. and recr. (1) (d) 1., cr. (2) (i), Register, March, 1993, No. 447, eff. 4–1–93; correction in (1) (a) 3. and (2) (e) 2. made under s. 13.93 (2m) (b) 7., Stats., Register, April, 1999, No. 520.

HFS 103.075 Prevention of spousal impoverishment. (1) APPLICABILITY. For resource eligibility, this section applies to all institutionalized applicants for and recipients of MA who began a continuous period of institutionalization on or after September 30, 1989, and to their spouses. For purposes of computing income available towards the cost of an institutionalized individual's care, this section applies to all institutionalized applicants for and recipients of MA who were residing in an institution on October 1, 1989, or who entered an institution subsequent to that date, and to their spouses.

(2) PURPOSE. This section implements s. 49.455, Stats., which provides for protection of a couple's income and resources when one spouse is institutionalized and the other spouse lives in the community.

(3) DEFINITIONS. In this section:

(a) "Community spouse" means an individual who is legally married as recognized under state law to an institutionalized spouse but is not himself or herself an institutionalized individual.

(b) "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.

(c) "Continuous period of institutionalization" means an individual has resided in or is likely to remain in an institution for at least 30 consecutive days.

(d) "Family member" means a minor or dependent child, dependent parent or dependent sibling of an institutionalized or community spouse who resides with the community spouse.

(e) "Institutionalized spouse" means either an individual who is in a medical institution or nursing facility and is legally married to an individual who is not in a medical institution or nursing facility or an individual who receives services under a waiver under 42 USC 1396n (c) or (d) and is legally married to an individual who is not in a medical institution or nursing facility and does not receive services under a waiver under 42 USC 1396n (c) or (d).

(f) "Medical institution" means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care;

2. Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health care needs of patients on a continuing basis in accordance with accepted professional standards;

3. Is authorized under state law to provide medical care; and

4. Is staffed by professional personnel who are responsible for professional medical and nursing services. The professional medical and nursing services shall include adequate and continual medical care and supervision by a physician, registered nurse or licensed practical nurse supervision and services and nurses' aide services sufficient to meet nursing care needs and a physician's guidance on the professional aspects of operating the institution.

(g) "Resources" does not include items excluded under 42 USC 1382b (a) or (d) or items that would be excluded under 42 USC 1382b (a) (2) (A) but for the limitation on total value established under that provision.

(4) ASSESSMENT. (a) An institutionalized spouse or the community spouse, or a representative acting on the behalf of either spouse, may request that an agency complete an assessment of the couple's assets for purposes of determining total countable assets of the couple and the community spouse resource allowance. If the request is not part of an application for medical assistance, the agency may charge a fee not exceeding the reasonable expenses of providing and documenting the assessment.

(b) Both the institutionalized spouse and the community spouse shall verify the assets that they own, jointly or individually, and the value of those assets at the beginning of the most recent continuous period of institutionalization.

(c) The agency shall:

1. Complete the assessment within 30 days after the date of the request for an assessment;

2. Determine and verify the total countable assets of the couple using the procedures under sub. (5) (b) 2.;

3. Determine the community spouse resource allowance pursuant to s. 49.455 (6) (b), Stats.; and

4. Notify in writing the institutionalized spouse and the community spouse, or a representative acting on the behalf of either spouse, of the couple's total countable assets, the community spouse resource allowance and the amount of assets that the couple may retain so that the institutionalized spouse may be asset–eligible for MA and of the right of either spouse to a fair hearing under sub. (8) after an application for medical assistance is filed.

(5) ASSETS. (a) *Applicability.* This subsection applies only to individuals who began their most recent continuous period of institutionalization after September 29, 1989. Those individuals who began their most recent continuous period of institutionalization before September 30, 1989, shall have their eligibility determined using asset eligibility criteria under s. HFS 103.06 (1) unless the individual left the institution or lost eligibility for a community–based services waiver program under 42 USC 1396n (c) or (d) for a period of at least 30 days and subsequently began a new continuous period of institutionalization after September 29, 1989.

(b) *Eligibility determination.* 1. Initial determination. The agency shall consider the total countable assets of the institutionalized spouse and his or her community spouse in determining initial MA eligibility for the institutionalized spouse.

2. Total countable assets. The agency shall count all available assets belonging to either spouse in the month for which eligibility is being determined except for the following:

a. Homestead property;

b. One vehicle, regardless of value;

c. Household and personal effects, regardless of value;

d. Burial assets and funds set aside for the purpose of meeting burial expenses, regardless of value. This includes burial trusts, burial funds, burial plots, burial insurance and other property or funds expressly set aside for burial expenses; and

e. Any other assets that would otherwise be excluded for purposes of SSI–related MA eligibility determination as provided under s. HFS 103.06.

3. Asset limit. The agency shall compare the value of the couple's assets to the amount obtained by adding the SSI–related one person asset limit under s. 49.47 (4) (b) 3g., Stats., to the community spouse resource allowance under s. 49.455 (6) (b), Stats. If the couple's available assets are equal to or less than the asset limit, the institutionalized spouse is asset eligible for MA.

(c) *Consideration of community spouse's assets.* During a continuous period of institutionalization after an institutionalized spouse is determined to be eligible for MA, no assets of the community spouse may be considered available to the institutionalized spouse.

(d) *Protected resources.* 1. For the 12 months after an institutionalized spouse has been initially determined eligible for MA,

an amount equal to the amount of assets comprising the community spouse resource allowance for which an institutionalized spouse has title interest that does not exceed the limits described in s. 49.455 (6) (b), Stats., shall be exempt from consideration;

2. After 12 months, the exemption of the protected spousal asset share ceases to exist;

3. In subsequent redeterminations of eligibility after 12 months, the agency shall compare the assets of an institutionalized spouse to the SSI–related MA asset limit provided under s. 49.47 (4) (b) 3g., Stats. If the institutionalized spouse's assets exceed those limits, he or she is ineligible for MA.

4. Limits on countable assets shall be determined as provided in par. (b) 2. as long as there is a community spouse.

(e) *Exceptions to resource ineligibility.* The agency may not determine an institutionalized spouse ineligible if one or more of the following conditions exists:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse;

2. The institutionalized spouse lacks the ability to execute an assignment under subd. 1. due to a physical or mental impairment but the agency has the right to bring a support proceeding against the community spouse without an assignment; or

3. The agency determines and documents in the case record that denial of eligibility would work an undue hardship for the institutionalized spouse. In this subdivision, "undue hardship" means that a serious impairment to the institutionalized individual's immediate health status exists.

(6) INCOME. (a) *Income attribution.* 1. No income of a community spouse may be deemed available to an institutionalized spouse applying for MA, except if a court order is in effect.

2. The agency shall count voluntary contributions of a community spouse towards the cost of his or her institutionalized spouse's care as income in determining an institutionalized spouse's eligibility and the amount that an institutionalized spouse is required to contribute towards the cost of his or her care. An agency may not request or suggest that a community spouse make a voluntary contribution toward the institutionalized spouse's cost of care.

3. Unless an institutionalized spouse establishes by a preponderance of evidence through a fair hearing that ownership interest is other than as provided under s. 49.455 (3) (b), Stats., and this subdivision, non–trust income shall be considered the income of the person in whose name the payment is made or, if the income is paid in both spouses' names or is unspecified, half shall be considered as the income of each or, if the income is shared with others, amounts equal to each spouse's proportionate share shall be considered available.

4. The agency shall consider trust income as available based upon the specific terms of the trust. Income paid to a spouse from the trust belongs to that spouse alone. If trust income is paid to both spouses or if the percentage is unspecified, half of the income shall be considered to belong to each spouse.

5. The income eligibility standards against which an institutionalized spouse's income is tested shall be the same as those under s. HFS 103.04 (4).

(b) *Protecting income for the community spouse and dependent family members.* 1. Community spouse income allowance. An MA–eligible institutionalized spouse may allocate income to his or her community spouse to provide for the monthly maintenance of the community spouse. An institutionalized spouse may allocate enough of his or her income, after deducting a personal needs allowance as provided under s. 49.45 (7) (a), Stats., or 42 CFR 435.726 (c) in the case of an institutionalized spouse participating in a home and community–based care waiver program under s. 46.277, Stats., to bring the community spouse's monthly income up to the amount specified in s. 49.455 (4) (b), Stats., or an amount ordered by a court, whichever is greater. The community spouse's monthly gross income shall be determined by the agency as provided under s. 49.47 (4) (c), Stats., without regard to the SSI–related MA deductions.

2. Family member income allowance. An MA–eligible institutionalized spouse may deduct from his or her income, sufficient funds to bring each dependent family member's monthly income up to the amount specified in s. 49.455 (4) (a) 3., Stats., or an amount ordered by a court, whichever is greater. A dependent family member is:

a. Any minor natural or adopted child or step–child of either the institutionalized spouse or the community spouse who resides with the community spouse;

b. Any adult natural or adopted child or step–child of either the institutionalized spouse or the community spouse who is claimed as a dependent by either the institutionalized spouse or the community spouse for tax purposes under the internal revenue service code or who could be claimed as a dependent for tax purposes if a tax return were filed and who resides with the community spouse;

c. A sibling of either the institutionalized spouse or the community spouse who is claimed as a dependent by either the institutionalized spouse or the community spouse for tax purposes under the internal revenue service code or who could be claimed as a dependent for tax purposes if a tax return were filed and who resides with the community spouse; or

d. A parent of either the institutionalized spouse or the community spouse who is claimed as a dependent by either the institutionalized spouse or the community spouse for tax purposes under the internal revenue service code or who could be claimed as a dependent for tax purposes if a tax return were filed and who resides with the community spouse.

(c) *Computing income available towards the cost of care.* An institutionalized recipient shall apply his or her available income toward the cost of his or her care. In this paragraph, "available income" means any income remaining after the following deductions are made from the recipient's gross monthly income:

1. A personal needs allowance as provided under s. 49.45 (7) (a), Stats., or 42 CFR 435.726 (c), as appropriate;

2. The community spouse monthly income allowance under par. (b) 1. that is actually made available by the institutionalized spouse to the community spouse or to another individual for the benefit of the community spouse;

3. The total family member income allowance calculated under par. (b) 2., whether or not actually made available by the institutionalized spouse to a family member; and

4. The amount incurred as expenses for remedial or medical care for the institutionalized spouse as follows:

a. For an individual participating in a community–based care waiver program, the amount incurred as expenses for remedial or medical care and the cost of the individual's health insurance premiums; and

b. For an individual residing in a medical institution, the cost of the institutionalized spouse's health insurance premiums.

(7) NOTICE. The agency shall notify both spouses when it determines that an institutionalized spouse is eligible for MA, or it shall notify the spouse who requested a determination of MA eligibility. The notice shall be in writing and shall include the following information:

(a) The amount of the community spouse monthly income allowance calculated under sub. (6) (b) 1.;

(b) The amount of any family allowance calculated under sub. (6) (b) 2;

(c) The amount of the couple's total countable assets determined under sub. (4) (c);

(d) The amount of the community spouse resource allowance and the method used to calculate the allowance under sub. (4) (c) 3.;

(e) The amount of income that the institutionalized spouse is required to contribute toward the cost of his or her care; and

(f) Each spouse's right to a fair hearing under sub. (8) concerning ownership or availability of income or resources and the determination of the community spouse monthly income or resource allowance.

(8) FAIR HEARING. (a) An institutionalized spouse or a community spouse may request a fair hearing in accordance with the procedures set out in s. HFS 104.01 (5) in regard to any of the following:

1. The determination of the community spouse monthly income allowance under sub. (6) (b) 1.;

2. The determination of the amount of the monthly income otherwise available to the community spouse used in the calculation under sub. (6) (b) 1.;

3. The amount of the couple's total countable assets determined under sub. (4) (c);

4. The determination of the spousal share of resources under sub. (4) (c) 3.; and

5. The determination of the community spouse resource allowance under sub. (4) (c) 3.

(b) If the institutionalized spouse has made an application for MA and a fair hearing is requested under par. (a), the agency shall hold the hearing within 30 days after the request.

(c) If either spouse establishes at a fair hearing that, due to exceptional circumstances resulting in financial duress, the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance determined under sub. (6) (b), the hearing officer shall determine an amount adequate to provide for the community spouse's needs. In this paragraph,"exceptional circumstances resulting in financial duress" means situations that result in the community spouse not being able to provide for his or her own necessary and basic maintenance needs. The agency shall use the amount determined by the hearing officer in place of the minimum monthly maintenance needs allowance determined under sub. (6) (b).

(d) If either spouse establishes at a fair hearing that the community spouse resource allowance determined by the agency under sub. (4) (c) 3. does not generate enough income to raise the community spouse's income to the minimum monthly maintenance needs allowance under s. 49.455 (4) (c), Stats., the hearing officer shall establish an amount to be used under sub. (5) (b) that results in a community spouse resource allowance that generates sufficient income to raise the community spouse's monthly income to the minimum monthly maintenance needs allowance under s. 49.455 (4) (c), Stats.

(e) Neither the institutionalized spouse nor the community spouse shall have the right to a fair hearing under this section until after an MA application is filed and MA eligibility and the benefit level are determined.

History: Cr. Register, March, 1993, No. 447, eff. 4–1–93.

HFS 103.08 Beginning of eligibility. (1) DATE. Except as provided in subs. (2) to (5), eligibility shall begin on the date on which all eligibility requirements were met, but no earlier than the first day of the month 3 months prior to the month of application. Retroactive eligibility of up to 3 months may occur even though the applicant is found ineligible in the month of application.

(2) SPEND–DOWN PERIOD. (a) 1. The spend–down period shall begin on the first day of the month in which all eligibility factors except income were met, but no earlier than the first day of the month 3 months prior to the month of application. However, at the recipient's option, it may begin on the first day of any of the 3 months prior to the date of application if all eligibility factors, except income, were met in that month. A recipient's decision to choose an optional beginning date shall be recorded in the agency's case record. For persons who previously received MA and then reapply, the spend–down period cannot cover the time during which they were receiving MA.

2. The AFDC–related or SSI–related MA group shall be eligible as of the date within the spend–down period on which the expenditure of excess income or the obligation to expend excess income is achieved.

3. The applicant shall be responsible for some bills or parts of bills for services received on the first day of eligibility if there is remaining unspent and unobligated excess income on that day.

(b) If the amount of the monthly excess income changes before the expenditure or obligation of excess income is achieved, the expenditure or obligation of excess income for the remainder of the 6–month period shall be recalculated. When the size of the AFDC–related or SSI–related MA group changes, the monthly income limit shall be adjusted appropriately to the size of the new group, and the amount of excess income to be expended or obligated shall be adjusted accordingly. If any change is reported that may affect eligibility, the eligibility of the entire AFDC–related or SSI–related MA group may be redetermined and, if there is determined to be excess income, a new spend–down period shall be established.

(c) 1. Once the expenditure or obligation of excess income has been achieved, the AFDC–related or SSI–related MA group shall be eligible for the balance of the 6–month spend–down period, unless it is determined that assets have increased enough to make the MA group ineligible, or that a change in circumstances has caused someone in the MA group to become ineligible for non–financial reasons.

2. If the entire group is determined ineligible, the MA benefits shall be discontinued with proper notice. If only one person in the MA group is determined ineligible for non–financial reasons, only that person's AFDC–related or SSI–related MA benefits shall, with proper notice, be discontinued. The other person or persons in the MA group continue their eligibility until the end of the 6–month period.

3. If the size of the MA group increases due to the addition of a child, that child is eligible for benefits during the rest of the spend–down period. An adult caretaker who enters the AFDC–related or SSI–related MA group, except a woman who is medically verified as pregnant or a person who is SSI–related, is not eligible for benefits during the remainder of the spend–down period.

(3) PRESUMPTIVE DISABILITY CASES. If, in a presumptive disability case, the applicant meets all other conditions for eligibility, MA benefits shall begin on the date the presumptive disability finding is made and shall continue at least until the official disability determination is completed. Presumptive disability eligibility shall not be granted retroactively. MA benefits based on presumptive disability shall not be continued pending an appeal of a negative official disability determination.

(4) PREGNANCY–RELATED MA CASES. For pregnancy–related cases pursuant to ss. 49.46 (1) (a) 1m. and 9. and 49.47 (4) (ag) 2. and (am) 1., Stats., eligibility shall begin on the date pregnancy is verified or the date of application, whichever is earlier, but eligibility may only be backdated as provided under sub. (1).

(5) BADGERCARE CASES. Eligibility for BadgerCare shall begin on the first day of the month in which all eligibility requirements are met, but no earlier than the first day of the month of application.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; am. (4), Register, March, 1993, No. 447, eff. 4–1–93; emerg. am. (1), (2) (a) 2., (b) and (c), eff. 7–1–99; am. (1), (2) (a) 2., (b) and (c) and cr. (5), Register, March, 2000, No. 531, eff. 4–1–00; **correction in (4) made under s. 13.93 (2m) (b) 7., Stats.**

HFS 103.085 Conditions for continuation of eligibility for BadgerCare. (1) PREMIUMS. (a) *Authority.* Subject to s. 49.665 (5), Stats., and this section, a group eligible for BadgerCare may be required to pay a premium.

(b) *Applicability.* 1. A group eligible for BadgerCare with budgetable income at or below 150% of the poverty line is not required to pay a premium toward the cost of the health care coverage.

2. Except as provided in subd. 3. or 4., a group eligible for BadgerCare with budgetable income above 150% of the poverty line shall pay a premium toward the cost of the health care coverage.

3. A BadgerCare applicant group does not owe a premium for the first month of BadgerCare unless a member of the BadgerCare fiscal test group was an MA recipient in the previous month.

4. A BadgerCare applicant group does not owe a premium for the first month of BadgerCare unless a member of the BadgerCare fiscal test group was a BadgerCare recipient in the previous 12 months.

(c) *Amounts.* A group eligible for BadgerCare required under this subsection to pay a premium shall pay the amount indicated in the schedule provided in Table 103.085. Income shall be determined according to s. HFS 103.07.

Table 103.085

BadgerCare Premium Schedule

Monthly Income		Monthly
From	To	Premium
$ 1,000	$ 1,499.99	$ 30
$ 1,500	$ 1,999.99	$ 45
$ 2,000	$ 2,499.99	$ 60
$ 2,500	$ 2,999.99	$ 75
$ 3,000	$ 3,499.99	$ 90
$ 3,500	$ 3,999.99	$105
$ 4,000	$ 4,499.99	$120
$ 4,500	$ 4,999.99	$135
$ 5,000	$ 5,499.99	$150
$ 5,500	$ 5,999.99	$165
$ 6,000	$ 6,499.99	$180
$ 6,500	$ 6,999.99	$195
$ 7,000	$ 7,499.99	$210
$ 7,500	$ 7,999.99	$225
$ 8,000	$ 8,499.99	$240
$ 8,500	$ 8,999.99	$255
$ 9,000	$ 9,499.99	$270
$ 9,500	$ 9,999.99	$285
$10,000	$10,499.99	$300
$10,500	$10,999.99	$315

(d) *Payment.* 1. A group otherwise eligible for BadgerCare that is required to pay a premium under this section shall pay the premium amount in full to the agency before the agency may certify the group's initial eligibility for BadgerCare.

2. Premiums are due by the 10th of the month prior to the month for which the premium is required.

3. If no payment is received by the end of the month for which the premium is required, the department shall terminate the group's eligibility for BadgerCare, effective at the end of the month.

4. The department shall allow a variety of premium payment methods. A group may choose one of the following methods for premium payment:

a. Wage withholding.

b. Electronic funds transfer (EFT).

c. Direct payment by check or money order.

5. A group may pay premiums in advance for more than one month, but only for months in the group's BadgerCare eligibility period.

(e) *Refunds.* The department shall issue a refund for a premium which has been paid in advance when the premium is for one of the following:

1. A month that the group is ineligible for BadgerCare.

2. A month that the group's budgetable income drops to or below 150% of the poverty line and the change in income that brought the group's budgetable income to or below 150% of the poverty line was reported within 10 days of the date the change occurred.

3. A month which requires a lower premium amount due to a change in circumstances which was in effect for the entire month so long as the change was reported within 10 days of the date it occurred. In a case where the change was not reported within 10 days of the date it occurred, the effective date of the lower premium amount due is the first day of the month in which the change was reported.

(f) *Consequence of failure to pay BadgerCare premiums.* A group required to pay a premium shall be ineligible for re–enrollment for the period specified in sub. (3) when the group fails to pay its premium within the time specified in par. (d).

(2) QUITTING BADGERCARE. (a) *Termination of benefits.* Except as provided in par. (b), a group eligible for BadgerCare and required under sub. (1) to pay a premium shall be subject to re–enrollment restrictions under sub. (3) when that group voluntarily terminates BadgerCare eligibility.

(b) *Reasons for quitting BadgerCare.* A group that quits BadgerCare shall not be subject to a restrictive re–enrollment period if the group requests termination of BadgerCare for one of the following reasons:

1. The BadgerCare group is moving out of Wisconsin.

2. No one in the BadgerCare group remains non–financially eligible for BadgerCare.

3. A member of the BadgerCare group is starting employment that provides health care benefits.

4. Other health insurance coverage has become available to the BadgerCare group.

5. Any other reason, as determined by the department, not related to payment of the premium.

(3) RE–ENROLLMENT RESTRICTION. (a) *Period of ineligibility.* A BadgerCare group that fails to make a premium payment under sub. (1) or quits BadgerCare under sub. (2) is not eligible for BadgerCare for a period of at least 6 consecutive calendar months following the date that BadgerCare eligibility ends, unless one of the circumstances in par. (b) applies. Eligibility is restored as described in par. (c). After 6 calendar months, the group shall be eligible for BadgerCare only if all past premiums due are paid in full or 12 calendar months have passed after the expiration of BadgerCare eligibility, whichever is sooner.

(b) *Reasons restriction on re–enrollment may not apply.* The restriction on re–enrollment under this section does not apply for either of the following reasons:

1. The failure to pay premiums was due to a circumstance beyond the group's control, provided that all past due premiums have been paid in full. A circumstance beyond the group's control includes any of the following:

a. A problem with an electronic funds transfer from a bank account to the BadgerCare program.

b. A problem with an employer's wage withholding.

c. An administrative error in processing the premium.

d. Any other circumstance affecting payment of the premium which the department determines is beyond the group's control, but not including insufficient funds.

2. A significant change in household composition occurred. A significant change occurs when one of the following events occurs:

a. A parent or a parent's spouse in the group eligible for BadgerCare no longer resides in the home and has not resided in the home for at least 30 consecutive days.

b. A person not in the group eligible for BadgerCare, but who is legally responsible for a group member, no longer resides in the home and has not resided in the home for at least 30 consecutive days.

c. A caretaker relative of a minor in a group eligible for BadgerCare, or the caretaker relative's spouse, no longer resides in the home and has not resided in the home for at least 30 consecutive days.

(c) *Resuming BadgerCare eligibility.* Eligibility for BadgerCare shall resume in the following manner for persons with a re–enrollment restriction that ended due to a reason described in par. (b):

1. For a BadgerCare group with a reason under par. (b) 1. for the re–enrollment restriction not to apply, BadgerCare eligibility shall be restored for any months that the group had been closed during the restriction period, provided that payment of any outstanding premiums owed is made and the group was otherwise eligible for BadgerCare in those months.

2. For a BadgerCare group with a reason under par. (b) 2. for the re–enrollment restriction not to apply, the restriction on re–enrollment shall not apply to the remainder of the 6–month period. Beginning the first of the month after the adult has been out of the home for 30 days, the group may again be eligible for BadgerCare, provided that payment of any outstanding premiums owed is made and the group is otherwise eligible. The BadgerCare group remains ineligible for any prior months when the restriction on re–enrollment was in effect.

(4) ENROLL IN AVAILABLE EMPLOYER–SUBSIDIZED HEALTH PLAN. (a) A BadgerCare recipient is ineligible for BadgerCare when one of the following fail to enroll in an available employer–subsidized health care coverage:

1. The recipient.

2. The recipient's spouse when the spouse is residing with the recipient.

3. The recipient's parent, step–parent or other caretaker relative residing with the recipient, when the recipient is under 19 years of age.

(b) Except as provided in par. (c), the recipient is ineligible for BadgerCare effective on the first day of the month that the employer–subsidized health care coverage would have been in effect for the recipient if the family had been enrolled in the plan. The individual remains ineligible for each month that coverage would have been available up to 19 months from the month the failure to enroll in the plan occurred.

(c) Paragraph (b) does not apply if there was coverage and it ended for a good cause reason. A good cause reason is any of the following:

1. The employment ended for a reason other than voluntary termination.

2. The person changed to a new employer that does not offer family coverage.

3. The person's employer discontinued health plan coverage for all employees.

4. Any other reason determined by the department to be a good cause reason.

(5) COOPERATION WITH BUY–IN TO A GROUP HEALTH INSURANCE PLAN. An adult in a group eligible for BadgerCare shall cooperate when the department determines whether it is cost–effective to purchase coverage for the group in an employer's group health insurance plan under s. HFS 108.02 (13). In this subsection, "cooperation" means providing necessary information in order to determine cost effectiveness, signing up with the plan when requested by the department and cooperating with any other requirements of the health insurance plan. A person who fails or refuses to cooperate with buy–in is not eligible for BadgerCare.

(6) MAXIMUM INCOME. A BadgerCare group remains eligible for BadgerCare while the fiscal test group's income is at or below 200% of the poverty line and the group is otherwise eligible for BadgerCare.

History: Emerg. cr. eff. 7–1–99; cr. Register, March, 2000, No. 531, eff. 4–1–00.

HFS 103.087 Conditions for continuation of eligibility. (1) PREMIUMS. (a) *Authority.* Subject to this section and s. 49.472, Stats., a person eligible for the medicaid purchase plan shall pay a monthly premium.

(b) *Applicability.* 1. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is at or above 150% of the poverty line for the applicable household size shall pay a monthly premium and the applicant shall pay all retroactive premium amounts assessed or other premium payments due.

2. An applicant or recipient eligible for the medicaid purchase plan whose total earned and unearned income is below 150% of the poverty line for the applicable household size need not pay a monthly premium.

3. An applicant or recipient eligible for the medicaid purchase plan whose premium, calculated as described in par. (c), is greater than $10.00 shall pay a premium for the cost of the health care coverage offered under the medicaid purchase plan.

(c) *Premium amounts.* 1. An applicant or recipient eligible for the medicaid purchase plan shall pay a monthly premium in accordance with this subsection and the premium schedule in Table 103.087.

2. The county agency shall determine the amount of the premium an applicant shall pay according to the guidelines described in this subsection at the time of application.

3. All earned and unearned sources of income available to the applicant or recipient, except for the interest, dividends or other gains accrued from a recipient's independence account, shall be used in the premium determination.

4. The applicant's or recipient's monthly premium shall be calculated by locating the sum of the monthly adjusted unearned income plus the monthly adjusted earned income on the premium schedule in Table 103.087.

(d) *Calculating the monthly adjusted unearned income.* 1. An applicant's or recipient's monthly adjusted unearned income shall be calculated by subtracting the monthly income disregards in subd. 1. a. to c. from 100% of the applicant's or recipient's gross monthly countable unearned income.

a. The allowance shall be equal to the sum of the monthly federal supplemental security income cash benefit, the monthly state supplemental security cash benefit, and $20, rounded to the nearest dollar.

b. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

c. To be claimed as a monthly income disregard, the cost may not have been claimed by the applicant or recipient under any other medicaid purchase plan income disregard.

2. If the applicant or recipient has monthly unearned income equal to $0, the monthly income disregards described in subd. 1. a. to c. apply to the applicant's or recipient's gross monthly earned income. If the applicant or recipient has monthly income disregards greater than his or her monthly unearned income, the difference shall be applied as a deduction to the applicant's or recipient's monthly earned income.

(e) *Calculating monthly adjusted earned income.* An applicant's or recipient's monthly adjusted earned income shall be 3% of the applicant's or recipient's gross monthly earned income after the amount of any monthly income disregards greater than the applicant's or recipient's total unearned income have been subtracted.

(f) *Calculating the total monthly premium.* 1. The sum of the amounts determined in pars. (d) and (e) shall be applied to the premium schedule in Table 103.087. If the sum of the monthly adjusted earned and monthly adjusted unearned income is greater than $1025.00, the total monthly premium amount is the exact amount of the sum.

Table 103.087: Medicaid Purchase Plan Premium Schedule

PREMIUM SCHEDULE					
Sum of Monthly Adjusted Earned and Adjusted Unearned Income		The premium is:	Sum of Monthly Adjusted Earned and Adjusted Unearned Income		The premium is:
FROM	TO	**PREMIUM**	FROM	TO	**PREMIUM**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	10.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.00	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
425.01	450.00	425.00	950.01	975.00	950.00
450.01	475.00	450.00	975.01	1000.00	975.00
475.01	500.00	475.00	1000.01	1025.00	1000.00

2. The monthly premium shall be recalculated by the county agency to reflect any changes in earned or unearned income as reported by the recipient. A recipient's premium amount may change for any of the following reasons:

a. Termination of the recipient from the medicaid purchase plan.

b. A change in the poverty line or SSI federal or state benefit payment rate.

c. Changes in income, impairment–related work expense costs or medical and remedial expense costs.

d. Contributions to a recipient's independence account greater than an amount equal to 50% of earned income as described in s. HFS 103.06 (15).

e. Other changes in personal or financial status that alter medical assistance eligibility.

(g) *Monthly payments.* 1. Before the county agency may certify an applicant as eligible for the medicaid purchase plan, the applicant who owes a premium under this subsection shall pay the premium amount. The premium amount owed shall include the premiums for all retroactive and current months in which the applicant owes a premium as of the date eligibility is determined.

2. An applicant may claim retroactive medicaid purchase plan eligibility for a period of up to 3 months prior to the month of application, but not prior to January 1, 2000. To be eligible for retroactive eligibility, an applicant shall pay the retroactive premium amount for each month claimed, in full, to the state's fiscal agent via the county agency, prior to the county agency certifying the applicant's eligibility for the medicaid purchase plan.

3. Based on arrangements made by the applicant or recipient, entities other than the applicant or recipient may pay monthly premiums on behalf of the applicant or recipient. The applicant or recipient shall be ultimately responsible for his or her monthly premium payment.

4. If the county agency does not receive payment by the last day of the calendar month for which the premium is owed, the department shall terminate the recipient's eligibility for the medicaid purchase plan, effective the last calendar day of the month.

5. An applicant or recipient may pay monthly premiums in advance, but only for the months in the applicant's or recipient's current medicaid review period. The applicant or recipient shall pay advance monthly premium amounts in full.

6. If no premium is required and the applicant meets all other eligibility factors, the county agency shall approve the applicant for the medicaid purchase plan.

(h) *Non–payment of medicaid purchase plan premiums.* 1. An applicant or recipient required to pay a monthly premium shall be ineligible for re–enrollment for the period specified in par. (i) 2. when the applicant or recipient fails to pay his or her monthly premium within the time specified in par. (g) 4. resulting in a finding of premium non–payment.

2. Premium non–payment shall include attempted payment with an instrument such as a check or direct deposit, that has been returned, refused or dishonored. A guaranteed form of payment such as a cashier's check or money order shall be required to replace a returned, refused or dishonored payment.

3. Failure to pay premiums due to circumstances beyond the recipient's control may not be considered non–payment, provided that all past due premiums are paid in full. Circumstances beyond the recipient's control are any of the following:

a. Problems with an electronic funds transfer or direct deposit from a financial institution to the medicaid purchase plan program.

b. Problems with an employer's wage withholding.

c. Administrative error in processing the premium.

d. Any other circumstances that may be found to be good cause as determined by the department on a case–by–case basis.

4. At the time of application or anytime thereafter, an applicant or recipient may sign a release statement identifying an emergency contact to receive copies of the person's notice of decision letters.

(i) *Consequences of premium non–payment.* 1. A person eligible for the medicaid purchase plan who fails to pay his or her monthly premium shall be terminated from the medicaid purchase plan and subject to restrictive re–enrollment as described under subd. 2.

2. A medicaid purchase plan participant who fails to make his or her monthly premium payments in the medicaid purchase plan shall be ineligible for a period of at least 6 consecutive calendar months following the date that the medicaid purchase plan eligibility ends. After 6 calendar months, the person shall be eligible for the medicaid purchase plan only if all past premiums due are paid in full or 12 calendar months have passed since the expiration of medicaid purchase plan eligibility, whichever is sooner.

(2) COOPERATION WITH BUY–IN TO EMPLOYER–PROVIDED HEALTH CARE COVERAGE. (a) The applicant eligible for the medicaid purchase plan and the applicant's parent, if the applicant is a dependent child aged 18 or 19, shall cooperate when the department determines whether it is cost–effective to purchase coverage under the employer–provided health plan for the person under s. HFS 108.02 (14). In this subsection, "cooperate" means provide necessary information in order to determine cost–effectiveness, sign up with the health plan when requested by the department and comply with any other requirements of the health plan.

(b) 1. Except as provided in subd. 2., a person who fails or refuses to cooperate with the department's buy–in to employer–provided health care coverage is not eligible for the medicaid purchase plan.

2. An exception to subd. 1. shall be made in cases where a person who is otherwise eligible for medical assistance is unable to enroll in the group health plan on his or her own behalf. An example of a person who is otherwise eligible for medical assistance but unable to enroll in the group health plan on his or her own behalf may be a child whose parent refuses to enroll the child or a spouse unable to enroll on his or her own behalf.

History: Cr. Register, November, 2000, No. 539, eff. 12–1–00.

HFS 103.09 Termination of medical assistance. **(1)** FINAL MONTH COVERAGE. When eligibility ends, except in the case of death of the recipient, the MA benefits shall continue until the end of the calendar month.

(2) FOUR–MONTH CONTINUATION OF ELIGIBILITY. When an MA group becomes ineligible for AFDC due solely to excess income, is receiving child support payments and all of the excess income consists of child support collections, and has received an AFDC payment in at least 3 of the 6 months immediately preceding the month in which ineligibility begins, eligibility for MA shall continue for 4 months from the date that AFDC eligibility was terminated. The 6 months preceding the month in which ineligibility begins includes the month in which the MA group became ineligible for AFDC if the MA group was eligible for and received AFDC for that month.

(3) TWELVE–MONTH CONTINUATION OF ELIGIBILITY. (a) When an MA group becomes ineligible for AFDC due to loss of the earned income disregards under s. 49.19 (5) (a) 4. and 4m., or (am), Stats., or to a change in the amount of earned income disregards under s. 49.19 (5) (a) 4. and 4m., or (am), Stats., eligibility for MA shall continue for 12 months from the date that AFDC eligibility was terminated.

(b) When an MA group becomes ineligible for AFDC due to an increase in earned income or an increase in hours of employment or a combination of increased earned income and increased hours of employment, eligibility for MA shall continue for 12 months from the date that AFDC eligibility was terminated provided that at least one member of the MA group received AFDC for at least 3 of the 6 months immediately preceding the month in which AFDC was discontinued and at least one member of the MA group is continuously employed during that period.

(c) When an MA group becomes ineligible for AFDC due to an increase in earned income, or to a combination of an increase in earned income and in increase in child support payments, and has received an AFDC payment in at least 3 of the 6 months immediately preceding the month in which ineligibility begins, eligibility for MA shall continue for 12 months from the date that AFDC eligibility was terminated. The 6 months preceding the month in which ineligibility begins includes the month in which the MA group became ineligible for AFDC if the MA group was eligible for and received AFDC for that month.

(4) TIMELY NOTICE. The agency shall give the recipient timely advance notice and explanation of the agency's intention to terminate MA. This notice shall be in writing and shall be mailed to the recipient at least 10 calendar days before the effective date of the proposed action. The notice shall clearly state what action the agency intends to take and the specific regulation supporting that action, and shall explain the right to appeal the proposed action and the circumstances under which MA is continued if a fair hearing is requested.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; am. (3) (a), r. (2) (a), renum. (2) (b) to be (2) and am., r. and recr. (3) (b), cr. (3) (c), Register, March, 1993, No. 447, eff. 4–1–93.

HFS 103.10 Redetermination of eligibility. The agency shall give the recipient timely advance notice of the date on which the recipient's eligibility will be redetermined. This notice shall be in writing and mailed to the recipient at least 15 calendar days but no more than 30 calendar days before the redetermination date. The requirement for timely advance notice of eligibility redetermination does not apply to spend–down cases in which the period of certification is less than 60 days.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86.

HFS 103.11 Presumptive eligibility for pregnant women. **(1)** REQUIREMENTS. Pregnant women may be determined presumptively eligible for MA on the basis of verification of pregnancy and preliminary information about family income. That determination shall be made by providers designated by the department who are qualified in accordance with this section. A provider qualified to make determinations of presumptive eligibility shall meet the following requirements:

(a) Be certified as an MA provider under ch. HFS 105; and

(b) Provide one or more of the following services:

1. Outpatient hospital services;

2. Rural health clinic services; or

3. Clinic services furnished by or under the direction of a physician; and

(c) Receive funding or participate in a program under:

1. The migrant health center or community health center programs under section 329 or 330 of the public health service act;

2. The maternal and child health services block grant programs;

3. The special supplemental food program for women, infants and children under section 17 of the child nutrition act of 1966;

4. The commodity supplemental food program under D.4 (a) of the agriculture and consumer protection act of 1973; or

5. A state prenatal [perinatal] program; and

Note: Although "prenatal" was used in the filed rule order, the department's medical assistance manual uses the term "perinatal".

(d) Have been determined by the department to be a qualified provider under this section.

(2) DUTIES AND RESPONSIBILITIES. (a) A qualified provider shall ascertain presumptive MA eligibility for a pregnant woman by:

1. Verifying or obtaining verification of the woman's pregnancy; and

2. Determining on the basis of preliminary information that the woman's family income meets the applicable income limits.

(b) The provider shall inform the woman, in writing, of the determination of presumptive eligibility and that she has 14 calendar days from the date of the determination to file an application for MA eligibility with the county department of social services.

(c) Within 5 working days following the date on which the determination was made, the provider shall in writing notify the department and the agency where the woman will apply for MA eligibility of the woman's presumptive eligibility.

(d) In the event that the provider determines that a woman is not presumptively eligible, the provider shall inform her that she may file an application for MA eligibility at the county department of social services.

History: Cr. Register, February, 1988, No. 386, 3–1–88.

(22) MEDICAL ASSISTANCE SERVICES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS. If the department contracts with health maintenance organizations for the provision of medical assistance it shall give special consideration to health maintenance organizations that provide or that contract to provide comprehensive, specialized health care services to pregnant teenagers. If the department contracts with health maintenance organizations for the provision of medical assistance, the department shall determine which medical assistance recipients who have attained the age of 2 but have not attained the age of 6 and who are at risk for lead poisoning have not received lead screening from those health maintenance organizations. The department shall report annually to the appropriate standing committees of the legislature under s. 13.172 (3) on the percentage of medical assistance recipients under the age of 2 who received a lead screening test in that year provided by a health maintenance organization compared with the percentage that the department set as a goal for that year.

(24) PRIMARY CARE PROVIDER PILOT. The department may request a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (b) (1) to permit the establishment of a primary care provider pilot project. If the waiver is granted, the department may establish a primary care provider pilot project under which primary care providers act as case managers for medical assistance beneficiaries. If the department establishes a primary care provider pilot project, it shall reimburse a case manager for the allowable charges for case management services provided to a beneficiary participating in the pilot project.

(24g) MANAGED CARE FOR DENTAL SERVICES PILOT. (a) The department shall, in consultation with the Wisconsin Dental Association, develop a pilot project for the provision of dental services under a managed care system. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to implement the pilot project developed under this subsection. If the waiver is granted and in effect, and if the department of health and family services determines that the costs of providing dental services under s. 49.46 (2) (b) 1. under the pilot project will not exceed the costs of providing those dental services in the absence of the pilot project, the department shall implement the pilot project in Ashland, Douglas, Bayfield and Iron counties. Only those dental services covered under s. 49.46 (2) (b) 1. may be covered under the pilot project.

(b) In developing the pilot project under this subsection, the department shall provide that recipients who are subject to the pilot project are required to select a dental provider from among those dentists participating in the pilot project. The department shall also provide that, if a recipient does not make a selection, a dental provider will be assigned to the recipient.

(c) If the department is able to implement the pilot project under this subsection, the department shall contract with a person to do all of the following:

1. Accept a capitation payment from the department for each recipient who is subject to the pilot project.

2. Enroll dentists to be participating providers under the pilot project.

3. Coordinate with county departments to provide outreach and education to recipients and persons who are eligible to be recipients.

4. Pay all allowable charges on a fee–for–service basis to participating dentists on behalf of recipients in the pilot counties for dental services received by those recipients.

(24m) HOME HEALTH CARE AND PERSONAL CARE PILOT PROGRAM. From the appropriations under s. 20.435 (4) (b), (o), and (w), in order to test the feasibility of instituting a system of reimbursement for providers of home health care and personal care services for medical assistance recipients that is based on competitive bidding, the department shall:

(a) By September 1, 1990, select a county in this state and solicit bids from providers of home health care and personal care services in that county for the provision, on a contractual basis, of home health and personal care services authorized under ss. 49.46 (2) (a) 4. d. and (b) 6. j. and 49.47 (6) (a) 1.

(b) Award contracts for the provision of home health care and personal care services from the bids received under par. (a) only if the department determines that the contracts would result in a lower cost alternative to fee–for–service reimbursement.

(24r) FAMILY PLANNING DEMONSTRATION PROJECT. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide family planning services, as defined in s. 253.07 (1) (b), under medical assistance to any woman between the ages of 15 and 44 whose family income does not exceed 185% of the poverty line for a family the size of the woman's family. If the waiver is granted and in effect, the department shall implement the waiver no later than July 1, 1998, or on the effective date of the waiver, whichever is later.

(25) CASE MANAGEMENT SERVICES. (a) In this subsection, "severely emotionally disturbed child" means an individual under 21 years of age who has emotional and behavioral problems that:

1. Are severe in degree;

2. Are expected to persist for at least one year;

3. Substantially interfere with the individual's functioning in his or her family, school or community and with his or her ability to cope with the ordinary demands of life; and

4. Cause the individual to need services from 2 or more agencies or organizations that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education or health.

(am) Except as provided under pars. (be) and (bg) and sub. (24), case management services under s. 49.46 (2) (b) 9. and (bm) are reimbursable under medical assistance only if provided to a medical assistance beneficiary who receives case management services from or through a certified case management provider in a county, city, village or town that elects, under par. (b), to make the services available and who meets at least one of the following conditions:

1. Has a developmental disability, as defined under s. 51.01 (5) (a).

2. Has a chronic mental illness, as defined under s. 51.01 (3g).

3. Has Alzheimer's disease, as defined under s. 46.87 (1) (a).

4. Is an alcoholic, as defined under s. 51.01 (1).

5. Is drug dependent, as defined under s. 51.01 (8).

6. Is physically disabled, as defined by the department.

7. Is a severely emotionally disturbed child.

8. Is age 65 or over.

9. Is a member of a family that has a child who is at risk of serious physical, mental or emotional dysfunction, as defined by the department.

10. Has HIV infection, as defined in s. 252.01 (2).

11. Is a child who is eligible for early intervention services under s. 51.44.

12. Is infected with tuberculosis.

13. Is a child with asthma.

14. Is a woman who is aged 45 to 64 and who is not a resident of a nursing home or otherwise receiving case management services under this paragraph.

(b) A county, city, village, town or, in a county having a population of 500,000 or more, the department may elect to make case management services under this subsection available in the county, city, village or town to one or more of the categories of beneficiaries under par. (am) through the medical assistance program. A county, city, village, town or, in a county having a population of 500,000 or more, the department that elects to make the ser-

JCRAR HEARING

- Include Family Planning Emergency Rule
  - ~~Scott~~ Lazich / Seratti to do letter to co-chairs

- CWD - Baiting (allow it Hwy 29 North) / Feeding (limit on amount & feed) except Erad. Zone / Man. Zone
- DOC
- Senior Care
- Bill Drafts

Next ~~Issue~~ Hearing

- Bring up ~~non~~ floodproofing issue next ⇨ meeting

- Insurance
  - HMO's: employers to get together for purchasing pools

- Volunteers EMT Training Rule

- WMC: Regulatory Reforms
  - letters to Trade Orgs.
  - Let us know

3/20 PLW: JCRAR FE: $8.8 million savings

- Notice Entire rule
- CMS: Checking if this is required family. (Greg Chesmore)

Suspend Emergency Rule could kill Permanent

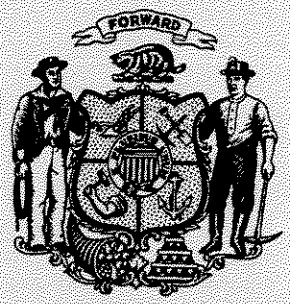
- Options
  - Kill Rule (not emergency)
  - Emergency Contraception: standard
  - Parental Consent

Glen

- Does this save money? Need studies American LifeLeague.
- This practice is already happening? Just giving more money.
- Get family planning services w/o parental consent.
- Abortaphacia nature (Emergency Contra)

TIMEFRAME

LAZICH LEAD?



1997-99 WISCONSIN STATE BUDGET

COMPARATIVE SUMMARY OF BUDGET PROVISIONS

ENACTED AS 1997 ACT 27

VOLUME I

LEGISLATIVE FISCAL BUREAU
DECEMBER, 1997

selection, a dental provider would be assigned to the recipient. In addition, specify that DHFS would contract with an entity to do the following: (a) accept a capitation payment from DHFS for each recipient who is enrolled in the pilot project; (b) enroll dentists to be participating dentists under the pilot project; and (c) coordinate with county departments to provide outreach and education to recipients and persons who are eligible to be recipients; and (d) pay all allowable dental charges on a fee-for-service basis to participating dentists on behalf of recipients in the pilot counties for dental services received by those recipients.

Veto by Governor [C-4]: Delete the beginning and ending dates of the pilot project. Consequently, there would be no statutory date by which DHFS would be required to establish or end the pilot project.

[Act 27 Section: 1942m]

[Act 27 Vetoed Section: 1942m]

42. TRANSPORTATION SERVICES

	Chg. to Base
GPR	$63,000

Joint Finance/Legislature: Provide $63,000 GPR in 1997-98 for DHFS to reimburse providers of transportation services for repayments of medical assistance overpayments that were made between January 1, 1992, and May 14, 1993, in situations where: (a) the provider's private pay rate was less than the usual medical assistance rate; and (b) the provider's private pay billings for a year were less than 10% of total billings for that year.

43. MA FAMILY PLANNING

	Chg. to Base
GPR	$460,200
FED	4,141,800
Total	$4,602,000

Joint Finance: Direct DHFS to develop a proposal to expand access to family planning services currently covered under the MA program to all women between the ages of 15 and 44 who live in families with income below 185% of the federal poverty level. Direct DHFS to seek approval, by January 1, 1998, of a demonstration waiver from the U.S. Department of Health and Human Services, Health Care Financing Administration to implement this proposal. Specify that, if DHFS receives approval of the demonstration proposal, DHFS would submit legislation authorizing the implementation of this proposal to the appropriate standing committee of the Senate and Assembly.

Senate/Legislature: Modify provision by: (a) providing $460,200 GPR and $4,141,800 FED in 1998-99 to support the costs of implementing the project; (b) deleting the provision that requires DHFS to seek approval of the demonstration waiver by January 1, 1998; (c) deleting the provision that would require DHFS to submit legislation authorizing the implementation of the proposal to the appropriate standing committee of the Senate and Assembly; and (d) directing DHFS to begin conducting the project no later than July 1, 1998, or the date on which the waiver is granted,

whichever is later. Under these provisions, no additional legislation would be required in order for DHFS to implement the project.

[Act 27 Section: 1943c]

44. RURAL MEDICAL CENTERS

Joint Finance/Legislature: Direct DHFS to assist the Wisconsin congressional delegation, if requested, to prepare federal legislation to enable Wisconsin to operate a demonstration project for rural medical centers. Specify that the assistance of DHFS would end before December 31, 1997.

[Act 27 Section: 9123(10t)]

45. HOLD HARMLESS FOR RACINE COUNTY FOR LABOR COST RECLASSIFICATION

	Senate/Leg. (Chg. to Base)	Veto (Chg. to Leg.)	Net Change
GPR	$1,316,600	- $1,316,600	$0
FED	1,875,100	- 1,875,100	0
Total	$3,191,100	- $3,191,100	$0

Senate/Legislature: Provide $644,900 GPR and $923,500 FED in 1997-98 and $671,700 GPR and $951,600 FED in 1998-99 to reflect the cost of maintaining Racine County as a high-cost labor region for purposes of determining the medical assistance (MA) reimbursement of direct care costs for nursing home services. Specify that Racine County would continue to be classified as a high-cost labor region at least through June 30, 1999.

Veto by Governor [C-2]: Delete provision.

[Act 27 Bill Section: 9123(15s)]

[Act 27 Vetoed Sections: 169 (as it relates to s. 20.435(5)(b)) and 9123(15s)]

Background on HFS Emergency Rule
Rule on Federal Waiver for Extending Medicaid to cover Family Planning Services

Issue

The Department of Health and Family Services (DHFS) has issued an Emergency Rule that would allow Wisconsin (following approval in the form of federal waiver) to extend family planning services to females age 15 to 44 who would otherwise not be eligible for Medicaid, to receive these services to eligible females who are on Medicaid.

Background Information

The process for seeking the federal waiver and formulating rules to expand the family planning services was approved by the legislature as part of 1997 AB 100 (The State Budget). The budget provision was approved by the GOP-Controlled Assembly and Dem-Controlled Senate and signed by Governor Thompson. DHFS submitted the application for the waiver in June of 1999, and it was granted in June of 2002, citing the policy to come effective January 1, 2003.

DHFS plans to proceed with a permanent rule, but has created this emergency rule to make the policy effective immediately, and carry it through the time the permanent rule made its way through the clearinghouse process.

The Joint Committee on Review of Administrative Rules (JCRAR) will hold a public hearing and possible executive session on the Emergency Rule on March 27, 2003.

Current Administrative Rule

There is no current administrative rule governing this policy – the Emergency Rule and Clearinghouse Rule will create the rule.

Emergency Rule

Females who are currently not eligible for Medicaid and the family planning benefits that accompany it, would be eligible for these services under waiver if they meet the following criteria:

1. Be a woman at least 15 years old and no older than 44.

2. Not receiving Medicaid, unless the person is eligible for medical assistance
3. Meet the other non-financial criteria – as listed for MA, BadgerCare, etc.

Key provision:
HFS 102.01(5)(e) – When a person is under the age of 18 and is a single parent or is pregnant, but is not married and is not under the care of a relative as specified in rules related to eligibility for welfare – THE AGENCY SHALL DETERMINE INDIVIDUALLY THE ELIGIBILITY OF THE PERSON – WHEN A PERSON APPLIES SOLELY FOR BENEFITS UNDER THE FAMILY PLANNING DEMONSTRATION PROJECT, THE DEPARTMENT SHALL DETERMINE THE ELIGIBILITY OF THE PERSON WITHOUT REGARD TO THE PERSON'S PARENT OR PARENTS.

ISSUES:

Committee could suspend entire rule on the grounds that there is no need for this emergency rule. Emergency Rules are supposed to be proposed by an agency when the immediacy for the rule is needed to preserve public peace, health, safety or welfare.

JCRAR could also just suspend the portions of the rule that allow females under 18 to obtain these services without the knowledge of their parents – certainly on the grounds that parental notification is needed in this situation.

3/17 : Pro-Life; Grothman Meet next week!

'97 Budget – put in by state
2002 – Feds approve waiver

JCRAR – to Stop Emergency Rule.

Pro-Life WI
- Against push of contraceptives (pill)

- Presumptive eligibility: met standard basics; presumed initially eligible

- SUSPEND: Under 18 – no fiscal requirement; without parental notification
  - not financially responsible

Lobby Rule on next hearing

Minors' access to contraception:

Courts have held that Medicaid requires only two preconditions to the state's obligation to provide family planning services to sexually active minors: the minor must be "eligible" and the person must "voluntarily request assistance." See T.H. v. Jones, 425 F. Supp. 873, 878 (D. Utah 1975) (3-judge court), aff'd on statutory grounds, 425 U.S. 986 (1976). The courts have ruled that state laws mandating parental involvement in a minor's decision to use contraception are impermissible as applied to Medicaid recipients because they "engraft" an additional requirement onto the only two requirements set forth in the Medicaid statute itself. See T.H.; see also Planned Parenthood v. Dandoy, 810 F.2d 984 (10th Cir. 1987). The T.H. v. Jones case says: "The legislative history of the 1972 amendments [to the Social Security Act] bears out Congress' concern that . . . Medicaid family planning services be provided to sexually active minors who desire them on a confidential basis; in this way Congress has sought to stem the rising number of births out of wedlock and the consequent increase in numbers of welfare recipients." Id.

This interpretation of the Medicaid statute is based on two statutory provisions: 42 U.S.C. § 1396a(a)(8), which requires states participating in Medicaid to provide: "medical assistance" to all "eligible individuals"; and 42 U.S.C. § 1396d(a)(4)(C), which defines "medical assistance" as "payment of part or all of the cost of . . . family planning services and supplies furnished . . . to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies. . . ." These provisions imply that any eligible individual, including sexually active minors, is entitled to family planning services and supplies under Medicaid if she desires to have the services and/or supplies. The statute's silence as to any other preconditions for eligibility for family planning services means that no other preconditions may lawfully be imposed.

Courts have considered that this language requires that minors be treated on a confidential basis. See, e.g., Planned Parenthood Ass'n of Utah v. Dandoy, 810 F.2d 984 (10th Cir. 1987) . See also T_H_ v. Jones, 425 F. Supp. 873 (D. Utah 1975), aff'd on statutory grounds, 425 U.S. 986 (1976) (holding that the state cannot require parental consent in the Medicaid program).

49.45(24r)
(24r) Family planning demonstration project. The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide family planning services, as defined in s. 253.07 (1) (b), under medical assistance to any woman between the ages of 15 and 44 whose family income does not exceed 185% of the poverty line for a family the size of the woman's family. If the waiver is granted and in effect, the department shall implement the waiver no later than July 1, 1998, or on the effective date of the waiver, whichever is later.

253.07(1)(b)
(b) "Family planning services" mean counseling by trained personnel regarding family planning; distribution of information relating to family planning; and referral to licensed nurse practitioners within the scope of their practice, licensed physicians or local health departments for consultation, examination, medical treatment and prescriptions for the purpose of family planning. "Family planning" does not include the performance, promotion, encouragement or counseling in favor of, or referral either directly or through an intermediary for, voluntary termination of pregnancy, but may include the providing of nondirective information explaining any of the following:

253.07(1)(b)1.
1. Prenatal care and delivery.

253.07(1)(b)2.
2. Infant care, foster care or adoption.

253.07(1)(b)3.
3. Pregnancy termination.

The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible?

A special report commissioned by

The Consortium of
State Physicians Resource Councils

January 7, 1999

The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible?

By Jeffrey M. Jones, M.D., Ph.D., William Toffler, M.D., Reed Bell, M.D., Joanna K. Mohn, M.D., Gaylen Kelton, M.D., Robert Weeldreyer, M.D., Hal Wallis, M.D., G. Steven Suits, M.D., John R. Diggs, Jr., M.D., Harold Cox, M.D. and Kent Jones, M.D.

Background: *During the 1990s the rates of pregnancy, birth and abortion among adolescents in the United States have declined. Taken in composite, these declines are the first in several decades. The question remains: What factor or factors are most responsible for the declines?*

Approach: *The data on adolescent pregnancy and birth rates, abortion, contraceptive use, and sexual behavior and attitudes were analyzed in order to ascertain correlation and possible cause-and-effect relationships.*

Findings: *The specific factors and the exact interrelationship of the factors responsible for the decline in teen pregnancy, birth and abortion rates cannot be precisely determined. However, the contention that these declines are due to increased contraceptive use by teenagers does not withstand critical analysis and review. Out-of-wedlock birthrates to sexually experienced female teens rose 29% from 1988 to 1995, despite a 33% increase in the use of condoms at last intercourse.*

Decreased rates of pregnancy, abortion and births among the entire adolescent cohort seem to correlate with a corresponding decrease in teenage sexual activity. Because of the difficulty in precisely determining the cause of these positive trends, the issue as to why adolescents have become increasingly involved in abstinent behavior should be the subject of further study.

Summary: *Abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for the decline during the 1990s in adolescent pregnancy, birth and abortion rates. Attributing these declines to increased contraception is not supported by the data. Intervention programs focused on abstinence may have significantly contributed to the decline in sexual activity, but further research is needed to test this hypothesis.*

Background

Beginning in the 1960s and 1970s, various statistical measures confirmed a dramatic increase in sexual activity by adolescents as reflected by the consequences.

- The birthrate among unmarried females aged 15 to 19 years increased 90% from 22.4 per 1,000 in 1970 to 42.5 per 1,000 in 1990.[1]
- The abortion rate among females aged 10 to 19 years rose 94% from 9.7 per 1,000 in 1972 to 18.8 in 1990.[2]

With few period-to-period exceptions through the late 1980s, these consequential statistics reflected a steady increase in teens having sex. However, in recent years the trend in the measures of these consequences has begun to moderate and even reverse.

The birthrate declined 4.2 percent for unmarried female teens and 11.9 percent for all female teens from 1991 to 1996 (Table A).

Table A	1991	1996	% change
Birthrate per 1,000 females aged 15 to 19			
Total[3]	62.1	54.7	-11.9%
Unmarried[4]	44.8	42.9	-4.2%

Abortions were not responsible for the drop in the birthrate. In fact, rate of abortions for teens dropped during a similar period (Table B).

Table B	1990	1995	% change
Abortion rate per 1,000 females aged 10 to 19 years[5]	18.8	13.5	-28.2%

Correspondingly, the rate at which teenagers became pregnant fell 9.1 percent between 1992 and 1995 (Table C).

Table C	1992	1995	% change
Teenage pregnancy rate per 1,000 famales[6]	99.7	90.6	-9.1%

An Increase in Contraception?

Immediately after the data above were released in May and June of this year, advocates of safer-sex programs pointed to increased condom use by teens as a principle reason for the declines in pregnancy and birth rates. Consider the following:

"Contributing to this decline in [birthrates] are indications that...sexually active teenagers are more likely to use contraception." Centers for Disease Control

"Those [teens] who do have sex are using contraceptives more reliably." Washington Post

"Their [female teens] likelihood of pregnancy has decreased. Increases in contraceptive use by adolescent females contribute to this change." HHS

"Increased contraceptive use – especially condoms – was a major factor in the decline of unintended pregnancies." NARHP

And their claims were not without some statistical support. After all, condom use at last intercourse increased significantly by both teenage males (+21%) and females (+33%) from the late 1980s through the mid 1990s (see Table D). Condom use increased even more among specific high-risk teenage demographic groups, such as black females, a cohort that also experienced a significant increase in the use of Norplant and Depo-Provera.

The decline in pregnancy and birth rates and increase in condom use led to the premature conclusions that total contraception rates increased and were responsible for the declining birthrates. But, in matters of statistical and behavioral research, formulating conclusions during the initial review of data is a careless practice.

Contraception-Use Rates Have Not Increased

A more complete review of sexual practices by teenagers from 1988 to 1995 is not compatible with the view that contraception-use rates increased. Total contraception-use rates not only did not increase – the data indicate that they may have actually declined slightly (Table D).

Table D Contraceptive use during last intercourse by sexually active teens	1988			1995			Change in combined contraceptive use, '88 to '95
	Condoms	Oral	Combined	Condoms	Oral	Combined	
Males, 15-19 (and partner)[7]	53%	37%	90%	64%	28%	92%	+2.2%
Females, 15-19 (and partner)[8]	27%	42%	69%	36%	23%	59%	-14.5%

In order to compare 1995 with 1988, the data for oral and condom contraceptive use was added in Table D to yield combined contraceptive use at last intercourse. This calculation includes only oral and condom contraceptives for two reasons. First, these two methods represent the dominant contraception of choice by teens in both comparison years. Second, data for injectable and implantable contraception is not available for 1988.

The combined data show that while condom use did increase, the rise was more than offset by a decrease in the use of oral contraceptives. From 1988 to 1995, sexually active adolescent females increased their use of condoms at last intercourse by 33 percent (36% vs. 27%), but decreased their use of oral contraceptives by 45 percent (23% vs. 42%).

Thus, these females were 14.5 percent less likely to use condoms or oral contraception in 1995 compared to 1988. This fact led Joyce Abma from the National Center for Health Statistics and Freya L. Sonenstein from the Urban Institute to make the following statement:

> *"Between 1988 and 1995 there has been little change in the proportion of currently sexually active teens reporting that they used no method of contraception at the last intercourse."*[9]

This combined calculation ignores two factors that could influence the data on the proportion of female teens protected against pregnancy.

The first factor is that the combined calculation assumes no dual use. But, dual use at last intercourse among never-married young people aged 14 to 19 is relatively small at 5.8 percent of females and 4.1 percent of males.[10] Further, the combined calculation was performed in the same manner for both 1988 and 1995. Therefore, combined data without an adjustment for dual use is valid as a relative comparison of contraceptive use in 1995 to 1988.

The second factor is that injectables/implantables are not included in the combined calculations. However, even if the use of injectable/implantable contraception was included for this cohort on Table D (7% usage rate at last intercourse in 1995),[11] total contraception use still fell.

The decline in the use of contraception by female teens has been confirmed in other research literature. In the January/February 1998 issue of *Family Planning Perspectives* ("Trends in Contraceptive Use In the United States: 1982-1995," Table 1), authors Piccinino and Mosher included data that indicate a slight drop from 1988 to 1995 in the proportion of sexually experienced U.S. females aged 15-19 reporting use of any method of contraception. The data on Table E show that the use of any method of contraception (including injectables and implantables) by sexually experienced female teens dropped from 61.0 to 60.1 percent.

Table E	1988	1995
A. Percent of all females aged 15 to 19 currently using any contraceptive method[12]	32.1%	29.8%
B. Percent of females aged 15 to 19 who are sexually experienced[13]	52.6%	49.6%
C. Proportion of sexually experienced females aged 15 to 19 who are using any method (C=A/B)	61.0%	60.1%

Safer-sex advocates may claim that even without a net increase in contraceptive use teens are better protected against the risk of pregnancy because of the effectiveness of injectables/implantables. But it is important to note that the sizable shift from oral contraception to condoms represents a shift to less efficacious protection against pregnancy.

It is possible to statistically calculate the change in protection from pregnancy among female teens by the switch from oral contraception to condoms and injectables/implantables. To make this calculation it is necessary to factor the percentage of teens using different methods of contraception by the accepted levels of effectiveness for each method.

Table F provides a risk-adjusted contraceptive protection index. For example, in 1988, 69 percent of sexually active females aged 15 to 19 used condoms and/or oral contraception at last intercourse. But adjusted for method effectiveness, the percentage index dropped to 65 percent. Using the same formula for 1995, the percent of the cohort using contraception (including I/I) dropped from 66 percent to 61 percent after the adjustment for effectiveness.

Table F Sexually Active Females 15-19	1988				1995			
	Condom	Oral	I/I	Total	Condom	Oral	I/I	Total
A. % usage at last intercourse	27%	42%	N/A	69%	36%	23%	7%	66%
B. Method effectiveness[14]	85%	99%			85%	99%	99 %	
C. Hypothetical Protection Index (C=AxB)	23%	42%		65%	31%	23%	7%	61%

Thus, the use of injectable/implantable contraception in 1995 did not offset the reduced protection represented by the switch from birth control pills to condoms. This is yet another reason why contraception would not account for reduced pregnancy and birth rates.

In summary, based on lower reported contraceptive use and a switch to a less effective prevention method (condoms vs. oral), sexually active adolescent females in 1995 were less protected against pregnancy than in 1988. The claim that the drops in pregnancy, birth and abortion rates are due to increased contraceptive use is inconsistent with the data.

Non-Marital Birthrates Among Sexually Experienced and Active Teens Have Risen Sharply

The out-of-wedlock birthrates to sexually experienced female teens (have ever had sex) and sexually active teens (sex in past 3 months) have increased sharply during the 1990s.

To calculate the birthrate among adolescents, the government uses the total number of births by female teens as the numerator and the total number of female teens as the denominator. This formula is misleading because it does not recognize that abstinent female teens do not become pregnant.

The convention of reporting on birthrates within the entire cohort of 15 to 19 year-old females has masked the steady increase in the out-of-wedlock birthrate among sexually experienced and sexually active teens.

A more revealing way to consider the data is to calculate the out-of-wedlock birthrate among sexually experienced and sexually active female teens. This calculation would allow researchers to more accurately determine the impact of national interventions aimed at reducing non-marital births.

Table G shows the out-of-wedlock birthrate to sexually experienced females aged 15 to 19. The birthrates per 1,000 unmarried females, aged 15 to 19, are from the National Center for Health Statistics. The percent of females 15 to 19 who have had premarital sex is from the National Survey of Family Growth. See footnote (a) for a more complete discussion on calculating birthrates to sub-groups of teens.

This calculation shows that the long-term trend of out-of-wedlock birthrates to sexually experienced female teens has increased substantially during the 1990s. Based on this data, the out-of-wedlock birthrate to sexually experienced females aged 15 to 19 increased 41.8 percent from 1976 to 1995 and 29.3 percent from 1988 to 1995.

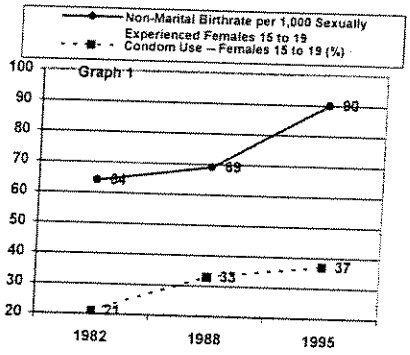
Table G Year	Birthrate per 1,000 unmarried females aged 15 to 19[15]	% of females 15 to 19 who have had premarital sex (sexually experienced)[16]	Non-marital birthrate per 1,000 sexually experienced females 15 to 19
1976	24.6	39.0%	63.1
1982	28.7	45.2%	63.5
1988	36.4	52.6%	69.2
1995	44.4	49.6%	89.5
Percent change '76 to '95 '88 to '95			 +41.8% +29.3%

Table H shows the same analysis for sexually active females, aged 15 to 19.

Table H Year	Birthrate per 1,000 unmarried females aged 15 to 19[17] (Entire teen female cohort)	% of females 15 to 19 who are sexually active (sex in past 3 months)[18]	Non-marital Birthrate per 1,000 sexually active females 15 to 19
1988	36.4 (53.0)	42.7%	85.2
1995	44.4 (56.8)	39.7%	111.8
Percent change '88 to '95			+31.2%

Based on this data, the out-of-wedlock birthrate to sexually active females aged 15 to 19 increased 31.2% from 1988 to 1995.

The increases shown in Tables G and H occurred despite sharply higher condom usage, as illustrated in Graph 1.



From 1982 to 1995, the out-of-wedlock birthrate per 1,000 sexually experienced females aged 15 to 19 increased 40.9 percent, from 63.5 to 89.5 (Table G).

During the same time span the proportion of teenage females who reported using contraceptives increased their use of condoms 76 percent (from 21% to 37%).[19] The implications of the data in Table G and H and Graph 1 should not be minimized – out-of-wedlock birthrates have increased among sexually experienced and sexually active female teens despite an increased use of condoms.

It should be noted that the proportion of female teens who reported premarital sex was used as a proxy for unmarried female teens in Table G. It is possible that some females who reported having had premarital sex were married at the time of reporting.

However, the authors believe that the use of specific data limited to never-married female teens would not significantly alter the results shown. This is because (1) the proportion of married teens in this age category is low (4.5% in 1995 NSFG), and, (2) the proportion of never-married female teens who have ever had sex is not much different than the proportion of all teens who have ever had sex.

For example, in 1995, 48.1 percent of never-married female teens reported having had sex compared to 50.4 percent of all teens. So while the exact calculations of out-of-wedlock birthrates to sexually experienced and sexually active female teens might change if a pure data set limited to

a) The calculation of non-marital birthrates to sexually experienced female teens was performed by using the total out-of-wedlock birthrate to females aged 15 to 19 as the numerator and the proportion of female teens who reported premarital sex as the denominator. For example, the non-marital birthrate of 89.5 per 1,000 sexually experienced female teens in 1995 was calculated by dividing 496 (number of female teens per 1,000 who reported premarital sex) into 44.4 (births per 1,000 unmarried females aged 15 to 19)

The birthrates to sexually active female teens were calculated in the same manner.

For a more complete discussion on calculating birthrates by adolescent sub-groups, see the discussion in the article "The Decline in US Teen Pregnancy Rates, 1990-1995," *Pediatrics*, Vol. 102, No. 5, November 1998.

The *Pediatrics* article concluded that the pregnancy, abortion and birthrates among sexually experienced and sexually active teens have held steady or declined significantly since the 1980s. However, authors Kaufmann, et al. used data for all teen births. The calculation of out-of-wedlock birthrates among sexually experienced and sexually active teens, as shown herein, leads to a dramatically different conclusion.

never married teens was used, the pattern of the results would remain the same. The authors encourage other researchers to further expand the study of out-of-wedlock birthrates.

Declining Sexual Activity Rates

Obviously, programs in safer-sex education and condom distribution have not reduced out-of-wedlock birthrates among sexually experienced teens. On the other hand, there has been a decrease in the overall teen birthrate. The following data suggest reasons why. Tables I and J confirm that more teens are choosing abstinence.

Table I % teens 15-19 who have ever had sex[20]	1988	1995	% change '95 vs. '88
Never-married Males – NSAM	60.4%	55.0%	-8.9%
Females – NSFG	52.6%	49.6%	-5.7%

Table J % high school teens 15-19 who have ever had sex[21]	1990	1997	% change '97 vs. '90
Males – YRBS	60.8%	48.9%	-19.6%
Females - YRBS	48.0%	47.7%	-.6%

Sexually experienced teen males have become less sexually active and have fewer partners (Table K).

Table K % H.S. teens[22]	1990	1995	1997	% change '97 vs. '90
Had intercourse in past 3 months	39.4%	37.9%	34.8%	-11.7%
Males	42.5%	35.5%	33.4%	-21.4%
Females	36.4%	40.4%	36.5%	+.3%
Had four or more partners	19.0%	17.8%	16.0%	-15.8%
Males	26.7%	20.9%	17.6%	-34.1%
Females	11.8%	14.4%	14.1%	+19.5%

A very strong trend is reflected in Tables I, J and K. The positive correlation between the reductions in teen sexual activity and teen pregnancy rates may be mostly due to more abstinent behavior by male, rather than female, adolescents. From 1990 to 1997 there was a 19.6 percent decline in the proportion of adolescent males who have ever had sex compared to a .6 percent decline among adolescent females (Table J). From 1990 to 1997 there was a 21.4 percent drop in the proportion of adolescent males who have had sex in the past three months compared to a .3 percent increase among adolescent females (Table K). And, from 1990 to 1997 there was a 34.1 percent decline in the proportion of adolescent males who have had four or more partners compared to a 19.5 percent increase among adolescent females (Table K). So while the percent of all female teens who have ever had sex has declined, those females remaining sexually active have become increasingly promiscuous. A discussion of this phenomenon is not within the scope of this paper, but should be the subject of further study.

Promotion of Abstinence

Tables I, J and K show that there has been a significant overall decline in teen sexual activity from 1988 to 1995 and beyond, simultaneous with an overall decline in teen pregnancy, birth and abortion rates (Tables A, B and C). Increased condom use has been invoked to explain the latter, yet increased condom use is outweighed by a shift away from using more efficacious oral contraceptives. Tables G and H show that the non-marital birthrate to sexually experienced and sexually active female teens actually increased sharply from 1988 to 1995.

Thus we find it more reasonable to suggest reduced sexual activity as the hypothesis capable of explaining reduced pregnancy, birth and abortion rates. In fact, the decline in the overall birthrates among adolescent females during the 1990s is due primarily to teens that have never had sex or are not currently having sex.

Abstinence-only programs may be playing an increasing role in bringing about reduced teen sexual activity. In the remainder of this publication, therefore, we present: 1.) Observations on the history and nature of abstinence programs; 2.) Societal factors that support the choice of abstinence; and 3.) Promising preliminary results of abstinence-only programs.

1. History and Nature of Abstinence Programs

Abstinence component of comprehensive sexuality programs. In the early 1990s comprehensive sexuality programs began emphasizing abstinence as the preferred choice for teenagers. Such programs are called "abstinence-based." While abstinence-only advocates accuse abstinence-based education of sending a confusing dual message, it is likely that the abstinence component has influenced some adolescents. All of this raises a very interesting question: If comprehensive sexuality education has contributed to the decline in teen pregnancy, might it be due primarily to the abstinence component? This is a very real possibility since, as shown earlier in this research study, contraceptive use is not associated with reduced unintended out-of-wedlock births.

Abstinence-only programs. There has been an explosive growth in privately funded abstinence-only programs during the 1990s. An indication of that growth is shown in Table L.[23]

Table L Abstinence-only category	# of students reached - 1986	# of students reached - 1989	# of students reached - 1997
Pledge card based	0	0	750,000
Crisis pregnancy centers	12,164	69,918	620,250
Private curriculum/speakers	234,950	572,656	1,676,032
Total	247,114	642,574	3,046,282

As a result, there has been a 12-fold increase in the number of teens reached by privately funded abstinence programs in the span of a decade.

Opponents of abstinence-only programs point out that the effectiveness of such programs has not been documented. This may be based more on philosophical opposition to the abstinence-only message than on an objective consideration of all the facts. Accordingly, four observations are worthy of note.

First, very little research has been conducted on abstinence-only programs. Douglas Kirby in his booklet "No Easy Answers" stated that "*more research should be done on*

these programs...very few such programs have been well evaluated, and, thus, there is little evidence to determine whether or not abstinence-only programs can delay intercourse." In other words, the jury is still out.

Second, the abstinence-only programs that have been evaluated in peer-reviewed research journals have been very narrowly defined in scope and low in intensity. An example is an abstinence program in Philadelphia recently declared as ineffective in *JAMA*.[24] The entire abstinence message therein studied was delivered during just two Saturday sessions. Researchers have concluded that any intervention program, in order to be effective, must be multi-faceted and of adequate intensity and duration.[25]

Third, some of the abstinence programs that have been evaluated do not meet the standards set by abstinence-only education experts. An example is Education Now and Babies Later (ENABL), the well publicized program in California. ENABL was a limited scope program. But more importantly, ENABL was never fully endorsed by abstinence-only education experts. From the onset, abstinence-education advocates did not acknowledge ENABL as a true abstinence program because of its limited duration, use of values-clarification methods and reliance on teachers who were not trained in or did not philosophically agree with an abstinence-only message.

Philosophical buy-in by teachers to a message correlates highly with the impact of the message upon students. In a 1994 study researchers reported *"that teachers are a vital and important ingredient in the successful implementation of these programs [meaning] that an abstinence sex education program may succeed or fail not simply because of the merit of the program but because of the lack of either teacher commitment to implementation or support for the program objectives or both."*[26]

Finally, abstinence-only advocates also claim that a much higher standard of research protocol is applied to abstinence-only programs than to comprehensive sexuality programs. One example of this apparent double standard is the research on condom availability in Los Angeles area high schools. In that study there was a 41 percent pre-to-post test participant-dropout rate due to parental opposition.[27]

Another example of the double standard is the Center for Disease Control's "Programs That Work" initiative. "Programs That Work" features five interventions that CDC claims are quite effective. Not one of the five has data measuring a reduction in teen pregnancy or STD rates. Yet, these programs were developed to reduce pregnancy and STD rates.

2. Societal Factors That Encourage Abstinence

A number of societal factors also encourage abstinence.

HIV/AIDS Education. Perhaps not since the polio crisis of the 1950s has the national consciousness on a medical issue been so raised as it has been for HIV/AIDS. Almost all teens now receive instruction on HIV/AIDS: 92 percent of males and 94 percent of females.[28] The HIV/AIDS scare has likely impacted the sexual behaviors of many adolescents in favor of abstinence.

Instruction on Refusal Skills. As equally common among females as HIV/AIDS information is instruction on how to say "no" to sex. In fact, 93 percent of adolescent females received instruction on refusal skills in 1995. Three quarters of adolescent males received similar instruction.[29]

Generational Changes in Attitudes. There are several theories of generational sociology. One view holds that generational history is seamless -- each new generation simply builds upon the foundation established by its predecessors. Another view holds that generational history is cyclical -- attitudes abandoned by one generation often reappear after a skip of two or more generations. If the latter theory is true, then the recent declines in teen sexual activity may, in some part, be due to generational factors. Teenagers today could be rejecting the view of sexual behavior held by their baby-boomer parents (who are widely credited with the sexual revolution of the 1960s and 70s) in favor of the traditional view held by today's more senior citizens. If this observation is valid, then an unambiguous abstinence message should be quite well received by the next few generations.

A recent article in *Family Planning Perspectives* confirms the link between more conservative attitudes among teens and declining sexual activity rates.[30] In the article, "Understanding Changes in Sexual Activity Among Young Metropolitan Men: 1979-1995," authors Ku, et al. state *"More permissive attitudes about premarital sex were strongly associated with high rates of intercourse. Adolescent males who completely disapproved of premarital sex were far less likely to have had sex recently than were those who approved of it."* The study also demonstrates that *"religiosity is part of reason for the shift in attitudes."*

The article suggests that these attitudinal *"changes reflect a growing trend and not merely a unique fluctuation in the sexual beliefs of American youth."*

General Societal Attitudes. There have been a number of studies in recent years showing that society in general has embraced an abstinence-until marriage viewpoint.

A survey of nearly 4,980 people by Wirthlin Worldwide found that 71 percent of the national respondents believe couples should wait to have sex until marriage.[31] A *New York Times* poll found that nearly half of teens polled said sex before marriage is always wrong.[32] In an Emory University survey of 1,000 sexually active teen girls, 84 percent said they would like to learn how to say no to sex.[33] In a 1994 Roper-Starch study, 54 percent of students who have already tried sex indicated they should have waited.[34] In a study commissioned by the National Campaign to Prevent Teen Pregnancy, 95 percent of both adults and teens stated that it is important for high school students to be given a strong abstinence message from society.[35]

3. Promising Results of Abstinence-Only Programs

There is increasing evidence that an unambiguous abstinence message shows promise in changing the behavior of teens.

Add Health Study. The September 10, 1997 issue of *JAMA*[36] published an article on the first wave of findings from the National Longitudinal Study on Adolescent Health (Add Health) -- the most extensive study on adolescent risk behavior ever conducted. The study showed that the factor

most strongly associated with a delay in the onset of sexual activity was a pledge of abstinence. In fact, the pledge of abstinence was three times more strongly associated with a delay in sex than the next most positively correlated factor. A pledge of abstinence is the cornerstone of a program popular among many church youth groups called True Love Waits. Nearly 16 percent of all female teens and 10 percent of all male teens have signed pledge cards and joined peer support groups through True Love Waits and similar programs.[37]

Simply signing a pledge of abstinence -- in and of itself -- is probably not the sole reason signers significantly delay sexual activity. There are likely a number of familial, religious and personal risk-protective factors that lead an adolescent to sign the pledge. Nevertheless, the signing itself does represent a point of decision and commitment, which the Add Health data show is highly significant as a singular risk-protective factor. Further research is needed to more thoroughly understand the dynamics of the abstinence pledge.

Other factors reported by Add Health as significantly associated with a delay in the age of sexual debut are parental disapproval of adolescent contraception and parental disapproval of adolescent sex.

STARS. "Students Aren't Ready for Sex" began in 1994 as a pilot project in Multnomah County, Oregon in four middle schools that served about 1,000 students. In 1998/99 STARS will reach all but five of Oregon's 36 counties and serve more than 33,000 students through its peer-mentoring abstinence program. In December 1997 the Oregon STARS Foundation contracted with the Oregon Health Policy Institute to evaluate STARS. The evaluation concluded in July 1998. Among the results:[38]

- 70 percent of students said STARS helped them decide to abstain from sex.
- 77 percent of students said the program helped them understand their personal rights to set limits.
- Rates of sexual involvement among participating middle school students surveyed dropped from 9.7 percent before to 5.3 percent after STARS.[39]

The Michigan Abstinence Partnership. In the early 1990s the State of Michigan began a major campaign called "The Michigan Abstinence Partnership." The partnership has provided communities with technical assistance, education materials and promotional items. Each participating community has developed a coalition which develops and implements unique abstinence activities, such as youth rallies, educational sessions for parents, abstinence curricula, family activity days, recreational events and peer education sessions.

Importantly, the partnership has had a goal of making teen abstinence the culturally accepted norm. The result has been a decline in teen birthrates far exceeding the national average. From 1991 to 1996 the teen birthrate in Michigan declined 19.1 percent from 58.7 to 47.5 births per 1,000 females aged 15 to 19.[40] This compares to a national decline of only 11.9 percent during the same period (see Table A).

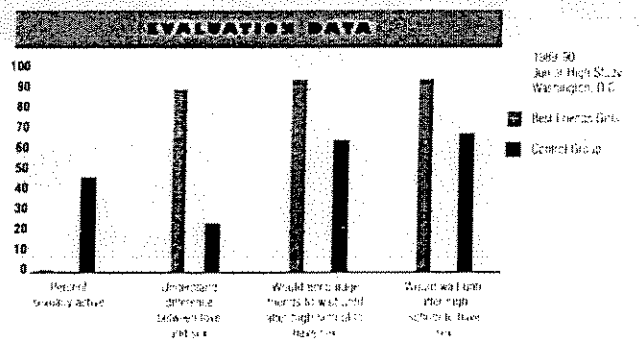
Tennessee Study. Of the 10 largest counties in Tennessee with statistics on pregnancy broken-down among black and white adolescents, research indicates that teen pregnancies in the three that taught abstinence-only in schools declined between 14 and 38 percent from 1991 to 1996. By comparison, the four that taught safer-sex education or had no system-wide sex education experienced a maximum decline of only 7 percent.[41]

Table M. Teen Pregnancy Rates in Counties with Populations over 50,000 and Black and White Statistics, 1991 to 1996

County	Sex Ed	1991 (per 1,000)	1996 (per 1,000)	% Change
Madison	Abstinence	79.9	49.3	-38.3%
Hamilton	Abstinence	69.6	52.1	-25.1%
Shelby	Abstinence	92.1	79.1	-14.1%
Davidson	Community initiatives	74.3	64	-13.9%
Knox	Mixed message	46.2	40.5	-12.3%
Summer	Teachers guide	49.2	44.5	-9.6%
Williamson	Safer-sex education	23.9	22.2	-7.1%
Montgomery	Safer-sex education	47.8	45.3	-5.2%
Rutherford	No systematic sex ed	41.0	39.9	-2.7%
Wilson	No systematic sex ed	36.3	36.5	+0.5%

Best Friends.[42] The Best Friends mentoring and abstinence education program in Washington, D.C. has been highly effective. Only 10 percent of Best Friends girls reported having sexual intercourse compared to 37 percent of D.C. middle school girls. Best Friends girls also were found to have a one-percent pregnancy rate, compared to a 26-percent rate among all high school-aged D.C. girls. Graph 2 reports on other aspects of the effectiveness of Best Friends.[43]

Graph 2



Denmark, SC Community Program. Between 1982 and 1987, a program was implemented in Denmark, SC. The community-based program had multiple components -- classroom abstinence education, adult education, motivational speakers, newspaper articles, intensive teacher training, and faith community and civic leadership involvement. Prior to the implementation of the program, the area had an adolescent pregnancy rate of 61 out of every 1,000 adolescent girls aged 14 to 17. In the second and third years of the program, the adolescent pregnancy rate dropped to 25 out of every 1,000 girls, while comparison schools not