

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/PA

PJK:wlj:mad

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PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

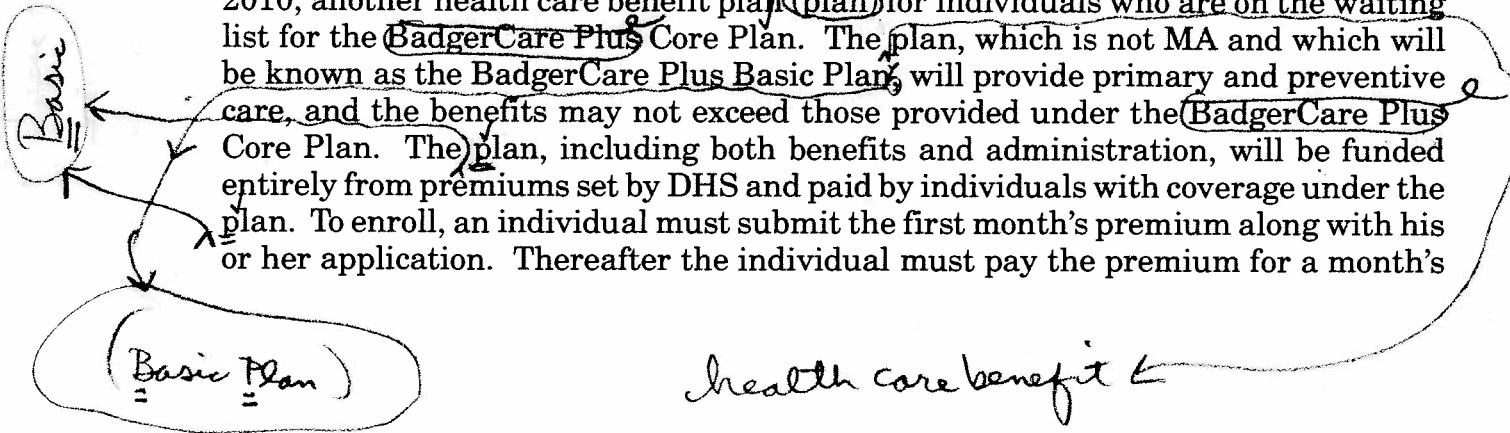
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Friday please
Regen

1 AN ACT *to amend* 49.471 (11) (m); and *to create* 20.435 (4) (hm), 49.471 (11) (s),
2 49.67, 227.01 (13) (ur) and 227.42 (7) of the statutes; **relating to:** the
3 BadgerCare Plus Basic Plan, Benchmark Plan benefits, and making an
4 appropriation.

Analysis by the Legislative Reference Bureau

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

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



Basic
whose coverage under the Basic Plan terminates for any reason, including *for failure*

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 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 may 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 a certified provider 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.

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:

- 1 SECTION 1. 20.435 (4) (hm) of the statutes is created to read:
- 2 20.435 (4) (hm) *BadgerCare Plus Basic Plan; benefits and administration.* All
- 3 moneys received from premiums under s. 49.67 (4), to pay for the provision of services

Emergency

under the Basic Plan

Basic

Basic

Basic

Insert A-2

Insert A-3

An amount that is no higher than

1 under the BadgerCare Plus Basic Plan under s. 49.67 and for administration of the
2 plan.

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

4 49.471 (11) (m) Transportation to obtain emergency medical care only, as
5 medically necessary, and, to the extent permitted under federal law, subject to
6 coinsurance payment of no more than 10 percent of the allowable payment rates
7 under s. 49.46 (2) for the services provided.

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

9 49.471 (11) (s) Early and periodic screening and diagnosis, and all services
10 included in the definition of "medical assistance" under 42 USC 1396d (a) that are
11 found necessary by this screening and diagnosis, for recipients under 21 years of age.

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

13 **49.67 BadgerCare Plus Basic Plan. (1) DEFINITIONS.** In this section:

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

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

19 (2) ESTABLISHMENT AND OPERATION. The department may establish and, no
20 sooner than March 1, 2010, begin operating a plan providing coverage of limited
21 primary and preventive health care benefits to individuals who satisfy the eligibility
22 criteria under sub. (3). ^{not} The benefits covered under the plan under this section may

23 not exceed the benefits covered under the health care benefit plan under s. 49.45 (23).

24 The department shall pay for its administrative costs and for the cost of benefits

Insert 6-2

1 provided under the plan under this section from the appropriation under s. 20.435
2 (4) (hm).

par (a) and (c)
par (b)

3

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

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

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

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

Insert 4-112

12 (4) COST SHARING. (a) *Premiums*. 1. The plan under this section shall be funded
13 through premiums paid by individuals with coverage under the plan. The
14 department shall set premiums at a level necessary to pay for the benefits covered
15 and to maintain the fiscal soundness of the plan. The department, or its agent, shall
16 credit premiums received from individuals to the appropriation account under s.
17 20.435 (4) (hm).

18

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

calendar

An individual whose coverage is
22 discontinued for failure to pay a premium when due is ineligible for coverage under
23 the plan under this section for 12 calendar months, beginning with the first month
24 after the last month in which he or she had coverage.

Insert 4-24

nonemergency

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(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?

(c) *Other*. The department may set other cost-sharing requirements that the department determines are necessary to keep the plan actuarially 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 the amount that is payable for the same service under the Medical Assistance program under subch. IV. Subject to subd. 2., 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 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 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?

an amount that is no higher than

subject to subd. 2.

nonemergency

insert 5-21v

Insert 6-1
Insert 6-2 (Sec p. 3)

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

4 (b) *Coordination of benefits.* 1. Benefits under the plan ^{under this section} shall not include any
5 charge for care for injury or disease for which benefits are payable without regard
6 to fault under coverage statutorily required to be contained in any motor vehicle or
7 other liability insurance policy or equivalent self-insurance, for which benefits are
8 payable under a worker's compensation or similar law, or for which benefits are
9 payable under another policy of health care coverage, Medicare, or any other
10 governmental program, except as otherwise provided by law. ~~Insert 6-10~~ ✓

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

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

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

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

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

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

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

- 14 (a) It is not medical assistance under subch. IV.
- 15 (b) It is exempt from chs. 600 to 646.

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

17 227.01 (13) (ur) Relates to the benefit design of the health care benefits plan
18 under s. 49.67.

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

20 227.42 (7) This section does not apply to a decision denying enrollment or
21 discontinuing coverage under s. 49.67.

22 (END)

Insert 7-17

Insert 7-21

D-note

2009-2010 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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

INSERT A-1

not

If an individual with coverage under the Basic Plan is removed from the 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 to pay for enrolling in the Core Plan.

Core Plan

(END OF INSERT A-1)

had

INSERT A-2

not

, unless the individual's coverage terminated for a good cause reason

(END OF INSERT A-2)

INSERT A-3

not

an amount that is higher than the amount that would be payable by DHS for inpatient or nonemergency

would pay the provider

(END OF INSERT A-3)

INSERT 4-11

(11)

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

(END OF INSERT 4-11)

INSERT 4-24

(4)

- 7 3. If an individual with coverage under the plan under this section is removed
8 from the waiting list for the health care benefit plan under s. 49.45 (23) and begins

1 receiving coverage under that health care benefit plan, the department shall not
2 refund any portion of a premium paid by the individual for coverage under the plan
3 under this section for the calendar month in which the individual's coverage under
4 the health care benefit plan under s. 49.45 (23) commences. The department shall,
5 however, waive any enrollment fee that would be payable by the individual for
6 enrolling in the health care benefit plan under s. 49.45 (23).

(END OF INSERT 4-24)

INSERT 5-21

7 *not* an amount that is higher than the amount that would be payable to the provider
8 under subd. 1 for those services

(END OF INSERT 5-21)

INSERT 6-1

9 *not* *May not exceed benefits under other plan*

(END OF INSERT 6-1)

INSERT 6-10

10 *not* If an individual who has coverage under the plan under this section also has
11 coverage under the plan under subch. II of ch. 149, benefits under the plan under this
12 section are secondary to the benefits provided under the plan under subch. II of ch.
13 149

(END OF INSERT 6-10)

INSERT 7-17

14 *not*, cost-sharing requirements, or administration

(END OF INSERT 7-17)

INSERT 7-21



Ens. 7-21 contd

1 *not*, to a decision about benefits covered under s. 49.67, or to a payment made under
2 s. 49.67

(END OF INSERT 7-21)

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-3882/1dn

PJK./:....

WLj

Date

Under the draft, if an individual's coverage under the Basic Plan terminates, the individual is ineligible for coverage under the Basic Plan for 12 months. I assume that, if the individual still satisfies the eligibility criteria, he or she may be placed back on the Core Plan waiting list during those 12 months, and that his or her coverage under the Core Plan could commence during that time. Is that correct? If, on the other hand, the individual is also ineligible for coverage under the Core Plan during those 12 months, this should be explicitly stated in the draft.

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-3882/1dn
PJK:wjl:ph

January 15, 2010

Under the draft, if an individual's coverage under the Basic Plan terminates, the individual is ineligible for coverage under the Basic Plan for 12 months. I assume that, if the individual still satisfies the eligibility criteria, he or she may be placed back on the Core Plan waiting list during those 12 months, and that his or her coverage under the Core Plan could commence during that time. Is that correct? If, on the other hand, the individual is also ineligible for coverage under the Core Plan during those 12 months, this should be explicitly stated in the draft.

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

Kahler, Pam

From: Becker, Kelly
Sent: Thursday, January 21, 2010 8:39 AM
To: Kahler, Pam
Subject: Change

Attachments: change to basic.pdf

Hi Pam!

Can you please make this change to LRB 3882? We need it as soon as possible please!

Thank you!



change to basic.pdf
(69 KB)

Kelly Becker

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

BILL

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

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

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

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

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

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

22 (4) COST SHARING. (a) *Premiums.* 1. The plan under this section shall be funded
23 through premiums paid by individuals with coverage under the plan. The
24 department shall set premiums at a level necessary to pay for the benefits covered
25 and to maintain the fiscal soundness of the plan. The department, or its agent, shall



State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-3882/1

PJK:wlj:ph

stays
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2009 BILL

D-note
today
(see p 4)

Regen

1 AN ACT *to amend* 49.471 (11) (m); and *to create* 20.435 (4) (hm), 49.471 (11) (s),
2 49.67, 227.01 (13) (ur) and 227.42 (7) of the statutes; **relating to:** the
3 BadgerCare Plus Basic Plan, Benchmark Plan benefits, and making an
4 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

BILL

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.

BILL

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:

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

2 20.435 (4) (hm) *BadgerCare Plus Basic Plan; benefits and administration.* All
3 moneys received from premiums under s. 49.67 (4), to pay for the provision of services
4 under the BadgerCare Plus Basic Plan under s. 49.67 and for administration of the
5 plan.

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

7 49.471 (11) (m) Transportation to obtain ~~emergency~~ medical care ~~only~~, as
8 medically necessary, and, to the extent permitted under federal law, subject to
9 coinsurance payment of no more than 10 percent of the allowable payment rates
10 under s. 49.46 (2) for the services provided.

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

12 49.471 (11) (s) Early and periodic screening and diagnosis, and all services
13 included in the definition of “medical assistance” under 42 USC 1396d (a) that are
14 found necessary by this screening and diagnosis, for recipients under 21 years of age.

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

16 **49.67 BadgerCare Plus Basic Plan. (1) DEFINITIONS.** In this section:

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

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

BILL

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

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

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

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

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

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

22 (4) COST SHARING. (a) *Premiums.* 1. The plan under this section shall be funded
 23 through premiums paid by individuals with coverage under the plan. The
 24 department shall set premiums at a level necessary to pay for the benefits covered
 25 and to maintain the fiscal soundness of the plan. The department, or its agent, shall

BILL

1 credit premiums received from individuals to the appropriation account under s.
2 20.435 (4) (hm).

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

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

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

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

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

23 (b) *Payments and charges*. 1. The department shall pay a certified provider
24 for a service that is covered under the plan under this section an amount that is no
25 higher than the amount that is payable for the same service under the Medical

BILL

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

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

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

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

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

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1 the individual caused by the act of a 3rd person to the extent that benefits are
2 provided under the plan.

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

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

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

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

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

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

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

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

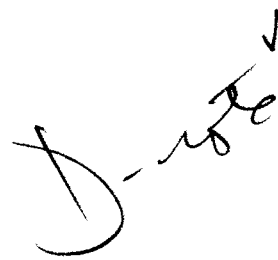
2 **SECTION 5.** 227.01 (13) (ur) of the statutes is created to read:

3 227.01 (13) (ur) Relates to the benefit design, cost-sharing requirements, or
4 administration of the health care benefits plan under s. 49.67.

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

6 227.42 (7) This section does not apply to a decision denying enrollment or
7 discontinuing coverage under s. 49.67, to a decision about benefits covered under s.
8 49.67, or to a payment made under s. 49.67.

9 (END)



**2009-2010 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-3882/2ins
PJK:.....

INSERT 4-6

not

1 and, if needed to pay the cost of incurred program benefits, from the
2 appropriation under s. 20.435 (4) (ma)✓

(END OF INSERT 4-6)

**DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU**

LRB-3882/2dn

PJK:/:.....

WLY

Date

The only change I made to the proposed language was changing "or" to "and" because I assumed the intention was to use both appropriations, but with the stated limit on the use of par. (ma). Let me know if that assumption was not correct and "and" should be changed to "or."

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-3882/2dn
PJK:wlj:rs

January 21, 2010

The only change I made to the proposed language was changing “or” to “and” because I assumed the intention was to use both appropriations, but with the stated limit on the use of par. (ma). Let me know if that assumption was not correct and “and” should be changed to “or.”

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

Kahler, Pam

From: Becker, Kelly
Sent: Thursday, January 21, 2010 1:30 PM
To: Kahler, Pam
Subject: RE: new draft

Hi Pam!
I ran that by DHS and that is ok with them. Thanks again!
Kelly

From: Kahler, Pam
Sent: Thursday, January 21, 2010 1:05 PM
To: Becker, Kelly
Subject: RE: new draft

Kelly:

I would change the language somewhat to make it more grammatical, so before I do that, could you run this by DHS to make sure it's ok? I would say, "..... 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)."

From: Becker, Kelly
Sent: Thursday, January 21, 2010 12:51 PM
To: Kahler, Pam
Subject: FW: new draft

Hi Pam!
Thanks for your help on this. Please see below from DHS.
Kelly

From: Currans-Sheehan, Rachel H - DHS [<mailto:Rachel.CurransSheehan@dhs.wisconsin.gov>]
Sent: Thursday, January 21, 2010 12:49 PM
To: Becker, Kelly
Subject: RE: new draft

Our legal counsel would like the following two words added in to clarify.... Sorry we are going back and forth on this...

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 to pay the cost of incurred program benefits, may pay from the appropriation under s. 20.435 (4) (ma).

Rachel Currans-Sheehan
Executive Assistant, Office of the Secretary
Department of Health Services
(608) 266-9622

From: Becker, Kelly [<mailto:Kelly.Becker@legis.wisconsin.gov>]
Sent: Thursday, January 21, 2010 12:05 PM
To: Currans-Sheehan, Rachel H - DHS
Subject: new draft

<< File: 09-38822dn.pdf >> << File: 09-38822.pdf >>

Kelly Becker

Office of State Senator

JON ERPENBACH

27th District

Ph: 608-266-6670

Fax: 608-266-2508



Steps
r m is run

2009 BILL

today
(see p. 4)

Regen

1 AN ACT *to amend* 49.471 (11) (m); and *to create* 20.435 (4) (hm), 49.471 (11) (s),
 2 49.67, 227.01 (13) (ur) and 227.42 (7) of the statutes; **relating to:** the
 3 BadgerCare Plus Basic Plan, Benchmark Plan benefits, and making an
 4 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

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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.

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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:

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

2 20.435 (4) (hm) *BadgerCare Plus Basic Plan; benefits and administration.* All
3 moneys received from premiums under s. 49.67 (4), to pay for the provision of services
4 under the BadgerCare Plus Basic Plan under s. 49.67 and for administration of the
5 plan.

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

7 49.471 (11) (m) Transportation to obtain ~~emergency~~ medical care ~~only~~, as
8 medically necessary, and, to the extent permitted under federal law, subject to
9 coinsurance payment of no more than 10 percent of the allowable payment rates
10 under s. 49.46 (2) for the services provided.

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

12 49.471 (11) (s) Early and periodic screening and diagnosis, and all services
13 included in the definition of "medical assistance" under 42 USC 1396d (a) that are
14 found necessary by this screening and diagnosis, for recipients under 21 years of age.

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

16 **49.67 BadgerCare Plus Basic Plan. (1) DEFINITIONS.** In this section:

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

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

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

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

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

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

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

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

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

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1 and to maintain the fiscal soundness of the plan. The department, or its agent, shall
2 credit premiums received from individuals to the appropriation account under s.
3 20.435 (4) (hm).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Barman, Mike

From: Becker, Kelly
Sent: Thursday, January 21, 2010 3:16 PM
To: LRB.Legal
Subject: Draft Review: LRB 09-3882/3 Topic: BadgerCare Plus Basic Plan

Please Jacket LRB 09-3882/3 for the SENATE.