State of Wisconsin
2013 - 2014 LEGISLATURE

December 2013 Special Session

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ASSEMBLY BILL 1

December 2, 2013 – Introduced by JOINT COMMITTEE ON FINANCE, by request of Governor Scott Walker. Referred to Joint Committee on Finance.

AN ACT ***to repeal*** 49.471 (4m) and 49.67 (9m); ***to amend*** 20.145 (5) (k), 71.07 (5g) (b), 71.07 (5g) (c) 1., 71.07 (5g) (d) 2., 71.28 (5g) (b), 71.28 (5g) (c) 1., 71.28 (5g) (d) 2., 71.47 (5g) (b), 71.47 (5g) (c) 1., 71.47 (5g) (d) 2., 76.655 (2), 76.655 (3) (a), 76.655 (5), 177.075 (3), 895.514 (2), 895.514 (3) (a) and 895.514 (3) (b); ***to repeal and recreate*** 49.45 (23) (a), 49.45 (23) (a) and 49.471 (4) (a) 4. b. of the statutes; and ***to affect*** 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c., 2013 Wisconsin Act 20, section 9122 (1L) (b) 2. and 3. a. and c., 2013 Wisconsin Act 20, section 9122 (1L) (b) 4., 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.), 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b., 2013 Wisconsin Act 20, section 9418 (7), 2013 Wisconsin Act 20, section 9418 (7m) and 2013 Wisconsin Act 20, section 9418 (9); **relating to:** delaying eligibility changes to BadgerCare Plus and BadgerCare Plus Core and delaying other changes to the Medical

Assistance program; and extending coverage under, and the deadline for the dissolution of, the Health Insurance Risk–Sharing Plan.

Analysis by the Legislative Reference Bureau

Medical Assistance

Currently, the Department of Health Services (DHS) administers the Medical Assistance (MA) program, which is a joint federal and state program that provides health services to individuals who have limited resources. Some services are provided through programs that operate under a waiver of federal Medicaid laws, including services provided through the BadgerCare Plus (BC+) and BadgerCare Plus Core (BC+ Core) programs. Under current law, BC+ provides health and medical services to eligible recipients and has a standard plan with a larger set of benefits and a Benchmark plan with fewer benefits. The 2013–2015 biennial budget act, 2013 Wisconsin Act 20 (Act 20), makes changes to BC+, BC+ Core, and MA, and some of those changes are not in effect until January 1, 2014.

Under current law, unless DHS has a policy that conflicts with current state law eligibility requirements, certain individuals are eligible for benefits under the BC+ standard plan. Beginning on January 1, 2014, Act 20 reduces the income eligibility level for the BC+ standard plan for parents and caretaker relatives from not more than 200 percent of the federal poverty line (FPL) to not more than 100 percent of the FPL before a 5 percent income disregard is applied. Act 20 also defines, beginning on January 1, 2014, for purposes of eligibility of a parent or caretaker relative, a "dependent child." In addition, Act 20 eliminates the distinction between self–employment income and other income. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, certain individuals are eligible for benefits under the BC+ Benchmark plan including pregnant women whose family income exceeds 200 percent but does not exceed 300 percent of the FPL and children under one year of age of those women; certain other pregnant women; children whose family income exceeds 200 percent but does not exceed 300 percent of the FPL; and parents or caretaker relatives whose family income includes self–employment income and does not exceed 200 percent of the FPL under a certain calculation. Act 20, beginning on January 1, 2014, provides benefits under the standard plan to the pregnant women and children who are currently eligible for the BC+ Benchmark plan. Under Act 20, parents and caretaker relatives are covered only under the standard plan. Certain individuals, under current law, may pay the full member per month cost of coverage to receive benefits under the Benchmark plan. On January 1, 2014, Act 20 eliminates the ability of children whose family incomes exceed 300 percent of the FPL to receive Benchmark plan benefits. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, BC+ Core provides basic primary and preventive care to eligible individuals. Adults who are under age 65, who have family incomes that do not exceed 200 percent of the FPL, and who are not otherwise eligible for MA,

including BC+, are eligible for benefits under BC+ Core. Beginning January 1, 2014, Act 20 allows only those individuals whose family incomes do not exceed 100 percent of the FPL, before a 5 percent income disregard is applied, to be eligible for BC+ Core. Act 20 removes limitations on the benefits provided to individuals in BC+ Core and, thus, allows DHS to provide standard plan benefits to these individuals. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, family income is the total gross earned and unearned income received by all members of a family. Beginning on January 1, 2014, under Act 20, for purposes of determining eligibility for BC+ and BC+ Core, family income has the meaning given for household income under a federal regulation, which uses an income calculation based on modified adjusted gross income. Act 20 also requires DHS, beginning on January 1, 2014, to apply the definition of household in federal regulations to determinations of income. Act 20 also makes other changes to the calculation of income and family size for BC+ and BC+ Core on January 1, 2014. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

DHS also currently administers the BadgerCare Plus Basic (BC+ Basic) plan, which is not an MA program but is funded by premiums paid by plan participants. To be eligible for the BC+ Basic plan, an individual must be on the waiting list for BC+ Core. BC+ Basic provides health care benefits that do not exceed those benefits provided by BC+ Core. Under current law, BC+ Basic terminates on January 1, 2014, and Act 20 repeals the BC+ Basic statutory language on that same date. The bill eliminates the statutory termination date and delays the repeal of BC+ Basic enacted in Act 20 until April 1, 2014.

Under current law, DHS is required to develop a purchasing pool, known as Badger Rx Gold, for pharmacy benefits and set eligibility requirements to obtain prescription drug coverage through the purchasing pool. Current law allows DHS to contract with an entity to operate the purchasing pool, which is not an MA program. Act 20 eliminates the purchasing pool, Badger Rx Gold, on January 1, 2014. The bill delays the elimination of Badger Rx Gold until April 1, 2014.

Dissolution of the Health Insurance Risk–Sharing Plan

The Health Insurance Risk–Sharing Plan (HIRSP), which is administered by the Health Insurance Risk–Sharing Plan Authority (authority), provides health insurance coverage in individual policies for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons (called "eligible individuals" in the statutes) who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. HIRSP is funded by premiums paid by covered persons, insurer assessments, and provider payment discounts.

Current law provides for the dissolution of HIRSP and the authority. Generally, coverage under HIRSP may not be issued to any person after December 1, 2013,

existing coverage under HIRSP will end on January 1, 2014, or on the date that any health insurance coverage that is accessed through an American health benefit exchange in this state is effective, if that is later than January 1, 2014, and the authority must pay the costs of HIRSP that are incurred before administrative responsibility for HIRSP and HIRSP's remaining cash assets, tangible personal property, contracts and agreements, and all other matters, including grievances and independent reviews, are transferred to the Office of the Commissioner of Insurance (OCI). Thereafter, OCI must take any action necessary or advisable to wind up the affairs of HIRSP.

Extension of coverage under the Health Insurance Risk-Sharing Plan

The bill makes various modifications to the timetable for the dissolution of HIRSP, including the following:

1. Under the bill, all coverage under HIRSP terminates at 11:59 p.m. on December 31, 2013, but an individual who has coverage on December 1, 2013, and who has paid the December premium may elect to obtain a policy under HIRSP by making a timely payment of the January 2014 premium. Any such new policy must have the same benefits, including the deductible amount, that were in effect on December 1, 2013, and may not extend beyond March 31, 2014. An individual who is eligible for Medicare has the same option to extend coverage under a HIRSP policy until March 31, 2014, if the individual was covered under HIRSP on December 1, 2013, has paid the December premium, did not enroll in Medicare Advantage during the federal open enrollment period in 2013, and, for individuals whose coverage is funded under a contract with the federal Department of Health and Human Services, the federal Department of Health and Human Services takes certain actions.

2. Under current law, provider claims for payment for medical services provided to individuals with coverage under HIRSP must be filed no later than 90 days after coverage terminates or they will not be paid. Under the bill, all provider claims for services provided to HIRSP enrollees must be filed no later than June 1, 2014, or they will not be paid. All provider claims must be adjudicated by September 30, 2014.

3. Under current law, a grievance must be submitted no later than 180 days after coverage terminates or be barred, and an independent review must be requested no later than 60 days after the individual receives notice of the disposition of his or her grievance. The bill provides that a grievance must be received no later than July 1, 2014, or be barred, and that an individual who submits a grievance after March 31, 2014, must request an independent review with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review.

4. Under current law, the transfer from the authority to OCI of administrative responsibility for HIRSP and HIRSP's remaining cash assets, tangible personal property, contracts and agreements, and all other matters takes place 60 days after coverage under HIRSP terminates. Under the bill, the transfer takes place on February 28, 2014.

5. Under current law, the authority must pay HIRSP's costs incurred in 2013 and those that are incurred before the transfer to OCI. The authority must make every effort to pay costs in accordance with the manner provided in the statutes,

which is that costs are to be paid 60 percent from premiums, 20 percent from insurer assessments, and 20 percent from adjustments to provider payments. Under the bill, the authority before March 1, 2014, and OCI on and after March 1, 2014, must pay all of HIRSP's costs in accordance with the manner provided in the statutes, except that any available surplus may be used before an assessment is imposed against insurers. OCI must determine no later than July 1, 2014, whether an insurer assessment is necessary.

Time–limited guaranteed issue under Medicare supplement and replacement policies

Under current law, an insurer that offers a Medicare supplement or replacement policy must provide coverage to any individual who is eligible for Medicare, who had coverage under HIRSP, whose coverage terminates on January 1, 2014, or on the date that any health insurance coverage that is accessed through an American health benefit exchange in this state is effective, if that is later than January 1, 2014, who applies for coverage before 63 days after their coverage terminated, and who pays the premium. Coverage may not be denied on the basis of health status, receipt of health care, claims experience, or medical condition. Under the bill, the requirement to provide coverage applies if the individual's coverage under HIRSP terminated on December 31, 2014, which is the new date for coverage termination under the bill. In addition, the bill imposes the same requirement on an insurer that offers a Medicare supplement or replacement policy to provide coverage under such a policy to an individual who is eligible for Medicare, whose coverage under HIRSP terminates on March 31, 2014, who applies for coverage under the Medicare supplement or replacement policy before 63 days after their coverage terminated, and who pays the premium.

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. 20.145 (5) (k) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

20.145 **(5)** (k) *Operational expenses.* All moneys transferred from the appropriation account under par. (g) for operational expenses related to ~~winding up~~ the affairs of the Health Insurance Risk–Sharing Plan, including hiring consultants, limited–term employees, and experts.

SECTION 2. 49.45 (23) (a) of the statutes, as affected by 2013 Wisconsin Act 20, section 1046, is repealed and recreated to read:

49.45 **(23)** (a) The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide health care coverage to adults who are under the age of 65, who have family incomes not to exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d), and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq. If the department creates a policy under sub. (2m) (c) 10., this paragraph does not apply to the extent that it conflicts with the policy.

SECTION 3. 49.45 (23) (a) of the statutes, as affected by 2013 Wisconsin Act 20, section 1047, and 2013 Wisconsin Act .... (this act), is repealed and recreated to read:

49.45 **(23)** (a) The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide health care coverage to adults who are under the age of 65, who have family incomes not to exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d), and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq.

SECTION 4. 49.471 (4) (a) 4. b. of the statutes, as affected by 2013 Wisconsin Act 20, is repealed and recreated to read:

49.471 **(4)** (a) 4. b. The individual's family income does not exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d).

SECTION 5. 49.471 (4m) of the statutes, as created by 2013 Wisconsin Act 20, is repealed.

SECTION 6. 49.67 (9m) of the statutes is repealed.

SECTION 7. 71.07 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.02 an amount that is equal to the amount of the assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 8. 71.07 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats., and shall not exceed 100 percent. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies

the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.28 (5g), 71.47 (5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

SECTION 9. 71.07 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 10. 71.28 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.23 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 11. 71.28 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the

percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats., and shall not exceed 100 percent. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.47 (5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

SECTION 12. 71.28 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 13. 71.47 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.43 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 14. 71.47 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats., and shall not exceed 100 percent. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.28 (5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

SECTION 15. 71.47 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 16. 76.655 (2) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

76.655 **(2)** FILING CLAIMS. Subject to the limitations provided under this section, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the fees imposed under ss. 76.60, 76.63, 76.65, 76.66 or 76.67 an amount that is equal to the amount of assessment

under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under sub. (3).

SECTION 17. 76.655 (3) (a) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

76.655 **(3)** (a) The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under sub. (2) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats., and shall not exceed 100 percent. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.28 (5g), and 71.47 (5g) for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

SECTION 18. 76.655 (5) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

76.655 **(5)** SUNSET. No credit may be claimed under this section for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this section for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 19. 177.075 (3) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

177.075 **(3)** Any intangible property distributable in the course of the dissolution of the Health Insurance Risk–Sharing Plan under 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 32 (1) (b), is presumed abandoned as otherwise provided under this chapter if sub. (1) (a), (b), or (c) does not apply with respect to the distribution.

SECTION 20. 895.514 (2) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(2)** No cause of action of any nature may arise against, and no liability may be imposed upon, the authority, plan, or board; or any agent, employee, or director of any of them; or insurers participating in the plan; or the commissioner; or any agent, employee, or representative of the commissioner, for any act or omission by any of them in the performance of their powers and duties under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 32 (1) (b), unless the person asserting liability proves that the act or omission constitutes willful misconduct.

SECTION 21. 895.514 (3) (a) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (a) Except as provided in 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 32 (1) (b), neither the state nor any political subdivision of the state nor any officer, employee, or agent of the state or a political subdivision acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

SECTION 22. 895.514 (3) (b) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (b) All of the expenses incurred by the authority, or the commissioner, or any agent, employee, or representative of the commissioner, in exercising its duties and powers under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 32 (1) (b), shall be payable only from funds of the authority or from the appropriation under s. 20.145 (5) (g) or (k), or from any combination of those payment sources.

SECTION 23. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b. is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 1. b. Coverage under the policies issued under the plan, including to persons whose coverage under the plan is funded under a contract with the federal department of health and human services, terminates at 11:59 p.m. on December 31, 2013. At least 60 days before coverage terminates, the authority shall provide notice of the date on which coverage terminates to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in subsection (1m) (b) 1.

SECTION 24. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c. is repealed.

SECTION 25. 2013 Wisconsin Act 20, section 9122 (1L) (b) 2. and 3. a. and c. are repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 2. 'Provider claims.' Providers of medical services and devices and prescription drugs to covered persons must file claims for payment no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a

provider may not bill a covered person who receives a covered service or article and shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

3. a. Except for a grievance related to a prior authorization, any grievance by a covered person must be in writing and received no later than July 1, 2014, or be barred.

c. A covered person who submits a grievance after March 31, 2014, must request an independent review, if any, with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review with respect to the grievance.

SECTION 26. 2013 Wisconsin Act 20, section 9122 (1L) (b) 4. is amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 4. 'Payment of plan costs.' ~~The~~ To the extent possible, the authority shall pay plan costs incurred in 2013 and all other costs associated with dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office under subdivision 8. The authority and the office shall make every effort to pay plan costs in accordance with, or as closely as possible to, the manner provided in section 149.143 of the statutes.

SECTION 27. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.) is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. 'Transfer to the office.' (intro.) On February 28, 2014, all of the following shall occur:

SECTION 28. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b. are amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. a. Administrative responsibility for the operations and dissolution of the plan is transferred to the office. The commissioner shall take any action necessary or advisable to manage and wind up the affairs of the plan and shall notify the legislative audit bureau when the windup is completed and provide to the legislative audit bureau the final financial statements of the plan. For purposes of chapter 177 of the statutes, as affected by this act, the dissolution, and winding up of the affairs, of the plan shall be considered a dissolution of an insurer in accordance with section 645.44 of the statutes, except that a court order of dissolution is not required to effect the dissolution of the plan.

9. a. There is created, ~~60 days after the date coverage under the plan terminates under subdivision 1. b.~~ on March 1, 2014, a Health Insurance Risk–Sharing Plan advisory committee consisting of the commissioner, or his or her designee, and the other 13 members of the board holding office on the date the advisory committee is created.

10. a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. The notice shall be sent by first class mail to the last–known addresses at least 60 days before the date on which coverage terminates under subdivision 1. b. Notice to potential claimants of the plan shall require the claimants to file their claims, together with proofs of claims, ~~within 90 days after the date on which coverage terminates under subdivision 1. b.~~ by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not ~~more than 210 days after the date on which coverage terminates under subdivision 1. b.~~ later than September 1, 2014. Any such late claim that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by first class mail at least 10 days before the insured event occurred.

11. b. Complete a final audit of the plan, after the termination of the plan in 2014, ~~within 90 days after the office provides the final financial statements of the plan under subdivision 8. a.~~ by June 30, 2015.

SECTION 29. 2013 Wisconsin Act 20, section 9418 (7) is amended to read:

[2013 Wisconsin Act 20] Section 9418 (7) PATIENT PROTECTION AND AFFORDABLE CARE ACT CHANGES. The treatment of sections 49.45 (23) (a) (by SECTION 1046)~~, (b) (by SECTION 1048),~~ and (e), 49.46 (1) (a) 15., 49.47 (4) (a) 1. ~~and (c) 1. and 3.~~, 49.471 (1) (f), ~~(2),~~ (3) (a) 1. and 3., (4) (a) 4. a., b., and c.~~, and 5.~~ and (b) (intro.), 1., 1m., 2., 3., and 4., (6) (d), (7) (a), (b) 1. and 2. and (e), (8) (d) 1. b., (9) (a) 2. b., and (10) (b) 1. (by SECTION 1143) and 4. b., 49.84 (6) (c) 1. d., and 66.0137 (3) of the statutes, the repeal of section 49.471 (7) (c) of the statutes, and SECTION 9318 (14) of this act take effect on ~~January~~ April 1, 2014.

SECTION 30. 2013 Wisconsin Act 20, section 9418 (7m) is created to read:

[2013 Wisconsin Act 20] Section 9418 (7m) CHILDLESS ADULT WAIVER; MEDICAL ASSISTANCE FOR THE MEDICALLY INDIGENT; ELIGIBILITY FOR THOSE LEAVING FOSTER CARE. The treatment of sections 49.45 (23) (b) (by SECTION 1048), 49.47 (4) (c) 1. and 3., and 49.471 (2) and (4) (a) 5. of the statutes takes effect on January 1, 2014.

SECTION 31. 2013 Wisconsin Act 20, section 9418 (9) is amended to read:

[2013 Wisconsin Act 20] Section 9418 (9) BADGERCARE PLUS BENCHMARK ELIGIBILITY; BADGER RX GOLD; BADGERCARE BASIC. The treatment of sections 20.435 (4) (a), (bm), (jw), and (jz), 49.471 (4) (c), (10) (b) 5. (by SECTION 1152), and (11) (a), 49.67, 146.45, 227.01 (13) (ur), and 227.42 (7) of the statutes takes effect on ~~January~~ April 1, 2014.

SECTION 32. Nonstatutory provisions.

(1) COVERAGE EXTENSION OF THE HEALTH INSURANCE RISK-SHARING PLAN; ISSUANCE OF MEDICARE SUPPLEMENT AND REPLACEMENT POLICIES.

(a) *Definitions.* In this subsection:

1. "Authority" means the Health Insurance Risk–Sharing Plan Authority under subchapter III of chapter 149 of the statutes.

2. "Commissioner" means the commissioner of insurance.

3. "Covered person" means a person who has coverage under the plan.

4. "Medicare" has the meaning given in section 149.10 (7) of the statutes.

5. "Medicare Advantage" has the meaning given in section INS 3.39 (3) (r), Wisconsin Administrative Code.

6. "Medicare replacement policy" has the meaning given in section 600.03 (28p) of the statutes.

7. "Medicare supplement policy" has the meaning given in section 600.03 (28r) of the statutes.

8. "Office" means the office of the commissioner of insurance.

9. "Plan" means the Health Insurance Risk–Sharing Plan under subchapter II of chapter 149 of the statutes.

(b) *Extension of the plan and authority.* Notwithstanding any statute, administrative rule, or provision of a policy or contract or of the plan to the contrary, the dissolution of the plan and the authority as provided in 2013 Wisconsin Act 20, section 9122 (1L), is modified as follows:

1. 'Coverage provisions.' Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., all of the following apply:

a. A covered person whose coverage under the plan was in effect on December 1, 2013, who paid his or her December premium, and who, if eligible for Medicare, had not enrolled in Medicare Advantage during the federal open enrollment period in 2013 may elect to obtain a policy under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment until the premium payment is received.

b. If a covered person's coverage under the plan is funded under a contract with the federal department of health and human services, the covered person's coverage will end as provided in 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., unless the

federal department of health and human services issues a contract amendment that extends the contract and coverage to a date later than December 31, 2013, and the terms of the contract amendment are such that the federal government will be financially liable for all costs related to the operation of the contract that exceed member premium collections.

c. If the requirements under subdivision 1. b. are satisfied, a covered person whose coverage is funded under a contract with the federal department of health and human services, whose coverage under the plan was in effect on December 1, 2013, who paid his or her December premium, and who had not enrolled in Medicare Advantage during the federal open enrollment period in 2013 may elect to obtain a policy under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment until the premium payment is received.

d. No later than February 1, 2014, the authority shall provide notice that coverage shall terminate on March 31, 2014, to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in paragraph (c) 1.

2. 'Provider claims.' Providers of medical services and devices and prescription drugs to covered persons whose coverage is extended as provided in this paragraph must file claims for payment no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a provider may not bill a covered person who receives a covered service or article and shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

3. 'Grievances and review.'

a. Any grievance by a covered person whose coverage is extended as provided in this paragraph must be in writing and received no later than July 1, 2014, or be barred.

b. A covered person whose coverage is extended as provided in this paragraph who submits a grievance after March 31, 2014, must request an independent review, if any, with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review with respect to the grievance.

4. 'Payment of plan costs.'

a. To the extent possible, the authority shall pay plan costs incurred in 2013 and 2014 and all other costs associated with operating and dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office on February 28, 2014.

b. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 4., the authority, before March 1, 2014, and the office, on and after March 1, 2014, shall pay plan costs in the manner provided in section 149.143 of the statutes, except that the

authority or office may use all available surplus before imposing an assessment against insurers, as described in subdivision 4. c. All provider claims shall be adjudicated by September 30, 2014.

c. The authority, before March 1, 2014, and the office, on and after March 1, 2014, but no later than July 1, 2014, shall determine whether an assessment of insurers under section 149.13 of the statutes is necessary to cover in full the plan's expenses related to operations, winding up operations, and dissolution of the plan. Any such assessment shall be based on the 2013 filed plan assessment form.

5. 'Dissolution notice, claims, and updates.'

a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 10. a., the notice shall be sent by 1st class mail to the last–known addresses no later than February 1, 2014. Notice to potential claimants of the plan shall require the claimants to file their claims, together with proofs of claims, by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not later than September 1, 2014. Any such late claim

that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by 1st class mail at least 10 days before the insured event occurred.

(c) *Medicare supplement and replacement policy issuance.*

1. In addition to the requirement under 2013 Wisconsin Act 20, section 9122 (1m), an insurer offering a Medicare supplement policy or a Medicare replacement policy in this state shall provide coverage under the policy to any individual who satisfies all of the following:

a. The individual is eligible for Medicare.

b. The individual had coverage under the plan.

c. The individual's coverage under the plan terminated on March 31, 2014.

d. The individual applies for coverage under the policy before 63 days after the date specified in subdivision 1. c.

e. The individual pays the premium for the coverage under the policy.

2. An insurer under subdivision 1. may not deny coverage to any individual who satisfies the criteria under subdivision 1. a. to e. on the basis of health status, receipt of health care, claims experience, or medical condition including disability.

3. In addition to any other notice requirements to insurers, no later than February 1, 2014, the authority shall provide notice to the insurers described in subdivision 1. of the requirements under this paragraph.

SECTION 33. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE RISK-SHARING PLAN. The treatment of section 895.514 (2) and (3) (a) and (b) of the statutes takes effect on January 1, 2015.

(2) MEDICAL ASSISTANCE ELIGIBILITY. The treatment of sections 49.45 (23) (a) (by SECTION 2) and 49.471 (4) (a) 4. b. of the statutes takes effect on April 1, 2014.

(3) RECONCILIATION WITH 2011 WISCONSIN ACT 32. The treatment of section 49.45 (23) (a) (by SECTION 3) of the statutes takes effect on January 1, 2015.

(END)