2009 DRAFTING REQUEST

Bill

Received: **11/24/2009**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Jon Richards (608) 266-0650**

By/Representing: **Jeff Kostelic**

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

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**
Public Assistance - misc
Public Assistance - med. assist.
Health - miscellaneous

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Richards@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

BadgerCare Plus Basic Plan and BC+ Benchmark Plan changes

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 12/03/2009	jdyer 12/07/2009		_____ _____			State
/1	pkahler 01/21/2010	wjackson 01/21/2010	jfrantze 12/07/2009	_____ _____	sbasford 12/07/2009		State
/2			mduchek 01/22/2010	_____ _____	sbasford 01/22/2010	sbasford 01/22/2010	

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required

FE Sent For:

at intro

<END>

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See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler	12/7 jld	12/7	12/7 ph			

FE Sent For:

<END>

Kahler, Pam

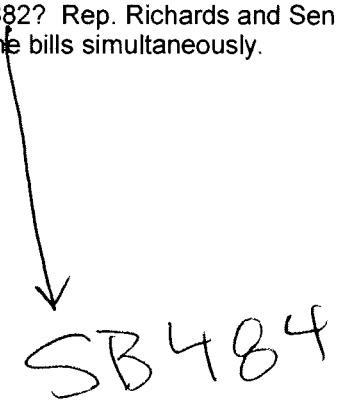
From: Kostelic, Jeff
Sent: Tuesday, November 24, 2009 1:55 PM
To: Kahler, Pam
Subject: Companion Bills

Pam,

Could you please draft a companion bill to LRB3882? Rep. Richards and Sen Erpenbach would like to move together with a joint hearing so that both houses can work on the bills simultaneously.

Thanks.

Jeff



Kahler, Pam

From: Currans-Sheehan, Rachel H - DHS [Rachel.CurransSheehan@dhs.wisconsin.gov]
Sent: Wednesday, November 18, 2009 1:59 PM
To: Kostelic, Jeff; Johnson, Kelly
Cc: Kahler, Pam; Malofsky, Shelley F - DHS; Johnston, James - DHS
Subject: FW: BadgerCare Plus Basic

Attachments: WI CHIPRA 2009 letter.pdf; BM plan CHIPRA WI stat amdmts (2).doc; Stat lang 11.6.09.doc

Kelly and Jeff:

Thank you for helping to prepare yesteday's informational hearing. I thought the conversation went very well. I am now following up with the bulk of the drafting instructions we believe we will need for the BC + Basic Plan. Obviously, we are still working out the details on which of the three options we will move forward with, as we discussed yeterday. We anticipate that we will have a few additional elements with the details of the plan we choose that we will need to get to you. Given the timing, we thought it would be best to send you the instructions so the drafter can begin working on this bill. As you can see below, Pam Kahler, reached out to us today with regard to the drafting instructions. Shelley Malofsky is the legal counsel at DHS who prepared these drafting instructions and can be our point of contact with the drafter. I have included both Pam and Shelley on this email.

As we finalize the actual benefit package, we will forward the additional drafting instructions to you to complete the final bill.

Additionally, we were hoping we could bundle statutory changes directed by CMS to include two beneifts in our Benchmark Plan in the BadgerCare Plus Basic bill. I have attached CMS guidance requiring WI to cover transportation under the Benchmark plan (right now we only cover emergency medical transportation) and EPSDT (physical exams, vision, dental, and hearing services) for kids up to age 21 (right now we only cover up to age 19). I have attached drafting instructions and a letter from CMS informing our Department of the need to change our benefit plan. Our hope would be that Jon and Jon would be willing to include this provision in the bill draft on BC + Basic.

Please let me know if you have any questions. Look forward to our continued partnership on this exciting endeavor in health care reform in Wisconsin.

Thanks,


WI CHIPRA 2009 letter.pdf (78 ...


3M plan CHIPRA WI stat amdmts ...


Stat lang 11.6.09.doc (30 KB)

Rachel H. Currans-Sheehan
Legislative Liaison
Department of Health Services
Phone: (608) 266-3262
Email: rachel.curranssheehan@wisconsin.gov

From: Malofsky, Shelley F - DHS
Sent: Wednesday, November 18, 2009 1:34 PM
To: 'Kahler, Pam - LEGIS'
Cc: Jones, James D - DHS; Johnston, James - DHS; Currans-Sheehan, Rachel H - DHS
Subject: RE: BadgerCare Plus Basic

Hi Pam,

Yes, we will be looking for legislation. Rachel (our legislative liaison) is handling that end of it. I'm copying her so that she knows you're looking for information.

Shelley

From: Jones, James D - DHS

Sent: Wednesday, November 18, 2009 12:09 PM
To: Johnston, James - DHS; Malofsky, Shelley F - DHS
Subject: FW: BadgerCare Plus Basic

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Wednesday, November 18, 2009 10:18 AM
To: Jones, James D - DHS
Subject: BadgerCare Plus Basic

Hi, Jim:

I've been hearing and reading quite a bit about the new plan for those on the waiting list for the BadgerCare Plus Core Plan and have been wondering if any new legislation will need to be drafted for it. I want to make plans for Thanksgiving! Thanks, Jim.

Pam

Pamela J. Kahler
Legislative Attorney
Legislative Reference Bureau
608-266-2682

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 12, 2009

Jason Helgerson, Administrator
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P.O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Helgerson:

As you are aware, and per our discussion on Friday June 12, 2009, Section 6044 of the Deficit Reduction Act (DRA) of 2005 amended the Social Security Act (the Act) to add a new section 1937. Section 1937 provided authority for States to provide medical assistance to certain beneficiaries through enrollment in benchmark or benchmark equivalent coverage plans. Nine States currently have approved benchmark or benchmark equivalent benefit plans, including Wisconsin.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 includes two technical changes to the DRA that affect benchmark and benchmark equivalent plans. These changes take effect as if included in the DRA. Section 611(a)(1)(C) and section 611(a)(3) of CHIPRA amend section 1937 of the Act to require States to assure that children under the age of 21, rather than only those under 19 as originally specified in the DRA, who are included in benchmark or benchmark equivalent plans, have access to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Section 611(a)(1)(A)(i) of CHIPRA amends section 1937 of the Act by changing the language that originally read "Notwithstanding any other provision of this title..." to read "Notwithstanding section 1902(a)(1)(relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title which would be directly contrary to the authority...". This change in the law clarifies that the authority under section 1937 to deviate from otherwise applicable Medicaid requirements is limited.

In addition, and pursuant to section 1902(a)(4) of the Act and 42 CFR section 431.53, assurance of necessary transportation for beneficiaries to and from providers is a mandatory State plan requirement. Since this assurance would not conflict with the offering of benchmark or benchmark equivalent benefit packages as authorized by section 1937, the assurance of transportation remains applicable even when the State has elected the 1937 option, and regardless of whether it is or is not a covered benefit under a benchmark or benchmark equivalent benefit plan.

We have reviewed Wisconsin's Benchmark Benefit plan which we approved on November 27, 2007, and have found that the State's current Benchmark plan does not provide full EPSDT services to 19 and 20 year olds enrolled in this benefit plan, nor does the Benchmark plan provide non-emergency transportation to enrolled beneficiaries, contrary to the above.

As such, we respectfully request the State to implement the needed changes to its Benchmark Benefit plan incorporating the statutory requirements noted in this correspondence as soon as possible by submitting a State Plan Amendment to the Chicago Regional Office within 30 days from the receipt of this letter addressed to my attention.

If you have any further questions or concerns, please contact Cynthia Garraway, of my staff, at (312) 353-8583 or Cynthia.Garraway@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Coverage of Benefits under the Benchmark Benefit Plan as Required by New Federal Laws

Per guidance from the Centers for Medicare and Medicaid (CMS),Wisconsin must change two provisions in its benchmark plan under WI statute to ensure compliance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

As the attached letter from CMS suggests, Wisconsin must ensure that under the benchmark plan:

1) Children under the age of 21, rather than those under 19, have access to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, known as Health Check visits in Wisconsin.

2) Transportation to and from providers is a mandatory benefit.

The Department offers the following drafting recommendations to meet these requirements:

Section 49.471(11)(m) of the Statutes is amended to read:

49.471(11)(m). Transportation to obtain ~~emergency~~ medical care ~~only~~, as medically necessary, and subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided, to the extent permitted under federal law.

Section 49.471(11)(s) of the Statutes is created to read:

49.471(11)(s). Early and periodic screening and diagnosis of persons under 21 years of age and all services included within the federal definition of "medical assistance" under 42 USC § 1396d (a) that are found necessary by this screening and diagnosis.

For questions during the drafting process, please contact DHS Attorney Neil Gebhart, 608 267-2002, Neil.Gebhart@wisconsin.gov.

Statutory Language for BadgerCare Plus Basic Plan

20.435(4)(xx) *BadgerCare Plus Basic Plan program benefits and administration.* All moneys received from premiums under s. 49.xx(4) to be expended for the provision of services under the BadgerCare Plus Basic Plan benefit under s. 49.xx(3) and for administration of the plan under s. 49.xx(3).

49.xxx BadgerCare Plus Limited Plan [To be placed under subch. V of ch. 49]

(1) APPROPRIATION. From the appropriation account under s. 20.435(4)(xx), the department shall pay administrative costs and costs of benefits for a limited health care plan for individuals eligible under sub. (2) if the plan under sub. (3) is in effect.

(2) ELIGIBILITY. An individual is eligible for the benefits under sub. (3) if the plan under sub. (3) is in effect and if all of the following conditions are met. Notwithstanding fulfillment of the eligibility requirements under this subsection, no individual is entitled to health care coverage under this section.

(a) The individual is currently on the wait list that is established for the health care benefit plan under s. 49.45(23).

(b) The individual applies for the plan under this section in the manner prescribed by the department.

(c) The individual submits with the application the first month's premium set under sub. (4).

(d) The individual maintains premium payments set by the department under sub. (4) and pays the cost sharing set under sub. (4).

(3) LIMITED HEALTH CARE PLAN. No earlier than March 1, 2010, the department may begin paying benefits for a plan to provide limited primary and preventive health care to individuals who are eligible under sub. (2). The benefits may not exceed the benefits available under the health care benefit plan under s. 49.45(23).

(4) COST-SHARING. (a) The plan under sub. (3) shall be funded through payment of premiums by eligible individuals that are deposited by the Department or its agent in the appropriation account under s.20.435(4)(xx) The department shall calculate premiums that are actuarially set for the benefits that the department will include in the plan and that allows the department to fiscally maintain the plan.

(b) Premiums shall be due in the month prior to the month of coverage. An individual may not enroll in the plan or continue enrollment in the plan if the premium is not paid when due. If an individual is disenrolled from the plan for a failure to pay a premium when due, the individual is not eligible for the plan under this section for 12 calendar months following the month in which the individual was disenrolled.

(c) The department may set cost sharing requirements that the department determines are necessary to fiscally maintain the plan under sub. (3).

(5) PROVIDER REQUIREMENTS. The department shall pay for covered services the amount that is payable for those services under medical assistance. As a condition of participation of a provider in the program under s. 49.45, 49.46. 49.47 or 49.471, the provider shall accept the department's payment as payment in full and may not bill an eligible individual for any amount other than for the cost sharing required under sub. (4).

(6) REVIEW. Any individual who is denied enrollment or is disenrolled from the plan under this section may request a review by the department by filing a written request that includes the reasons that the individual disagrees with such action. A request for review must be filed within 60 days of the denial or disenrollment. The decision of the department after review shall be final and is not subject to ch. 227.

(7) INAPPLICABILITY. (a) The limited health care plan under this section is not medical assistance under subch. IV of ch. 49.

(b) The limited health care plan under this section is not subject to chs. 600 to 646.

State of Wisconsin
2009 - 2010 LEGISLATURE

3907/1
LRB-~~3882/P2~~
PJK:wlj:~~jf~~
Keep

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

D-note
(i-12-3)

X Regen

AN ACT ***to amend*** 49.471 (11) (m); and ***to create*** 20.435 (4) (hm), 49.471 (11) (s), 49.67 and 227.42 (7) of the statutes; **relating to:** the BadgerCare Plus Basic Plan, Benchmark Plan benefits, and making an appropriation. ✓

Analysis by the Legislative Reference Bureau

Current law authorizes the Department of Health Services (DHS) to establish a Medical Assistance (MA) health care benefit plan providing basic primary and preventive care for adults under age 65 who have family incomes not exceeding 200 percent of the poverty line and who are not otherwise eligible for MA or Medicare. This plan for childless adults is commonly known as the BadgerCare Plus Core Plan. Due to the volume of applications for the plan, which exceeded the plan's ability to provide benefits for all who applied, DHS suspended enrollment on October 9, 2009, and established a waiting list.

This bill authorizes DHS to establish and operate, no sooner than March 1, 2010, another health care benefit plan (plan) for individuals who are on the waiting list for the BadgerCare Plus Core Plan. The plan, which is not MA and which will be known as the BadgerCare Plus Basic Plan, will provide primary and preventive care, and the benefits may not exceed those provided under the BadgerCare Plus Core Plan. The plan, including both benefits and administration, will be funded entirely from premiums set by DHS and paid by individuals with coverage under the plan. To enroll, an individual must submit the first month's premium along with his or her application. Thereafter the individual must pay the premium for a month's coverage in the preceding month. An individual who fails to pay a premium when due loses coverage and is not again eligible for coverage under the plan for 12 months.

DHS will pay providers for services provided to individuals with coverage under the plan the amount that is payable for the service under MA, and a provider may not bill the individual who received the service for any additional amount other than cost sharing established by DHS. Any individual who is denied coverage or whose coverage is discontinued may file a written request for review by DHS and must exhaust that process before commencing any action in court.

Also under current law, DHS administers BadgerCare Plus, which is an MA program that provides health care benefits under two different plans, depending on the basis for a recipient's eligibility, to recipients who satisfy financial and nonfinancial eligibility criteria. One of the plans, known as the Benchmark Plan, provides specified benefits, including transportation to obtain emergency medical care. The bill expands the transportation benefit under the Benchmark Plan so that transportation to obtain medical care, rather than just emergency medical care, is covered. The bill also specifically adds as a benefit for recipients under the age of 21 early and periodic screening and diagnosis, and all services included under the federal definition of "medical assistance" that are found necessary as a result of the screening and diagnosis. Currently under the Benchmark Plan recipients under the age of 19 receive early and periodic screening and diagnosis and services found necessary as a result of the screening and diagnosis.

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

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

SECTION 1. 20.435 (4) (hm) of the statutes is created to read:

20.435 **(4)** (hm) *BadgerCare Plus Basic Plan; benefits and administration.* All moneys received from premiums under s. 49.67 (3), to pay for the provision of services under the BadgerCare Plus Basic Plan under s. 49.67 and for administration of the plan.

SECTION 2. 49.471 (11) (m) of the statutes is amended to read:

49.471 **(11)** (m) Transportation to obtain ~~emergency~~ medical care ~~only~~, as medically necessary, and subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided, to the extent permitted under federal law.

SECTION 3. 49.471 (11) (s) of the statutes is created to read:

49.471 **(11)** (s) Early and periodic screening and diagnosis, and all services included in the definition of "medical assistance" under 42 USC 1396d (a) that are found necessary by this screening and diagnosis, for recipients under 21 years of age.

SECTION 4. 49.67 of the statutes is created to read:

49.67 BadgerCare Plus Basic Plan. (1) ESTABLISHMENT AND OPERATION. The department may establish and, no sooner than March 1, 2010, begin operating a plan providing coverage of limited primary and preventive health care benefits to individuals who satisfy the eligibility criteria under sub. (2). The benefits covered under the plan under this section may not exceed the benefits covered under the health care benefit plan under s. 49.45 (23). The department shall pay for its administrative costs and for the cost of benefits provided under the plan under this section from the appropriation under s. 20.435 (4) (hm).

(2) ELIGIBILITY. (a) Subject to par. (b) and sub. (3) (a) 2., an individual may receive coverage for benefits under the plan under this section if the individual satisfies all of the following criteria:

1. The individual is on the waiting list established for the health care benefit plan under s. 49.45 (23).

2. The individual applies for coverage for benefits under the plan under this section in the manner prescribed by the department.

3. The individual submits, with the application under subd. 2., the first month's premium and pays the monthly premiums as required under sub. (3) (a) 2.

(b) Notwithstanding satisfaction of the criteria under par. (a), no individual is entitled to benefits under the plan under this section.

(3) COST SHARING. (a) 1. The plan under this section shall be funded through premiums paid by individuals with coverage under the plan. The department shall

set premiums at a level necessary to pay for the benefits covered and to maintain the fiscal soundness of the plan. The department, or its agent, shall credit premiums received from individuals to the appropriation account under s. 20.435 (4) (hm).

2. Premiums shall be due in the month before the month of coverage. An individual may not enroll in the plan if he or she does not submit the premium required with the application and may not continue coverage under the plan if he or she does not pay a premium when due. An individual whose coverage is discontinued for failure to pay a premium when due is ineligible for coverage under the plan under this section for 12 calendar months following the month in which his or her coverage was discontinued.

(b) The department may set other cost-sharing requirements that the department determines are necessary to keep the plan actuarily sound.

(4) PROVIDER REQUIREMENTS. The department shall pay a provider for a service that is covered under the plan under this section the amount that is payable for the service under the Medical Assistance program under subch. IV. A provider that provides a covered service to an individual with coverage under the plan under this section shall accept the department's payment as payment in full and may not bill the individual to whom the service was provided for any amount other than any cost sharing required under sub. (3) (b).

(5) REVIEW OF COVERAGE DENIAL OR DISCONTINUATION. Any individual who is denied enrollment or whose coverage is discontinued may request that the department review the action by filing with the department a written request that includes the reasons why the individual disagrees with the denial or discontinuation of coverage. The written request must be filed within 60 days after the coverage denial or discontinuation. An individual must exhaust the process under this

subsection before commencing any action in court relating to the coverage denial or discontinuation.

(6) INAPPLICABLE PROVISIONS. All of the following apply to the plan under this section:

(a) It is not medical assistance under subch. IV.

(b) It is exempt from chs. 600 to 646.

SECTION 5. 227.42 (7) of the statutes is created to read:

227.42 **(7)** This section does not apply to a decision denying enrollment or discontinuing coverage under s. 49.67.

(END)

LRB-3907/1
PJK:jld

D-note

This is the
~~This is the~~ latest version of the Basic Plan bill. It includes the changes to the Benchmark Plan.

PJK

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3907/1dn
PJK:jld:jf

December 7, 2009

This is the latest version of the Basic Plan bill. It includes the changes to the Benchmark Plan.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

Kahler, Pam

From: Kahler, Pam
Sent: Thursday, January 21, 2010 3:44 PM
To: Kostelic, Jeff
Subject: RE: BCB Draft

Yes, that would be LRB-3907 with the latest changes.

From: Kostelic, Jeff
Sent: Thursday, January 21, 2010 3:43 PM
To: Kahler, Pam
Subject: FW: BCB Draft

Pam,

Could you please draft an Assembly companion to the attached draft?

Thank you.

Jeff Kostelic
Office of Rep. Jon Richards
266-0650

From: Becker, Kelly
Sent: Thursday, January 21, 2010 3:17 PM
To: Kostelic, Jeff
Subject: BCB Draft

Attached is the final draft of the Basic bill approved by DHS if you want to have the companion done!
Here in the Senate it is 3882/3
<< File: 09-38823BCB.pdf >>

Kelly Becker
Office of State Senator
JON ERPENBACH
27th District
Ph: 608-266-6670
Fax: 608-266-2508

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3907/2
PJK:wlj:md

2009 BILL

for LRB-3907/2, please use LRB-3892/3 SOON (in 1-21)

Regen

AN ACT ***to amend*** 49.471 (11) (m); and ***to create*** 20.435 (4) (hm), 49.471 (11) (s), 49.67, 227.01 (13) (ur) and 227.42 (7) of the statutes; **relating to:** the BadgerCare Plus Basic Plan, Benchmark Plan benefits, and making an appropriation.

Analysis by the Legislative Reference Bureau

Current law authorizes the Department of Health Services (DHS) to establish a Medical Assistance (MA) health care benefit plan providing basic primary and preventive care for adults under age 65 who have family incomes not exceeding 200 percent of the poverty line and who are not otherwise eligible for MA or Medicare. This plan for childless adults is commonly known as the BadgerCare Plus Core Plan (Core Plan). Due to the volume of applications for the plan, which exceeded the plan's ability to provide benefits for all who applied, DHS suspended enrollment on October 9, 2009, and established a waiting list.

This bill authorizes DHS to establish and operate, no sooner than March 1, 2010, another health care benefit plan for individuals who are on the waiting list for the Core Plan. The health care benefit plan, which is not MA and which will be known as the BadgerCare Plus Basic Plan (Basic Plan), will provide primary and preventive care, and the benefits may not exceed those provided under the Core Plan. The Basic Plan, including both benefits and administration, will be funded entirely from premiums set by DHS and paid by individuals with coverage under the Basic Plan. To enroll, an individual must submit the first month's premium along with his or her application. Thereafter the individual must pay the premium for a month's

coverage in the preceding month. If an individual with coverage under the Basic Plan is removed from the Core Plan waiting list and begins receiving coverage under the Core Plan, DHS will not refund any portion of a premium that the individual paid for coverage under the Basic Plan for the month in which his or her coverage under the Core Plan commences, but DHS will waive any enrollment fee that the individual would have had to pay for enrolling in the Core Plan. An individual whose coverage under the Basic Plan terminates for any reason, including for failure to pay a premium when due, is not again eligible for coverage under the Basic Plan for 12 months, unless the individual's coverage terminated for a good cause reason. DHS may set a deductible not exceeding $7,500 per enrollment year for inpatient and nonemergency outpatient hospital services, as well as other cost-sharing requirements.

DHS will pay a provider that provides services to individuals with coverage under the Basic Plan if the provider is certified by DHS to provide services under MA. For those services, DHS will pay a certified provider an amount that is no higher than the amount that is payable for the service under MA. A certified provider may not bill the individual who received the service for any additional amount, other than cost sharing established by DHS, and a certified provider may not charge a covered individual an amount that is higher than the amount that DHS would pay the provider for inpatient or nonemergency outpatient hospital services to which a deductible applies.

Any individual who is denied coverage under the Basic Plan or whose coverage is discontinued may file a written request for review by DHS and must exhaust that process before commencing any action in court. DHS may recover amounts incorrectly paid on behalf of an individual if the individual, when first enrolled, was on the Core Plan waiting list due to a misstatement or omission of fact made by the individual, or if the individual's coverage under the Basic Plan was continued due to a misstatement or omission of fact made by the individual.

Also under current law, DHS administers BadgerCare Plus, which is an MA program that provides health care benefits under two different plans, depending on the basis for a recipient's eligibility, to recipients who satisfy financial and nonfinancial eligibility criteria. One of the plans, known as the Benchmark Plan, provides specified benefits, including transportation to obtain emergency medical care. The bill expands the transportation benefit under the Benchmark Plan so that transportation to obtain medical care, rather than just emergency medical care, is covered. The bill also specifically adds as a benefit for recipients under the age of 21 early and periodic screening and diagnosis, and all services included under the federal definition of "medical assistance" that are found necessary as a result of the screening and diagnosis. Currently under the Benchmark Plan recipients under the age of 19 receive early and periodic screening and diagnosis and services found necessary as a result of the screening and diagnosis.

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

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

SECTION 1. 20.435 (4) (hm) of the statutes is created to read:

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

SECTION 2. 49.471 (11) (m) of the statutes is amended to read:

49.471 **(11)** (m) Transportation to obtain ~~emergency~~ medical care ~~only~~, as medically necessary, and, to the extent permitted under federal law, subject to coinsurance payment of no more than 10 percent of the allowable payment rates under s. 49.46 (2) for the services provided.

SECTION 3. 49.471 (11) (s) of the statutes is created to read:

49.471 **(11)** (s) Early and periodic screening and diagnosis, and all services included in the definition of "medical assistance" under 42 USC 1396d (a) that are found necessary by this screening and diagnosis, for recipients under 21 years of age.

SECTION 4. 49.67 of the statutes is created to read:

49.67 BadgerCare Plus Basic Plan. (1) DEFINITIONS. In this section:

(a) "Certified provider" means a provider that is certified by the department under s. 49.45 (2) (a) 11. as a provider of medical assistance.

(b) "Enrollment year" means a 12-month period during which an individual has coverage under the plan under this section beginning with the effective date of the individual's coverage or with the anniversary of that date.

(2) ESTABLISHMENT AND OPERATION. The department may establish and, no sooner than March 1, 2010, begin operating a plan providing coverage of limited primary and preventive health care benefits to individuals who satisfy the eligibility criteria under sub. (3). The department shall pay for its administrative costs and for the cost of benefits provided under the plan under this section from the appropriation under s. 20.435 (4) (hm) and, if needed, may pay the costs of incurred program benefits from the appropriation under s. 20.435 (4) (ma).

(3) ELIGIBILITY. (a) *Criteria.* Subject to pars. (b) and (c) and sub. (4) (a) 2., an individual may receive coverage for benefits under the plan under this section if the individual satisfies all of the following criteria:

1. The individual is on the waiting list established for the health care benefit plan under s. 49.45 (23).

2. The individual applies for coverage for benefits under the plan under this section in the manner prescribed by the department.

(b) *No entitlement.* Notwithstanding satisfaction of the criteria under par. (a), no individual is entitled to benefits under the plan under this section.

(c) *After termination of coverage.* An individual whose coverage under the plan under this section ends for any reason, including for failure to pay a premium when due, is ineligible for coverage under the plan for 12 calendar months, beginning with the first calendar month after the last calendar month, which need not be a full month, in which he or she had coverage. This paragraph does not apply if the department determines that the individual's coverage ended for a good cause reason.

(4) COST SHARING. (a) *Premiums.* 1. The plan under this section shall be funded through premiums paid by individuals with coverage under the plan. The department shall set premiums at a level necessary to pay for the benefits covered

and to maintain the fiscal soundness of the plan. The department, or its agent, shall credit premiums received from individuals to the appropriation account under s. 20.435 (4) (hm).

2. Premiums shall be due in the calendar month before the calendar month of coverage. An individual may not enroll in the plan if he or she does not submit the first month's premium with the application and may not continue coverage under the plan if he or she does not pay a premium when due.

3. If an individual with coverage under the plan under this section is removed from the waiting list for the health care benefit plan under s. 49.45 (23) and begins receiving coverage under that health care benefit plan, the department shall not refund any portion of a premium paid by the individual for coverage under the plan under this section for the calendar month in which the individual's coverage under the health care benefit plan under s. 49.45 (23) commences. The department shall, however, waive any enrollment fee that would be payable by the individual for enrolling in the health care benefit plan under s. 49.45 (23).

(b) *Deductible.* The department may set a deductible that applies to inpatient and nonemergency outpatient hospital services and that does not exceed $7,500 in an enrollment year.

(c) *Other.* The department may set other cost-sharing requirements that the department determines are necessary to keep the plan actuarily sound.

(5) PROVIDER REQUIREMENTS. (a) *Certification.* Only a certified provider may receive payment from the department for services provided to individuals under the plan under this section.

(b) *Payments and charges.* 1. The department shall pay a certified provider for a service that is covered under the plan under this section an amount that is no

higher than the amount that is payable for the same service under the Medical Assistance program under subch. IV. A certified provider that provides a covered service to an individual with coverage under the plan under this section shall accept the department's payment as payment in full and, subject to subd. 2., may not bill the individual to whom the service was provided for any amount other than any cost sharing required under sub. (4).

2. A certified provider that provides to an individual with coverage under the plan under this section inpatient or nonemergency outpatient hospital services to which a deductible under sub. (4) (b) applies may not charge for those services an amount that is higher than the amount that would be payable to the provider under subd. 1. for those services.

(6) BENEFITS. (a) *May not exceed benefits under other plan.* The benefits covered under the plan under this section may not exceed the benefits covered under the health care benefit plan under s. 49.45 (23).

(b) *Coordination of benefits.* 1. Benefits under the plan under this section shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care coverage, Medicare, or any other governmental program, except as otherwise provided by law. If an individual who has coverage under the plan under this section also has coverage under the plan under subch. II of ch. 149, benefits under the plan under this section are secondary to the benefits provided under the plan under subch. II of ch. 149.

2. The department is subrogated to the rights of an individual with coverage under the plan under this section to recover special damages for illness or injury to the individual caused by the act of a 3rd person to the extent that benefits are provided under the plan.

(c) *Recovery of incorrectly paid benefits.* 1. The department may recover a payment made incorrectly for benefits provided under this section on behalf of an individual if the incorrect payment was made as a result of any of the following:

a. At the time the individual obtained coverage under the plan under this section, the individual was on the waiting list established for the health care benefit plan under s. 49.45 (23) because of a misstatement or omission of fact by the individual.

b. The individual's coverage under the plan under this section was continued because of a misstatement or omission of fact by the individual.

2. The department's right of recovery is against the individual with coverage under the plan under this section on whose behalf the incorrect payment was made. The extent of the recovery is limited to the amount of the benefits actually paid.

(7) REVIEW OF COVERAGE DENIAL OR DISCONTINUATION. Any individual who is denied enrollment in the plan under this section or whose coverage is discontinued may request that the department review the action by filing with the department a written request that includes the reasons why the individual disagrees with the denial or discontinuation of coverage. The written request must be filed within 60 days after the coverage denial or discontinuation. An individual must exhaust the process under this subsection before commencing any action in court relating to the coverage denial or discontinuation.

(8) INAPPLICABLE PROVISIONS. All of the following apply to the plan under this section:

(a) It is not medical assistance under subch. IV.

(b) It is exempt from chs. 600 to 646.

SECTION 5. 227.01 (13) (ur) of the statutes is created to read:

227.01 **(13)** (ur) Relates to the benefit design, cost-sharing requirements, or administration of the health care benefits plan under s. 49.67.

SECTION 6. 227.42 (7) of the statutes is created to read:

227.42 **(7)** This section does not apply to a decision denying enrollment or discontinuing coverage under s. 49.67, to a decision about benefits covered under s. 49.67, or to a payment made under s. 49.67.

(END)

Duerst, Christina

From: Kostelic, Jeff
Sent: Friday, January 22, 2010 12:23 PM
To: LRB.Legal
Subject: Draft Review: LRB 09-3907/2 Topic: BadgerCare Plus Basic Plan and BC+ Benchmark Plan changes

Please Jacket LRB 09-3907/2 for the ASSEMBLY.