2009 DRAFTING REQUEST

Bill

Received: **11/19/2009**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Johnson**

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

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous**

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

BadgerCare Plus Basic Plan

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/20/2009	wjackson 11/23/2009		_____ _____			State
/P1			jfrantze 11/24/2009	_____ _____	sbasford 11/24/2009		State
/P2	pkahler 12/01/2009	wjackson 12/03/2009	jfrantze 12/03/2009	_____ _____	sbasford 12/03/2009		State
/P3	pkahler	wjackson	mduchek	_____	cduerst		State

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/2	pkahler 01/21/2010	wjackson 01/21/2010	rschluet 01/21/2010	_____ _____	cduerst 01/21/2010		State
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→ At Intro.

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FE Sent For: /3 WLJ 1/21

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1/15 Dh 1/15 DH/MD

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/P3 WLJ 12/23

12/30 - 5 PM

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Drafter: **pkahler**

May Contact: Shelley Malofsky DHS 6-0387

Addl. Drafters:

Subject: **Health - miscellaneous**

Extra Copies:

Submit via email: **YES**

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/?	pkahler	/pl wlj 11/23		11/24			

FE Sent For:

<END>

Kahler, Pam

From: Johnson, Kelly
Sent: Wednesday, November 18, 2009 4:00 PM
To: Kahler, Pam
Subject: RE: BadgerCare Plus Basic

Thank you, I'll let you know as soon as possible, and understand your time restrictions, I will only be here on Tuesday next week.

From: Kahler, Pam
Sent: Wednesday, November 18, 2009 3:59 PM
To: Johnson, Kelly
Subject: RE: BadgerCare Plus Basic

Yes - but chances are you will know whether to include those other changes before you receive the first version of the bill, so just let me know as soon as you find out. It's not a complicated draft, but there are a couple of other things I need to get out of the way first, and I plan to be here only Monday and Tuesday of next week.

From: Johnson, Kelly
Sent: Wednesday, November 18, 2009 3:54 PM
To: Currans-Sheehan, Rachel H - DHS; Kostelic, Jeff
Cc: Kahler, Pam; Malofsky, Shelley F - DHS; Johnston, James - DHS
Subject: RE: BadgerCare Plus Basic

Pam:
Since you were copied on the email, I know that you have the instructions and would really appreciate your help in drafting this for Sen. Erpenbach. (and also Rep. Richards)
I will speak with Jon about the additional changes directed by CMS outside of the BC+ Basic, and make sure he is ok with including those in the draft. For now, can you please draft the bill without those provisions. (I've copied everyone else to make sure that they are in the loop.)

Thank you!!
Kelly

From: Currans-Sheehan, Rachel H - DHS [mailto: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

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,

<< File: WI CHIPRA 2009 letter.pdf >> << File: BM plan CHIPRA WI stat amdmts (2).doc >> << File: Stat lang 11.6.09.doc >>

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

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

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WI CHIPRA 2009 letter.pdf (78 ...


3M plan CHIPRA WI stat amdmts ...


Stat lang 11.6.09.doc (30 KB)

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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.

Rachel → 6-3262

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).

49.67 or 49.69

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. Exclude from ch 227?

227.42

(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.

11-19 Call to Shelley M.

(1) providers cannot bill individuals – not sure yet if providers must be MA-certified

(2) no review of DHS decision on coverage denial, etc., under ch 227 or by a court

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/1
PJK:...:...

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** establishing the BadgerCare Plus Basic Plan and making an appropriation.

Analysis by the Legislative Reference Bureau

Current law authorizes the Department of Health Services (DHS) to establish a Medical Assistance 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 Medical Assistance 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, ~~enrollment was~~ suspended on October 9, 2009, and a waiting list ~~was~~ established.

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 Medical Assistance 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 Medical Assistance, 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, whose decision on review is final and binding.

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. 49.67 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. The decision of the department on review is final and binding on the individual.

(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 3. 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)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3882/P1dn
PJK:...:...

WLJ

Date

As you requested, this draft does not contain the two changes to BadgerCare Plus.

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

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3882/P1dn
PJK:wlj:jf

November 24, 2009

As you requested, this draft does not contain the two changes to BadgerCare Plus.

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

Kahler, Pam

From: Becker, Kelly
Sent: Tuesday, November 24, 2009 1:37 PM
To: Kahler, Pam; Currans-Sheehan, Rachel H - DHS; Kostelic, Jeff
Subject: LRB 3882

Pam:
I spoke with Jon and he is ok with including the changes to BadgerCare Plus in LRB 3882 regarding BadgerCare Basic.
Thanks!

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

Kahler, Pam

From: Malofsky, Shelley F - DHS [Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Tuesday, December 01, 2009 11:19 AM
To: Kahler, Pam
Cc: Currans-Sheehan, Rachel H - DHS
Subject: RE: BC+ Basic Plan

I believe so. But, could you add that the 49.67 review process must be exhausted before one can bring a court action?

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Tuesday, December 01, 2009 10:58 AM
To: Malofsky, Shelley F - DHS
Cc: Currans-Sheehan, Rachel H - DHS
Subject: RE: BC+ Basic Plan

I think, then, that if you want to allow a court action after internal review, I should remove the statement that a decision of the department is binding on the individual. OK?

From: Malofsky, Shelley F - DHS [mailto:Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Tuesday, December 01, 2009 10:52 AM
To: Kahler, Pam
Cc: Currans-Sheehan, Rachel H - DHS
Subject: RE: BC+ Basic Plan

Pam –

The goal is to keep our administrative costs down. As you know there won't be any state dollars contributed to the plan, so we are trying to keep the admin costs portion of the premium as low as reasonably possible to put more towards benefits. Our thought was that getting tangled up in administrative hearings would eat up too many resources. We also would like to have reviews go through the internal process so that we can catch any mistakes before being sued in court.

So, if possible we'd like any non-court review limited to the internal review (no ch. 227 admin hearings) and require that the internal review be exhausted before resort to court action.

I'm copying Rachel so that if she's aware of a different department preference she can correct me.

Thanks.

Shelley

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Monday, November 30, 2009 12:02 PM
To: Malofsky, Shelley F - DHS
Subject: BC+ Basic Plan

Hi, Shelley:

We discussed whether a person had a right to appeal a decision of DHS (regarding an enrollment denial or coverage discontinuation) to a court and I mentioned that no such right exists after independent review under s. 632.835. I started thinking about it and remembered that independent review is just an option, so an individual could bring a court action instead. The Basic Plan language makes a review by DHS an option too (any individual who is denied enrollment or whose coverage is discontinued *may* request that the department review ....), so the individual could bring a court action instead - if they choose a DHS review, that decision is final, but they could go to court instead. Would you like me to add

language to the effect that an individual may commence a civil proceeding instead, or just leave the language as is (which doesn't rule it out)? Thanks.

Pam

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

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/P2
PJK:wlj:jf

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT *to create* 20.435 (4) (hm), 49.67 and 227.42 (7) of the statutes; **relating to:** establishing the BadgerCare Plus Basic Plan and making an appropriation.

Analysis by the Legislative Reference Bureau

Current law authorizes the Department of Health Services (DHS) to establish a Medical Assistance 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 Medical Assistance 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 Medical Assistance 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 Medical Assistance, 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, whose decision on review is final and binding. 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. 49.67 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. The decision of the department on review is final and binding on the individual.

insert 4-10

(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 3. 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)

insert 4-15

INSERT A-1

and must exhaust that process before commencing any action in court

(END OF INSERT A-1)

INSERT A-2

Also under current law, DHS administers BadgerCare Plus (BC+), 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.

(END OF INSERT A-2)

INSERT 4-10

An individual must exhaust the process under this subsection before commencing any action in court relating to the coverage denial or discontinuation.

(END OF INSERT 4-10)

INSERT 4-15

SECTION 1. 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.

History: 2007 a. 20; 2009 a. 28.

SECTION 2. 49.471 (11) (s) of the statutes is created to read:

lns 4-15 cont'd

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.

(END OF INSERT 4-15)

Kahler, Pam

From: Currans-Sheehan, Rachel H - DHS [Rachel.CurransSheehan@dhs.wisconsin.gov]
Sent: Tuesday, December 15, 2009 3:12 PM
To: Kahler, Pam
Subject: RE: The draft you requested

Both whether a copay may be charged at all and, if so, to the amount of the copay

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

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Tuesday, December 15, 2009 2:09 PM
To: Currans-Sheehan, Rachel H - DHS
Subject: RE: The draft you requested

Rachel,

Does "to the extent under federal law" relate to charging a copay at all or to the amount of the copay?

From: Currans-Sheehan, Rachel H - DHS [mailto:Rachel.CurransSheehan@dhs.wisconsin.gov]
Sent: Monday, December 14, 2009 4:57 PM
To: Kahler, Pam
Subject: FW: The draft you requested

Pam- Please see the comments below pertaining to the Benchmark language in the bill draft. "To the extent permitted under federal law" applies to the coinsurance as opposed to the transportation benefit, so we have a minor change recommended.

Thanks,

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

From: Gebhart, Neil R - DHS
Sent: Monday, December 14, 2009 4:50 PM
To: Currans-Sheehan, Rachel H - DHS
Subject: RE: The draft you requested

You're right, it was my language, and quite clearly it applies to coinsurance, not the transportation service itself. To clarify this, it should be revised as shown in one of the following two alternatives:

- Section 2, which would amend 49.471 (11) (m) to read:

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

OR

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.

[Note that the second alternative just removes the comma prior to "to the extent permitted by federal law."

Sorry about the confusion.

# # #

Kahler, Pam

From: Malofsky, Shelley F - DHS [Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Wednesday, December 16, 2009 2:11 PM
To: Kahler, Pam
Subject: RE: BC+ Basic

Thanks.

-----Original Message-----
From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Wednesday, December 16, 2009 1:01 PM
To: Malofsky, Shelley F - DHS
Cc: Currans-Sheehan, Rachel H - DHS
Subject: RE: BC+ Basic

In response to the question about the deductible language and DHS's intention not to charge for or apply a deductible to the first admission or visit, I don't see any problem with doing that under general language.

-----Original Message-----
From: Malofsky, Shelley F - DHS [mailto:Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Monday, December 14, 2009 1:46 PM
To: Kahler, Pam
Cc: Currans-Sheehan, Rachel H - DHS
Subject: BC+ Basic

[My first attempt at sending this came back undeliverable. Hopefully that was true and you're not getting this a second time.]

Pam,

Rachel asked that I forward you a few additions we need to the stat language based upon policy decisions that have recently been made. Hopefully this is it. Please see attached and call/email me with any questions.

One question about your last draft: under (3)(a)2, the 12-month crowd out provision applies "following the month in which his or her coverage was discontinued." Should that be "following the last month of coverage" or "beginning with the first month coverage was discontinued?" If someone failed to pay the March premium so February was the last coverage, I don't want a picky reader arguing that the 12 months begins in April ('following the discontinued month').

Thanks.

Shelley

Provider certification:
To participate in the plan a provider must be certified under subch. IV as a provider of medical assistance.

Deductible:
The department may set a deductible that applies to inpatient hospital admissions and outpatient hospital visits, combined, of $7500 in incurred charges during each enrollment year. (An enrollment year is the twelve month period that follows the effective date of coverage and each anniversary of the effective date.)

[Question to Pam: The decision for now is that the first admission and visit will be covered and the deductible will then apply to subsequent admissions or visits. DHS would like to keep the language as general as possible in all regards to allow flexibility so would prefer not to put in the statutes that the first are covered. Acceptable?]

As a condition of participation in the plan, during a deductible period set under sub. ( ) the provider may not charge an eligible individual for an inpatient hospital admission or a non-emergency outpatient hospital visit an amount that exceeds the amount that is payable for those services under medical assistance.

Maximum benefit:
The benefits paid by the plan for each individual with coverage under the plan may not exceed $250,000 for services received in each enrollment year.

Coordination of Benefits/Subrogation
(a) Benefits under the plan 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 insurance, medicare, or any other governmental program, except as otherwise provided by law.

(b) The department is subrogated to the rights of an eligible individual to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan.

Recovery of Incorrectly Paid Benefits
(a) The department may recover any payment made incorrectly for benefits provided under this section if the incorrect payment results from any of the following:

1. at the time that the individual obtains coverage under the plan 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; or

2. the individual continues coverage under the plan because of a misstatement or omission of fact by the individual.

(b) The department's right of recovery is against the individual with coverage under the plan. The extent of recovery is limited to the amount of the benefits incorrectly granted.

Kahler, Pam

From: Malofsky, Shelley F - DHS [Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Tuesday, December 15, 2009 2:20 PM
To: Kahler, Pam
Subject: RE: BC+ Basic

Pam,

I agree with your suggestion. We had thought there was a nuance to premium payment being an eligibility criterion, but I doubt there truly is; as long as one cannot begin or continue without payment it serves the same purpose.
Also, good to add the rule-making exception.

Thanks.

Shelley

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Tuesday, December 15, 2009 1:49 PM
To: Malofsky, Shelley F - DHS
Subject: RE: BC+ Basic

Hi, Shelley:

I'm just getting to this stuff - pretty hectic around here right now. Sorry, but I don't see that Neil's suggested language makes any substantive change, since paying is still one of the criteria. What I could do, though, is take out s. 49.67 (2) (a) 3. entirely, since the intro. says "subject to sub. (3) (a) 2., which is the requirement that the individual pay the first moth's premium along with the application to enroll and that he or she pays the monthly premiums to continue coverage. Yes, I can add the benefit design to s. 227.42 (7), created in the draft.

Pam

From: Malofsky, Shelley F - DHS [mailto:Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Monday, December 14, 2009 5:17 PM
To: Kahler, Pam
Cc: Currans-Sheehan, Rachel H - DHS
Subject: BC+ Basic

Pam -

Neil Gebhart raised the following two points that I thought would be good to get your take on:

1. He suggested rewording proposed s. 49.67 (2) to read:

> (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 and submits the first month's premium and pays the monthly premiums as required under sub. (3) (a) 2.:
>
> 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) Notwithstanding satisfaction of the criteria under par. (a) 1. and 2., no individual is entitled to benefits under the plan under this section.

He thought that the current structure could suggest that an applicant can be charged the applicable premiums and still not be entitled to benefits, which isn't the Dept's intent.

2. He suggested expressly saying that the department's benefit design is not subject to rule-making.

Shelley

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/P3
PJK:wlj:rm

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

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.

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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 (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 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. (3). 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.

(3) 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 same 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.

(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. 227.42 (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)

insert 5-6

INSERT 2-A

DHS may set a deductible not exceeding $7,500 per enrollment year for inpatient and outpatient hospital services, as well as other cost-sharing requirements. The maximum amount that will be paid for benefits under the plan for any individual is $250,000 per enrollment year.

DHS will pay a provider that provides services to individuals with coverage under the plan if the provider is certified by DHS to provide services under MA. For those services, DHS will pay certified providers 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 more than the amount payable under MA for inpatient or outpatient hospital services to which a deductible applies.

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. DHS may recover amounts incorrectly paid on behalf of an individual if the individual, when first enrolled, was on the BadgerCare Plus Core Plan waiting list due to a misstatement or omission of fact made by the individual, or if the individual's coverage under the BadgerCare Plus Basic Plan was continued due to a misstatement or omission of fact made by the individual.

(END OF INSERT 2-A)

INSERT 3-5

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)

(END OF INSERT 3-5)

INSERT 3-13

Insert 3-13

Criteria.

(END OF INSERT 3-13)

INSERT 3-22

No entitlement.

(END OF INSERT 3-22)

INSERT 3-24

Premiums.

(END OF INSERT 3-24)

INSERT 4-10

, beginning with the first month after the last month in which he or she had coverage

(END OF INSERT 4-10)

INSERT 4-11

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

****NOTE: Do you want $7,500 to be the maximum deductible amount, as drafted?

(END OF INSERT 4-11)

INSERT 4-11A

Other.

(END OF INSERT 4-11A)

INSERT 4-13

Insert 4-13

(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.

(END OF INSERT 4-13)

INSERT 4-19

2. A certified provider that provides to an individual with coverage under the plan under this section inpatient or outpatient hospital services to which a deductible under sub. (4) (b) applies may not charge for those services more than the amount that is payable for the same services under the Medical Assistance program under subch. IV.

****NOTE: I did not make a provider's "participation in the plan" explicitly conditioned on this requirement. Do you think it is necessary? Isn't it enough that the statutes require certified providers to comply with certain requirements, implicitly in exchange for payment from DHS for the services they provide to individuals with coverage under the plan?

(6) BENEFITS. (a) *Maximum.* The department may not pay more than $250,000 in benefits for any individual for services received under the plan in an enrollment year.

(b) *Coordination of benefits.* 1. Benefits under the plan 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.

2. The department is subrogated to the rights of an individual with coverage under the plan to recover special damages for illness or injury to the individual

Ins 4-19 cont'd 2 of 2

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 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 on whose behalf the incorrect payment was made. The extent of the recovery is limited to the amount of the benefits actually paid.

on behalf of an individual

(END OF INSERT 4-19)

INSERT 5-6

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

227.01 **(13)** (ur) Relates to the benefit design of the health care benefits plan under s. 49.67.

(END OF INSERT 5-6)

Kahler, Pam

From: Malofsky, Shelley F - DHS [Shelley.Malofsky@dhs.wisconsin.gov]
Sent: Friday, January 08, 2010 4:40 PM
To: Kahler, Pam
Cc: Becker, Kelly; Kostelic, Jeff; Currans-Sheehan, Rachel H - DHS; Albertoni, Richard S - DHS
Subject: BC+ Basic Stat Language

Attachments: Added stat language 1.8.10.doc

Added stat
ınguage 1.8.10.doc.

Pam,

Rachel asked that I directly send you our additional drafting requests. We also reviewed LRB 09-3882/P3 that was sent to us this past Monday and have no suggested changes other than in the attached.

If you have any questions, feel free to call me directly.

Thanks.

Shelley

Restrictive Reenrollment Periods: Add good cause exemption and expand RRP so that it covers any disenrollment (including voluntarily dropping coverage) and not just for non-payment.

> An individual whose coverage ends for any reason, including for failure to pay a premium when due, is ineligible for coverage under the plan under this section for 12 calendar months, beginning with the first month after the last month in which he or she had coverage. This paragraph does not apply if the department determines there was a good cause reason for the coverage to end.
>
> > [Note to drafter: A person may be disenrolled mid-month. We want the RRP to be at least 12 full calendar months which could mean the RRP could be more than 12 months (365 days). Ex: Disenrolled on June 11, 2010; RRP would continue through June 30, 2011. Should the highlighted phrase be modified so that it is clear that 'last month' does not mean last full month?

Transfer to Core Plan: If an enrollee transfers to an opened slot in Core plan we will not refund any part of a premium already paid for the month in which Core benefits begin but we will not charge the enrollee the Core plan enrollment fee. Please create language to this effect.

Medicaid rates: We are not going to factor into Basic inpatient coverage one of the components that comprises the medicaid inpatient hospital rate. Therefore, we need to modify the language regarding payments to providers [p.5, line 10] and charges during the deductible period [p.5, line 20].

> (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 no higher than the amount that is payable for the same service under the Medical Assistance program under subch. IV.
>
> 2. A certified provider that provides to an individual with coverage under the plan under this section inpatient or outpatient hospital services to which a deductible under sub. (4) (b) applies may not charge for those services an amount higher than the amount that would be payable to the provider under para. (b). ~~more than the amount that is payable for the same services under the Medical Assistance program under subch. IV.~~

Outpatient hospital services: We are not going to consider emergency department visits as outpatient services. Add 'non-emergency' to the reference to outpatient hospital services at p. 5, line 2 and p. 5, line 18.

Maximum benefit: We are no longer capping benefits in an enrollment year. Delete p. 6, lines 1-3.

Right to Review: We do not want a provider to have any ch. 227 hearing rights or an enrollee to have a ch. 227 right to challenge amount of services or payments. Modify p. 7, line 21:

> 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.

Rule-Making: The draft exempts benefit design from rule-making. To make clear that all aspects of the Basic plan are exempt, modify p. 7, lines 17-18:

> Relates to the benefit design, cost sharing requirements and administration of the health care benefits plan under s. 49.67.

Coordination with HIRSP: If dual coverage, HIRSP payments should be primary. Currently, § 149.14(7) states that HIRSP does not cover services that are "payable under another policy of health care insurance, medicare, medical assistance or any other governmental program, except as otherwise provided by law." The draft adopts similar language for Basic. We need language in Basic so that even if Basic is argued to be a 'governmental program' within the HIRSP language, the law will provide that Basic is secondary coverage. Please modify p. 6, lines 4-10 accordingly.