State of Wisconsin
2009 – 2010 LEGISLATURE

LRB–3882/en
SRM:cjs:...

2009 SENATE BILL 484

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

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 meets the eligibility requirements, and 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.

(am) *Verification and information.* The department shall do all of the following:

1. Verify monthly that an individual with coverage under the plan under this section meets the eligibility criteria, including by using income, insurance coverage, and other eligibility verification systems.

2. Provide to an applicant all of the following:

a. Information about the Health Insurance Risk−Sharing Plan under ch. 149, including an estimate of the applicant's premium under that plan and the differences between the benefits provided under that plan and the benefits provided under the health care benefit plan under s. 49.45 (23).

b. If the applicant is under 27 years of age, notice that he or she may be eligible for coverage as a dependent under his or her parent's health care plan in accordance with s. 632.885, and that his or her parent's plan must include coverage for services that are not covered under the plan under this section.

c. Information about the applicant's right to purchase continuation coverage under certain circumstances, as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 and under s. 632.897, and about any state or federal premium tax credits or other premium subsidies that might be available to the applicant for that coverage.

(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 not less than the amount that is payable for the same service under the Medical Assistance program under subch. IV, except that the department shall make payments to federally qualified health centers and hospital outlier payments in an amount that is no higher than the amount that is payable 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.

3. The department shall not make any payments that are required under s. 49.45 (3) (e) 11. under the plan under this section.

(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.

(6m) DISCLOSURE OF BENEFITS AND COST SHARING. When an individual applies for coverage under the plan under this section, the department shall provide to the individual written disclosure of the benefits provided under the plan and the premiums, deductibles, copayments, and any other cost sharing required under the plan.

(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.

(7m) AUDIT. The legislative audit bureau shall perform a performance evaluation audit of the plan under this section no later than one year after the effective date of this subsection .... [LRB inserts date]. The bureau shall submit copies of the audit report to the chief clerk of each house of the legislature for distribution to the appropriate standing committees under s. 13.172 (3).

(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.

(9) REPORTS TO JOINT COMMITTEE ON FINANCE. The department shall on a quarterly basis submit a report to the joint committee on finance that includes information on the solvency of the plan under this section and that describes any changes that have been made under the plan since the last report was submitted to premiums, benefits, or provider payment rates.

(9g) REPORTS TO JOINT COMMITTEE ON FINANCE. The department shall on a quarterly basis submit a report to the joint committee on finance that includes, relevant to the period since the last report, all of the following concerning the plan under this section:

(a) Information about solvency, including claims paid, premium collected, and condition of reserves.

(b) A description of any changes to premiums, benefits, enrollee cost sharing, or provider payment rates.

(c) Demographic information about applicants and enrollees, including age, gender, residence, health status, employment, income, health insurance history, and claims history under the plan under this section.

(d) A description of the department's process for verifying eligibility of applicants and enrollees and information about the number of applicants and enrollees found to be eligible and the number of applicants and enrollees found to be ineligible under the plan's eligibility criteria.

(9m) TERMINATION OF PLAN. The plan under this section shall terminate on January 1, 2014. The department shall not pay any claim under this section for services provided after December 31, 2013, to an individual with coverage under the plan under this section.

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)