

WAHU Summary of the 2009-2010 Budget Provisions

Provision	Joint Finance Comm.	Assembly	Senate
<p>REQUIRE DHS TO SUBMIT PLAN TO IMPLEMENT UNSPECIFIED MA EFFICIENCIES AND REDUCTIONS</p>	<p>Include unspecified reductions to the MA and MA-related programs of approximately 238,051,500 (\$59,117,000 GPR and \$178,934,500 FED) in 2009-10 and by \$307,054,000 (\$91,617,000 GPR and \$215,437,000 FED) in 2010-11.</p>	<p>Require DHS to submit to the Joint Committee on Finance, by August 1, 2009, its plan to administer the MA and SeniorCare programs within the funding appropriated for those programs during the 2009-11 biennium. Further, require DHS to include in its plan a description of the manner in which efficiencies and reductions shall be realized, including an estimate of the state and federal cost savings, by state fiscal year, which would result from each component of the plan and from the plan as a whole. Provide that if the Committee does not schedule a meeting and approve an alternative plan by September 1, 2009, the original plan submitted by DHS shall be deemed approved.</p>	<p>No change to Joint Finance.</p>
<p>COVERAGE OF PODIATRY SERVICES FOR BADGERCARE PLUS CHILDLESS ADULTS</p>		<p>Require the Department of Health Services to prepare a report and submit it to the Joint Committee on Finance by August 15, 2009, that details the fiscal impact of covering podiatric medicine and surgery services of podiatrists under BadgerCare Plus for individuals enrolled in the medical assistance (MA) childless adult demonstration project. Currently, individuals who participate in the childless adult project are covered under the BadgerCare Plus Core plan, which provides coverage for a more limited set of services than are provided to most BadgerCare Plus enrollees under the standard plan and benchmark plan. Podiatry services are currently covered under the standard plan and the benchmark plan, but not under the BadgerCare Plus Core plan.</p>	<p>Require DHS to provide coverage of podiatry services for individuals enrolled in the childless adult demonstration project.</p>

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<p>CREATE NEW ELIGIBILITY CATEGORY FOR COVERAGE UNDER THE BADGERCARE PLUS BENCHMARK PLAN</p>		<p>No change to Joint Finance.</p>	<p>Provide that an individual is eligible to purchase coverage under the BadgerCare Plus benchmark plan for himself or herself and for his or her spouse and dependent children, at the full per member per month cost of coverage, if all of the following apply: (a) the individual lost his or her employer-sponsored health care coverage as a result of his or her employer's or former employer's bankruptcy; (b) after losing his or her employer-sponsored health care coverage, the individual received health care coverage through a voluntary employment benefit association that was established before August 2006; (c) the individual is not otherwise eligible for coverage under BadgerCare Plus; and (d) the individual is under 65 years of age. BadgerCare Plus provides health care coverage to its members under two different plans:</p> <p>(a) the standard plan, which provides essentially the same level of coverage as the state's previous medical assistance program; and</p> <p>(b) the benchmark plan, which provides more limited benefits and includes higher cost-sharing features.</p> <p>Under current law, children under age 19, parents and caretaker relatives of children, and pregnant women, among others, are eligible for health care coverage under BadgerCare Plus if they satisfy non-financial and financial eligibility factors. With respect to the latter, adults, with the exception of pregnant women for whom a higher threshold applies, are eligible for BadgerCare Plus only if their family income does not exceed 200% of the federal poverty level (FPL). Children are eligible for BadgerCare Plus regardless of their family income, but children in families with income greater than 300% of the FPL are eligible only for the benchmark plan, and only if they pay the full per member per month cost of coverage.</p> <p>The Senate's provision would establish a new eligibility category for coverage under BadgerCare Plus, as set forth above. Individuals who satisfy the new eligibility criteria would not be subject to the program's other eligibility criteria, but would be required to pay their full per member per month cost for coverage under the benchmark plan.</p>

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INSURANCE PAYMENT INTERCEPT AND INSURANCE AGENT APPOINTMENT FEES	<p>Under Joint Finance, insurers would be required, prior to paying certain types of insurance claims to an individual that exceed \$500, to verify with DHS whether the individual has an MA liability and to check the statewide support lien docket to determine whether the individual has a support liability. If DHS determined that the individual had such a liability, the insurer would be required to pay the claim, either to the Department of Children and Families or DHS, to reduce the liability.</p>	<p>Delete the provision of Joint Finance that would establish an insurance payment intercept program, and increase insurance appointment fees to fund the cost of deleting this item. Increase the annual fees paid by insurance companies for appointments and renewals of appointments of resident and nonresident insurance agents, from \$14 and \$48, respectively (as provided in the JFC substitute amendment), to \$16 and \$50, respectively, and increase estimated revenue generated by the fee increase by \$1,724,400 annually. Because 10% of insurance fee revenue OCI collects is deposited to the general fund, increase GPR-earned estimates by \$172,400 annually. Finally, increase the amount of insurance fee revenue that OCI would be required to lapse to the general fund by \$1,614,100 in 2009-10 and by \$1,628,200 in 2010-11 to reflect: (a) 90% of the additional revenue OCI would collect with the fee increase (\$1,552,000 annually); and (b) a correction to the required lapse amount under Joint Finance (\$62,100 in 2009-10 and \$76,200 in 2010-11).</p>	<p>No change to Joint Finance.</p>

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<p>MINIMUM COVERAGE REQUIREMENTS FOR TREATMENT OF AUTISM SPECTRUM DISORDER</p>	<p>require health policies to provide coverage for treatment of autism spectrum disorder. These services would be provided to individuals with autism spectrum disorder by qualified providers specified in the substitute amendment. Policies would be required to include coverage of: (a) at least \$60,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of four years; and (b) at least \$30,000 for non-intensive level services per insured per year. These minimum coverage requirements would be adjusted annually, beginning in 2011, to reflect changes in the consumer price index.</p>	<p>Reduce, from \$60,000 to \$50,000, the minimum coverage that health policies would be required to provide for intensive-level services per insured per year. In addition, reduce, from \$30,000 to \$25,000, the minimum coverage that policies would be required to provide for non-intensive level services per insured per year. Finally, modify the definition of non-intensive level services to specify that these services must be evidence-based.</p> <p>"Intensive-level services" would be defined as evidence-based behavioral therapy designed to help an individual with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with the disorder. "Non-intensive-level services" would be defined as therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, therapy that will improve the individual's condition.</p>	<p>No change to Joint Finance.</p>

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<p>INDEPENDENT REVIEW OF COVERAGE DENIAL DETERMINATIONS AND RESCISSIONS -- INSURER LIABILITY</p>	<p>Modify current law relating to the types of adverse decisions that are eligible for a review under a group or individual health benefit plan's independent review procedure to include: (a) the rescission of a policy or certificate; and (b) a coverage denial determination based on a preexisting condition exclusion. A rescission may occur if an insurer determines that a policyholder failed to disclose material information at the time the policyholder applied for coverage under the policy.</p>	<p>Provide that an insurer is not liable for punitive damages for actions taken in compliance with a decision rendered by a certified independent review organization that relates to a preexisting condition denial or rescission. Provide that, if an insured brings a civil action against an insurer relating to a pre-existing condition exclusion denial determination or a rescission with respect to which an independent review organization has issued a decision, the decision is presumed to be correct, and the insured has the burden of proof of rebutting the presumption.</p>	<p>No change to Joint Finance.</p>
<p>HEALTH INSURANCE COVERAGE -- COVERAGE REQUIREMENT FOR DEPENDENTS</p>	<p>require health insurance policies that provide coverage for a person as a dependent of an insured to provide dependent coverage for a child of an insured unless: (a) the child is 27 years of age or older; (b) the child is married; (c) the child has other health care coverage; (d) the child is employed full time and his or her employer offers health care coverage to its employees; or (e) coverage of the insured through whom the child has dependent coverage under the policy or plan is discontinued or not renewed. Under the JFC substitute amendment; these requirements would take effect on the first day of the seventh month beginning after the bill's publication.</p>	<p>No change to Joint Finance.</p>	<p>Delete the provisions of Joint Finance. Instead, incorporate the provisions of 2009 SB 70, which are described below. <i>Coverage of Dependents.</i> Require all commercial health insurance policies, and all self-insured governmental health plans to offer and provide (if so requested by an insured or an applicant) coverage for an adult child of the insured or applicant, if the child satisfies all of the following criteria: a. The child is over 17 but less than 27; b. The child is not married; and c. The child is not eligible for coverage under a group health benefit plan that is offered by the child's employer, and for which the child's premium contribution is not greater than the premium amount for his or her coverage as a dependent under this provision. Additionally, an adult child would be eligible for coverage as a dependent if he or she meets all the following criteria: (a) the child is a full-time student, regardless of age; (b) the child meets the criteria under (b) and (c) of the previous paragraph; (c) the child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis; and (d) the child was under 27 years of age when called to federal active duty. <i>Determination of Premiums.</i> Require an insurer or self-insured governmental health plan to determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for coverage of a dependent who is 18 years</p>

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			<p>of age or younger. Permit an insurer or self-insured governmental health plan to require that an applicant or insured seeking coverage of a dependent child provide written documentation, initially and annually thereafter, that the dependent child satisfies the criteria for coverage.</p> <p><i>Effective Date and Initial Applicability.</i> The new requirements would take effect on the first day of the seventh month beginning after the bill's publication. However, the requirements would first apply to: (a) health policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on that date; (b) health policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with these requirements that are issued or renewed on the earlier of the day on which the collective bargaining agreement expires, or the day on which the collective bargaining agreement is extended, modified, or renewed (after the effective date); and (c) governmental or school district self-insured plans covering employees who are affected by a collective bargaining agreement containing provisions that are inconsistent with these requirements that are established, extended, modified, or renewed on the earlier of the day on which the bargaining agreement expires, or on the day which the collective bargaining agreement is extended, modified or renewed.</p>
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