Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

February 16, 2010

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Senate Bill 484: BadgerCare Plus Basic Plan

Senate Bill 484 would authorize the Department of Health Services (DHS) to offer health care coverage for individuals who are eligible for the state's BadgerCare Plus Core Plan, but who have been placed on a statewide waiting list for the program due to an enrollment cap DHS implemented in the fall of 2009. The plan is intended to be funded entirely from premiums paid by enrollees.

On February 12, 2010, the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue adopted Senate Amendment 1 to SB 484 by a vote of 7 to 0, and recommended the bill for passage by a vote of 4 to 3. The Assembly Committee on Health and Healthcare Reform has not yet taken executive action on Assembly Bill 697, the companion bill for SB 484.

BACKGROUND

The 2007-09 biennial budget act authorized DHS to request a waiver from the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), that would permit the state to receive federal financial participation to support health care services to adults without dependent children, ages 19 through 64, who live in families with income up to 200% of the federal poverty level (FPL), and who are not eligible for medical assistance (MA), Medicare, or benefits provided under the children's health insurance program.

CMS approved the state's waiver request in December, 2008, subject to a budget neutrality requirement that limits the amount of federal financial participation for benefits in any given federal fiscal year to the funds the state would have received in that year for disproportionate share hospital (DSH) payments. DHS was permitted to limit enrollment in the plan as a means of complying with this federal budget neutrality requirement. In federal fiscal year 2008-09, the state's DSH allotment

was approximately $95 million FED.

In 2009, the DHHS Health Resources and Services Administration (HRSA) awarded a five-year, $50 million grant (approximately $10 million per year) to implement a program designed to provide the uninsured access to affordable health care coverage. At the time the grant was awarded, DHS indicated that the funding would be used to support Core Plan costs.

DHS began enrolling individuals in the new program (the Core Plan) in January, 2009. The first enrollees were primarily individuals previously enrolled in Milwaukee County's general assistance medical program. DHS began enrolling individuals from all areas of the state in July, 2009.

The funding budgeted for the program in Act 28 assumed that monthly enrollment in the Core Plan would average 24,900 individuals in 2009-10, and 39,500 individuals in 2010-11. Because the number of applications quickly exceeded these projections, and because DHS needed to comply with the budget neutrality requirement of the waiver agreement, DHS obtained approval from CMS to limit program enrollment to individuals who applied for the program by October 9, 2009. As of January 8, 2010, enrollment in the Core Plan equaled 63,644 individuals. Approximately 21,000 individuals are currently on the Core Plan waiting list.

At the time DHS implemented the enrollment cap, the Governor directed DHS to design a health care plan for individuals on the waiting list for Core Plan benefits. Due to fiscal constraints, the Governor directed DHS to develop a plan funded entirely by premiums paid by enrollees. DHS used its contracted actuarial firm, PricewaterhouseCoopers, to estimate the monthly benefits costs for the new plan.

On January 20, 2010, the Governor proposed the creation of the BadgerCare Plus Basic Plan, which would be offered to individuals who are on the Core Plan waiting list. The Department prepared a 28-page Concept Paper that describes the plan, including program eligibility, program benefits, and the basis of the premium calculations produced by PricewaterhouseCoopers.

DHS has posted preliminary information on the Basic Plan on its website, including how individuals can apply for the plan if authorizing legislation is enacted. According to the website, enrollees would pay a monthly premium of $130 to receive coverage for the following services:

- Diagnostic services (laboratory and radiology, including mammograms);
- Emergency dental services;
- Emergency ambulance transportation;
- Durable medical equipment (DME) -- Full coverage, up to $500 per year;
- Disposable medical supplies (DMS) -- Limited to syringes, diabetic pens, ostomy

supplies and DMS that are required with the use of a DME item;

- Emergency room visits -- Limited to five visits per enrollment year;

- Chiropractic services;

- Hospital -- One inpatient hospital stay and five outpatient visits. Enrollees must meet a $7,500 deductible to receive additional covered hospital services. During the deductible period, the rates charged to members would be set at the Basic Plan (MA) payment rate, rather than the hospital's usual and customary charges. Inpatient psychiatric stays in an institution for mental disease or psychiatric ward of an acute care hospital are not covered;

- Physician services -- Limited to 10 visits per enrollment year for the following services: (a) primary and preventive care; (b) specialist care; (c) surgical and medical services; and (d) chronic disease management;

- Prescription drugs, limited to the following: (a) generic drugs; (b) some over-the-counter drugs; (c) preferred brand insulins; and (d) Tamiflu and Relenza, used to prevent and treat influenza. Basic Plan participants would be enrolled in the BadgerRx Gold plan, which provides brand name drug discounts; and

- Physical, occupational, and speech therapies -- Services are limited to 10 visits per therapy, per enrollment year.

SUMMARY OF SENATE BILL 484

Senate Bill 484 ("the bill") contains certain provisions of the proposal outlined by the Governor, but also provides considerable authority to DHS to determine the details of the plan.

The bill would authorize DHS to establish and operate, no sooner than March 1, 2010, a health care benefit plan ("the plan") for individuals who are on the waiting list for the Core Plan.

Funding. The bill would create a program revenue appropriation in DHS to support plan benefits and administration costs. The appropriation would be funded entirely with premium revenue DHS collects from individuals enrolled in the plan.

In addition, the bill would authorize DHS to pay benefit costs from a current federal project aids appropriation. This provision would permit DHS to use federal funds the state received under the HRSA grant to support benefits costs for enrollees, if premium revenue is insufficient to support benefits costs.

Eligibility. An individual would be eligible for the plan if they are on the waiting list for the Core Plan, and they apply for Basic Plan coverage in a manner prescribed by DHS. No individual would be entitled to benefits under the plan. An individual whose coverage under the plan ends for

any reason, including for failure to pay a premium, would be ineligible for coverage under the plan for 12 calendar months (beginning with the first calendar month after the last calendar month, which need not be a full month, in which he or she had coverage). However, this period of ineligibility could be waived if DHS determines that the individual's coverage ended for a good cause reason.

Premiums. The plan would be funded through premiums paid by individuals with coverage under the plan. The bill does not specify premium levels, and DHS would be required to set premiums at a level necessary to pay for the benefits covered, and to maintain the fiscal soundness of the plan. DHS, or its agent, would be required to credit all premiums paid by the plan's enrollees to the new program revenue appropriation.

Premiums would be due in the calendar month before the calendar month of coverage. An individual could not enroll in the plan if he or she does not submit the first month's premium with the application, and could not continue coverage under the plan if he or she does not pay a premium when due. If an individual with coverage under the Basic Plan begins receiving coverage under the Core Plan, DHS could not refund any portion of a premium paid by the individual for coverage under the Basic Plan for the calendar month in which the individual's coverage under the Core Plan commences. DHS would be required to waive any Core Plan enrollment fee for individuals enrolled in the Basic Plan.

Benefits. The bill does not specify the benefits that would be covered under the plan, but does specify that the plan's benefits could not exceed the benefits covered under the Core Plan. The benefits DHS intends to offer to the plan's enrollees are described in the background section of this memorandum.

The bill states that the plan's benefits could not include any charge for care for injury or disease for which benefits are payable under coverage statutorily required in any motor vehicle or other liability insurance policy or equivalent self-insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another health insurance policy, Medicare, or any other governmental program, except as otherwise provided by law. If an individual who has coverage under the plan also has coverage under one of the plans offered by the Health Insurance Risk-Sharing Plan (HIRSP) Authority, the benefits under the plan would be secondary to the benefits provided under HIRSP.

The bill specifies that DHS is subrogated to the rights of an individual with coverage under the plan to recover damages for illness or injury to the individual caused by the act of a third person to the extent that benefits are provided under the plan.

The bill would authorize DHS to recover a payment made incorrectly for benefits provided under the plan on behalf of an individual if the incorrect payment was made as a result of any of the following: (a) at the time the individual obtained coverage under the plan, the individual was on the Core Plan waiting list because of a misstatement or omission of fact by the individual; or (b) the individual's coverage under the plan was continued because of a misstatement or omission of fact

by the individual. The Department's right of recovery would be against the individual with coverage under the plan on whose behalf the incorrect payment was made, and the extent of the recovery would be limited to the amount of the benefits actually paid.

Inapplicable Provisions. The bill states that the plan is not medical assistance, nor is it subject to any of the provisions of the state's insurance statutes (Chapters 600 to 646).

Review of Coverage Denial or Discontinuation. An individual who is denied enrollment in the plan, or whose coverage is discontinued, could request that DHS review the action by filing a written request with DHS that includes the reasons why the individual disagrees with the denial or discontinuation of coverage. The written request would need to be filed within 60 days after the coverage denial or discontinuation. Individuals would be required to exhaust this process before commencing any action in court relating to the coverage denial or discontinuation.

Deductible and Other Cost-Sharing Requirements. DHS would be authorized to set a deductible that applies to inpatient and non-emergency outpatient hospital services and that does not exceed $7,500 in an enrollment year. In addition, DHS could set other cost-sharing requirements which it determines are necessary to keep the plan actuarially sound.

Provider Requirements and Reimbursement Rates. Only MA-certified providers could be reimbursed for services they provide to individuals covered under the plan, and payment rates for services could be not exceed MA payment rates. A certified provider that provides a covered service would be required to accept the Department's payment as payment in full, and could not bill the individual to whom the services were provided for any amount other than any required cost sharing. In addition, a certified provider that provides inpatient or non-emergency outpatient hospital services to which a deductible applies (as described above) could not charge more the amount payable for those services under the MA program.

Administrative Procedure and Review. The bill would specify that a "rule" as defined in Chapter 227 would not include any action or inaction of an agency that relates to the benefit design, cost-sharing requirements, or administration of the plan. The bill would exempt decisions that deny enrollment or discontinue coverage under the plan, decisions about benefits covered under the plan, and decisions about payments made to providers under the plan, from review through the administrative hearing process set forth in Chapter 227.

Changes to the BadgerCare Plus Benchmark Plan. The bill would also make two changes to benefits provided under the BadgerCare Plus Benchmark Plan. As of December, 2009, approximately 14,000 people, or 2% of the total BadgerCare Plus population, were enrolled in the Benchmark Plan. First, the transportation benefit would no longer be limited to transportation services for the purpose of obtaining emergency medical care only, as medically necessary, subject to a 10% coinsurance payment. Instead, the benefit would include transportation to obtain medical care, as medically necessary, and, to the extent permitted under federal law, subject to a 10% coinsurance payment. Second, the Benchmark Plan would include early and periodic screening, diagnosis, and treatment (EPSDT), and all services that are found necessary by this screening and

diagnosis, for recipients under 21 years of age.

These changes to the BadgerCare Plus Benchmark Plan are required to comply with federal changes enacted as part of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA requires states that offer benchmark plans funded by the Children's Health Insurance Program (Title 21 of the Social Security Act) to extend coverage of EPSDT services to children up to age 21, rather than up to age 19, as under previous law. In addition, CHIPRA limited the ability of states that offer benchmark plans to deviate from certain MA requirements, including the requirement that states offer non-emergency transportation to individuals in the benchmark plan. In June, 2009, CMS notified DHS of the need to make these changes to its BadgerCare Plus Benchmark Plan.

SUMMARY OF SENATE AMENDMENT 1

As introduced, the bill specified that DHS would pay a certified health care provider an amount that is no higher than the amount that is payable for the same service under the MA program.

Senate Amendment 1 would specify that DHS could pay no less (rather than no more, as provided in the bill) for services under the Basic Plan than the amount that is payable for the same service under MA. Consequently, the amendment would establish a "floor," rather than a "ceiling" on MA payment rates for services provided under the plan. However, the amendment would specify that DHS payments to federally qualified health care centers and hospital outlier payments could not exceed amounts that would be paid for these services under the MA program. The Department's concept paper indicates the Department's intention not to provide outlier payments to hospitals that serve the plan's enrollees, and that hospitals would be required to accept MA inpatient reimbursement without outliers as a condition of program participation.

In addition, Senate Amendment 1 would prohibit DHS from making any payments that it is required to make to hospitals and managed care systems under the hospital assessment, under the plan.

Finally, Senate Amendment 1 would require DHS to submit quarterly reports to the Joint Committee on Finance that include information on the solvency of the plan and that describes any changes that have been made under the plan since the last report was submitted to premiums, benefits, or provider payment rates.

FISCAL EFFECT

The bill would authorize DHS to expend all moneys it collects from premiums to support the plan's benefits and administrative costs and to use federal funds the agency receives to support health services provided to individuals enrolled in the plan. In its fiscal note, DHS indicates that, in working with its actuary, it has designed a plan and premium level that it expects would pay all benefit and administrative costs of the plan. However, the Department has not estimated how many individuals on the Core Plan waiting list would enroll in the Basic Plan, since many factors would

affect individuals' decisions to enroll in the plan, including alternative coverage options. This section discusses these factors, as well as potential ways DHS could, if necessary, address a potential funding shortfall. In addition, this section discusses enrollees' access to services, and the costs of administering the program.

Enrollment and Participation in the Basic Plan. If the bill were enacted, DHS plans to mail an information letter to all individuals on the Core Plan waiting list that would include a premium payment slip applicants could use to enroll in the plan. Enrollees would be required to submit the premium payment by the 15th of the month in order to be enrolled the following month. If an initial payment is received after the 15th, the individual would have to wait an additional month to enroll in the plan. Members would continue to be enrolled in the plan during the 12-month certification period as long as they pay the monthly premium (due on the 5th of each month prior to the month of coverage, although a 10-day grace period would be allowed) and continue to meet the plan's eligibility criteria. Changes in income during that 12-month certification period would not, in and of themselves, disqualify a person from participating in the plan. As with the Core Plan, there would be no "backdating" of enrollment, so that any services provided to an individual enrolled in the Basic Plan prior to the enrollee's application and premium payment would not be covered.

As indicated, the bill specifies that an individual whose coverage under the plan ends for any reason, including for failure to pay a premium, would be ineligible for coverage under the plan for 12 calendar months, beginning with the first calendar month after the last calendar month in which he or she had coverage. However, the bill would not prevent an individual who knows he or she requires a service covered under the plan (for example, a service that would require an inpatient hospital admission) to enroll in the plan, pay the required premium, then terminate their enrollment after receiving the service. The plan does not have a pre-existing condition exclusion period.

In addition, it appears likely that individuals with chronic conditions would be especially attracted to the plan if their current out-of-pocket health care costs for services covered under the plan exceed the premiums they would be required to pay. The term "adverse selection" describes the phenomenon where individuals with disproportionately high health care needs enroll in an insurance plan, thereby increasing the plan's costs. Because enrollment in the plan is voluntary and does not have a pre-existing condition exclusion, and because low-income individuals in good health may decide that the $130 monthly premium is prohibitively expensive, some adverse selection is likely to occur. In recognition of that possibility, PricewaterhouseCoopers increased the plan's estimated premiums by 20%.

It is difficult to project how many individuals on the Core Plan waiting list would choose to enroll in the Basic Plan The decision to purchase health insurance (whether the Basic Plan or a private insurance plan) depends upon a variety of factors, including the individual's income, assets, age, health status, the price of the plan, and the coverage offered under the plan.

With respect to income, DHS reports that as of mid-January 2010, 53% of the individuals currently on the waiting list reported having no monthly income, and 74% reported having income of less than 100% of the FPL ($10,830 annually for an individual). Assuming that the monthly

premium charged for the Basic Plan would equal $130, the premium would represent 14% of monthly income for an individual at 100% of the FPL, 9.6% of income for an individual at 150% of the FPL, and 7.2% of income for an individual at 200% of the FPL. It is not clear whether a $130 monthly premium would be prohibitive for people with these income levels, or with no income at all. However, as there is no asset test for eligibility in the Core Plan, some of these individuals may have minimal monthly income but some level of assets that would be available to purchase the Basic Plan (for instance, a person who recently lost his or her job, but still has a savings account).

Although there would be a monthly premium and a deductible for the Basic Plan, certain characteristics of the plan may encourage enrollment. First, the deductible would apply to hospital visits only after the first inpatient stay, or the fifth non-emergency outpatient visit. The plan would also provide up to 10 physician visits per year. This "first-dollar" coverage, though limited, may encourage enrollment.

Second, there would be no pre-existing condition exclusion period for the Basic Plan, unlike most plans in the private individual insurance market. Pre-existing conditions would be covered, subject to the other provisions of the plan. Third, enrollment in the plan would not affect eligibility for the Core Plan, or the individual's placement on the Core Plan waiting list. Finally, some individuals currently on the waiting list may hold some level of assets, but have no current income. These individuals may view the Basic Plan as a way to protect those assets in the case of catastrophic health care costs. However, it is not possible to say whether these types of individuals are currently on the Core Plan waiting list.

Discussion of Alternative Coverage Options. Some individuals currently on the waiting list, especially younger individuals, may be able to find coverage in the individual market that charges premiums and cost-sharing comparable, or less than, those proposed for the Core Plan. Although the plans offered in the individual market would be required to comply with the state's private insurance mandates (unlike the Basic Plan), they would likely also include a pre-existing condition exclusion period. While low-cost options in the private market may exist for younger individuals, such plans would likely be more expensive for older individuals, or individuals with existing health issues. As of mid-January, 45% of the individuals on the Core Plan waiting list were 30 years old or younger. It should be noted that under the waiver agreement, enrolling in a private individual plan would disqualify the individual from enrolling in the Core Plan.

Another option for certain individuals on the Core Plan waiting list may be coverage under HIRSP, the state's high-risk health insurance pool. HIRSP offers coverage to individuals who are unable to obtain coverage in the private market due to a medical condition, and to certain individuals who have lost access to group health insurance coverage (this second group is referred to as "HIPAA eligible individuals"). Premiums vary according the policyholder's age and sex. For example, a 39 year-old male who qualifies for HIRSP coverage could enroll in a HIRSP plan with a $5,000 deductible for a quarterly premium of $396 ($132 per month). In addition, the HIRSP premium and deductible amount may be reduced through the HIRSP premium subsidy program for individuals with household income under $33,000 (approximately 300% of the FPL).

However, individuals must meet certain criteria to qualify for HIRSP coverage. To qualify as a HIPAA eligible individual, an individual must meet certain criteria related to prior group insurance coverage, including having at least 18 months of continuous previous coverage, and applying for HIRSP within 63 days of losing access to that coverage. Individuals may also qualify for HIRSP due to medical condition if, up to nine months prior to applying for HIRSP coverage, an insurer rejected an application for coverage, cancelled coverage, or raised premiums by over 50 percent. It is not possible to determine the number of individuals on the Core Plan waiting list who may qualify for HIRSP coverage, based on information currently available on this population.

Unlike most commercial health insurance coverage, participation in HIRSP does not disqualify a person from enrollment in the Core Plan. In addition, the benefits offered through HIRSP are more comprehensive than those proposed for the Basic Plan. However, the HIRSP medical deductible applies to the first dollar of coverage (excluding prescription drugs, diabetic supplies, and some preventive services), where the proposed $7,500 Basic Plan deductible would only apply to after one inpatient stay and five non-emergency outpatient hospital visits. For HIPAA eligible individuals enrolling in HIRSP, there is no pre-existing condition exclusion period; individuals who qualify for HIRSP due to a medical condition are subject to a six-month pre-existing condition exclusion period.

Addressing Potential Funding Shortfalls. If the actual cost of providing services under the basic plan exceeds the premiums collected, DHS would have several options, including the following: (a) using federal funds from the HRSA grant to support the plan's benefits; (b) decreasing the scope of benefits offered under the plan; (c) increasing premiums; (d) reducing rates paid to providers; or (e) some combination of these options. No legislation would be required for DHS to implement any of these options, since the bill would not limit the amount of funding from HRSA that DHS could use to support the plan, and neither the plan's benefits nor premium costs are specified in the bill. However, all of these options have potential consequences. For instance, increasing premiums or reducing benefits may exacerbate the effects of adverse selection, as the plan's remaining enrollees might be those with disproportionately high health care costs. In addition, using HRSA grant money to support the Basic Plan would reduce the amount of federal funding that would otherwise be available to support Core Plan benefits.

Under the bill, DHS could not support the costs of the plan with state funds budgeted to support MA or its subprograms (such as BadgerCare Plus, Family Care, SeniorCare, or the Core Plan).

As previously indicated, the bill would create a program revenue appropriation, funded with enrollee premium revenue, to support benefits costs. Agencies are not prohibited from incurring temporary deficits in program revenue appropriations. Under s. 16.513 of the statutes, state agencies and the Department of Administration have specified responsibilities to monitor and address projected insufficiencies in program revenue- and segregated fund-supported appropriations. Under this section of the statutes, the Department of Administration may submit a plan to address a projected shortfall to the Joint Committee on Finance under a passive review process.

Access to Services. It is anticipated that all individuals enrolled in the plan would receive services on a fee-for-service basis. Consequently, enrollees would need to obtain services from providers who are willing to accept payment rates determined by the state. Under the bill, DHS could pay providers rates that are no higher than the rates DHS pays for services to MA recipients. MA reimbursement rates are typically significantly lower than providers' usual and customary charges.

DHS indicates that individuals in the Core Plan are currently not finding it difficult to access health services. Providers have expressed concern, however, that the continuing increase in health services provided through the state's Medicaid program, and the decline in coverage by commercial insurance, has increased cost-shifting to private payers. To the extent that such cost-shifting occurs, it is not clear the degree to which the Basic Plan would contribute to that process, since the plan's enrollment is likely to be relatively small compared to the current BadgerCare Plus enrollment of nearly 750,000 people.

Administrative Costs. The bill would not limit the amount or percentage of premium revenue DHS could use to administer the program -- both benefits costs and administrative costs could be funded from the new PR appropriation. In developing the premium estimate, PricewaterhouseCoopers assumed an administrative allowance of $8.05 per month per enrollee, or approximately 6.6% of total estimated benefits costs ($121.95 per month for benefits, and $8.05 per month for administration).

It is anticipated that DHS would absorb some one-time staff costs in establishing the new plan. These costs would include programming changes to the Medicaid management information system (MMIS), development of informational materials for potential applicants, revisions to information currently available on the DHS website, and actuarial analysis. Electronic Data Systems (EDS), the contracted fiscal agent for DHS, would provide the same services, including claims processing, as it currently provides for MA claims. It is anticipated that DHS would be required to amend its contract with EDS to include claims processing under the new plan.

Prepared by: Charles Morgan and Sam Austin