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November 26, 2013

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: December, 2013, Special Session Bills -- Medical Assistance and HIRSP

Attached is a paper, prepared by this office, on December, 2013, Special Session Bills LRB 3678/1 and LRB 3687/1. These are identical bills relating to delaying eligibility changes to the BadgerCare Plus and BadgerCare Plus Core plans under the medical assistance program and extending coverage under the Health Insurance Risk-Sharing Plan.

Also attached is a copy of the bill.

The Joint Committee on Finance is scheduled to introduce the companion bills, hold a public hearing, and take executive action on the bills on Monday, December 2.

The meeting will be held on Monday, December 2, beginning at 11:00 a.m. in Room 412 East, State Capitol.

BL/sas
Attachments

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December 2, 2013

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: LRB 3678/1 and 3687/1: Medical Assistance and HIRSP Coverage

LRB 3678/1 and 3687/1 are identical bills that would modify medical assistance (MA) eligibility standards so that most of the new standards that were enacted as part of 2013 Wisconsin Act 20 (the biennial budget act) that are scheduled to take effect on January 1, 2014, would instead take effect on April 1, 2014.

In addition, the bill would permit individuals who had health insurance policies issued by the Health Insurance Risk-Sharing Plan (HIRSP) Authority that were in effect on December 1, 2013 to maintain coverage under HIRSP through March 31, 2014. Under provisions in Act 20, these policies will terminate on December 31, 2013.

The bill would enable MA recipients and HIRSP enrollees who are scheduled to lose their current health insurance coverage to remain eligible for these programs for up to three additional months while they find other health care coverage through the online Marketplace at www.healthcare.gov.

The Affordable Care Act

The federal Affordable Care Act (ACA) requires states, the federal government, or a partnership of the two to create health insurance exchanges in every state so that individuals who wish to buy individual insurance coverage can view and compare competing plans or, if eligible, enroll in MA. Thirty-six states, including Wisconsin, have chosen to let the federal Department of Health and Human Services (DHHS) establish the health insurance exchange in their states. On October 1, 2013, the federal exchange website began allowing individuals to register and enroll in health plans. Due to problems with the website, many individuals who attempted to enroll in health plans through the federal exchange were unable to do so. DHHS released information on November 13, 2013, that only 877 individuals in Wisconsin were able to enroll into health plans through HealthCare.gov for the period October 1 through October 31, 2013.

As determined by DHHS, individuals have five months, from October 1, 2013, to March 31, 2014, to obtain minimum essential coverage. If individuals do not have minimum essential coverage by January 1, 2014, they risk being subject to a penalty. In the first year that the exchanges are in effect these penalties are equal to the lesser of $95 per month or 1.0% of their taxable household income.

Federal regulations specify that for all individuals who complete health plan selections on or before December 15, 2013, DHHS must have coverage in effect for those individuals on January 1, 2014. However, on November 22, DHHS announced that individuals could complete enrollment by December 23 and still have their coverage start January 1. The federal regulations also specify when individuals are to receive health coverage if they select their health plan after January 1. Under federal regulations, if an individual enrolls in a health plan between the first and the fifteenth of a month, they begin coverage on the first day of the following month. If an individual enrolls in a health plan between the sixteenth and the last day of the month, his or her coverage begins on the first of the second following month. For example, if an individual enrolls in a plan on January 15, they would receive coverage beginning February 1, but if they enrolled in a plan on January 16, they would not receive coverage until March 1.

The ACA allows exemptions from the penalty for short-term coverage gaps that extend for less than three months. This exemption was expected to prevent individuals who sign up for health insurance through the exchange by March 31, 2014, from being subject to the individual mandate penalty. However, under the coverage regulations described above, it was possible for an individual to sign up for coverage within the open enrollment period, but not begin coverage until after April 1, and therefore be subject to the penalty. DHHS announced on October 28, 2013, that individuals who sign up for coverage by March 31, 2014, will not be subject to the individual mandate penalties, even if their coverage does not begin until after March 31, 2014.

Individuals with incomes less than 400% of the federal poverty level (FPL) are eligible for premium tax credits if they purchase plans through the health insurance exchange operating in their state. The amount of the tax credits is based on the second lowest cost silver plan in the state and the individual's household income. The ACA provides a schedule for the maximum amount an individual would have to pay in premiums for the second lowest cost silver plan in their area, based on their income as a percentage of the federal poverty level. The schedule ranges from no more than 2.0% of household income for individuals with incomes up to 133% of the FPL to no more than 9.5% of household income for individuals with income between 300% and 400% of the FPL. Individuals are eligible to receive premium tax credits equal to the amount that their premium costs exceed their maximum premium payment. Individuals with household incomes below 100% of the FPL are not eligible for premium tax credits, however they are also not subject to the individual penalty described above.

Federal poverty guidelines for calendar year 2013 are shown in the following table.

Annual Income Based on Percentages of the 2013 Federal Poverty Level

	Percent of the Federal Poverty Level					
Family Size	100	133	150	200	300	400
One	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
Two	15,510	20,628	23,265	31,020	46,530	62,040
Three	19,530	25,975	29,295	39,060	58,590	78,120
Four	23,550	31,322	35,325	47,100	70,650	94,200

This memorandum contains two main sections - the first describes the MA-related changes in the bill, the second describes changes relating to HIRSP.

I. MA-RELATED CHANGES

Background

Under current law, the MA program provides health care coverage for three groups of non-elderly, non-disabled adults, as described below.

BadgerCare Plus for Parents and Caretaker Relatives. Parents and caretaker relatives of children under age 19 are eligible for coverage under the standard plan if their family income does not exceed 200% of the FPL. Non-pregnant, non-disabled adults enrolled in BadgerCare Plus are required to pay premiums if their family income exceeds 133% of the FPL. The premiums start at 3.0% of family income for adults at 133% of the FPL and increase to 6.3% of family income for adults at 200% of the FPL. For non-pregnant, non-disabled adults with family incomes greater than 200% of the FPL (primarily, adults in transitional MA), the premiums range from 6.3% of family income for those at 200% of the FPL to 9.5% of family income for those at 300% of the FPL or higher. Under provisions enacted as part of Act 20, parents and caretakers with household incomes greater than 100% of the FPL will no longer be eligible for BadgerCare Plus on January 1, 2014.

Transitional MA. Individuals in families with dependent children whose family incomes were initially less than 100% of the FPL but whose income increased above 100% of the FPL as a result of earned income or child support remain eligible for coverage under the standard plan during their transitional MA period, even if their income increases to a level that would otherwise disqualify them from coverage. If the additional income is earned income, their transitional MA period is twelve months. If the additional income is from increased child support, their transitional MA period is four months.

The adult premium schedule for parents and caretaker relatives applies to non-pregnant, non-disabled adults in transitional MA with incomes greater than 133% of the FPL. The following provisions enacted as part of Act 20 take effect on January 1, 2014: (1) individuals currently eligible for a twelve-month transitional MA period will continue to be eligible for the duration of their existing transitional MA period; (2) individuals who become newly eligible for transitional MA will have a four-month transitional MA period; and (3) if approved by the Centers for

Medicare and Medicaid Services (CMS), the Department of Health Services (DHS) could charge premiums to individuals during their four-month transitional MA period.

Childless Adults. The BadgerCare Plus Core Plan provides coverage for basic primary and preventive care to non-pregnant, non-elderly adults without dependent children who are not otherwise eligible for MA or Medicare and whose family incomes are not greater than 200% of the FPL. The program operates under a waiver of federal law. The program has been closed to new enrollees since late 2009. Since July 1, 2012, Core Plan enrollees with family incomes greater than 133% of the FPL have been required to pay monthly premiums based on the new adult premium schedule described above. The current Core Plan waiver expires December 31, 2013.

Under Act 20, on January 1, 2014, childless adults with household incomes below 100% of the FPL will be eligible for the MA standard plan. Current Core Plan enrollees with incomes above 100% of the FPL will no longer be eligible for MA coverage on this date.

Summary of Bill -- MA-Related Provisions

The bill would maintain eligibility for parents and caretakers with incomes up to 200% of the FPL, and delay coverage of childless adults with household incomes up to 100% of the FPL until April 1, 2014. This change would extend the current eligibility requirements through the end of the open enrollment period. The bill would also maintain coverage of current Core Plan, BadgerCare Basic, and BadgerRx Gold program enrollees during this period. DHS would need to receive approval from CMS to extend the Core Plan beyond the expiration date of the Core Plan waiver on December 31, 2013.

Act 20 provisions affected and their new effective dates under the bill are described in greater detail below. Act 20 provisions not described below, including the creation of an alternate benchmark plan, establishment of new transitional MA premiums, and the codification of policy changes approved by the Committee, would not be affected by the bill and would go into effect as specified in Act 20.

Delayed Act 20 Provisions

Under the bill, the following Act 20 provisions would not go into effect until April 1, 2014.

BadgerCare Plus Changes

Income Eligibility Limits. Act 20 reduced income eligibility limits for parents and caretaker relatives under BadgerCare Plus (stated in terms of the individual's family income) from 200% of the FPL to 100% of the FPL. The new income limit of 100% of the FPL is before application of the 5% income disregard established under the ACA for purposes of determining eligibility for medical assistance.

Require Child be a "Dependent Child" For Parents and Caretakers to Qualify for BadgerCare Plus. Currently, until January 1, 2014, the term "child" is defined as a child under age 19 for purposes of establishing BadgerCare Plus eligibility for parents and caretaker relatives. Act 20 replaced the term "child" for these purposes with the term "dependent child," and defined a

"dependent child" as an individual who is under age 18, or who is age 18 and is a full-time student in secondary school or equivalent vocational or technical training if before attaining age 19 the individual is reasonably expected to complete the school or training.

Repeal Provisions Related to Treatment of Depreciation for Individuals with Self-Employment Income. Currently, until January 1, 2014, if an adult family member has self-employment income, their "net self-employment earnings" are included when determining a parent's or caretaker relative's eligibility for BadgerCare Plus. In such instances, the parent or caretaker can qualify for the BadgerCare Plus standard plan if their family income does not exceed 200% of the FPL without deducting depreciation, and they can qualify for the BadgerCare Plus benchmark plan if their family income exceeds 200% of the FPL before deducting depreciation but does not exceed 200% of the FPL after deducting depreciation. Act 20 repealed these provisions effective January 1, 2014. Thereafter, parents and caretakers with self-employment income are eligible for BadgerCare Plus if their family income does not exceed 100% of the FPL.

Spend-Down Eligibility for Children. Currently, until January 1, 2014, children in families with incomes greater than 150% of the FPL who are ineligible for the program due to other insurance coverage may qualify for BadgerCare Plus if the difference between the child's family's income and 150% of the FPL is obligated or expended on behalf of the child or any member of the child's family for medical care or personal health insurance premiums. Act 20 amended spend-down eligibility for children by adding a provision that allows children in families with incomes greater than 300% of the FPL to qualify for BadgerCare Plus if the difference between the child's family's income and 150% of the FPL is obligated or expended on behalf of the child or any member of the child's family for the above-stated purposes.

Buy-In for Children in Families with Income Greater than 300% of the FPL. Act 20 repealed a provision that allows a child who is not an unborn child in a family with income greater than 300% of the FPL to obtain coverage under the BadgerCare Plus benchmark plan if the child's family pays monthly premiums on behalf of the child in an amount equal to the full per member per month cost of coverage.

Redefine "Family Income" as "Household Income." Currently, until January 1, 2014, "family income" is defined for BadgerCare Plus eligibility purposes as the total gross earned and unearned income received by all members of a family. Act 20 redefined the term "family income" in this context to mean "household income" as the latter term is defined in federal law regarding application of modified adjusted gross income (MAGI) for purposes of determining MA eligibility. Those federal law provisions define "household income," with some exceptions, as the sum of the MAGI-based income of every individual included in the individual's "household" minus an amount equivalent to five percentage points of the FPL for the applicable family size.

Under Act 20, DHS is required to apply the federal definition of the term "household" when determining family income for BadgerCare Plus eligibility purposes. In addition, it requires DHS, when determining the family size for a pregnant woman, to include the pregnant woman and the number of babies she is expecting.

Act 20 also requires DHS to apply the federal definition of "household income" when

establishing family income for purposes of determining MA eligibility for the following: (1) individuals infected with tuberculosis who meet the income and resource eligibility requirements for the federal supplemental security income program; and (2) individuals under age 21 who reside in an intermediate care facility, skilled nursing facility, or inpatient psychiatric hospital.

Rules Pertaining to Other Insurance Coverage for BadgerCare Plus Recipients. Act 20 provides that if DHHS approves the Department's request to add private major medical insurance as a type of insurance which causes ineligibility, an individual who is not disabled, not pregnant, whose family income exceeds 133% of the FPL, and who has coverage under private major medical insurance for which the monthly premium does not exceed 9.5% of the family's monthly income is not eligible for BadgerCare Plus. These are changes approved by the Committee as part of 2011 Act 32 program changes which require federal approval to implement. They are largely unaffected by the bill. However, the bill would delay a provision in Act 20 which repealed an exemption from these rules for children under age one whose mothers, when pregnant, had family income between 200% and 300% of the FPL and who were determined eligible for the program.

Premiums under BadgerCare Plus. Currently, a BadgerCare Plus recipient who is an adult, who is not pregnant, and whose family income is greater than 150% of the FPL but not greater than 200% of the FPL is required to pay a premium for coverage under the program that does not exceed 5% of his or her family income. If the recipient is a parent or caretaker relative with self-employment income who is eligible for BadgerCare Plus because their family income is less than 200% of the FPL after deducting depreciation, the premium may not exceed 5% of family income calculated before depreciation was deducted.

Act 20 repealed the reference to parents and caretaker relatives with self-employment income from this section of the statutes.

Act 20 also modified sections that currently exempt certain BadgerCare Plus recipients from paying premiums, as follows: (1) made the current exemptions subject to Act 20's new premium requirements for non-disabled children with family incomes of at least 150% of the FPL; and (2) repealed the current exemption that applies to children under age one whose mothers, when pregnant, had family income between 200% and 300% of the FPL and who were determined eligible for the program.

Restrictive Re-Enrollment Period. Currently, until January 1, 2014, if a BadgerCare Plus recipient who is required to pay a premium does not pay a premium when due, or requests that his or her coverage be terminated, their coverage under the program terminates and they are not eligible for six consecutive calendar months following the date on which their coverage terminated, except for any month during that six-month period when their family income does not exceed 150% of the FPL.

Act 20 revised the restrictive re-enrollment period for adults from six consecutive calendar months to twelve consecutive calendar months except for any month during that twelve-month period when the adult's family income does not exceed 133% of the FPL. These changes codified temporary program changes DHS implemented under 2011 Act 32.

Act 20 also amended the current statute to extend the restrictive re-enrollment period for children from six months to twelve months, if the federal DHHS approves that change. These are 2011 Act 32 program changes approved by the Joint Committee on Finance that require federal approval to implement.

BadgerCare Plus Core Plan Changes

Core Plan Demonstration Project. Act 20 modified statutes relating to the Core Plan to require DHS to request a waiver from the DHHS to provide health care coverage for basic primary and preventive care to adults who are under age 65, who are not otherwise eligible for MA or Medicare, and whose income does not exceed 100% of the FPL (rather than 200% of the FPL, as under current law) before application of the ACA's 5% income disregard.

In addition, Act 20 requires DHS to apply revised definitions of family income and the federal regulations defining "household" to determinations of income for purposes of eligibility under the demonstration project.

Act 20 deleted the reference to "basic primary and preventive care" in the current statutory sections relating to coverage under the Core Plan to provide benefits to the new MA enrollees in the childless adult enrollment group under the standard plan.

BadgerRx Gold

Act 20 repealed current statutory sections authorizing DHS to establish and administer a pharmacy benefits purchasing pool (BadgerRx Gold), and repealed references to this pharmacy benefits purchasing pool in various statutory appropriations which currently authorize DHS to administer and contract with an entity to operate a pharmacy benefits purchasing pool.

BadgerCare Plus Basic Plan

Act 20 repealed current statutory sections, including statutory appropriations, authorizing DHS to operate the BadgerCare Plus Basic Plan. The BadgerCare Plus Basic Plan was created in 2010 to provide limited health care coverage to childless adults on the waitlist for services under the BadgerCare Plus Core Plan. Under current law, the Basic Plan terminates January 1, 2014, but the bill repeals this termination date.

Repealed Act 20 Provisions

The bill would repeal provisions created in Act 20 that were intended to prevent several of the act's provisions from taking effect on January 1, 2014, under the circumstances described below.

A. If, by October 15, 2013, DHS did not receive a certification of an American health benefit exchange, as described in 42 USC 18031, from DHHS, if such certification was required under federal law, DHS was required to do all of the following for 90 days after December 31, 2013:

(i) Allow parents and caretaker relatives whose family income does not exceed 200% of

the FPL and who would otherwise be eligible for standard plan benefits under BadgerCare Plus to receive those benefits.

(ii) If approved by DHHS, allow only those individuals whose family income does not exceed 200% of the FPL and who are receiving benefits under the BadgerCare Plus Core Plan on December 31, 2013, to continue to be eligible to receive those benefits.

(iii) If, before the 90 days under A. expire, DHS determined it had not yet received the federal certification of an exchange, if required, apply the eligibility standards in A.(i) and A.(ii) to eligibility determinations under BadgerCare Plus and the BadgerCare Plus Core Plan for a 90-day period after the determination is made. DHS could have continued to apply the eligibility standards under A. (i) and A.(ii) for successive 90-day periods if it had not yet received a required federal certification of an exchange.

B. If, after consulting with the Office of the Commissioner of Insurance, DHS determined that in at least one county of the state, but not in all counties of the state, there is no qualified health plan offered through an exchange in which residents of the county may enroll, DHS was required to allow parents and caretaker relatives whose family incomes do not exceed 200% of the FPL who would otherwise be eligible for standard plan benefits under BadgerCare Plus except for the income limit, and who reside in a county in which there is no qualified health plan available under an exchange, to be eligible for standard plan benefits under BadgerCare Plus if DHS determined that any of the following was satisfied:

(i) DHS determined that a waiver of federal Medicaid law was not required to implement the eligibility standards described in B.

(ii) DHS requested a waiver of federal Medicaid law to implement the eligibility standards described in B. and DHHS approved the waiver request.

(iii) If, before the 90 days under B. expired, and before the expiration of any subsequent 90-day period, DHS determined that a county still had no qualified health plan available for enrollment, DHS was required to apply the eligibility standards under B.

Fiscal Effect -- MA Related Provisions

The bill would make no funding changes to state appropriations that support MA benefits and Department of Corrections health services for inmates. However, the bill would likely reduce MA benefits costs and increase Department of Corrections costs in the 2013-15 biennium, as discussed below.

Under the bill approximately 72,000 parents and caretakers in families with incomes greater than 100% but less than 200% of the FPL would remain eligible for BadgerCare Plus benefits for an additional three months (January through March, 2014). The total number of enrolled member months would increase by approximately 212,200 over the 2013-15 biennium, compared to the Act 20 budgeting assumptions. Individuals with incomes greater than 133% of the FPL would continue to have to pay premiums. After premiums and drug rebates are deducted, these individuals would have an average per member per month (PMPM) cost of approximately $197. The total cost of maintaining eligibility for parents and caretakers through March 31, is estimated to be

approximately $41.9 million ($17.2 million GPR and $24.7 million FED) in 2013-14.

In addition, approximately 83,000 childless adults who expected to begin enrolling in MA on January 1, 2014, would remain ineligible through March 31, 2014. Under Act 20, it was assumed that 50% of these individuals would enroll in the first month of eligibility, 20% in the second month, and 5.8% in the third, with the percentage decreasing in subsequent months until all newly eligible individuals would be enrolled by December, 2014. The current estimate is based on the Act 20 assumptions regarding the rate at which newly-eligible individuals enroll in the program, but enrollment would begin on April 1, 2014, rather than January 1, 2014.

When compared to Act 20, this delay in enrollment for childless adults would result in approximately 253,200 fewer member months that would be funded during the 2013-15 biennium. The average PMPM for these individuals, after premiums and drug rebates is estimated to be $368, so the savings resulting from the three-month delay are estimated to be approximately $76.0 million ($31.1 million GPR and $44.9 million FED) in 2013-14 and $19.0 million ($7.8 million GPR and $11.2 million FED) in 2014-15. In addition, delaying the expansion of childless adults would delay, for three months, MA eligibility for inpatient hospital services provided to inmates of Department of Corrections (DOC) facilities. This delay would result in a reduction of MA benefit costs of $3.4 million (-$1.4 million GPR and -$2.0 million FED) in 2013-14 but an unsupported cost increase of approximately $2.8 million GPR for DOC.

The net effect of maintaining current eligibility for parents and caretakers through March 31, 2014, and delaying the start date for MA eligibility for childless adults until April 1, 2014, would be an estimated reduction in MA benefits costs of approximately $37.5 million (-$15.3 million GPR and -$22.1 million FED) in 2013-14 and $19.0 million (-$7.8 million GPR and -$11.2 million FED) in 2014-15. The following table summarizes these funding changes.

Summary of GPR Costs and Savings
(In Millions)

	Change to Act 20		
	2013-14	2014-15	Total
MA Benefits			
Extend Eligibility for Parents/Caretakers (Costs)	$17.2	$0.0	$17.2
Delay Eligibility for Childless Adults (Savings)	-31.1	-7.8	-38.9
Inmate Hospital Services (Savings)	-1.4	0.0	-1.4
MA Total (Savings)	-$15.3	-$7.8	-$23.1
Corrections			
Inmate Hospital Services (Costs)	$2.8	$0.0	$2.8

As previously indicated, childless adults in families with incomes up to 100% of the FPL are not eligible for premium tax credits for health insurance purchased through the federal health insurance exchange. Consequently, under the bill, for a three-month period, the state would have a "coverage gap" for this population, as they would not be eligible for MA or premium assistance if they chose to purchase private insurance coverage. If the Committee modified the bill so that childless adults would become eligible for MA on January 1, 2014, it is estimated that this change

would increase MA benefits costs, compared to the bill, by approximately $90.1 million ($36.9 million GPR and $53.2 million FED) in 2013-14 and by $18.9 million ($7.8 million GPR and $11.1 million FED) in 2014-15. This estimate includes approximately $10.7 million ($4.4 million GPR and $6.3 million FED) to fund Core Plan enrollees with incomes between 100% and 200% of the FPL who, under the bill would remain eligible from January through March of 2014. These changes would also eliminate the MA savings associated with DOC inmates, as described above. Compared to Act 20, the bill, if amended, would increase MA benefits costs by approximately $52.6 million ($21.6 million GPR and $31.0 million FED) in 2013-14.

II. HIRSP-RELATED CHANGES

The bill would permit individuals who had health insurance policies issued by the Health Insurance Risk-Sharing Plan Authority that were in effect on December 1, 2013, to maintain coverage under HIRSP through March 31, 2014. Under provisions in 2013 Wisconsin Act 20 (the 2013-15 biennial budget act), these policies will terminate on December 31, 2013. The bill would enable policyholders to maintain their HIRSP coverage for up to three additional months.

The HIRSP Federal plan is operated and funded under a contract with the U.S. Department of Health and Human Services that will terminate on December 31, 2013. DHHS has not yet indicated whether it intends to extend HIRSP federal policies beyond that date. The bill includes provisions that would permit the HIRSP Authority to continue to administer such policies, should DHHS decide, through a contract amendment, to extend the contract and coverage under these policies beyond December 31, 2013.

Background

HIRSP provides health insurance to Wisconsin residents who are unable to find adequate health insurance coverage in the private market due to their medical conditions, and to individuals who have lost their employer-sponsored group health insurance coverage. Applicants are required to meet HIRSP eligibility criteria to qualify for coverage, although enrollment in HIRSP is not dependent on the individual's income or assets. Enrollees with annual household income less than $34,000 may qualify for reductions in premiums, deductibles and drug copayments.

HIRSP offers several plans, including two plans that qualify the enrollee to open a health savings account (HSA) and a plan for members who are enrolled in Medicare. The names of most HIRSP plans refer to the medical deductible the enrollee is required to pay, such as "HIRSP 1,000" or "HIRSP 5,000." The premiums policyholders pay vary, depending on the plan and the age and gender of the enrollee. For example, in 2013, the monthly premium for a 50-year old male enrolled in the HIRSP 1,000 plan is $1,008, while the same individual would pay a monthly premium of $334 for coverage under the HIRSP 5,000 plan, assuming the individual did not qualify for premium assistance.

The following table shows the number of individuals who were enrolled in each of the HIRSP plans, as of November 25, 2013.

HIRSP Plan Enrollment
November 25, 2013

Plan	Enrollment
HIRSP 1,000	769
HIRSP 2,500	6,062
HIRSP 5,000	10,079
HIRSP 7,500	2,082
Subtotal	18,992
Health Savings Account Plans	
HSA 2,500	829
HSA 3,500	792
Subtotal	1,621
Medicare Supplement Policies	1,217
Total	21,830
HIRSP -- Federal	1,989

HIRSP is funded through three sources: (a) premiums paid by members; (b) assessments paid by Wisconsin health insurance companies; and (c) reductions in reimbursement to HIRSP-certified health care providers. In general, premiums fund 60% of HIRSP costs, with insurer assessments and provider discounts each funding 20% of plan costs. In calendar year 2013, it is anticipated that program costs will total approximately $205.30 million, of which approximately $118.98 million will be funded from premium payments, $43.16 million from revenue the state collects from the insurer assessment, and $43.16 million from health care providers (through discounted payments for services they provide to enrollees).

All health insurance companies that do business in Wisconsin pay the HIRSP assessment. The amount of each participating insurer's assessment is based on the insurer's share of aggregate Wisconsin health insurance premiums for all participating insurers during the preceding calendar year. Insurers that pay the assessment can claim a tax credit, which is limited to $5 million in each year.

In response to the enactment of the federal Affordable Care Act, Act 20 included provisions to dissolve HIRSP, and terminate HIRSP coverage on January 1, 2014, the effective date for health plans available on the health benefit exchange. Act 20 contains provisions that specify how the dissolution of HIRSP would occur in the 2013-15 biennium. A summary of all of the Act 20 provisions relating to the termination of HIRSP coverage and the HIRSP Authority can be found beginning on page 412 of the Legislative Fiscal Bureau's August, 2013 Comparative Summary of Act 20.

Summary of Bill -- HIRSP Provisions

The bill would authorize the HIRSP Authority to extend coverage for up to three months for those enrollees who wish to maintain their HIRSP coverage.

Nonstatutory Provisions Relating to Coverage Extension of HIRSP Policies

The bill would specify that the dissolution of the plan and the Authority as provided in Act 20 would be modified as follows.

Coverage. A person whose coverage under the plan (other than HIRSP-Federal plan) that was in effect on December 1, 2013, and who paid his or her December premium could elect to obtain a policy by making a timely payment of the January, 2014, premium. The covered person would have the same policy benefits, and deductible amount, that were in effect on December 1, 2013. A new deductible period would commence on January 1, 2014. Enrollees would be required to pay the premium for January, 2014, no later than February 1, 2014. Thereafter, the covered person would be required to pay premiums in accordance with the terms of the contract for coverage, which could not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the person incurs after December 31, 2013, and before the plan received the premium payment for January, 2014, would be held in abeyance and the plan would not be responsible for payment.

If a person's coverage under the plan is funded under a contract with DHHS (HIRSP-Federal), the coverage would end as provided in Act 20 (December 31, 2013) unless DHHS 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 would be financially liable for all costs related to the operation of the contract that exceed member premium collections.

If these requirements are satisfied, a HIRSP-Federal policyholder whose coverage was in effect on December 1, 2013, and who paid his or her December premium and who had not enrolled in Medicare Advantage during the federal open enrollment period in 2013, or earlier, could elect to obtain a policy under the plan by making a timely payment of the January, 2014, premium. The covered person would have the same policy benefits and deductible amount that were in effect on December 1, 2013. A new deductible period would commence on January 1, 2014. Thereafter, the person would be required to pay premiums in accordance with the terms of the contract, which could not extend beyond 11:59 p.m. on March 31, 2014. Any medical claim that the person incurs after December 31, 2013, and before the plan receives the premium payment for January, 2014, would be held in abeyance and the plan would not be responsible for payment.

No later than February 1, 2014, the HIRSP Authority would be required to provide notice all covered persons that coverage will terminate on March 31, 2014, all insurers, and providers that are affected by the termination of the coverage, Office of the Commissioner of Insurance (OCI), and the Legislative Audit Bureau.

Provider Claims. The bill would require that providers of medical services and devices and prescription drugs to persons whose coverage is extended file claims for payments no later than June 1, 2014. Any claim filed after that date would not be payable, and could not be charged to the covered person who received the service, device or drug. Except for copayments, coinsurance, or deductibles, the bill would prohibit a provider from billing a covered person who receives a covered service and require providers to accept as payment in full the HIRSP payment rate.

Grievances and Review. The bill would specify that, notwithstanding provisions in Act 20,

any grievance by a person whose coverage is extended, must be in writing and received by the plan no later than July 1, 2014. A person whose coverage is extended 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.

Payment of Plan Costs and Insurer Assessment. The bill would require, to the extent possible, the HIRSP Authority to 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 OCI on February 28, 2014. Further, the bill would require the Authority, before March 1, 2014, and OCI, on and after that date, to pay plan costs as provided under current statutes, except that the Authority or OCI could use all available surplus before imposing an assessment against insurers. All claims for payments would be adjudicated by September 30, 2014. By July 1, 2014, the Authority and OCI would be required to determine whether an assessment is necessary to cover in full the plan's expenses relating to the operations, winding up operations, and dissolution of the plan. Any such assessment would be based on the 2013 filed plan assessment form.

Dissolution Notice, Claims and Updates. On behalf of OCI Commissioner, the Authority would be required to provide notice of the plan's dissolution to all persons known, or expected from the plan's records, to have claims against the plan, including all covered persons. This notice would be sent by first class mail to the last-known addresses no later than February 1, 2014. The bill would specify that the notice to potential claimants require the claimants to file their claims, together with proofs of claims, by June 1, 2014, and that the notice be consistent with any relevant terms of the policies under the plan and contracts, and with notification requirements in Chapter 645 ("Insurers Rehabilitation and Liquidation") of the statutes. The bill would specify that this notification would serve as a final notice, consistent with Chapter 645.

The bill would specify that proofs of all claims must be filed with OCI as provided under Chapter 645, on or before the last day for filing specified in the notice. For good cause shown, OCI would be required to 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. The bill would provide that any such late claim that would have been payable under the policy, if it had been filed timely would be permitted, unless the claimant had actual notice of the termination of the plan or notice was mailed to the claimant by first class mail at least 10 days before the insured event occurred.

Issuance of Medicare Supplement and Replacement Policies. The bill would provide that, in addition to complying with other Act 20 provisions, insurers offering a Medicare supplement policy or a Medicare replacement policy must provide coverage under the policy to any individual who satisfies all of the following conditions: (a) the individual is eligible for Medicare; (b) the individual has coverage under HIRSP; (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 March 31, 2014; and (e) the individual pays the premium for the coverage under the policy.

Insurers offering these Medicare supplement and replacement policies would be prohibited from denying coverage to any individual who satisfies the criteria listed above on the basis of health status, receipt of health care, claims experience, or medical condition including disability.

In addition to complying with any other notice requirements to insurers, the HIRSP Authority would be required to provide notice to these insurers of these requirements by February 1, 2014.

HIRSP Assessment Credit

Under current law, for taxable years beginning after December 31, 2005, and before January 1, 2014, insurance companies may claim a state income and franchise or insurance premiums tax credit equal to the amount of the assessment under the HIRSP program that the claimant paid in the claimant's taxable year, multiplied by a percentage determined by the Department of Revenue (DOR) and OCI, as described below.

DOR, in consultation with OCI, must determine the credit percentage for each claimant for each taxable year. The percentage must be equal to $5 million divided by the aggregate HIRSP assessment on all insurers. OCI must 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 for all claimants participating in the cost of administering HIRSP may not exceed $5 million in each fiscal year.

Partnerships, limited liability companies (LLCs), and tax-option corporations may not claim the credit, but eligibility for, and the amount of, the credit are based on their payment of HIRSP assessments. A partnership, LLC, or tax-option corporation must compute the amount of credit that each of its partners, members, or shareholders may claim and provide that information to each of them. Partners, LLC members, and shareholders of tax-option corporations may claim the credit in proportion to their ownership interests.

The credit is not refundable, but unused amounts may be carried forward for 15 years to offset future tax liabilities.

Under 2013 Act 20, no credit may be claimed for taxable years beginning after December 31, 2013. Credits for taxable years that begin before January 1, 2014, may be carried forward to taxable years that begin after December 31, 2013.

The bill would make several changes regarding the HIRSP assessment credit. First, the credit would be extended for one additional year -- through December 31, 2014. Second, the maximum amount of total credits that could be claimed would be reduced from $5 million annually to $1.25 million for tax year 2014. Finally, the credit percentage would be calculated using the $1.25 million amount (instead of $5 million) and would be limited to no more than 100%.

The fiscal effect of extending the tax credit would depend upon whether there will be a HIRSP assessment in calendar year 2014, and the amount of any assessment. Essentially, the tax credit would cover the first $1.25 million of any HIRSP assessment in that year. The HIRSP Authority indicates that it is unknown whether an assessment will be necessary in 2014 under the bill, because of uncertainty regarding the number of enrollees in the program. Any assessment of up to $1.25 million would result in a dollar-for-dollar decrease in general fund tax revenues. If an assessment for more than $1.25 million were imposed, the general fund impact would be a revenue loss of $1.25 million.

Other Provisions

The bill would make a number of changes to statutory provisions created or amended by Act 20 to reflect the extension of HIRSP policies.

First, the bill would modify an appropriation created in Act 20 for OCI, funded from moneys transferred from HIRSP, for operational expenses relating to winding up the affairs of HIRSP, so that the appropriation could be used for operational expenses related to the affairs of HIRSP.

Second, the bill would create references as they relate to: (a) custody of intangible unclaimed property; and (b) civil liability for the HIRSP Authority and Board, Plan, agents or employees (effective on January 1, 2015).

Finally, the bill would modify other provisions enacted as part of Act 20 to make them consistent with the bill by: (a) deleting provisions relating to the operation of the health benefit exchange and potential coverage extensions; (b) requiring providers of medical services and devices and prescription drugs to file claims for payment no later than June 1, 2014; (c) specifying that *to the extent possible,* the HIRSP Authority must pay plan costs incurred in 2013 and all other costs, before the administration of the plan is transferred to OCI; (c) specifying that OCI would assume responsibility for the plan, including the responsibility to manage the plan, on February 28, 2014, rather than 60 days after coverage in the plan terminates; (d) creating the HIRSP Advisory Committee on March 1, 2014, rather than 60 days after HIRSP coverage ends; (e) permitting claimants to make late filings (in cases where the existence of the claimant is not known to the clamant and the claimant files the claim within 30 days after learning of the claim) no later than September 1, 2014, rather than 210 days after the date on which HIRSP coverage terminates; and (f) requiring the Legislative Audit Bureau to complete its last audit of HIRSP from within 90 days after OCI provides required financial statements to June 30, 2015.

Fiscal Effect -- HIRSP

Funding for HIRSP benefits and administration costs are not part of the state budget, as the HIRSP Authority is not a state agency. The extension of HIRSP plans would increase revenue and costs for the HIRSP Authority, which would be funded from policyholder premiums, assessment revenue from insurers (if imposed), provider discounts, and surplus funding available to HIRSP that is carried forward to calendar year 2014. It is anticipated that the HIRSP Authority will end calendar year 2013 with a surplus of approximately $14.6 million.

As previously noted, the bill could reduce GPR revenue by up to $1.25 million if the Authority and OCI assess insurers for that amount or more to fund HIRSP program costs in calendar year 2014. However, as it is not known how many current HIRSP policyholders would request extensions of their policies and the expenses that would be incurred for these individuals, it is not known whether an assessment will be necessary in 2014.

Prepared by: Grant Cummings, Charles Morgan and Rob Reinhardt

State of Wisconsin
2013 – 2014 LEGISLATURE
December 2013 Special Session
LRB–3678/1
PJK/TJD/JK:jld/kjf/eev/cjs:jf

BILL

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)