SENATE BILL 484 (LRB -3882)

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. (FE)

2010

01-25.	S.	Introduced by Senator **Erpenbach**; cosponsored by Representative **Richards**.
01-25.	S.	Read first time and referred to committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue 503
02-02.	S.	Fiscal estimate received.
02-11.	S.	Public hearing held.
02-12.	S.	Executive action taken.
02-12.	S.	Report introduction and adoption of Senate Amendment 1 recommended by committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue, Ayes 7, Noes 0 **(LRB a1529)** 557
02-12.	S.	Report passage as amended recommended by committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue, Ayes 4, Noes 3 557
02-12.	S.	Available for scheduling.
02-12.	S.	Referred to joint committee on Finance by committee on Senate Organization pursuant to Senate Rule 41 (1)(e), Ayes 5, Noes 0 558
02-16.	S.	Senator Jauch added as a coauthor 562
02-16.	S.	Executive action taken.
02-16.	S.	Report adoption of Senate Amendment 1 recommended by joint committee on Finance, Ayes 16, Noes 0 .. 561
02-16.	S.	Report passage as amended recommended by joint committee on Finance, Ayes 12, Noes 4 561
02-16.	S.	Available for scheduling.
02-18.	S.	Placed on calendar 2-23-2010 pursuant to Senate Rule 18(1) 572
02-22.	S.	Senate amendment 2 offered by Senator Vinehout **(LRB a1611)** 574
02-22.	S.	Senate amendment 3 offered by Senator Vinehout **(LRB a1612)** 574
02-22.	S.	Senate amendment 4 offered by Senator Vinehout **(LRB a1613)** 574
02-23.	S.	Read a second time 582
02-23.	S.	Senate amendment 5 offered by Senator Sullivan **(LRB a1640)** 582
02-23.	S.	Senate amendment 6 offered by Senator Sullivan **(LRB a1639)** 582
02-23.	S.	Senate amendment 7 offered by Senator Sullivan **(LRB a1642)** 582
02-23.	S.	Senate amendment 8 offered by Senators Sullivan, Kreitlow and Vinehout **(LRB a1653)** 582
02-23.	S.	Referred to committee on Senate Organization 582
02-23.	S.	Made a special order at 12:05 P.M. on the calendar of 2-25-2010 by committee on Senate Organization 578
02-25.	S.	Read a second time 591
02-25.	S.	Refused to refer to committee on Senate Organization, Ayes 15, Noes 18 592
02-25.	S.	**Senate amendment 1 adopted** 592
02-25.	S.	Senate amendment 2 laid on table, Ayes 17, Noes 16 592
02-25.	S.	Refused to table Senate amendment 3, Ayes 16, Noes 17 592
02-25.	S.	**Senate amendment 3 adopted**, Ayes 23, Noes 10 592
02-25.	S.	Senate amendment 4 laid on table, Ayes 17, Noes 16 592
02-25.	S.	Senate amendment 5 withdrawn and returned to author 592
02-25.	S.	Senate amendment 6 withdrawn and returned to author 592
02-25.	S.	Senate amendment 7 withdrawn and returned to author 592
02-25.	S.	**Senate amendment 8 adopted** 592
02-25.	S.	Ordered to a third reading 592
02-25.	S.	Rules suspended 592
02-25.	S.	Read a third time and **passed**, Ayes 17, Noes 16 592
02-25.	S.	Ordered immediately messaged 595
02-26.	A.	Received from Senate 707
02-26.	A.	Read first time and referred to committee on Health and Healthcare Reform 708
03-29.	A.	Assembly amendment 1 offered by Representatives Shilling and Bernard Schaber **(LRB a1933)** 767
03-30.	A.	Assembly amendment 2 offered by Representative Nygren **(LRB a1703)** 770
03-31.	A.	Executive action taken.
04-02.	A.	Report Assembly Amendment 1 adoption recommended by committee on Health and Healthcare Reform, Ayes 12, Noes 0 782
04-02.	A.	Report concurrence as amended recommended by committee on Health and Healthcare Reform, Ayes 8, Noes 4 782
04-02.	A.	Referred to committee on Rules 782
04-15.	A.	Made a special order of business at 11:49 A.M. on 4-20-2010 pursuant to Assembly Resolution 23 869
04-20.	A.	Placed at the foot of the calendar of 4-20-2010.
04-20.	A.	Read a second time.

04-20.	A.	Assembly substitute amendment 1 offered by Representative Nygren **(LRB s0452)**.
04-20.	A.	Assembly substitute amendment 1 laid on table, Ayes 51, Noes 47.
04-20.	A.	**Assembly amendment 1 adopted.**
04-20.	A.	Assembly amendment 3 offered by Representative Kramer **(LRB a1702)**.
04-20.	A.	Assembly amendment 3 laid on table, Ayes 51, Noes 47.
04-20.	A.	Assembly amendment 4 offered by Representative Nygren **(LRB a1699)**.
04-20.	A.	**Assembly amendment 4 adopted.**
04-20.	A.	Assembly amendment 5 offered by Representative Nygren **(LRB a2094)**.
04-20.	A.	Assembly amendment 5 laid on table, Ayes 51, Noes 47.
04-20.	A.	Ordered to a third reading.
04-20.	A.	Rules suspended.
04-20.	A.	Read a third time and **concurred in** as amended, Ayes 50, Noes 47, Paired 2.
04-20.	A.	Ordered immediately messaged.
04-21.	S.	Received from Assembly amended and concurred in as amended, Assembly amendment 1 and Assembly amendment 4 adopted.
04-21.	S.	Available for scheduling.
04-21.	S.	Placed on calendar 4-22-2010 pursuant to Senate Rule 18(1) 0
04-22.	S.	Assembly amendment 1 **concurred in**.
04-22.	S.	Assembly amendment 4 **concurred in**.
04-22.	S.	Action ordered immediately messaged.

2009
ENROLLED BILL

09en SB-484

ADOPTED DOCUMENTS:

☒ Orig ☐ Engr ___ SubAmdt ___ 09-3882/3*

Amendments to above (if none, write "NONE"): SA 1 – a 1529/1*

AA 1 – a 1933/1* SA 3 – a 1612*/1

AA 4 – a 1699/1* SA 8 – a 1653*/1

Corrections - show date (if none, write "NONE"): ~~NONE~~

CCC in enrolling (4-26-10)

Topic Rel

4-23-10 S R Miller

Date Enrolling Drafter

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/3
PJK:wlj:md

2009 SENATE BILL 484

January 25, 2010 - Introduced by Senator ERPENBACH, cosponsored by Representative RICHARDS. Referred to Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue.

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:

INS. SA 8-1

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.

INS. SA 8-2

(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.

INS. AA4-1

(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.

INS. 5A3-1

(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.

INS. SA1-5

INS. AA 1-1

INS. SA8-3

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)

State of Wisconsin
2009 – 2010 LEGISLATURE

LRBa1529/1
PJK:kjf&jld:ph

SENATE AMENDMENT 1,

TO 2009 SENATE BILL 484

February 12, 2010 – Offered by COMMITTEE ON HEALTH, HEALTH INSURANCE, PRIVACY, PROPERTY TAX RELIEF, AND REVENUE.

At the locations indicated, amend the bill as follows:

1. Page 5, line 25: delete "no" and substitute "not".

2. Page 6, line 1: delete "higher" and substitute "less".

3. Page 6, line 2: after "subch. IV" insert ", 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".

4. Page 6, line 11: after that line insert:

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

5. Page 8, line 4: after that line insert:

"**(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.".

(END)

State of Wisconsin
2009 – 2010 LEGISLATURE

LRBa1612/1
PJK:nwn:rs

SENATE AMENDMENT 3,

TO 2009 SENATE BILL 484

February 22, 2010 – Offered by Senator VINEHOUT.

SA 3-1

At the locations indicated, amend the bill as follows:

1. Page 7, line 24: after that line insert:

"**(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).".

(END)

State of Wisconsin
2009-2010 LEGISLATURE

CORRECTIONS IN:

SENATE AMENDMENT 8,

TO 2009 SENATE BILL 484

Prepared by the Legislative Reference Bureau
(April 26, 2010)

In enrolling, the following correction was made:

1. Page 2, line 13: delete "**(9)**" and substitute "**(9g)**".

****NOTE: Senate amendment 1 and senate amendment 8 both inserted subsections numbered "**(9)**" into s. 49.67, which is created in the bill. This correction changes the number of the subsection inserted by senate amendment 8. The substance of the subsection is not affected.

(END)

LRBa1653/1ccc-1
CJS:md

Minor clerical corrections in legislation are authorized under s. 35.17, stats.; Senate Rule 31; Assembly Rule 36; and Joint Rule 56.

State of Wisconsin
2009 – 2010 LEGISLATURE

LRBa1653/1
PJK:bjk:ph

SENATE AMENDMENT 8,

TO 2009 SENATE BILL 484

February 23, 2010 – Offered by Senators SULLIVAN, KREITLOW and VINEHOUT.

SA 8-1

At the locations indicated, amend the bill as follows:

1. Page 4, line 11: delete "is on the waiting list established" and substitute "meets the eligibility requirements, and is on the waiting list established,".

2. Page 4, line 14: after that line insert:

SA 8-2

"(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.".

3. Page 8, line 4: after that line insert:

"(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, 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.".

(END)

State of Wisconsin
2009 – 2010 LEGISLATURE

LRBa1933/1
PJK:nwn:jf

ASSEMBLY AMENDMENT 1,

TO 2009 SENATE BILL 484

March 29, 2010 – Offered by Representatives SHILLING and BERNARD SCHABER.

AA1-1

At the locations indicated, amend the bill as follows:

1. Page 8, line 5: before that line insert:

"**(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.".

(END)

State of Wisconsin
2009 – 2010 LEGISLATURE

LRBa1699/1
PJK:bjk:rs

ASSEMBLY AMENDMENT 4,

TO 2009 SENATE BILL 484

April 20, 2010 – Offered by Representative NYGREN.

AA4-1

At the locations indicated, amend the bill as follows:

1. Page 7, line 16: after that line insert:

"**(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.".

(END)