A

2007 DRAFTING REQUEST

Bill

Received: **09/18/2006**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget**

By/Representing: **Pink**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**

Subject: **Health - medical assistance**
Public Assistance - misc

Extra Copies:

Submit via email: **YES**

Requester's email:

Carbon copy (CC:) to: **robin.ryan@legis.wisconsin.gov**

debora.kennedy@legis.wisconsin.gov

Pre Topic:

DOA:.....Pink, BB0012 -

Topic:

Third-party liability; sharing health data

Instructions:

See Attached

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/?	dkennedy 09/28/2006	jdyer 10/16/2006		_____ _____			S&L
/P1	dkennedy 11/10/2006 dkennedy 11/13/2006		jfrantze 10/16/2006	_____ _____ _____ _____	mbarman 10/16/2006		S&L

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/2	dkennedy 01/09/2007	jdyer 01/10/2007	sherritz 01/10/2007	_____ _____	sbasford 01/10/2007		S&L
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forsaac@dhfs.state.wi.us

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DAK | RLR
-0248

2007-09 Budget Bill Statutory Language Drafting Request

- Topic: Medicaid Third Party Liability Enhancements
- Tracking Code: BB0012
- SBO team: Health and Insurance
- SBO analyst: Michelle Pink
  - Phone: 7-7980
  - Email: michelle.pink@wisconsin.gov
- Agency acronym: DHFS
- Agency number: 435

High priority

DHFS

Department of Health and Family Services
2007-2009 Biennial Budget Statutory Language Request
September 13, 2006

Medicaid Third Party Liability Enhancements

Current Language

Under 42 USC 1396a, sec. 1902 (a) of the Social Security Act, any state or local agency administering a medical assistance plan must take all reasonable measures to identify the legal liability of third parties to pay for care and services that are otherwise available under a Medicaid plan. Reasonable measures are defined as two broad processes: identification or discovery by the state of third party liability (TPL) prior to payment and pursuit of reimbursement from liable third parties subsequent to the state's payment for services. Currently, Wisconsin has processes in place for both.

Under s.49.475, an insurer that issues or delivers a disability insurance policy for health care coverage to a Wisconsin resident must submit eligibility, coverage, and policy holder information at the Department's request. The Office of the Commissioner of Insurance enforces this statute.

Under a waiver from the Centers for Medicare and Medicaid Services (CMS), the Department has established a process for pursuing reimbursement from liable third parties that are identified subsequent to payment of services by Medicaid.

42 USC 1396a (a)(25)

Proposed Change

The federal Deficit Reduction Act (P.L. 109-171) enacted in February 2006, broadened the category of entities from which the state may require submission of health care policy and coverage information. In addition to health insurers, the state must now require policy information to be submitted by self-insured plans (health benefit plans previously exempt under the Department of Labor's Employer Retirement Income Security Act of 1974), managed care organizations, pharmacy benefit managers, and "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service."

To comply with the Deficit Reduction Act, the Social Security Act, and the Health Insurance Portability and Accountability Act, and to enhance the state's current Medicaid cost avoidance systems, state statutes (s.49.475) should be revised to incorporate language consistent with the new federal regulations and to broaden enforcement language to cover self-insured plans and other entities included in the Deficit Reduction Act.

Background and Rationale for the Change

Federal law, as established by the Deficit Reduction Act, requires states to broaden identification of third party liabilities. Failure to comply with the new federal requirements will risk the loss of

federal Medicaid funding. In addition to meeting federal requirements, expanded identification of third party payers will reduce the costs of the state's Medicaid program.

Desired Effective Date:	Upon passage
Agency:	DHFS
Agency Contact:	Kirstin Nelson-
Phone:	(608) 266-5362

42 USC 1396a(a)(25)

third parties, including:

① insurers - s. 49.475

② self-insured plans (health benefit plans previously exempt under ERISA)

~~632.745(3)~~ 632.747(3)(b)

See 149.10(5) lang: any person providing h's cov for indiv on a ~~a~~ basis w/o the intervention of other entities

③ group health plans - defined @ 1167(1) Title 29

Are insurers as interp by OCI 600327

632.745

④ service benefit plans

no stat ref

Service insurance corporations?

⑤ managed care organizations

no stat def.

Are insurers, as interp by OCI

⑥ pharmacy benefit managers (Waivers)

no stat ref.

⑦ other parties that are by stat., rule, or K legally responsible for payment of a claim for a health care item or service

1186

§2699. Prescription drug practices (CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

Pharmacy benefits managers shall and contracts for **pharmacy** benefits management must comply with the requirements of this section. [2003, c. 456, §1 (new).]

1. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Covered entity" means a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization licensed pursuant to Title 24 or 24-A; a health program administered by the department or the State in the capacity of provider of health coverage; or an employer, labor union or other group of persons organized in the State that provides health coverage to covered individuals who are employed or reside in the State. "Covered entity" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited **benefit** health insurance policies and contracts. [2003, c. 456, §1 (new).]

B. "Covered individual" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. "Covered individual" includes a dependent or other person provided health coverage through a policy, contract or plan for a covered individual. [2003, c. 456, §1 (new).]

C. "Generic drug" means a chemically equivalent copy of a brand-name drug with an expired patent. [2003, c. 456, §1 (new).]

D. "Labeler" means an entity or person that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and that has a labeler code from the federal Food and Drug Administration under 21 Code of Federal Regulations, 270.20 (1999). [2003, c. 456, §1 (new).]

E. "**Pharmacy** benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation within this State to covered individuals, the administration or management of prescription drug benefits provided by a covered entity for the **benefit** of covered individuals or any of the following services provided with regard to the administration of **pharmacy** benefits:

(1) Mail service **pharmacy**;

(2) Claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals;

(3) Clinical formulary development and management services;

(4) Rebate contracting and administration;

(5) Certain patient compliance, therapeutic intervention and generic substitution programs; and

(6) Disease management programs.

[2003, c. 456, §1 (new).]

F. "**Pharmacy** benefits **manager**" means an entity that performs **pharmacy** benefits management. "**Pharmacy** benefits **manager**" includes a person or entity acting for a **pharmacy** benefits **manager** in a contractual or employment relationship in the performance of **pharmacy** benefits management for a covered entity and includes mail service **pharmacy**. [2003, c. 456, §1 (new).]

[2003, c. 456, §1 (new).]

2. Required practices. A **pharmacy** benefits **manager** owes a fiduciary duty to a covered entity and shall discharge that duty in accordance with the provisions of state and federal law.

A. A **pharmacy** benefits **manager** shall perform its duties with care, skill, prudence and diligence and in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims. [2003, c. 456, §1 (new).]

B. A **pharmacy** benefits **manager** shall notify the covered entity in writing of any activity, policy or practice of the **pharmacy** benefits **manager** that directly or indirectly presents any conflict of interest with the duties imposed by this subsection. [2003, c. 456, §1 (new).]

C. A **pharmacy** benefits **manager** shall provide to a covered entity all financial and utilization information requested by the covered entity relating to the provision of benefits to covered individuals through that covered entity and all financial and utilization information relating to services to that covered entity. A **pharmacy** benefits **manager** providing information under this paragraph may designate that material as confidential. Information designated as confidential by a **pharmacy** benefits **manager** and provided to

a covered entity under this paragraph may not be disclosed by the covered entity to any person without the consent of the **pharmacy** benefits **manager**, except that disclosure may be made in a court filing under the **Maine** Unfair Trade Practices Act or when authorized by that Act or ordered by a court of this State for good cause shown or made in a court filing under seal unless or until otherwise ordered by a court. Nothing in this paragraph limits the Attorney General's use of Civil Investigative Demand Authority under the **Maine** Unfair Trade Practices Act to investigate violations of this section.
[2003, c. 456, §1 (new).]

D. With regard to the dispensation of a substitute prescription drug for a prescribed drug to a covered individual the following provisions apply.

(1) If a **pharmacy** benefits **manager** makes a substitution in which the substitute drug costs more than the prescribed drug, the **pharmacy** benefits **manager** shall disclose to the covered entity the cost of both drugs and any **benefit** or payment directly or indirectly accruing to the **pharmacy** benefits **manager** as a result of the substitution.

(2) The **pharmacy** benefits **manager** shall transfer in full to the covered entity any **benefit** or payment received in any form by the **pharmacy** benefits **manager** either as a result of a prescription drug substitution under subparagraph (1) or as a result of the **pharmacy** benefits **manager** substituting a lower priced generic and therapeutically equivalent drug for a higher priced prescribed drug.

[2003, c. 456, §1 (new).]

E. A **pharmacy** benefits **manager** that derives any payment or **benefit** for the dispensation of prescription drugs within the State based on volume of sales for certain prescription drugs or classes or brands of drugs within the State shall pass that payment or **benefit** on in full to the covered entity. [2003, c. 456, §1 (new).]

F. A **pharmacy** benefits **manager** shall disclose to the covered entity all financial terms and arrangements for remuneration of any kind that apply between the **pharmacy** benefits **manager** and any prescription drug manufacturer or labeler, including, without limitation, formulary management and drug-switch programs, educational support, claims processing and **pharmacy** network fees that are charged from retail pharmacies and data sales fees. A **pharmacy** benefits **manager** disclosing information under this paragraph may designate that material as confidential. Information designated as confidential by a **pharmacy** benefits **manager** and disclosed to a covered entity under this paragraph may not be disclosed by the covered entity to any person without the consent of the **pharmacy** benefits **manager**, except that disclosure may be made in a court filing under the **Maine** Unfair Trade Practices Act or when authorized by that Act or ordered by a court of this State for good cause shown or made in a court filing under seal unless or until otherwise ordered by a court. Nothing in this paragraph limits the Attorney General's use of Civil Investigative Demand Authority under the **Maine** Unfair Trade Practices Act to investigate violations of this section. [2003, c. 456, §1 (new).]

[2003, c. 456, §1 (new).]

3. Compliance. Compliance with the requirements of this section is required in all contracts for **pharmacy** benefits management entered into in this State or by a covered entity in this State. [2003, c. 456, §1 (new).]

4. Enforcement. A violation of this section is a violation of the **Maine** Unfair Trade Practices Act, for which a fine of not more than $10,000 may be adjudged. [2003, c. 456, §1 (new).]

appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g) of this section and in section 1396n of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 1167(1) of Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement

the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396*o* of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396*o* of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396*o* of this title), exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3–year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;

(B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-0248/2 P1
DAK&PJK:.....

D-NOTE

LRS-Fix request sheet

DOA:.....Pink, BB0012 – Medical Assistance third-party liability

FOR 2007-09 BUDGET -- NOT READY FOR INTRODUCTION

don't gen

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Currently, DHFS may obtain from insurers information DHFS needs to identify a recipient of Medical Assistance (MA) who is eligible for benefits under a disability insurance policy or, if enrolled as the dependent of a beneficiary, would be eligible for benefits; claims submittal information; and types of benefits provided under the policy. DHFS must enter into an agreement with the insurer that identifies the information to be disclosed, safeguards confidentiality, and specifies how the insurer's reasonable costs will be determined and paid from state general purpose revenues and federal moneys. Insurers must provide the information within specified deadlines, and the commissioner of insurance may initiate enforcement proceedings for noncompliance.

This bill expands the sources from whom DHFS may receive health care services coverage information to include entities that are responsible for payment of a claim for a health care item or service. These entities include persons providing health services coverage for individuals on a self-insurance basis, service insurance corporations, and pharmacy benefit managers.

(5)

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

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

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

20.435 **(4)** (bm) *Medical Assistance, food stamps, and Badger Care administration; contract costs, ~~insurer~~ reports, and resource centers.* Biennially, the amounts in the schedule to provide the state share of administrative contract costs for the Medical Assistance program under s. 49.45, the food stamp program under s. 49.79, and the Badger Care health care program under s. 49.665, other than payments to counties and tribal governing bodies under s. 49.78 (8), to develop and implement a registry of recipient immunizations, to reimburse insurers and third parties for their costs under s. 49.475, for costs associated with outreach activities, and for services of resource centers under s. 46.283. No state positions may be funded in the department of health and family services from this appropriation, except positions for the performance of duties under a contract in effect before January 1, 1987, related to the administration of the Medical Assistance program between the subunit of the department primarily responsible for administering the Medical Assistance program and another subunit of the department. Total administrative funding authorized for the program under s. 49.665 may not exceed 10% of the amounts budgeted under pars. (bc), (p), and (x).

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105; 2003 a. 33, 139, 186, 318, 320, 326, 327; 2005 a. 15, 22; 2005 a. 25 ss. 299 to 331, 2498 to 2500, 2510; 2005 a. 74, 107, 199, 228, 264, 388, 406, 434.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

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

20.435 **(4)** (pa) *Federal aid; Medical Assistance and food stamp contracts administration.* All federal moneys received for the federal share of the cost of contracting for payment and services administration and reporting, other than moneys received under par. (nn), to reimburse insurers and third parties for their costs under s. 49.475, for administrative contract costs for the food stamp program under s. 49.79, and for services of resource centers under s. 46.283.

History: 1971 c. 125 ss. 138 to 155, 522 (1); 1971 c. 211, 215, 302, 307, 322; 1973 c. 90, 198, 243; 1973 c. 284 s. 32; 1973 c. 308, 321, 322, 333, 336; 1975 c. 39 ss. 153 to 173, 732 (1), (2); 1975 c. 41 s. 52; 1975 c. 82, 224, 292; 1975 c. 413 s. 18; 1975 c. 422, 423; 1975 c. 430 ss. 1, 2, 80; 1977 c. 29 ss. 236 to 273, 1657 (18); 1977 c. 112; 1977 c. 203 s. 106; 1977 c. 213, 233, 327; 1977 c. 354 s. 101; 1977 c. 359; 1977 c. 418 ss. 129 to 137, 924 (18) (d), 929 (55); 1977 c. 428 s. 115; 1977 c. 447; 1979 c. 32 s. 92 (11); 1979 c. 34, 48; 1979 c. 102 s. 237; 1979 c. 111, 175, 177; 1979 c. 221 ss. 118g to 133, 2202 (20); 1979 c. 238, 300, 331, 361; 1981 c. 20 ss. 301 to 356b, 2202 (20) (b), (d), (g); 1981 c. 93 ss. 3 to 8, 186; 1981 c. 298, 314, 317, 359, 390; 1983 a. 27 ss. 318 to 410, 2202 (20); 1983 a. 192, 199, 245; 1983 a. 333 s. 6; 1983 a. 363, 398, 410, 427; 1983 a. 435 ss. 2, 3, 7; 1983 a. 538; 1985 a. 24, 29, 56, 73, 120, 154, 176, 255, 281, 285, 332; 1987 a. 27, 339, 368, 398, 399, 402; 1987 a. 403 ss. 25, 256; 1987 a. 413; 1989 a. 31, 53; 1989 a. 56 ss. 13, 259; 1989 a. 102; 1989 a. 107 ss. 11, 13, 17 to 37; 1989 a. 120, 122, 173, 199, 202, 318, 336, 359; 1991 a. 6, 39, 189, 269, 275, 290, 315, 322; 1993 a. 16, 27, 76, 98, 99, 168, 183, 377, 437, 445, 446, 450, 469, 479, 490, 491; 1995 a. 27 ss. 806 to 961r, 9126 (19); 1995 a. 77, 98; 1995 a. 216 ss. 26, 27; 1995 a. 266, 276, 289, 303, 404, 417, 440, 448, 464, 468; 1997 a. 27 ss. 211, 214, 216, 217, 527 to 609; 1997 a. 35, 105, 231, 237, 280, 293; 1999 a. 5, 9, 32, 52, 84, 103, 109, 113, 133, 185, 186; 2001 a. 16, 69, 103, 105; 2003 a. 33, 139, 186, 318, 320, 326, 327; 2005 a. 15, 22; 2005 a. 25 ss. 299 to 331, 2498 to 2500, 2510; 2005 a. 74, 107, 199, 228, 264, 388, 406, 434.

SECTION 3. 49.475 (1) (a) of the statutes is renumbered 49.475 (1) (ar).

SECTION 4. 49.475 (1) (ag) of the statutes is created to read:

49.475 **(1)** (ag) "Covered entity" means any of the following that is not an insurer, as defined in s. 600.03 (27):

1. A nonprofit hospital, as defined in s. 46.21 (2) (m).

2. An employer, as defined in s. 101.01 (4), labor union, or other group of persons organized in this state if the employer, labor union, or other group provides prescription drug coverage to covered individuals who reside or are employed in this state.

3. A comprehensive or limited health care benefits program administered by the state that provides prescription drug coverage.

SECTION 5. 49.475 (1) (am) of the statutes is created to read:

49.475 **(1)** (am) "Covered individual" means an individual who is a member, participant, enrollee, policyholder, certificate holder, contract holder, or beneficiary

of a covered entity, or a dependent of the individual, and who receives prescription drug coverage from or through the covered entity.

SECTION 6. 49.475 (1) (c) of the statutes is created to read:

49.475 **(1)** (c) "Pharmacy benefits management" means the procurement of prescription drugs at a negotiated rate for dispensation in this state to covered individuals; the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals; or any of the following services provided in the administration of pharmacy benefits:

1. Dispensation of prescription drugs by mail.

2. Claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to covered individuals.

3. Clinical formulary development and management services.

4. Rebate contracting and administration.

5. Conduct of patient compliance, therapeutic intervention, generic substitution, and disease management programs.

SECTION 7. 49.475 (1) (d) of the statutes is created to read:

49.475 **(1)** (d) "Pharmacy benefits manager" means a person that performs pharmacy benefits management functions.

SECTION 8. 49.475 (1) (e) of the statutes is created to read:

49.475 **(1)** (e) "Third party" means an entity, other than an insurer, that by statute, rule, or contract is responsible for payment of a claim for a health care item or service. "Third party" includes all of the following:

1. A person providing health services coverage for individuals on a self-insurance basis without the intervention of other entities.

2. A service insurance corporation under ch. 613.

3. A pharmacy benefit manager.

SECTION 9. 49.475 (2) (intro.) of the statutes is amended to read:

49.475 **(2)** (intro.) An insurer that issues or delivers a disability insurance policy that provides coverage to a resident of this state and a third party shall provide to the department, upon the department's request, information contained in the insurer's or third party's records regarding all of the following:

History: 1991 a. 39; 1999 a. 9.

SECTION 10. 49.475 (2) (a) 1. of the statutes is amended to read:

49.475 **(2)** (a) 1. Are eligible for benefits under a disability insurance policy or under coverage provided by a third party for health care items or services.

History: 1991 a. 39; 1999 a. 9.

SECTION 11. 49.475 (2) (a) 3. of the statutes is created to read:

49.475 **(2)** (a) 3. Would be eligible for health care items or services coverage provided by a third party if the beneficiary were enrolled or otherwise specified for coverage as a dependent of a person who receives such coverage provided by the third party.

SECTION 12. 49.475 (2) (b) of the statutes is amended to read:

49.475 **(2)** (b) Information required for submittal of claims under the insurer's disability insurance policy or for the third party's coverage for health care items or services.

History: 1991 a. 39; 1999 a. 9.

SECTION 13. 49.475 (3) (intro.) of the statutes is amended to read:

49.475 **(3)** (intro.) Upon requesting an insurer or third party to provide the information under sub. (2), the department shall enter into a written agreement with the insurer or third party that satisfies all of the following:

History: 1991 a. 39; 1999 a. 9.

SECTION 14. 49.475 (3) (c) of the statutes is amended to read:

49.475 **(3)** (c) Specifies how the insurer's or third party's reimbursable costs under sub. (5) will be determined and specifies the manner of payment.

History: 1991 a. 39; 1999 a. 9.

SECTION 15. 49.475 (4) (a) of the statutes is amended to read:

49.475 **(4)** (a) An insurer or third party shall provide the information requested under sub. (2) within 180 days after receiving the department's request if it is the first time that the department has requested the insurer or third party to disclose information under this section.

History: 1991 a. 39; 1999 a. 9.

SECTION 16. 49.475 (4) (b) of the statutes is amended to read:

49.475 **(4)** (b) An insurer or third party shall provide the information requested under sub. (2) within 30 days after receiving the department's request if the department has previously requested the insurer or third party to disclose information under this section.

History: 1991 a. 39; 1999 a. 9.

SECTION 17. 49.475 (5) of the statutes is amended to read:

49.475 **(5)** From the appropriations under s. 20.435 (4) (bm) and (pa), the department shall reimburse an insurer or third party that provides information under this section for the insurer's or third party's reasonable costs incurred in providing the requested information, including its reasonable costs, if any, to develop and operate automated systems specifically for the disclosure of information under this section.

History: 1991 a. 39; 1999 a. 9.

(END)

D-NOTE

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0248/1dn
DAK&PJK:...

To Michelle Pink and Kirsten Nelson:

Please review this draft very carefully; I have drafted it in preliminary form because I have the following questions about it:

1. The federal DEFRA statute that broadened the types of entities from which the state may require health care policy and coverage information (42 USC 1396a (a) (25)) uses the terms (in addition to health insurers, which are currently specified under s. 49.475, stats.): self-insured plans; group health plans, as defined in 29 USC 1167 (1); service benefit plans; managed care organizations; pharmacy benefit managers; or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service. Please review the definition of "third party" under s. 49.475 (1) (e), which, in consultation with Pam Kahler, the insurance drafter, I have drafted to meet requirements of the federal statute:

a. The definition as a whole does not mention group health plans or managed care organizations; according to Pam, these are regarded by, and regulated by, OCI as "insurers" under the definition in s. 600.03 (27), stats., and so are already covered under s. 49.475, stats.

b. For "self-insured plans," which are not defined in our statutes, I have used language in current law under s. 149.10 (5), stats.

c. For "service benefit plans," I have referred to service insurance corporations under ch. 613, stats. The term is not defined in the federal law, and this reference, we think, approximates what the federal statute means. It might be helpful to have OCI review this.

d. The reference to "pharmacy benefit managers" entailed drafting definitions of "covered entity," "covered individual," and "pharmacy benefit management." These definitions are taken from Maine legislation enacted in 2003, as modified.

2. Section 49.475 (4) (c), stats., permits DHFS to notify the commissioner of insurance if an insurer fails to comply with s. 49.475 (4) (a) or (b), stats.; the commissioner may initiate enforcement proceedings against the insurer under s. 601.41 (4) (a), stats. (which requires issuance of orders). What authority, if any, do you want drafted to deal with noncompliance by non-insurers?

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0248/P1dn
DAK:jld:jf

October 16, 2006

To Michelle Pink and Kirsten Nelson:

Please review this draft very carefully; I have drafted it in preliminary form because I have the following questions about it:

1. The federal DEFRA statute that broadened the types of entities from which the state may require health care policy and coverage information (42 USC 1396a (a) (25)) uses the following terms (in addition to health insurers, which are currently specified under s. 49.475, stats.): self-insured plans; group health plans, as defined in 29 USC 1167 (1); service benefit plans; managed care organizations; pharmacy benefit managers; or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service. Please review the definition of "third party" under s. 49.475 (1) (e), which, in consultation with Pam Kahler, the insurance drafter, I have drafted to meet requirements of the federal statute:

a. The definition as a whole does not mention group health plans or managed care organizations; according to Pam, these are regarded by, and regulated by, OCI as "insurers" under the definition in s. 600.03 (27), stats., and so are already covered under s. 49.475, stats.

b. For "self-insured plans," which are not defined in our statutes, I have used language in current law under s. 149.10 (5), stats.

c. For "service benefit plans," I have referred to service insurance corporations under ch. 613, stats. The term is not defined in the federal law, and this reference, we think, approximates what the federal statute means. It might be helpful to have OCI review this.

d. The reference to a "pharmacy benefits manager" entailed drafting definitions of "covered entity," "covered individual," and "pharmacy benefits management." These definitions are taken from Maine legislation enacted in 2003, as modified.

2. Section 49.475 (4) (c), stats., permits DHFS to notify the commissioner of insurance if an insurer fails to comply with s. 49.475 (4) (a) or (b), stats.; the commissioner may initiate enforcement proceedings against the insurer under s. 601.41 (4) (a), stats. (which requires issuance of orders). What authority, if any, do you want drafted to deal with noncompliance by noninsurers?

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.wisconsin.gov

Kennedy, Debora

From: Kirstin Nelson [nelsokb@dhfs.state.wi.us]
Sent: Monday, October 30, 2006 12:25 PM
To: Kennedy, Debora
Cc: Dybevik, Kenneth; Forsaith, Andrew; Kevin Hayden; LaPlant, Tricia; McIlquham, Cheryl; Megna, Richard
Subject: Fwd: Comments on Budget Request for DRA-TPL Language

Attachments: Fwd: Comments on Budget Request for DRA-TPL Language

Fwd: Comments on Budget Reques...

Debora,

Here are our comments on the DRA-TPL draft language.

Let me know if you have any questions.

Regards,
Kirstin

Kirstin Nelson
Budget and Policy Analyst
Office of Strategic Finance
Department of Health and Family Services
(608) 266-5362
nelsokb@dhfs.state.wi.us

* * * * * * * * *

Kennedy, Debora

From: Dybevik, Kenneth
Sent: Friday, October 27, 2006 1:39 PM
To: Kirstin Nelson
Cc: Forsaith, Andrew; Kevin Hayden; LaPlant, Tricia; McIlquham, Cheryl; Megna, Richard
Subject: Fwd: Comments on Budget Request for DRA-TPL Language

Attachments: DRA budget comments oct 24.doc; DRA Budget language from CMS.doc; 07-0248P1.pdf; 07-0248P1dn.pdf


DRA budget ɪmments oct 24.doc


DRA Budget nguage from CMS.d


07-0248P1.pdf (33 KB)


07-0248P1dn.pdf (10 KB)

Kristin, here is our response. Please let me know if you or LRB have any questions. Ken

>>> Tricia LaPlant 10/25/06 >>>
Ken,

We have reviewed the draft budget paper. Attached are our comments on the Drafter's Note Paper and some additional comments we had on the paper. Please let me know if you have any questions. If they have any questions for us on this please have them schedule a meeting with Karla, Larry and I. We think this would be easier than trying to respond to this information via email. Thanks.

1. We are requesting you add the words in bold.

Proposed language states "49.475 (2) (intro.) An insurer that issues or delivers a disability insurance policy that provides coverage to a resident of this state and a 3rd party shall provide to the department, upon the department's request, in a Department specified format, information contained in the insurer's or 3rd party's records regarding all of the following:....

2. WI Stat changes must include all provisions from attached Federal DRA language. This includes stat language to address (i), (ii), (iii),(iv),(I),(II)...Statutory language is required as the DRA requires States in provide assurance to CMS that they have state laws in place to cover all provision of DRA for TPL. All provision are required to achieve the budget savings in the DHFS budget.

Please let us know if you have any questions. Thanks Ken

Markup of Title 19 to Include Sec. 6035 of the DRA
NOTE: New language is underlined and highlighted. Old language is marked through.
Sec. 1902 [42 U.S.C. 1396a] (a) A State plan for medical assistance must—
(25) provide--
(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, selfinsured plans, group health plans (as defined in section 607 (1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--
(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;
(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;
(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title) exceeds the total of the amount of the liabilities of third parties for that service;
(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;
(E) that in the case of prenatal or preventive pediatric

care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--
(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
(ii) seek reimbursement from such third party in accordance with subparagraph (B);
(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--
(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and
(ii) seek reimbursement from such third party in accordance with subparagraph (B);
(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, and a health maintenance organization a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State; and
(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and
(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--
(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the

individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;.

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU
LRB–0248/P1dn
DAK:jld:jf
October 16, 2006
To Michelle Pink and Kirsten Nelson:
Please review this draft very carefully; I have drafted it in preliminary form because I have the following questions about it:

1. The federal DEFRA statute that broadened the types of entities from which the state may require health care policy and coverage information (42 USC 1396a (a) (25)) uses the following terms (in addition to health insurers, which are currently specified under s. 49.475, stats.): self–insured plans; group health plans, as defined in 29 USC 1167 (1); service benefit plans; managed care organizations; pharmacy benefit managers; or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service. Please review the definition of "third party" under s. 49.475 (1) (e), which, in consultation with Pam Kahler, the insurance drafter, I have drafted to meet requirements of the federal statute:

The state definition for third party doesn't match the Federal definition. The Federal definition includes all types of coverage (insured and non insurers). The state definition only includes non insurers. We suggest removing the statement "other than an insurer" in (1) (e) and add #4 to state the following: "Insurers" has the meaning given in S.600.03 (27).

Insurers are already defined in 49.475 (1)(b) and are already required!

a. The definition as a whole does not mention group health plans or managed care organizations; according to Pam, these are regarded by, and regulated by, OCI as "insurers" under the definition in s. 600.03 (27), stats., and so are already covered under s. 49.475, stats. **Yes, we agree**

b. For "self–insured plans," which are not defined in our statutes, I have used language in current law under s. 149.10 (5), stats.

Did you also look at stat. 149.10 3JA?

From Fred: No — I am insurer; is group health plan under fed def

c. For "service benefit plans," I have referred to service insurance corporations under ch. 613, stats. The term is not defined in the federal law, and this reference, we think, approximates what the federal statute means. It might be helpful to have OCI review this. **We have no comments on this and agree you should check with OCI.**

d. The reference to a "pharmacy benefits manager" entailed drafting definitions of "covered entity," "covered individual," and "pharmacy benefits management." These

definitions are taken from Maine legislation enacted in 2003, as modified.

We believe this part is incorrect. A covered entity should include everything. The way this is written now states that a covered entity would have to cover only drugs otherwise it would not be considered a covered entity

No, it does not; it states that a covered entity wd. have to provide pds drugs - cd, could provide other benefits

2. Section 49.475 (4) (c), stats., permits DHFS to notify the commissioner of insurance if an insurer fails to comply with s. 49.475 (4) (a) or (b), stats.; the commissioner may initiate enforcement proceedings against the insurer under s. 601.41 (4) (a), stats. (which requires issuance of orders). What authority, if any, do you want drafted to deal with noncompliance by noninsurers?

We suggest adding a statement that says…If a Third Party fails to comply, notify the Office of Attorney General.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266–0137
E–mail: debora.kennedy@legis.wisconsin.gov

0248/P1

"/10/06 Conversation with Fred Nepple, OCI:

① Would "group health plan," as defined in s. 149.10 (3j) (as DHFS suggests) be a better way to refer to "self-insured plans" than as the draft does under 49.475 (1)(e)1. ("A person providing health services coverage for individuals on a self-insurance basis without the intervention of other entities" — PJK's language)?

Fred: No; 149.10 (3j)(a) refers to "an employee welfare plan, as defined in section 3(1) of federal ERISA of 1974" — this definition (in 29 USC 1167 (1)) includes self funded or insured plans.

Could use the definition in ERISA, but should exclude "multiple employer welfare arrangements"

Fed ERISA def: employee benefit plan described in 29 USC 1003 (a) that is not exempt under 29 USC 1003 (b) and is not a multiple employer welfare arrangement

(2) Re "service benefit plan" in Fed language

Draft: (49.475(1)(e)2.) refers to "service corp. under ch. 613"

Fred Nepple: (a) A "service corp" is an insurer + regulated by OCI; is a "group health plan" under fed def.

(b) Unknown what feds are referring to as a "service benefit plan"

(c) May have to refer to it as "service benefit plan" under 42 USC 1396a (25)(I)

11/14/06 Conversation w/ Michelle Pinke

I don't know if I should:

(a) Integrate "insurer" in c. law into these requirements, as requested in commentary

(b) Draft all 3 DRA requirements as requested in commentary — original DHFS request refers to "process" DHFS had established under a Waiver from CMS

11/14/06 Response from Michelle:

(a) OK to integrate "insurer" — CMS has apparently requested it

(b) Draft all DRA reqmts — again, CMS has requested