AN ACT to create 20.435 (4) (c), 20.435 (4) (hv) and 146.10 of the statutes; relating to: a health care program for certain veterans, providing an exemption from emergency rule-making procedures, granting rule-making authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

This bill creates an interim health care plan for Wisconsin veterans, administered by the Department of Health and Family Services (DHFS). The plan would apply to a veteran who is not eligible for any state or federal health care, who has not had any private health care coverage for at least 90 days, who is between the ages of 18 and 65, and who has a household income that is less that 200 percent of income threshold established by the federal Department of Veterans Affairs for his or her county of residence. The bill requires DHFS to seek federal or private funds that may be available to help pay the costs of the plan.

The bill requires the veteran to pay a monthly premium of $50 and copayments for certain services and limits the time benefits can be received to a cumulative period of 24 months. The bill gives DHFS the right to make a claim for any benefits paid to the veteran from a person who was responsible for the injury that created the veteran’s need for benefits from the plan. The bill establishes the procedure that is used if DHFS has a claim. The bill gives a prepaid health care plan that contracts with DHFS for provision of health benefits the same rights as DHFS to recover from any person who was responsible for the injury that created the veteran’s need for benefits from the plan.
The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>2007-08</th>
<th>2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and family services, department of Health services planning, reg &amp; delivery, health care fin; other support pgms</td>
<td></td>
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<tr>
<td>Veteran interim health care GPR A</td>
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SECTION 2. 20.435 (4) (c) of the statutes is created to read:

20.435 (4) (c) Veteran interim health care. The amounts in the schedule for the provision or purchase of veteran interim health care benefits under s. 146.10.

SECTION 3. 20.435 (4) (hv) of the statutes is created to read:

20.435 (4) (hv) Veteran interim health care premiums. All moneys received in premiums under s. 146.10 (3) for providing or purchasing veteran interim health care benefits under s. 146.10.

SECTION 4. 146.10 of the statutes is created to read:

146.10 Veteran interim health care. (1) Definition. In this section:

(a) “Health care benefits” means the benefits listed under s. 49.46 (2) (a), except for the benefit under s. 49.46 (2) (a) 4. c., and under s. 49.46 (2) (b), except for nonemergency transportation under s. 49.46 (2) (b) 3.
(b) “Veteran” means a person who served on active duty in the U.S. armed forces or in forces incorporated in the U.S. armed forces, in a reserve component of the U.S. armed forces, or in the national guard and who has received a discharge from that service other than a dishonorable discharge.

(2) ELIGIBILITY. The department shall provide to or purchase health care benefits for a veteran if all of the following conditions are met:

(a) The veteran is a resident of this state and has been a resident for 12 consecutive months prior to his or her application for health care benefits under this section.

(b) The veteran is not eligible for any federal or state health care programs or benefits.

(c) The veteran has not been covered under any private health care coverage, and has not had access to any employer-provided health care coverage, for at least 90 days before application.

(d) The veteran is over the age of 18 and under the age of 65.

(e) The annual income of the veteran and his or her spouse exceeds, but does not exceed 200 percent of, the Geographic Means Test Income Threshold established by the federal department of veterans affairs for the year of his or her application and the county of his or her residence.

(3) MONTHLY PREMIUMS. The veteran shall pay a monthly premium of $50 to the department for the provision of the health care benefits. Amounts received under this subsection shall be credited to the appropriation account under s. 20.435 (4) (hv).

(4) COPAYMENTS. The veteran shall pay the following amounts as copayments:

(a) Doctor visit — $15.

(b) Generic prescription drug — $6.
(c) Brand name prescription drug — $14.

(d) Hospital emergency room visit — $50.

(e) Hospital admission — $150.

(f) Outpatient hospital or clinic services — 10 percent of covered services.

(g) Dental visit — $15.

(5) DISQUALIFYING FACTORS. No health care benefits may be provided under this section to a veteran who has received those benefits for a cumulative period of 24 months during his or her lifetime. No health care benefits may be provided under this section to a veteran who has not paid the monthly premium under sub. (3).

(6) SUBROGATION. (a) In this subsection:

1. “Beneficiary” means a veteran who received or is receiving benefits under this section.

2. “Insurer” includes a sponsor, other than an insurer, that contracts to provide health care services to members of a group.

(b) If the department provides benefits under this section, as a result of the occurrence of an injury, sickness, or death that creates a claim or cause of action, whether in tort or contract, on the part of a beneficiary or the estate of a beneficiary against a 3rd party, including an insurer, the department is subrogated to the rights of the beneficiary or estate and may make a claim or maintain an action or intervene in a claim or action by the beneficiary or estate against the 3rd party.

(c) By applying for benefits under this section a veteran assigns to the department the right to make a claim to recover an indemnity from a 3rd party, including an insurer, if the benefits are provided as a result of the occurrence of injury, sickness, or death that results in a possible recovery of an indemnity from the 3rd party.
(d) An attorney retained to represent a beneficiary, or the beneficiary’s estate, in asserting a claim that is subrogated under par. (b) or assigned under par. (c) shall provide notice under par. (f). If no attorney is retained to represent a beneficiary, or the beneficiary’s estate, in asserting a claim that is subrogated under par. (b) or assigned under par. (c), the beneficiary or his or her guardian or, if the beneficiary is deceased, the personal representative of the beneficiary’s estate, shall provide notice under par. (f).

(e) A person against whom a claim that is subrogated under par. (b) or assigned under par. (c) is made, or that person’s attorney or insurer, shall provide notice under par. (f), if that person, attorney, or insurer knows, or could reasonably determine, that the claimant is a beneficiary, or is the estate of a beneficiary.

(f) If a person is required to provide notice under this paragraph, the person shall provide notice by certified mail to the department as soon as practicable after the occurrence of each of the following events for a claim under par. (d):

1. The filing of the action asserting the claim.
2. Intervention in the action asserting the claim.
3. Consolidation of the action asserting the claim.
4. An award or settlement of all or part of the claim.

(g) The beneficiary or any party having a right under this subsection may make a claim against the 3rd party or may commence an action and shall join the other party as provided under s. 803.03 (2). Each shall have an equal voice in the prosecution of such claim or action.

(h) Reasonable costs of collection including attorney fees shall be deducted first from any recovery under this subsection. The amount of benefits paid as a result of the occurrence of the injury, sickness, or death shall be deducted next from any
recovery and the remainder shall be paid to the beneficiary or other party entitled

to payment.

(i) The department shall enforce its rights under this subsection and may
contract for the recovery of any claim or right of indemnity arising under this
subsection.

(j) No person who has or may have a claim or cause of action in tort or contract
and who has received benefits under this section as a result of the occurrence that
creates the claim or cause of action may release the liable party or the liable party’s
insurer from liability to the department. Any payment to a beneficiary in
consideration of a release from liability is evidence of the payer’s liability to the
department.

(k) Liability under par. (j) is to the extent of benefits provided under this section
resulting from the occurrence creating the claim or cause of action, but not in excess
of any insurance policy limits, counting payments made to the injured person.

(L) A health maintenance organization or other prepaid health care plan has
the powers of the department under pars. (b) to (h) to recover the costs that the
organization or plan incurs in treating an individual if all of the following
circumstances are present:

1. The costs result from an occurrence of an injury or sickness of an individual
who is a beneficiary.

2. The occurrence of the injury or sickness creates a claim or cause of action on
the part of the beneficiary or the estate of the beneficiary.

3. The medical costs are incurred during a period for which the department
pays a capitation or enrollment fee for the beneficiary.
(7) Rules. The department shall promulgate rules for the administration of
the health care benefit program under this section.

(8) Application for grants. The department shall seek to obtain any federal
or private funds that may be available to pay for the health care benefits provided
under this section and for the administrative costs incurred under this section.

SECTION 5. Nonstatutory provisions.

(1) The department of health and family services may promulgate emergency
rules under section 227.24 of the statutes implementing section 146.10 of the
statutes, as created by this act. Notwithstanding section 227.24 (1) (a) and (3) of the
statutes, the department is not required to provide evidence that promulgating a rule
under this subsection as an emergency rule is necessary for the preservation of public
peace, health, safety, or welfare and is not required to provide a finding of an
emergency for a rule promulgated under this subsection.

SECTION 6. Fiscal changes.

(1) Veterans interim health care. In the schedule under section 20.005 (3) of
the statutes for the appropriation to the department of health and family services
under section 20.435 (4) (a) of the statutes, as affected by the acts of 2007, the dollar
amount is increased by $−0− for fiscal year 2007−08 and the dollar amount is
increased by $−0− for fiscal year 2008−09 to pay for the costs of administering the
veterans interim health care program under section 146.10 of the statutes, as created
by this act.

(END)