Date of enactment: **April 14, 1992**
1991 Assembly Bill 803 Date of publication*: **April 28, 1992**

1991 WISCONSIN ACT 178

AN ACT ***to repeal*** 49.46 (2) (c) 1. c., 632.755 (1) and 632.755 (1m); ***to amend*** 47.02 (3) (c), (d) and (j), 47.02 (5), 47.03 (8), 48.535 (5) (b), 49.19 (5) (d), 49.46 (2) (c) 4 and 5, 49.47 (6) (a) 6. a., d. and e., 50.53 (1m), 140.05 (17) (d) (intro.), 140.595 (2), 143.15 (4), 146.028 (2) (a), 146.028 (2) (b) 1, 146.028 (6) (a), 153.60 (1), 632.72, 632.755 (1g) and 632.755 (2); and ***to create*** 49.46 (1) (a) 6, 49.46 (2) (c) 5m, 49.47 (6) (a) 6. f. and 49.493 of the statutes, **relating to:** eligibility for medical assistance benefits of persons considered to be receiving aid to families with dependent children or supplemental security income; reimbursement of counties for funeral, burial and cemetery expenses of recipients of aid to families with dependent children; uninsured health plans covering persons eligible for medicaid assistance and medical assistance benefits for persons eligible for medicare; assessments on hospitals to fund the office of health care information and to certain permit periods and fees; certificates of approval and specialty fees for certain laboratories; an exception to the radiation protection laws for on–site activities of nuclear reactors; changes in reporting and information distribution requirements concerning conditions of infants or children resulting from adverse neonatal outcomes, birth defects or developmental or other severe disabilities; the duty of the division of youth services in the department of health and social services to consult in the development of intensive aftercare plans under the intensive aftercare pilot program; changes to hearing rights and to individualized written rehabilitation plans for persons receiving vocational rehabilitation services; and granting rule–making authority (suggested as remedial legislation by the department of health and social services).

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

LAW REVISION COMMITTEE PREFATORY NOTE: This bill is a remedial legislation proposal, requested by the department of health and social services and introduced by the law revision committee under s. 13.83 (1) (c) 4., stats. After careful consideration of the various provisions of this bill, the law revision committee has determined that this bill makes minor substantive changes in the statutes, and that these changes are desirable as a matter of public policy.

SECTION 1. 47.02 (3) (c), (d) and (j) of the statutes are amended to read:

47.02 **(3)** (c) Provide assessment and evaluation services appropriate to each individual, develop an individualized written rehabilitation ~~plan~~ program with each handicapped person and develop and supervise services that are part of any handicapped person's vocational rehabilitation program.

(d) Aid handicapped persons in securing the services needed to make them more employable, place handicapped persons in suitable occupations and provide postemployment services, as defined in the handicapped person's rehabilitation ~~plan~~ program developed under par. (c), necessary to maintain employment.

(j) Except as provided in par. (o), determine the financial need of handicapped persons based upon a uniform fee schedule as provided under s. 46.03 (18) for the provision or purchase of vocational rehabilitation services specified in the person's rehabilitation ~~plan~~ program developed under par. (c).

SECTION 2. 47.02 (5) of the statutes is amended to read:

47.02 **(5)** Any person aggrieved by a determination of eligibility or ineligibility for vocational rehabilitation services or by the furnishing or denial of vocational reha-

bilitation services may commence an appeal as provided ~~in 29 USC 722 (d) or ch. 227, as appropriate~~ under rules promulgated by the department.

NOTE: This SECTION changes the appeal process for persons aggrieved by an eligibility determination or by furnishing or denying vocational rehabilitation services from a procedure specified under federal law or ch. 227, stats., to an appeal procedure exclusively established under rules promulgated by DHSS, which have been in effect since June 1989.

SECTION 3. 47.03 (8) of the statutes is amended to read:

47.03 **(8)** A blind person participating in the supervised business enterprise program who is aggrieved by an act or omission of the department may commence a ~~contested case~~ grievance proceeding under ~~ch. 227~~ rules promulgated by the department.

NOTE: This SECTION provides a rule–created grievance procedure for aggrieved blind persons participating in the supervised business enterprise program.

SECTION 4. 48.535 (5) (b) of the statutes is amended to read:

48.535 **(5)** (b) That, if a child participating in the pilot program enters a secured correctional facility or a child caring institution as a result of an adjudication of delinquency under s. 48.34, the grant recipient will designate a case manager for that child. For any child who meets the criteria under sub. (4) (a) 2., a case manager will be appointed at the earliest possible opportunity prior to the child's release. The case manager shall act as a liaison between the secured correctional facility or child caring institution and the aftercare program and develop an intensive aftercare plan to be implemented upon the child's release from the secured correctional facility or child caring institution. The plan shall specify the number of contacts that the child shall receive under the aftercare program, the programs and services to be provided to the child while on aftercare, the planning and treatment goals of the child's participation in the pilot program and the estimated length of time that the child will participate in the pilot program. The plan shall be developed in consultation with ~~the subunit of~~ representatives of the division of youth services in the department ~~administering corrections and a representative of the juvenile offender review program~~.

NOTE: This SECTION deletes "subunit of the department (of health and social services) administering corrections" and substitutes "representatives of the division of youth services in the department (of health and social services)" in the statute governing the intensive aftercare pilot program for juveniles. By making this change, this SECTION implements the statutory policy decision made when the department of corrections was created to administer the adult correctional system that DHSS would continue to administer the juvenile correctional system.

SECTION 5. 49.19 (5) (d) of the statutes is amended to read:

49.19 **(5)** (d) The department shall reimburse the county for the funeral ~~and,~~ burial and actual cemetery expenses of a dependent child or the child's parents as provided in s. 49.30. ~~In addition, the department shall reimburse the county fully for actual cemetery expenses paid under this section.~~

NOTE: This SECTION simplifies and clarifies the statutory requirement that the state reimburse a county for certain funeral, burial and cemetery expenses incurred in behalf of a child, or a parent of a child, who dies while receiving assistance under the AFDC program. In general, the reimbursement is limited to those expenses detailed and limited under s. 49.30, stats., and to situations in which the estate of the deceased person is insufficient to pay those expenses.

SECTION 6. 49.46 (1) (a) 6. of the statutes is created to read:

49.46 **(1)** (a) 6. Any person not described in pars. (c) to (e) who is considered, under federal law, to be receiving aid to families with dependent children or supplemental security income for the purpose of determining eligibility for medical assistance.

NOTE: This SECTION provides medical assistance benefits to persons not presently eligible under state law but who are required to be covered under federal law. These persons are referred to as "deemed recipients" because they are considered under federal law to be receiving aid to families with dependent children or supplemental security income.

SECTION 7. 49.46 (2) (c) 1. c. of the statutes is repealed.

NOTE: This SECTION and SECTIONS 8 and 10 repeal the definition of "institutionalized" and delete the use of the term "institutionalized" in the statutes related to medical assistance payment of medicare deductibles and coinsurance because eligibility for that payment is not limited to institutionalized persons.

SECTION 8. 49.46 (2) (c) 4. and 5. of the statutes are amended to read:

49.46 **(2)** (c) 4. For an ~~institutionalized~~ individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and meets the eligibility criteria for medical assistance under sub. (1), but does not meet the limitation on income under subd. 6, medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

5. For an ~~institutionalized~~ individual who is only entitled to coverage under part A of medicare and meets the eligibility criteria for medical assistance under sub. (1), but does not meet the limitation on income under subd. 6, medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396.

NOTE: This SECTION and SECTIONS 9, 10 and 11 provide that medical assistance payment of medicare deductibles and coinsurance includes payment of the deductibles and coinsurance for medicare services that are not covered under this state's medical assistance program.

SECTION 9. 49.46 (2) (c) 5m of the statutes is created to read:

49.46 **(2)** (c) 5m. For an individual who is only entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (1), but does not meet the limitation on income under subd. 6, medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395j to 1395w, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

NOTE: This SECTION and SECTION 11 provide that, for a medical assistance recipient who is entitled only under part B of medicare and whose income exceeds 100% of the federal poverty line, medical assistance pays the deductible and coinsurance for services provided under part B of medicare. The payment of coinsurance may not exceed the allowable charge for a service under medical assistance minus the medicare payment.

SECTION 10. 49.47 (6) (a) 6. a., d. and e. of the statutes are amended to read:

49.47 **(6)** (a) 6. a. In this subdivision: 1) "entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f; 2) "entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395L; and 3) "income limitation" means income that is equal to or less than 100% of the poverty line, as established under 42 USC 9902 (2)~~; and 4) "institutionalized" means in a medical institution or nursing facility~~.

d. An ~~institutionalized~~ individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and meets the eligibility criteria for medical assistance under sub. (4) (a) but does not meet the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

e. An ~~institutionalized~~ individual who is only entitled to coverage under part A of medicare and meets the eligibility criteria for medical assistance under sub. (4) (a), but does not meet the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i, including those services that are not included in the approved state plan for services under 42 USC 1396.

SECTION 11. 49.47 (6) (a) 6. f. of the statutes is created to read:

49.47 **(6)** (a) 6. f. For an individual who is only entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (4), but does not meet the income limitation, medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395j to 1395w, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

SECTION 12. 49.493 of the statutes is created to read:

49.493 Benefits under uninsured health plans. (1) In this section, "uninsured health plan" means a partially or wholly uninsured plan, including a plan that is subject to 29 USC 1001 to 1461, providing health care benefits.

(2) The providing of medical assistance constitutes an assignment to the department, to the extent of the medical assistance benefits provided, for benefits to which the recipient would be entitled under any uninsured health plan.

(3) An uninsured health plan may not do any of the following:

(a) Exclude a person or a person's dependent from coverage under the uninsured health plan because the person or the dependent is eligible for medical assistance.

(b) Terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for medical assistance.

(c) Provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for medical assistance than it provides to persons and their dependents who are not eligible for medical assistance.

(4) Benefits provided by an uninsured health plan shall be primary to those benefits provided under medical assistance.

NOTE: This SECTION and SECTIONS 21 to 25 transfer the statutory provisions for health benefit plans that are self–funded by employers under the federal employee retirement income security act (ERISA) from ch. 632, stats. (relating to insurance contracts), to ch. 49, stats. (relating to public assistance). As a result, DHSS becomes responsible for the enforcement of regulatory provisions affecting health benefit plans under ERISA. The transfer responds to federal court decisions holding that self–funded health care plans under ERISA are not subject to state insurance regulations. This SECTION and SECTION 25 clarify that payments under an uninsured health plan and under a disability insurance policy are primary to payments under medical assistance.

SECTION 13. 50.53 (1m) of the statutes is amended to read:

50.53 **(1m)** In addition to the fee under sub. (1) or (1g), a penalty fee of $20 is required for renewal of each permit if the annual fee under sub. (1) or the biennial fee under sub. (1g) is not paid ~~prior to expiration~~ within the first 15 days of the renewal permit period.

NOTE: This SECTION changes the payment date to avoid a penalty fee for permit renewals by hotels, restaurants and vending of food and beverages to "within the first 15 days of the renewal permit period" from "prior to the expiration of the permit". The provision places revenues from permit fees in the fiscal year for which the permit is issued in order to lessen a large fee surplus at the end of a fiscal year.

SECTION 14. 140.05 (17) (d) (intro.) of the statutes is amended to read:

140.05 **(17)** (d) (intro.) Permits issued under this subsection expire on June 30, except that permits initially issued during the period beginning on April 1 and ending on June 30 expire on June 30 of the following year. Except as provided in s. 50.535 (2) (d) and (e):

NOTE: This SECTION extends the expiration date for recreational sanitation permits to June 30 of the following year for permits initially issued between April 1 and June 30. The extension provides consistency in the expiration dates of initial permits for campgrounds and camping resorts, recreational and educational camps, mobile home parks and public swimming pools with initial permits issued for hotels, restaurants and vending of food and beverages.

SECTION 15. 140.595 (2) of the statutes is amended to read:

140.595 **(2)** Sections 140.50 to 140.60 ~~shall~~ do not apply to ~~on site~~ on–site activities of any nuclear reactor plant licensed ~~or operated~~ by the nuclear regulatory commission.

NOTE: This SECTION deletes an error in s. 140.595 (2), stats. No nuclear reactor plants are operated by the U.S. nuclear regulatory commission. Therefore, it is not necessary to except such plants from the statutory provisions of ss. 140.50 to 140.60, stats., the radiation protection act.

SECTION 16. 143.15 (4) of the statutes is amended to read:

143.15 **(4)** The department, after conducting an evaluation or approving an evaluation meeting departmental standards under sub. (5) for each specialty area, and after receiving a fee for each specialty area ~~by~~ from the laboratory, shall issue ~~an appropriate~~ a certificate of approval to the laboratory, covering those examinations which have met the minimum standards established by the department. ~~A~~ The department shall issue an interim certificate of approval for an approved laboratory that applies for initial certification, which shall be valid for ~~12 months from the date of issue but~~ the remainder of the calendar year for which it is issued. Certification renewals shall be issued on a calendar–year basis. Specialty fees for certification of an initially certified laboratory and a certified laboratory that applies to expand its current certification with newly established specialties shall be prorated at one–twelfth of the annual fee for each month remaining in the calendar year for which the certificate of approval is issued. A certificate of approval shall be revoked by the department if the minimum standards established by the department for certification are not met within 2 successive evaluations. ~~The evaluations must occur within 60 days of the annual renewal of the certificate of approval.~~

NOTE: This SECTION establishes calendar year certification periods for renewals of certificates of approval for certain laboratories and provides for a prorated fee for initial certificates that are effective for only part of a calendar year. The laboratories affected include those established and operated to perform bacteriological, biological, serological, chemical, hematological, immunological, cytological or microscopic examinations to protect public health. The SECTION requires DHSS to revoke its certification at any time of the year if its minimum standards are not met by a laboratory after 2 successive evaluations.

SECTION 17. 146.028 (2) (a) of the statutes is amended to read:

146.028 **(2)** (a) Beginning on ~~January 1, 1989~~ the effective date of this paragraph .... [revisor inserts date], the persons specified in par. (b) shall report all of the following to the department:

1. The appearance of the condition, within ~~60~~ 90 days after a ~~suspected or confirmed~~ physician first makes a diagnosis or confirms a suspected diagnosis or a nurse knows or suspects that the infant or child has the condition.

2. Information which disputes, augments or clarifies the ~~suspected or confirmed~~ physician's diagnosis or the nurse's knowledge or suspicion under subd. 1, within ~~60~~ 90 days after receipt of the information.

NOTE: This SECTION and SECTION 18 extend the period within which a physician must report a condition resulting from an adverse neonatal outcome, a birth defect or a developmental disability or other severe disability from 60 days to 90 days after the condition is first diagnosed or confirmed by a physician or known or suspected by a nurse if no physician has treated the child.

SECTION 18. 146.028 (2) (b) 1. of the statutes is amended to read:

146.028 **(2)** (b) 1. A physician licensed under ch. 448 ~~who is~~, regardless of whether he or she is the primary treating physician for an infant or child ~~treated or visited by the physician and who makes~~ or is a consulting physician to whom the infant or child is referred by the primary treating physician, who is the first physician to make a diagnosis or ~~suspects with reasonable medical certainty~~ confirm a suspected diagnosis that the infant or child has a condition resulting from an adverse neonatal outcome, a birth defect or a developmental disability or other severe disability.

SECTION 19. 146.028 (6) (a) of the statutes is amended to read:

146.028 **(6)** (a) If a local health officer submits to the department a written request for receipt of information submitted under sub. (2), the department shall forward to the public health officer~~, no later than the 10th day of the~~

~~month following receipt of information under sub. (2),~~ an abstract of information received for an infant or child for whom the parent or guardian has provided informed, written consent to a release of the information and who resides in the area of jurisdiction of the public health officer.

NOTE: This SECTION deletes the time period within which DHSS must provide an abstract of the information in the report to a local health official upon request, under certain conditions.

SECTION 20. 153.60 (1) of the statutes is amended to read:

153.60 **(1)** The office shall, by the first October 1 after the commencement of each fiscal year, estimate the total amount of expenditures for the office and the board for that fiscal year. The office shall assess the estimated total amount for that fiscal year less the estimated total amount to be received under s. 20.435 (1) (hi), (hj) and (mr) during the fiscal year and the unencumbered balances of the amounts received under s. 20.435 (1) (hg), (hi), (hj) and (mr) from the prior fiscal year, to hospitals in proportion to each hospital's respective gross private–pay patient revenues during the hospital's most recently concluded entire fiscal year. Each hospital shall pay the assessment on or before December ~~31~~ 1. All payments of assessments shall be deposited in the appropriation under s. 20.435 (1) (hg).

NOTE: This SECTION unifies the dates for collecting assessments against hospitals for funding 3 programs: the office of health care information (OHCI) in DHSS, Wisconcare (a state primary health care service) and the state health insurance program (SHIP). The 30–day difference between the December 1 collection date for Wisconcare and SHIP and the December 31 date for OHCI necessitates 2 separate collection processes, which is an inefficient use of DHSS and hospital staffs.

SECTION 21. 632.72 of the statutes is amended to read:

632.72 Medical assistance; assignment. The providing of medical benefits under s. 49.02 or 49.046 or of medical assistance under s. 49.45, 49.46, 49.465, 49.468 or 49.47 constitutes an assignment to the department of health and social services or the county providing the medical benefits or assistance. The assignment shall be, to the extent of the medical benefits or assistance provided, for benefits to which the recipient would be entitled under any policy of health and disability insurance ~~or under any partially or wholly uninsured health and disability plan, including a plan that is subject to 29 USC 1001 to 1461~~.

SECTION 22. 632.755 (1) of the statutes is repealed.

SECTION 23. 632.755 (1g) of the statutes is amended to read:

632.755 **(1g)** (a) A disability insurance policy ~~or disability plan~~ may not exclude a person or a person's dependent from coverage because the person or the dependent is eligible for assistance under ch. 49.

(b) A disability insurance policy ~~or disability plan~~ may not terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for assistance under ch. 49.

(c) A disability insurance policy ~~or disability plan~~ may not provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for assistance under ch. 49 than it provides to persons and their dependents who are not eligible for assistance under ch. 49.

SECTION 24. 632.755 (1m) of the statutes is repealed.

SECTION 25. 632.755 (2) of the statutes is amended to read:

632.755 **(2)** Benefits provided by a disability insurance policy ~~or disability plan~~ shall be primary to those benefits provided under ch. 49. ~~Benefits provided by a federally regulated disability plan shall be primary to those benefits provided under ss. 49.45 to 49.47.~~

NOTE: See the NOTE following SECTION 12.

SECTION 9325. Initial applicability; health and social services.

(1) ASSESSMENTS TO HOSPITALS. The treatment of section 153.60 (1) of the statutes first applies to assessments to hospitals from estimates that are made by October 1, 1992.

(2) LABORATORY CERTIFICATES OF APPROVAL. The treatment of section 143.15 (4) of the statutes first applies to a renewal of a certificate of approval for a laboratory that is issued for calendar year 1992, and to a certificate of approval for an initially certified laboratory or a certified laboratory that applies to expand its certification that is issued on the effective date of this subsection.

(3) VOCATIONAL REHABILITATION HEARINGS. The treatment of sections 47.02 (5) and 47.03 (8) of the statutes first applies to appeals or grievances filed on the effective date of this subsection.