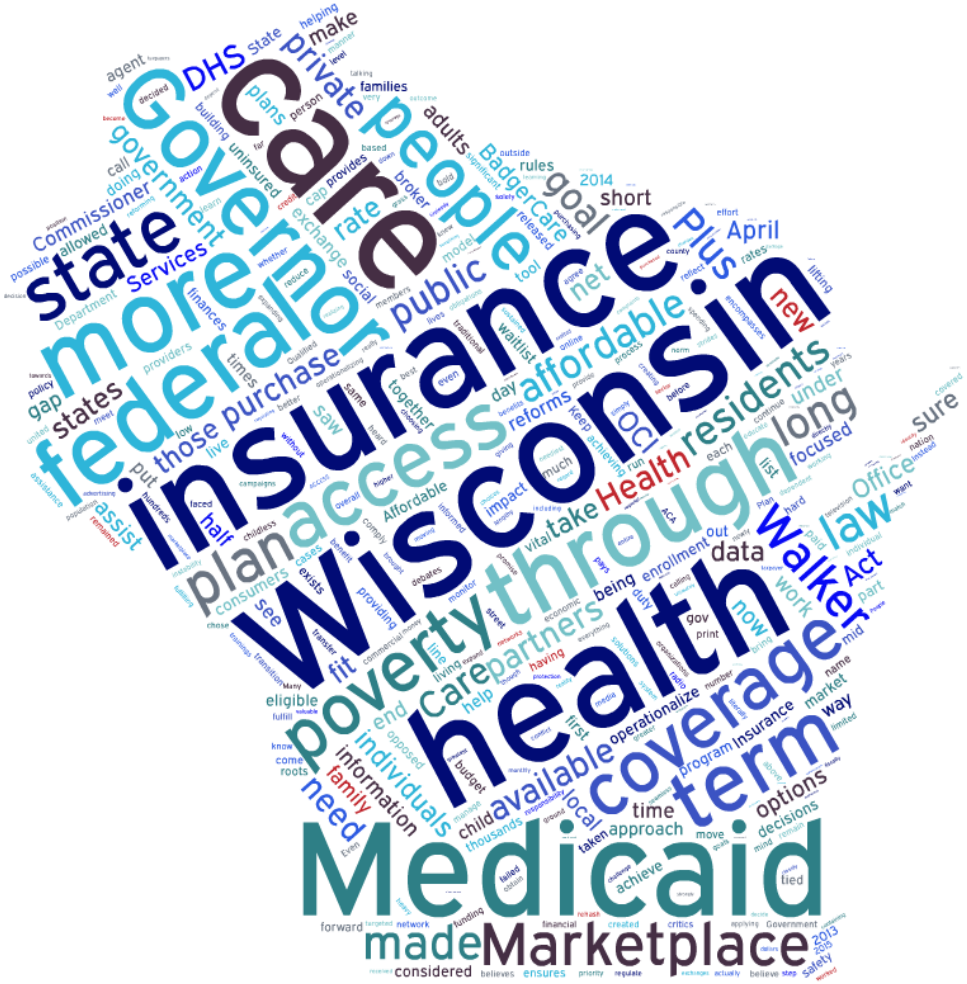
THE WISCONSIN HEALTH INSURANCE MARKET AND WISCONSIN ENTITLEMENT REFORMS



Wisconsin's Unique Approach to Operationalizing the Affordable Care Act

MARCH 31, 2014

Wisconsin Office of the
Commissioner of Insurance

Wisconsin
Department of Health Services

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The Wisconsin Health Insurance Market and Wisconsin Entitlement Reforms

WISCONSIN'S UNIQUE APPROACH TO OPERATIONALIZING THE AFFORDABLE CARE ACT

EXECUTIVE SUMMARY

Wisconsin has much to be proud of when it comes to the quality and access of health care in our state, including the access to coverage of health care. Wisconsin has had one of the best uninsured rates in the country—well below the national average with an uninsured rate that has been ranked the 6th lowest or better in the country. This coverage includes government programs like Medicaid, but also Wisconsin's highly competitive commercial insurance market. In addition, Wisconsin has been a leader in protecting consumers by having reasonable and prudent regulations, which combined with federal requirements existing well before 2010, created a healthy environment for our health care consumers and taxpayers. In Wisconsin, well before the advent of the Affordable Care Act, consumers could not have their policies dropped or cancelled because of health conditions or pre-existing conditions; Wisconsin has long provided guaranteed access to health insurance coverage through the Health Insurance Risk-Sharing Plan (HIRSP) and guaranteed issue for our small group market; dependent children up to the age of 27 were allowed to stay on their parents insurance plan; and consumers had a free-look option to return a policy and receive a refund of the first month's premium. Additionally, Wisconsin law served as a model for many of the other consumer protections adopted by the National Association of Insurance Commissioners (NAIC) and eventually incorporated into the ACA, including: independent external review, rescission reforms, network adequacy standards, and coverage of certain health care costs related to cancer clinical trials. Wisconsin consumers had a plethora of choices from a vast field of insurance companies of all types (For Profit, Non-Profit, Cooperatives, HMOs, PPOs, Association Plans, local, regional and national insurers, etc.). For those covered by Medicaid, Wisconsin has been a leader in Medicaid and CHIP program innovation for many years. Wisconsin was one of the first states to streamline and simplify our programs for families, pregnant women and children and one of the few states that expanded Medicaid to cover adults without dependent children.

This very sound system of health care coverage access and health care quality resulted in relatively low premium rates, high insured rates and vast choice and was upended with the passage and implementation of the federal law known as The Patient Protection and Affordable Care Act (ACA). In order to protect the health insurance market for our state's consumers while preserving a vital safety net for the neediest, Wisconsin, like some other states, moved forward with innovative reforms and created a Wisconsin-specific solution by working within the limited flexibility allowed by the federal government. These actions allow Wisconsin to be able to provide quality health care services and options for individuals and families living in our state. Wisconsin is now in a position to better manage its finances long-term, while creating a system where every individual and family has access to affordable health insurance either through the federal exchange, our state's existing competitive commercial insurance market, or through Medicaid. The Wisconsin model ensures people in poverty are covered through Medicaid while also realizing the instability that exists with regard to federal funding. The Wisconsin model protects taxpayers because decisions were based on what would be best both now and in the long term. Finally, the Wisconsin model protects consumers by

maximizing consumer choice within the federal constraints.

When Wisconsin, like other states, could have been tempted by the promise of the federal government to foot the full cost for Medicaid coverage for those covered by the ACA for the first three years and no less than 90 percent through 2022; Wisconsin decided to stay the course of bringing financial sustainability to our state government and not gamble on the federal promise of these funds being available. Moving forward, Wisconsin taxpayers will be able to budget for Medicaid and not be susceptible to the financial uncertainty of excessive dependence on federal funding. We need not fearfully wait for the next shutdown or decision from the federal government that it cannot live up to its lofty promises of being able to foot all or most of the bill for paying for the healthcare of our great nation's citizens living in poverty.

The plan to implement the Affordable Care Act, as required under the federal law, while reforming Wisconsin's entitlement programs, and preserving the choice and competition in Wisconsin's insurance market that has existed for consumers for the last decade, is one that was uniquely Wisconsin.

In operationalizing the Affordable Care Act, Wisconsin started at a much different place than other states. Relative to Medicaid, while many other states traditionally implemented the federal minimum coverage levels for Medicaid, Wisconsin expanded its Medicaid program above federal minimum coverage levels for parents, caretaker relatives, children and pregnant women before the federal government implemented the Affordable Care Act. However, this expansion led Wisconsin on a financially unsustainable path which Governor Walker has been working to correct since taking office in January 2011.

Wisconsin's unique solution was to cover all adults living in poverty and allow individuals with incomes above the poverty line to utilize tax credits and cost-sharing assistance to purchase private coverage through the federal exchange. Consumers in states that chose not to commit to the "expansion" solution were able to begin accessing the tax credits and cost-sharing assistance at 100% of the Federal Poverty Level (FPL); whereas consumers in expansion states were able to begin accessing the tax credits and cost-sharing assistance at 138% FPL.

Wisconsin's solution also continued to cover kids and pregnant women up to 300% of the FPL. It is important to note that kids with household incomes above 300% FPL had been able to buy into BadgerCare Plus by paying the full monthly cost. Since coverage was now available through the federal exchange, Wisconsin no longer allows families with household incomes greater than 300% FPL to buy their children into BadgerCare Plus.

Relative to Wisconsin's insurance market, the federal exchange didn't need to create a vast array of insurance options as Wisconsin already enjoyed the most competitive insurance market in the country. In fact, the intent of the federal exchanges and the ACA was to expand consumer choice but Wisconsin's market already offered broad consumer choice and continues to do so today.

It is because of Wisconsin's unique solution that most reports and studies looking at the Affordable Care Act simply don't apply to Wisconsin because they don't accurately account for the different solutions that Wisconsin implemented; one that was neither expansion nor rejection, and didn't fit into the one-size-fits-all methodology which many reports used. (See Appendix 1) The best summary and explanation of Wisconsin's situation is contained in the Kaiser Family Foundation issue brief about The Coverage Gap; however, it only became accurate after clarifying edits requested by the Department of Health Services (DHS) were made.

This report contains Wisconsin's story – a process that began with operationalizing federal law, as well as maintaining regulatory authority over our insurance market, and will result in a financially stable, secure Medicaid program that will be available as a safety net for Wisconsin's poorest citizens for years to come. This report also documents the actions taken by DHS and the Office of the Commissioner of Insurance (OCI) to operationalize the very law that Governor Walker has opposed. These actions demonstrate that even though

there are philosophical disagreements surrounding the Affordable Care Act, Governor Walker, DHS and OCI took Wisconsin's obligation to implement this law very seriously.

- DHS and OCI worked with community partners to establish 11 grassroots, Regional Enrollment Networks across the state with more than 1,500 partners to assist people with learning about and enrolling in health care coverage. There have been more than 40 meetings since July 2013 between DHS personnel and these stakeholders.
- OCI and DHS planned and participated in 16 public town hall meetings and 8 editorial boards throughout the state to inform the public of upcoming changes in health insurance in September and October.
- OCI also worked with DHS to provide free Navigator and Certified Application Counselor (CAC) training to 578 individuals, and online training for 400 insurance agents.
- DHS has sent more than 400,000 letters to those on Medicaid or newly eligible for Medicaid, and made hundreds of thousands of follow up phone calls to individuals receiving the letters to make sure they understood the letter and took appropriate action.
- DHS also sent more than 56,000 paper applications to individuals transitioning from Medicaid to the federal exchange after the failed rollout of HealthCare.gov to ensure they had another way to apply.

The focus at each and every step was creating a fiscally responsible solution meeting the needs of consumers, including taking every action possible to mitigate the disruption of the individuals who were transitioning from receiving health care through BadgerCare Plus to purchasing it in the private market through the federal exchange.

INTRODUCTION

Wisconsin, like every other state in the nation has been faced with a new challenge—operationalizing Medicaid under newly imposed rules contained in the Affordable Care Act (ACA) and regulating the health insurance market operating under this new set of federal rules. Despite Governor Walker's strong opposition to the Affordable Care Act (ACA), it is the law of the land, and, as such, he directed the Wisconsin Department of Health Services (DHS) and the Wisconsin Office of the Commissioner of Insurance (OCI) to ensure that we are all fulfilling our obligations to protect Wisconsin consumers and taxpayers under the law.

DHS and OCI have worked tirelessly to fulfill our obligations to comply with and regulate the markets impacted by the ACA, including compliance with requirements articulated in federal regulation and guidance that continues to be released, and is not always consistent with the ACA. We believe it is our responsibility to ensure that Wisconsin residents have the information they need to access the new public and private health insurance options available to them.

Commercial Health Insurance Market

OCI remains the primary regulator over Wisconsin's health insurance market despite additional federal requirements. Insurers are required to obtain a state license as well as meet state marketing and financial standards. OCI continues to review all rate and form filings, conduct financial and market conduct examinations; and respond to consumer complaints.

A key goal as the primary regulator is to protect our competitive health insurance market against adverse impacts resulting from the ACA and federal exchange problems. Unlike most other states, Wisconsin has a very competitive insurance market where the top 10 health insurers in the individual market comprise approximately 67% of the market and the top 10 health insurers in the small group market insure 60% of the market. The competitive nature of our market has been a significant benefit to health insurance consumers, resulting in premiums that more accurately reflect medical costs, demographics and utilization patterns of health care delivery in the state. Our regulatory framework relies on the competitiveness of the market in order to best serve the market's participants, consumers, insurers, and health care providers.

The Federal Department of Health and Human Services (HHS) has been inconsistent in their issuance of federal regulations and guidance implementing the ACA. Guidance changes weekly and is not always consistent with the statutory language of the ACA. ACA deadlines are a moving target, definitions of who qualifies for an exception to federal penalties for not purchasing coverage continues to grow, and the demands on insurers increases as the problems with HealthCare.gov continue (e.g., requests to accept late premiums and offer coverage back to the first of the month; emphasis on HHS's preference that when HealthCare.gov displays a plan in an area where the insurer does not offer coverage, that the insurer allow the consumer to keep the plan, etc.). (See Appendix 2) It has been a very challenging regulatory environment over the past couple of years, and OCI has shifted resources in order to keep up with the federal rule changes. OCI worked hard to analyze state law and ensure we accurately communicated to consumers and insurers the requirements of the new health law.

OCI has been at the forefront of ensuring insurers are aware of any flexibility, when it exists, so that consumers can benefit from more options as they determine what type of health insurance plan best suits their needs. OCI allowed for early renewals of non-ACA compliant plans so that consumers could keep their current plans longer and avoid having to purchase a more expensive plan that includes benefits they are not interested in having. OCI also used its state regulatory authority to help consumers when the HealthCare.gov website displayed errors and began to impact the plans they were purchasing. OCI directed insurers to immediately reach out to these consumers and help them enroll in new coverage, rather than wait for the

Center for Consumer Information and Insurance Oversight (CCIIO) to develop a way to handle the back-end data transfers that would need to occur as a result of consumers changing their plans.

OCI and DHS have been very proactive in ensuring consumer access to coverage and in gaining an understanding of their responsibility under the law. Together the two agencies held 16 town hall meetings which served as an opportunity for interested members of the public to receive an explanation of key ACA requirements and have their questions answered. Press attended these events as well, further expanding the information across the state. Separate meetings with editorial boards, presentations to consumer and employer groups, and meetings with state legislators and federal congressional members also were used to educate the public about the ACA.

Public Assistance Changes

Wisconsin has made fiscally responsible decisions to leverage the solutions that the federal government made available to states. Wisconsin is the only state out of the 25 states not expanding their Medicaid programs as part of the ACA that will provide access to health insurance to everyone, ensuring that Wisconsinites will not have a gap in access to health care coverage as of April 1, 2014. (See Appendix 1)

The 2013-2015 biennial budget transforms Medicaid to a program that more closely reflects the way the people of Wisconsin live their lives. These reforms re-focus Medicaid on the population that it was created for—people in poverty. The plan ensures long-term sustainability and predictability for a Medicaid program that serves those who are most in need in our state. As of March 1, 2014, approximately 1 in 5 Wisconsin residents receive services through Medicaid.

The Medicaid reforms also addressed the unfairness and inconsistency under the previous Medicaid rules—people in poverty were not eligible for the program because their eligibility was tied to their household structure, not their income. For a long time, adults at twice the federal poverty level were able to access Medicaid because they had a dependent child in their care, whereas many adults without dependent children living at or below the federal poverty level were not able to get Medicaid coverage simply because they did not have a child. In allowing access to Medicaid for all people in poverty, Wisconsin has strengthened its commitment to the poor and has maintained the health care safety net for those who need it most. It is important to note that these were solely for the BadgerCare Plus program and did not make changes to the Medicaid programs for those who are elderly, blind or disabled.

The newly improved Wisconsin model preserves Medicaid as a vital safety net for our state's neediest, supports residents' health so they can live more quality lives, and provides long-term protection for Wisconsin taxpayers. These reforms will continue to move Wisconsin forward.

Some say Wisconsin should have taken the promise of short-term federal money to expand Medicaid. More people dependent on government-run Medicaid should not be our end goal. People who are not living in poverty should be allowed to purchase a plan of their own choosing in the private market and they should remain in the private sector for their health insurance coverage. Our approach is based on what will provide the best outcome for our citizens, not on obtaining short-term financial assistance for the state.

These entitlement reforms and our approach have put Wisconsin in a position to better manage its finances long-term, while creating a system where every Wisconsin individual and family has access to affordable health insurance either through the private market outside of the federal health insurance exchange, the federal exchange, or through Medicaid. The Wisconsin model ensures people in poverty are covered while not putting Wisconsin taxpayers potentially at risk financially due to the instability that exists with regard to the long-term viability of federal funding.

Keep in mind that the Wisconsin approach is about making sure that hundreds of thousands of Wisconsinites now have access to affordable health insurance that they did not have access to before. This is a decision that should be a model for other states across the nation. For the first time in Wisconsin's history, on April 1, 2014, every person in poverty can be covered under the same Medicaid benefits. No limited benefit package. No waitlist. No enrollment cap. These reforms will ensure all Wisconsin residents have access to affordable health insurance coverage and seek to reduce Wisconsin's uninsured rate by half. (See Appendix 3)

Wisconsin will achieve the greatest economic impact for our state by having people who live above the poverty level purchasing their health insurance coverage through the federal health insurance exchange. We have all heard providers' complaints about Medicaid reimbursement rates being too low. In contrast, the traditional commercial market pays providers a higher rate than Medicaid. The more people we have who are purchasing their insurance through the federal exchange and the more providers we have being paid the commercial rates, the greater the overall economic impact.

Ultimately, it is up to each person and each family to decide to purchase this health care coverage, now that all residents in Wisconsin will have access and choices. The federal government has decided what is considered to be "affordable health care coverage" and it will be up to every individual and family to fit this into their monthly budget. While government can make these health care options available, it should not control the choices and decisions that individuals and families make.

Wisconsin has made a significant effort to be involved collaborators and leaders in the effort to build a grassroots infrastructure to assist the public in learning about and applying for public and private health insurance coverage, despite the very minimal federal resources being made available to support such efforts. Instead of spending valuable taxpayer dollars on short-term marketing with television, print, radio advertising and social media campaigns (all with limited reach), Wisconsin has been building a comprehensive network of partners informed about health insurance options for residents that encompasses the entire state. (See Appendix 4) Our public and private partners are now formally united and working together in a coordinated manner that can be sustained for years to come.

Wisconsin's successes in helping individuals and families learn about their health care options is not something that Governor Walker, the DHS or the OCI can solely take credit for—there are literally thousands of individuals across the state—the members of our Regional Enrollment Networks (people from all over the state representing community organizations, county income maintenance and social service personnel, providers, insurance agents, assisters, and navigators) who were there every step of the way with us and did a lot of the heavy lifting. Implementing Wisconsin's entitlement reforms and the ACA would have not have been nearly as successful if it had not been for our community partners.

While Wisconsin government did our part by providing information and trainings—and helped to obtain as much information as we could from the federal government, it was the individuals and organizations on the ground who pounded the pavement and strategized, in some cases down to neighborhood and street, on how to ensure that Wisconsin residents knew about and understood their health care options. Another important role that our partners perform is getting people to make the choice to take action – whether it was applying for BadgerCare Plus at their local county or tribal agency, calling the federal exchange call center, talking with an agent or broker—and not giving up when call times were lengthy, or when the federal government's website failed to work. At the end of the day, it was the hard work and dedication at the local level through our partners that has allowed Wisconsin to achieve success and help us take very important strides towards our shared goal of reducing the uninsured rate. Progress towards achieving this goal is expected throughout the biennium. (See Appendix 3)

DHS and OCI have crafted plans to operationalize the law and the entitlement reforms—including strategies on how to educate our community partners and consumers to plans and on how to monitor the insurance market under the ACA. We have been doing everything possible to ensure a seamless transition, however the federal government has often been unable to assist us. Many of the issues that we have been brought to their attention are often not considered a priority for them and are often not addressed. (See Appendix 5) As of March 26, 2014, they have yet to provide a data match so we can identify those Wisconsin residents who no longer meet BadgerCare Plus program rules and who have not purchased health insurance through the federal health insurance exchange. Our goal is to do more targeted outreach to this population to ensure that they do not have a gap in health care coverage.

Wisconsin has been doing everything that we can do, as you will see throughout this document, to ensure our residents are educated about their health insurance options and enroll in affordable health insurance—whether it is a Medicaid plan through BadgerCare Plus, private health insurance through a Qualified Health Plan in the federal exchange, or a plan they purchase outside of the exchange through an agent or broker. At the end of the day, we have a shared goal of making sure that Wisconsin residents have access to affordable health insurance.

An epilogue will be released in mid-April containing information from DHS and OCI including BadgerCare Plus enrollment data directly through Wisconsin's online application tool, ACCESS.wi.gov; data on members Wisconsin received through the account transfer process from the federal exchange; number of childless adults who were newly eligible and began receiving health insurance coverage through BadgerCare Plus on April 1, 2014; and federal exchange enrollment numbers from the open enrollment period.

The epilogue, along with this report, will be available online at http://www.dhs.wisconsin.gov/health-care/index.htm or at www.oci.wi.gov

THE ROLE OF THE WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE AND THE AFFORDABLE CARE ACT

Office of the Commissioner of Insurance (Agency Overview)

OCI was created by the legislature in 1871. The original intent of OCI has not changed drastically over the past 125 years. In 1871, OCI was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

OCI performs a variety of tasks to protect insurance consumers and ensure a competitive insurance environment. OCI's major functions include:

- Reviewing insurance policies that are sold in Wisconsin to make sure they meet the requirements set forth in Wisconsin law;
- Conducting examinations of domestic and foreign insurers to ensure compliance with Wisconsin laws and rules;
- Monitoring the financial solvency of licensed companies to make sure that consumers have the insurance coverage they expect when they need it;
- Issuing licenses to the various parties involved in selling and marketing insurance products;
- Assisting insurance consumers with their insurance problems;
- Researching special insurance issues to understand and assess their impact on Wisconsin;

- Providing technical assistance on legislation and promulgating administrative rules to interpret insurance laws;
- Creating and distributing public information and consumer education pieces to educate people about insurance; and
- Operating a state life insurance fund, a property fund for the property owned by local units of government, and a patients' compensation fund insuring health care providers for medical malpractice.

Effective Rate Review Program

The ACA provides a process for states to seek certification as an effective rate review program (ERRP). ERRP certification allows states to retain their primary enforcement authority over federal and state rate regulations. In July 2011, Wisconsin was certified by the federal government as an ERRP state. Insurers are required to file rates with OCI annually, consistent with the ACA. OCI reviews rate filings to determine whether the rates filed are unreasonable, subject to the standards of the Wisconsin insurance laws and regulations.

Retaining state authority over the rate review process is critical to ensuring Wisconsin is able to maintain a competitive market. OCI understands the state-specific dynamics that impact rates and is able to make review determinations with that information in mind. Federal control over this process would result in a one-size-fits-all approach that would compromise the state's competitive insurance market. Maintaining a competitive market is necessary to ensure both the availability of affordable coverage and a marketplace that offers an abundance of consumer choice. Many states have one or two large insurers dominating a majority of their individual market which results in few consumer options.

Affordable Care Act: Market Changes

The ACA contains a number of significant market changes that impact health insurance plans with effective dates beginning on or after January 1, 2014. These new market rules impact individual and group plans sold on the federal exchange and plans sold off the exchange. Some of the most notable changes are listed below.

- All insurers must sell a health insurance policy to any person who applies for coverage, except in cases where fraudulent information is intentionally provided by the applicant. This is called guaranteed issue. (Prior to the ACA, Wisconsin had guaranteed issue in the small group market and high-risk individuals had guaranteed issue through the Health Insurance Risk-Sharing Plan or HIRSP).

- Insurers are prohibited from excluding or limiting coverage for a preexisting condition. A preexisting condition is a health condition an individual has been treated for or was made aware of within a defined period of time before purchasing a health insurance plan. [Prior to the ACA, the Health Insurance Portability and Accountability Act (HIPAA) excluded the use of preexisting conditions for the majority of all markets.]

- Insurers must set premium rates for their individual and small group market plans based on market-wide claims experience and may only take four items into account when determining the premium a policyholder is charged for coverage under a plan. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.

- Plans are required to offer "essential health benefits." (Prior to the ACA, a majority of plans covered the essential health benefits, with the exception of pediatric dental, vision and habilitative services.

- Plans are categorized into one of four different levels, which the federal government calls "metal tiers." Consumers know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average portion of expected costs a plan will cover for the average individual. The metal tiers include: bronze plans covering 60%; silver plans covering 70%; gold plans covering 80%; and platinum plans covering 90%. (Prior to the ACA, consumers had unlimited benefit choices.)

- All plans will limit in-network out-of-pocket expenses to $6,350 for self-only coverage and $12,700 for family coverage.

- Insurers have the option to sell their plans through the federal exchange, as well as selling health insurance plans off the federal exchange.

Essential Health Benefits

Also required under the ACA, beginning January 1, 2014, insurers in the individual and small group markets must now offer a minimum level of coverage called "essential health benefits." The essential health benefits that insurers must minimally cover include the following categories:

- Emergency services
- Ambulatory services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Insurers are not allowed to impose annual or lifetime dollar limits on essential health benefits.

Large group health insurance plans are not required to cover essential health benefits. However, if a large employer chooses to offer a health insurance plan that includes essential health benefits, the plan cannot impose any annual or lifetime dollar limits on those benefits.

Each state had the opportunity to identify their Essential Health Benefit Benchmark plan or default to the plan identified by the federal government. Insurers must offer benefits that are substantially similar to the benchmark plan.

The federal government has identified a plan sold by UnitedHealthcare as Wisconsin's benchmark. It is their Choice Plus Definity HSA Plan (A92NS). A copy of the Wisconsin EHB Benchmark plan can be found at: http://oci.wi.gov/healthcare_ref/ehb_certificate.pdf (See Appendix 38)

Federal Tax on Consumers for Not Having Coverage

Beginning January 1, 2014, individuals must have health insurance or pay a tax. The federal government refers to this as the "individual shared responsibility payment." The tax is set to increase each year as follows:

- In 2014 it will be the greater of $95 per adult or 1% of taxable income.
- In 2015 it will be the greater of $325 per adult or 2% of taxable income.
- In 2016 it will be the greater of $695 per adult or 2.5% of taxable income.
- After 2016 the tax penalty increases annually based on a cost-of-living adjustment.

There are certain circumstances under which individuals may be exempt from this federal tax.

Frequently Asked Questions

Beginning in April 2013, OCI began posting health care reform FAQ documents to its website. These are directed toward consumers, employers, agents and insurers. The FAQs are consistently updated to reflect new guidance and regulations that federal agencies have slowly issued throughout the past year. As with most of the health care reform information posted to OCI's website, the FAQs are easily accessible by clicking the "Health Care Reform" button on the homepage. (See Appendix 6)
http://oci.wi.gov/healthcare_ref/healthcarereform_agentfaq.pdf
http://oci.wi.gov/healthcare_ref/healthcarereform_consumerfaq.pdf
http://oci.wi.gov/healthcare_ref/healthcarereform_employerfaq.pdf
http://oci.wi.gov/healthcare_ref/healthcarereform_insurerfaq.pdf

Working to Identify Fraud and Alert Consumers

Due to concerns among several state agency General Counsels that the initial open enrollment period under the ACA could be a prime opportunity for the occurrence of fraud against Wisconsin consumers, the General Counsels coordinated an anti-fraud multi-agency taskforce comprised of OCI, the Department of Justice (DOJ), the Department of Agriculture, Trade and Consumer Protection (DATCP), and DHS. The task force held bi-weekly calls beginning October 17, 2013, through March 20, 2014. During the calls each participating agency provided updates and shared information about any suspicious activity they had seen. Throughout this period OCI received one referral from DATCP concerning a possible insurance fraud issue that is still under investigation. Also, the reimbursement enrollment network identified two organizations that were holding themselves out as certified assisters but who had not complied with the navigator and non-navigator assister statutes and emergency regulations. The task force will continue to meet as fraud-related issues arise.

The agencies represented on this group issued a press release on March 4, 2014, "State Warns Consumers to be on the Alert When Signing up for the Affordable Care Act." Late last year, OCI issued its own release, "Scammers Take Advantage of Health Reform Confusion: State Insurance Regulators Warn Consumers to Be on Alert." (See Appendix 7)

http://oci.wi.gov/pressrel/0314aca.htm
http://oci.wi.gov/pressrel/0913scammers.htm

OCI Life and Health Advisory Council

The OCI Life and Health Advisory Council met several times over the course of the last three years. The Life and Health Advisory Council is comprised of 11 members who represent industry, small business, agents and consumers. The Council advises the Insurance Commissioner on regulatory matters in the area of Life and Health insurance.

Council meetings are open to the public and can be attended in-person or via teleconference. Meeting agendas are distributed in advance of the meeting via e-mail to interested parties and posted according to state open meetings laws. Council meetings are well attended by consumers, agents, insurers and employers; all of whom have opportunities throughout the meeting to offer feedback, ask questions and raise concerns. OCI staff leading the meetings encourage active participation and dialogue.

OCI provides detailed updates and explanations of healthcare reform related issues at every meeting. Issues discussed include information on newly released federal guidance, HealthCare.gov challenges, agency outreach and educational efforts, etc. (See Appendix 8)

2014 Wisconsin Individual Health Insurance Market and OCI Efforts to Educate Consumers on Insurers Participating in the Market

For the 2014 plan year, there are 13 insurers selling plans in the individual market on the federal exchange. All but one of these plans is actively marketing products in the market outside of the federal exchange as well. With these insurers and 5 additional insurers selling only in the outside market, there are a total of 17 insurers actively selling individual health insurance off the federal exchange. (See Table 1)

On August 6, 2013, OCI released a list of insurers who requested their plans be certified as qualified health plans and be made available on the federal exchange. On September 3, 2013, OCI also released a preliminary analysis of the rates filed by those insurers to caution that rates overall seemed to be on the rise but that consumers would be impacted differently. A follow-up release was issued on September 19, 2013 (in advance of the initial open enrollment period) with a list of insurers who had officially signed an agreement with the federal government to sell their plans on the federal exchange. OCI felt it was important to share this information as soon as possible to keep consumers informed about their options going into 2014. (See Appendix 7)
http://www.oci.wi.gov/pressrel/0813qhp.htm
http://www.oci.wi.gov/pressrel/0913rateinfo.htm
http://www.oci.wi.gov/pressrel/0913serviceareas.htm

Upon OCI's receipt of the insurer's initial filings, OCI discovered that initially there were counties in Wisconsin where no insurers in the individual market were planning to offer qualified health plans on the federal exchange. It was through OCI's efforts in serving as a resource and answering questions that insurers ultimately decided to sell plans on the federal exchange in those areas.

In an effort to help consumers easily find insurers actively selling individual coverage in their area, OCI posted a map with insurer names listed in each county. The map includes insurers selling on the federal exchange and those selling in the market outside of the federal exchange. A table with contact information for each insurer is also provided. County-by-county, there are more insurers selling outside the federal exchange than on the exchange. Here is a link to the map and contact information:
http://www.oci.wi.gov/healthcare_ref/find_health_insurer.pdf (See Appendix 9)

As an additional resource for consumers and insurers, OCI posted a color coded map which identifies the 16 rating areas across the state. Federal law allows insurers to consider geographical location when pricing their products. This map allows a consumer to easily identify the geographical location insurers in their area are taking into account when pricing their products.
http://www.oci.wi.gov/ociforms/comphlth_geographicrating.pdf (See Appendix 10)

Table 1

On Exchange		Off Exchange
Medica Health Plans of WI		Medica Health Plans of WI
Common Ground Health Care Cooperative		Common Ground Health Care Cooperative
Mercy Care HMO, Inc.		Mercy Care HMO, Inc.
WPS Health Plan, Inc. (Arise)		WPS Health Plan, Inc. (Arise)
Dean Health Plan, Inc.		Dean Health Plan, Inc.
Health Tradition		Health Tradition
Group Health Cooperative South Central WI		Group Health Cooperative South Central WI
Gundersen Health Plan, Inc.		Gundersen Health Plan, Inc.
Physicians Plus Insurance Corporation		Physicians Plus Insurance Corporation
Security Health Plan of WI.		Security Health Plan of WI.
Unity Health Plans Insurance Corp.		Unity Health Plans Insurance Corp.
Compcare Health Services Insurance Corp.		Compcare Health Services Insurance Corp.
Molina Healthcare of WI, Inc.		Celtic Insurance Company
		Humana Insurance Company
		Time Insurance Company
		United Healthcare Life Insurance Corporation
		WI Physicians Service Insurance Corporation

New Opportunity to Renew non-ACA Compliant Plans

Beginning in early 2013, OCI became concerned that consumers would soon receive cancellation notices from their insurers indicating that their current coverage was not ACA compliant and would be discontinued. OCI analyzed federal and state law to determine whether there was an opportunity to allow Wisconsin consumers a choice between keeping their plan or moving to a new, ACA-compliant plan. Through this analysis and discussions with insurers to understand what might be feasible from their perspective, OCI used its authority to allow insurers to offer enrollees an early renewal opportunity that would allow consumers to keep their non-ACA compliant plans for one additional plan year. OCI reached out to insurers to make sure they were aware of this and provided additional information to help insurers make the decision to move forward with offering this renewal option.

A majority of consumers exercised their option to keep their pre-ACA coverage. Consumers benefited from OCI's decision to allow renewal of non-compliant ACA plans by increasing their options when considering their health care coverage needs. In many cases, choosing to keep their non-ACA compliant plan will be less expensive than moving to a new ACA compliant plan. Due to OCI's work to allow early renewals, Wisconsin consumers, unlike consumers in most other states, were not inundated with cancellation notices. Pre-ACA cancellation notices were a non-issue in Wisconsin.

As with many requirements in the ACA, the federal government unilaterally and without statutory authority, sent a letter to state insurance commissioners on November 14, 2013, permitting states to allow insurers to extend renewal of non-ACA compliant plans into 2014. For example, a consumer could choose to renew their plan between January 1, 2014 and October 1, 2014, which would give them coverage under their non-ACA compliant plan into 2015. OCI released a bulletin making insurers aware that they could pursue this extended renewal opportunity. On March 5, 2014, additional federal guidance was released allowing states to extend the renewal opportunity through October 1, 2016. On March 20, 2014, OCI released a bulletin to insurers making them aware that OCI is permitting insurers to continue to renew non-ACA compliant plans through October 1, 2016. (See Appendix 11) Here are links to the November 21, 2013 and March 20, 2014 guidance documents:

http://oci.wi.gov/bulletin/1113healthplans.htm

http://oci.wi.gov/bulletin/0314transitionalpol.htm

2013-2015 WISCONSIN BIENNIAL BUDGET

Entitlement Reforms

In its 2013-15 biennial budget, Wisconsin state government invested in priorities, while continuing to reform government with the goal of to creating prosperity for its citizens.

The biennial budget reformed Medicaid through Governor Walker's entitlement reforms. These entitlement reforms provide an estimated 82,000 childless adults living in poverty access to the same Medicaid benefit package for the first time in Wisconsin's history. Adults without dependent children living in poverty traditionally did not have access to Medicaid and the BadgerCare Plus Core Plan coverage that had been offered in 2009 for a few short months was a limited benefit with fewer covered services. The reforms provide Medicaid coverage to all eligible adults living in poverty, with those above the poverty level able to access coverage through the federal health insurance exchange. (See Appendix3)

The Wisconsin vision and commitment is to ensure that every resident has access to health insurance, to create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it most. We are working towards reducing the number of uninsured, non-elderly adults in our state and encouraging consumers to be active participants in their health care. These reforms simplify the Medicaid program by creating one standard set of comprehensive benefits that will lead to improved health care outcomes.

The biennial budget added roughly $760 million in state funds to Medicaid; however a large portion of that funding increase was a direct result of federal decisions outside the State's control, including implementation of the Affordable Care Act and reductions in the federal Medicaid matching rate for Wisconsin. Wisconsin's Medicaid program had been expanded repeatedly in recent decades and could not continue to operate on this unsustainable path. Wisconsin expanded its Medicaid program above federal minimum coverage levels for parents, caretaker relatives, children and pregnant women before it was required and before the federal government implemented the Affordable Care Act.

- Enrollment in Medicaid has nearly tripled since BadgerCare's inception in 1999.
- In fiscal year 2000, the state spent $134 million, All Funds, for coverage of low-income families.
- In Fiscal Year 2014, the state will spend more than $1.7 billion.
- The overall Medicaid program cost about $1 billion in 1987. By 2015, it will exceed $8 billion.

DHS also requested $75 million in state funds to address the systems changes and projected spike in eligibility workload caused by the Affordable Care Act implementation. Much of this funding ($55.5 million) went to the County Income Maintenance Consortia, and Milwaukee Enrollment Services (MilES). These are local agencies that administer and manage some of Wisconsin's public assistance benefits. The remaining $19.7 million was reserved for state-level system changes and other costs.

Part of the Department's biennial budget request included 88 Full Time Equivalent (FTE) positions to address the federally mandated Medicaid administration workload associated with implementing the ACA. Seventy of those 88 positions were slated for the increased workload at MilES for ongoing eligibility determinations and case management. MilES not only administers and manages income maintenance programs for Milwaukee County residents; it also serves to support the consortia.

Eighteen of the positions are project positions. These positions are budgeted for 18 months beginning in 2013-2014 to perform project management tasks, administrative support, training for state and local Income Maintenance staff, policy implementation, systems work (including facilitating the exchange of data between the state systems and health insurance exchange, facilitating the implementation of Modified Adjusted Gross Income, systems and user acceptance testing), communications and outreach, and technical assistance to the Income Maintenance agencies.

Each consortium made decisions on how best to utilize those funds. The ACA-related funding in the biennial budget served to help build the infrastructure so Wisconsin could effectively and efficiently operationalize the Affordable Care Act.

Health Insurance Risk Sharing Plan (HIRSP)

HIRSP is the state's high risk pool, originally created to provide health insurance coverage to individuals who could not obtain coverage in the commercial market; largely due to a serious health condition. HIRSP was an independent authority with its own governing board and was not part of either DHS or OCI.

Prior to the ACA, individuals had guaranteed renewal rights and small employers already had guaranteed issue and renewability rights. With the requirement that insurers accept anyone who applies for coverage beginning with plans effective January 1, 2014, keeping HIRSP operational was not necessary. Individuals have guaranteed access to health insurance in the commercial market and access to federal premium tax credits and cost sharing subsidies to offset their premium costs. Additionally, childless adults under 100% FPL are newly eligible for Medicaid beginning April 1, 2014.

The biennial budget included language to end HIRSP on December 31, 2013; however, with the failed launch of HealthCare.gov, Governor Walker signed a bill extending the program through March 31, 2014 to give HIRSP enrollees additional time to purchase a plan during open enrollment.

However, throughout this timeframe, HIRSP continued to engage in informing their members about upcoming changes. HIRSP included numerous articles about changes in their newsletter, website, and Facebook page. HIRSP engaged a marketing firm to assist with communications and ensure the messaging was clear and concise. The administrator engaged members through their call center and on billing notices.

From an administrative perspective, the HIRSP Authority, the quasi-governmental entity that managed HIRSP, closed its offices at the end of February 2014. OCI assumed responsibility for the dissolution of HIRSP on March 1, 2014. OCI has staff equipped to handle any consumer issues that arise during the wind down of this program.

Navigator and other Assister Regulation

The 2013-2015 budget included a state licensure requirement for navigators and a registration requirement for certified application counselors (CACs) and other assisters. Among other things, state law requires individuals serving in these capacities to do the following before licensure or registration can occur:

- Complete 16 hours of pre-licensing training,
- Receive a passing score on a state examination,
- Submit fingerprints,
- Complete a criminal background check,
- Maintain a $100,000 bond or other evidence of financial responsibility (navigator entities), and
- Complete 8 hours of continuing education training annually.

OCI developed FAQs to assist interested organizations and individuals in understanding both state and federal requirements related to navigators, CACs and requirements for licensed health insurance agents wishing to serve as either a navigator or CAC. (See Appendix 6) These are posted to the OCI website at:
http://oci.wi.gov/navigator/navigator-faq.pdf
http://oci.wi.gov/navigator/cac-faq.pdf
http://oci.wi.gov/navigator/cacentity-faq.pdf
http://oci.wi.gov/navigator/navigator-agentfaq.pdf

BADGERCARE PLUS DEMONSTRATION WAIVER

Waiver Overview

Before DHS could implement the Medicaid reforms included in the biennial budget, the Department needed to obtain federal approval to make these changes to BadgerCare Plus. To accomplish these Medicaid reforms, DHS needed to modify the existing Medicaid State Plan for parents, caretaker relatives, children and pregnant women and request a new waiver for childless adults and those who receive Transitional Medical Assistance. (See Appendix 12 and 13) Wisconsin's BadgerCare Plus Core Plan for Adults Without Dependent Children Demonstration Project Waiver was slated to expire on December 31, 2013 at the same time the majority of the Affordable Care Act changes were going to be implemented by the federal government. Wisconsin created a new waiver, the BadgerCare Reform Waiver, that would allow Wisconsin to implement the BadgerCare Plus reforms when the new coverage available through the ACA began. (See Appendix 13) The Waiver, as originally proposed, implemented the following changes to BadgerCare Plus:

- All BadgerCare Plus members would receive health care coverage through the BadgerCare Plus Standard Plan,
- The BadgerCare Plus Core Plan annual enrollment fee and monthly premiums would be eliminated,
- The current enrollment cap for childless adults under 100% FPL would be removed, and
- Parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA) would now have to pay a monthly premium.

DHS did extensive outreach on the proposed waiver to stakeholders including media, Income Maintenance consortia/counties, tribes, advocates, members and the Wisconsin Legislature in order to keep them informed of the progress of the Waiver request. (See Appendix 13,14,15,16)

DHS held three town hall meetings in Green Bay, Eau Claire and Milwaukee to discuss the changes and to solicit feedback. (See Appendix 15) The Department also held a consultation with Wisconsin tribes to discuss the changes and solicit feedback.

TABLE 2 – BadgerCare Plus Waiver Town Hall Meetings

Eau Claire	
Wednesday July 10, 2013 11:00 a.m. to 1:00 p.m.	Chippewa Valley Technical College Health Education Center 615 W. Clairemont Avenue Eau Claire, WI
Wausau – Tribal Consultation	
Wednesday, July 10, 2013 9:00 a.m. to 1:00 p.m.	Best Western - Midway 2901 Hummingbird Road Wausau, WI
Milwaukee	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Radisson Milwaukee West 2303 North Mayfair Road Milwaukee, WI
Green Bay	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Green Bay Kroc Center Walnut and Oak Rooms 1315 Lime Kiln Road Green Bay, WI

Individuals who were unable to attend the public information sessions were able to provide comments directly to DHS by mail, fax, e-mail, or online. At the town hall meetings, the Department presented an overview of the waiver and then opened it up for comments from the public. (See Appendix 13)

Each comment that was submitted to the Department was reviewed. Many of the comments that the Department received were in regard to definitions and clarifications of certain terms used in the waiver application, questions on the benefits to be received under the new waiver proposal, questions on differences between the new waiver and existing waivers, and the identification and communication process for those who may need to transition off of BadgerCare Plus to the federal health insurance federal exchange. Several comments relating to outreach and enrollment strategies were extremely informative and helpful in the development of Wisconsin's grassroots Regional Enrollment Network (REN) outreach strategy, which is discussed in greater detail in later sections of this report.

The Department also received several comments that were outside the scope of the waiver proposal. Many commenters expressed disagreement with the decision to forego the full Medicaid expansion, asked questions about what the federal exchange will do for them, and inquired about changes to Medicaid that were unrelated to the waiver proposal.

As part of the final waiver application, the Department made the following changes and clarifications in consideration of those comments received from the public:

- Added presumptive eligibility for childless adults, which is a temporary eligibility for health care benefits if an individual meets certain financial and non-financial rules. Presumptive eligibility is granted for no more than two calendar months and the individual needs to complete a full application during that time period to remain eligible for benefits. Presumptive eligibility is required for parents and caretakers under the Affordable Care Act. Presumptive eligibility for parents, caretaker relatives and childless adults will only be able to be completed by qualified hospitals;
- Clarified that the length of the Transitional Medical Assistance (TMA) extension will be based upon applicable federal law, rather than stating that it will be 12 months in length;
- Clarified that only children, pregnant women and adult parents and caretaker relatives, not childless adults, may qualify for TMA. Currently these are the only populations who are eligible for TMA and this will remain the same moving forward;
- Clarified language related to the 5% disregard to align it with statutory language included in 2013 Wisconsin Act 20, Section 1097;
- Removed headings related to cost-effectiveness within the Budget Neutrality Section;
- Included additional information on the hypotheses and proposed evaluation of the demonstration; and
- Clarified language around the applicable income levels for eligibility to use the phrases "does not exceed 100% FPL" and "exceeds 100% FPL."

All of the comments related to the waiver proposal were compiled and communicated to the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) as part of the final waiver request on August 9, 2013. (See Appendix 13) When submitted, the BadgerCare Plus Demonstration Project Waiver was slated to become effective on January 1, 2014.

Waiver Negotiations with CMS

After the waiver was submitted, it began progressing through the federal approval process. After being reviewed for completeness, certified as complete and posted online for public comment and review, the federal government then reviewed the waiver and asked for clarifications and adjustments. Thus, the Waiver negotiations began.

A continual sticking point of the waiver negotiation process was Wisconsin's proposed plan for uniformly charging premiums to all adults enrolled in BadgerCare Plus through an extension (TMA), along the lines of premiums for extensions that was approved in the previous waiver. (See Appendix X)

In the previous waiver, Wisconsin, with the federal government's approval, received approval to apply certain provisions (monthly premiums) of the ACA to the BadgerCare Plus population beginning July 1, 2012. Wisconsin modeled the premiums after what would be required of individuals to pay through the federal exchange – a figure that is defined by federal law.

Wisconsin requested through the BadgerCare Reform Waiver to continue the premiums for the individuals in an extension that were put in place July 1, 2012 and to begin requiring monthly premiums for parents and caretaker relatives with incomes between 100% and 133% FPL who were on an extension. Again, the sliding scale premiums that Wisconsin would charge align with the federal exchange premiums parents and caretakers with the same income level are paying to get coverage through the federal exchange. (See Appendix 14)

It is the Department's belief that it only makes sense, when looking at this issue in terms of equity, that individuals with incomes above 100% FPL who are getting BadgerCare Plus coverage because of an extension pay the same monthly premium as a proportion of monthly income as an individual with the same income who is not on an extension and purchases health insurance through the private market. (See Appendix 15)

CMS was not supportive of this provision and continually requested that the extension premiums not begin until the individual's income was at or above 133% FPL. Eventually, after months of negotiation, CMS and Wisconsin came to an agreement that parents and caretaker relatives with incomes between 100% and 133% FPL who were on an extension would pay monthly premiums; however, they would not begin until after the sixth month of coverage through the extension. (See Appendix 15)

OPERATIONALIZING BADGERCARE PLUS CHANGES AND THE AFFORDABLE CARE ACT

In late summer 2013, work around the state began to intensify to operationalize the Affordable Care Act and BadgerCare Plus changes included in the biennial budget. In order to successfully implement the ACA and reform of Wisconsin's Medicaid program to minimize impact and disruption to Wisconsin consumers, a system or mechanism was created to help people learn about their health care options and take action.

Regional Enrollment Networks

DHS has a variety of outreach strategies for ACA changes and Medicaid reform; however one of Wisconsin's most significant strategies to assist Wisconsin residents with enrolling in the appropriate public or private health insurance coverage is through the creation of 11 Regional Enrollment Networks (RENs). The RENs are comprised of various community partners, insurance agents and brokers, health care providers, income maintenance consortia, tribal representatives and other key local stakeholders.

The Department has a strong community partner network throughout the state. These partners have worked with the Department on various program launches as well as serving as a point of contact for existing BadgerCare Plus members and the uninsured. We realized that the Department could not take on this undertaking of helping Wisconsin residents understand their health care options alone. We also understand that people may be less likely to listen to government and more likely to learn about their options and listen to trusted individuals in their community—their doctor, pharmacist, neighbor, nurse, or pastor.

DHS staff located in Milwaukee were invited to join efforts of an enrollment network that was created in the Milwaukee area, the Milwaukee Enrollment Network (MKEN). MKEN is a multi-stakeholder collaboration that was established in the summer of 2013. The MKEN is organized by the Milwaukee Health Care Partnership, Covering Kids and Families and DHS to improve consumer outreach and education, strengthen enrollment support resources, and assist Milwaukee County residents in securing adequate and affordable public or private health insurance. MKEN is a group of more than 100 public and private organizations supporting enrollment of eligible residents of Milwaukee County in public or private insurance with a focus on low-income, vulnerable populations. In anticipation of the roll out of the Facilitated federal health insurance exchange and the BadgerCare Plus eligibility changes, the MKEN put together a community-wide plan to help individuals understand, buy and keep health care coverage. The structure was established to have a steering committee, sub-committees focused on various area, and co-host large scale meetings to facilitate community wide approaches. All participants are there on a collaborative basis by incorporating these tasks into their existing roles as there was not notable funding to support facilitation of such mobilization.

Goals of MKEN:

- Support consumer and mobilizer outreach and education.
- Build the capacity and capability of the enrollment assister workforce and infrastructure.
- Support insurance take-up and retention, including alternative, consumer friendly payment options.
- Measure and monitor coverage and enrollment processes and outcomes.

DHS quickly realized the benefits of this type of collaboration and that the MKEN was exactly the type of effort that could be leveraged in other parts of the state. On July 16, 2013, the DHS and OCI presented a proposed model for the RENs at the UW-Population Health Institute's Wisconsin Health Insurance Outreach & Enrollment Summit. The RENs were modeled after the MKEN. (See Appendix 4)

This coordinated public relations and outreach campaign allows for consistent information to be shared in all regions of the state, as well as allow each REN to tailor the message to meet the needs of its residents and decide how to best reach individuals to assist them with enrolling in the appropriate public or private health care coverage. The RENs have been tasked with assisting transitioning BadgerCare Plus members and uninsured Wisconsin residents to enroll in the appropriate health care coverage.

The Department began work with Covering Kids & Families Wisconsin and the Wisconsin Primary Health Care Association to establish 11 Regional Enrollment Networks spanning the state. The RENs are geographically defined using the same regions as the Income Maintenance Consortia. This was advantageous because we believed that the local agencies in the Income Maintenance Consortia would be one of the main points of contact for individuals who had questions about the Affordable Care Act and Medicaid reforms. The Income Maintenance agencies would then have the ability to refer individuals to the in-person assisters in the RENs for help with securing private coverage and the RENs could refer individuals to the Income Maintenance agencies for assistance with Medicaid or other public assistance benefits.

The Department also pulled together and currently facilitates Regional Enrollment Network Strategic Planning Committee, (See Appendix 17) that meets bi-weekly and includes individuals representing the following organizations:

- Department of Health Services
- Office of the Commissioner of Insurance
- Wisconsin Primary Health Care Association
- Covering Kids & Families – Wisconsin
- Milwaukee Health Care Partnership
- Wisconsin Hospital Association
- Forest County Potawatomi Community Insurance
- Alliance of Health Insurers, U.A.
- University of Wisconsin Population Health Institute
- Wisconsin Association of Health Plans

Because DHS had already established a large, statewide network of community advocates and partners, the Department utilized that list to introduce this outreach model and concept as well as to solicit interest for attending REN kick-off meetings to be held in each region.

Each REN held a kick-off meeting in late August or early September. Community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders were invited to attend the REN meeting in their area. Each meeting was hosted and facilitated by a regional host, in partnership with DHS, Covering Kids and Families, and the Wisconsin Primary Health Care Association. (See Appendix 4)

These RENs were developed at the local level and may be different from each other depending on the needs of the local region, but each REN has dedicated facilitators that lead each region's efforts of supporting partners and mobilizers.

The Wisconsin Primary Health Care Association (WPHCA) received a grant from the Corporation for National and Community Service to fund nine AmeriCorps members. Because the Department had been working with the WPHCA on the creation of RENs it was natural that these resources be used to support the RENs. DHS agreed to sponsor these AmeriCorps members and WPHCA agreed to find host sites around the state. These AmeriCorps members, along with staff from the host site and the Department, became the core team that supported each RENs efforts.

AmeriCorps members provided coordination and communication within and across RENs. Each region had a dedicated staff person to serve as the liaison between the Department and the REN. This link has proved critical in keeping local regions informed of the many rapid changes the ensued over the course of the implementation. In addition, the AmeriCorps members were responsible for maintaining the RENs presence on the Enrollment for Health (E4Health) Wisconsin website. This website is a tool for enrollment assistors and mobilizers to share information and for RENs to post events happing in their region. Additional information about Wisconsin's RENs is available on the E4Health Wisconsin website: http://e4healthwi.org/regional-enrollment-networks/

The Department's statewide outreach initiative developed materials for and provided information to various stakeholders, including tribes and legislators, regarding the implementation of certain ACA provisions. DHS

staff supported the RENs by attending Regional Enrollment Network Steering Committees, co-hosting larger REN meetings, fielding questions from REN members on an ongoing basis, supporting the regional AmeriCorps member, and participating in smaller subcommittee meetings as needed. DHS staff met with Income Maintenance supervisors and directors prior to the kick-off of the RENs to solicit their participation and explain the vision for RENs. Bi-weekly REN calls with the REN leads and AmeriCorps members have been co-hosted by DHS staff in collaboration with the Wisconsin Primary Care Association. (See Appendix X)

DHS developed a comprehensive web presence to support RENs, stakeholders, and both potential and existing members. All training materials, including archived webinars are available on the DHS website, dhs.wisconsin.gov/health-care.

This website provided a single location for information, including copies of mailings to current BadgerCare Plus members and potential members, links to other helpful sites including HealthCare.gov, and an evolving FAQ section. DHS also set up a dedicated e-mail address to field questions from anyone about the ACA or changes to BadgerCare Plus. In most cases, general responses were provided, but when the Department saw trends in the line of questioning, these questions and answers would be added to the FAQ portion of the website.

The following directories were developed by as guides for individuals looking for in-person assistance to help them navigate their health care coverage options:

Wisconsin Enrollment Directory – Enrollment for Health Wisconsin
http://e4healthwi.org/wp-content/uploads/Enrollment-Directory_11_27_2013.pdf

MKEN Directory
http://mkehcp.org/wp-content/uploads/2014/02/enrollment_Mar2014.pdf

Town Hall Meetings

Recognizing the complexity of the ACA and the need for consumers to understand how this law may impact them, OCI and DHS held 16 informational sessions across the state in the form of town hall meetings. These meetings, held prior to open enrollment, provided a forum for citizens to gather unbiased information about the ACA. Meetings were open to anyone who had an interest and were informal in nature to allow for an open dialog between attendees and OCI/DHS staff. Issues of interest centered on the new rules governing the health insurance products consumers are newly required to purchase, federal taxes consumers will face if they fail to purchase coverage, the opportunity to offset premiums through premium tax credits/cost-sharing subsidies and changes to Medicaid. In addition to members of the public, news outlets also attended the meetings, further spreading the information shared at these meetings to consumers across the state.

Table 3 – OCI/DHS Town Hall Meetings

Date	Location
September 3	Rhinelander, Wausau, Eau Claire and La Crosse
September 4	West Allis and Pewaukee
September 5	Kenosha, Green Bay and Appleton
September 6	Madison and Cleveland
September 25	City of Milwaukee (2 sessions)
September 26	Janesville
October 2	Platteville
October 3	Superior

Town hall meeting locations and dates were distributed through press releases. Legislative offices also received the releases so that they could make their constituents aware of the opportunity. (See Appendix 18)
http://oci.wi.gov/pressrel/0813townhallmtgs.htm
http://oci.wi.gov/pressrel/0913janesville_townhall.htm
http://oci.wi.gov/pressrel/0913milwaukee_townhall.htm
http://oci.wi.gov/pressrel/0913superior_platteville.htm
OCI/DHS Presentations: http://www.dhs.wisconsin.gov/health-care/ren/index.htm#ACATownHallMeetings

Tribal Outreach

OCI and DHS agency leaders met with tribal representatives from all 11 tribes, including tribal health directors, several times over the past couple of years on many issues, including health care reform. The agencies are a resource for tribal leaders as they work to understand how the ACA affects their members. OCI leadership met one-on-one with tribal leaders. There were also two state tribal consultation meetings, one in 2012 and 2013. The Governor and agency Secretaries led a tribal dinner in the summer of 2013. Additionally, OCI's Educational and Outreach Specialist attends the quarterly Great Lakes Inter-Tribal Council (GLTC) meetings and sent a formal letter on July 3, 2013, to the GLTC Executive Director offering OCI's assistance in facilitating a discussion with federal representatives regarding the ACA. (See Appendix 14)

In addition, some Wisconsin tribes also administer income maintenance functions for Wisconsin Medicaid programs. DHS regularly met with the tribes to further discuss the ACA and Medicaid reforms. This forum also provided an opportunity for DHS staff and the tribes to discuss and work through the ACI provisions and requirements specific to tribes to ensure Wisconsin was correctly operationalizing and complying with these requirements.

Presentations and Editorial Board Visits

In addition to the town hall meetings, OCI and DHS leadership delivered presentations at numerous events across the state. They educated consumers, and those working with consumers, on key ACA provisions, Medicaid reforms and new opportunities for parents with income over 100% of the FPL who can now use federal dollars to purchase health insurance in the commercial market. Leadership from both agencies also traveled the state to get the word out through eight editorial board visits.

Table 4 - Editorial Board Visits

Date	Location
September 3	Milwaukee
September 4	Appleton
September 5	Janesville and Wausau
September 6	La Crosse and Eau Claire
September 23	Madison
October 2nd	Platteville (OCI Only)

Educating congressional members on the direct impact of the ACA through one-on-one visits in October was another outreach opportunity OCI and DHS pursued, and viewed as critical to ensuring federal representatives had the information they needed to advocate for Wisconsin consumers at the federal level.

Presentations at various employer events has also helped disseminate information to Wisconsin employers about the ACA provisions that impact them, like the federal SHOP exchange and employer shared responsibility requirements that result in federal employer penalties if a certain minimum level of coverage is not offered to employees.

Leadership from both agencies continue to present on the ACA at events and serve as a resource on countless ACA related issues that have developed, both pre and post October 1, 2013. (See Appendix 19 for examples)

Training for Individuals Assisting Consumers

Navigators and Certified Application Counselors (CACs): Who they are and "permitted and prohibited activities"

A navigator can be an individual or an entity that supervises or employs an individual who performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange.

On August 15, 2013, HHS announced that six Wisconsin organizations were awarded federal navigator grants totaling approximately $1.0 million. (See Appendix 20) A list of all the grant recipients and their award amounts are posted on the OCI website at: http://oci.wi.gov/healthcare_ref/grant_recipients.pdf

Wisconsin insurance law defines non-navigator assisters as individuals who have been designated by or are working on behalf of the federal exchange. The state definition includes certified application counselors who

must become authorized by the federal exchange to provide non-navigator assistance to consumers and be registered with OCI.

Both navigators and CACs help individuals determine their eligibility for public assistance programs and help consumers sort through the health insurance plans that display on the federal exchange website, HealthCare.gov. A distinction between the two is that CACs are not federally funded; however they must work for an organization designated by the federal government as a CAC entity.

Under state and federal law, CACs and navigators are not qualified to and cannot legally sell health insurance or provide advice to consumers about which health insurance plan best meets their individual needs. Only state-licensed health insurance agents may sell and provide advice about health insurance. On July 26, 2013 OCI released a bulletin that details the permitted and prohibited activities for navigators and CACs (and other non-navigator assisters). (See Appendix 11) Here is a link to that bulletin: http://oci.wi.gov/navigator/navigator-faq.pdf

Navigators, CACs and other assisters work very closely with vulnerable populations who rely on their expertise when trying to understand public and commercial health care coverage options. Understanding the Wisconsin health insurance market and Wisconsin Medicaid rules is critical for any assister helping individuals secure health care coverage; in particular, to those enrollees who are transitioning from the Medicaid program into the commercial market. As such, OCI/DHS invested significant state resources to ensure the new state training and examination requirements did not pose a barrier to allowing navigators and CACs carry out their responsibilities during the initial open enrollment period, that began October 1, 2013. The two agencies joined efforts to coordinate free training sessions, often held in one location but broadcast to several other areas of the state for greater accessibility. Each session was two days in length. The table below details the free, state sponsored training opportunities that were made available.

Table 5 - Navigator and Certified Application Counselor Training

Date	Location
August 20 – 21	Madison
September 10 - 11	Milwaukee
September 17- 18	*Host site*: Sauk City *Broadcast to:* Fennimore, Eau Claire, Waukesha and Marshfield
September 24- 25	*Host site*: Madison (DHS) *Broadcast to*: Madison (OCI), Lac du Flambeau, Weston, Iron River
October 9 – 10	*Host site*: Racine *Broadcast to*: Menasha, Rice Lake and Green Bay
October 30-31	Medical College of Wisconsin and St. Joseph's Hospital

Information for pursuing online training through a vendor was posted to the OCI website for any individual or entity interested in that option.

As a result of the free training opportunities, 578 individuals were trained. An additional 212 individuals completed the training requirements through a private vendor, for a total of 790 trained individuals.

516 individuals who completed the training also completed the state examination. 512 out of 516 individuals taking the state examination passed. To help facilitate a targeted understanding of the concepts captured in the state examination, OCI developed an Examination Content Outline, a Navigator Study Guide and a State Public Assistance Programs document, (See Appendix 21) available at:
http://oci.wi.gov/navigator/examoutline.pdf
http://oci.wi.gov/navigator/pi-230.pdf
http://oci.wi.gov/navigator/healthcare-assistance.pdf

Additionally, OCI worked with the vendor administering the examination to ensure testing sites had additional space to accommodate the volume of people expected to sit for the examination. This was important because examination sites are not limited to one state examination; rather, they are shared spaces between individuals sitting for the various other state professional licenses, such as teachers and nurses.

OCI staff dedicated many hours to developing training/examination and additional materials attendees could use as resources during training sessions while also serving in their capacity as a navigator or CAC. (See Appendix 22)

OCI was also charged with developing administrative rules to further detail state navigator and CAC requirements included in 2013-15 biennial budget. OCI initially prepared an emergency rule to provide the detail individuals and entities needed more immediately to prepare for their upcoming roles. This emergency rule was signed by the Governor at the end of August 2013. (See Appendix 22) Since that time, OCI has incorporated input received from interested parties on the emergency rule into the proposed permanent regulation. OCI staff reviewed written comments that were submitted, revised the emergency rule, held two additional public hearings, made further adjustments in response to feedback and submitted a final draft permanent rule to the Governor in March 2014. The permanent rule could be in effect in the summer of 2014.
Here is a link to the emergency rule: http://oci.wi.gov/rules/0691em13.pdf

As referenced earlier, the 2013-15 biennial budget included annual training requirements for both CACs and Navigators. To clarify the type of training that can be applied to the CACs annual eight hour training requirement, OCI issued a guidance document. (See Appendix 37) http://oci.wi.gov/navigator/ce-guidance-memo.pdf

With such significant change to the health insurance market due to the ACA and the creation of the federal exchange, there is an increased risk of fraud and abuse in the federal exchange. As such, OCI lists all licensed navigator entities and individuals as well as all registered CAC entities and individuals on its website. These lists are a resource for consumers to verify that navigators and CACs they may come into contact with are indeed who they say they are. If a consumer worked with someone using "navigator" or "CAC" in their title but they are not listed on the OCI website, consumers are encouraged to contact OCI by calling 1-800-236-8517 or completing a complaint form online at https://ociaccess.oci.wi.gov/complaints-public/. Individuals also have the ability to verify that a health insurance agent is licensed. This functionality was in place well before the ACA.

Links to the navigator and CAC lists are below, along with the link to the agent look-up feature.
http://oci.wi.gov/navigator/naventities-registered.htm
http://oci.wi.gov/navigator/cac-registered.htm
https://ociaccess.oci.wi.gov/ProducerInfo/PrdInfo.oci

Medicaid Training for Agents/Public List

While Income Maintenance employees are newly working with individuals who qualify for the federal assistance to purchase commercial health insurance, many licensed health insurance agents are newly working with individuals just leaving public assistance or who newly qualify for public assistance. To ensure agents working with individuals transitioning between the commercial health insurance market and Medicaid have an understanding of the Medicaid program, OCI asked licensed agents intending to work with this population to complete a four hour Medicaid training course. Nearly 400 licensed health insurance agents across the state completed training. This training provided licensed health insurance agents with continuing education credit hours.

In an effort to provide a resource to county income maintenance employees and other community organizations working with individuals ineligible for Medicaid but who may be eligible for federal premium tax credits and cost-sharing subsidies through the federally facilitated exchange (FFE), OCI posted a list of licensed agents who completed the four hour Medicaid training and who agreed to help this population enroll in private health insurance coverage through the FFE. The list can be found at: https://ociaccess.oci.wi.gov/ren/. The list is user friendly as it is sortable by county.

However, the list is an exhaustive list of licensed agents available to assist individuals interested in purchasing coverage on the FFE. There are many agents not listed who have completed the necessary federal requirements to sell products on the FFE.

Educating Income Maintenance Case Workers

DHS Education Efforts

As part of operationalizing the ACA, DHS also had to make significant and changes to its eligibility determination systems to reflect the new BadgerCare Plus and federal policies. As such, DHS needed to train Income Maintenance case workers in the state and ensure they understood the new program rules.

Wisconsin's 10 consortia and MilES are responsible for conducting eligibility determinations and as well as ongoing case management for BadgerCare Plus members. The staff at the consortia and MilES not only need to fully understand BadgerCare Plus policies and procedures in order to accurately and fairly administer the program, but they also have to be able to explain how the program works to members and the general public. Their staff assist individuals and families in completing BadgerCare Plus and Medicaid applications and gather the information and materials that they need to submit a complete and accurate applications on a daily basis.

DHS worked very closely with local agencies. Much of the content on the agenda of two monthly meetings, Income Maintenance Advisory Committee (IMAC) and the IMAC PPACA Sub-Committee, with local agencies was devoted to working through operationalizing the ACA and BadgerCare Plus reforms. (See Appendix 23 and 24)

Implementation of the Affordable Care Act and Entitlement Reforms as specified in the biennial budget meant a complete overhaul of the BadgerCare Plus program rules and policies for case workers. Since the policy and program changes were so extensive, the entire 384-page BadgerCare Plus handbook was completely revised. One of the main ACA changes that impacted many different BadgerCare Plus policies and

procedures was redefining household composition and income in public health care programs to align them with the way the Internal Revenue Service calculates adjusted gross income, called Modified Adjusted Gross Income (MAGI). MAGI is how the federal government is calculating eligibility for premium subsidies as well. In general, it is an individual's adjusted gross income plus any tax-exempt Social Security, interest or foreign income an individual has.

As a result of implementing MAGI rules, Wisconsin's eligibility determination system and the BadgerCare Plus program rules and procedures were updated to include MAGI. BadgerCare Plus members and applicants are now asked some different questions than previously required about their household composition, tax status, tax dependents and tax deductions. There are two key differences between current BadgerCare Plus rules and BadgerCare Plus under MAGI rules:

- Household sizes are determined based on a combination of tax relationships and family relationships instead of just looking at family relationships.
- Certain income types are no longer be counted. The key types that are currently counted but are not counted under MAGI include child support, workers compensation, and veteran's benefits.

These extensive program and policy changes necessitated mandatory training for approximately 1,200 workers at the consortia and MilES that was completed in four different phases. The first phase was a broad overview of the policy changes that was conducted in May 2013. In August and September 2013, DHS conducted 29 in-person training sessions statewide for caseworkers at the consortia. Each session was six-and-a-half hours long. MilES conducted their training through eight sessions in September and October. The purpose of this training was to give in-depth information about the new BadgerCare Plus policies and how to determine eligibility according to the new policies. In October and November 2013, the third phase of training was completed during a three hour training presented to show how the new policies were reflected in Wisconsin's eligibility determination system, Client Assistance for Re-employment and Economic Support (CARES). Phase four of training was a self-paced practice scenario intended to keep the new policies fresh for the workers during the three month delay. This phase of training was released in January 2014. In addition to the required Income Maintenance training, all MilES employees completed the federal Certified Application Counselor training.

OCI "Insurance 101" Training for Income Maintenance Employees

As Income Maintenance agencies across the state prepared to work with individuals who may be transitioning between two markets, many income maintenance employees expressed an interest in obtaining a baseline understanding of the commercial health insurance market. Most did not have much knowledge about how the commercial market operates and knew that under the ACA they would likely have some interface with that market. In response to this demand for training, OCI developed an "Insurance 101" webinar for income maintenance employees. The webinar can be found at:
http://dhsmedia.wi.gov/main/Play/bf07076993cc4ee2a1298fa60636e52c1d

Lines of Communication between Wisconsin and the Federal Government

Beginning in January 2013, key DHS staff have been meeting with the CMS State Operations and Technical Assistance (SOTA) team. (See Appendix 25) These calls were monthly until October 2013 and then were held every other week. The SOTA teams were created by CMS to serve as a dedicated group of CMS staff with a variety of background expertise (systems, policy, operations, etc.) to be the established point of contact for each state to coordinate that's state's implementation of the ACA.

The SOTA meetings were also DHS' main conduit and forum for asking questions related to the ACA law; clarifying how Wisconsin should operationalize the requirements and policies, asking questions received from partners and stakeholders on what the online application tool looks like, how an application will be completed, what information members will receive in the notices, how to interpret the notices that members receive, how the special enrollment period will work, etc.

It was during SOTA calls that DHS had the opportunity to work through the implementation of the ACA requirements and optional provisions that states could implement as well as negotiate Wisconsin's BadgerCare Reform Waiver and State Plan Amendments. After the 2013-2015 biennial budget passed, Wisconsin had to obtain federal approval for many of the Medicaid changes included in the budget. It was through the SOTA workgroup that Wisconsin staff and federal staff were able to work together to negotiate and formalize an agreement, and ultimately receive federal approval for the changes in the biennial budget.

In addition, to the SOTA calls DHS has a weekly conference call with CMS to further discuss Wisconsin Medicaid State Plan Amendments.

Additional DHS Preparation and Communication Efforts Leading up to the Federal Exchange Launch: October 1, 2013

Transition Plan

The DHS worked extensively with CMS to develop and finalize a comprehensive plan to identify and ensure a smooth transition for the BadgerCare Plus members that no longer met the program rules because they would have access to affordable health insurance through the federal health insurance exchange in 2014. The Department's transition plan included a comprehensive outreach strategy for working with the RENS, health care providers, and directly to members to help ensure that they were able to successfully purchase private health insurance through the federal exchange and did not face a gap in health insurance coverage. The Department's finalized transition plan was submitted to CMS on September 11, 2013. (See Appendix 26)

Partner Notification and Training

Through the REN infrastructure, as well as utilizing its existing community partner network, DHS communicated information about implementation of the Affordable Care Act and Entitlement Reform, provided policy clarifications, announced training dates, etc. through extensive series of email communications. (See Appendix 15) Throughout this time, DHS also conducted a series of four webcasts, one each in August 2013, September 2013, October 2013, and January 2014 and in-person trainings in October and November 2013 and January and February 2014 to ensure that the partners who would be assisting individuals had the information they needed to successfully assist someone with applying for health care coverage.

Health Care Provider Outreach

DHS also worked with BadgerCare Plus health care providers and HMOs so providers could do direct outreach to members who would be no longer eligible for BadgerCare Plus in 2014 and would need to purchase health insurance through the federal exchange. As Wisconsin had learned during the Medicare Part D launch in 2005, individuals faced with new health care options and needing to make a decision about their health insurance turn to their health care provider to help them make an educated decision. As a result, the Department made a list available to interested health care providers and HMOs of the BadgerCare Plus members that they had served in the last year who would likely need to transition to the federal exchange, empowering the providers and HMOs to work with these specific members and help them transition to purchasing health care through the federal exchange.

Health care providers and HMOs also received a series of provider updates regarding changes to BadgerCare Plus because of the ACA and entitlement reform. In addition, select partner updates were also shared with providers as an alert message on the secure provider portal.

Letters to BadgerCare Plus Members and Individuals on the Core Plan Waitlist

The Department took a multi-faceted approach to notifying current BadgerCare Plus members who needed to transition to the federal exchange to purchase private health insurance as well as to reach out to individuals who may be newly eligible for BadgerCare Plus. (See Appendix 27) In late September 2013 through January 2014, the DHS sent out a number of targeted informational letters notifying current members and individuals on the BadgerCare Plus Core Plan Waitlist about the BadgerCare Plus changes.

The first letter – the one sent to the households likely transitioning from BadgerCare Plus to the federal exchange was mailed to a total of 56,246 households representing 77,472 individual members. The letter sent to the individuals on the Core Plan Waitlist was mailed to 163,808 individuals.

The purpose for sending these informational letters was to allow current BadgerCare Plus members to report a change impacting their eligibility and possibly keep them on the program, as well as to allow members whose incomes are above 100% FPL as much time as possible to research their health care options and apply for coverage through the federal exchange. Individuals who received letters that indicated their income may place them above the limits for BadgerCare Plus were encouraged to visit HealthCare.gov or call 1-800-318-2596 after October 1, 2013. If people had questions about these letters, they were encouraged to contact the Income Maintenance agency at the top of the letter and those workers could help them directly, refer them to a community based enrollment resource, or refer them to an insurance agent or broker if they needed help deciding on a health care plan through the federal exchange.

DHS has sent more than 400,000 letters to those on Medicaid or newly eligible for Medicaid.

Outbound Calls

After the informational letters were mailed in late September and early October, the Department initiated proactive phone calls to all households receiving one of the informational notices mentioned previously to ensure the letter was received, the individual understood the letter, and the individual is taking action by either making sure their information is up to date with their income maintenance agency in order to ensure they remained eligible for BadgerCare Plus; or depending on their household income, applying for coverage through the federal exchange or BadgerCare Plus. The Department continues to make these proactive calls to the individuals who received letters from the Department. At of the time of this writing, more than 350,000 calls have been made in an effort to reach individuals who have received letters from DHS.

While the federal government had said in the lead-up to launch of the federal health insurance exchange that there is no wrong door for an individual or family to complete an application, Wisconsin wanted to help people find the best door and give them the information to make the best decision about their health care needs, especially in light of technological challenges with HealthCare.gov.

THE LAUNCH OF HEALTHCARE.GOV: OCTOBER 1, 2013

Problems with the Launch

Despite the extensive preparation that DHS and OCI took to prepare internally as well as externally with Medicaid members, partners, agents, insurers, brokers, consumers and the general public; the best laid plans could not account for the massive systems malfunction of the federal exchange and the ineffective coordination between the federal entities implementing this inordinately large project. Wisconsin's preparation was based on repeated federal assurances—both public and private—that the federal exchange would be fully operational on October 1, 2013.

On October 1, 2013, the federal exchange website, HealthCare.gov, was scheduled to accept enrollments into both public assistance programs and private health insurance plans. However, the website's scheduled launch was plagued by significant technical problems that prevented consumers from having the option to enroll online. Problems persisted for nearly two months, leaving consumers, assisters, agents and insurers frustrated and looking for answers. Federal guidance during this time was inconsistent and often confusing. Consumers were encouraged to submit paper applications to avoid the website problems and then told that if they had filed paper applications, they should instead go ahead and try to enroll online by creating a new account (and abandoning any progress made in a previously created account).

The issues with the federal exchange directly affected tens of thousands of Wisconsin residents. DHS, OCI, Governor's Office, as well as our local counties and partners were contacted directly by many concerned and frustrated individuals who wanted to learn about and purchase the health insurance that was marketed by the federal exchange.

In addition to consumers contacting DHS about needing to reapply several times due to lost applications and others being unable to access the application tool, HealthCare.gov, DHS received many complaints and concerns related to the integrity of the federal exchange.

Concerns included:

- Social Security numbers that an individual enters being linked by the tool to the wrong family member;
- Income not being counted, resulting in a Medicaid determination being made;
- Individuals being found eligible for both Medicaid and tax credits;
- Individuals being found ineligible for both Medicaid and tax credits;
- Individuals being found incorrectly eligible for Medicaid but unable to purchase private health insurance because their application could not be moved;
- Families who were eligible for private health insurance (parents) and children eligible for BadgerCare Plus (children) being only found eligible for private health insurance and paying for private health insurance for children who should be covered by Medicaid;
- Individuals whose only recourse to an incorrect determination because of a malfunction of the logic, programming and systems of the federal exchange was to submit an appeal that had a 90 day window to be resolved; and

- Partners who had begun the process to become a certified application counselor before the launch of the federal exchange who waited weeks for the federal government to deem them certified and allow them to begin assisting the public.

In addition, there were other problems with the Wisconsin information that the federal government was putting in notices sent to Wisconsin residents. All of the notices from the federal exchange were directing all Wisconsin residents to contact **one** of 11 income maintenance entities in Wisconsin, instead of providing information that would serve all Wisconsin residents. After identifying this issue in early November, an entire month went by with no action taken by the federal Government to address this issue. Wisconsin clearly communicated the issue with CMS using the Bay Lakes Consortium phone number in an email on November 5, 2013.

After CMS responded that they would work to the make the necessary changes, the Department found out that on December 2, 2013 the Bay Lakes Consortium was still getting calls from notices being generated on December 1, 2013 to call the Consortium's phone number. Due to systems and staffing limitations on their end, CMS was not able to accommodate Wisconsin's request to modify language from their one-size-fits-all solution to something that would best serve our citizens.

As CMS has still not been able to update the notice language because of higher priority systems changes they need to make, DHS has worked with the consortia to accommodate the limitations to the notice text and to ensure that consumers are able to talk to the correct consortium.

As a result of the many inquiries from individuals having a problem submitting an application online at HealthCare.gov or not wanting to wait on hold for a long amount of time to do an application over the phone, in November DHS mailed out an additional letter to the 77,472 BadgerCare Plus members anticipated to transition to the federal exchange. This letter contained a reminder that the individual will likely be no longer eligible for BadgerCare Plus under the new program rules and as a result needs to apply for and purchase private health insurance through the federal exchange. The letter also contained the paper federal health insurance exchange application and instructions. (See Appendix 27)

Prior to October 1, 2013 media outlets were publishing articles citing a lack of coordinated testing of the federal exchange. After the problematic launch of the online application tool on October 1, 2013 and as this implementation continued to unfold, more press articles were written about the technical issues with the federal exchange as well as the systemic issues with the implementation. (See Appendix 28)

Wisconsin's Work to Help Improve Access

Despite Wisconsin being a federally facilitated exchange state, Wisconsin needed to problem solve and help find "out of the box" solutions to improving access during the failed launch of HealthCare.gov. For example, Governor Walker sent a letter to HHS asking that consumers have access to federal subsidies for coverage purchased in the market outside of the federal exchange. This would have allowed individuals who did not want to risk being uninsured on January 1, 2014 due to HealthCare.gov delays, to benefit from the federal government's promise that individuals with income between 100 and 400 percent of the federal poverty level could access federal tax credits and cost sharing subsidies to offset premium costs. The federal Department of Treasury (DOT) and HHS sent a joint response indicating that tax credits are available only to taxpayers who enroll in coverage through the federal exchange. OCI sent a similar letter and received a similar response. (See Appendix 29) A week later, on February 27, HHS released guidance allowing for an "exceptional circumstance" for individuals who were unable to enroll in a Qualified Health Plan (QHP) through the federal exchange due to technical issues. The "exceptional circumstance" allows these individuals to access the federal premium tax credits and cost sharing subsidies for coverage purchased outside of the

federal exchange on a retroactive basis after the federal exchange determines they are eligible for assistance and have enrolled in a QHP through the federal exchange. On March 26, 2014, Insurance Commissioner Nickel sent a letter to the federal DOT and HHS pointing out the conflicting information contained in the agencies' initial response and requesting that the federal government provide the same flexibility and increased options to all Wisconsin consumers, regardless of whether they have yet attempted to purchase plans on the federal exchange. (See Appendix 37)

The OCI letter addressing the premium tax credits also asked that HHS include Wisconsin insurers in its pilot project to operationalize direct enrollment. Direct enrollment allows consumers to enroll in a qualified health plan offered on the federal exchange directly through the insurer. Wisconsin was not given an opportunity to participate in the pilot. (See Appendix 37)

Healthcare.gov Display Errors/"Back-End" Issues and OCI Efforts to Help Consumers

By early December 2013, some of the more significant technical issues relating to account creation, the ability to compare plans and ability to move forward in the enrollment process were improved. However, beginning in early 2014, serious display errors and "back-end" issues began to surface. "Back-end" refers to the transfer of enrollment information between insurers and the federal exchange using 834 enrollment forms, which are the federally required forms used to track enrollment between the federal exchange and insurers.

Wisconsin insurers reported to OCI that plan information was displayed incorrectly on HealthCare.gov resulting in consumers purchasing plans with features that did not match the information posted to the federal website. For example, one insurer's plan was described as having no deductible when in fact a deductible was tied to the plan. HHS was slow and overwhelmed with all the technical issues with the HealthCare.gov website. Consumers were confused and received limited assistance with their questions. OCI, as the primary regulator, refused to allow such a delay in responding to this issue and directed the affected insurer to make consumers aware of the HealthCare.gov error and provide them with an option to keep their plan, purchase a different plan from the insurer or purchase a plan from another insurer. OCI did not want "back-end" issues to stymie action necessary to make sure consumers were aware of the HealthCare.gov errors and their opportunity to change plans.

Similar display issues related to incorrect cost-sharing information and consumers having access to plans that should not have displayed as available in their service area continued through February and March 2014. OCI took a proactive role in all cases where problems were identified and proactively surveyed insurers to find out how widespread some of these issues were. If not for OCI's action on this, many more consumers may have been negatively impacted. Asserting its state regulatory authority over health insurers doing business in Wisconsin enabled insurers to quickly respond to consumers and help them find a plan that best suits their needs.

In addition to HealthCare.gov display issues, there are problems with the 834 enrollment forms that are sent between the federal exchange and the insurers. In some cases there are inaccuracies and in others there is no CCIIO accountability as to what happened to enrollment forms once received from the insurers and enrollment forms that were never sent to insurers. If an insurer does not receive the 834 enrollment form, it does not know to enroll the consumer. The consumer, on the other hand, thinks they have coverage and waits for their identification cards and to be charged for their first month's premium.

Some insurers are also seeing enrollment forms come back with inaccurate effective dates. At OCI's direction, the Wisconsin insurer that brought this issue to our attention is honoring the correct effective dates and working out the inaccuracies with CCIIO on the back-end.

OCI continues to use its primary regulatory authority to protect consumers. It is our job to ensure timely correspondence and options for consumers when HealthCare.gov misleads consumers into purchasing a product that either does not exist or is not available to them based on their location. OCI's proactive role in addressing these issues spares consumers from further confusion and delay. Because insurers are comfortable working with their local regulator and find it difficult to get timely responses from HHS on federal exchange issues, OCI is able to gather information on the problems at hand and quickly give insurers direction on consumer outreach and options. OCI is also communicating these problems on behalf of consumers and insurers to HHS in an effort to get technical problems resolved.

OCI issued two consumer alerts to make people aware of the display issues and offered suggested steps they should take to ensure they are enrolled in the plan they think they are. (See Appendix 7)

Links to OCI Consumer Alerts:
http://oci.wi.gov/pressrel/0114exchange.htm
http://oci.wi.gov/pressrel/0314healthins.htm

OCI posted a FAQ document specific to enrollment issues to its website. OCI sent the document to all state legislative offices and Wisconsin Congressional members to assist them in responding to constituent concerns and questions. (See Appendix 6)
http://oci.wi.gov/healthcare_ref/healthcarereform_enrollmentfaq.pdf

A third consumer alert was released reminding consumers that the open enrollment period ends March 31, 2014 and depending on individual circumstances, a consumer who does not enroll in coverage by March 31, 2014 may not have another opportunity to enroll until the next open enrollment period starting November 15, 2014. (See Appendix 7)
http://oci.wi.gov/pressrel/0314openenroll.htm

State Based Exchanges did not Successfully Launch

Similar to the decision made to reform Medicaid, Governor Walker sought to protect both consumers and taxpayers with the decision to allow the federal government to operate the exchange in Wisconsin. States similar to Wisconsin—like Minnesota, Ohio, and Indiana—estimated the operational costs of the exchange to cost consumers and taxpayers from $35-60 million annually.

Despite stories that those states operating their own exchange fared better than the federal exchange, this turned out not to be the case. States that developed their own exchanges, such as Oregon, Minnesota, Maryland and Vermont, also experienced a problematic rollout and continue to experience technology challenges that are limiting enrollment.

Oregon received $300 million in federal grants to establish its exchange and was viewed as a leader in its development of a state based exchange. Despite the resources dedicated to their effort, Cover Oregon failed to launch and, according to a March 20 Washington Post article, "How Oregon wound up with the nation's worst Obamacare website," Oregon still has not launched an online enrollment portal. The article also points out that, "Oregon is still weighing whether to rescue its exchange technology, use technology from

another state or even join the federal exchange before the enrollment period starting in November." (See Appendix 2) A March 20 New York Times article, "Health Care Exchange in Oregon Not Meeting High Hopes," also highlights the state's enrollment problems and states, "With a March 31 deadline for first year enrollment looming, the online exchange, Cover Oregon, is still unable to process an applicant from start to finish without help or paperwork." (See Appendix 30)

In January 2014, Oregon, similar to the request made by Governor Walker, asked for HHS approval to give federal premium tax credits to consumers unable to purchase coverage through Cover Oregon due to the technical problems the state based exchange experienced.

Wisconsin Concern for Transitioning Members Results in Entitlement Reform Delay: November 14, 2013

Wisconsin elected officials as well as other partners and stakeholders continued to contact Governor Walker, DHS and OCI expressing their concerns about the systemic problems with the federal exchange. (See Appendix 38) Due to the many problems individuals and families were having with submitting an application and enrolling in private health insurance, many individuals began expressing concern regarding whether the transitioning BadgerCare Plus members would be able to secure private health insurance coverage before December 31, 2013. These concerns were shared by Governor Walker as well as the DHS and OCI.

As was mentioned in previous sections of this report, the DHS and OCI initiated a comprehensive communication plan including hosting town hall meetings, meeting with editorial boards, and providing training for in-person assisters and insurance agents. DHS also communicated with thousands of Wisconsin residents who will have access to Medicaid for the first time and those who have the opportunity to purchase private health insurance through the federal exchange.

Due to significant technical issues that made it difficult for Wisconsin individuals to access HealthCare.gov, Wisconsin faced a challenging situation by November 2013. Because the Wisconsin Medicaid reforms included in the biennial budget were scheduled to take effect on January 1, 2014, many of the individuals who were transitioning from Medicaid into the insurance products offered through HealthCare.gov would have had less than one month to apply, select and pay for an insurance plan. Rather than allow these 77,000 individuals to fall through the cracks and experience a gap in coverage, on November 14, 2013, Governor Walker announced a three-month delay in the implementation of the Wisconsin Medicaid reforms and a three-month extension of the Health Insurance Risk-Sharing Plan (HIRSP) in order to provide a safety net during the transition for some of the state's most vulnerable residents.

On November 22, Governor Walker issued Executive Order #123 calling a special session of the Legislature to address the implications of the failed federal launch of the Affordable Care Act. (See Appendix 31) The special session began on December 2, 2013.

DHS then began working with staff at the federal Centers for Medicare and Medicaid Services to address the programmatic and system changes needed to meet the three month delay while waiver negotiations continued to focus on policies related to premium payments. Between November 14, 2013 and December 19, 2013, DHS met and corresponded with CMS frequently regarding the exact terms of the delay.

In addition, during these critical weeks, DHS had to plan simultaneously for at least three or four different implementation dates because we did not know the status of the final CMS negotiations.

In late December, CMS wrote to Wisconsin confirming an agreement between the two entities related to the

state's delay of entitlement reforms until April 1, 2014. (See Appendix 32) The agreement, outlined by CMS, meets the key objectives of the state, while providing both the state and federal governments with systems flexibility to ensure a smooth transition. Under the agreement, CMS agreed to the state's delay in implementing the entitlement reforms originally approved in the 2013-15 state budget and subsequently delayed under 2013 Wisconsin Act 116.

Under the agreement, all enrolled BadgerCare parents and caretakers who had incomes between 100% and 200% of the Federal Poverty Level (FPL) remain eligible for Wisconsin Medicaid until March 31, 2014. DHS continues communication and outreach efforts to provide these individuals with the most up-to-date information about HealthCare.gov. In addition, DHS continues to remind all populations that access to insurance coverage through the federal exchange's open enrollment period ends March 31, 2014 and that premiums are due March 15, 2014.

At the request of CMS, the agreement did make one modification to new parents and caretakers between 100% and 200% FPL. Under this provision, any new parent or caretaker who applied for Medicaid before February 1, 2014 will be eligible for Wisconsin Medicaid until March 31, 2014. While these individuals will be covered under Wisconsin Medicaid, the Department continues to provide information on the federal exchange since Medicaid eligibility for these individuals will end March 31, 2014. Eligibility for new parents and caretakers who applied for Medicaid coverage after February 1, 2014 were tested for eligibility under the new Modified Adjusted Gross Income (MAGI) rules and new income eligibility standards.

As a result of CMS's request, this technical modification was needed to allow Wisconsin to implement the Governor's entitlement reforms envisioned by the state budget on February 1, 2014 instead of April 1, 2014. As such, a technical bill was required to bring Wisconsin statutes and the agreement between Wisconsin and CMS into compliance. (See Appendix 31)

Governor Scott Walker signed Special Session Assembly Bill 1, 2013 Wisconsin Act 116, into law on December 20, 2013. (See Appendix 31)

OPERATIONALIZING THE DELAY

DHS Outreach during the Delay

During the delay process and special sessions, similar to fall 2013, DHS continued to keep the RENs, community partners, health care providers, tribes, and other stakeholders informed of the changes through a series of notification emails, meetings, webcasts and in-person trainings. (See Appendix 15)

In addition, the Department continued the outbound calls to the transitioning members and individuals on the BadgerCare Plus Core Plan waitlist that had begun in October 2013. Scripting for these calls was frequently updated to reflect the adjusted dates, and policy changes with the waiver agreement; however the key message and directive to members did not change. These proactive phone calls were made to ensure the members or individuals on the waitlist received the letters and notices from DHS, that the individual understood the letter, and that the individual was taking action by either making sure their information is up to date with their local agency in order to ensure they remained eligible for BadgerCare Plus; or depending on their household income, applying for coverage through the federal health insurance exchange or BadgerCare Plus. (See Appendix 27)

In early 2014, the Department took these efforts to another level when we began using these outreach calls as an opportunity to do more targeted outreach and offer more direct assistance to current BadgerCare Plus

members with moderate and high-risk health conditions. DHS wants to ensure these transitioning members (i.e. those with chronic illnesses) are successful in securing ongoing coverage. We accomplished this by having care coordinators call these identified members to provide additional assistance such as which of their current providers are offered in the qualified health plans, or which qualified health plans treat their chronic illness well, etc. In addition, the care coordinators also assisted with connecting the members to a navigator, agent, broker, certified application counselor, or in-person assister to assist with completing a federal exchange application and purchasing private health insurance.

Communication to HIRSP Members

HIRSP members were among the most vulnerable population when the federal website's problems persisted and HIRSP took a number of important steps. They worked to communicate with their members through e-mail, website, mailings, Facebook page, and billing notices. The administrative call center staff were trained to assist HIRSP members. For most HIRSP members, the exchange plans offered lower premium payments—if the member was eligible for subsidy. However, the federal website problems added to the confusion, especially for those currently receiving medical care.

Updating Wisconsin's BadgerCare Plus Application and Program Policies

Coming to an agreement with the federal government regarding Wisconsin's implementation of the Affordable Care Act, including implementing MAGI rules, and the policy changes to BadgerCare Plus as well as having the legislative approval reflecting the agreement with the federal government and codifying the delay, allowed Wisconsin to move forward with planned systems changes and operationalizing the new policies in early 2014.

The BadgerCare Reform Waiver agreement with CMS sped up the date in which Wisconsin had intended to implement the new MAGI rules. The application of the MAGI rules was included in the program changes that the Wisconsin Legislature agreed to delay to April 1, 2014 as part of the special session in December 2013. As CMS required Wisconsin to implement these changes earlier than planned and enacted into law by the Legislature, the second special session was needed in January 2014 to make the technical modification needed to implement the MAGI rules for new applicants beginning February 1, 2014. (See Appendix 39)

As such this created a situation in which beginning February 1, 2014, all new BadgerCare Plus applicants have the new MAGI rules, including the new income limit for parents and caretaker relatives applied, to their application. At the same time, from February 1, 2014 through March 31, 2014, existing parent, caretaker relative, and childless adult BadgerCare Plus members with household incomes between 100 % FPL and 200% FPL were able to remain enrolled through March 31, 2014.

Although the new BadgerCare Plus income limit (100% FPL) was applied to parents and caretakers that applied on or after February 1, 2014, newly eligible childless adults were not able to begin BadgerCare Plus coverage until April 1, 2014.

In order to comply with the February 1, 2014 requirement for MAGI implementation, updating the online application to contain the new MAGI questions was completed on February 1, 2014 so individuals could fill out and submit their applications. This was especially significant for childless adults living in poverty. Being able to complete the application was a long-awaited step in being able to apply directly for affordable health care coverage beginning April 1, 2014. Also included in the systems updates the weekend of February 1, 2014 was an update to the "Am I Eligible" screening tool to include the new BadgerCare Plus program rules. By entering a few pieces of information their household, an individual or family can get an overview of the Wisconsin public assistance programs they may be eligible for. It also lets the individual or

family know if they appear to be eligible for BadgerCare Plus or if they should apply for and purchase private health insurance through the federal exchange.

Updating Wisconsin's eligibility determination system and delaying the implementation of the Affordable Care Act and BadgerCare Plus changes by three months had significant systems implications.

Even prior to the formally approved delay of the BadgerCare Plus changes, Wisconsin was put in a challenging position in terms of system modifications. Due to CMS's timeline for releasing the final eligibility rules, Wisconsin did not have enough time to make the complex system changes to implement MAGI and thoroughly test them by October 1, 2013. It is our understanding that other states were operating under timeframes other than October 1, 2013 for implementing the MAGI rules as well, and CMS has been flexible with regard to DHS's timelines for implementation of many of the ACA related systems changes.

Wisconsin had been planning to implement the MAGI changes in mid-November. However, when the decision was made on November 14, 2013 to delay the BadgerCare Plus changes by three months, these systems changes needed to be delayed as well because the 2013 BadgerCare Plus program rules and logic programed in the eligibility determination system had to remain in place for three additional months.

Making changes to the eligibility determination system isn't as easy as flipping the switch or simply entering a new piece of code or rule. In order to delay the BadgerCare Plus policy changes by three months, DHS had to also delay all of the systems changes that were intended to be made on November 18, 2013 and reschedule them for February 1, 2014.

The delay and resulting schedule change not only impacted the systems changes that were supposed to be made in November 2013, but also impacted future systems changes that were scheduled from December 2013 through April 2014. In a matter of days and weeks, DHS and vendor staff had to reorganize and reconfigure major systems changes to meet the needs of the three month delay as well as make additional changes to policies to reflect the final agreement that CMS and DHS made to approve the BadgerCare Reform Waiver. This has included articulating thousands of detailed business requirements for systems functionality and testing and re-testing the code continuously from October 2013 through February 1, 2014. State staff worked additional hours and overtime throughout the 2013 holiday season to accommodate the additional changes necessitated by the 90 day delay as a result of the technical problems with HealthCare.gov.

Workload Adjustments at the Local Level

Delaying the ACA and BadgerCare Plus changes by three months also had very unique implications for the workload of the Income Maintenance consortia and MilES.

Delaying the ACA and BadgerCare Plus changes by three months modified the dates in which the systems would be ready for case workers to begin processing new applications (childless adults applying for BadgerCare Plus coverage beginning April 1, 2014 under the new program rules and account transfers for individuals determined and assessed eligible for BadgerCare Plus by the federal health insurance exchange).

As a result, case processing (new BadgerCare Plus applications for coverage through the new program rules and account transfers from the federal exchange) that was planned to begin in late November was rescheduled for February 2014. This meant that the consortia and MilES had to make workload and caseload adjustments to case workers, especially the ones who had recently been hired and trained to assist with implementation of the Affordable Care Act, to reflect the shift in processing dates. However, it's important to

note that the consortia and MilES were still processing new applications according to the 2013 BadgerCare Plus program rules and managing ongoing cases for the more than 1 million Wisconsin residents receiving health and nutrition benefits.

From November 2013 to February 14, 2014, the focus at the consortia, and MilES shifted to answering consumer questions and addressing consumer frustrations related to problems learning about and getting coverage at HealthCare.gov as well as the three month delay. Consortia staff also assisted the public with paper federal exchange applications.

When the changes were made to the eligibility determination system on February 1, 2014, local agencies were left with the unique challenge of processing four month backlog of account transfers from the federal Health Insurance exchange (as those applications needed to be processed with the MAGI rules) as well as process the new BadgerCare Plus applications that thousands of previously uninsured childless adults were submitting so they could have BadgerCare Plus coverage beginning April 1, 2014.

TFI Form

In coming to an agreement with CMS regarding the BadgerCare Reform Waiver, DHS agreed to do additional outreach to the transitioning members to allow them to request to have their case processed under the new MAGI rules to see if they could remain enrolled in BadgerCare Plus after April 1, 2014. In order for a member to get be processed under the new rules, they had to provide tax filer information to the Department. In late December, DHS sent the tax filing information (TFI) form to the members who will likely need to transition to purchasing private health insurance through the federal exchange. (See Appendix 27) If members filled out the TFI form and it was determined that they will remain eligible under the new program rules, their enrollment will continue after April 1, 2014, as long as they continue to meet current program rules.

If the member filled out the TFI form and they were determined to not be eligible under the new program rules or if the member did not return the TFI form, the new BadgerCare Plus income limits were applied to their case on February 15, 2014 when the eligibility conversion was run. If any of the members in the household were no longer eligible for BadgerCare Plus after March 31, 2014, then they received a notice of decision that was mailed on Feb. 17, 2014 letting them know that they needed to apply for and purchase private health insurance through the federal exchange.

Individuals who filled out and returned the TFI form and were determined to not be able to stay enrolled in BadgerCare Plus under the new MAGI rules still had their accounts transferred to the federal exchange. However, since at the time of mailing the notice of decision in mid-February the Department did not know if the federal exchange had begun processing the account transfers, the notice of decision directed the individuals to apply for and purchase private health insurance directly at the federal exchange so they would not have a gap in health care coverage.

Wisconsin is an Assessment State

The agreement with CMS that allowed for the three month delay in implementing the BadgerCare Plus changes also allowed Wisconsin to become an assessment state as of January 1, 2014. Wisconsin was a determination state for applications that were submitted to the federal exchange between October 1, 2013 and December 31, 2013; meaning that for applications submitted to the federal exchange between October 1, 2013 and December 31, 2013, the federal exchange determines BadgerCare Plus and Medicaid eligibility for applications that Wisconsin residents submit. Those applications were still processed by

Wisconsin, but Wisconsin needed to accept the eligibility determination made by the federal exchange during this timeframe. (See Appendix 33)

Wisconsin is an assessment state for applications that were submitted to the federal exchange beginning January 1, 2014. For applications submitted to the federal exchange beginning January 1, 2014, the federal exchange will transfer applications of Wisconsin residents who appear to be eligible for BadgerCare Plus and Wisconsin IM workers process the application and determine BadgerCare Plus eligibility. (See Appendix 33)

Becoming an assessment state was a very important step for Wisconsin because this meant that applications submitted through the federal health insurance exchange after January 1, 2014 were truly allowed to be treated the same way as a BadgerCare Plus application submitted directly to a local agency in Wisconsin. As was seen during the implementation of HealthCare.gov in fall 2013 and as the Department heard from members, applicants, partners, legislators and the media, there were issues with the functionality of HealthCare.gov that led to incorrect determinations being made, to application data being incorrectly submitted (i.e. someone entering that they had income but the application tool registered the individual have $0 income), etc. This led to the federal government determining individuals eligible for Medicaid in October through December 2013 that truly were not eligible. Had Wisconsin already been an assessment state, we would have been able to process the application according to our BadgerCare Plus application processing rules, including requesting any needed proof of information. However, for the period in which Wisconsin was a determination state, Wisconsin is required by the federal government to accept the determination made by HealthCare.gov and enroll the individual in BadgerCare Plus even if the determination was incorrect. (See Appendix 34)

Incorrect Determinations

CMS notified states in January 2014 that there had been issues with the data that they collected from applicants on HealthCare.gov and defects in the process by which they completed some determinations and provided guidance regarding timeframes in which states are allowed to re-process determinations made by HealthCare.gov. (See Appendix 34) Families were enrolled for at least one month depending on their application date and childless adults will be enrolled for at least April 2014. Wisconsin is allowed to re-process the applications after enrolling the member to determine if the member meets the BadgerCare Plus program rules and can continue to be enrolled in BadgerCare Plus.

Wisconsin re-ran eligibility for individuals determined eligible for BadgerCare Plus by the federal exchange the weekend of March 22, 2014. Members found to be no longer eligible for BadgerCare Plus, received a notice of decision the week of March 24, 2014 that let them know that they are no longer eligible for BadgerCare Plus as of May 1, 2014. This loss of insurance qualifies them for a special enrollment period allowing them to still enroll through the federal exchange. The member also received the standard notice of decision in the mail that includes a short message about why they are not eligible and what they should do (i.e., apply for and purchase private health insurance through the federal exchange). The notice also includes their hearing and appeal rights and the information used to make the determination. (See Appendix 274)

There are two primary reasons why individuals determined eligible for BadgerCare Plus by the federal exchange could be found to no longer be eligible for BadgerCare Plus:

- The federal exchange incorrectly applied MAGI rules. For example, the federal exchange used household sizes that were too big or income amounts that were too low, or both.

- The member already has an open case with current income information, but they did not report that income to the federal exchange.

When eligibility was re-run on March 22, 2014, CARES correctly applied MAGI rules and considered all current income information known to the case.

In addition, as the individuals who were determined eligible for BadgerCare Plus by the federal exchange incorrectly have received many different notices and letters over the past number of months after initially applying through the federal exchange, the consortia and MilES will be making proactive outbound calls to these individuals. The calls are intend to:

- Help make sure they understand why they received a notice saying they are no longer eligible for BadgerCare Plus;
- Check and see if there have been any changes (income, household size, etc.) since they first applied at the federal exchange to see if they may affect their eligibility for BadgerCare Plus;
- Let the individual know that because they were enrolled in BadgerCare Plus and lost coverage, they have a 60-day Special Enrollment Period after the BadgerCare Plus coverage ends to purchase a health plan through the federal exchange, even though the initial open enrollment period has closed;
- Encourage the member to contact the federal exchange to complete the application process or file a new application if needed; and
- Refer the member to a certified navigator, certified application counselor, insurance agent or broker, or other assister if they need additional assistance completing a federal exchange application.

Identifying and Notifying Members Who Will Be Transitioning from BadgerCare Plus to the Federal Exchange

On February 15, 2014, the new BadgerCare Plus income limits were applied to the individuals who will likely be transitioning from BadgerCare Plus to the federal exchange (the members who received Letters 1, 1A, 9). As a result, members who no longer meet BadgerCare Plus program rules were mailed a notice of decision the week of February 22, 2014 letting them know that they will need to apply for and purchase private health insurance through the federal health insurance exchange. (See Appendix 27)

Individuals who were determined to not be able to stay enrolled in BadgerCare Plus under the new MAGI rules had their accounts transferred to the federal exchange. However, since at the time of mailing the notice of decision in mid-February the Department did not know if the federal exchange had begun processing the account transfers, the notice of decision will direct the individuals to apply for and purchase private health insurance directly at the federal exchange so they would not have a gap in health care coverage.

Account Transfers – Federal Exchange to Wisconsin

CMS had originally planned for the account transfer functionality to be ready and available on October 1, 2013. However, in September 2013, CMS delayed the account transfers until November 1, 2013 and in October 2013 again delayed the account transfers until an unspecified date. (See Appendix 28)

Wisconsin had planned on being able to begin accepting account transfers beginning mid-November 2013 as part of the extensive systems implementation that included the new program rules. When the delay was announced, implementation of this functionality was also delayed until February 2014.

Wisconsin began receiving the Account Transfers from the federal government in mid-December and the eligibility determination system was updated February 1, 2014 to allow local agencies to begin processing the account transfers. As of Friday, March 21, DHS has received 71,065 account transfers. Note that this figure includes individuals and families who applied at the federal exchange between October 1, 2013 and December 31, 2013 and were determined eligible for BadgerCare Plus; individuals and families who applied on or after January 1, 2014 and were assessed by the federal exchange to likely be eligible for BadgerCare Plus; as well as individuals who were referred to Wisconsin because they may be eligible for services because they have special health care needs like needing help with daily living or having a disability.

As this was a very new process, one which DHS has never previously done with the federal government, DHS worked very closely with the local agencies to ensure the process went as smoothly as possible as well as to test and validate the data Wisconsin received through the account transfers. DHS also needed to conduct extensive testing and validation because CMS had changed their base logic at least two times for how states needed to program their systems to accept the account transfers. This process was made even more challenging due to staffing issues with the CMS vendor who worked with states because different staff were assigned during different parts of the account transfer planning and implementation. There were several instances of meetings where Wisconsin was ready and available to discuss the account transfer process, but due to confusion on the part of the vendor, needed staff were not in attendance, requiring these calls to be rescheduled.

As a result of all of these factors, the account transfers were sent to the agencies in a series of batches over the course of February and March 2014. Once the agency successfully processed an account, the applicant was notified about their enrollment status through the mail via a notice of decision or a verification checklist.

Account Transfers – Wisconsin to the Federal Exchange

Wisconsin confirmed with HealthCare.gov in January 2014 that DHS is able to successfully transfer the accounts of people who are no longer eligible for BadgerCare Plus back to the federal exchange. (See Appendix 35) As of March 21, 2014, DHS has transferred 48,630 accounts to the federal exchange. In late February 2013, CMS indicated that they had begun processing the account transfers that they have received from states according to the order in which they received the account transfers from states. As some states began sending account transfers in October 2013 and Wisconsin was not able to begin sending the account transfers until February 3, 2014. Until the Department knows that CMS is processing Wisconsin's account transfers, the Department will be directing individuals whose applications have been transferred to the federal exchange to follow up directly with the federal exchange to complete the application process or file a new application if needed. (See Appendix 27)

WISCONSIN OUTREACH: END OF OPEN ENROLLMENT

Wisconsin has been repeatedly criticized for being ranked as the state with the lowest amount of advertising funding spent per capita—funding that was allocated by the federal government for purposes of sharing information about the ACA. However, despite the lack of federal taxpayer dollars being spent on marketing the ACA in Wisconsin, our grass-root enrollment efforts to inform individuals of their health care options appear to be working. (See Appendix 28)

Wisconsin's RENs and partners statewide continued to work with Wisconsin residents in March 2014 to hold more than 200 local enrollment events statewide where CACs and in-person assisters are available to help them complete an application. (See Appendix 15) Proof of the success of such effort is demonstrated by the

fact that only 17 states have enrolled more of their citizens in an exchange (state or federal) than Wisconsin at this time. When comparing all state's uninsured populations, Wisconsin ranked 8th best.

Additional Outreach to Individuals Transitioning to the Federal Exchange

In April, the Department will send one final letter to the BadgerCare Plus members who no longer met the program rules as of April 1, 2014 because they now have access to affordable health insurance through the federal health insurance exchange. The letter will remind them that they need to take action to apply for and purchase health insurance through the federal exchange since they no longer have BadgerCare Plus coverage. These individuals will have until May 30, 2014 to apply for and purchase private health insurance through the federal exchange because losing their BadgerCare Plus coverage is a qualifying event that allows individuals to purchase health insurance through the federal exchange outside of the open enrollment through a special enrollment period (SEP).

The Department will also be conducting one final round of outbound calls to these individuals once the letter has been mailed to make sure that they received the letter, that they understood the letter, and that they are taking action to purchase private health insurance through the federal exchange.

Special Enrollment Period

The individuals who were enrolled in BadgerCare Plus and HIRSP in February and/or March 2014 and are transitioning to the federal exchange are experiencing a qualifying event that makes them subject to a special enrollment period. (See Appendix 36)

As a result, these individuals have 60 days from the date of the qualifying event to purchase health insurance through the federal exchange. While additional information about the special enrollment period through the federal exchange is available on the HealthCare.gov website, the information is only focused on a broad summary of what a special enrollment period is and has some examples of what kinds of qualifying events would make someone eligible for a special enrollment period. HealthCare.gov, however, does not have any specific information for individuals regarding how they should apply for coverage during this special enrollment period. DHS has asked CMS for additional clarifying information about SEPs, including screenshots of the process that individuals should follow to request coverage through a SEP; however, as of the time of publication, this guidance and additional information has not been received. As the Department has had to throughout the process of operationalizing the Affordable Care Act, it is directing individuals to call the federal exchange so the individual can be walked through the process by the HealthCare.gov call center.

In addition, DHS has also ben communicating with CMS in mid-March 2014 regarding Special Enrollment Periods and how this directly relates to the BadgerCare Plus members who are no longer eligible under the new policy rules as the procedural documents released by CMS in mid-February made it very difficult for both partners and health insurers to ascertain whether or not the transitioning members are eligible for a SEP. After discussing the policy with CMS, it was determined that the BadgerCare Plus members are, in fact, eligible for a SEP since BadgerCare Plus benefits met the threshold for minimal essential coverage.

Federal Adjustments to ACA

Throughout 2014 the federal government has continued to release new guidance related to ACA provisions and rules. In March 2014 a proposed rule was released to update policy based on experience with initial open enrollment. Updates may include clarifying federally-managed services available for states in the second year of operations, expanding the use of data for efficient operations of the federal exchange instead of minimum exchange functions, developing privacy standards in the exchange for the federal

exchange and non-exchange entities, implementing penalties related to false, fraudulent, or improper use of information, clarifying eligibility and appeals coordination responsibilities with state Medicaid agencies, and addressing treatment of retroactive eligibility from an appeal. This proposed rule would also establish requirements for exchanges and QHPs to implement specific quality-related provisions of the Affordable Care Act. The 279 page proposed rule is available on the CMS website at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf

In early March 2014, the federal government also announced a number of regulatory changes, including that it was going to be extending the 2015 open enrollment period for one month longer than originally intended. It will now occur from November 15, 2015 until February 15, 2015. (See Appendix 28)

Ongoing Issues

There have been a couple of ongoing issues and lingering questions that DHS has asked of CMS but has not received any additional guidance and feedback. These issues include the status of paper applications that were submitted to the federal exchange and the Department's request for outcome data that lets us know how many of the individuals who transitioned to the federal exchange actually successfully purchased private health insurance. (See Appendix 5)

The Department, as well as consumers, advocates, partners and stakeholders, has asked CMS for an update regarding what is happening with the thousands of federal health insurance exchange paper applications that have been submitted. What we know is that they are sent to one operations center in Kentucky, but CMS has never provided a clear update or status on paper application processing. It is our understanding that due to the issues with HealthCare.gov CMS began discouraging people from sending in a paper application in December because the operations center was having problems entering the applications due to technical issues. We hope that these applications are being processed and as of publication we are still waiting for CMS to provide a status update.

Our agreement with the federal government to delay implementation of the Governor's entitlement reforms by three months stated that, "CMS will continue to work with the state to establish acceptable mechanisms for tracking who do and do not successfully make the transition to coverage through the federal exchange, including the strategies discussed below." This text is taken from page 3 of a letter sent to Brett Davis on December 20, 2013 by Eliot Fishman from CMS. (See Appendix 16)

DHS first submitted our request to CMS to do a data match in October 2013 for the individuals who are transitioning from BadgerCare Plus to the federal exchange to determine if they purchased private health insurance through a QHP and began receiving benefits. DHS submitted the request through the federal State Operations Technical Assistance Group (SOTA). CMS has responded that our data match request is on their to-do list; however, due to many different priorities they do not know when they will be able to complete our request. CMS did reach out to DHS on March 14, 2014 to begin this process, but a timeframe has not yet been set for when this data will be provided.

Since October 2013, when DHS made the data match request, the data match request has been an agenda item on every one of our SOTA calls. CMS has not yet been able to provide the requested data match nor have they indicated when it will be available. (See Appendix 5)

We do not have access to information regarding individuals that have purchased health insurance through the federal exchange – only CMS does. We, as well as our state legislators, congressional delegation, local media, and Wisconsin citizens are eagerly waiting for this data.

WISCONSIN'S LANDSCAPE MOVING FORWARD

The DHS and the OCI will continue to fulfill our obligations to operationalize Medicaid under ACA rules and will protect Wisconsin consumers and taxpayers under the law.

April 1, 2014 marks a very significant day for Wisconsin. It is the first day of a new era for Wisconsin's Medicaid program, one in which all adults in poverty have access to the same benefits regardless of their household composition. More importantly it is the first day of a new Wisconsin – one in which health care entitlement programs have been redefined to serve the people they were created for – individuals and families living in poverty – and one in which these programs will be on a financially sustainable path.

Moving forward, Wisconsin taxpayers will be able to budget for Medicaid and not be susceptible to financial uncertainty of excessive dependence on federal funding. Wisconsin will not need to fearfully wait for the next shutdown or worry about receiving news from the federal government that it cannot keep its lofty promises of being able to foot all or most of the bill for paying for the health care of our state's citizens living in poverty. Wisconsin is living up to and embracing its long reputation of taking care of our own and has taken the appropriate and necessary steps to make our Medicaid program stable and sustainable so we can ensure that all of our residents have access to the comprehensive health care we all need to stay healthy, strong, and continue to move Wisconsin forward.

OCI will monitor and protect our competitive adverse insurance market against adverse impacts resulting from the ACA. Looking forward, we anticipate consumers in the commercial health insurance market will choose to stay with their pre-ACA compliant plan, since that opportunity will extend until at least 2016. We also anticipate that Wisconsin will continue to have a robust market outside of the federal exchange, despite challenges faced by insurers as a result of the ACA. OCI will continue to be the primary regulator of the insurance market and be nimble enough to address problems so that Wisconsin consumers do not need to rely on the federal government for assistance.

Our agencies will continue to fulfill our responsibilities to ensure that Wisconsin residents have the information they need to access public and private health insurance options available to them.

Report Appendix

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Reports Referencing Wisconsin ACA Implementation

Report Name	Website
The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid	http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
Wisconsin's BadgerCare Program and the ACA	http://kff.org/medicaid/fact-sheet/wisconsins-badgercare-program-and-the-aca/
A Tale of Two States - Why Wisconsin Premiums are Higher than Minnesota	http://www.citizenactionwi.org/report_mn_wi
Opting Out of Medicaid Expansion: The Health and Financial Impacts	http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/
State Medicaid Choices and the Hidden Tax Surprises for Employers	http://www.jacksonhewitt.com/uploadedFiles/JacksonHewitt2014com/Content/Resource_Center/Healthcare_and_Taxes/Resources/MedicaidChoices_TaxSurprises.pdf
Cost of the Future Newly Insured under the Affordable Care Act (ACA)	http://www.soa.org/newlyinsured/

Communication with Kaiser Family Foundation re: Coverage Gap Issue Brief

Email from WI to KFF: October 18, 2013:

Good Evening,

The Wisconsin Department of Health Services has reviewed your recent issue paper: The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – that was published earlier this week. Upon reviewing the paper in its entirety, we would like to provide some clarifying information to you so that you can make a correction.

Wisconsin's current section 1115 demonstration waiver that covers childless adults expires December 31, 2013. Currently, childless adults are provided health care through the BadgerCare Plus Core Plan, a more limited health care benefit plan that also has a cap and waiting list. This waiver provides coverage to childless adults up to 200% of the federal poverty level.

Wisconsin's pending section 1115 demonstration waiver that will be effective January 1, 2014, will provide coverage to childless adults ages 19-64 up to 100% of the federal poverty level. Beginning January 1, 2014 – all individuals and families (including children and parents) enrolled in BadgerCare Plus will receive the exact same health care benefits through the BadgerCare Plus Standard Plan. Beginning January 1, 2014 – Wisconsin will no longer have different Medicaid health care benefit plans available (i.e. the BadgerCare Plus Benchmark and Core Plans) and all Wisconsin residents enrolled in Medicaid/BadgerCare Plus will receive the standard Medicaid benefit through the Standard Plan.

As a result, footnotes #4 and #5 need to be corrected for Wisconsin.

Footnote #4:

"Some of these states currently provide more limited benefits than Medicaid to childless adults under Section 1115 Medicaid waiver demonstration authority." This is correct for Wisconsin through December 31, 2013. However, this will not be true as of January 1, 2014.

"Wisconsin extends Medicaid to childless adults with incomes up to 100% FPL." This will be correct as of January 1, 2014. Currently and through December 31, 2013 – childless adults in WI are covered up to 200% FPL with a more limited benefit plan. In addition, this program has a cap and a waiting list. However, as indicated above, beginning January 1, 2014 – childless adults will be covered up to 100% FPL with the full Medicaid benefit not subject to any program caps or waitlists.

Since WI's programs are changing January 1, 2014 due to 1115 waiver changes, it is important to qualify each of those sentences with the point in time that they are referring to. Sentence 1 is correct when looking at the program and eligibility criteria through December 2013. Sentence two is correct according to the 2014 program and eligibility criteria.

Footnote #5:

"January 2014 eligibility limits in Idaho, Indiana, Louisiana, Maine, Missouri, Montana, Ohio, Oklahoma, Utah and Wisconsin reflect coverage under the Medicaid state plan. These states have additional coverage for parents or other adults above state plan limits through a section 1115 demonstration or a pending demonstration proposal. The demonstrations include limits on eligibility and/or benefits, do not offer coverage to all residents of the state, and/or include an enrollment cap."

Again, when referring to Wisconsin in January 2014, coverage (income limits, benefit levels, access to coverage through the Medicaid program) for parents, caretaker relatives and childless adults will be the same in both the state plan as well as the section 1115 demonstration waiver. Through these, as of January 1, 2014 all adults in Wisconsin who are living in poverty (incomes at or below 100% FPL) will have access to the Medicaid program. And as of January 1, 2014 there will no longer be any caps or waiting lists for the Medicaid program. Taking this information into account, the last sentence does not apply, as written, to Wisconsin. A correction is needed to reflect Wisconsin's health care coverage and benefits that will be in place beginning January 1, 2014.

Please feel free to call me or email me if you have any questions.

Email from KFF to Wisconsin: October 21, 2014

Thank you very much for the clarifying note. We are in the process of updating the language in the brief to more accurately reflect Wisconsin's program and will post the corrected version ASAP. We appreciate you taking the time to get in touch on this issue.

Media Articles

Article Date	Article Name	Media Outlet	Website
12/18/12	Health Care Guide: Roundup – Affordable Care Act	Milwaukee Business Journal	http://www.bizjournals.com/milwaukee/news/2012/12/18/health-care-guide-roundup-affordable.html?page=all
7/24/13	Obamacare Outreach Campaign To Cost At Least $684 Million Annually	Associated Press via the Huffington Post	http://www.huffingtonpost.com/2013/07/24/obamacare-marketing-campaign_n_3644961.html
7/25/13	Bobby Jindal and Scott Walker: Unworkable ObamaCare	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424127887324110404578626452647631608
9/4/13	State officials explain health insurance exchanges	Appleton Post Crescent	http://www.postcrescent.com/article/20130904/APC06/309040455/State-officials-explain-health-insurance-exchanges
9/29/13	Health Law Hits Late Snags as Rollout Approaches	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424052702304373104579105451166759812
9/29/13	Health Insurance Exchanges Scramble to Be Ready as Opening Day Nears	New York Times	http://www.nytimes.com/2013/09/30/us/as-opening-day-nears-insurance-exchanges-scramble-to-prepare.html?pagewanted=all&_r=0
10/4/13	Federal Insurance Marketplace Can't Yet "Talk" To State Medicaid Agencies	Kaiser Health News	http://capsules.kaiserhealthnews.org/index.php/2013/10/federal-insurance-marketplace-cant-yet-talk-to-state-medicaid-agencies/
10/6/13	Obama adviser: Demand overwhelmed HealthCare.gov	USA Today	http://www.usatoday.com/story/news/nation/2013/10/05/health-care-website-repairs/2927597/
10/4/13	Experts Suggest Software Problems, Not Just Demand May Be Behind Marketplace Glitches	Kaiser Health News	http://www.kaiserhealthnews.org/stories/2013/october/04/federal-exchange-software-problems.aspx
10/8/13	Many remain locked out of federal health-care Web site	Washington Post	http://www.washingtonpost.com/national/health-science/many-remain-locked-out-of-federal-health-care-web-site/2013/10/08/be8e71e6-302c-11e3-bbed-a8a60c601153_story.html
10/10/13	Healthcare.Gov's Flaws Found, Fixes Eyed	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424052702304500404579127783931191264
10/11/13	Federal health	Washington Post	http://www.washingtonpost.com/national

	exchange sending confusing enrollment information to insurers		/health-science/federal-health-exchange-sending-confusing-enrollment-information-to-insurers/2013/10/11/a2f3ce2e-31ec-11e3-9c68-1cf643210300_story.html
10/12/13	From the Start, Signs of Trouble at Health Portal	New York Times	http://www.nytimes.com/2013/10/13/us/politics/from-the-start-signs-of-trouble-at-health-portal.html
10/17/13	Health Website Woes Widen as Insurers Get Wrong Data	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424052702304410204579142141827109638
10/17/13	Tech experts: Health exchange site needs total overhaul	USA Today	http://www.usatoday.com/story/news/nation/2013/10/17/health-exchange-week-three-start-over/2995989/
10/19/13	ObamaCare site glitches run risk of turning off millenials	Fox News	http://www.foxnews.com/politics/2013/10/19/obamacare-site-glitches-run-risk-turning-off-millenials/
10/20/13	Contractors See Weeks of Work on Health Site	New York Times	http://www.nytimes.com/2013/10/21/us/insurance-site-seen-needing-weeks-to-fix.html
10/24/13	Feds Delay Medicaid Enrollment on Exchanges, Again	Governing	http://www.governing.com/topics/health-human-services/CMS-again-delays-Medicaid-enrollment-in-federal-health-exchange.html
10/25/13	'Glitches' hit Obamacare paper, phone applications too	Politico	http://www.politico.com/story/2013/10/obamacare-glitches-paper-phone-applications-98872.html
10/27/13	Health Site's Woes Could Dissuade Vital Enrollee: the Young and Healthy	New York Times	http://www.nytimes.com/2013/10/28/us/health-sites-woes-could-dissuade-vital-enrollee-the-young-and-healthy.html
10/28/13	Federal Health Site HealthCare.gov Stymied By Lack of Direction as Obamacare Was Formulated	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424052702304682504579158043537719338
10/30/13	Obama claims 'full responsibility' for health care website fixes as security concerns surface	Associated Press via Minneapolis StarTribune	http://www.startribune.com/229820521.html
11/2/13	HealthCare.gov: How political fear was pitted against technical needs	Washington Post	http://www.washingtonpost.com/politics/challenges-have-dogged-obamas-health-plan-since-2010/2013/11/02/453fba42-426b-11e3-a624-41d661b0bb78_story.html

11/4/13	Wisconsin Governor Scott Walker Looks for Own Way to Insure Poor	Time	http://nation.time.com/2013/11/04/in-wisconsin-scott-walker-looks-for-his-own-way-to-insure-the-poor/
11/7/13	States respond to fears of Jan. 1 health coverage lapses	Politico	http://www.politico.com/story/2013/11/obamacare-health-insurance-gaps-states-99537.html
11/12/13	Troubled HealthCare.gov unlikely to work fully by end of November, as White House vowed	Washington Post	http://www.washingtonpost.com/national/health-science/troubled-healthcaregov-unlikely-to-work-fully-by-end-of-november-as-white-house-vowed/2013/11/12/daf9670a-4bca-11e3-be6b-d3d28122e6d4_story.html
12/2/13	Health Website Problems Weren't Flagged in Time	Wall Street Journal	http://online.wsj.com/news/articles/SB10001424052702304579404579234493689797088
12/5/13	Feds' site gives states incomplete Medicaid data	Associated Press via San Diego Union-Tribune	http://www.utsandiego.com/news/2013/Dec/05/feds-site-gives-states-incomplete-medicaid-data/
3/6/14	Changes to Health Law Rules Include Extra Month to Enroll In 2015	Kaiser Health News	http://www.kaiserhealthnews.org/stories/2014/march/06/changes-to-health-law-rules-include-extra-month-to-enroll-in-2015.aspx
3/8/14	Timeline of major change to the Affordable Care Act	Washington Post	http://www.washingtonpost.com/national/health-science/timeline-of-major-change-to-the-affordable-care-act/2014/03/08/10859e88-a630-11e3-a5fa-55f0c77bf39c_story.html
3/12/14	Health Mandate Won't Be Delayed, Sebelius Says	New York Times	http://www.nytimes.com/2014/03/13/us/politics/no-plan-to-extend-health-care-enrollment-deadline-or-delay-mandate.html
3/20/14	How Oregon wound up with the nation's worst Obamacare Web site	Washington Post	http://www.washingtonpost.com/blogs/wonkblog/wp/2014/03/20/how-oregon-wound-up-with-the-nations-worst-obamacare-website/
3/20/14	Health Care Exchange in Oregon Not Meeting High Hopes	New York Times	http://www.nytimes.com/2014/03/21/us/health-care-exchange-in-oregon-not-meeting-high-hopes.html
3/22/14	A glitch in Obamacare marketplace no one noticed	Philadelphia Inquirer	http://articles.philly.com/2014-03-22/news/48443001_1_tax-credit-insurance-premium-healthcare-gov
3/24/14	Exclusive interview: Gov. Scott Walker's limited government pragmatism	Washington Examiner	http://washingtonexaminer.com/exclusive-interview-gov.-scott-walkers-limited-government-pragmatism/article/2546143

3/25/14	A brief history of Obamacare delays	Politico	http://www.politico.com/story/2014/03/obamacare-affordable-care-act-105036.html
3/25/14	Obama administration will allow more time to enroll in health care on federal marketplace	Washington Post	http://www.washingtonpost.com/national/health-science/obama-administration-will-allow-more-time-to-enroll-in-health-care-on-federal-marketplace/2014/03/25/d0458338-b449-11e3-8cb6-284052554d74_story.html

SCOTT WALKER

OFFICE OF THE GOVERNOR

GOVERNOR SCOTT WALKER ANNOUNCES ADDITIONAL ENTITLEMENT REFORM

REJECTS FEDERAL MEDICAID EXPANSION, STILL REDUCES NUMBER OF UNINSURED BY 224,580

Wednesday, February 13, 2013 - Press Release

Madison - Governor Scott Walker recently announced entitlement reforms in his upcoming budget, including requiring worker training for food stamp eligibility and increasing required work searches for unemployment insurance eligibility. Governor Walker is focused on moving people from government dependence to independence.

Today, Governor Walker announced additional entitlement reform to the state's Medicaid program. The Governor's proposal will: reduce the number of uninsured individuals in the state by nearly 50 percent with the number of uninsured adults ages 19-64 to be reduced by 224,580 and reduce the number of individuals dependent on government-run health care.

"Government can provide a hand up, but should not provide a permanent handout," added Governor Walker. "We need to break cycles of generational dependence on the government. Reforming entitlements, like Medicaid and unemployment insurance, puts an emphasis on independence and the dignity that comes with working hard to build a prosperous future of your own choosing."

Governor Walker's proposal will cover people living in poverty through Medicaid and allow individuals above that level to access affordable health insurance coverage through the federal health insurance exchange. This proposal affects non-elderly, non-disabled adults. Under this plan, Wisconsinites in poverty will be covered by Medicaid and those above poverty up to four times the poverty level would receive federal health insurance premium subsidies to purchase health insurance offered in the exchange. By doing so, Wisconsin is projected to reduce the number of uninsured adults, ages 19-64, by 47 percent with 224,580 fewer people uninsured.

"With these Medicaid reforms, we will preserve an essential safety net for our neediest, while protecting our state's taxpayers from uncertainty," said Governor Walker. "In Wisconsin, we made tough, but prudent, decisions in the last two years to get our state on the right track. We truly understand the consequences of avoiding tough choices. Our plan safeguards Wisconsin taxpayers from unnecessary risk and builds on Wisconsin's strong track record of providing affordable health care to our people."

Unlike the proposed expansion under the Affordable Care Act, Governor Walker's proposal works to make people less reliant on government and place responsibility for individual health care decisions with individuals through private solutions.

Governor Walker's proposed changes to Medicaid eligibility will take effect when the federal health insurance exchanges open. According to the federal Center for Medicaid and Medicare Services in Washington, DC, the exchanges will be operational on January 1, 2014.

Click here for Governor Walker's presentation on Entitlement Reform.

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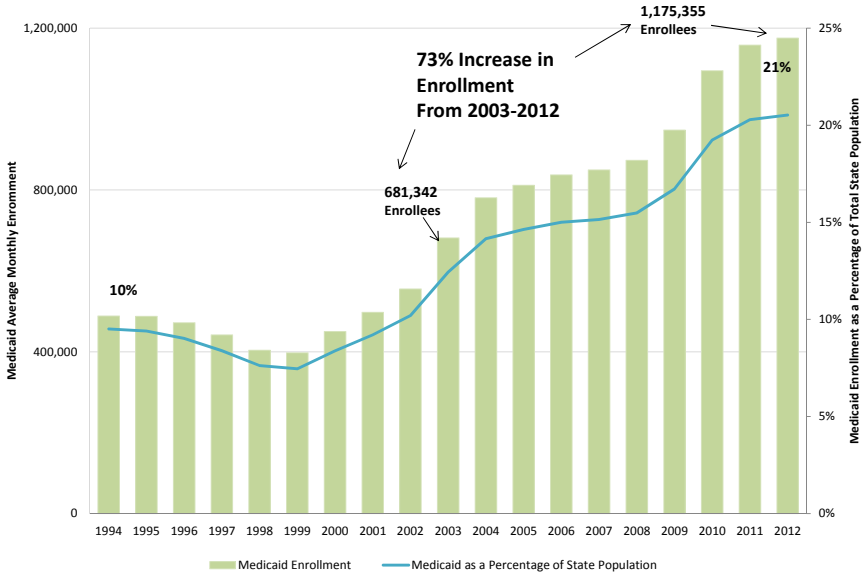
From Dependence to Independence – Entitlement Reform in Wisconsin

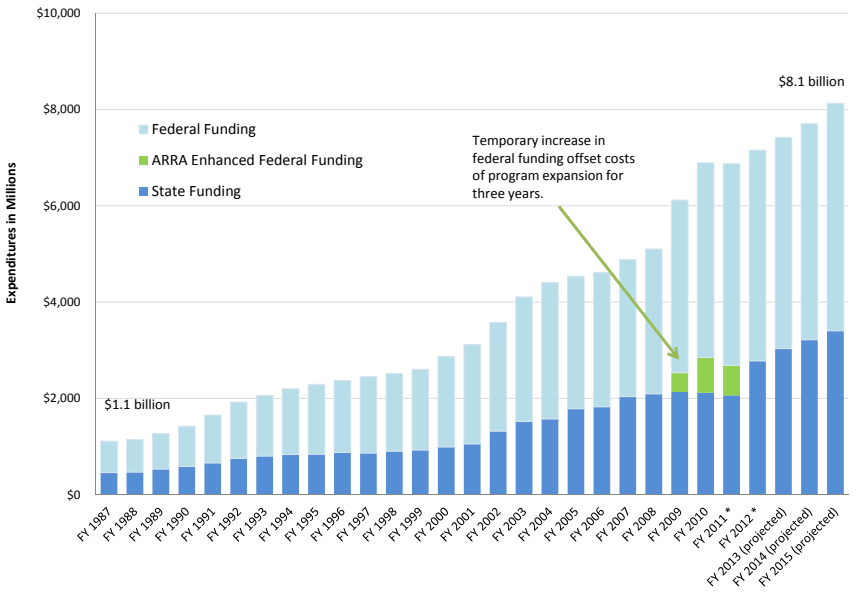
Governor Scott Walker
February 13, 2013

Dependence

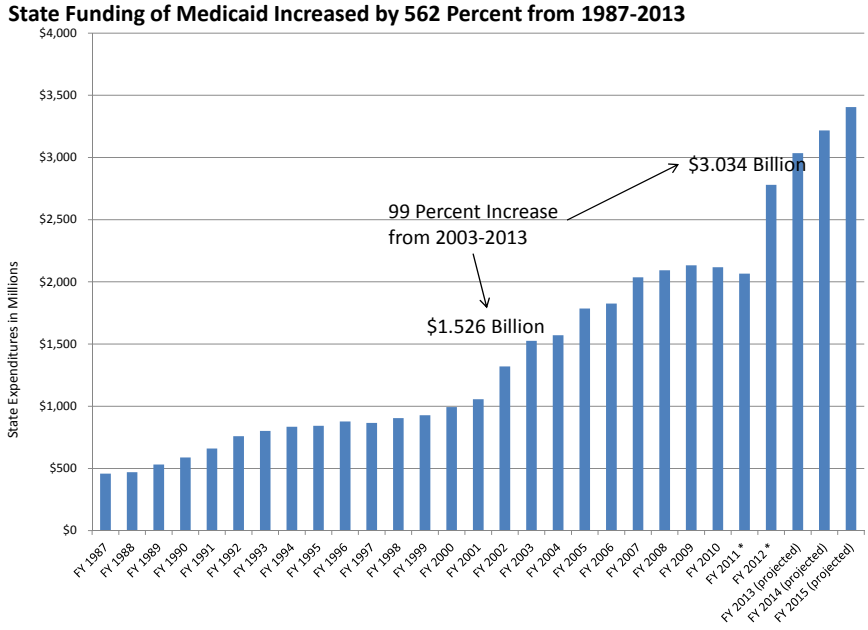
The Number of Medicaid Enrollees Has Grown from 10% to 21% of the State's Population



The Medicaid Program Spending Has Grown From $1 billion in 1987 to Over $8 Billion by 2015



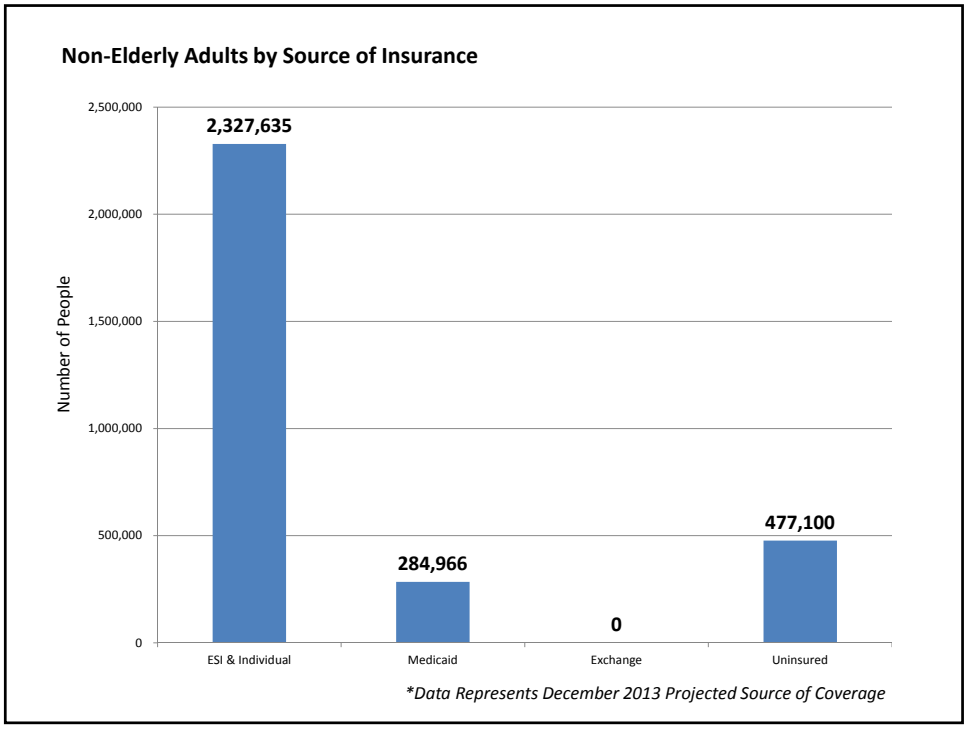
State Funding of Medicaid Increased by 562 Percent from 1987-2013



Medicaid Funding Under Governor Walker

- Governor Walker Provided $1.24 billion in new GPR in FY 2011-13, and an additional $644 million GPR in the current budget.
- Of the $644 million GPR over the biennium required to cover ongoing costs, nearly 40 percent, or about $258 million, is due to the federal government reducing funding for Medicaid for our state, increasing costs due to changes in the Affordable Care Act, and increasing payments for Medicare coverage.

	FY 2012	FY 2013	FY 2014	FY 2015
Base Budget	$1,416,326,200	$1,416,326,200	$2,015,761,200	$2,015,761,200
GPR Increase in Budget	$645,478,700	$599,019,400	$221,354,500	$422,275,500
Total GPR	$2,061,804,900	$2,015,345,600	$2,237,115,700	$2,438,036,700


Non-Elderly Adults by Source of Insurance
Number of People
2,500,000
2,000,000
1,500,000
1,000,000
500,000
0
2,327,635
284,966
0
477,100
ESI & Individual
Medicaid
Exchange
Uninsured
*Data Represents December 2013 Projected Source of Coverage

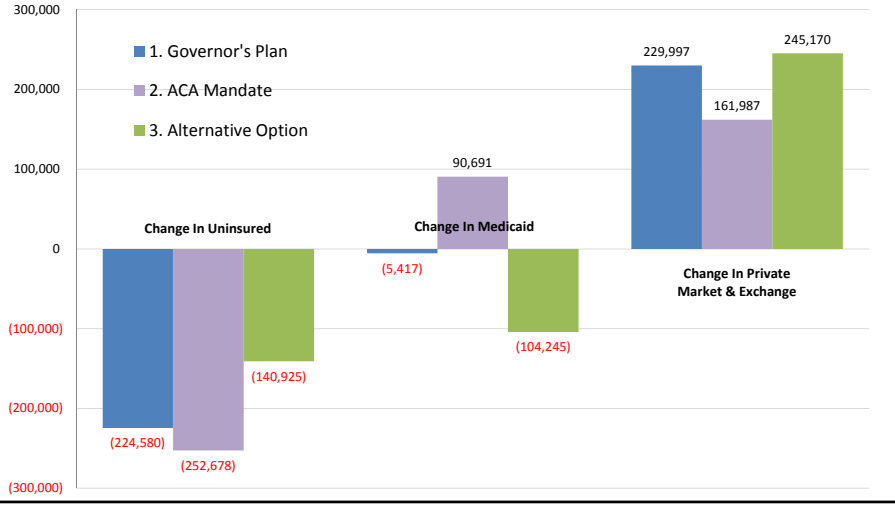
224,580

Impact on Uninsured Non-Elderly Adults Under Various Proposals

Uninsured Non-Elderly Adults		Number	Rate
Current – Census CPS ASEC 2011		477,100	14%
Change	Governor's Proposal	252,520 (224,580)	7%
	ACA Mandate	224,422 (252,678)	6%
	Alternative Option	336,175 (140,925)	10%

Comparing the Outcomes

Plan	Uninsured			Medicaid			Private Market & Exchange		
	Total	Change	% Change	Total	Change	% Change	Total	Change	% Change
1. Governor's Plan	252,520	(224,580)	-47%	279,549	(5,417)	-2%	2,557,632	229,997	10%
2. ACA Mandate	224,422	(252,678)	-53%	375,657	90,691	32%	2,489,622	161,987	7%
3. Alternative Option	336,175	(140,925)	-30%	180,721	(104,245)	-37%	2,572,805	245,170	11%



224,580

Enrollment Scenarios Based on Income Under Federal Health Insurance Exchange

Household	Annual Income (2013 FPL)	FPL	Premium as % of Income	Monthly Individual/ Family Premium Share*
Individual	$11,490	100%	2%	$19
Family of 4	$23,550	100%	2%	$39
Individual	$15,282	133%	3%	$38
Family of 4	$31,322	133%	3%	$78
Individual	$22,980	200%	6.3%	$121
Family of 4	$47,100	200%	6.3%	$247

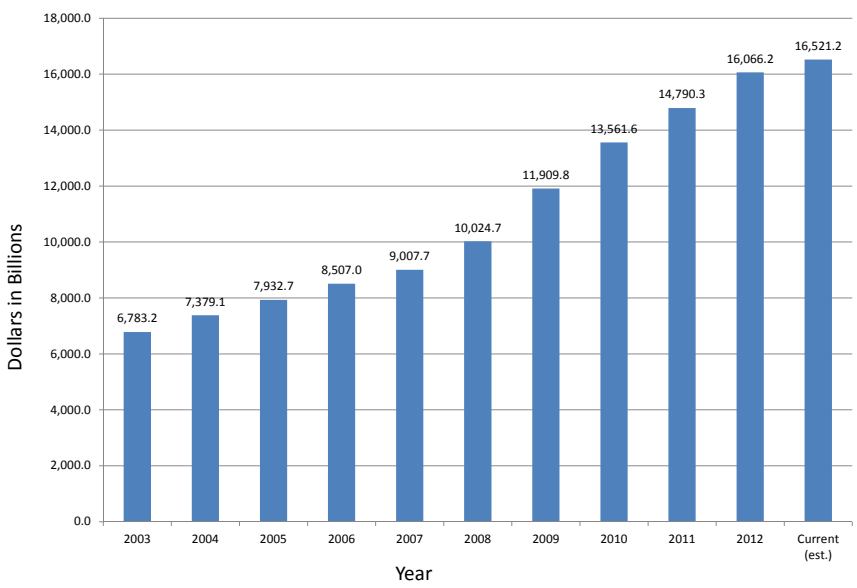
*The premium amounts are the maximum that persons would have to pay for the second-lowest cost silver plan. Depending on the plans people choose, their premiums could be higher or lower than these amounts. These amounts are based on the 2013 Poverty Levels.

Monthly premiums above were calculated by the Department of Health Services based on criteria outlined in the Affordable Care Act.

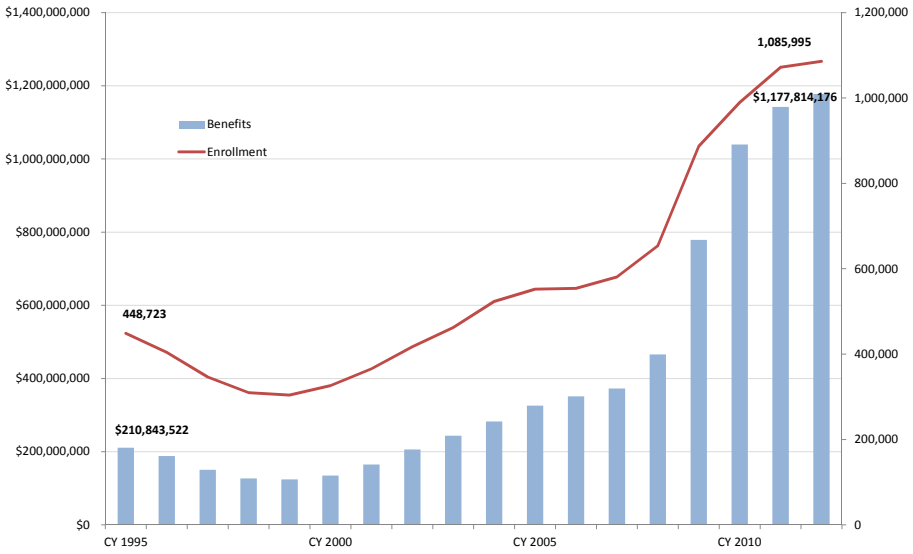
US National Debt Clock

$16,521,200,000,000

Source: USDebtClock.org



After Dropping as a Result of Welfare Reform in 1998, FoodShare Enrollment Has Grown, on Average 11% Per Year, While Benefits Payments Are Growing an Average of 20% Per Year.

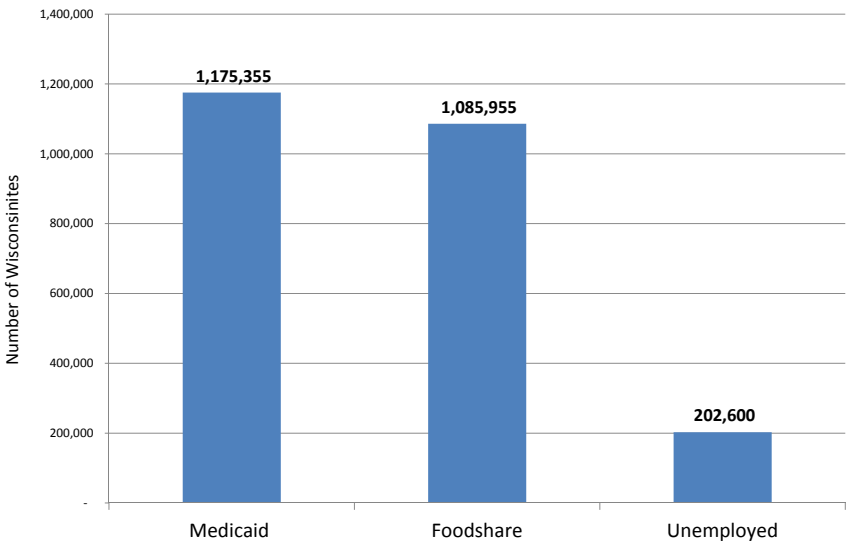


75,878
Job Training

Unemployment Insurance in Wisconsin

- 121,791 Residents Currently Receive Unemployment Benefits
- Average Time Individuals are on UI – 16.6 weeks
- 2/3rds Are Not Required to Search for Work Due to Current Work Search Exemptions
- 40,200 Registrants Required to Search for Job 2 x Per Week

Proposed 4 or More Searches Per Week



BOLD ENTITLEMENT REFORM

Reforming Entitlements in Wisconsin

- ✓FS: Job Training
- ✓UI: 2 to 4 per week
- ✓MA: Reduce Uninsured and Those Dependent on Government Healthcare

SELF RELIANCE

Independence!

From Dependence to Independence – Entitlement Reform in Wisconsin

Governor Scott Walker
February 13, 2013

Marketplace Enrollment Assumed in the Governor's Budget

Transitioning adults are adults transitioning from the BadgerCare Plus program to the Marketplace as of January 1, 2014.

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	Septembe	October	November	December	January	February	March	April	May	June	Total
All populations																			
Adams County, WI	918	437	202	214	143	125	100	85	89	68	34	23	15	16	31	21	6	12	2,540
Transitioning Adults	*461*																		
Ashland County, WI	1,101	525	242	256	172	150	120	102	107	82	41	28	19	20	37	25	7	14	3,048
Transitioning Adults	*629*																		
Barron County, WI	2,237	1,066	491	520	350	304	243	208	218	166	84	57	38	40	76	50	15	29	6,191
Transitioning Adults	*1,278*																		
Bayfield County, WI	734	350	161	171	115	100	80	68	71	55	28	19	12	13	25	16	5	9	2,031
Transitioning Adults	*424*																		
Brown County, WI	9,715	4,629	2,134	2,261	1,519	1,322	1,055	902	946	722	365	247	163	173	331	217	65	125	26,892
Transitioning Adults	*4,102*																		
Buffalo County, WI	490	234	108	114	77	67	53	46	48	36	18	12	8	9	17	11	3	6	1,358
Transitioning Adults	*282*																		
Burnett County, WI	768	366	169	179	120	105	83	71	75	57	29	20	13	14	26	17	5	10	2,127
Transitioning Adults	*440*																		
Calumet County, WI	1,099	524	241	256	172	150	119	102	107	82	41	28	18	20	37	25	7	14	3,041
Transitioning Adults	*507*																		
Chippewa County, WI	2,781	1,325	611	647	435	378	302	258	271	207	105	71	47	49	95	62	19	36	7,697
Transitioning Adults	*1,705*																		
Clark County, WI	1,558	743	342	363	244	212	169	145	152	116	59	40	26	28	53	35	10	20	4,313
Transitioning Adults	*907*																		
Columbia County, WI	1,781	848	391	414	278	242	193	165	173	132	67	45	30	32	61	40	12	23	4,929
Transitioning Adults	*910*																		
Crawford County, WI	729	347	160	170	114	99	79	68	71	54	27	19	12	13	25	16	5	9	2,018
Transitioning Adults	*461*																		
Dane County, WI	12,510	5,961	2,747	2,911	1,956	1,703	1,358	1,162	1,219	930	470	318	210	223	426	280	84	161	34,629
Transitioning Adults	*4,857*																		
Dodge County, WI	2,784	1,326	611	648	435	379	302	259	271	207	105	71	47	50	95	62	19	36	7,706
Transitioning Adults	*1,390*																		
Door County, WI	1,003	478	220	233	157	137	109	93	98	75	38	26	17	18	34	22	7	13	2,777
Transitioning Adults	*643*																		
Douglas County, WI	1,963	935	431	457	307	267	213	182	191	146	74	50	33	35	67	44	13	25	5,432
Transitioning Adults	*920*																		
Dunn County, WI	1,709	815	375	398	267	233	186	159	167	127	64	44	29	30	58	38	12	22	4,732
Transitioning Adults	*878*																		
Eau Claire County, WI	3,882	1,850	853	903	607	528	421	361	378	289	146	99	65	69	132	87	26	50	10,746
Transitioning Adults	*2,048*																		
Florence County, WI	161	76	35	37	25	22	17	15	16	12	6	4	3	3	5	4	1	2	444
Transitioning Adults	*102*																		
Fond du Lac County, WI	3,176	1,513	697	739	497	432	345	295	309	236	119	81	53	56	108	71	21	41	8,790
Transitioning Adults	*1,555*																		
Forest County, WI	519	247	114	121	81	71	56	48	51	39	20	13	9	9	18	12	3	7	1,436
Transitioning Adults	*258*																		
Grant County, WI	1,662	792	365	387	260	226	180	154	162	124	62	42	28	30	57	37	11	21	4,601
Transitioning Adults	*908*																		
Green County, WI	1,322	630	290	308	207	180	143	123	129	98	50	34	22	24	45	30	9	17	3,658
Transitioning Adults	*736*																		

Marketplace Enrollment Assumed in the Governor's Budget

Transitioning adults are adults transitioning from the BadgerCare Plus program to the Marketplace as of January 1, 2014.

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	Septembe	October	November	December	January	February	March	April	May	June	Total
All populations																			
Green Lake County, WI	686	327	151	160	107	93	74	64	67	51	26	17	12	12	23	15	5	9	1,900
Transitioning Adults	*329*																		
Iowa County, WI	792	377	174	184	124	108	86	74	77	59	30	20	13	14	27	18	5	10	2,192
Transitioning Adults	*498*																		
Iron County, WI	283	135	62	66	44	39	31	26	28	21	11	7	5	5	10	6	2	4	784
Transitioning Adults	*195*																		
Jackson County, WI	875	417	192	204	137	119	95	81	85	65	33	22	15	16	30	20	6	11	2,422
Transitioning Adults	*437*																		
Jefferson County, WI	2,841	1,354	624	661	444	387	308	264	277	211	107	72	48	51	97	64	19	37	7,864
Transitioning Adults	*1,338*																		
Juneau County, WI	1,298	619	285	302	203	177	141	121	126	96	49	33	22	23	44	29	9	17	3,594
Transitioning Adults	*666*																		
Kenosha County, WI	7,626	3,634	1,675	1,775	1,192	1,038	828	708	743	567	287	194	128	136	259	171	51	98	21,108
Transitioning Adults	*2,837*																		
Kewaunee County, WI	631	301	139	147	99	86	69	59	61	47	24	16	11	11	21	14	4	8	1,747
Transitioning Adults	*323*																		
La Crosse County, WI	3,785	1,804	831	881	592	515	411	352	369	281	142	96	64	67	129	85	25	49	10,478
Transitioning Adults	*1,923*																		
Lafayette County, WI	636	303	140	148	99	87	69	59	62	47	24	16	11	11	22	14	4	8	1,760
Transitioning Adults	*376*																		
Langlade County, WI	1,053	502	231	245	165	143	114	98	103	78	40	27	18	19	36	24	7	14	2,916
Transitioning Adults	*590*																		
Lincoln County, WI	1,189	566	261	277	186	162	129	110	116	88	45	30	20	21	40	27	8	15	3,290
Transitioning Adults	*697*																		
Manitowoc County, WI	2,630	1,253	578	612	411	358	286	244	256	195	99	67	44	47	90	59	18	34	7,281
Transitioning Adults	*1,379*																		
Marathon County, WI	5,366	2,557	1,178	1,249	839	730	583	498	523	399	202	137	90	95	183	120	36	69	14,854
Transitioning Adults	*2,684*																		
Marinette County, WI	1,819	867	399	423	284	248	197	169	177	135	68	46	31	32	62	41	12	23	5,034
Transitioning Adults	*1,058*																		
Marquette County, WI	605	288	133	141	95	82	66	56	59	45	23	15	10	11	21	14	4	8	1,674
Transitioning Adults	*336*																		
Menominee County, WI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transitioning Adults	*0*																		
Milwaukee County, WI	60,914	29,025	13,377	14,176	9,524	8,290	6,612	5,657	5,934	4,527	2,290	1,550	1,024	1,083	2,073	1,362	410	783	168,613
Transitioning Adults	*17,083*																		
Monroe County, WI	1,908	909	419	444	298	260	207	177	186	142	72	49	32	34	65	43	13	25	5,283
Transitioning Adults	*878*																		
Oconto County, WI	1,394	664	306	324	218	190	151	129	136	104	52	35	23	25	47	31	9	18	3,859
Transitioning Adults	*823*																		
Oneida County, WI	1,509	719	331	351	236	205	164	140	147	112	57	38	25	27	51	34	10	19	4,177
Transitioning Adults	*1,015*																		
Outagamie County, WI	5,433	2,589	1,193	1,264	849	739	590	505	529	404	204	138	91	97	185	122	37	70	15,038
Transitioning Adults	*2,812*																		
Ozaukee County, WI	1,391	663	306	324	218	189	151	129	136	103	52	35	23	25	47	31	9	18	3,851
Transitioning Adults	*790*																		

Marketplace Enrollment Assumed in the Governor's Budget

Transitioning adults are adults transitioning from the BadgerCare Plus program to the Marketplace as of January 1, 2014.

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	Septembe	October	November	December	January	February	March	April	May	June	Total
All populations																			
Pepin County, WI	246	117	54	57	38	33	27	23	24	18	9	6	4	4	8	5	2	3	680
Transitioning Adults	*135*																		
Pierce County, WI	992	473	218	231	155	135	108	92	97	74	37	25	17	18	34	22	7	13	2,745
Transitioning Adults	*545*																		
Polk County, WI	1,845	879	405	429	289	251	200	171	180	137	69	47	31	33	63	41	12	24	5,108
Transitioning Adults	*1,037*																		
Portage County, WI	2,207	1,051	485	514	345	300	240	205	215	164	83	56	37	39	75	49	15	28	6,108
Transitioning Adults	*1,237*																		
Price County, WI	661	315	145	154	103	90	72	61	64	49	25	17	11	12	22	15	4	8	1,829
Transitioning Adults	*478*																		
Racine County, WI	8,831	4,208	1,939	2,055	1,381	1,202	959	820	860	656	332	225	148	157	301	198	59	113	24,445
Transitioning Adults	*3,086*																		
Richland County, WI	822	392	181	191	129	112	89	76	80	61	31	21	14	15	28	18	6	11	2,276
Transitioning Adults	*424*																		
Rock County, WI	7,769	3,702	1,706	1,808	1,215	1,057	843	722	757	577	292	198	131	138	264	174	52	100	21,506
Transitioning Adults	*3,181*																		
Rusk County, WI	823	392	181	191	129	112	89	76	80	61	31	21	14	15	28	18	6	11	2,277
Transitioning Adults	*512*																		
St. Croix County, WI	2,227	1,061	489	518	348	303	242	207	217	165	84	57	37	40	76	50	15	29	6,163
Transitioning Adults	*1,358*																		
Sauk County, WI	2,461	1,172	540	573	385	335	267	229	240	183	92	63	41	44	84	55	17	32	6,811
Transitioning Adults	*1,248*																		
Sawyer County, WI	1,035	493	227	241	162	141	112	96	101	77	39	26	17	18	35	23	7	13	2,866
Transitioning Adults	*555*																		
Shawano County, WI	1,851	882	407	431	289	252	201	172	180	138	70	47	31	33	63	41	12	24	5,125
Transitioning Adults	*1,044*																		
Sheboygan County, WI	4,021	1,916	883	936	629	547	437	373	392	299	151	102	68	72	137	90	27	52	11,131
Transitioning Adults	*1,729*																		
Taylor County, WI	930	443	204	216	145	127	101	86	91	69	35	24	16	17	32	21	6	12	2,573
Transitioning Adults	*634*																		
Trempealeau County, WI	1,121	534	246	261	175	153	122	104	109	83	42	29	19	20	38	25	8	14	3,104
Transitioning Adults	*500*																		
Vernon County, WI	1,230	586	270	286	192	167	134	114	120	91	46	31	21	22	42	28	8	16	3,406
Transitioning Adults	*689*																		
Vilas County, WI	1,110	529	244	258	174	151	121	103	108	83	42	28	19	20	38	25	7	14	3,074
Transitioning Adults	*626*																		
Walworth County, WI	4,062	1,935	892	945	635	553	441	377	396	302	153	103	68	72	138	91	27	52	11,243
Transitioning Adults	*1,888*																		
Washburn County, WI	883	421	194	205	138	120	96	82	86	66	33	22	15	16	30	20	6	11	2,444
Transitioning Adults	*557*																		
Washington County, WI	2,941	1,401	646	684	460	400	319	273	286	219	111	75	49	52	100	66	20	38	8,141
Transitioning Adults	*1,650*																		
Waukesha County, WI	6,570	3,130	1,443	1,529	1,027	894	713	610	640	488	247	167	110	117	224	147	44	84	18,185
Transitioning Adults	*3,381*																		
Waupaca County, WI	1,908	909	419	444	298	260	207	177	186	142	72	49	32	34	65	43	13	25	5,280
Transitioning Adults	*1,096*																		

Marketplace Enrollment Assumed in the Governor's Budget

Transitioning adults are adults transitioning from the BadgerCare Plus program to the Marketplace as of January 1, 2014.

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	Septembe	October	November	December	January	February	March	April	May	June	Total
All populations																			
Waushara County, WI	933	445	205	217	146	127	101	87	91	69	35	24	16	17	32	21	6	12	2,583
Transitioning Adults	*462*																		
Winnebago County, WI	5,495	2,618	1,207	1,279	859	748	596	510	535	408	207	140	92	98	187	123	37	71	15,210
Transitioning Adults	*2,643*																		
Wood County, WI	3,546	1,690	779	825	554	483	385	329	345	264	133	90	60	63	121	79	24	46	9,816
Transitioning Adults	*1,959*																		
Menominee Tribe	488	232	107	114	76	66	53	45	48	36	18	12	8	9	17	11	3	6	1,350
Transitioning Adults	*84*																		
Red Cliff	2	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	8
Transitioning Adults	*4*																		
Stockbridge Munsee	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Transitioning Adults	*2*																		
Potawatomi	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	7
Transitioning Adults	*4*																		
Lac du Flambeau	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	20
Transitioning Adults	*7*																		
Bad River	3	2	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	10
Transitioning Adults	*4*																		
Sokaogon	2	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	7
Transitioning Adults	*3*																		
Ho Chunk	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transitioning Adults	*0*																		
Oneida	3	2	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	10
Transitioning Adults	*3*																		
Lac Courte Oreilles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transitioning Adults	*0*																		
St. Croix Tribe	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transitioning Adults	*0*																		
TOTAL	**226,287**	**107,828**	**49,699**	**52,666**	**35,386**	**30,803**	**24,565**	**21,015**	**22,044**	**16,818**	**8,507**	**5,760**	**3,805**	**4,026**	**7,701**	**5,062**	**1,524**	**2,909**	**626,403**

Notes:

Figures differ slightly from the Governor's budget assumptions due to rounding.

Members currently in the BadgerCare Plus program with income above 100% of the FPL are a subset of the Marketplace group.
Adults transitioning from Medicaid to the Marketplace will not be eligible for BadgerCare Plus after January 1, 1014.

County percentages are based on county of residence and percentage of recipients in each county in March 2013.

BadgerCare Plus New Enrollees Assumed in the Governor's Budget

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	Total
																			Total
Adams County, WI	180	80	32	33	22	19	15	13	14	10	4	2	2	2	3	2	0	1	434
Ashland County, WI	217	94	37	38	27	23	19	15	17	13	5	3	2	2	4	3	0	2	521
Barron County, WI	440	194	75	79	54	47	37	31	33	25	10	6	4	5	8	5	2	3	1,058
Bayfield County, WI	144	64	24	27	17	15	13	10	11	8	4	2	2	2	3	2	0	1	349
Brown County, WI	1,908	843	329	349	234	203	163	139	145	111	42	27	18	19	35	24	8	14	4,611
Buffalo County, WI	96	42	17	17	13	10	8	7	8	6	2	2	1	1	2	1	0	0	233
Burnett County, WI	150	67	27	28	19	15	13	11	11	9	4	2	2	2	3	2	0	1	366
Calumet County, WI	216	94	37	38	27	23	19	15	17	13	5	3	2	2	4	3	0	2	520
Chippewa County, WI	546	242	93	99	66	58	46	40	42	31	12	7	5	5	10	7	2	3	1,314
Clark County, WI	306	135	52	56	37	33	27	22	23	17	6	4	3	3	5	3	1	2	735
Columbia County, WI	350	155	59	64	42	37	29	25	27	20	7	5	3	3	6	5	1	2	840
Crawford County, WI	143	64	24	27	17	15	13	10	11	8	4	2	2	2	3	2	0	1	348
Dane County, WI	2,457	1,083	422	447	301	262	209	178	187	144	54	33	22	23	45	29	8	17	5,921
Dodge County, WI	547	242	93	99	66	58	46	40	42	31	12	7	5	5	10	7	2	3	1,315
Door County, WI	196	87	34	36	23	21	17	14	15	11	4	3	2	2	3	2	0	2	472
Douglas County, WI	386	170	65	70	47	41	33	28	29	22	8	5	3	3	7	5	2	3	927
Dunn County, WI	336	147	57	61	41	36	28	24	26	20	7	5	3	3	6	4	1	2	807
Eau Claire County, WI	763	336	131	139	93	80	64	55	58	44	16	10	7	7	13	9	3	5	1,833
Florence County, WI	32	14	5	6	4	3	3	1	3	1	0	0	0	0	0	0	0	0	72
Fond du Lac County, WI	624	276	107	113	76	66	52	45	47	36	13	8	5	6	11	7	2	5	1,499
Forest County, WI	102	45	17	19	13	11	9	8	8	6	2	2	1	1	2	1	0	0	247
Grant County, WI	325	144	56	59	41	34	28	23	24	19	7	5	3	3	6	4	1	2	784
Green County, WI	259	114	45	47	31	28	22	19	20	15	6	3	2	2	5	3	1	2	624
Green Lake County, WI	135	59	23	24	17	14	11	9	10	8	3	2	1	1	2	2	0	1	322
Iowa County, WI	155	69	27	28	19	17	13	11	13	9	4	2	2	2	3	2	0	1	377
Iron County, WI	55	24	9	9	6	6	5	5	5	3	1	0	0	0	1	0	0	0	129
Jackson County, WI	172	76	29	31	21	19	14	13	13	9	4	2	2	2	3	2	0	1	413
Jefferson County, WI	559	246	95	101	69	59	47	41	42	33	12	8	5	5	10	7	2	3	1,344
Juneau County, WI	255	112	43	46	31	27	22	19	19	14	6	3	2	2	5	3	1	2	612
Kenosha County, WI	1,497	660	257	273	183	159	127	108	114	87	33	20	13	15	27	18	5	10	3,606
Kewaunee County, WI	124	55	22	22	15	13	10	9	9	8	2	2	1	1	2	2	0	1	298
La Crosse County, WI	744	329	129	136	91	79	63	55	56	43	16	10	7	7	13	8	3	5	1,794
Lafayette County, WI	125	55	22	23	15	14	10	9	9	8	2	2	1	1	2	2	0	1	301
Langlade County, WI	207	91	36	37	25	22	17	15	15	13	4	3	2	2	3	2	0	2	496
Lincoln County, WI	233	103	41	42	28	24	20	17	17	14	6	3	2	2	5	3	1	2	563
Manitowoc County, WI	517	229	88	93	63	55	43	37	38	29	12	7	5	5	10	6	2	3	1,242
Marathon County, WI	1,054	465	181	192	130	112	89	76	79	61	22	15	10	10	18	13	3	7	2,537
Marinette County, WI	358	159	61	65	43	37	30	27	27	20	8	5	3	3	7	5	1	2	861
Marquette County, WI	119	53	20	22	14	13	9	9	9	6	2	2	1	1	2	2	0	0	284
Menominee County, WI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Milwaukee County, WI	11,962	5,274	2,056	2,178	1,463	1,273	1,016	869	911	696	263	163	107	113	218	144	44	82	28,832
Monroe County, WI	375	164	64	69	45	41	31	27	28	22	8	5	3	3	7	5	2	3	902
Oconto County, WI	274	121	47	50	33	29	23	20	20	15	6	3	2	3	5	3	1	2	657
Oneida County, WI	296	130	51	55	36	31	25	22	22	17	6	4	3	3	5	3	1	2	712
Outagamie County, WI	1,067	471	183	194	131	113	91	78	81	62	24	15	10	10	20	13	3	7	2,573
Ozaukee County, WI	273	121	47	50	33	29	23	20	20	15	6	3	2	3	5	3	1	2	656

BadgerCare Plus New Enrollees Assumed in the Governor's Budget

	2014												2015						
Benefit Month	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	Total
Pepin County, WI	48	21	8	9	6	5	5	3	4	3	1	0	0	0	1	0	0	0	114
Pierce County, WI	194	86	33	36	23	20	17	14	15	11	4	3	2	2	3	2	0	2	467
Polk County, WI	363	160	62	65	44	38	31	27	28	22	8	5	3	3	7	5	2	2	875
Portage County, WI	434	192	74	79	52	46	37	31	33	25	10	6	4	4	8	5	2	3	1,045
Price County, WI	130	57	22	23	15	14	11	9	9	8	2	2	1	1	2	2	0	1	309
Racine County, WI	1,735	765	298	315	213	185	148	127	132	101	38	23	15	16	31	20	6	12	4,180
Richland County, WI	162	71	28	29	20	17	14	13	13	9	4	2	2	2	3	2	0	1	392
Rock County, WI	1,526	673	262	278	187	163	130	110	116	88	34	20	13	15	28	18	5	10	3,676
Rusk County, WI	162	71	28	29	20	17	14	13	13	9	4	2	2	2	3	2	0	1	392
St. Croix County, WI	438	194	74	79	53	47	37	31	33	25	10	6	4	4	8	5	2	3	1,053
Sauk County, WI	484	214	83	87	59	51	41	35	37	28	10	7	5	5	8	5	2	3	1,164
Sawyer County, WI	203	90	35	37	24	22	17	14	15	13	4	3	2	2	3	2	0	2	488
Shawano County, WI	364	161	62	65	44	38	31	27	28	22	8	5	3	3	7	5	2	2	877
Sheboygan County, WI	791	348	136	144	96	84	66	57	60	45	18	10	7	8	15	10	3	5	1,903
Taylor County, WI	182	81	31	33	22	19	15	13	14	10	4	2	2	2	3	2	0	1	436
Trempealeau County, WI	220	97	37	41	27	23	19	15	17	13	5	3	2	2	4	3	0	2	530
Vernon County, WI	241	106	42	43	29	26	20	17	19	14	6	3	2	2	5	3	1	2	581
Vilas County, WI	218	95	37	40	27	23	19	15	17	13	5	3	2	2	4	3	0	2	525
Walworth County, WI	798	352	138	145	98	84	67	57	60	46	18	11	7	8	15	10	3	5	1,922
Washburn County, WI	173	76	29	31	22	19	14	13	13	9	4	2	2	2	3	2	0	1	415
Washington County, WI	578	255	99	105	70	61	49	42	43	34	12	8	5	5	10	7	2	4	1,389
Waukesha County, WI	1,290	569	222	236	158	138	109	93	98	74	28	18	12	12	23	15	5	8	3,108
Waupaca County, WI	375	164	64	69	45	41	31	27	28	22	8	5	3	3	7	5	2	3	902
Waushara County, WI	183	81	31	33	22	20	15	14	14	10	4	2	2	2	3	2	0	1	439
Winnebago County, WI	1,080	476	186	196	132	116	93	79	83	64	25	16	11	11	21	14	5	8	2,616
Wood County, WI	697	307	121	127	86	75	60	51	53	42	17	11	7	8	14	9	4	6	1,695
Menominee Tribe	95	42	17	17	13	10	8	6	8	6	2	2	1	1	2	1	0	0	231
Red Cliff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stockbridge Munsee	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Potawatomi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lac du Flambeau	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bad River	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sokaogon	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ho Chunk	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oneida	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lac Courte Oreilles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
St. Croix Tribe	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**44,443**	**19,602**	**7,628**	**8,082**	**5,429**	**4,726**	**3,770**	**3,222**	**3,378**	**2,578**	**977**	**605**	**404**	**424**	**808**	**537**	**150**	**302**	**107,065**

Note:
Figures differ slightly from the Governor's budget assumptions due to rounding.

Wisconsin Regional Enrollment Outreach Strategy

UW Population Health Enrollment Summit

July 16, 2013

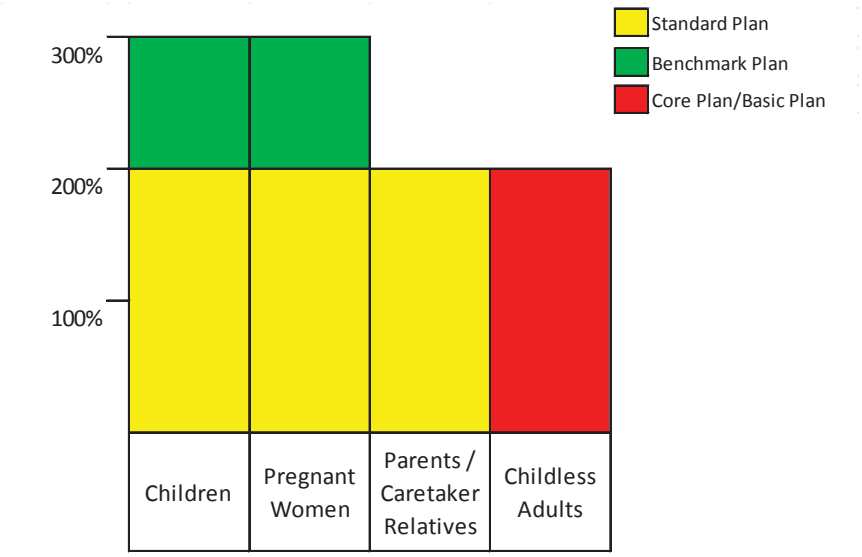
Outline

- Wisconsin Vision and Commitment
- Enrollment Background and Estimates
- Proposed Outreach Strategy; Regional Enrollment Networks
- DHS Targeted Outreach
- Enrollment Considerations
- Outreach Timeline
- Questions

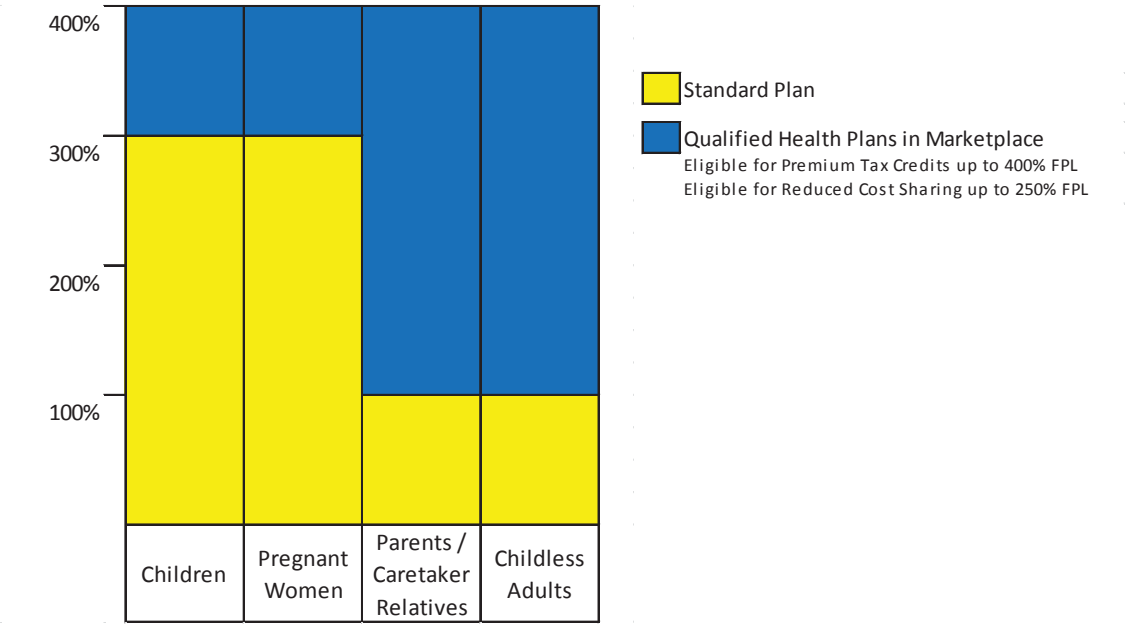
Wisconsin Vision and Commitment

- Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.
- Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.
- Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

Current BadgerCare Plus Enrollment and Benefits



Future BadgerCare Plus & Marketplace Enrollment and Benefits



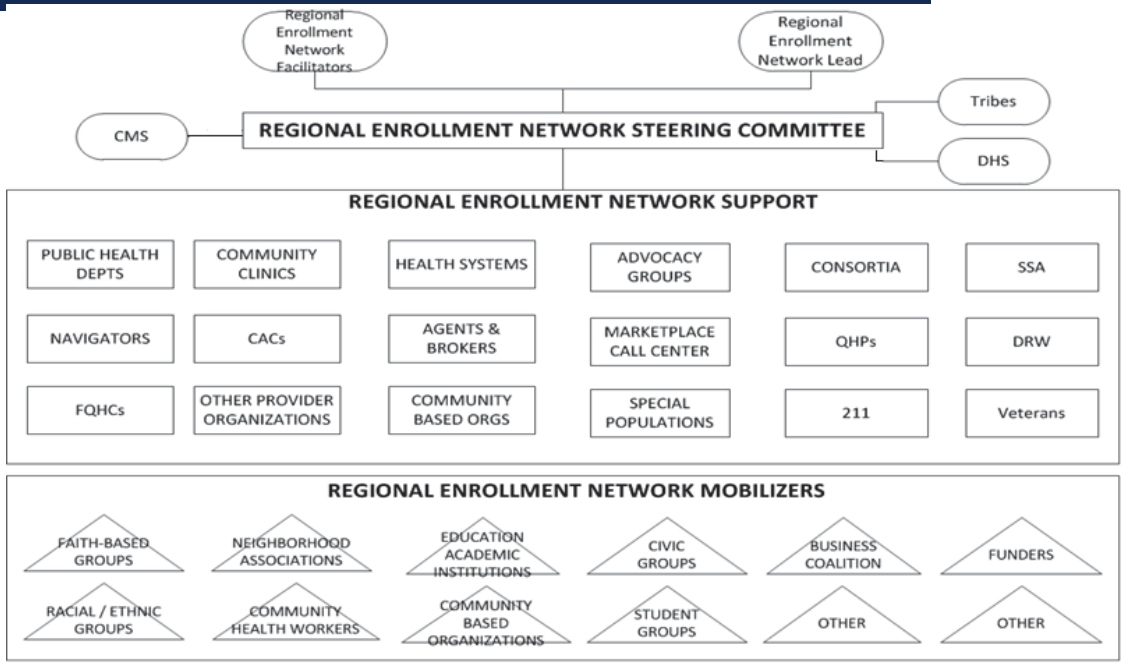
BadgerCare Plus & Marketplace Estimated Enrollment

	BadgerCare Plus	Marketplace
Children	522,695	No Estimate
Pregnant Women	20,804	No Estimate
Parents / Caretaker Relatives	160,255	232,551
Childless Adults	98,641	459,757

Proposed Outreach Strategy

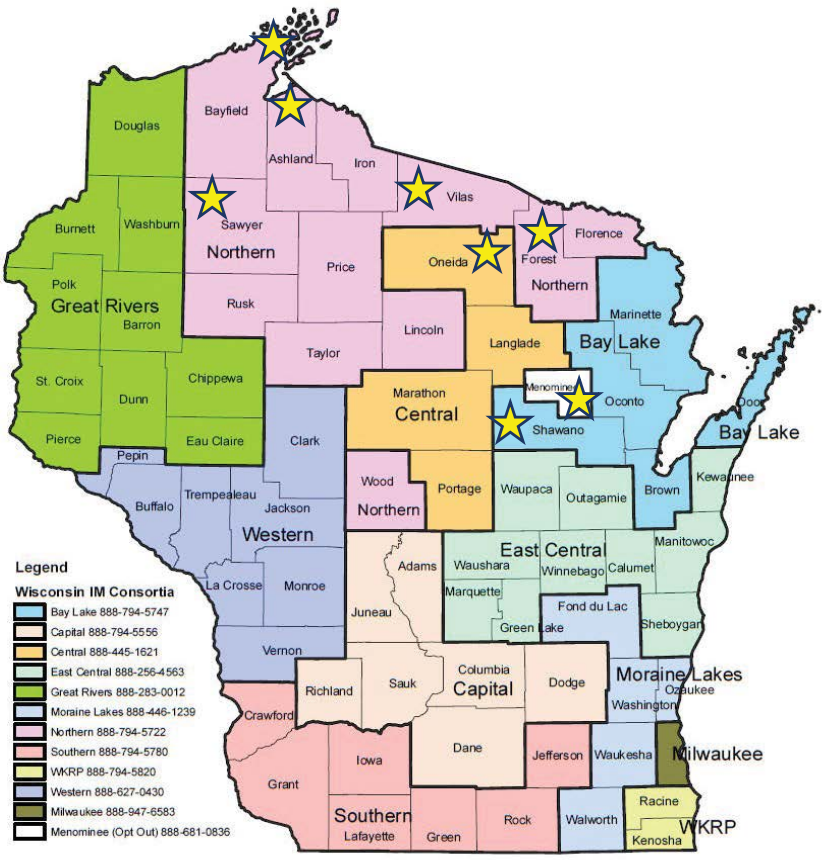
- Leverage Milwaukee Enrollment Network effort currently underway.
- Create regional enrollment networks throughout the state with regional partners, including tribes.
  - Provide application and enrollment assistance.
  - Mobilize other local resources to assist people in gaining healthcare coverage.

Proposed Regional Enrollment Network

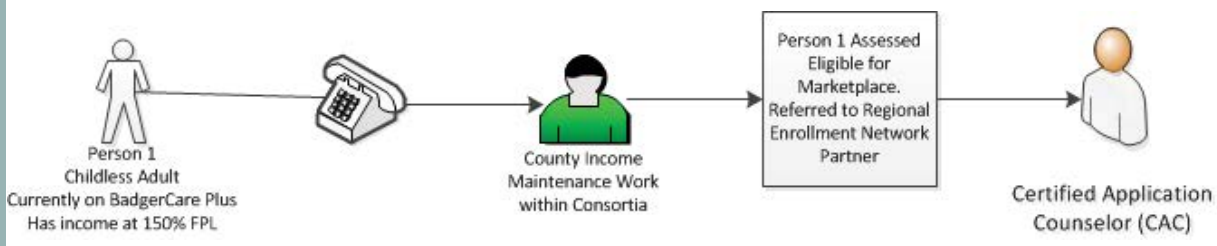


Proposed Wisconsin Regional Enrollment Networks

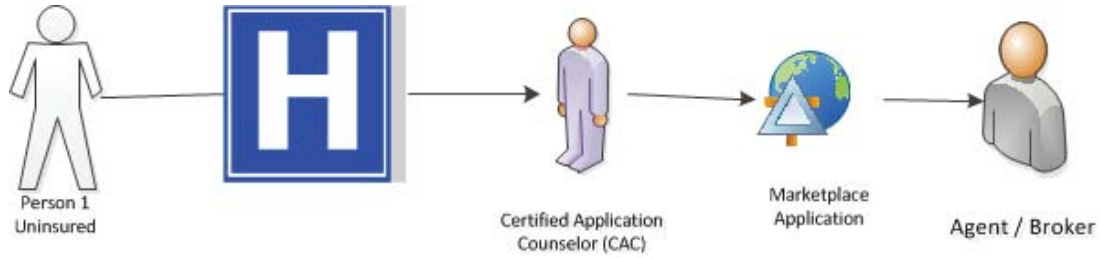
Wisconsin Income Maintenance Consortia



Example #1



Example #2



Regional Enrollment Network Identification

- Regional Enrollment Network Lead in collaboration with DHS working to ensure maximum participation.
- Regional Enrollment Network Lead in collaboration with DHS will facilitate identification of enrollment assisters and mobilizers.
- Deliverable: Regional Enrollment Network Partners Identified (August 15, 2013).

Regional Enrollment Network Planning

- Determine roles and responsibilities for each partner organization.
- Determine education and training needs for each partner organization.
- Determine capacity for each partner organization.
- Identify supporting materials.
- Identify workload based on enrollment estimates for each partner organization.
- Deliverable: Operations Plan (September 16, 2013).

Regional Enrollment Network Operations

- Periodic checkpoints.
- Adjustments based on regional needs.
- Reporting.
- Deliverable: Regular reporting from each network.

DHS Targeted Outreach

- DHS is focused on outreach to those current members that may transition to the Marketplace, and those uninsured individuals that will be eligible for BadgerCare Plus.
  - DHS will notify current members that may be impacted by coverage changes starting September 20, 2013.
    - 87,000 parents and caretaker relatives.
    - 5,000 childless adults.
  - DHS will notify individuals on Core Plan waitlist and Basic Plan members starting September 29, 2013.
  - DHS anticipates call volumes and foot traffic in the Consortia and MilES will significantly increase.
  - DHS is working closely with the WI Department of Veterans Affairs and will proactively outreach to Veterans (i.e. through Veteran homeless shelters, County Veteran Service Officers, and Veteran Organizations).
- DHS will provide information to contracted HMOs and providers for their members that may be transitioning to the marketplace starting September 20, 2013.
- DHS will begin contacting members that may be impacted by changes starting September 20, 2013.

BadgerCare Plus Enrollment Considerations

- Current members and uninsured individuals may apply for insurance through the Marketplace starting on October 1, 2013.
  - Due to significant eligibility system modifications, DHS will begin processing applications for childless adults transferred from the Marketplace starting November 18, 2013.

BadgerCare Plus Enrollment Considerations cont.

- Starting November 18, 2013, DHS will begin processing applications using the new Modified Adjusted Gross Income (MAGI) based eligibility determination rules.
  - For all people applying at their local consortia/MilES or online via ACCESS, that are determined ineligible for BadgerCare Plus, DHS will electronically transfer their information to the Marketplace.
- On November 23, 2013, DHS will begin notifying members of coverage changes effective January 1, 2014.

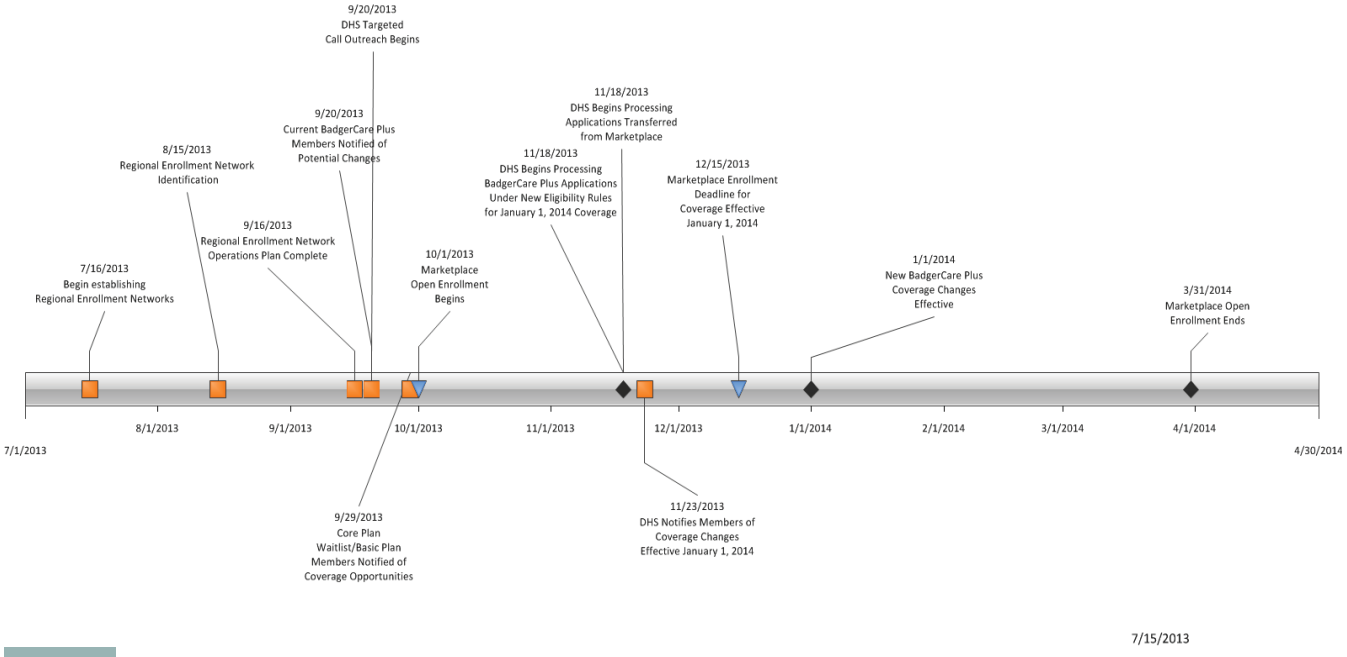
Marketplace Enrollment Considerations

- Individuals have until December 15, 2013 to enroll in a QHP.
  - Individuals will be required to pay the first month's premium to ensure coverage effective January 1, 2014.
  - Individuals will have 75 days from October 1, 2013 to enroll.
- Open enrollment for the Marketplace ends March 31, 2014.
- Currently unclear how long it will take for an individual to complete an online application for the Marketplace.
  - This will be important in determining capacity for those partners participating in Regional Enrollment Networks.

Regional Enrollment Network Operational Timeline

- Network Identification: Now to August 15, 2013.
- Network Planning: August 15, 2013 to September 16, 2013.
- Network Operations: Beginning October 1, 2013.

Overall Outreach Timeline



Questions

Good afternoon,

I wanted to take this opportunity to share some important information with you about Wisconsin's plans for implementing the Patient Protection and Affordable Care Act and state Entitlement Reforms Initiative. Please feel free to pass along to your partners as well.

The Patient Protection and Affordable Care Act (PPACA) and state Entitlement Reforms present an opportunity to reduce Wisconsin's uninsured rate. We all share the goal of ensuring Wisconsin residents have access to affordable health care coverage. By working together we can achieve our shared goal of reducing Wisconsin's uninsured rate.

One of Wisconsin's most significant strategies to assist Wisconsin residents with enrolling in the appropriate public or private health care coverage will be through the recently announced Regional Enrollment Networks (RENs). The RENs will be comprised of various community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders like you. These RENs will be developed at the local level and may be different from each other depending on the needs of the local region.

On July 16, 2013, the Department of Health Services and the Office of the Commissioner of Insurance presented a proposed model for the RENs at the UW-Population Health Institute's Wisconsin Health Insurance Outreach & Enrollment Summit. The RENs were modeled after and leverage the current outreach and enrollment efforts underway in Milwaukee through the Milwaukee Enrollment Network. The presentation announcing the RENs is available online at http://www.dhs.wisconsin.gov/aboutdhs/initiatives/budget/initiatives/er/071613ren.pdf

Each REN will have dedicated facilitators that will lead each region's efforts of supporting partners and mobilizers.

Many partner organizations including public health departments, community based organizations, advocacy groups, Qualified Health Plans (QHPs), veterans groups, tribes and others have shown interest in collaborating to assist Wisconsin individuals and families navigate these new health care coverage changes.

As you know, we are faced with a very aggressive timeline to operationalize the RENs and begin the very important task of assisting Wisconsin individuals and families enroll in the appropriate public or private health care coverage. If you are interested in partnering with the Regional Enrollment Network in your area, please fill out the form at http://4.selectsurvey.net/dhs/TakeSurvey.aspx?PageNumber=1&SurveyID=m61L3895&Preview=true. The co-conveners of the RENs will contact you within the next couple of weeks to announce a REN kick-off meeting in each region.

For additional information, regionally based Department of Health Services staff listed below would be happy to assist you:

Region	Counties	Contact	Email address
Bay Lakes	Brown, Door, Marinette, Menominee Oconto, Shawano	Elizabeth Jungers	Elizabeth.jungers@dhs.wisconsin.gov
Capital	Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk	Amy Bell	Amy1.bell@dhs.wisconsin.gov
Central	Langlade, Marathon, Oneida, Portage	Bill Hanna	William.hanna@dhs.wisonsin.gov
East Central	Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago	Elizabeth Jungers	Elizabeth.jungers@dhs.wisconsin.gov
Great Rivers	Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, Washburn	Michelle Larson	Michelle.larson@dhs.wisconsin.gov
Milwaukee	Milwaukee	Sarah Fraley	Sarah.fraley@wisconsin.gov
Moraine Lakes	Fond du Lac, Ozaukee, Walworth, Washington, Waukesha	Angie Moran	Angela.moran@dhs.wisconsin.gov
Northern	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Melody Yeager	Melody.yeager@dhs.wisconsin.gov
Southern	Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock	Julie Milleson	Julie.milleson@dhs.wisconsin.gov
Western	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon	Jamie Fawcett	Jamie.fawcett@dhs.wisconsin.gov
WKRP	Kenosha, Racine	Sarah Fraley	Sarah.fraley@wisconsin.gov

In addition, DHS will be hosting Partner and Provider Medicaid policy overviews and trainings via webinar beginning in August 2013. The first webinar will be held Monday, August 12 from 10am to noon. Additional information, including how to participate in the webinar, will be available in the near future on the Department's website at www.dhs.wisconsin.gov.

Thank you,

Brett Davis,
Medicaid Director

Good Morning,

As follow-up to the Partner Update: Regional Enrollment Network e-mail distributed last week, we encourage you to save the date!

You are invited to attend the regional enrollment network kick-off meeting in your area(s). Each meeting will be hosted and facilitated by a regional host, in partnership with the Department of Health Services, Covering Kids and Families, and the Wisconsin Primary Health Care Association.

Meeting time: 8:00am – 3:00pm* (Agenda to follow)

Please register no later than Friday, August 16, 2013 at
http://4.selectsurvey.net/dhs/TakeSurvey.aspx?PageNumber=1&SurveyID=761L4pm5&Preview=true

Region	Counties	Date	Location	Contact
Bay Lake	Brown, Door, Marinette, Menominee Oconto, Shawano	Tuesday, August 20th	University Union, University of Wisconsin-Green Bay (Room Phoenix B)	Elizabeth Jungers Elizabeth.jungers@dhs.wisconsin.gov
Southern	Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock	Tuesday, August 20th	Hilton Garden Inn – Middleton, WI	Julie Milleson Julie.milleson@dhs.wisconsin.gov
East Central	Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago	Wednesday, August 21st	Winnebago County Expo Center, 500 E. County Road Y, Oshkosh, WI	Elizabeth Jungers Elizabeth.jungers@dhs.wisconsin
Great Rivers	Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, Washburn	Wednesday, August 21, 2013	Wisconsin Indianhead Technical College (WITC) Rice Lake, WI	Michelle Larson Michelle.Larson@wisconsin.gov
Capital	Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk	Thursday, August 22nd	Alliant Energy Center, Madison, WI (Mendota Rooms 2-4)	Amy Bell Amy1.bell@dhs.wisconsin.gov
Northern	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Friday, August 23rd Monday, August 26th Wednesday, August 28th	Flat Creek Inn, 10290 Highway 27 South Hayward, WI Eagles Club, 1104 South Oak Avenue, Marshfield, WI Forest County Potawatomi Auditorium, 5416 Everybodys Road, Crandon, WI	Melody Yeager Melody.yeager@dhs.wisconsin.gov

Central	Langlade, Marathon, Oneida, Portage	Tuesday, August 27th	Best Western Midway Hotel, Wausau, WI	Bill Hanna William.hanna@dhs.wisonsin.gov
Moraine Lakes	Fond du Lac, Ozaukee, Walworth, Washington, Waukesha	Tuesday, August 27th	County Springs Hotel and Conference Center, Waukesha, WI	Angie Moran Angela.moran@dhs.wisconsin.gov
Western	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon	Monday, August 26th	Lunda Center, Western Technical College, LaCrosse, WI	Jamie Fawcett Jamie.fawcett@dhs.wisconsin.gov
WKRP	Kenosha, Racine	Wednesday, September 4th (*10:30am – 3:30pm)	Gateway Technical College Auditorium, Sturtevant, WI	Sarah Fraley Sarah.fraley@wisconsin.gov

Thank you,

Brett Davis,
Medicaid Director

BAY LAKE

REGIONAL ENROLLMENT NETWORK

KICK-OFF MEETING

What is a Regional Enrollment Network?

A public/private collaboration organized to support the enrollment of Wisconsin residents in public health benefits via BadgerCare Plus or private health insurance via the Federal Marketplace

AUGUST 20, 2013

8:00 a.m. – 3:00 p.m.

University of Wisconsin – Green Bay

University Union, Room Phoenix B

2420 Nicolet Drive, Green Bay

Hosted by

Covering Kids and Families,

Wisconsin Primary Health Care Association,

and the Department of Health Services

Regional Enrollment Kick Off Meeting

AGENDA

8:00-8:40	Welcome/Opening Remarks - Introduction to Regional Lead - Introduction to fellow participants - Preview of plans for network assistance
8:40-9:00	Review Objectives - DHS Objectives - Discussion of #'s of uninsured by region and capacity
9:00-9:30	Structure and goals of regional enrollment networks - Enrollment assistance roles - Model for REN structure

9:30-10:15	Group Discussion
	- Determining appropriate structure for each region
	  o Discuss Community Assets
	  o Enrollment Assisters
	  o Mobilizers
	  o Discussion of required resources and training

10:15-10:30	Break
10:30-11:15	Group Discussion - Determining appropriate goals for each region o Steering Committee
11:15-12:15	Working Lunch – Networking *(Sponsored by Wisconsin Hospital Association, Wisconsin Medical Society, Rural Wisconsin Health Cooperative, Group Health Cooperative of South Central Wisconsin)*
12:15-1:30	Case Scenarios - What roles and resources are needed to meet the demand?
1:30-2:30	Taking Inventory & Discussion
2:30-3:00	Next Steps

Bay Lakes Region – Enrollment Network Kickoff Meeting

August 20, 2013

Conveners & Sponsors:

- Covering Kids and Families
- Wisconsin Primary Health Care Association
- Wisconsin Department of Health Services
- The GHC "Better Together" Project
- Rural Wisconsin Health Cooperative
- Molina Healthcare
- Wisconsin Hospital Association
- Wisconsin Medical Society

Background

- Big Task! Not enough resources!
- Insurance coverage is important (and enrollment is not political)
- We have a lot of assets to build on and it is better to be coordinated
- Information is changing quickly
- "Regional Enrollment Networks" don't really exist yet (we made it up)

WPHCA/CKF Goals for Today

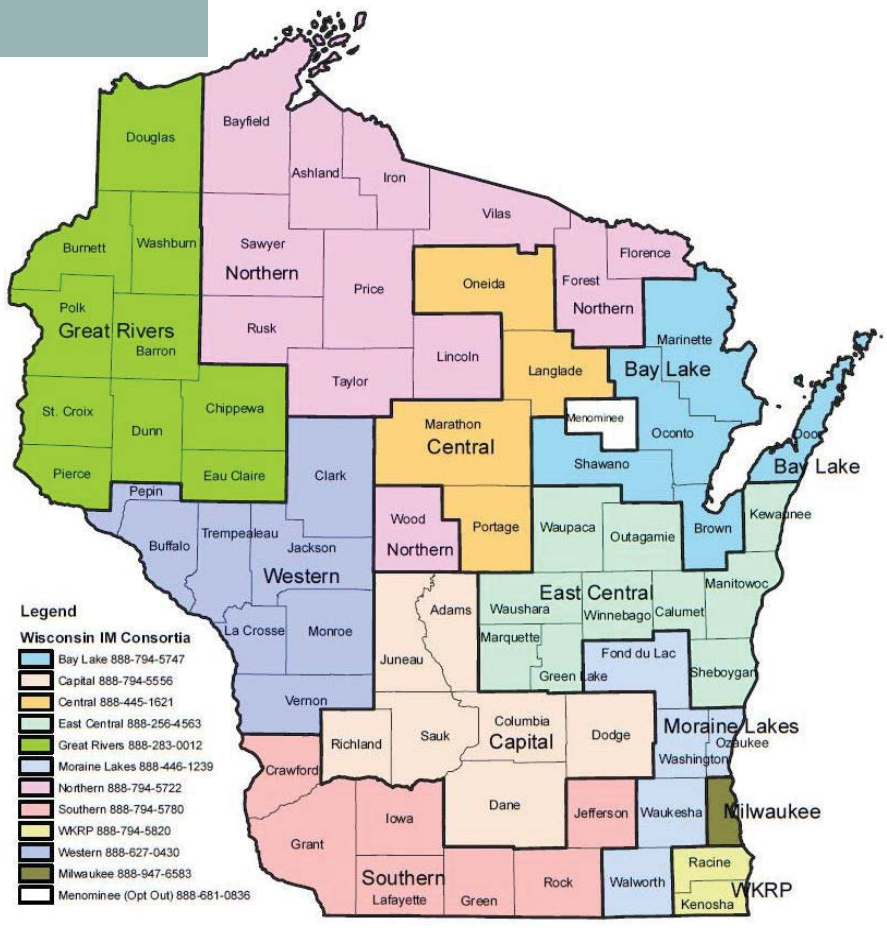
- Make connections with people
- Name your role
- Assess capacity
- Coordinate and communicate beyond today?
  - Form a Regional Enrollment Network?
- Determine next steps and opportunities
  - Form a local/regional Enrollment Steering Committee?

Wisconsin Vision and Commitment

- Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.
- Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.
- Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

How DHS views Regional Enrollment Networks (REN)

- Public/private collaboration organized to support the enrollment of Wisconsin residents in public health benefits via BadgerCare Plus or private health insurance via the Federal Marketplace.
- Committed to making networks successful in each region



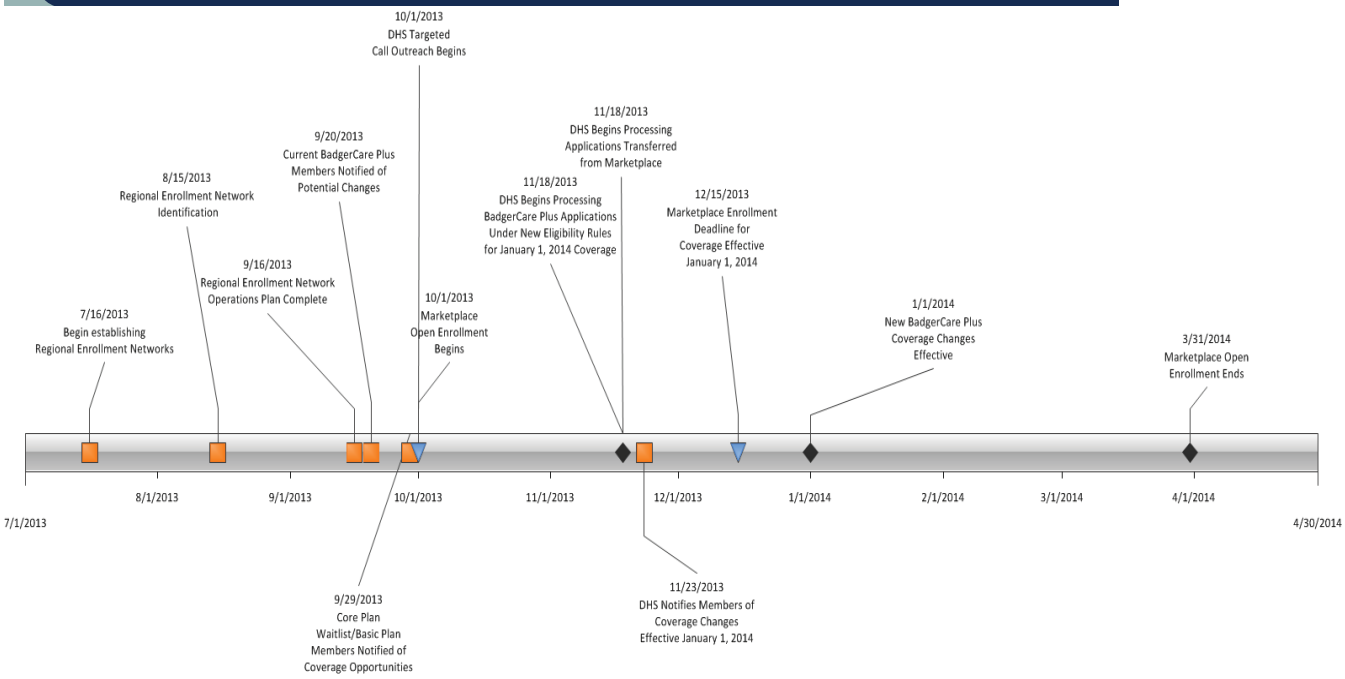
Bay Lake Region

- Brown
- Door
- Marinette
- Menominee*
- Oconto
- Shawano

DHS' REN Goals

- Determine roles and responsibilities for each partner organization.
- Determine education and training needs for each partner organization.
- Determine capacity for each partner organization.
- Identify supporting materials.
- Identify workload based on enrollment estimates for each partner organization.

Outreach Timeline



BadgerCare Plus & Marketplace Estimated Enrollment

	BadgerCare Plus	Marketplace
Children	522,695	No Estimate
Pregnant Women	20,804	No Estimate
Parents/Caretakers	160,255	232,551
Childless Adults	98,641	459,757

BadgerCare Plus Estimated New Enrollees

	2014											
County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Brown	1,908	843	329	349	234	203	163	139	145	111	42	27
Door	196	87	34	36	23	21	17	14	15	11	4	3
Marinette	358	159	61	65	43	37	30	27	27	20	8	5
Oconto	274	121	47	50	33	29	23	20	20	15	6	3
Shawano	364	161	62	65	44	38	31	27	28	22	8	5
Bay Lakes	**3,100**	**1,371**	**533**	**565**	**377**	**328**	**264**	**227**	**235**	**179**	**68**	**43**

Marketplace Estimated Enrollment

	2014											
County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Brown	9,715	4,629	2,134	2,261	1,519	1,322	1,055	902	946	722	365	247
Door	1,003	478	220	233	157	137	109	93	98	75	38	26
Marinette	1,819	867	399	423	284	248	197	169	177	135	68	46
Oconto	1,394	664	306	324	218	190	151	129	136	104	52	35
Shawano	1,851	882	407	431	289	252	201	172	180	138	70	47
Bay Lakes	**15,783**	**7,520**	**3,466**	**3,673**	**2,468**	**2,148**	**1,713**	**1,466**	**1,537**	**1,173**	**593**	**402**

Marketplace Estimated Enrollment

	2014											
Tribes	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Menominee Tribe	488	232	107	114	76	66	53	45	48	36	18	12
Red Cliff	2	1	1	1	1	1	0	0	0	0	0	0
Stockbridge Munsee	2	1	0	0	0	0	0	0	0	0	0	0
Potawatomi	1	1	1	1	1	1	0	0	0	0	0	0
Lac du Flambeau	2	1	1	1	1	1	1	1	1	1	1	1
Bad River	3	2	1	1	1	1	0	0	0	0	0	0
Sokaogon	2	1	1	1	1	1	0	0	0	0	0	0
Ho Chunk	-	-	-	-	-	-	-	-	-	-	-	-
Oneida	3	2	1	1	1	1	0	0	0	0	0	0
Lac Courte Oreilles	-	-	-	-	-	-	-	-	-	-	-	-
St. Croix Tribe	-	-	-	-	-	-	-	-	-	-	-	-
Tribes	502	242	114	120	83	73	55	47	49	38	20	14

Current Enrollment Assistance

A few examples:

- Agents and Brokers
- Hospital/Clinic enrollment staff
- Community-based organization enrollment staff
- Aging & Disability Resource Centers (ADRCs)
- Income Maintenance Agencies

New categories of “Enrollment Support” created by ACA

- Certified Application Counselors
  - CMS certification of CAC Organizations
  - OCI training
- Navigators
  - Federal grant
  - OCI training

Who else?

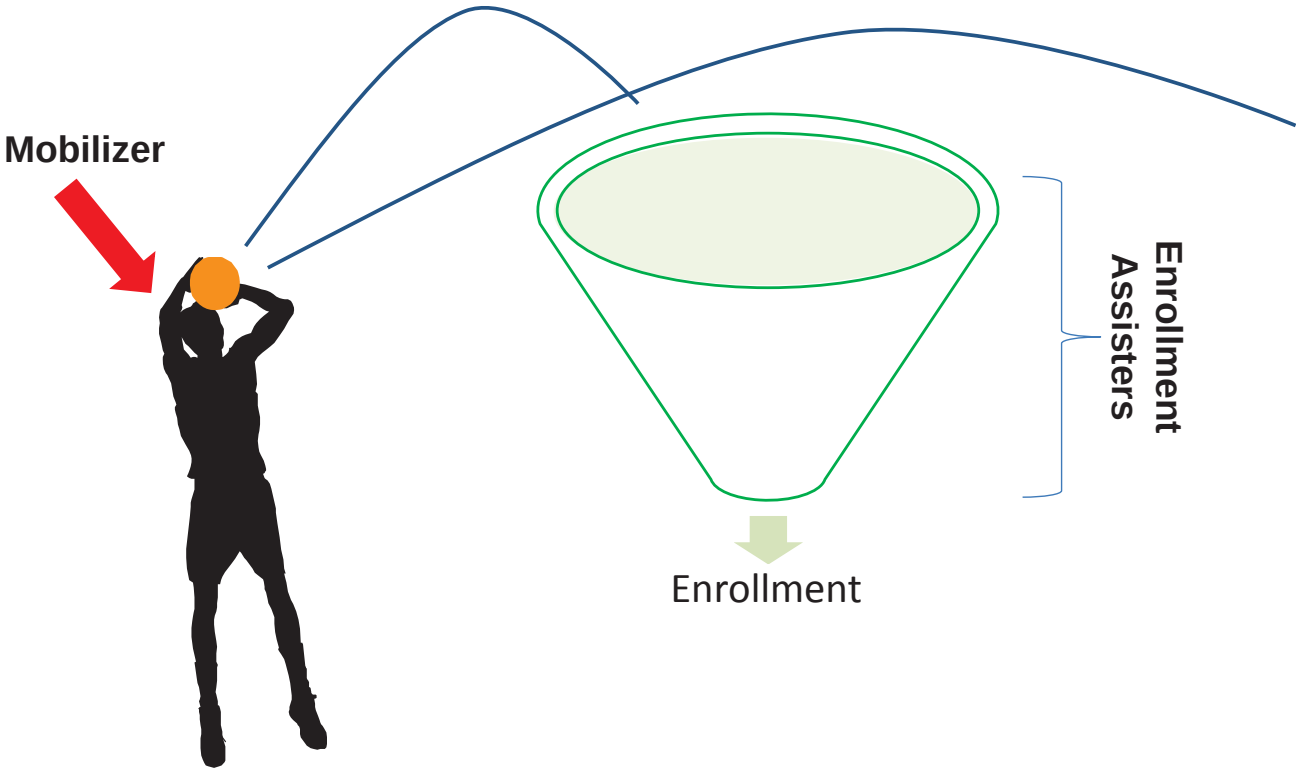
- “Mobilizers”
- Information and Referral Agents
- UW-Extension
- Volunteers
- Others specific to your region?

Projected Capacity Needs
Bay Lakes

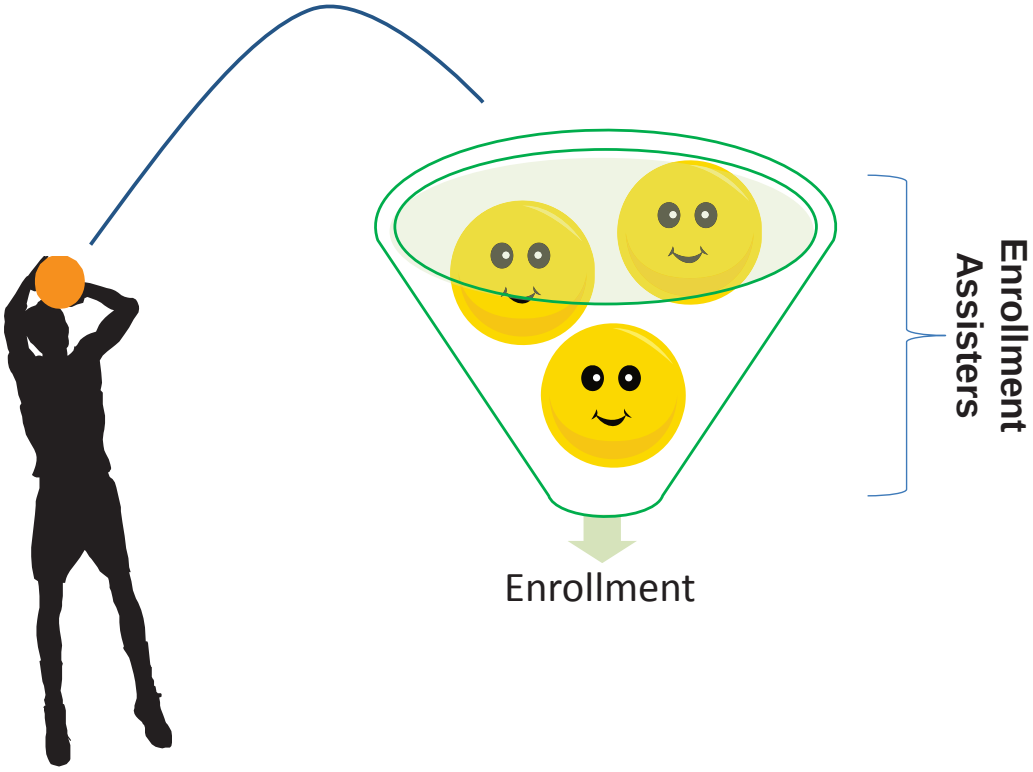
- Enroll America's research found that 75% of surveyed consumers want someone to help them apply for coverage in-person.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
15,783	7,520	3,466	3,673	2,468	2,148	1,713	1,466	Enrollment #
11,837	5,640	2,600	2,755	1,851	1,611	1,285	1,099	N*75% = # Seeking in person help
74	35	16	17	12	10	8	7	N/160 /month = # of Enrollment Assisters

Another Way to Think About It



Thoughts on Capacity



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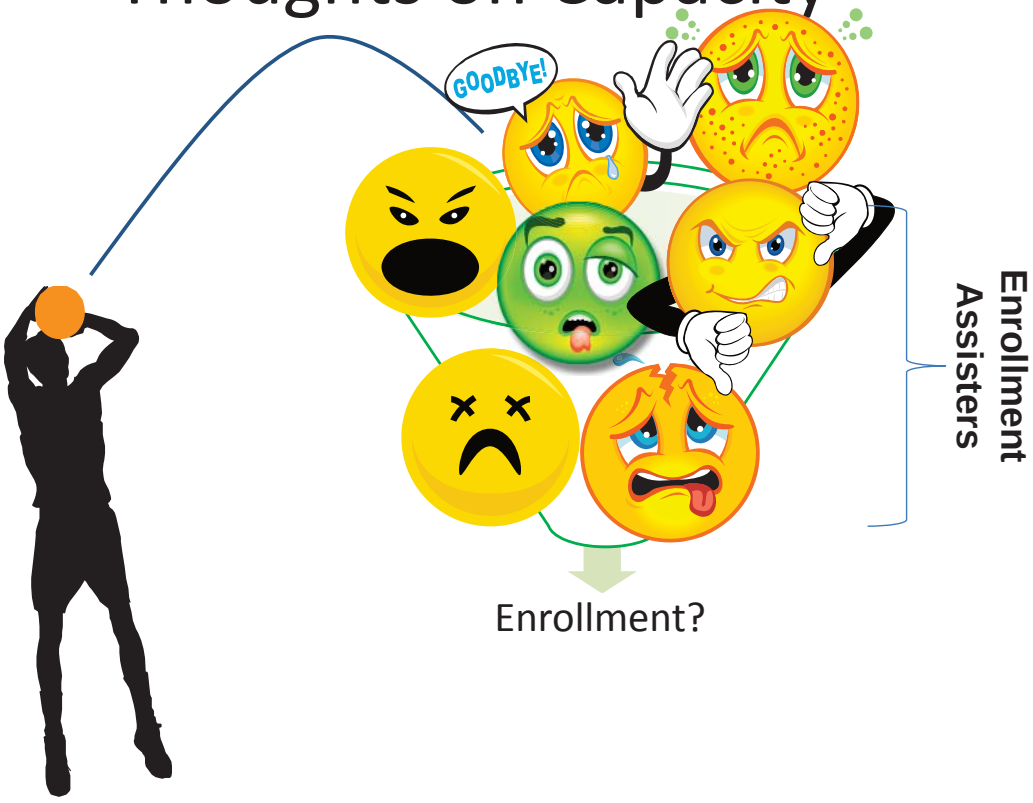
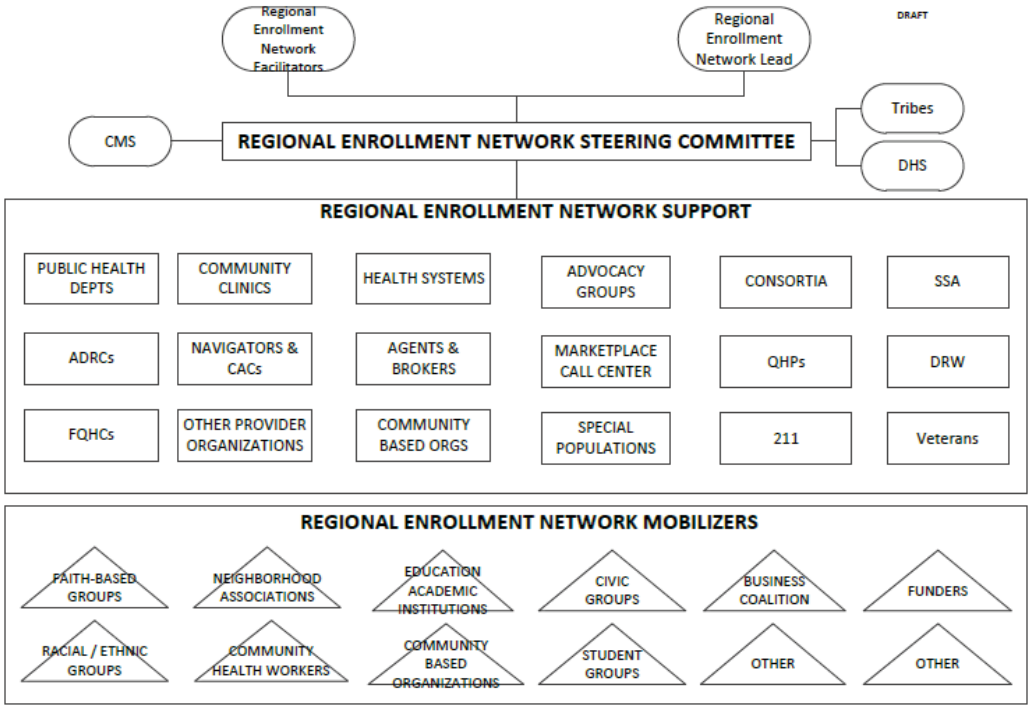


One Idea for Structure



Enrollment Support Network

Public Health Depts	Community Clinics	Health Systems	Advocacy Groups	Consortia	SSA
ADRCs	Navigators & CACs	Agents and Brokers	Marketplace Call Center	QHPs	Disability Groups
FQHCs	Provider Orgs	Community Based Orgs	Special Populations	2-1-1	Veterans Affairs

Mobilizers

Faith Based Groups

Neighborhood Associations

Academic Institutions

Civic Groups

Business Coalitions

Funders

Racial / Ethnic Groups

Community Health Workers

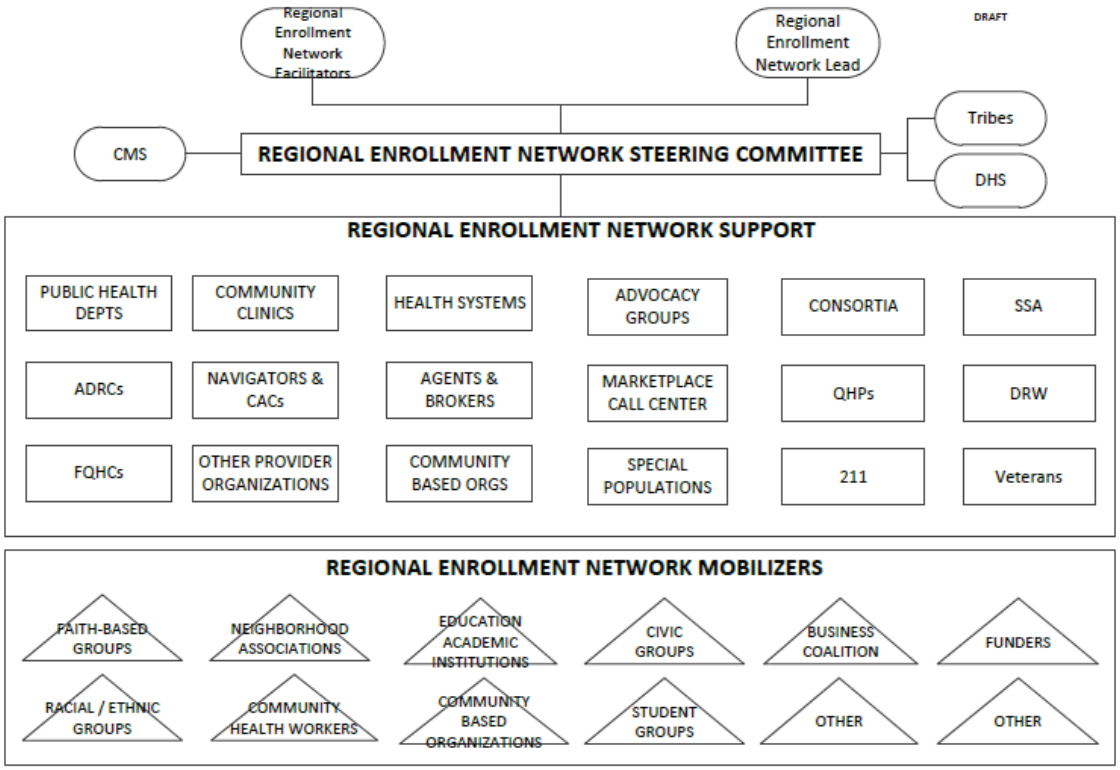
Community Based Organizations

Student Groups

Others?

Others?

One Idea for Structure



Group Discussion of Roles/Structure

- Who does this work now?
  - Enrollment
  - Information to consumers
- What is your capacity to do that work now and in the future?
- How is information already being disseminated?
  - Will those people still do it in the same way?
- Who is missing to make this work well?

Client/Consumer Scenarios

- Individual who has never had health insurance and wants to know if she is eligible for "ObamaCare"

- Current BadgerCare recipient who received a notice from DHS stating that he will be losing his BadgerCare+ eligibility on January 1, 2014

CKF Next Steps

- Covering Kids and Families
  - Identify REN training needs
  - Provide training for REN members when possible
  - Assist with coordination of non-CKF training when appropriate
  - Partner with WPHCA on E4Health website
  - Facilitate requests for technical assistance support amongst REN members

WPHCA Next Steps

- Wisconsin Primary Health Care Association / E4Health
  - Website (with CKF) to go live in September
  - Strategic support for RENs, communication between RENs
  - Statewide enrollment coordination

DHS Next Steps

- Continue to be a supportive partner to the RENs
  - Provide technical assistance and training related to BadgerCare Plus changes
- DHS scheduled outreach to BadgerCare Plus members that may be transitioning to the Marketplace
  - September 20, 2013 – DHS will issue an informational letter to members of potential impacts, need to report changes, and how to connect with the Marketplace
  - October 1, 2013 – DHS will be contacting members directly to confirm that they received the informational letter and verify if they need assistance

Wisconsin Regional Enrollment Outreach Strategy

Wisconsin Cancer Council
Annual Meeting
October 17, 2013

Wisconsin Vision and Commitment

- Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.
- Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.
- Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

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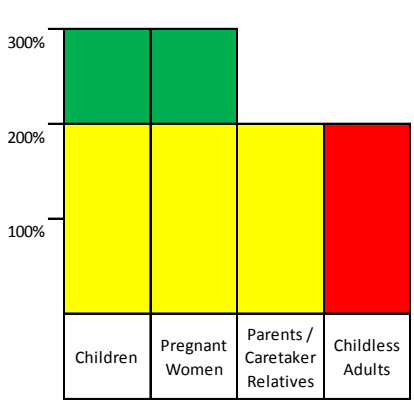
Current BadgerCare Plus Enrollment and Benefits

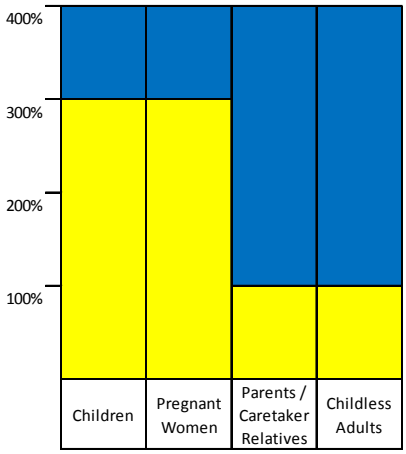


Standard Plan
Benchmark Plan
Core Plan/Basic Plan

BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	484,164	247,712	16,450	769,130

3

Future BadgerCare Plus & Marketplace Enrollment and Benefits



Standard Plan

Qualified Health Plans in Marketplace
Eligible for Premium Tax Credits up to 400% FPL
Eligible for Reduced Cost Sharing up to 250% FPL

BadgerCare Plus Enrollment - Projected in Budget				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	522,695	160,255	98,641	802,395

4

BadgerCare Plus & Marketplace Estimated Enrollment

	BadgerCare Plus	Marketplace
Children	522,695	No Estimate
Pregnant Women	20,804	No Estimate
Parents / Caretaker Relatives	160,255	232,551
Childless Adults	98,641	459,757

5

The Marketplace (or Exchange)

- Place for qualified individuals and employers to directly compare private health insurance options
  - Known as Qualified Health Plans (QHPs)
  - http://oci.wi.gov/pressrel/0913serviceareas.htm
  - 13 QHPs in Wisconsin
- Can directly compare on the basis of price, benefits, quality and other factors

Information taken from Health Insurance Marketplace 101 (July 2013) available at http://marketplace.cms.gov/training/get-training.html

6

Qualified Health Plans

- A Qualified Health Plan:
  - Is offered by an issuer that is licensed by the state and is in good standing
  - Covers Essential Health Benefits
  - Is offered by an issuer that offers at least one plan at the "silver" level and one at the "gold" level of cost sharing
  - Is offered by an issuer that agrees to charge the same premium rate whether offered directly through the Marketplace or outside the Marketplace

Information taken from Overview of the Health Insurance Marketplace (July 2013) available at http://marketplace.cms.gov/training/get-training.html

7

Essential Health Benefits

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management;
- pediatric services, including oral and vision care.

8

Eligibility and Enrollment in the Marketplace

- The Marketplace initial open enrollment period starts October 1, 2013 and ends March 31, 2014.
- Marketplace eligibility requires you to
  - Live in its service area, and
  - Be a U.S. citizen or national, or
  - Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
  - Not be incarcerated
    - Can apply for Marketplace if pending disposition of charge

Information taken from Health Insurance Marketplace 101 (July 2013) available at http://marketplace.cms.gov/training/get-training.html

9

Eligibility and Enrollment in the Marketplace Continued

- Consumers must select a plan by the 15th of the month for coverage to start on the 1st of the following month (but no earlier than January 1, 2014). If health plans are chosen after the 15th, coverage will start on the 1st day of the next following month
  - Coverage begins January 1, 2014 for someone who applies between October 1, 2013 – December 15, 2013.
  - Coverage begins February 1, 2014 for someone who applies between December 16, 2013 and January 15, 2014
- If an individual does not enroll during the open enrollment period (October 1, 2013 – March 31, 2014) they may not have the opportunity to enroll until the next open enrollment period (October 15, 2014 – December 7, 2014) for benefits starting in 2015.

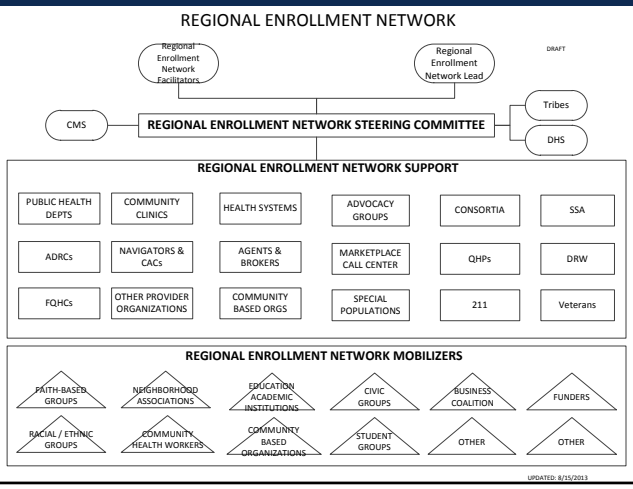
10

Wisconsin Outreach Strategy

- Leverage Milwaukee Enrollment Network effort currently underway.
- Create regional enrollment networks throughout the state with regional partners, including tribes.
  - Provide application and enrollment assistance.
  - Mobilize local grassroots resources to assist people in gaining healthcare coverage.

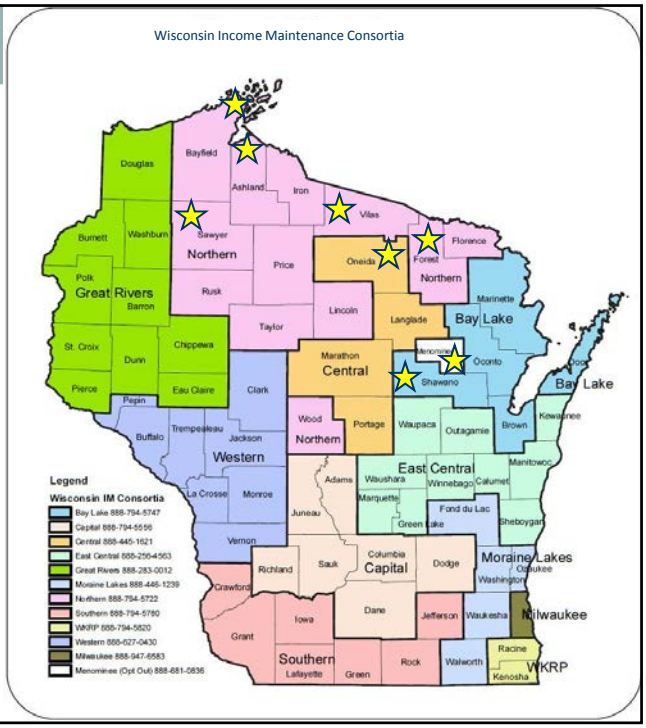
11

Sample Regional Enrollment Network



12

Wisconsin Regional Enrollment Networks



13

Wisconsin Outreach Strategy

- Regional Enrollment Network kick-off meetings have been held across Wisconsin.
- Office of the Commissioner of Insurance (OCI), along with DHS, have hosted town hall meetings across the state on ACA changes and impacts.
- Trainings for Certified Application Counselors are being held across the state and online.

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Outreach Timeline

Date	Milestone
07/16/2013	Begin establishing Regional Enrollment Networks
08/15/2013	Regional Enrollment Network Identification
09/16/2013	Regional Enrollment Network Operations Plan Complete
09/20/2013	Current BadgerCare Plus Members Notified of Potential Changes
09/29/2013	Core Plan Waitlist / Basic Plan Members Notified of Potential Changes
10/01/2013	DHS Targeted Call Outreach Begins for Transitioning Members
10/01/2013	Marketplace Open Enrollment Begins
11/18/2013	DHS Begins Processing BadgerCare Plus Applications Under New Eligibility Rules for January 1, 2014 Coverage
11/18/2013	DHS Begins Processing Applications Transferred from Marketplace
11/23/2013	DHS Notifies Members of Coverage Changes Effective January 1, 2014
12/15/2013	Marketplace Enrollment Deadline for Coverage Effective January 1, 2014
01/01/2014	New BadgerCare Plus Coverage Changes Effective
03/31/2014	Marketplace Open Enrollment Ends

15

HOW TO APPLY FOR BC+

A customer may use the following methods to contact or initiate an application:

Online through ACCESS.wi.gov

Walk-In at IM Agency (Face to Face)

Phone Call to IM Agency

Mail-In Application from badgercareplus.org

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INCOME MAINTENANCE (IM) AGENCY INFORMATION

Throughout Wisconsin there are 10 Consortia, 11 tribal agencies and Milwaukee Enrollment Services (MilES). Contact information including address and phone number for each consortia and tribal agency is listed on the following website:

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Note: IM agencies process applications and determine eligibility for BadgerCare Plus

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How to Apply for Health Insurance in the Marketplace

- 1-800-318-2596 (TTY (1-855-889-4324)
  - Customer services representatives 24/7
  - English and Spanish
    - Language line for 150 additional languages
- https://www.healthcare.gov/
  - Marketplace application available October 1, 2013
  - CuidadoDeSalud.gov for Spanish
- In person assistance

18

Resources

- https://www.healthcare.gov/
- http://marketplace.cms.gov/
- http://www.dhs.wisconsin.gov/health-care/
- http://oci.wi.gov/healthcare_reform.htm
- http://e4healthwi.org

19

Questions

20

Affordable Care Act Roles & Responsibilities

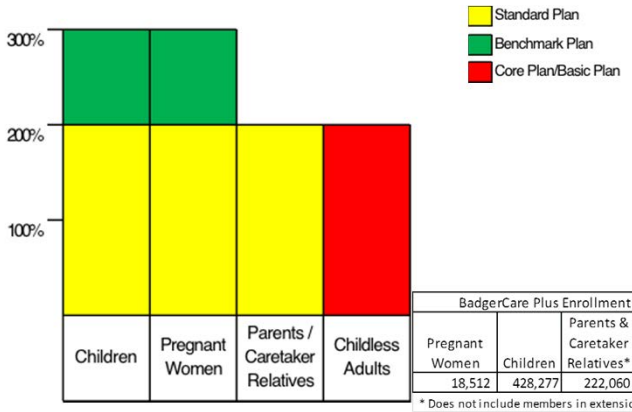
Bill Hanna
Area Administration Director
December 6, 2013

Wisconsin Vision and Commitment

- Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.
- Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.
- Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

2

Current BadgerCare Plus Enrollment and Benefits (Updated 10-22-2013)

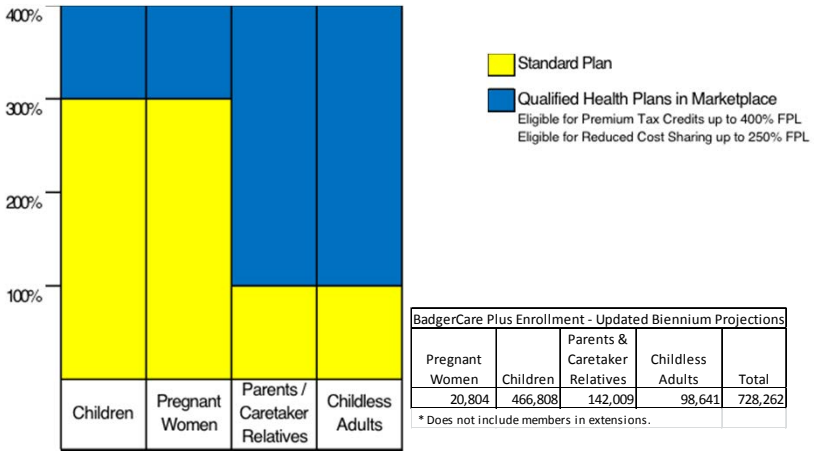


BadgerCare Plus Enrollment - September 2013				
Pregnant Women	Children	Parents & Caretaker Relatives*	Childless Adults	Total
18,512	428,277	222,060	16,774	685,623

* Does not include members in extensions.

4

Future BadgerCare Plus & Marketplace Enrollment and Benefits (Updated 10-22-2013)



BadgerCare Plus Enrollment - Updated Biennium Projections				
Pregnant Women	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	466,808	142,009	98,641	728,262

* Does not include members in extensions.

5

Current ACA Provisions

- Free preventive care for those with insurance
- No lifetime limits on coverage of essential benefits
- Young adults may remain on their parents' private insurance plan until 26
- Children cannot be denied coverage for pre-existing conditions

2014 ACA Provisions

- Adults cannot be denied coverage for pre-existing conditions
- Annual limits on insurance coverage eliminated
- Tax credits and cost-sharing available in the Marketplace
- Individual mandate

Individual Responsibilities

- Individual Mandate
  - 2014 penalty 1% of household income or $95 per adult and $47.50 per child whichever is greater
  - 2015 penalty 2% of household income or $325 per person whichever is greater
  - 2016 penalty 2.5% of household income or $695 per person whichever is greater
- Exemptions may apply

Source: https://www.healthcare.gov/what-if-someone-doesnt-have-health-coverage-in-2014/

Employer Shared Responsibility

- Employers with 50 or more FTEs
  - Begins 2015
  - Must provide affordable coverage
    - Employee only coverage less than 9.5% of annual household income
  - Meets minimum value
    - Plans share of the cost covers at least 60%
- Penalty $2,000 per employee (excluding first 30 employees)

Source: https://www.healthcare.gov/what-is-the-employer-shared-responsibility-payment

DHS Roles & Responsibilities

- Support Regional Enrollment Networks (RENs)
- Communicate with Members
- Support Income Maintenance Consortia
- Communicate with Centers for Medicare and Medicaid Services (CMS)

Support Regional Enrollment Networks (RENs)

- 12 kick-off meetings held around the state in August
- Trained over 700 individuals to be certified application counselors (CACs) or Navigators
- Completed 3 webcast trainings and 8 in-person trainings to partners and providers
- Hold bi-weekly phone conferences with RENs

Communicate with Members

- Sent 56,246 letters to 77,472 transitioning members
  - Called 77,266 members between Oct. 15 – Oct 31
  - Called 53,875 members between Nov. 4 – Nov. 9
- Sent 11,431 letters to 14,932 members in transitional Medicaid (100% - 133% FPL)
- Sent letters to 163,808 members on the Core Plan waitlist
- Provided list of transitioning members to HMOs
- Providers may request lists of transitioning members

Support Income Maintenance Consortia

- Provided additional $38.1 in income maintenance funding
- Communicate regularly with consortia and county staff
- CARES system updates and training

Communicate with Centers for Medicare and Medicaid Services

- Bi-weekly phone calls with CMS desk officer
- Regular State Operations and Technical Assistance (SOTA) calls with CMS
- Negotiate childless adult waiver
- Negotiate extension of current waiver

County Roles & Responsibilities

- Perform Income Maintenance functions and services
- Provide for the well-being, treatment and care of individuals to extent required by state law (chs. 46, 51, 55 etc.)

- Optional Roles & Responsibilities
  - Participate in RENs
  - Hire certified application counselor (CAC)
  - Outreach

Public & Private Sector Roles & Responsibilities

- Navigators
- Certified Application Counselors
- Licensed Insurance Agents and Brokers
- Assistors

- http://e4healthwi.org/
  - **The Enrollment Directory - http://e4healthwi.org/wp-content/uploads/Enrollment-Directory_11_27_2013.pdf**

Coordinating Assistance Efforts:
Lessons from Wisconsin

This brief was written by Elizabeth Hagan

Special thanks to reviewers: Jessica Kendall, Sophie Stern, and Jenny Sullivan from Enroll America; Ingrid VanTuinen from Families USA; and Lisa Olson from the Wisconsin Primary Health Care Association

Consumer outreach and enrollment assistance is critical to maximizing the number of people who enroll in health coverage. Yet the programs designed to connect consumers to coverage—and the resources devoted to those programs—vary widely from state to state. This brief explores a promising strategy from Wisconsin, where stakeholders have created regional enrollment assistance networks throughout the state despite limited state and federal resources and the reluctance of state policymakers to embrace implementation of the Affordable Care Act (ACA).

The Landscape of National Outreach and Enrollment Assistance Efforts

State and federal decisions about program design and resource allocation have greatly affected the size and scope of enrollment assistance programs. In states with federally facilitated marketplaces, it has been more difficult to create strong assistance programs. This is due to the limited funding that is available and the often tepid support—or outright opposition—from state policymakers. On the other hand, states with state based and partnership marketplaces have more resources at their disposal, and they also often have state policymakers and agencies invested in ensuring that robust assistance is available. For example, California, a state running its own marketplace with more than 7 million uninsured residents, has secured nearly $58 million for outreach, education, and consumer assistance.[1] Texas, which has a federally facilitated marketplace and 6 million uninsured residents, will receive just over $20 million for its navigator and community health center assistance efforts.[2]

States with federally facilitated marketplaces face an uphill climb: relatively few resources have been dedicated to creating enrollment assistance programs, and the federal funding for navigator programs in these states was not announced until August 15, 2013. This left less than two months for organizations to create programs and hire and train staff before open enrollment began. Stakeholders in these states, such as health care providers, community health centers, hospitals, and community-based organizations, recognize the need to educate and assist the individuals they reach about the new health coverage options, but without state-based marketplaces, there is often little institutional leadership in place to organize and propel individual stakeholder-based assistance efforts.

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Why Coordinating Consumer Assistance Is Important

Consumers want help from different sources for different steps in the enrollment process.

Although the public's understanding of the ACA is growing, many uninsured consumers who are looking for health coverage are unaware of their new options.[3] When these consumers do learn about their options, three out of four express a desire for in-person help with the application and enrollment process.[4]

One critical factor that determines whether consumers successfully enroll is their ability to find appropriate sources of assistance. Some consumers will want help completing the application. Others will want help understanding their options and selecting a health insurance plan that fits their budget and their health care needs. Some will prefer to get enrollment assistance from an eligibility worker, while others will seek out help from a health care provider. Figure 1 below shows how consumers' preferred messengers and sources of help vary.

Figure 1: Consumers' Preferred Messengers and Sources of Help

Demographic	Preferred Messengers	Preferred Sources of Help
African Americans	• Doctor • Someone who has already gotten insurance through marketplace • Local Medicaid office • State or federal health agency • Family member	• State worker whose job it is to help • Doctor or nurse • Health insurance plan • Local Medicaid office • Family member: spouse/partner or mom
Latinos	• Federal or state government agency • Local Medicaid office • Doctor • Family Member • Someone who has already gotten insurance through marketplace	• State worker whose job it is to help • Doctor or nurse • Local Medicaid office • Health insurance plan • Family member: Mom or partner/spouse • Someone from local clinic or hospital
Women	• Doctor • Someone who has already gotten insurance through marketplace • Family member • State or federal health agency • Local Medicaid office	• State worker whose job it is to help • Family member: Spouse/partner, mom, or sister • Doctor or nurse • Health insurance plan • Local Medicaid office
Young Adults	• Family member • Someone who has already gotten insurance through Marketplace • Doctor • Friend • Federal or state health agency • Local Medicaid office	• State worker whose job it is to help • Family member: mom or spouse/partner • Doctor or nurse • Health insurance plan • A friend

Figure 2: Strong Networks Lead Consumers to Coverage

COMMON CONNECTORS:

- Providers
- Family
- Community groups (faith-based groups, racial/ethnic groups, civic groups)
- Friends
- Media (news outlets, celebrities, advertisements)
- Navigators
- Community health centers
- CACs
- Marketplace call center
- Agents and brokers
- Public Health Departments
- In-person assisters
- Medicaid offices
- 211

As noted above, consumers have different preferences about how they receive information and get help with applying for coverage. And specific steps in the application and enrollment process will be very different for each consumer. But regardless of who is applying, the application and enrollment experience should be seamless and have limited handoffs from one entity to another. Assistance that is piecemeal will leave many consumers unable to get the help they need.

If groups aren't working with one other to identify community needs, there could be significant gaps in the kinds of assistance that are available to consumers. For example, a state could have an area where consumers are unable to receive local application assistance, while another area could have a strong network of application assisters but very limited Spanish language assistance.

Different stakeholder groups will assist the populations they serve in different ways. But it is clear that the more states coordinate their outreach and enrollment efforts, the more likely consumers will be to get the help they need from sources they trust. (See Figure 2.)

Stakeholder groups that are able to work together will be better positioned to identify and fill gaps that exist and to help one another build capacity where there is none. Collaboration also allows groups to focus on their own strengths rather than be hindered by their limitations. Creating strong networks of assistance will provide individuals and families with the help they need when they apply for and enroll in health coverage. Leveraging these relationships and creating robust assistance networks will ensure that consumers have a place to turn to for help and have positive experiences when seeking health coverage. It will also aid in the critical task of enrolling consumers successfully. And the need for community collaboration to provide in-person assistance is increasingly important for people that may be encountering technical problems with the enrollment process through Healthcare.gov or through their state-based marketplace.

If consumers have frustrating or confusing experiences, they may not complete the enrollment process, which would limit the overall number of people who successfully enroll. Establishing strong, collaborative networks will only enhance consumers' experiences, thus maximizing enrollment.

Wisconsin's Regional Enrollment Networks

To provide support to consumers who are looking for help applying for, enrolling in, and retaining health coverage, stakeholders in Wisconsin created a plan to develop Regional Enrollment Networks (RENs).

Wisconsin has taken a collaborative approach that incorporates many of the ideas outlined above to make outreach and enrollment work well. The state has nearly 500,000 uninsured residents,[5] has a federally facilitated marketplace, and has received about $2.7 million in federal funding for enrollment assistance programs ($1 million for navigator programs and $1.7 million for community health centers to conduct outreach and enrollment).[6] The state is simultaneously expanding and contracting its Medicaid program, known as BadgerCare. Childless adults in Wisconsin stand to gain form the expansion, as they will now be covered up to 100 percent of the federal poverty level. However, parents and caretaker relatives will lose their BadgerCare coverage at the end of this calendar year, and are being directed to apply for health coverage through the Marketplace. All of these factors make successful communication particularly important in the coming months—communication not only with uninsured residents, but also with consumers whose coverage is changing.

To provide support to consumers who are looking for help applying for, enrolling in, and retaining health coverage, stakeholders in Wisconsin—including the Wisconsin Primary Health Care Association, Covering Kids and Families-Wisconsin, and the Department of Health Services or DHS (which administers Wisconsin's Medicaid program)—created a plan to develop Regional Enrollment Networks (RENs). The plan called for 12 RENs across the state to be made up of local entities working on reaching out and enrolling consumers in health coverage. While participation in the RENs is voluntary, they create a basic infrastructure that allows organizations to interact and coordinate with one another. Organizations and volunteers who participate in the RENs will not be funded for their participation, though some have external funding sources that make their collaboration and participation possible.

This statewide plan was adapted from the existing Milwaukee Enrollment Network (MKEN) model. This Network has developed over the past several years, and focuses on supporting the enrollment of Milwaukee County residents in health coverage and includes more than 70 health care and community-based organizations. MKEN partners range from hospital systems and other providers to community health centers and the Milwaukee County Department of Health and Human Services. The Network was created by the Milwaukee Health Care Partnership, which is a broader public-private partnership focused on the overall health of low-income residents in the Milwaukee area.

Acknowledging that each REN is different in terms of its existing enrollment infrastructure and the characteristics of its uninsured populations, the 12 RENs will be able to tailor their structure and goals based on their specific needs and desires. The regions are working with different partners and are

at varying stages of integration with those partners, so regional networks can—and likely will—look very different from one another.

The more states coordinate their outreach and enrollment efforts, the more likely consumers will be to get the help they need from sources they trust.

The Work of RENs

Ensuring that uninsured consumers learn about their new and/or changing health coverage options and are able to successfully apply for coverage through the marketplaces presents a unique set of circumstances. In Wisconsin, large numbers of consumers who will be applying for health coverage through the Marketplace won't have had coverage previously. And although many consumers will be applying for coverage for the first time, there are also many consumers who will have to transition from one type of coverage to another.[7] The goal of the RENs is to have local groups collaborate to ensure that trusted messengers help consumers learn about available coverage and how they can get help with enrolling in and retaining health coverage. Additionally, the RENs are working together to coordinate handoffs between various organizations and various levels of enrollment staff. With a very limited number of certified application counselors (CACs) and navigators available, it is critical for these RENs to coordinate and ensure that there is no unnecessary duplication of efforts. For example, some regions have developed volunteer plans to help alleviate some pressure on the CACs by preparing consumers for their enrollment appointments.

Many diverse groups with different capacities and strengths will be working on outreach and enrollment, so supporting each other will be a key part of making the RENs successful. Bringing together the groups helping consumers apply and enroll (such as navigators and community health centers) with "mobilizers" (those who have influence in their communities—such as faith groups and civic groups) will provide residents with the help they will need. Wisconsin's navigator grantees will be key partners in the RENs. However, the RENs will also need the support of other enrollment stakeholders, such as CACs, community health centers, providers, businesses, and community organizations that have access to uninsured consumers and that can provide them with application assistance or information about the new Marketplace.

Who Created the RENs?

Enrollment for Health Wisconsin (E4Health) is the primary driving force behind the creation of the 12 RENs. E4Health is a public-private coalition, which began in May 2013 to coordinate statewide outreach and enrollment and to facilitate statewide communication about the implementation of Wisconsin's marketplace. The group has been successful in retaining a wide variety of partners, in large part, because of their commitment to keeping politics outside of enrollment. While E4Health itself is not funded or staffed, a few key organizations have made the work of enrollment possible, including the Wisconsin Primary Health Care Association, Covering Kids and Families-Wisconsin and the Milwaukee Health Care Partnership. DHS serves as a key partner on the REN initiative, and has devoted staff time to help advance the goals of the networks. Additionally, DHS has funded the placement of nine AmeriCorps members through the Primary Care Association's "Wisconsin HealthCorps" program to coordinate the work of the RENs.

Staffing and Support

Each of the Wisconsin regions will have a "Regional Enrollment Network Organizer" and a "Regional Enrollment Network Lead" who will work closely to facilitate the work being done in that region.

- The "Organizers" will be AmeriCorps members, and their role will be identifying and coordinating with organizations and people in each region who already work on outreach and enrollment and have a good understanding of what the region's needs are.
- The "Leads" in each region will be local community leaders who are

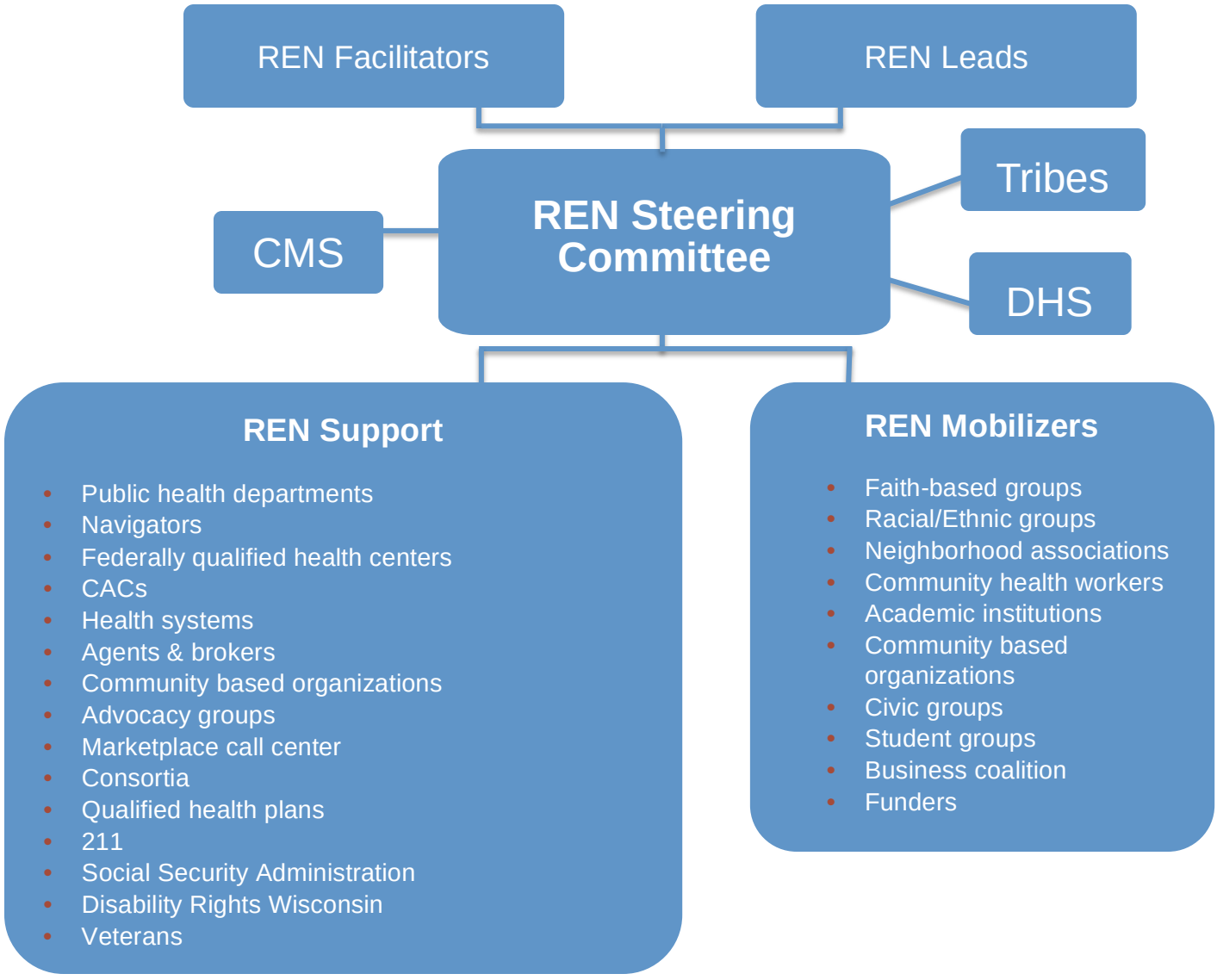
Establishing strong, collaborative networks enhances consumers' experiences, thus maximizing enrollment.

well known in the community as people who have multiple collaborative relations and can build successful coalitions. These individuals will serve as the main conveners of the RENs.

- The DHS employs Area Administration staff who currently serve as the primary link with local county human service agencies in a broad range of program areas. They are also providing support to the RENs.

Figure 3 below shows the basic structure for how the RENs will be organized—many diverse groups are serving important roles. Some of these groups may not be traditional partners and may not have worked together in the past, so it may be challenging to forge new relationships. The success of this plan relies on groups of all types to build new coalitions and partnerships and leverage the relationships they already have.

Figure 3: Example of Regional Enrollment Networks



Steps for Coordinating Assistance in Your State

Facilitating coordination across enrollment assistance entities in your state, region, or locality will help ensure the most seamless, consumer-friendly enrollment process possible. Below we list several immediate action steps that enrollment stakeholders can take to make outreach, education, and enrollment assistance work effectively:

- Determine which other organizations are working on outreach, enrollment, and application assistance, and talk with them about ways to collaborate.
- Identify the gaps in your region and think about logical ways they can be filled.
- Create a list of comprehensive goals you would like to achieve as an individual organization and as a region/state.
- Identify your organization's strengths and decide what role you can play in meeting those goals.
- Build an organizational plan to meet those goals (think about outreach best practices),[8] and assign tasks to specific staff members.

Challenges

As noted earlier, the organizations that are participating in the RENs will not be funded for their participation. The only full-time staff who will be working exclusively to support the RENs work are the AmeriCorps members. And, since the majority of the AmeriCorps members are brand new to this type of service, they are only able to be successful if they have strong volunteer leadership in their respective communities. The limited funding for the RENs will require partners on the ground to assist the networks in whatever ways they can, including giving financial support, lending expertise, or providing access to staff and volunteers.

There is also concern that there will be regions that don't have enough organizations that are interested in working with the RENs. Though assisting with outreach and enrollment is a natural extension of the work that several groups have been doing for years, some regions and groups have limited experience in this arena. Building these networks to the fullest extent possible will be a challenge, but stakeholders agree that working together to ensure their efforts are coordinated and complementary (and not duplicative) will be well worth the effort.

Looking Ahead

A number of key stakeholders, including the Primary Care Association, Covering Kids and Families, the Wisconsin Hospital Association, Alliance of Health Insurers, and others are have been meeting on a bi-weekly basis since before open enrollment began to discuss implementation successes and challenges with both the DHS and the Office of the Insurance Commissioner. In addition, a smaller team is convening the REN leads for similar purposes. The RENs have each completed draft operational plans to help guide their work moving forward. These plans take a first attempt at delineating the roles and responsibilities of organizations in each region and identifying partners' capacities and needs. Although operation plans are flexible, and each enrollment network will likely come up with its own individual goals, the enrollment networks do provide a strong framework for the first open enrollment period.

Conclusion

When enrollment stakeholders coordinate their efforts, consumers are less likely to fall through the cracks and go without the assistance they need. Coordination can be even more effective when state or local government is at the table and engaged in the effort. Wisconsin's approach draws on community groups' strengths and emphasizes their collective potential to create positive change. Their efforts suggest a model that other states, particularly those with limited enrollment assistance infrastructures and funding, can consider as they work to connect consumers to coverage.

End Notes

[1] Covered California, *Covered California Awards Community Organizations $37 Million in Grants for Outreach and Education* (Los Angeles, CA: Covered California, May 14, 2013), available online at http://www.coveredca.com/news/press-releases/pr-05-14-13.html; U.S. Department of Health And Human Services, Health Resources and Services Administration, *California Health Center Outreach and Enrollment Assistance* (Washington: HRSA, July 10, 2013), available online at http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/ca.html.

[2] Centers for Medicare and Medicaid Services (CMS), *Navigator Grant Recipients* (Washington: CMS, August 15, 2013), available online at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf; U.S. Department of Health And Human Services, Health Resources and Services Administration, Texas Health Center Outreach and Enrollment Assistance (Washington: HRSA, July 10, 2013), available online at http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/tx.html.

[3] Kaiser Family Foundation, *Kaiser Health Tracking Poll: August 2013* (Washington: Kaiser Family Foundation, August 2013).

[4] See *Informing Enroll America's Campaign: Findings from a National Study*, available online at http://files.www.enrollamerica.org/best-practices-institute/public-education-resources/EA_Final_Report.pdf.

[5] Centers for Medicare and Medicaid Services (CMS), *The Number of Estimated Eligible Uninsured People for Outreach Targeting* (Baltimore: CMS, April 18, 2013), available online at https://data.cms.gov/dataset/The-Number-of-Estimated-Eligible-Uninsured-People-/pc88-ec56 .

[6] Centers for Medicare and Medicaid Services (CMS), Navigator Grant Recipients, op. cit. and U.S. Department of Health And Human Services, Health Resources and Services Administration, *Wisconsin Health Center Outreach and Enrollment Assistance* (Washington: HRSA, July 10, 2013), available online at http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/wi.html.

[7] Wisconsin's Department of Health Services (DHS) estimates that 68,567 parents and caretaker relatives and 5,283 childless adults and 3,622 children will transition from their Medicaid program, BadgerCare Plus, to the marketplace.

[8] See Enroll America's *Outreach Planning 101*, available online at http://files.www.enrollamerica.org/best-practices-institute/enroll-america-publications/Outreach_101.pdf.

WI Correspondence with CMS regarding BC+ Data Match

Email from WI to CMS: October 17, 2013

Per our conversation yesterday we would like to move forward in conducting a data match with CMS. As part of this process we would provide CMS data extracts for those members/individuals that received the informational letters in September. The populations/extracts include:

1. Letter 1 – includes those transitioning adults (parents/caretaker relatives and childless adults) whose household income exceeds 100% of the federal poverty level (FPL), and transitioning children in households whose income exceeds 300% FPL.
2. Letter 2 – includes those parents/caretaker relatives who are currently in transitional medical assistance (TMA) whose household income is between 100% and 133% FPL that will be required to pay premiums starting January 1, 2014.
3. Letter 3 – includes those childless adults that are currently enrolled in the BadgerCare Plus Basic Plan.
4. Letter 4 – includes those childless adults that were on the Core Plan waitlist as of September 20, 2013.

Following are the case (household) and individual counts for each population/extract:

	Case Count	Individual Count
Letter 1 - Transitioning Members		
Parents/Caretakers (over 100% FPL not eligible for an extension)		68,567
Childless Adults (over 100% FPL)		5,283
Children (Over 300% FPL)		3,622
Total	56,246	77,472
Letter 2 - Members Eligible for TMA (Extension)		
Parents/Caretakers (100% FPL to 133% FPL that will have premiums starting Jan 1, 2014)	11,431	14,932
Letter 3 - CORE Waitlist Members	N/A	163,808
Letter 4 - Basic Plan Members	N/A	1,222

Ideally, depending on what you may be able to provide, we would want to match/confirm at the individual level for the following milestones.

1. Account Created
2. Application Started
3. Application Complete – BadgerCare Plus Determination
4. Application Complete – APTC/QHP Determination
5. QHP Enrollment
6. QHP Initial Premium Payment

Please let us know how you would like to proceed. I can provide file layouts for the extracts if that would be helpful.

Email from CMS to WI: October 17, 2013

Thanks, Craig – let us talk and one of us will get back to you ASAP.

Email from CMS to WI: March 21, 2014

I'd like to work with you to identify the data elements that you'd need from us for the data match. If we were to send, via secure flat file, the WI QHP enrollees so WI could do the match with those whose waiver coverage was ending, what would be the minimum data set you'd need? Name, plus what other identifiers? Trying to keep it to the minimum, obviously. We have attention focused on this now so I'll be on alert this weekend if need be.

Email from CMS to WI: March 21, 2014

These are the fields in the report so far. Any you can nix? Anything missing?

Field List Currently Included:
ISSR_STATE_CD=WI
HIOS_ID
BENE_SBSCBR_IND
BENE_SBSCBR_EXCHG_ASGNED_ID
BENE_EXCHG_ASGNED_ID
BENE_ISSR_ASGNED_ID
BENE_SBSCBR_ISSR_ASGNED_ID
PRSN_LAST_NAME
PRSN_1ST_NAME
PRSN_MDL_NAME
PRSN_RSDNTL_ADR_LINE_1_TXT
PRSN_RSDNTL_ADR_LINE_2_TXT
PRSN_RSDNTL_CITY_NAME
PRSN_RSDNTL_STATE_CD
PRSN_RSDNTL_ZIP_CD
PRSN_RSDNTL_CNTRY_CD
PRSN_PHNE_NUM
PRSN_EMAIL_ADR
PLAN_BNFT_STRT_DT
PLAN_BNFT_END_DT
PLCY_APTC_AMT
PLCY_APTC_EFCTV_DT
PLCY_APTC_END_DT

Email from WI to CMS: March 21, 2014

So from a matching standpoint we would typically match on First Name, Last Name, DOB, and SSN to make sure we are pulling the correct people. Even if someone moved out of state we would not want to limit the search to only those with a state_cd = WI, and include in the report. From a reporting perspective our intent is to conduct outreach, both letters and phone calls, to the people that have not yet enrolled in a QHP, realizing that some people may have obtained other coverage (e.g. ESI), to connect them with local assistance. In fact our county agencies are considering doing the call outreach depending on the final counts.

With all of this said, could we give you a file with First Name, Last Name, DOB, and SSN for those people that have lost BadgerCare Plus eligibility and have you match against the comprehensive QHP enrollees and return the following?
BENE_SBSCBR_IND
BENE_SBSCBR_EXCHG_ASGNED_ID
BENE_EXCHG_ASGNED_ID
BENE_ISSR_ASGNED_ID
BENE_SBSCBR_ISSR_ASGNED_ID
PRSN_LAST_NAME
PRSN_1ST_NAME
PRSN_MDL_NAME
PRSN_RSDNTL_ADR_LINE_1_TXT
PRSN_RSDNTL_ADR_LINE_2_TXT
PRSN_RSDNTL_CITY_NAME
PRSN_RSDNTL_STATE_CD
PRSN_RSDNTL_ZIP_CD
PRSN_RSDNTL_CNTRY_CD
PRSN_PHNE_NUM
PRSN_EMAIL_ADR
PLAN_BNFT_STRT_DT
PLAN_BNFT_END_DT
PLCY_APTC_AMT
PLCY_APTC_EFCTV_DT
PLCY_APTC_END_DT

If we take this approach, specifically considering what is being requested, then we will be able to provide accurate counts for those people that have lost BadgerCare Plus and enrolled in a QHP. If you simply give us a report of those who have enrolled in a QHP in Wisconsin, we will likely violate HIPAA privacy rules as some of those people were never enrolled in BadgerCare Plus and there would be no operational justification for providing the information. From a volume perspective I am estimating (and can provide final counts next week) that we would have less than 75K people to match and report.

Also, it is my understanding that there is currently no way for HHS/CMS to confirm if a QHP enrollee has paid their initial premium. So to level set expectations I just want to confirm that is the case, or if we might have to do a subsequent data match, say in May, to confirm if any of the people have been disenrolled due to not payment of premium.

Let me know what you think, if it is really just simpler for you to provide the entire list of those in Wisconsin who are enrolled in a QHP I just want to have an opportunity to discuss with our legal counsel to confirm that we have the legal authority to receive it.

Email from CMS to WI: March 22, 2014

Ok- we talked about this option but don't think it can happen quickly. We would have to build the person-matching query for this and are nearing a code freeze for a period of time given the end of open enrollment. Our initial pull is about 67000 from WI. Good point about having moved though not sure how we'd overcome it. Can you please check with your legal counsel? The operational justification may be that there isn't an easier/possible way. Maybe if we don't use SSN? Would DOB work instead? We match on email address, successfully.

I'll check on the premium payment.

Email from CMS to WI: March 24, 2014

We're also still pursuing the idea of you giving us a file, the FFM producing a file and then doing a cross walk here (as opposed to a person-finder match within the FFM system). We're talking to our OGC today about the HIPAA issues.

TAMMY BALDWIN
WISCONSIN

COMMITTEES:
HEALTH, EDUCATION, LABOR, AND PENSIONS
BUDGET
SPECIAL COMMITTEE ON AGING
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

United States Senate
WASHINGTON, DC 20510

March 17, 2014

The Honorable Scott Walker
Governor of Wisconsin
115 East Capitol
Madison, WI 53702

Dear Governor Walker:

I am writing to request an update on your efforts to transition 77,000 Wisconsinites from the BadgerCare coverage they can currently enjoy to coverage through the Affordable Care Act's Health Insurance Marketplace. Under your plan, these Wisconsin families will lose their BadgerCare coverage at the end of March, with the hope that they have successfully obtained Marketplace coverage. This plan is a key part of your promise to use Medicaid and the Affordable Care Act Marketplace to cut Wisconsin's uninsured rate in half. With Open Enrollment ending on March 31, now is the time to provide a public report on transition efforts.

As you know, I believe that you took our state taxpayers down a fiscally irresponsible path by adopting your plan instead of accepting a federal investment to strengthen BadgerCare. The state Legislative Fiscal Bureau has concluded that your plan covers fewer people at a higher cost to Wisconsin taxpayers.[1] In addition, according to the Congressional Budget Office, the path you have chosen will come at a higher cost to the federal government.[2] Your plan also kicks vulnerable individuals off their current care. However, now that you have received federal approval for your proposal, and there is no signal that you will adopt different policies, I am hoping for successful implementation of your transition plan so that Wisconsinites losing BadgerCare remain insured and do not experience a lapse in health coverage.

In order to help maintain continuity of coverage, the federal government built in terms and conditions to its approval of your plan.[3] The State has agreed to these terms.[4] It is critical that you hold up your end of the bargain and abide by these federal terms and conditions so that more Wisconsin families make a seamless transition and receive the Marketplace coverage they deserve.

One important condition of federal approval was that the State would continue to work with the Centers for Medicare & Medicaid Services (CMS) to establish mechanisms for tracking

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[1] Legislative Fiscal Bureau

[2] In July 2012, the Congressional Budget Office (CBO) released a report that estimates that, by 2022, the average annual cost to the federal government per Medicaid enrollee will be $6,000, while the cost for providing subsidies to an analogous exchange enrollee will be $9,000. CBO attributes this difference primarily to Marketplace plans' higher health care provider reimbursement rates and administrative costs.

[3] December 30, 2013 letter from CMS Administrator Marilynn Tavenner to Wisconsin Medicaid Director Brett Davis

[4] January 9, 2014 letter from Wisconsin Department of Health Services Director Kitty Rhoades to CMS

the 77,000 individuals who were forced to transition from BadgerCare coverage to Marketplace coverage.[5] Tracking this transition is critical to ensuring low-income Wisconsinites don't fall through the cracks and lose access to vital health coverage. However, your Administration has failed to provide any reporting on this matter to date. Though we have received statistics from CMS on total Wisconsin Marketplace enrollments through February, we have not seen any breakdown on the number of those individuals who transitioned to Marketplace coverage from BadgerCare. According to the terms of your CMS waiver approval, the State should have been working to track such individuals.

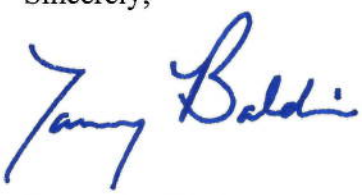
With just two weeks before Open Enrollment ends, I am requesting that you immediately provide a report on the status of the transition these 77,000 people have to make from BadgerCare to the federal Marketplace.

A second important condition of the CMS approval was that the State would communicate constructively with all BadgerCare applicants.[6] This includes much needed and effective outreach to all childless adults living in poverty who can't access BadgerCare until April 1, 2014 because of your decision and the State Legislature's action to postpone their coverage. These vulnerable Wisconsinites have fallen into a coverage gap since January 1, 2014. According to the CMS waiver, the State must explain the delay in coverage to individuals falling in the coverage gap. Constructive communication also includes the State developing written and telephone messages for BadgerCare applicants who currently qualify for BadgerCare coverage but will be kicked off BadgerCare at the end of March. Results of these communications are to be recorded and reported. Therefore, I also am requesting an update on communication efforts to those vulnerable Wisconsinites who have been awaiting BadgerCare coverage since January, and those soon to be kicked off coverage at the end of March. Likewise, I ask that you ramp up these communication and outreach efforts in order to ensure that as many Wisconsin families as possible remain covered.

If you keep your word and abide by the public reporting and constituent communications requirements in the CMS approval, it will be a positive step in keeping your promise to cut Wisconsin's uninsured rate in half. If, on the other hand, you do not keep your word, our state will have far more uninsured individuals than we should at the beginning of April.

I look forward to receiving your updates. As always, I am happy to work together to ensure that Wisconsin families receive the quality, affordable health coverage they deserve.

Sincerely,



Tammy Baldwin
United States Senator

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[5] December 20, 2013 letter from CMS to Wisconsin Medicaid Director Brett Davis
[6] December 20, 2013 letter from CMS to Wisconsin Medicaid Director Brett Davis

Media Inquiry re: CMS and WI BC+ Data Match

From: Kraus, John (Baldwin) [mailto:John_Kraus@baldwin.senate.gov]
Sent: Tuesday, March 18, 2014 11:41 AM
To: David Wahlberg
Subject: Letter to Walker on BadgerCare

David,

Here is a copy of a letter that went to Walker's office on his plan to kick 77,000 people off of their BadgerCare coverage and move them into the Marketplace through the federal exchange

As part of the federal waiver that the Walker Administration accepted to pursue their plan, they promised to track and report out the transition of these 77,000 off BadgerCare and into the Marketplace.

They should know today how many of the 77,000 being kicked of BadgerCare make up the 71,0000 that have signed up in the Marketplace through the federal exchange to date.

We are simply asking them to let everyone else know how many of the 77,000 are in the Marketplace today.

"*I am writing to request an update on your efforts to transition 77,000 Wisconsinites from the BadgerCare coverage they can currently enjoy to coverage through the Affordable Care Act's Health Insurance Marketplace. Under your plan, these Wisconsin families will lose their BadgerCare coverage at the end of March, with the hope that they have successfully obtained Marketplace coverage. This plan is a key part of your promise to use Medicaid and the Affordable Care Act Marketplace to cut Wisconsin's uninsured rate in half. With Open Enrollment ending on March 31, now is the time to provide a public report on transition efforts…*"

"One important condition of federal approval was that the State would continue to work with the Centers for Medicare & Medicaid Services (CMS) to establish mechanisms for tracking the 77,000 individuals who were forced to transition from BadgerCare coverage to Marketplace coverage.[1] *Tracking this transition is critical to ensuring low-income Wisconsinites don't fall through the cracks and lose access to vital health coverage. However, your Administration has failed to provide any reporting on this matter to date. Though we have received statistics from CMS on total Wisconsin Marketplace enrollments through February, we have not seen any breakdown on the number of those individuals who transitioned to Marketplace coverage from BadgerCare. According to the terms of your CMS waiver approval, the State should have been working to track such individuals."*

[1] December 20, 2013 letter from CMS to Wisconsin Medicaid Director Brett Davis

"With just two weeks before Open Enrollment ends, I am requesting that you immediately provide a report on the status of the transition these 77,000 people have to make from BadgerCare to the federal Marketplace."

From: David Wahlberg [mailto:DWahlberg@madison.com]
Sent: Tuesday, March 18, 2014 11:50 AM
To: Evenson, Tom - GOV; Smith, Claire F - DHS
Subject: FW: Letter to Walker on BadgerCare

Tom:

I was just asking Claire for this same info (before I saw the letter from Sen. Baldwin), and she said it's not yet available. Does anyone at the state level have this info? Why not?

Thanks, David

From: Smith, Claire F - DHS
Sent: Tuesday, March 18, 2014 5:22 PM
To: 'David Wahlberg'
Cc: DHS Media
Subject: RE: Letter to Walker on BadgerCare

Hi David,

As I mentioned in my previous email and over the phone, we should have updated data regarding BadgerCare Plus members available in early April. This will include our monthly enrollment data; information regarding the members that were no longer eligible for BadgerCare Plus because they had access to affordable private health insurance through the Marketplace; and information regarding members that Wisconsin received through the account transfer process from the Marketplace.

You are correct that our agreement with the federal government to delay implementation of the Governor's entitlement reforms by three months that , "CMS will continue to work with the state to establish acceptable mechanisms for tracking who do and do not successfully make the transition to coverage through the Marketplace, including the strategies discussed below." This text is taken from page 3 of a letter sent to Brett Davis on December 20, 2013 by Eliot Fishman from CMS.

We first submitted our request to CMS to do a data match in November 2013 for the individuals who are transitioning from BadgerCare Plus to the Marketplace to determine if they purchased private health insurance through a QHP and began receiving benefits. We submitted our request through the federal State Operations Technical Assistance Group (SOTA) that we meet with every other week. CMS responded that our data match request is on their to-do list; however, due to many different priorities they do not know when they will be able to complete our request.

Since November 2013, when we made the data match request, the data match request has been an agenda item on every one of our SOTA calls. CMS has not yet been able to provide the requested data match nor have they indicated when it will be available.

We do not have access to information regarding individuals that have purchased health insurance through the Marketplace – only CMS does. We, as well as our state legislators, congressional delegation, local media, and Wisconsin citizens are eagerly waiting for this data. We would appreciate any assistance Senator Baldwin and her staff could provide in helping get this data match in an accurate and timely matter.

It's also important to note that the Department has been working closely with our community partners, advocates and Regional Enrollment Networks since September to ensure that Wisconsin residents are able to understand their health care options.

A couple of the outreach strategies that we have implemented include mailing letters to individuals who are transitioning from BadgerCare Plus to the exchange, and those on the Core Plan waitlist letting them know about the changes to BadgerCare Plus and that they may be eligible for the program if they have incomes below 100% of the Federal Poverty Level and meet other eligibility criteria. Since October we have also been making follow-up outbound calls to all households or individuals who received one of our informational notices to make sure that they received the letter, that they understood the letter, and that they are taking action by either reporting changes if they are a current BadgerCare Plus member, or applying for coverage if they are a childless adult on the waitlist, or if they need to transition to the Marketplace (exchange), that they have all of the information/resources they need to complete an application in the federal Marketplace. In April, will send one final letter to the BadgerCare Plus members who no longer met the program rules as of April 1, 2014 and have access to affordable health insurance through the federal Health Insurance Marketplace reminding them that they need to take action to apply for and purchase health insurance through the Marketplace since they no longer have BadgerCare Plus coverage. These individuals will have until May 31, 2014 to apply for and purchase private health insurance through the Marketplace because losing their BadgerCare Plus coverage is a qualifying event that allows individuals to purchase health insurance through the Marketplace outside of open enrollment. We will also be conducting another round of outbound calls to these individuals once the letter has been mailed to make sure that they received the letter, that they understood the letter, and that they are taking action.

Again, without data from the federal government, we have no way to extract the number of BadgerCare Plus members those no longer meeting the program rules who have successfully transitioned to the marketplace and purchased private health insurance coverage through a qualified health plan.

Thanks,

Claire

SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. BOX 7863
MADISON, WI 53707

March 27, 2014

The Honorable Tammy Baldwin
United States Senate
717 Hart Senate Office Building
Washington, DC 20510

Dear Senator Baldwin:

Thank you for your recent letter expressing continued interest in state efforts to help Wisconsinites navigate through the ongoing issues related to the troubled rollout of the federal Affordable Care Act (ACA).

As you know from our past correspondence, Wisconsin state agencies implemented an aggressive outreach effort to increase awareness of changes made necessary by the federal law and to provide information and assistance for those transitioning as a result of the ACA. Specifically, in September 2013, the Department of Health Services (DHS) mailed letters to individuals who are transitioning from BadgerCare Plus to the exchange. DHS also mailed letters to individuals on the Core Plan waitlist letting them know about the changes to BadgerCare Plus that may make them eligible for the program, if they have incomes below 100 percent of the Federal Poverty Level and meet other eligibility criteria. In October 2013, the Department also made follow-up calls to all who were sent a notice to ensure they received and understood the letter and to offer assistance with applying for appropriate services based on their circumstances. Furthermore, after the failed federal rollout of Healthcare.gov left most users unable to sign up for health plans through the exchange, DHS mailed out 56,246 paper applications in November 2013.

In April, DHS will send another letter to the BadgerCare Plus members, who will be transitioning into the private health care market as of April 1, 2014, to let them know they have until May 31, 2014 to apply for and purchase private health insurance through the federal exchange. Those people transitioning from BadgerCare Plus into private health insurance plans due to the change in their eligibility are provided additional time to apply on the exchange outside the normal open enrollment window. You can find a list of the various letters sent on the DHS website at http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm, as well as in the attachments to this letter.

Additionally, the Wisconsin Office of the Commissioner of Insurance (OCI) planned and participated in 16 public town halls and eight editorial boards throughout the state to inform the public of upcoming changes in health insurance in September and October

leading up to its implementation. OCI also worked with DHS to provide free Navigator and Application Counselor Training, more comprehensive online training for insurance agents, and an "Insurance 101" video, which is also available online to the public. As a result of the free training opportunities, 578 individuals were trained and 212 more completed the training requirements through a private vendor. A total of 512 out of 516 individuals passed the state examination. To help facilitate a targeted understanding of the concepts captured in the state examination, OCI developed an Examination Content Outline, a Navigator Study Guide, a State Public Assistance Programs document, and a Frequently Asked Questions document covering various aspects of the ACA.

Both OCI and DHS focused on a grassroots effort to engage stakeholders into "regional enrollment networks," including 49 meetings since July 2013 between DHS personnel and these stakeholders. By linking county personnel, community health centers, insurance agents, health provider systems and navigators, we were able to make most consumers aware of the options they had for insurance coverage, whether through the federal exchange, through Medicaid, or in Wisconsin's robust health insurance market. Due to these efforts, Wisconsin has been one of the more successful states in enrolling consumers through the federal exchange. As of January 1, according to the U.S. Department of Health and Human Services (HHS), total enrollment for Wisconsin was 71,443 individuals. Only 16 states have enrolled more individuals than Wisconsin with 12 of those states taking part in the federal exchange, and Wisconsin is eighth best when compared uninsured populations of each state. As you know, Wisconsin is also the only state to not operate its own exchange that has no coverage gap, as reported by the Kaiser Family Foundation.

I appreciate your shared interest in tracking those individuals who transitioned to private health insurance plans from BadgerCare and would welcome your assistance in working with the federal Centers for Medicare and Medicaid Services to help us do so. You may be interested to know DHS first submitted its request to have CMS do a data match on those persons transitioning in October 2013. Since receiving our request, we have had 12 calls with CMS, where this topic was listed as an agenda item, and it was only this last Friday, March 21 that CMS contacted DHS to inquire about the proceeding with a data match. Since the United States Congress has oversight of CMS, I ask you to use your position in Congress to help us get more timely cooperation from CMS in the future.

Additionally, I would welcome your help in getting a resolution to our request to the federal government to provide Wisconsin consumers increased flexibility and additional health insurance options. On November 15, 2013, I asked the federal government to allow Wisconsinites to use available tax credits to purchase any qualified health plan, whether on the exchange or not, and not to limit their choices to those plans available through the federal exchange website.

On February 27, 2014, we received a response from the Department of Treasury (Treasury) and HHS stating the two Departments do not have the statutory authority to accommodate our request. Simultaneously, on February 27, HHS issued guidance allowing consumers unable to access plans through the federal exchange website, due to its previous and ongoing issues, to use their tax credits to purchase qualified plans outside of the exchange. Both of these communications are attached.

The federal government's conflicting responses are unnecessarily confusing. It only makes sense to give all consumers the same choices, especially given HHS has already made this accommodation for some consumers.

Yesterday, we, again, asked the federal government to give the same flexibility and increased options to all Wisconsin consumers, regardless of whether or not they have yet attempted to purchase plans through the federal exchange website. The letter is attached.

Clearly, based on the recent action from HHS, the federal government does have the statutory authority to allow consumers to use their tax credits to purchase qualified health plans off the exchange. I hope you can work with Wisconsin to convince Treasury and HHS to make this practical change for all our state's consumers.

Thank you again for your interest in this matter. I look forward to working with you to find solutions to help our citizens cope with the ongoing issues related to the federal health care law.

Sincerely,

Scott Walker
Governor

[CONSORTIA]
[P O BOX XXXX]
[XXXXX WI XXXXX-XXXX]

MEMBER SHOULD APPLY AT MARKETPLACE

DATE

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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXX XXX XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXX WI 99999 9999

State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Important Information about Your BadgerCare Plus Enrollment

This letter is to let you know about new income limits for BadgerCare Plus and new options for health care coverage through the federal Health Insurance Marketplace, also known as the Exchange.

Due to changes in state law, adult members with household income above 100% of the Federal Poverty Level (FPL) and children with household income above 300% FPL will no longer be eligible for BadgerCare Plus. These changes will take effect January 1, 2014.

You have received this letter because you or someone in your household may be above these limits. If anyone in your household is affected by the change in income limits and you are still enrolled in BadgerCare Plus, you will get another letter in December letting you know exactly who is affected and how their eligibility will change.

Please Note: These new limits do not affect pregnant women or people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD). If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away, as it may affect your enrollment.

What Can I Do?

Members who are above the new income limits for BadgerCare Plus in 2014 may apply for private health insurance through the federal Health Insurance Marketplace.

You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

Please Note: For any coverage that you get through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

The Marketplace offers help with paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

If you have questions about this letter or about your BadgerCare Plus enrollment, call the agency number listed at the top of page 1.

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

[CDPU]
[P O BOX XXXX]
[XXXXX WI XXXXX-XXXX]

MEMBER FYI PLUS TAX INFO FORM

DATE

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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXX XXX XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXX WI 99999 9999

State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

New Information about Your BadgerCare Plus Enrollment

You recently received a letter stating that you or someone in your household would no longer be enrolled in BadgerCare Plus as of December 31, 2013, because of new income limits. Due to difficulties with HealthCare.gov, **the new BadgerCare Plus income limits will now be effective April 1, 2014.** As long as you continue to meet program rules, your coverage will continue through March 31, 2014. For more information about the new BadgerCare Plus rules, see the section in this letter called "What Are the New BadgerCare Plus Rules Effective April 1, 2014?"

What Do I Need to Do?

- If you or someone in your household is enrolled in BadgerCare Plus with a premium, you must keep paying your monthly premiums to remain enrolled.
- You should apply and pay for private health insurance through the federal Health Insurance Marketplace, also called the Exchange, before March 31, 2014. See the section in this letter called "How Do I Apply Through the Marketplace?"
- If you want to see if you may be able to stay enrolled in BadgerCare Plus after March 31, 2014 under new program rules, you should fill out the form in this letter and answer questions about how you plan to file your taxes. You may want to complete the form if you receive child support because child support is no longer counted as income. **Fill out the form in this letter and return it by January 17, 2014.** We will also use this information to tell the Marketplace that you may be eligible for tax credits so your application at the Marketplace can be completed more easily.

Please Note: Completing the form is optional, but is strongly encouraged to help make sure you do not have a gap in health insurance coverage. As long as you continue to meet current program rules, you will stay enrolled in BadgerCare Plus through March 31, 2014. You will receive a letter about your enrollment status in early March.

What Happens Next?

- If you complete and return the form, we will send you a letter about your enrollment status in early March.
- If you do not complete and return the form, we will not be able to use new program rules when checking if the people in your home are over the new income limits. If you or someone in your home is over the new income limits, we will send you a letter in early March telling you that your BadgerCare Plus enrollment is ending and you need to purchase private health insurance through the Marketplace. Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014.**

What Are the New BadgerCare Plus Rules Effective April 1, 2014?

Due to changes in state law, as of April 1, 2014 non-pregnant adult members with household income up to 100% of the Federal Poverty Level (FPL) will be able to enroll in BadgerCare Plus. Children with a household income up to 300% of the FPL will be able to enroll in BadgerCare Plus. Some children above 300% FPL may be able to enroll in BadgerCare Plus by meeting a deductible. All BadgerCare Plus members will get the same benefit plan – the Standard Plan.

BadgerCare Plus will also be changing how it determines your household size and income. In addition to child support no longer being counted as income, you will be asked new questions about things like how you plan to file your taxes.

Please Note: The new program rules do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

How Do I Apply Through the Marketplace?

If you have not already done so, you should complete an application through the federal Health Insurance Marketplace.

Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014. Do not wait to apply or you risk having a gap in health insurance coverage.**

You can apply through the federal Health Insurance Marketplace:

- Online at HealthCare.gov,
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov,
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org or 211wisconsin.org.

Keep In Mind: If you want to see if you may be able to stay enrolled in BadgerCare Plus under new program rules, you will need to answer questions about how you plan to file taxes. Fill out the form in this letter and return it by January 17, 2014. We will use the information provided to see if you or someone in your household is eligible for BadgerCare Plus, under the new program rules. For example, child support is no longer counted as income. You may want to complete the form if you receive child support. We will also use this information to tell the Marketplace that you may be eligible for tax credits so your application at the Marketplace can be completed more easily.

Please Note: Completing the form is optional, but strongly encouraged to help make sure you do not have a gap in health insurance coverage. As long as you continue to meet current program rules, you will stay enrolled in BadgerCare Plus through March 31, 2014. You will receive a letter about your enrollment status in early March.

If you have questions about this letter, please call the agency listed at the top of page 1.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Heath Care Access and Accountability
F-00914 (12/13)

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BADGERCARE PLUS TAX FILER INFORMATION

On April 1, 2014, BadgerCare Plus program rules will be changing. These changes include new income limits, new rules for counting household income, and one benefit plan for all members.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus members whose household income is currently above the new income limits can choose to fill out this form to see if new rules for counting household income will allow people in their household to stay enrolled in BadgerCare Plus after April 1, 2014.

You will see the term "other income" on this form. Other income means income that you receive that isn't from a job or self-employment, such as Unemployment Insurance, alimony, payments from an annuity, interest payments, payments from property you have sold, etc.

Please Note: You may be asked to provide personally identifiable information or your Social Security Number. Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

Complete, sign and return this form by January 17, 2014. Mail or fax it to:

If you live in Milwaukee County:

MDPU
PO Box 05676
Milwaukee WI 53205
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County

CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 1-855-293-1822

If you need help filling out this form or want to answer the questions in person or by telephone, contact your agency. To get the address or phone number of your agency, call **1-800-362-3002** or go to dhs.wi.gov/em/customerhelp.

TFI

SECTION ONE: INFORMATION ABOUT YOUR HOUSEHOLD

We are asking about how you and the people in your household plan to file taxes because it may affect who is included in your household and how their income is counted. Please answer the following questions:

CARES Case Number (listed at the top of your letter)
Is anyone in your home planning to file a tax return, for income received in 2014? ☐ Yes - Complete Sections Two, Three and Four ☐ No – Complete Sections Three and Four

SECTION TWO: TAX INFORMATION FOR YOUR HOUSEHOLD

Each tax filer in your household must fill out Section Two A or B. Please note: if anyone is married and filing a joint tax return, only one spouse needs to fill out Section Two A or B. Use additional paper if there are more than two tax filers in the household.

A. TAX FILER 1

Name of Tax Filer 1	Name of Spouse (if married and filing jointly)
Tax Filing Status ☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household	
Will this tax filer be claimed as a dependent by someone outside of the home ☐ Yes ☐ No	

Tax Dependents: Answer the questions below for the dependents this tax filer will be claiming on his or her taxes. Include any tax dependents not living with the tax filer. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			
Is this tax dependent living outside of the home? ☐ Yes ☐ No		Is this tax dependent deceased ☐ Yes ☐ No	

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			
Is this tax dependent living outside of the home? ☐ Yes ☐ No		Is this tax dependent deceased ☐ Yes ☐ No	

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			
Is this tax dependent living outside of the home? ☐ Yes ☐ No		Is this tax dependent deceased ☐ Yes ☐ No	

B. TAX FILER 2

Name of Tax Filer 2	Name of Spouse (if married and filing jointly)

Tax Filing Status ☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

Will this tax filer be claimed as a dependent by someone outside of the home ☐ Yes ☐ No

Tax Dependents: Answer the questions below for the dependents this tax filer will be claiming on his or her taxes. Include any tax dependents not living with the tax filer. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

SECTION THREE: INFORMATION ABOUT CHILDREN LIVING IN YOUR HOUSEHOLD

Answer the questions below for any children under age 19 who are living in the home and who are NOT listed as a tax dependent above. Provide this information even if no one in your home is filing taxes. Use an additional sheet of paper if more room is needed.

Are any children under age 19 living with you?

☐ Yes – Complete the rest of Section Three and Section Four

☐ No – Complete Section Four

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Name of Child 1	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			

Name of Child 2	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			

Name of Child 3	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			

SECTION FOUR: SIGNATURE

Signature of Member	Date Signed	Case Number

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00914A (12/13)

STATE OF WISCONSIN

BADGERCARE PLUS TAX FILER INFORMATION
MORE ABOUT FORM F-00914 FOR CONSORTIA, PARTNERS AND STAKEHOLDERS

On April 1, 2014, BadgerCare Plus program rules for counting household income will be changing.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus members whose household income is currently above the new income limits can choose to fill out a form to see if new rules for counting household income will allow people in their household to stay enrolled in BadgerCare Plus after April 1, 2014.

- If someone fills out and returns the form by January 17, 2014, we will use the new rules for counting household income.
- If someone does not fill out and return the form, we will not be able to use the new rules when applying new income limits for BadgerCare Plus.

Providing the information in the form will also allow us to forward a member's application automatically to the federal Health Insurance Marketplace (also known as the Exchange) if they are above the new income.

The main differences between current rules and new rules for counting household income are:

- Child support income is no longer counted.
- Household sizes may be larger or smaller depending on how someone plans to file taxes.
- For self-employed households, depreciation is an allowable expense.
- In most cases, the income of children under 19 and tax dependents is only counted if they are expected to be required to file taxes.

The answers to the questions in this form should be based on whether someone *expects* to file their taxes for the 2014 tax year. If they don't know for sure, they should give their best estimate of what their tax filing plans will be.

Section One: Information about people in your household
In this section, we're asking if anyone plans to file a tax return for income they will get during the 2014 tax year. Since we need information about the current tax year, we are referring to the taxes they would file in 2015 for income they get in 2014.

By tax return, we mean the tax form or forms used to file federal taxes, either on paper or electronically. Someone can file a tax return even if they do not have any income or owe any tax.

Section Two: Tax information for your household
In this section, we're asking about the people in the home who plan to file a tax return in 2015 for income they will get during the 2014 tax year.

First, provide the name of the first tax filer. If a married couple is filing taxes jointly, they should list both filers in this section and they do not have to list the spouse again later.

Next, tell us the person's filing status.

- For someone who is married, choose "married filing jointly" or "married filing separately." By "filing jointly", we mean that they are filing one tax return for the income they both have. Almost all married couples file jointly, but if the couple plans to file separately, they should choose "married filing separately."
- For someone who is not married, choose either "single" or "head of household". (If the person is not sure, choose single; this will not affect their eligibility results.)

Then tell us whether anyone who lives outside of the home is planning to claim the tax filer as a tax dependent.

For example, there may be a teenager in the home who has a part-time job and is planning to file taxes. If she or he is listed on this page as the tax filer, answer yes if she or he is going to be claimed as a dependent by a parent who does not live in the home.

Tax Dependents
Next, list all of the people whom this person plans to claim as tax dependents for the 2014 tax year. In most cases, this will be the person's children who live in the home, but it could include other people for whom the person provides support, even if they live outside of the home. For example, non-custodial children or adult children who are in college can be claimed as tax dependents.

If someone only claims a child as a tax dependent every other year, the child should be listed only if the person plans to claim them for the 2014 tax year. **Please Note**: Even if someone is not claiming a child as a tax dependent for the current tax year, they can still apply for health care benefits for that child.

Keep in mind that there are tax rules around who can be claimed as a tax dependent. For example, two people who are not married cannot claim the same tax dependent, and a married person cannot claim his or her spouse as a tax dependent. If someone is planning to claim a tax dependent who is deceased, they can only claim the deceased in the same year they passed away.

For each tax dependent, answer the questions about the income they **expect** to have in 2014:

Job Income
Answer yes if the tax dependent expects to earn more than $5,950 in income from a job in 2014. If you aren't sure, you should estimate based on the person's current monthly earnings, and whether they plan to work all of the months in the year.

Other Income
Answer yes if the tax dependent expects to get more than $950 from any taxable source other than a job or self-employment in the current tax year.

Include:
- Unemployment compensation
- Tribal per capita payments
- Alimony
- Taxable annuity or retirement income

Do *not* include:
- Child Support
- Supplemental Security Income (SSI)
- Social Security
- Veterans Benefits
- Workers Compensation

Section 3: Information about children living in your household
If there are any children under 19 living in the home, list them in this section only if they have NOT been listed as tax dependents above. For example, if the tax filer has a child living in the home but is not planning to claim them as a tax dependent for 2014, list the child in this section.

Job Income
Answer yes if the child expects to earn more than $5,950 in income from a job in 2014. If you aren't sure, you should estimate based on the child's current monthly earnings, and whether they plan to work all of the months in the year.

Other Income
Answer yes if the child expects to get more than $950 from any taxable source other than a job or self-employment in the current tax year.

Include:
- Unemployment compensation
- Tribal per capita payments
- Alimony
- Taxable annuity or retirement income

Do *not* include:
- Child Support
- Supplemental Security Income (SSI)
- Social Security
- Veterans Benefits
- Workers Compensation

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

BC+ Extension Premium Letter

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State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
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Important Information about Your BadgerCare Plus Enrollment

This letter is to let you know that you or someone in your household will now be required to pay a monthly premium for your BadgerCare Plus coverage in 2014.

Adults enrolled in BadgerCare Plus who are in an extension will now have premiums if they are above 100% of the Federal Poverty Level (FPL). You or someone in your household is enrolled in a BadgerCare Plus extension because of an increase in income from a job or child support.

If you are still enrolled in BadgerCare Plus in December, you will receive a letter letting you know the amount of your premiums and how to pay them.

It is very important that you pay your premiums on time. Your first payment will be due on **January 10, 2014**, for coverage in January 2014. If you do not pay your premiums, your BadgerCare Plus will end.

If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away, as it may affect your enrollment or your premium amount.

If you have questions about this letter or your BadgerCare Plus enrollment, contact the agency listed at the top of this page.

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

MEMBER SERVICES -- ACA
P O BOX 6678
MADISON WI 53716-0678

State of Wisconsin

Case #: XXXXXXXXXX

[MEMBER SERVICES]
Phone: 1-800-362-3002

CORE WAITLIST HEADS-UP LETTER

DATE

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Important Information about the BadgerCare Plus Core Plan Waitlist

Our records show that you are on the BadgerCare Plus Core Plan Waitlist. This letter is to let you know that the BadgerCare Plus Core Plan is ending as of December 31, 2013. The Waitlist for the Core Plan has also ended.

There are new health care options available to you. You may be able to enroll in BadgerCare Plus, or apply for private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

- If your household income is above 100% of the Federal Poverty Level (FPL), you should contact the new federal Marketplace to apply for private health insurance. For a single person in 2013, 100% FPL means you have monthly household income of $958. For a family of two, it means you have monthly household income of $1,293 (please see the chart on the following page).

- The Marketplace offers a variety of health insurance plan options and allows you to choose the one that is best for you and your family. You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

  Please Note: For any coverage through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

(OVER)

- The Marketplace offers help paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

- To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

- If your income is at or below 100% FPL, you may be eligible for BadgerCare Plus as of January 1, 2014. You may apply for these benefits on or after November 18, 2013. If you apply before this date, we will not be able to process your application. You can apply for BadgerCare Plus online at access.wi.gov, or through your local agency. To find your local agency, go to: dhs.wi.gov/forwardhealth/imagency/index.htm

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

If you have questions about this letter, please call Member Services at 1-800-362-3002.

MEMBER SERVICES -- ACA
P O BOX 6678
MADISON WI 53716-0678

CORE WAITLIST TRANSITION LETTER

DATE

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State of Wisconsin

Account #: XXXXXXXXXX

[MEMBER SERVICES]
Phone: 1-800-362-3002

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New Information about BadgerCare Plus Core Plan Waitlist and the Health Insurance Marketplace

Our records show that you were on the BadgerCare Plus Core Plan Waitlist. You received a letter in early October letting you know that the BadgerCare Plus Core Plan was ending as of December 31, 2013. The letter said that that beginning January 1, 2014, you would be able to enroll in BadgerCare Plus if your household income was below the income limits for the program. **Due to difficulties at HealthCare.gov and a change in state law, BadgerCare Plus will not be available to you until April 1, 2014.**

However, you may be able to purchase private health insurance through the federal Health Insurance Marketplace, also known as the Exchange, with coverage beginning as soon as January 1, 2014. For more information about how to apply through the Marketplace, see the section in this letter called "How Do I Apply Through The Marketplace?"

What Do I Need to Do?

- If your household income is above 100% of the Federal Poverty Level (FPL), you should apply for private health insurance through the Marketplace before March 31, 2014. For more information about this income limit, see the chart below.
- If you have already applied for private health insurance at the Marketplace and received a response that you may be eligible for BadgerCare Plus, you will receive a letter in March letting you know about your BadgerCare Plus enrollment starting April 1, 2014.

- If your household income is below 100% FPL, you should wait until February 3, 2014 to apply directly through BadgerCare Plus for benefits that start April 1, 2014. Beginning February 3, 2014, you can apply for BadgerCare Plus online at access.wi.gov or through your agency. To find your agency, go to: dhs.wi.gov/em/customerhelp or call 1-800-362-3002. If you apply directly to BadgerCare Plus before February 3, 2014, we will not be able to process your application.

How Do I Apply Through The Marketplace?

- Online at HealthCare.gov,
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov, or
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org or 211wisconsin.org.

Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014.**

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

What Should I Do If I Need To Go To The Doctor Before My Health Care Coverage Starts?

If you need to go to the doctor before your BadgerCare Plus coverage or private health insurance starts, there are health care facilities in Wisconsin that provide services for people with little or no health insurance. These facilities provide primary care and preventive care, including health, oral, and mental health/substance abuse services to people of all ages, regardless of their ability to pay. They charge for services on a sliding-fee scale that is based on your family income and size.

You can get additional information about free and low cost health clinics in Wisconsin at dhs.wi.gov/forwardhealth/clinics.htm.

If you have questions about this letter, please call Member Services at 1-800-362-3002.

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

State of Wisconsin

Case #: XXXXXXXXXX

[BASIC PROCESSING UNIT]
Phone: XXX-XXX-XXXX

BASIC PLAN HEADS-UP LETTER

DATE

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Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Important Information About Your BadgerCare Plus Basic Plan Enrollment

This letter is to let you know that the BadgerCare Plus Basic Plan is ending on December 31, 2013. If you continue to pay your premiums through November, there will be no change in your enrollment through December 31, 2013. As of January 1, 2014, you will no longer have BadgerCare Plus Basic coverage.

There are new health care options available to you. You may be able to enroll in BadgerCare Plus, or apply for private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

- If your household income is above 100% of the Federal Poverty Level (FPL), you should contact the new federal Marketplace to apply for private health insurance. For a single person in 2013, 100% FPL means you have monthly household income of $958. For a family of two, it means you have monthly household income of $1,293 (please see the chart on the following page).

- The Marketplace offers a variety of health insurance plan options and allows you to choose the one that is best for you and your family. You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

  Please Note: For any coverage through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

- The Marketplace offers help with paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

- To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

- If your income is at or below 100% FPL, you may be eligible for BadgerCare Plus as of January 1, 2014. You may apply for these benefits on or after November 18, 2013. If you apply before this date, we will not be able to process your application. You can apply for BadgerCare Plus online at access.wi.gov, or through your local agency. To find your local agency, go to: dhs.wi.gov/forwardhealth/imagency/index.htm

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

If you have questions about this letter, please call the agency listed number listed at the top of page 1.

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

4A BASIC PLAN 3 MONTH LETTER

DATE

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State of Wisconsin

Case #: XXXXXXXXXX

[BASIC PROCESSING UNIT]
Phone: XXX-XXX-XXXX

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New Information About Your BadgerCare Plus Basic Plan Enrollment

You recently received a letter that said the BadgerCare Plus Basic Plan would end December 31, 2013. **This letter is to let you know that due to early enrollment challenges for healthcare.gov, Governor Walker extended your coverage for BadgerCare Plus Basic.** Your BadgerCare Plus Basic Plan will now continue through March 31, 2014. Your January premium slip is included with this letter. If you want to stay enrolled in the BadgerCare Plus Basic Plan, you need to pay your premium by December 12, 2013.You should **continue to pay your premiums** and stay enrolled in the BadgerCare Plus Basic Plan through March 31, 2014 if any of these apply to you:

- You applied through the Marketplace (also known as the Exchange) and they said you would be enrolled in the BadgerCare Plus Standard Plan starting January 1, 2014. Because these benefits will not start until April 1, 2014, you should stay enrolled in Basic through March 31, 2014.
- You applied through the Marketplace but you have not yet paid your first premium to enroll in a private health plan (unless your premiums for private health insurance are less than your Basic premiums and you want to switch to private health insurance before March 31, 2014).
- You have not yet applied for private health insurance through the Marketplace. You can read more about how to apply through the Marketplace on the next page.

You should **stop paying your Basic Plan premiums** only if you have already signed up for private health insurance through the Marketplace AND you have paid your first premium for coverage starting January 1, 2014.

If you have questions about this letter, please call the agency listed at the top of this page.

Applying for Health Insurance through the Marketplace:

If you have not done so already, you will need to complete a health care application through the federal Health Insurance Marketplace (also called the Exchange) in order to have health insurance coverage after the Basic Plan ends. Keep in mind that March 15, 2014 is the deadline to apply for and purchase Marketplace coverage that begins on April 1, 2014.

You can apply health care coverage through the federal Health Insurance Marketplace:

- Online at HealthCare.gov
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov by clicking on the orange button with the paper icon, or
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org.

On the Marketplace application: It is important to answer "No" to Question 1 in Step 4 (on page 6 of the paper application), "Is anyone enrolled in health care coverage now from the following?" if BadgerCare Plus Basic is the only health insurance you currently have. This will tell the Marketplace that your BadgerCare Plus Basic Plan coverage will be ending and allow the Marketplace to process your application.

If you have questions about this letter, please call the agency listed at the top of page 1.

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[<<Return Address City>><<Return Address State>> <<Return Address Zip>>]

Mailing Date: MM/DD/YYYY

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<<city>> <<State>><<Zip>>

State of Wisconsin

Case #: <<CASE Num>>

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Important Information about Applying for Health Insurance for January 1, 2014

This letter is a follow up to the letter we sent to you in early October. We wanted to remind you there are new options for health care coverage through the federal Health Insurance Marketplace, also known as the Exchange.

Due to changes in state law, adult members with household income above 100% of the Federal Poverty Level (FPL) and children with income above 300% FPL will no longer be eligible for BadgerCare Plus. These changes will take effect January 1, 2014. For more information on the new income limits, see the next page.

You have received this letter because you or someone in your household may be above these limits and will need to take action.

What Do I Need to Do?

Members who are above the new income limits for BadgerCare Plus in 2014 may apply for private health insurance through the federal Health Insurance Marketplace.

You must apply for health insurance through the Marketplace before December 15, 2013, and pay your premium on time, for coverage starting on January 1, 2014.

How to Apply

(OVER)

To apply for private health insurance through the Marketplace, you can:

- go to HealthCare.gov and apply online
- call 1-800-318-2596 (TTY: 1-855-889-4325) to apply over the phone
- apply by mail. We have enclosed a paper application for you to fill out and send to:

  Health Insurance Marketplace
  Dept. of Health and Human Services
  465 Industrial Blvd.
  London, KY 40750-0001

  There are instructions for filling out the application included with this letter as well. However, if you need help with your application, you may call 1-800-318-2596 (TTY: 1-855-889-4325).

  Note: It is important to answer "No" to Question 1 in Step 4 (on page 6 of the paper application), "Is anyone enrolled in health care coverage now from the following?" if BadgerCare Plus is the only health insurance you currently have. This will tell the Marketplace that your BadgerCare Plus coverage may be ending on December 31, 2013, and will allow the Marketplace to process your application.

PLEASE NOTE: If you have already submitted an application online, over the phone, or by mail, you do not need to do anything else.

To find in-person help in your area, go to e4healthwi.org. You should be able to find people in your area that can help you apply.

BadgerCare Plus Income Limits

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

Please Note: These new limits do not affect pregnant women or people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD). If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away to your local agency, as it may affect your enrollment.

If you have questions about this letter or about your BadgerCare Plus enrollment, call the agency number listed at the top of page 1.

<<Return Address line1>>
<<Return Address line2>>
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[<<Return Address City>><<Return Address State>> <<Return Address Zip>>]

State of Wisconsin

Ref #: <<CASE Num>>

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Important Information About Your Application to the Federal Health Insurance Marketplace for BadgerCare Plus

You recently submitted an application through the federal health Insurance Marketplace (also called the Exchange) and you may have received a notice stating you may be eligible for Medicaid or BadgerCare Plus coverage beginning no earlier than January 1, 2014.

- If there are no children under age 19 living in your home, please read the information below.
- If you are a parent or caretaker relative living with and caring for a child under age 19 or if you are a child under age 19, please read the information on page two.
- If the Marketplace told you that you may be eligible for services because you have special health care needs like needing help with daily living or having a disability, we will contact you after the Marketplace sends us your complete information. There is no other action required on your part.

If there are no children under age 19 in your home

Due to a delay in program changes, BadgerCare Plus will continue to be closed to new enrollment until April 1, 2014 for adults age 19 to 64 who are not living with and caring for a child under age 19. **As a result, you will not be enrolled in the BadgerCare Plus Standard Plan until April 1, 2014.**

The Marketplace has not yet sent us your complete application. After the Marketplace sends your complete application for BadgerCare Plus, it will be processed and you will have BadgerCare Plus coverage beginning April 1, 2014.

You do not need to reapply or take any other action at this time. You will get a letter in March with more information about your enrollment in BadgerCare Plus.

What Should I Do If I Need To Go To The Doctor Before My Health Care Coverage Starts?

If you need to go to the doctor before your BadgerCare Plus coverage or private health insurance starts, there are health care facilities in Wisconsin that provide services for people with little or no health insurance. These facilities provide primary care and preventive care, including health, oral, and mental health/substance abuse services to people of all ages, regardless of their ability to pay. They charge for services on a sliding-fee scale that is based on your family income and size.

You can get additional information about free and low cost health clinics in Wisconsin at dhs.wi.gov/forwardhealth/clinics.htm.

Please Note: If you are already enrolled in the BadgerCare Plus Core Plan, your current Core Plan benefits will continue through March 31, 2014, as long as you continue to meet program rules. Your BadgerCare Plus Standard Plan benefits will begin April 1, 2014.

If there are children under age 19 in your home

If you are a parent or caretaker relative living with and caring for a child under age 19 or if you are a child under age 19, the Marketplace has not yet sent us your complete application. After the Marketplace sends your complete application for BadgerCare Plus, it will be processed and you will have BadgerCare Plus coverage that will be effective back to January 1, 2014. Depending on when you filed your application with the Marketplace, your coverage could be effective even earlier than January 1, 2014.

You do not need to reapply or take any other action at this time. You will get a letter with more information about your enrollment in BadgerCare Plus once we receive and process your application from the Marketplace.

Please Note: If you are already enrolled in BadgerCare Plus, your current enrollment will continue as long as you continue to meet program rules.

If you have questions or would like more information

If you have questions about this letter or would like more information about BadgerCare Plus:

- Go to dhs.wi.gov/em/customerhelp.
- Call Member Services at 1-800-362-3002.

Please Note: If you submitted more than one application through the Marketplace, you may receive more than one copy of this letter. There is no other action required on your part.

SCOTT WALKER
GOVERNOR
STATE OF WISCONSIN

November 15, 2013

The Honorable Jacob Lew
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Lew and Secretary Sebelius,

Given the ongoing issues Wisconsinites are facing in accessing the federal exchange, I am asking you to allow Wisconsin citizens to use their premium tax credits to purchase any qualified plan and not just plans on the exchange. According to the enrollment data released by the Department of Health and Human Services (HHS), only 877 Wisconsinites were able to enroll in health plans through the exchange. Meanwhile, the proposed fix is not expected to be complete until late November at the earliest. These timeframes place undue burden on Wisconsinites interested in enrolling by the December 15th deadline for January 1st effective dates.

We have repeatedly sent letters asking for flexibility, all of which have been denied. We warned you about the problems with your opaque and cumbersome regulatory approach, and now, Wisconsinites are paying the price through high premiums, limited choice, and a federal exchange website that does not work effectively. It is far past time to start fixing these problems. However, allowing Wisconsinites to use the subsidies for which they qualify with an insurer of their choice provides a very reasonable alternative to the federal exchange.

Wisconsin has one of the most competitive insurance markets in country. In our state, over 20 insurers are offering coverage in the individual market. Indeed, in looking at the Wisconsin map (http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf), you can clearly see nearly every county provides individuals four or more insurers off-exchange from which they can choose qualified health plans. In addition, our off-exchange market allows consumers to choose from different kinds of insurers, including for-profit and non-profit, HMO and PPO, local and national, and other choices. I am asking you to allow all consumers access to that market.

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983 •
WWW.WISGOV.STATE.WI.US

Due to the bottlenecks and the ongoing technology problems, the current process is unworkable. Wisconsinites need actual solutions and access to available health plans. I am asking for the IRS to issue regulations allowing consumers to access a premium tax credit for any qualified health plan they choose to purchase – on or off the exchange. These tax credits are based on the second least costly silver plan in each county, and there is no reason the tax credit cannot be applied uniformly. This solution would ensure that Wisconsinites will not be forced to attempt to purchase coverage through a website, which is currently not functioning and hosts a limited selection of insurers.

It is important to note the same market rules apply both on- and off-exchange. Consumers purchasing plans off the exchange will be purchasing essentially the same policies, but be allowed to choose from a wider variety of insurers.

The Affordable Care Act is the law, and it is my responsibility to protect consumers within my state in compliance with the law. It is our mutual responsibility to ensure consumers are not harmed. In that spirit, I am asking you to provide Wisconsinites with this commonsense solution and flexibility.

I look forward to your response.

Sincerely,

Scott Walker
Governor

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983 •
WWW.WISGOV.STATE.WI.US

FEB 27 2014

The Honorable Scott Walker
Governor of Wisconsin
Post Office Box 7863
Madison, WI 53707-7863

Dear Governor Walker:

Thank you for your letter regarding the use of premium tax credits by Wisconsinites seeking to purchase qualified health insurance plans. Because this issue involves a matter of tax policy as it relates to the Marketplaces, your letter was referred to us.

Treasury and the Internal Revenue Service take seriously the responsibility to implement the Tax Code. The statutory language of the Affordable Care Act indicates that premium tax credits are available only to taxpayers who enroll in coverage through a Marketplace. On February 12, 2014, HHS reported that nearly 3.3 million Americans have selected a plan through state and federal Marketplaces, reflecting the dramatic improvements in the federal website. We continue to work diligently to add new functionality to HealthCare.gov. It is also worth noting that consumers have several options when enrolling through a Marketplace. They can work with Navigators, in-person Assisters or brokers, and they can apply at the Marketplace's website, through an issuer's website, via telephone, or by paper application. In all cases, these individuals will enroll through a Marketplace, so they will be eligible to receive a premium tax credit on the same terms as others.

We share your commitment to making sure that Americans have access to affordable coverage and look forward to working with you further as we continue to implement the Affordable Care Act.

If you have additional questions on this topic, you may contact either of us, or your staff may contact Ahmed (A.J.) Bhadelia, Treasury's Office of Legislative Affairs, at (202) 622-1900.

Sincerely,

Mark J. Mazur
Assistant Secretary for Tax Policy
U.S. Department of the Treasury

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: February 27, 2014

Subject: CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances

Background

This guidance is being provided to Marketplaces that, due to technical issues in establishing automated eligibility and enrollment functionality, have had difficulty in providing timely eligibility determinations to applicants and enrolling qualified individuals in Qualified Health Plans (QHPs) through the Marketplace during the initial open enrollment period for the 2014 coverage year. Such a circumstance may be considered an exceptional circumstance for individuals who were unable to enroll in a QHP through the Marketplace due to these issues. In this guidance, we discuss the availability of advance payments of the premium tax credit (APTC) and advance payments of cost-sharing reductions (CSRs) on a retroactive basis to an issuer once the Marketplace has provided a qualified individual with an appropriate eligibility determination and has determined that the individual is eligible for such assistance and the individual has enrolled in a QHP through the Marketplace. We also clarify the attendant responsibilities of the QHP issuer in this circumstance.

Provision of APTCs and CSRs

In accordance with applicable Federal regulations under 45 CFR 155, Subpart D, individuals must receive an eligibility determination from the Marketplace to enroll in a QHP offered through the Marketplace and in order to receive CSRs and the premium tax credit (PTC) made available through the Affordable Care Act. In order for the Marketplace to perform a determination of eligibility for coverage offered through the Marketplace, an individual must have submitted an application for coverage to the Marketplace using an HHS-approved single, streamlined application during the open enrollment period.

Not otherwise enrolled in coverage

First, if an individual in the exceptional circumstance described above has *not* been enrolled in any health coverage continuously since January 1, 2014, including QHP coverage offered outside of the Marketplace or otherwise, before a successful eligibility determination is obtained, when he or she receives a determination of eligibility for coverage through the Marketplace and enrolls in a QHP through the Marketplace, the Marketplace may allow for coverage retroactive to the date, established by the Marketplace, on which coverage would have been effective absent the exceptional circumstance described above, as provided under 45 CFR 155.310(f)(1) and 45 CFR 155.420(b)(2)(iii). For instance,

the Marketplace may establish an effective enrollment date based on the date that the individual originally submitted an application for coverage to the Marketplace. The individual will be treated for all purposes as having been enrolled in the QHP since the effective enrollment date. The individual will be responsible for the enrollee's portion of the premium for the retroactive coverage period. If the Marketplace determines the individual eligible for APTCs and CSRs, and assigns the individual to a cost-sharing reduction plan variation, CMS will pay advance payments of the PTC and CSRs to the Marketplace QHP issuer on a retroactive basis, based on the effective enrollment date established by the Marketplace. The Marketplace QHP issuer must collect and adjudicate the claims incurred by the individual starting from the retroactive enrollment date as if the individual had been enrolled in the applicable plan variation since that date, and then must credit or refund any excess cost sharing as further detailed below. Cost-sharing reduction reconciliation will occur with respect to the Marketplace QHP for all cost-sharing reductions provided beginning with the (retroactive) effective date of coverage.

Enrolled in a QHP outside the Marketplace

Additionally, if an individual in the exceptional circumstance described above *is* enrolled in QHP coverage offered outside of the Marketplace, when he or she receives a determination of eligibility for coverage through the Marketplace, the Marketplace may deem the individual to have been enrolled in the QHP through the Marketplace retroactive to the date on which the individual first enrolled in the QHP outside of the Marketplace. In that case, the individual will be treated for all purposes as having been enrolled through the Marketplace since the initial enrollment date. The individual will be responsible for the enrollee's portion of the premium for the retroactive coverage period. If the Marketplace determines that the individual is eligible for APTCs and CSRs, and the individual is assigned to a cost-sharing reduction plan variation, CMS will provide advance payments of the PTC and CSRs to the issuer on a retroactive basis back to the effective date of Marketplace enrollment. In addition, the issuer must re-adjudicate the claims incurred by the individual starting from the retroactive enrollment date under the QHP as if the individual had been assigned to the applicable plan variation since that date, and then must credit or refund any excess cost sharing or premium amounts, as further detailed below. Cost-sharing reduction reconciliation will occur for all cost-sharing reductions provided beginning with the (retroactive) effective date of coverage.

In this case, the Marketplace will also provide a special enrollment period (SEP) under 45 CFR 155.420(d)(9) to allow these individuals the opportunity to change QHPs prospectively at the time the eligibility determination is received. When this SEP is made available, and should an individual elect to change QHP issuers, CMS would provide advance payments of the PTCs and CSRs to the new issuer prospectively based on the coverage effective date provided under the SEP.

Reimbursement of the enrollee for premiums and cost-sharing paid

In both of the situations described above, if an individual is determined eligible for retroactive CSRs or advance payments of the PTC, the issuer of the QHP will he required to adjudicate or re-adjudicate, as applicable, the enrollee's claims incurred during the retroactive period, and refund or credit to the enrollee any excess cost sharing or premiums paid if applicable, and ensure the provision of refunds or credits of any excess payments made by or for the enrollee for covered benefits and services incurred during the retroactive coverage period. Unless the individual requests the issuer provide a refund, the issuer may elect to provide a credit toward the individual's premium payment for each subsequent month for the

remainder of the period of enrollment or benefit year until the credit is fully applied. Any refund or credit for any excess cost-sharing or premium paid for or on behalf of the individual must be provided (or begin to be provided in the case of a credit) within 45 calendar days of the date of discovery of the excess cost-sharing or premium paid, as detailed in 45 CFR 156.410(c)(1). If a credit remains at the end of the period of enrollment or benefit year, the issuer must refund the enrollee any remaining excess cost sharing or premium paid by or for the enrollee within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

Arrangements between the State and the QHP issuer

If the State has been providing premium or cost-sharing subsidies to an individual who has existing QHP coverage outside of the Marketplace, upon the individual receiving an eligibility determination, any reimbursement to the State for premium subsidies and reductions in out-of-pocket expenses provided on behalf of the individual prior to the individual's enrollment in the QHP through the Marketplace will be the responsibility of the QHP issuer and the State.

Information reporting regarding APTCs

It is anticipated future guidance by the Treasury Department and the Internal Revenue Service will provide that the reporting under section 36B(f)(3) of the Internal Revenue Code of any APTCs paid on a retroactive basis must show the APTC amounts properly allocated to the month(s) for which they were paid. For example, if in April 2014 an individual is enrolled with a retroactive enrollment date of January 1, 2014, and APTCs are paid for retroactively for January through March, then the reporting would show the retroactive APTC amount properly allocated among January, February, and March.

Nondiscrimination

The Marketplace must not discriminate among issuers participating in the Marketplace, and should be consistent in its treatment of issuers when applying effective date rules. In accordance with 45 CFR 155.120(c), the Marketplace must treat enrollees in similar circumstances in a consistent manner and ensure that accessibility requirements under 45 CFR 155.205(c) are met.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

March 26, 2014

The Honorable Mark J. Mazur
Assistant Secretary (Tax Policy)
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Assistant Secretary Mazur and Administrator Tavenner:

On November 15, 2013, Governor Scott Walker sent a letter to Secretary Jacob Lew and Secretary Kathleen Sebelius asking for the federal government to provide increased flexibility and additional health insurance options to Wisconsin citizens. The letter requested Wisconsinites be allowed to use available tax credits to purchase any qualified health plan, whether on the exchange or not, and not to limit their choices to those plans available through the federal exchange Web site. As was highlighted, Wisconsinites in every county would have expanded health insurance choices if the federal government would provide this flexibility.

We received your response on behalf of your individual Departments on February 27, 2014. Unfortunately, it does not address the concerns of Wisconsin consumers. It also conflicts with guidance received simultaneously from the Department of Health and Human Services.

Due to the failed federal rollout of the Affordable Care Act (ACA), in recent months, Wisconsin took action to protect its citizens transitioning into ACA-qualified health insurance plans while the federal government worked to fix the problems with its exchange Web site. While the people of our state continue to cope with the troubled rollout of the ACA, it is important to give as many options and choices to them as possible.

It was indicated in your letter that your Departments do not have the statutory authority to accommodate our request to allow our citizens to use their subsidies to purchase qualified plans outside of the federal exchange Web site.

However, there are multiple instances where both the Department of Treasury and the Department of Health and Human Services have utilized broad regulatory authority to substantially alter the implementation of the law.

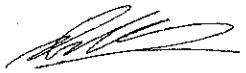
In addition, the same week we received the response letter, the Department of Health and Human Services issued a bulletin titled "CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances." In the bulletin the Department of Health and Human Services allowed consumers unable to access plans through the federal exchange Web site, due to its previous and ongoing issues, to use their tax credits to purchase qualified plans outside of the exchange.

These conflicting responses create unnecessary confusion. Clearly, based on this change issued by the Department of Health and Human Services, the federal government has the statutory authority to allow consumers to use their tax credits to purchase qualified health plans off the exchange.

Therefore, we again request that the federal government provide the same flexibility and increased options to all Wisconsin consumers, regardless of whether or not they have yet attempted to purchase plans through the federal exchange Web site. This is a practical tool to help our consumers cope with the ongoing issues in the federal exchange.

I look forward to your quick response.

Sincerely,



Theodore K. Nickel
Commissioner

UNIT TEST CASE INFORMATION

Policy Number: LM081T1121BW

Issue State: WISCONSIN

Plan Type Code: POS

Program Year: A9

Plan Code: 2

Drug Code: NS

Dental Code:

Vision Code:

Effective Date: 080112

RX Vendor Code: MX

Number of Elig: 9

Mand Benefits: HCR,PRV

Opt Benefits:

Day of Event: N

Waiting Period: None

Calendar/Policy Yr: calendar

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, CT 06103-3408

1-800-357-1371

Please read the copy of your enrollment form accompanying this certificate or which has been otherwise previously delivered to you by us or your employer. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write us within 10 days if any information shown on the enrollment form is not correct. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form were correct and complete.

Coverage of Eligible Expenses for Covered Health Services provided by non-Network providers is limited to the amount we determine solely in accordance with our reimbursement guidelines as defined in Section 9 of this certificate. We calculate Eligible Expenses based on available data resources of competitive fees in specific geographic areas. Eligible Expenses must not be greater than the fees that the non-Network provider would charge any other health plan in the same or similar situation for the same services. You are responsible for paying any difference between the amount the non-Network provider bills you and the amount we will pay for Eligible Expenses. You may call Customer Care at the telephone number listed on your ID card.

LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a Covered Health Service, benefit payments to such nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined in the Policy. **YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND COPAYMENT AMOUNT AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Nonparticipating providers may bill Covered Persons for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for Covered Health Services with no additional billing to the Covered Person other than copayment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the number on your identification (ID) card or by going to www.myuhc.com.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy.*
- The *Schedule of Benefits.*
- The Enrolling Group's application.
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate.* When that happens we will send you a new *Certificate,* Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Wisconsin. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Wisconsin are the laws that govern the Policy.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate.* This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations.* You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms.* You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

Don’t Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins.* To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits.*

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits.* You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate,* the *Schedule of Benefits,* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits,* unless the service is excluded in *Section 2: Exclusions and Limitations.* This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to

share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.
- Other diseases or disorders for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Routine patient care costs for clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.

- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying clinical trial, a clinical trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the *National Cancer Institute (NCI)* as a *Clinical Cancer Center* or *Comprehensive Cancer Center* or be sponsored by any of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).)*
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - *Department of Defense (DOD).*
  - *Veterans Administration (VA).*
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approvals.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

3. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include, but are not limited to, surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels, and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

4. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

5. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider.*

6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*, as required by Wisconsin insurance law.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits.*

Benefits under this section do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

7. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

8. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate,* only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits under this section include hearing aids for Enrolled Dependent children under 18 years of age as required under Wisconsin insurance law.

9. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

10. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

12. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray, including blood lead tests for children under the age of six.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services.*

13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

14. Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Mental Health Services include:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits,* inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

- One day at a Residential Treatment Facility.
- Two sessions of Partial Hospitalization/Day Treatment.
- Five sessions of Intensive Outpatient Treatment.
- Six outpatient visits.
- Ten days of Transitional Care.

Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Mental Health Services.*

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based

on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Coverage will be provided for the Mental Health clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Mental Health/Substance Use Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Use Disorder Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Mental Health/Substance Use Disorder Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a Full-time Student.

Mental Health Services received on a transitional care basis including:

- Services for children and adults in day treatment programs.
- Services for persons with chronic Mental Illness provided through a community support program.
- Residential treatment programs for alcoholism and other drug dependent Covered Persons.
- Substance Use Disorder Treatment for alcohol and drug dependent Covered Persons.
- Intensive outpatient programs for the treatment of psychoactive substance abuse disorders.
- Coordinated Emergency Mental Health Services for Covered Persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Covered Person is experiencing the crisis until he/she is stabilized or referred to other provider for stabilization.
- The Wisconsin Department of Health and Social Services must certify day treatment programs, community support programs and residential treatment programs and crisis intervention programs.

15. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

16. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Pharmaceutical Products are assigned to various tiers. The *Prescription Drug List Management Committee* makes the final classification of a Pharmaceutical Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Pharmaceutical Product, as well as whether notification requirements should apply. Economic factors may include, but are not limited to, the Pharmaceutical

Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Pharmaceutical Product.

NOTE: We may periodically change the placement of a Pharmaceutical Product among the tiers. These changes generally occur quarterly, but no more than six times per year. These changes may occur without prior notice to you. As a result of such changes, the tier status of a Pharmaceutical Product may change, and you may be required to pay more or less for that Pharmaceutical Product.

To determine the tiers to which Pharmaceutical Products are assigned, contact www.myuhc.com or *Customer Care* at the telephone number on your ID card. The amount that you are required to pay for Pharmaceutical Products will vary depending upon the tier to which the Pharmaceutical Product is assigned.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

17. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

18. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services.*

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.

19. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

20. Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Appropriate and necessary immunizations.
- Hearing screening.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening.
- Prostate cancer screening.
- Bone mineral density tests.

21. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

22. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

23. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy. This does not include services as described under *Autism Spectrum Disorders* in this section.
- Manipulative Treatment.
- Speech therapy. This does not include services as described under *Autism Spectrum Disorders* in this section.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. For speech therapy with relation to Autism Spectrum Disorders, please refer to the services described under *Autism Spectrum Disorders* in this section.

24. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services.*

25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

26. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.

The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. When limits apply to inpatient or Intermediate Care services in the *Schedule of Benefits,* inpatient days may be converted to Intermediate Care (such as Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment programs) or Transitional Care at the discretion of the Mental Health/Substance Use Disorder Designee.

One inpatient day is equivalent to:

- One day at a Residential Treatment Facility.
- Two sessions of Partial Hospitalization/Day Treatment.
- Five sessions of Intensive Outpatient Treatment.
- Six outpatient visits.
- Ten days of Transitional Care.

Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care.

Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for *Substance Use Disorder Services.*

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization /Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use and any associated Copayment, Coinsurance and deductible. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Coverage will be provided for the Substance Use Disorder clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Substance Use Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Use Disorder Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Substance Use Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a Full-time Student.

Substance Use Disorder Services received on a transitional care basis including:

- Services for children and adults in day treatment programs.
- Services for persons with chronic Mental Illness provided through a community support program.
- Residential treatment programs for alcoholism and other drug dependent Covered Persons.
- Substance Use Disorder Services for alcohol and drug dependent Covered Persons.
- Intensive outpatient programs for the treatment of psychoactive substance abuse disorders.
- Coordinated Emergency Mental Health Services for Covered Persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Covered Person is experiencing the crisis until he/she is stabilized or referred to other provider for stabilization.
- The Wisconsin Department of Health and Social Services must certify day treatment programs, community support programs and residential treatment programs and crisis intervention programs.

27. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

28. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

29. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

30. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

31. Vision Examinations

Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury.*

Additional Benefits Required By Wisconsin Law

32. Autism Spectrum Disorder Services

The following definitions apply for purposes of Autism Spectrum Disorders:

"Autism Spectrum Disorders" means any of the following:

- Autism disorder.
- Asperger's syndrome.

- Pervasive development disorder not otherwise specified.

"Intensive-level services" means evidence-based behavioral therapies that is designed to help an individual with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

"Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment for Intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

Intensive Level Services

Note: Benefits for intensive-level services begin after the Enrolled Dependent child turns two years of age but prior to turning nine years of age.

Benefits are provided for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the Enrolled Dependent child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising provider, qualified professional, qualified therapists or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goals of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meeting and active involvement of the Enrolled Dependent child's family and treatment team for implementation of the therapeutic goals developed by the team.
- The Enrolled Dependent child is directly observed by the qualified provider at least once every two months.
- Beginning after the Enrolled Dependent child is two years of age and before the Enrolled Dependent child is nine years of age.

Intensive-level services will be covered for up to four cumulative years. We may credit against any previous intensive-level services the Enrolled Dependent child received against the required four years of intensive-level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for autism spectrum disorders that was provided to the Enrolled Dependent child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the Enrolled Dependent child for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.

Travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for an Enrolled Dependent child with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to an Enrolled Dependent child by a qualified provider, professional, therapist or paraprofessional in either of the following conditions:

- After the completion of intensive-level services and designed to sustain and maximize gains made during intensive level services treatment.
- To an Enrolled Dependent child who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Enrolled Dependent child's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapist or qualified paraprofessionals.
- Provided in an environment most conducive to achieving the goal of the Enrolled Dependent child's treatment plan.
- Included training and consultation, participation in team meetings and active involvement of the Enrolled Dependent child's family in order to implement the therapeutic goals developed by the team.
- Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.

We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.

Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapists or qualified paraprofessionals in not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.

Intensive-level and Nonintensive-level services include but are not limited to speech, occupationa l and behavioral therapies.

The following services are not covered under the autism spectrum disorders:

- Acupuncture.
- Animal-based therapy including hippotherapy.
- Auditory integration training.
- Chelation therapy.
- Child care fees.
- Cranial sacral therapy.
- Custodial or respite care.
- Hyperbaric oxygen therapy.
- Special diets or supplements.
- Pharmaceuticals and durable medical equipment.

33. Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services

Hospital and ambulatory surgery center charges provided in conjunction with dental care, including anesthetics provided, if any of the following applies:

- The Covered Person is a child under the age of 5.
- The Covered Person has a chronic disability.
- The Covered Person has a medical condition requiring hospitalization or general anesthesia for dental care.

34. Kidney Disease Treatment

Inpatient and outpatient kidney disease treatment including dialysis, transplantation and donor-rela ted services.

35. Temporomandibular Joint Disorders

Diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular joint disorders, if all of the following apply:

- The condition is caused by congenital, developmental or acquired deformity, disease or Injury.
- The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.

- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.
- Benefits are not available for cosmetic or elective orthodontic care, periodontic care or general dental care.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services,* those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits.* Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits.* Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipula tive osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services.*

B. Autism Spectrum Disorders Services

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*

5. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee. This exclusion does not apply for Autism Spectrum Disorder Services provided as the result of an Emergency detention, commitment or court order.

7. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements , unless authorized by the Mental Health/Substance Use Disorder Designee. This exclusion does not apply for Autism Spectrum Disorder Services provided as the result of an Emergency detention, commitment or court order.

8. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

   The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

C. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and *Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services* and *Temporomandibular Joint Disorders* in *Section 1: Covered Health Services.*

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

   - Transplant preparation.
   - Prior to the initiation of immunosuppressive drugs.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and *Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services* and *Temporomandibular Joint Disorders* in *Section 1: Covered Health Services.*
3. Dental implants, bone grafts, and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* and *Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services* and *Temporomandibular Joint Disorders* in *Section 1: Covered Health Services.*
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

D. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

E. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

F. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

Determination on whether services are Experimental, Investigational and Unproven Services are made by our Medical Director in consultation with a specialty review panel. When we receive a request for an Experimental, Investigational, or Unproven Service, we will issue a Benefit decision within 5 working days. If we decide there is no coverage for the Experimental, Investigational, or Unproven treatment, procedure, or device for a Covered Person with a terminal condition or Sickness, we will include the following information in the non-coverage letter:

- A statement that includes the specific medical and scientific reasons for denying coverage.
- A notice of the Covered Person's right to appeal.
- A description of the appeal process.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services.*

G. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services.*
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

H. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services.*
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services.*

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*

I. Mental Health

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Mental Health Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Use Disorder Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the service will be covered.
6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*
8. Learning, motor skills, and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
9. Mental retardation disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
10. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
11. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms.* Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:
   - The date you have had Continuous Creditable Coverage for 12 months.
   - The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

This exclusion does not apply to newborn children, newly adopted children or children placed for adoption. This exception for newborn, adopted children and children placed for adoption no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

N. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder Services.
6. Psychosurgery.
7. Sex transformation operations.
8. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
9. Biofeedback.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer or temporomandibular joint disorder. Orthognathic surgery jaw alignment, except as a treatment of obstructive sleep apnea.
11. Surgical and non-surgical treatment of obesity.
12. Stand-alone multi-disciplinary smoking cessation programs.
13. Breast reduction except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*

O. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

P. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

Q. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

R. Substance Use Disorders

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Substance Use Disorder Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
3. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
4. Substance Use Disorder Services for the treatment of nicotine or caffeine use.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Use Disorder Designee. If services for a nervous or mental disorder occur as a result of an Emergency detention, commitment or court order, the service will be covered.
6. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

S. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services.*
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

T. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

U. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in *Section 1: Covered Health Services.*
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

V. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

W. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms.*
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language services.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms.*

Eligible Persons must reside within the United States.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms.*

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

In the case of a newborn infant, Coverage begins from the moment of birth and must include Congenital Anomalies and birth abnormalities as an Injury or Sickness.

We must receive notification of the event and any required Premium within 60 days after the date of birth.

If you fail to notify us and do not make any required payment beyond the 60 day period, coverage will not continue, unless you make all past due payments with 5 1/2% interest, within one year of the child's birth. In this case, Benefits are retroactive to the date of birth.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
  - The employer stopped paying the contributions.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Note: In the case of a newborn, the same situation applies as noted in *Adding a New Dependent* above.

Late Enrollees

A Late Enrollee is an Eligible Person or Dependent who does not enroll for coverage under the Policy when he or she is first eligible, and who does not enroll during the Initial Enrollment Period, Open Enrollment Period, or a special enrollment period as described above.

Coverage for a Late Enrollee begins on the date agreed to by the Enrolling Group after we receive the completed enrollment form and any required Premium.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

  Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

  This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**

  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Material Violation**

There was a material violation of the terms of the Policy.

- **Threatening Behavior**

  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year, after the two-year period immediately following the time the child reaches the limiting age.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy terminated.
- The maximum Benefit is paid.
- The succeeding insurer's policy provides coverage for the condition(s) causing the Total Disability.

Extended Coverage for Full-time Students

Coverage for an Enrolled Dependent child who is a Full-time Student and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- One year after the medically necessary leave of absence begins.
- The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment that causes the loss of Full-time Student status.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

If your coverage is terminated due to one of the qualifying events listed below and you were continuously covered under the Policy for a period of at least 3 months, you may elect to continue coverage, including that of any eligible Dependents.

- Reduction of hours or termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to the death of the Subscriber.
- Termination of coverage due to an annulment or divorce from the Subscriber.

Notification Requirements and Election Period for Continuation Coverage under State Law

The Enrolling Group will provide you with written notification of the right to continuation coverage within five days of the Enrolling Group receiving notice to terminate coverage. You must elect continuation coverage within 30 days of receiving this notification or 30 days after the qualifying event. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- The date the Covered Person establishes residence outside of the state.
- 18 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- For the spouse, the date the Subscriber's group coverage ends.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable Annual Deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Continuity of Care

If a provider's participation in the network has terminated, we will cover services, if we present the provider as a member of the network in the marketing materials that are provided or available at the most recent open enrollment period.

If you are undergoing a course of treatment with a Network provider who is no longer available, we will provide coverage for the remainder of the course of treatment or 90 days, whichever is shorter. If maternity care is the course of treatment and the Covered Person is in their 2nd or 3rd trimester of pregnancy, we will provide coverage until the completion of postpartum care for the mother and infant.

Coverage will not be provided, if the provider no longer practices in the Service Area or we terminate the provider's contract for misconduct on his/her part.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Medco Health Solutions, Inc.

P.O. Box 14711

Lexington, KY 40512

Payment of Benefits

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Grievances

The terms in this section mean:

Complaint - your expression of dissatisfaction with us or any Network provider.

Expedited Grievance - a Grievance where any of the following applies:

- The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum control.
- In the opinion of a Physician with knowledge of your condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance.
- A Physician with knowledge of your condition determines that the Grievance should be treated as an Expedited Grievance.
- **Grievance** - a dissatisfaction with our administration, claims practices or provision of services that is expressed in writing, to us by you or on your behalf.

To resolve a question, complaint, or grievance, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call and attempt to address your complaint through informal discussion during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

Grievance Process

Each time we deny a claim or Benefit or initiate disenrollment proceedings, we will notify you of your right to file a grievance.

We will acknowledge a grievance, in writing, within five business days of its receipt and resolve the grievance within 30 calendar days of its receipt. If we are unable to resolve the grievance within that time, we will extend the time period by an additional 30 calendar days. If you receive notification that the grievance has not been resolved, additional time is needed and the expected date the grievance will be resolved.

You or an authorized representative have the right to appear in person before the grievance committee to present written or oral information. We will notify you, in writing, of the time and place of the meeting at least seven calendar days before the meeting.

Following a review of your grievance, you will receive a written notification of the committee's decision, along with the titles of the people on the grievance committee.

What to Do if Your Grievance Requires Immediate Action

In situations where the normal duration of the grievance process could have adverse effects on you, a grievance will not need to be submitted in writing. Instead, you or your Physician should contact us as soon as possible. We will resolve the grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we will notify you of our decision by the end of the next business day following the receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that we do not consider urgent situations.

What to Do if You Disagree with Our Decision

You have the right to take your complaint to The Office of the Commissioner of Insurance, if you are not satisfied with our decision or at any time you are dissatisfied with our administration of your Benefits. The address and telephone number is as follows:

Office of the Commissioner of Insurance

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

You may also call to request a complaint form at (800)236-8517 (outside of Madison) or (608)266-0103 in Madison or email them at complaints@ociwi.state.us

Please note that our decision is based only on whether or not Benefits are available under the Policy. We do not determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

External Review Program

You or your authorized representative may request and obtain an external review of a medical adverse determination or the exclusion for Experimental, Investigational or Unproven Services, preexisting condition exclusion denial determinations, and the rescission of a policy or certificate after exhausting the internal Grievance process. In order to request an external review, the expected cost of the non-covered or terminated treatment or payment must be in accordance with the requirements set forth in Wisconsin Ins. 18.105. The request must be made in writing within four months of the date of the determination or within 4 months of the completion of the internal Grievance process, whichever is later.

The external review will be conducted by an independent review organization (IRO). You or your authorized representative must select an IRO from the list of IROs certified by the Office of the Commissioner of Insurance. In addition, your written request must contain the name of the IRO selected.

You will not have to exhaust the internal Grievance process before requesting an external review, if either of the following apply:

- All parties agree that the matter may proceed directly to the external review; or
- The independent review organization determines that proceeding through the internal Grievance process before an external review would jeopardize your life and health or ability to regain maximum function.
- If the external review is not terminated, the independent review organization shall make a decision based on any documents and information submitted, within 30 business days after the expiration of all time limits that apply in this matter. If it is determined that following the normal external review process would jeopardize your life and health or your ability to regain maximum function, the independent review organization shall make a decision within 72 hours, after the expiration of the time limits that apply in this matter.
- Any decision made by the independent review organization is binding on both parties involved, unless it is regarding a preexisting condition exclusion denial determination or a rescission it is not binding.

Contact us at the telephone number shown on your ID card for more information on the external review program or for a current listing of independent review organizations.

For purposes of this section coverage denial determination is an adverse determination, an Experimental, Investigational, or Unproven Service, a Preexisting Condition exclusion denial determination, or the rescission of a policy or certificate.

Preexisting condition exclusion is a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a Preexisting Condition exclusion.

Adverse determination means a determination by or on behalf of an insurer that issues a health benefit plan to which all of the following apply:

- An admission to a health care facility, the availability of care, the continued stay or other treatment that is a covered benefit has been reviewed.
- The treatment does not meet the health benefit plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The health benefit plan reduced, denied or terminated the treatment or payment for the treatment.
- The amount of the reduction or the cost or expected cost of the denied or terminated treatment or payment exceeds, or will exceed during the course of treatment, of the requirements set forth under Wisconsin INS 18.105.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent

(e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

      (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         (a) The Plan covering the Custodial Parent.

         (b) The Plan covering the Custodial Parent's spouse.

         (c) The Plan covering the non-Custodial Parent.

         (d) The Plan covering the non-Custodial Parent's spouse.

   c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits,

this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate.*
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. § 1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate,* the *Schedule of Benefits,* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group. Amendments that result in a reduction of Benefits will be effective upon 60 days prior written notice.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices.*

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including

Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this *Certificate,* we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and

- obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That after you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals.* After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate,* the *Schedule of Benefits,* the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate,* the *Schedule of Benefits,* and any attached Riders and/or Amendments.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- *The Federal Employees Health Benefits Program.*
- *The State Children's Health Insurance Program (S-CHIP).*
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act.*

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits.*
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child of an Enrolled Dependent child (until the Enrolled Dependent who is the parent turns 18).

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 27 years of age who is not eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent's

premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the Subscriber's Plan.

- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's 27th birthday.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

A Dependent also includes an adult child who meets the following requirements:

- A full-time Student, regardless of age.
- Not married or eligible for coverage under a group health benefit plan offered by their employer and for which the amount of the Dependent's premium contribution is no greater than the premium amount for his or her coverage as a dependent under the Subscriber's Plan.
- Was under age 27 when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the dependent was attending on a full-time basis, an institution of higher education.
- If the adult Dependent ceases to be a full-time Student due to medically necessary leave of absence, then coverage must be continued in accordance with the existing law for continued coverage of students on medical leave, and age is not a factor that would affect when such continued coverage would end.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits.*

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness including severe pain which would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

- Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.
- Serious impairment to the person's bodily functions.
- Serious dysfunction of one or more of the person's body organ or parts.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services.*
- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health.*

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care - Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment program.
- Care through an Intensive Outpatient Treatment program.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Policy at a time other than the following:

- During the Initial Enrollment Period.
- During an Open Enrollment Period.
- During a special enrollment period as described in *Section 3: When Coverage Begins.*
- Within 31 days of the date a new Eligible Person first becomes eligible.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Maximum Policy Benefit - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation

agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *FDA*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, clinical social worker, marriage and family therapist, nurse practitioner, professional counselor or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy.*
- This *Certificate.*
- The *Schedule of Benefits.*
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Preexisting Condition - an Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the three month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Policy or, if earlier, the first day of any waiting period under the Policy.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate.* Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area we serve and that has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Saving

Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Small Enrolling Group - an employer that had an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or reasonably expects to have an average of at least 2 but not more than 50 employees on business days during the current calendar year, if the employee was not in existence during the preceding calendar year and that employs at least 2 employees on the first day of the plan year.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association,* unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health Services and Substance Use Disorder Services provided in a less restrictive manner than inpatient Hospital services but more intensive than outpatient services.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health.*
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA),* it must be *FDA*-approved.

- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits.*

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Pre-service Benefit Confirmation

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying us. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Ambulance - non-emergent air and ground.
- Autism Spectrum Disorder Services.
- Clinical trials.
- Congenital heart disease surgery.
- Dental services - accidental.

- Dental/Anesthesia Services - Hospital or Ambulatory Surgery Services.
- Durable Medical Equipment over $1,000.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Kidney Disease Treatment.
- Reconstructive procedures.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, and post-cochlear implant aural therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Temporomandibular Joint Disorders.
- Therapeutics - only for the following services: dialysis.
- Transplants.

As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. After you contact us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Mental Health Services and Substance Use Disorder Services

Mental Health Services and Substance Use Disorder Services are not subject to the pre-service notification requirements described above. Instead, you must obtain prior authorization from the Mental Health/Substance Use Disorder Designee before you receive Covered Health Services. You can contact the Mental Health/Substance Use Disorder Designee at the telephone number on your ID card.

To receive the highest level of Benefits and to avoid incurring the penalties described in this *Schedule of Benefits* table within each Covered Health Service category, you must call the Mental Health/Substance Use Disorder Designee before obtaining Mental Health Services or Substance Use Disorder Services. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. When you call the Mental Health/Substance Use Disorder Designee as required, you will be given the names of Network providers who are experienced in addressing your specific problems or concerns.

The Mental Health/Substance Use Disorder Designee performs utilization review to determine whether the requested service is a Covered Health Service. The Mental Health/Substance Use Disorder Designee does not make treatment decisions about the kind of behavioral health care you should or should not receive. You and your provider must make those treatment decisions.

Care Coordination SM

When we are notified as required, we will work with you to implement the Care Coordination SM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the pre-service notification requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits.* You are not required to notify us before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	**Amounts**
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits,* including Covered Health Services provided under the *Outpatient Prescription Drug Rider.* Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.	***Network*** For single coverage, the Annual Deductible is $2,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $4,000 . No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied. ***Non-Network*** For single coverage, the Annual Deductible is $4,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $8,000 . No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible, or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this *Schedule of Benefits,* including Covered Health Services provided under the *Outpatient Prescription Drug Rider.* Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still	***Network*** For single coverage, the Out-of-Pocket Maximum is $4,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $8,000 . The Out-of-Pocket Maximum includes the Annual Deductible.

will be required to pay the following: • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not notify us as required. • Charges that exceed Eligible Expenses. • Copayments or Coinsurance for any Covered Health Service identified in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Maximum.	***Non-Network*** For single coverage, the Out-of-Pocket Maximum is $8,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $16,000 . The Out-of-Pocket Maximum includes the Annual Deductible.
Maximum Policy Benefit	
The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	***Network*** No Maximum Policy Benefit. ***Non-Network*** No Maximum Policy Benefit.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Pre-service Notification Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance	***Network*** *Ground Ambulance:* 100%	Yes	Yes
	Air Ambulance: 100%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	***Network*** *Ground Ambulance:* 100%	Yes	Yes
	Air Ambulance: 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network Same as Network	Same as Network	Same as Network
2. Clinical Trials			
Pre-service Notification Requirement You must notify us as soon as the possibility of participation in a clinical trial arises. If you don't notify us, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	***Non-Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
3. Congenital Heart Disease Surgeries			
Pre-service Notification Requirement For Non-Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.			
Network and Non-Network Benefits under this section include only the Congenital Heart Disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management	***Network*** 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
of CHD will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
Non-Network Benefits are limited to $30,000 per CHD surgery.	***Non-Network*** 80%	Yes	Yes
4. Dental Services - Accident Only			
Pre-service Notification Requirement For Network and Non-Network Benefits you must notify us five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify us before the initial Emergency treatment.) If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.	***Network*** 100%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network
5. Diabetes Services			
Pre-service Notification Requirement For Non-Network Benefits you must notify us before obtaining any diabetes equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	***Network*** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
Diabetes Self-Management Items Benefits for insulin pumps are limited to one pump per year.	***Network*** For diabetes supplies the Benefit is 100% of Eligible Expenses and Benefits are subject to payment of the Annual Deductible. Coinsurance does not apply to the Out-of-Pocket Maximum.		
	Non-Network For diabetes supplies the Benefit is 80% of Eligible Expenses and Benefits are subject to payment of the Annual Deductible. Coinsurance applies to the Out-of-Pocket Maximum.		
6. Durable Medical Equipment			
Pre-service Notification Requirement For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.			
Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician. Cochlear implants are included under the Durable Medical Equipment benefit as required by Wisconsin insurance law.	***Network*** 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 80%	Yes	Yes
7. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.	***Network*** 100% after you pay a Copayment of $250 per visit . If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network
8. Hearing Aids			
Limited to $2,500 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every three years. For Enrolled	***Network*** 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Dependent children under age 18, Benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law. Hearing aids for Enrolled Dependent children are not subject to dollar maximums.			
	Non-Network 80%	Yes	Yes
9. Home Health Care			
Pre-service Notification Requirement For Non-Network Benefits you must notify us five business days before receiving services or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	***Network*** 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
10. Hospice Care			
Pre-service Notification Requirement For Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
11. Hospital - Inpatient Stay			
Pre-service Notification Requirement For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
12. Lab, X-Ray and Diagnostics - Outpatient			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
14. Mental Health Services			
Prior Authorization Requirement You must obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
Any combination of Network and Non-Network Benefits for Inpatient/Intermediate Mental Health and/or Substance Use Disorder Services are limited to 30 days or $7,000 per calendar year, whichever is greater.	***Network*** *Inpatient/ Intermediate* 100%	Yes	Yes
Any combination of Network and Non-Network Benefits for outpatient Mental Health and/or Substance Use Disorder Services are limited to 20 visits or $2,000 per calendar year, whichever is greater.	*Outpatient* 100% after you pay a Copayment of $60 per visit	Yes	Yes
Any combination of Network and Non-Network Benefits for Transitional Care services are limited to 20 visits or $3,000 per calendar year, whichever is greater.	*Transitional Care* 100% after you pay a Copayment of $60 per visit	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network *Inpatient/ Intermediate* 80%	Yes	Yes
	Outpatient 80%	Yes	Yes
	Transitional Care 80%	Yes	Yes
15. Ostomy Supplies			
Limited to $2500 per year.	***Network*** 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
16. Pharmaceutical Products - Outpatient			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
17. Physician Fees for Surgical and Medical Services			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
18. Physician's Office Services - Sickness and Injury			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	***Network*** 100% after you pay a Copayment of $30 per visit for a Primary Physician office visit or $60 per visit for a Specialist Physician office visit	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 80%	Yes	Yes
19. Pregnancy - Maternity Services			
Pre-service Notification Requirement For Non-Network Benefits you must notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. **It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.**			
	Network Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
	Non-Network Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
20. Preventive Care Services			
Physician office services	***Network*** 100% No Copayment or Coinsurance applies to immunizations for children from birth to age six. No Copayment or Coinsurance applies to influenza immunizations.	No	No
	Non-Network 80%	Yes	Yes
Lab, X-ray or other preventive tests	***Network*** 100%	No	No
	Non-Network 80%	Yes	Yes
21. Prosthetic Devices			
Limited to $2,500 per year. Benefits are limited to a single purchase of each type of prosthetic device every three years.	***Network*** 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*	***Non-Network*** 80%	Yes	Yes
22. Reconstructive Procedures			
Pre-service Notification Requirement For Non-Network Benefits you must notify us five business days before a scheduled reconstructi ve procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
23. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Pre-service Notification Requirement For Non-Network Benefits you must notify us five business days before receiving Manipulative Treatment or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Limited per year as follows: • 20 visits of physical therapy. • 20 visits of occupational therapy. • 20 visits of speech therapy. • 20 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • Visit limits do not apply to Manipulative Treatment.	***Network*** 100% after you pay a Copayment of $30 per visit	Yes	Yes
	Non-Network 80%	Yes	Yes
24. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Pre-service Notification Requirement For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Skilled Nursing Facility Services, Benefits are limited to 30 days per Inpatient Stay. For Inpatient Rehabilitation Facility Services are limited to 60 days per year.	***Network*** 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
26. Substance Use Disorder Services			
Prior Authorization Requirement You must obtain prior authorization through the Mental Health/Substance Use Disorder Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.			
Any combination of Network and Non-Network Benefits for Inpatient/Intermediate Mental Health and/or Substance Use Disorder Services are limited to 30 days or $7,000 per calendar year, whichever is greater.	***Network*** *Inpatient/ Intermediate* 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Any combination of Network and Non-Network Benefits for outpatient Mental Health and/or Substance Use Disorder Services are limited to 20 visits or $2,000 per calendar year, whichever is greater.	*Outpatient* 100% after you pay a Copayment of $60 per visit	Yes	Yes
Any combination of Network and Non-Network Benefits for Transitional Care services are limited to 20 visits or $3,000 per calendar year, whichever is greater.	*Transitional Care* 100% after you pay a Copayment of $60 per visit	Yes	Yes
	Non-Network *Inpatient/ Intermediate* 80%	Yes	Yes
	Outpatient 80%	Yes	Yes
	Transitional Care 80%	Yes	Yes
27. Surgery - Outpatient			
	Network 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network 80%	Yes	Yes
28. Therapeutic Treatments - Outpatient			
Pre-service Notification Requirement For Non-Network Benefits you must notify us for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require notification: dialysis. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 100%	Yes	Yes
	Non-Network 80%	Yes	Yes
29. Transplantation Services			
Pre-service Notification Requirement For Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply. For Non-Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	***Network*** 100%	Yes	Yes
Non-Network Benefits are limited to $30,000 per transplant.	***Non-Network*** 80%	Yes	Yes
30. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under *Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.* • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*	***Network*** 100% after you pay a Copayment of $100 per visit	Yes	Yes
	Non-Network 80%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
31. Vision Examinations			
Limited to 1 exam every 2 years.	***Network*** 100% after you pay a Copayment of $30 per visit	Yes	Yes
	Non-Network 80%	Yes	Yes
Additional Benefits Required By Wisconsin Law			
32. Autism Spectrum Disorder Services			
Notification Requirements Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
Intensive Level Services Benefits for Intensive level services are covered to $51,700 per Enrolled Dependent child per year, with a minimum of 20 hours care per week for four years. **Non Intensive Level Services** Benefits for Non Intensive-level services are covered to $25,850 per Enrolled Dependent child per year.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
33. Dental/Anesthesia Services - Hospital Ambulatory Surgery Services			
Notification Requirements Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
34. Kidney Disease Treatment			
Notification Requirements Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
35. Temporomandibular Joint Disorders			
Notification Requirements Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*			
Benefits for diagnostic procedures and non-surgical treatment are limited to $1,250 per calendar year.	***Network*** Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate.*

If one or more alternative health services that meets the definition of Covered Health Service in the *Certificate* under *Section 9: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance use disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on the lesser of:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 100% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
        - Reference to available CMS schedules.
        - Methods similar to those used by CMS.
    - Fee(s) that are negotiated with the provider.
    - 50% of the billed charge.
    - A fee schedule that we develop.
- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care.* A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

Prior authorization requirements listed under *Mental Health Services and Substance Use Disorder Services* in the *Schedule of Benefits* are deleted. The following services are added to the list of services requiring pre-service notification under *Pre-service Benefit Confirmation* in the *Schedule of Benefits:*

Pre-service Benefit Confirmation

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

Mental Health Services and *Substance Use Disorder Services* in the *Certificate, Section 1: Covered Health Services* are deleted and replaced with the following:

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions . Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Coverage will be provided for the Mental Health clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Mental Health/Substance Use Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Use Disorder Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Mental Health/Substance Use Disorder Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a Full-time Student.

Mental Health Services received on a transitional care basis including:

- Services for children and adults in day treatment programs.
- Services for persons with chronic Mental Illness provided through a community support program.
- Coordinated Emergency Mental Health Services for Covered Persons who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Covered Person is experiencing the crisis until he/she is stabilized or referred to other provider for stabilization.
- The Wisconsin Department of Health and Social Services must certify day treatment programs, community support programs and residential treatment programs and crisis intervention programs.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

Coverage will be provided for the Substance Use Disorder clinical assessments of Dependent Full-time Students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a provider designated by the Substance Use Designee and who is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. If outpatient Mental Health/Substance Use Disorder Services are recommended, coverage will be provided for a maximum of 5 visits at an outpatient treatment facility or other provider designated by the Substance Use Designee, that is located in the State of Wisconsin and in reasonably close proximity to the Full-time Student's school. Coverage for the outpatient services will not be provided, if the recommended treatment would prohibit the Dependent from attending school on a regular basis or if the Dependent is no longer a Full-time Student.

Substance Use Disorder Services received on a transitional care basis including:

- Residential treatment programs for alcoholism and other drug dependent Covered Persons.
- Substance Use Disorder Services for alcohol and drug dependent Covered Persons.
- Intensive outpatient programs for the treatment of psychoactive substance abuse disorders.
- The Wisconsin Department of Health and Social Services must certify day treatment programs, community support programs and residential treatment programs and crisis intervention programs.

***Mental Health Services* and *Substance Use Disorder Services* in the *Schedule of Benefits* are deleted and replaced with the following:**

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
Mental Health Services			
Pre-Service Notification Requirement For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must notify us before the following services are received: intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network *Inpatient* 100%	Yes	Yes
	Outpatient 100% after you pay a Copayment of $60 per visit	Yes	Yes
	Transitional Care 100% after you pay a Copayment of $60 per visit	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Non-Network *Inpatient* 80%	Yes	Yes
	Outpatient 80%	Yes	Yes
	Transitional Care 80%	Yes	Yes
Substance Use Disorder Services			
Pre-Service Notification Requirement For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify us prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must notify us before the following services are received: Services requiring pre-service notification: intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network *Inpatient* 100%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	**Benefit *(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	Outpatient 100% after you pay a Copayment of $60 per visit	Yes	Yes
	Transitional Care 100% after you pay a Copayment of $60 per visit	Yes	Yes
	Non-Network *Inpatient* 80%	Yes	Yes
	Outpatient 80%	Yes	Yes
	Transitional Care 80%	Yes	Yes

Exclusions for *Mental Health* and *Substance Use Disorders* in the *Certificate* under *Section 2: Exclusions and Limitations* are deleted and replaced with the following:

Mental Health

Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*
7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
8. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* Benefits for autism spectrum disorder as a primary diagnosis are described under *Autism Spectrum Disorder Services* in *Section 1: Covered Health Services.*
9. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
    - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Substance Use Disorders

Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
    - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
    - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

The definition of Intermediate Care is deleted.

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Patient Protection and Affordable Care Act (PPACA) Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

Maximum Policy Benefit/Limits on Essential Benefits

The Maximum Policy Benefit provision in the *Schedule of Benefits,* the definition of Maximum Policy Benefit in the *Certificate* and all references to a Maximum Policy Benefit are deleted. Benefits under the Policy are not limited by a Maximum Policy Benefit.

Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential benefits include the following:

> Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all Benefits.

Preventive Care

Network Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Copayment, Coinsurance, or deductible) apply to the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Preexisting Conditions

Preexisting condition exclusions do not apply to Covered Persons under age 19. The preexisting condition exclusion in the *Certificate, Section 2: Exclusions and Limitations* is replaced with the following:

M. Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following:
   - The date you have had Continuous Creditable Coverage for 12 months.
   - The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.

   This exclusion does not apply to Covered Persons under age 19.

Dependent Children

The following *Dependent Child Special Open Enrollment* provision is added to the *Certificate, Section 3: When Coverage Begins:*

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

All references to Full-time Student status requirements are deleted. The definition of Dependent is replaced with the following:

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child of an Enrolled Dependent child (grandchild) until the Enrolled Dependent child who is the parent turns 18.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A Dependent also includes an adult child who meets all of the following requirements:

- The child is a Full-time Student, regardless of age.
- The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.
- The child was under age 27 when called to federal active duty.
- The child must apply to an institution of higher education as a Full-time Student within twelve months from the date the child has fulfilled his or her active duty obligation.

- When the child is called to active duty more than once within a four-year period of time, we will use the child's age when first called to active duty for determining eligibility.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Fraud or Intentional Misrepresentation of a Material Fact

The terminating provision for *Fraud, Misrepresentation or False Information* in the *Certificate, Section 4: When Coverage Ends* is replaced with the following:

- **Fraud or Intentional Misrepresentation of a Material Fact**

  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Claims and Appeals

Other changes provided for under the *PPACA* impact how claims and appeals are handled and are applicable to your plan:

- You have the right to appeal a rescission of coverage determination.
- If any new or additional evidence is relied upon or generated by us during the determination of an appeal we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- With respect to any urgent request for Benefits you will receive the notice of benefit determination within 24 hours after we have received all necessary information.

Other changes provided for under the *PPACA:*

Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these provisions. These include:

- Direct access to OB/GYN care without a referral or authorization requirement.
- The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
- The ability to designate any primary care physician (PCP) that is accepting new patients.
- Prior authorization is not required before you receive services in the emergency department of a Hospital.
- If you seek emergency care from non-Network providers in the emergency department of a Hospital your cost sharing obligations (Copayments/Coinsurance) will be the same as would be applied to care received from Network providers.

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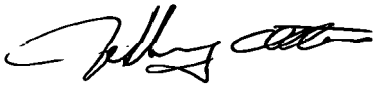

President

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Federal Health Care Law
Frequently Asked Questions for Consumers

Disclaimer:
Many of the responses to these questions are based on information currently available from the federal government. Federal guidance on the Affordable Care Act changes often and the Office of the Commissioner of Insurance (OCI) will update this document as new information becomes available

This FAQ is intended to provide information on how your health insurance plan in Wisconsin may be affected by the federal health care law known as the Affordable Care Act (ACA).

Glossary of Terms

(Terms reflect those used in this document.)

Essential Health Benefits (EHB):
The minimum level of coverage insurers in the individual and small group markets must offer beginning January 1, 2014.

Benefits in the following categories must be covered:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Insurers are not allowed to impose annual or lifetime limits on essential health benefits.

Large group health insurance plans are not required to cover essential health benefits. However, if a large employer chooses to offer a health insurance plan that includes

essential health benefits, the plan cannot impose any annual or lifetime limits on those benefits.

Each state must identify their Essential Health Benefit Benchmark plan. Insurers must offer benefits that are substantially similar to the benchmark plan.

The federal government has identified a plan sold by UnitedHealthcare as Wisconsin's benchmark. It is their Choice Plus Definity HSA Plan (A92NS).

A copy of the Wisconsin EHB Benchmark plan can be found at:

http://oci.wi.gov/healthcare_ref/ehb_certificate.pdf

FPL:
FPL means the federal poverty level. This level is set by the federal government and varies based on family size (so the federal poverty level for an individual is a lower dollar amount than the federal poverty level for a family of four). Individuals with incomes below the poverty level are believed to be lacking the resources to meet their basic needs.

Guaranteed Issue:
A requirement that health insurers sell a health insurance policy to any person who requests coverage.

Federal Exchange:
The federal exchange is a federal Web site that allows consumers to: (1) check their eligibility for government assistance programs, including any subsidies available to help pay for private health insurance; (2) compare health insurance plans based on cost; and (3) link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in.

The federal government refers to the federal Web site as both an “exchange” and a “marketplace.” In an effort to limit confusion, this document and Wisconsin will continue to use the term “exchange.”

The Web address for the federal exchange is www.healthcare.gov

Open Enrollment Period:
Open enrollment is a limited time period during which insurers are required to offer insurance coverage to any applicant. This is required of insurers both inside and outside the federal exchange. Under the law, individuals will first be able to purchase coverage during the initial open enrollment period which is scheduled for October 1, 2013, through March 31, 2014.

Following the first year, the annual enrollment period (for benefit years starting on or after January 1, 2015) is November 15, 2014, through February 15, 2015.

Private Health Insurance Market:
This refers to the Wisconsin health insurance market offering health insurance plans outside of the federal exchange.

Premium Tax Credits:
These are federal tax credits provided to certain eligible individuals and families to artificially reduce the actual premium charged by insurers.

General Health Insurance Market FAQs
(Responses apply to plans sold through the federal exchange or in the private health insurance market outside of the federal exchange.)

1. **What are the major changes I need to know about?**
   There are a number of major changes for comprehensive health insurance plans effective January 1, 2014. These include the following:

   - Insurers must sell a health insurance policy to any person who applies for coverage, except in cases where fraudulent information is provided by the applicant. This is called guaranteed issue.
   - Insurers are prohibited from excluding or limiting coverage for a preexisting condition. A preexisting condition is a health condition an individual has before purchasing a health insurance plan.
   - Insurers may only take four items into account when pricing their products. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.
   - Plans are required to offer "essential health benefits." See the "Glossary of Terms" section for more detail.
   - Plans are categorized into one of four different levels, which the federal government calls "metal tiers." Consumers will know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average portion of expected costs a plan will cover for the average individual. The metal tiers include: bronze plans covering 60%; silver plans covering 70%; gold plans covering 80%; and platinum plans covering 90%.
   - All plans will limit in-network out-of-pocket expenses to $6,350 for self-only coverage and $12,700 for family coverage.
   - Insurers have the option to sell their plans through the federal exchange, as well as selling health insurance plans through the traditional health insurance market like they do today.

2. **Is the federal government requiring me to purchase health insurance?**
   Yes, beginning January 1, 2014, individuals of all ages must have health insurance or pay a penalty. The federal government refers to this tax as the "individual shared responsibility payment."

   The penalty is set to increase each year as follows:

   - In 2014 it will be the greater of $95 per adult or 1% of taxable income.
   - In 2015 it will be the greater of $325 per adult or 2% of taxable income.

- In 2016 it will be the greater of $695 per adult or 2.5% of taxable income.
- After 2016 the tax penalty increases annually based on a cost-of-living adjustment.

A person will pay 1/12 of the total annual penalty for each month without coverage. The penalty for a child is half that of an adult.

3. **I have heard that some people may qualify for an exemption from the federal tax or "individual shared responsibility payment" related to not having health insurance. Is this true?**
Yes, individuals meeting certain circumstances may be exempt from the federal tax, referred to as the "individual shared responsibility payment."

According to an October 28, 2013, Q and A document released by the Center for Consumer Information & Insurance Oversight (CCIIO), if an individual enrolls in a plan through the federal exchange during the open enrollment period, the individual will be able to claim a hardship exemption from the shared responsibility payment for the months prior to the effective date of the individual's coverage. This can be done when filing a federal income tax return in 2015. A request for the exemption does not need to be made through the federal exchange. For more information on this exemption, please read through the CCIIO Q and A document at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/enrollment-period-faq-10-28-2013.pdf.

According to a January 3, 2014, Q and A document released by CCIIIO, if you have been notified that your health insurance policy will be cancelled and you believe that the individual market health plan options available in your area are unaffordable, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage available in your area. For more information on this exemption, visit http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf.

There are additional federal exemptions from having to purchase health insurance. For more information on those exemptions, below is a link to an IRS FAQ:

http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

3. After January 1, 2014, will consumers be able to keep their health insurance with their current health insurance company?
Many health insurance companies will continue to sell health insurance in Wisconsin. However, there are insurers who have left the market or have restricted their service areas due in part to costly changes the federal government requires insurers to take on starting in 2014.

4. Will consumers be able to keep their current health insurance plan (benefits) if they like it?

State and federal law allowed insurers the option of renewing their 2013 plans, extending coverage into 2014. If the insurer you had for the 2013 plan year chose to continue offering that same plan, you should have received a notification from the insurer indicating this. If the insurer stopped offering the plan you had in 2013, you should have received notification from the insurer letting you know the coverage is no longer available and that you should plan to purchase coverage during the open enrollment period ending March 31, 2014.

According to the Center for Consumer Information & Insurance Oversight, if you have been notified that your health insurance policy will be cancelled and you believe that the individual market health plan options available in your area are unaffordable, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage available in your area. Please visit this link for more information http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf.

For consumers who get their coverage from an employer, there will likely be fewer changes in your plan than the individual insurance market but many will see their current plan change.

5. Will premiums increase? If so, by how much?

From our analysis, it appears premiums will increase for most consumers. The federal government is imposing significant fees and other requirements onto insurers as a condition of being in compliance with the federal health care law. Consumers will feel the impact of these federal requirements through premium increases.

OCI issued a press release on September 3, 2013, with information comparing what Wisconsin consumers were paying in 2013 to what plans cost post 2014 under the new federal health law. The analysis done by OCI shows that a policy with a $2,000 deductible in the individual market could increase as high as 89% for a 21-year-old, 73% for a 40-year-old and 70 % for a 63-year-old in 2014, depending on where the individual lives.

While there is no question that some consumers will have subsidies and may not pay higher rates, someone will pay for the increased premiums whether it is the consumer or the federal government.

It is important to note that a number of factors will impact how much of an increase an individual consumer will pay. The best way to determine how much you will pay is to review the plan options available both on the federal exchange and in the private health insurance market. All of the health insurers selling health insurance plans in Wisconsin are listed on the OCI Web site at http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf.

6. **Will consumers receiving premium tax subsidies be impacted by these premium increases?**
Premium tax subsidies will not change an individual's premium but it will decrease how much premium the individual pays. The amount depends on how much of a subsidy they get from the federal government. It is quite possible that even with subsidies many consumers, particularly those closer to 400% of the federal poverty level (FPL), will pay more than they would if insurers did not have to adjust their premiums to reflect federally imposed fees and other requirements resulting from federal health care reform.

7. **I have recently heard that people with incomes between 100% and 200% of the FPL will no longer be eligible for Medicaid in 2014. Instead, these individuals will have the option of purchasing health insurance with a premium tax credit through the federal exchange. Will the premium increases discussed above impact those individuals?**
No. Individuals eligible for the federal premium tax credit who are at 100% of the FPL receive significant subsidies and cannot be required to pay more than approximately $19.00 a month. Similarly, individuals at 200% of the FPL cannot be required to pay more than approximately $117.00 a month.

8. **Will plans without the essential health benefits be available?**
If you had an individual health insurance plan in 2013 and the insurer offering that plan made it available to you for the 2014 plan year, it is possible that the plan does not contain all of the essential health benefits.

   Catastrophic plans are not required to meet the essential health benefits (see "Glossary of Terms" for more detailed information on essential health benefits). However, federal law only allows individuals under the age of 30, and those meeting certain other federal exemptions, to access those plans. For example, according to a January CCIIO Q and A document, if you have been notified that your health insurance policy will be cancelled and you believe that the individual market health plan options available in your area are unaffordable, you will be eligible for a hardship exemption and will be able to enroll in catastrophic coverage available in your area. For more information, visit http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf.

   In most cases, premiums for catastrophic plans will be less expensive because they will cover fewer benefits and require the consumer to take on more of the out-of-pocket expenses through co-pays and higher deductibles. These plans will likely attract individuals who need coverage due to the law, but do not need a lot of coverage.

9. **Are large group plans required to cover essential health benefits (EHBs)?**
No, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits. Plans may impose non-dollar limits that are at least actuarially equivalent to any annual dollar limits contained in the benchmark plan. Imposing visit limitations is an example.

10. How does an insurer know whether its large group plan offerings contain EHBs?

Insurers may refer to any state's EHB benchmark plan when identifying whether its large group plans contain EHBs. As stated in the response to question 9, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits.

There is no requirement for large group plans to cover benefits at the level provided in the benchmark plan or add benefits not currently covered by the large group plan.

Any large group insurance plan choosing another state's benchmark plan must continue to cover Wisconsin state mandated benefits in accordance with state law. A large group plan may continue to impose dollar limits on a state mandated benefit if the chosen EHB benchmark plan does not include the Wisconsin mandated benefits.

Individual and small group health plans must provide benefits contained in the Wisconsin benchmark plan and do not have the option to choose a different state's benchmark plan.

11. Will consumers be able to purchase coverage at any time throughout the year?

Individuals and families interested in purchasing coverage in the individual market that first becomes effective in 2014 can purchase health insurance coverage through the private market or the federal exchange during the *initial* open enrollment period, which began October 1, 2013, and ends March 31, 2014.

Following the *initial* open enrollment period, there will be an *annual* open enrollment period in subsequent years that runs from November 15 through February 15.

There are also special enrollment periods for an individual or family if they experience a "triggering event." Examples of common triggering events include: (1) loss of minimum essential coverage; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 60 days from the time of a triggering event to enroll in new or different health insurance coverage.

For individuals and families purchasing coverage through their employer, there will be no changes in timeframes.

12. What are navigators and will individuals and families be able to use navigators to purchase health insurance?

Navigators are federally funded entities and individuals who help consumers determine their eligibility for public assistance programs. They also help

consumers compare health insurance options displayed on the federal exchange Web site after consumers input their preferences.

In addition to federal training and licensure requirements, navigators serving Wisconsin consumers must obtain a state navigator license by completing 16 hours of state-specific training and successfully pass a state examination.

All navigators licensed in Wisconsin are registered with OCI and are listed on the OCI Web site. If you are uncertain whether the person you are working with is a navigator, you should look for their name on the OCI Web site at http://oci.wi.gov/navigator/naventities-registered.htm. If you have concerns with a navigator's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

By law, navigators are prohibited from selling health insurance. They are available to help individuals check for eligibility into public assistance programs through the federal exchange and help individuals interested in purchasing health insurance view plan options displayed on healthcare.gov, the federal exchange Web site.

Even for consumers interested in purchasing health insurance through the federal exchange, navigators are not permitted, by law, to assess whether one plan may be better for a consumer than another. Only state-licensed health insurance agents can provide advice and sell health insurance.

For a list of permitted and prohibited activities related to navigators, review the July 26, 2013, bulletin posted to the OCI Web site at: http://oci.wi.gov/bulletin/0713navigator.htm.

13. What are "Certified Application Counselors (CACs)"? Can they sell health insurance?

CACs, like navigators, help individuals check their eligibility for public assistance programs. CACs also help consumers sort through the health insurance plans that display on the federal exchange Web site after consumers enter their preferences.

CACs are not federally funded but must work for an organization designated by the federal government as a CAC entity. CACs must complete federal training and examination requirements as well as the same state training and examination requirements necessary for a Wisconsin navigator license. CACs are registered with the Office of the Commissioner of Insurance and are listed on the OCI Web site at http://oci.wi.gov/navigator/cac-registered.htm.

If you have concerns with a CAC's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

Under state and federal law, CACs and navigators are not qualified to and cannot legally sell health insurance or provide advice to consumers about which

health insurance plan best meets their needs. Only state-licensed health insurance agents may sell and provide advice about health insurance coverage.

Private Health Insurance Market (Outside of the federal exchange) FAQs

1. **I understand there will be a federal exchange but will I still be able to purchase health insurance in the private market outside of the federal exchange?**
   Yes. There e are many insurers offering plans in the private health insurance market. Consumers are encouraged to research options in the private market before committing to a purchase through the federal exchange. A map detailing all of the insurers selling health insurance in Wisconsin by county is posted on the OCI Web site. A table with contact information for each insurer is also provided. You can find the map and the table at http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf.

2. **Will I be penalized if I purchase health insurance in the private market rather than through the federal exchange?**
   No, you will not be penalized for purchasing health insurance in the private health insurance market outside of the exchange. There are no penalties associated with where you purchase your health insurance. The only penalty is a federal tax for not purchasing health insurance at all. This is explained further in question number two under General Health Insurance Market FAQs.

3. **How can consumers purchase plans in the private health insurance market? Can they still use agents?**
   Consumers can purchase plans through the private market directly from an insurer or through a licensed health insurance agent.

   Navigators, Certified Application Counselors, or any other type of assister are prohibited, by law, from selling health insurance policies.

4. **Is there a difference between health insurance plans offered in the private health insurance market vs. those available through the federal exchange?**
   Depending on the area of the state you live in, there are likely more plan options available in the private health insurance market because not all insurers sell their plans through the federal exchange. Additionally, those that do sell plans through the federal exchange may also offer additional plan options in the private health insurance market.

Exchange FAQs

1. **Are insurers required to sell their plans through the federal exchange?**
   No, and some have chosen to only sell their plans in the private health insurance market. For this reason, it is important for consumers to understand all of their options. Consumers may seek help from a state-licensed health insurance agent to ensure they choose a plan that best suits their needs.

A map detailing all of the insurers selling health insurance in Wisconsin by county is posted on the OCI Web site. A table with contact information for each insurer is also provided. You can find the map and the table at http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf.

2. Are consumers required to purchase health insurance through the federal exchange?

No. Consumers may purchase health insurance in either the private health insurance market or through the federal exchange. It will be important for consumers to use resources, such as state-licensed health insurance agents, to understand whether plans sold in the private health insurance market meet their needs better than those plans available through the federal exchange.

3. If purchasing health insurance through the federal exchange, can consumers still purchase health insurance through an agent?

Yes, agents continue to assist individuals and families in purchasing health insurance coverage. Agent services are available for consumers interested in purchasing coverage either in the private health insurance market or through the federal exchange.

For consumers interested in purchasing coverage through the federal exchange, agents will be able to help people understand whether it may be in their best interest to instead purchase coverage in the private health insurance market.

4. When can consumers purchase health insurance through the federal exchange?

Individuals and families can enroll in individual health insurance coverage through the exchange during the *initial* open enrollment period, which began on October 1, 2013, and will end on March 31, 2014. Health insurance coverage for plans purchased during that timeframe begins in 2014.

Following the *initial* open enrollment period, the *annual* enrollment period (for benefit years starting on or after January 1, 2015) is November 15, 2014, through February 15, 2015.

There are also special enrollment periods for an individual or family if they experience a "triggering event." Common examples of triggering events include: (1) loss of minimum essential coverage; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 30 days from the time of a triggering event to enroll in new or different health insurance coverage. A 60-day timeframe is provided for individuals who lose eligibility for Medicaid.

5. What will it cost to participate in the federal exchange?

There is no fee to individuals and families using the federal exchange. However, the federal government will charge insurers a fee to sell their products through the federal exchange. That fee, coupled with other fees and regulatory requirements the federal government is imposing on insurers, has resulted in significant increases in health insurance premiums.

See FAQ number five under General Health Insurance Market FAQs above.

6. **Can insurers charge more (or less) for policies sold through the federal exchange?**
No, insurers must charge the same for similar plans whether they are sold through the federal exchange or in the private health insurance market.

7. **What is the federal Small Business Health Options Program (SHOP) Exchange?**
It is the federal health insurance exchange for small employers. Small employers can either purchase their health insurance plan for their employees in the private health insurance market or through the federal SHOP Exchange. Additional FAQs for small employers and their employees are also available from OCI.

Premium Tax Credits FAQs

1. **Who is eligible for federal premium tax credits?**
Iindividuals and families with incomes between 100% and 400% of the federal poverty level (FPL), or $11,670 to $46,680 for individuals and $23,850 to $95,400 for a family of four.

   The premium tax credit is available to people who have no tax liability and can be paid directly to the individual's insurance company to help artificially reduce the cost of health insurance.

   Below is a link to a premium tax credit calculator available on the Kaiser Family Foundation Web site:

   http://healthreform.kff.org/subsidycalculator.aspx

2. **Are consumers who purchase health insurance in the private health insurance market outside of the exchange eligible for federal premium tax credits?**
No. The federal government only offers premium tax credits if health insurance is purchased through the federal exchange.

   Given all of the problems the federal exchange experienced when it became operational on October 1, and all of the complications it still poses for some consumers using the Web site, Governor Walker asked the federal Department of Health and Human Services to allow individuals purchasing coverage in the private health insurance market to receive federal subsidies. Here is a link to the Governor's press release: http://walker.wi.gov/newsroom/press-release/governor-scott-walker-calls-special-session-address-failed-federal-rollout.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
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Wisconsin.gov

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Health Care Reform
Agent Frequently Asked Questions

What are the major changes happening January 1, 2014?

There are a number of major changes that begin on January 1, 2014, including:

- Guaranteed issue in the individual market (small groups have had guaranteed issue since 1998).
- Modified community rating rates will only be allowed to vary based on family status, rating area, age, and tobacco use.
- Plan design changes:
    - All non-grandfathered plans will be required to offer "essential health benefits."
    - All non-grandfathered plans will be required to meet the standards set forth for a bronze, silver, gold, or platinum plan.
    - Plans will have more limited cost sharing.

Will my client's current plans change January 1, 2014?

No. The plans may change upon renewal, but in certain cases "grandfather plans" may not change initially. However, they will have the option to change plans during open enrollment.

Will individuals be able to purchase coverage in the individual market at any time?

No. Insurers are only required to offer coverage during specified open-enrollment time frames. There are certain "special enrollment" time frames depending on specific circumstances.

Will groups be able to purchase coverage throughout the year?

Yes. The small group market will continue to function with year-round guaranteed issue.

Will the outside market have the same open-enrollment time frame as the health insurance exchange?

Yes. The Office of the Commissioner of Insurance (OCI) interprets the language of both the ACA and the proposed rule as giving health insurers operating outside of the exchange in the individual market the option of limiting enrollment to open- and/or special-enrollment periods. If, however, a plan limits enrollment to open- and/or special-enrollment periods, the time for enrollment must mirror the open-enrollment periods in the exchange which are proposed as follows:

- Initial open-enrollment period – October 1, 2013, through March 31, 2014.
- Annual enrollment period – for benefit years starting on or after January 1, 2015, October 15 through December 7 of the preceding year.

Can an insurer have different open-enrollment time frames than those specified?

Minimally, insurers must have the same open-enrollment time frames as the exchange and the rest of the market. An insurer may add additional open-enrollment time frames, if desired.

Will agents be allowed to participate on the exchange?

Yes. Insurers are required to pay the same commission levels on and off the exchange.

What are navigators, certified application counselors, and assisters?

These are individuals that are intended to provide assistance to individuals applying for medical assistance and/or enrolling on the exchange. They will primarily be regulated by the exchange though Wisconsin has the right to require them to meet state standards.

What is the SHOP exchange?

It is the health insurance exchange for small employers. Currently, it appears to only offer an "employee choice" model which would allow employees to choose from any health plan in the exchange, or in any health plan in the metal tier designated by the employer. CCIO is currently seeking guidance on the offering of an "employer choice" model which would allow the employer to choose plans on behalf of their employees.

Are insurers required to sell in the exchange?

No. However, insurers must participate in both the SHOP and individual exchange if the insurer sells policies in both the small group and individual market and wish to participate in the exchange. Insurers only selling in the small group or individual markets are allowed to limit their participation to the markets in which they sell.

What are Wisconsin's essential health benefit requirements?

The federal government has established the essential health benefit requirements on behalf of the state. Wisconsin information can be found at http://cciio.cms.gov/resources/data/ehb.html#wisconsin.

The most current bulletin on the issue is listed below:

http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf

How will pediatric dental work?

On the exchange, insurers are not required to embed pediatric dental benefits in their plans so long as a dental plan is available to purchase on the exchange. Off the exchange, the benefits can be provided via contract with another insurer or by the insurer itself. We are exploring further options off the exchange.

What will it cost to participate in the exchange?

The initial estimate from the federal government is that the exchange will cost 3.5% of premium for all policies sold on the exchange. It will be paid by the insurer.

Can insurers charge more (or less) for policies sold through the exchange?

No. Similar plans must be priced the same on and off the exchange after taking into account any benefit differences.

Where can I get information about the Wisconsin exchange?

The federal government will be running the exchange in Wisconsin. At this time, we do not have any information but will provide links when more information becomes available.

What kind of training will I need to sell on the exchange?

The federal government is developing Web-based training for agents. We will provide links when more information becomes available.

Will I need to be appointed with every company on the exchange?

The federal government will be making that determination at some point in the future.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Federal Health Care Law
Frequently Asked Questions for Employers

Disclaimer:
Many of the responses to these questions are based on information currently available from the federal government. Federal guidance on the Affordable Care Act changes often and the Office of the Commissioner of Insurance (OCI) will update this document as new information becomes available.

This FAQ is intended to provide information on how the health insurance plan you select for your employees in Wisconsin may be affected by the federal health care law known as the Affordable Care Act (ACA).

Glossary of Terms

(Terms reflect those used in this document.)

Essential Health Benefits (EHB):
The minimum level of coverage insurers in the individual and small group markets must offer beginning January 1, 2014.

Benefits in the following categories must be covered:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Note: Insurers are not allowed to impose annual or lifetime limits on essential health benefits. Large employers are not required to offer essential health benefits but also cannot impose annual or lifetime limits on any essential benefits they do cover.

Each state must identify their Essential Health Benefit Benchmark plan. Insurers must offer benefits that are substantially similar to the benchmark plan.

Updated: March 10, 2014

The federal government has identified a plan sold by UnitedHealthcare as Wisconsin's benchmark. It is their Choice Plus Definity HSA Plan (A92NS).

A copy of the Wisconsin EHB Benchmark plan can be found at:
http://oci.wi.gov/healthcare_ref/ehb_certificate.pdf

Small Group Market:
Health insurance sold to employers with between 2 and 50 employees. In 2016 the small group market will be redefined as employers with up to 100 employees.

You may have seen or heard the federal government reference the small group market as including employers with 1 to 100 employees. Federal law allows a state to retain its current definition of small group until 2016. Wisconsin will continue to retain its current definition of 2 to 50. Note that the federal definition's reference to "1" includes a business owner plus one employee. This is the same as the state definition's reference to "2," which also includes the business owner plus one employee.

Sole proprietors are not able to purchase small group coverage. This is addressed further in question 12 below.

Large Group Market:
Health insurance sold to employers with more than 50 full-time equivalent employees. In 2016 the definition will change to employers with over 100 employees.

Out-of-Pocket Maximum:
The maximum amount of money a consumer will pay for in-network benefits. The law limits in-network cost-sharing to $6,350 for self-only coverage and $12,700 for families. For example, if billed charges were $20,000, the insurer would pay $13,650 and a consumer would pay no more than $6,350 (for self-only coverage).

Private Health Insurance Market
This refers to the Wisconsin health insurance market offering health insurance plans outside of the federal exchange and the SHOP Web sites.

Small Business Health Options Program (SHOP):
The federal health insurance exchange for employers with between 2 and 50 employees. It is a federal Web site that allows employers to compare health insurance plans based on cost. At this time, while employers can compare plans available in their area, employers interested in purchasing a plan through the SHOP must contact a health insurance agent or an insurance company directly.

In 2016, SHOP will be available to small employers with up to100 employees.

General Health Insurance Market FAQs

(Responses apply to plans sold through SHOP or in the private marketplace outside of the Exchange.)

1. **What are the major changes I need to know about?**
   There are a number of major changes for comprehensive health insurance plans effective January 1, 2014. These include the following:

   - Insurers must sell a health insurance policy to any person who applies for coverage, except in cases where fraudulent information is provided by the applicant.
   - Insurers must continue selling health insurance plans to any eligible small business who applies for coverage, except in cases where fraudulent information is provided. During open enrollment, small businesses that are not eligible for coverage due to not meeting participation requirements may purchase coverage.
   - Insurers are prohibited from excluding or limiting coverage for a preexisting condition.
   - Insurers may only take four items into account when pricing their products. These are: (1) whether the policy provides individual or family coverage; (2) the area of the state the policy is sold; (3) age; and (4) tobacco use.
   - Plans are required to offer "essential health benefits." See the "Glossary of Terms" section for more detail.
   - Plans are categorized into one of four different levels, which the federal government calls "metal tiers." Consumers will know the level of coverage expected by a plan based on the metal tier assigned to it. The percentages attached to each metal tier represent the average portion of expected costs a plan will cover for the average individual. The metal tiers include: bronze plans covering 60%; silver plans covering 70%; gold plans covering 80%; and platinum plans covering 90%.
   - Plans in all markets (individual, small group, and large group) will be required to limit in-network out-of-pocket expenses to $6,350 for self-only coverage and $12,700 for family coverage.
   - Plans in the small group market cannot have deductibles that exceed $2,000 for individual coverage or $4,000 for family coverage.
   - Insurers have the option to sell their plans through the SHOP in addition to selling their plans through the traditional health insurance market, like they do today.

2. **Are employers required to offer health insurance to their employees? Are there penalties for not offering coverage?**
   Federal law requires employers with 50 or more employees who work the equivalent of 30 or more hours per week to offer affordable health insurance to their employees. The federal government refers to this as "shared responsibility for employers."

   The health insurance offered must cover at least 60% of expected claims costs and an employee's share of the premium for self-only coverage cannot exceed 9.5% of the employee's income.

Employers, with 50 or more full-time equivalent employees, who do not offer their employees health insurance coverage could face a penalty of $2,000 per employee (but the employer can exempt the first 30 employees). If an employer offers coverage but it is not affordable (the health insurance costs the employee more than 9.5% of the employee's income for self-only coverage), employers may face a penalty of $3,000 for each employee accessing subsidized coverage through the federal exchange. The total penalty for not offering affordable coverage cannot exceed the penalty for not offering insurance coverage at all.

While the effective date for the penalties associated with the shared responsibility requirement was previously expected to be January 1, 2014, the federal government announced that it will phase in this requirement as follows:

- Employers with 100 or more employees that offer coverage to at least 70% of its employees in 2015, and any calendar months during the 2015 plan year that fall in 2016, will not be subject to the $2,000 penalty referenced above. They may still be subject to the $3,000 penalty for not offering affordable coverage if the employees access subsidized coverage in the exchange. For the 2016 plan year, employers must offer coverage to 95% of its employees.

- Employers with 50 to 99 employees are not subject to the shared responsibility penalties in 2015 or any calendar month during the portion of the 2015 plan year that falls in 2016.

Federal law does not require employers with under 50 employees to offer health insurance coverage.

The determination of whether an employer is subject to the federal requirement to offer health insurance and the extent to which any penalties apply is very complex. It is recommended that employers contact a tax professional to understand these issues. Licensed health insurance agents can also be helpful.

Below is a link to the final IRS regulation on employer requirements: Shared Responsibility for Employers Regarding Health Coverage.

https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

3. I am an employer with some full-time and part-time employees. How do I know which employees I am required to offer health insurance to?

All employers will want to assess whether they will be considered to have at least 50 full-time equivalent employees once the federal calculation for determining an employer's number of full-time equivalent employees is finalized.

Below is a link to the final IRS regulation: Shared Responsibility for Employers Regarding Health Coverage.

https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

4. **As a small employer, when should I start thinking about options for offering health insurance coverage to my employees for the 2014 plan year?**
If you offered health insurance to your employees in 2013, you may have been contacted by the insurer that sold you the plan. State and federal law allowed insurers the option of renewing their 2013 plans for the 2014 plan year. You should have received notice last year from your insurer making you aware of your options.

   If you did not have the option to stay with your 2013 plan, chose to try a different plan, or are offering coverage for the first time, you are able to purchase coverage in the small group market throughout the year. There is no set enrollment period like the individual market. However, if a small employer is unable to comply with employer contribution or group participation rules, health insurers may choose to limit enrollment of that employer to an annual enrollment period that begins November 15 and extends through December 15 of each year. SHOP will limit enrollment to that same time frame for employers who are unable to meet the SHOP participation requirement of 70%. Small group plans are available both through SHOP and the private health insurance market. While employers can compare plans on the SHOP Web site, they must contact a licensed agent or insurance company directly to purchase a plan offered on the SHOP. There are a lot of variables to consider and a licensed health insurance agent can help you make a decision that benefits you and your employees.

5. **Are there participation rates that must be met as a condition of purchasing small group coverage in either the private market or SHOP?**
Insurers offering coverage in the private market may impose participation rates consistent with state law.

   State law does not allow a small employer insurer to impose more stringent requirements than the following:

   - For a small employer with more than 10 eligible employees, 70% of the group.
   - For a small employer with 10 eligible employees, 6 eligible employees.
   - For a small employer with 8 or 9 eligible employees, 5 eligible employees.
   - For a small employer with 7 eligible employees, 4 eligible employees.
   - For a small employer with 5 or 6 eligible employees, 3 eligible employees.
   - For a small employer with 2 to 4 eligible employees, 2 eligible employees.

   The federal Center for Consumer Information and Insurance Oversight (CCIIO) has indicated the federal SHOP will use a participation rate of 70%.

6. **As a small employer, if I decide to continue offering health insurance coverage to my employees, will I see a rate increase?**
You will likely see a rate increase. Beginning for plans effective this year, insurers must have a single risk pool for its plans and can only take a few factors into account when pricing their products. These are: (1) whether the policy provides individual or family coverage, (2) the area of the state the policy is

sold, (3) age, (4) tobacco use, (5) plan design differences, and (6) network cost differences.

Additionally, the federal government is imposing significant regulatory fees and other requirements onto insurers as a condition of being in compliance with the federal health care law. Consumers, including small employers, will feel the impact of these federal requirements through premium increases.

7. **As a small employer, if I do not offer my employees health insurance coverage, will my employees be better off because of federal subsidies?** That may or may not be the case. Many variables must be considered, such as your employees' out-of-pocket expenses under the plan you offer, their personal circumstances, premiums of the individual plans available in this year, etc. In some cases, the amount the employee pays for the coverage you offer will be less expensive than the cost of coverage for the employee if he or she purchases coverage through the federal exchange, even with premium tax credits.

   There are a lot of variables to consider and a licensed health insurance agent can help you make a decision that benefits you and your employees.

8. **I have heard that some employers are looking at self-funding health care for their employees. Is this something I should consider as a small employer?** Small employers should look at all options available to them, including the option to self-fund. In doing so, it will be important to consult someone who is an expert in this area.

9. **Are <u>all</u> small employers eligible for the federal small business tax credits?** No. The following requirements must be met for an employer to qualify for the federal small business tax credits: (1) the employer must have fewer than 25 full-time employees, (2) the average annual wages of employees must be less than $50,000, and (3) the employer must pay at least half of the insurance premiums.

   The tax credit is worth **up to** 50% of the employer's contribution toward employees' premium costs (up to 35% for tax-exempt employers). The tax credit is highest for companies with fewer than 10 employees whose employees are paid an average of $25,000 or less. Additionally, the credit is only available to small employers purchasing health insurance through SHOP. Today, to purchase a plan offered on the SHOP, an employer must work directly with a licensed health insurance agent or an insurer.

   Below is a link to Internal Revenue Service FAQs on the small business tax credit. OCI is not responsible for the accuracy of the information provided at that site.

   http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit

10. I am a small employer in a county where there are no SHOP plans available. Can I still benefit from the small business health care tax credit?
Yes, the federal Department of Health Services issued guidance indicating there is an opportunity for small employers in Green Lake, Lafayette, Marquette, Florence, and Menominee counties to receive the tax credit. Please review the guidance available at http://www.irs.gov/pub/irs-drop/n-14-06.pdf.

11. As a small employer, are my employees eligible for federal health care premium tax credits if I offer them health insurance coverage?
No, unless the employee's share of the premium is more than 9.5% of their household income or the coverage does not meet minimum actuarial value requirements.

12. I operate my own business and I am the only employee. Can I purchase small group coverage either through the private market or SHOP?
No. Neither federal or state law allows insurers to sell small group health insurance plans to sole proprietors. This is the case whether coverage is purchased through the private market or SHOP.

Given the federal mandate requiring individuals to have health insurance, you will likely need to purchase an individual health insurance policy either from the private market or through the federal exchange (or obtain coverage under your spouse's plan, obtain public assistance, file for an exemption, etc.). A licensed health insurance agent can help you compare your options and determine whether a plan in the private market meets your needs better than one offered through the federal exchange. Note that the initial open enrollment period to obtain coverage for the 2014 plan year ends on March 31, 2014.

13. Are large group plans required to cover Essential Health Benefits (EHBs)?
No, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits. Plans may impose non-dollar limits that are at least actuarially equivalent to any annual dollar limits contained in the benchmark plan. Imposing visit limitations is an example.

14. How does an insurer know whether its large group plan offerings contain EHBs?
Insurers may refer to any state's EHB benchmark plan when identifying whether its large group plans contain EHBs. As stated in the response to question 13, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits. As a result, employers will want to know whether their large group plan covers EHBs for the purposes of determining whether annual or lifetime dollar limits will be prohibited or applied to various benefits.

There is no requirement for large group plans to cover benefits at the level provided in the benchmark plan or add benefits not currently covered by the large group plan.

Any large group insurance plan choosing another state's benchmark plan must continue to cover Wisconsin state mandated benefits in accordance with state law. A large group plan may continue to impose dollar limits on a state mandated benefit if the chosen EHB Benchmark plan does not include the Wisconsin mandated benefits.

Individual and small group health plans must provide benefits contained in the Wisconsin benchmark plan and do not have the option to choose a different state's benchmark plan.

Private Health Insurance Marketplace *(outside of SHOP)* FAQs

1. **Will small employers be penalized for purchasing health insurance from the private market rather than through the Small Business Health Options Program (SHOP)?**
   No, there are no penalties associated with purchasing health insurance from the private market. There are no penalties associated with where small employers or individuals purchase health insurance.

2. **How can small employers purchase health insurance from the private market? Can they still use agents?**
   Yes, small employers can continue to purchase health insurance from the private market either directly from an insurer or with the help of a licensed health insurance agent.

   Navigators and Application Counselors are not permitted, by law, to sell health insurance policies. Questions 5 and 6 below further explain the role of navigators and application counselors.

3. **I am not purchasing insurance coverage through SHOP. Will I be able to keep my plan?**
   State and federal law allowed insurers the option of renewing their 2013 plans for a plan year beginning in 2013 and extending into 2014. If the insurer you had for the 2013 plan year chose to continue offering that same plan into 2014, you should have received a notification from the insurer indicating this. If the insurer stopped offering the plan you had in 2013, you should have received notification from the insurer letting you know the coverage is no longer available and that you should plan to purchase new coverage.

Federal SHOP Exchange FAQs

1. **What is the federal Small Business Health Options Program (SHOP)?**
   It is the federal health insurance exchange for employers with up to 50 employees. Like the federal exchange available to individuals, SHOP is a federal Web site that allows employers and employees to compare health insurance plans based on cost. At this time, while employers can compare plans available in their area, employers interested in purchasing a plan through the SHOP must contact a health insurance agent or an insurance company directly.

2. **Are health insurers required to sell their plans through the federal SHOP?**
No and some have chosen to only sell their plans in the private health insurance market. For this reason, it is important for small employers to understand all of their options.

Small employers may seek help from a state-licensed health insurance agent to ensure they choose a plan that best suits their needs.

3. **As a small employer, am I required to purchase a health plan for my employees through SHOP?**
No, you may purchase health insurance for your employees in the private market, through SHOP or not at all. It is important for small employers to understand and compare all options available to them. State-licensed health insurance agents are available to help small employers compare options and determine which plan best meets their needs.

4. **Can small employers utilize licensed health insurance agents to purchase health insurance through SHOP?**
Yes, licensed health insurance agents are available to help small employers compare and determine which health plan best meets their needs. This is true whether they are interested in purchasing coverage in the private health insurance market or through SHOP.

Licensed health insurance agents are available to compare plans in the private health insurance market against those offered in SHOP to determine whether a better plan option may be available in the private health insurance marketplace.

5. **What are Navigators? Can small employers use navigators to purchase health insurance?**
Navigators are federally funded entities and individuals who are charged with helping consumers in a variety of ways. Navigators can help a consumer determine their eligibility for public assistance programs including any federal subsidies. Navigators may also help consumers, including small employers, compare health insurance options displayed on the federal exchange Web site and SHOP after consumers input their preferences.

In addition to federal training and licensure requirements, navigators serving Wisconsin consumers must obtain a state navigator license by completing 16 hours of state-specific training and successfully pass a state examination.

All navigators licensed in Wisconsin are registered with OCI and are listed on the OCI Web site at http://oci.wi.gov/navigator/naventities-registered.htm. If you have concerns with a navigator's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

Navigators largely assist individuals, rather than employers. By law, navigators are prohibited from selling health insurance and cannot recommend whether one plan may be better for a consumer than another. Only state-licensed health insurance agents can provide advice and sell health insurance.

For a list of permitted and prohibited activities related to navigators, review the July 26, 2013, bulletin posted to the OCI Web site at http://oci.wi.gov/bulletin/0713navigator.htm.

6. What are "Certified Application Counselors (CACs)"? Can they sell health insurance?

CACs, like navigators, will help individuals check their eligibility for public assistance programs. CACs will also help consumers sort through the health insurance plans that display on the federal exchange Web site after consumers enter their preferences.

CACs are not federally funded but must work for an organization designated by the federal government as a CAC entity. CACs must complete federal training and examination requirements as well as the same state training and examination requirements necessary for a Wisconsin navigator license. CACs are registered with the Office of the Commissioner of Insurance and are listed on the OCI Web site at http://oci.wi.gov/navigator/cac-registered.htm.

If you have concerns with a CAC's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

Under state and federal law, CACs and navigators are not qualified to and cannot legally sell health insurance or provide advice to consumers about which health insurance plan best meets their needs. Only state-licensed health insurance agents may sell and provide advice about health insurance coverage.

7. How does SHOP work? Do employers or employees choose the health insurance plan?

Today, small employers choosing to purchase coverage through SHOP compare plans, on their own or with the help of a licensed agent, and choose a plan that meets their needs. Small employers interested in purchasing a plan available on the SHOP must directly purchase the plan from a licensed health insurance agent or insurer. The small employer offers the chosen plan to its employees.

In 2015, a small employer purchasing coverage through SHOP will have the option to define a dollar amount it would like to contribute towards its employee's monthly health insurance premium (i.e., defined contribution). In this case, an employer will also choose a metal tier from which each employee may purchase a plan. Therefore, employees will utilize SHOP to compare and select a plan in the metal tier authorized by their employer.

Although federal law requires the defined contribution option be available beginning in 2014, the U.S. Department of Health and Human Services has delayed implementation of this option until January 1, 2015. Small employers can pursue this model in the outside private marketplace. There are insurers today, and there will be in future years, that offer the option of defining an amount of coverage and allowing employees to choose between various plans. Licensed health insurance agents can help in making small employers aware of those plans.

8. **What does it cost to participate in SHOP?**
   There is no fee for small employers using SHOP. However, the federal government charges insurers a fee to sell their products through SHOP. That fee, coupled with other regulatory fees and requirements the federal government is imposing on insurers, has contributed to increased health insurance premiums.

9. **Can insurers charge more (or less) for policies sold through SHOP?**
   No, insurers must charge the same for similar plans whether they are sold through SHOP or in the private market outside of SHOP.

10. **If I have under 50 employees today but increase the number of employees above 50 after I have purchased a small group plan through SHOP, what happens?**
    You will remain eligible to purchase health insurance through SHOP because you had 50 or fewer employees at the time you initially purchased coverage through SHOP.

11. **I am an employer with over 50 employees but fewer than 100. How will I be affected in 2016 when the definition of small group increases to 100?**
    Beginning in 2016, you will be eligible to purchase small group health insurance coverage through SHOP. However, you will still have the option to purchase coverage from the private health insurance market.

12. **In addition to this FAQ, are there other resources available for me to learn more about SHOP?**
    Yes, the links below will take you to external resources for information on small employer issues and federal health care reform. Please note that OCI does not take any responsibility for the content included on these Web sites.

    IRS Affordable Care Act News Releases, Multimedia and Legal Guidance
    http://www.irs.gov/uac/Affordable-Care-Act-of-2010:-News-Releases,-Multimedia-and-Legal-Guidance

    National Federation of Independent Business Healthcare Playbook
    http://www.nfib.com/Portals/0/PDF/AllUsers/advocacy/ppaca-healthcare-law-guide-nfib.pdf

    U.S. Department of Labor Patient Protection and Affordable Care Act Information
    http://www.dol.gov/ebsa/healthreform/

    U.S. Small Business Administration Health Care Reform Page
    http://www.sba.gov/healthcare

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Federal Health Care Law
Frequently Asked Questions—Enrollment

1. Is the federal exchange Web site working?

Generally, the basic functionality of the federal exchange Web site has improved (i.e., consumers can get on to the site, choose a plan, etc.). However, not all of the problems are fixed. For example, inaccurate plan information has been displayed; consumers have had access to plans outside of their service area; consumers have signed up for a plan but healthcare.gov failed to send the information to insurers; some consumers are still unable to get through the application process (start to finish); and many consumers have yet to pay for their insurance. The Office of the Commissioner of Insurance (OCI) continues to work with the insurers and the federal Department of Health and Human Services (HHS) to ensure all consumer concerns are appropriately addressed.

2. What specific problems are consumers facing when trying to purchase coverage through the federal exchange?

- **The federal Web site has allowed consumers to purchase plans outside their service areas.** Some insurers do not offer certain plans in certain counties because of the provider networks they have in place. The federal Web site unfortunately has allowed consumers to purchase plans outside their service area. This means that either the premium these consumers have to pay will now be incorrect (could be higher or lower), or the consumer will not have access to providers in their county.
- **Consumers who have signed up for coverage have learned that their files have been lost.** Consumers who have actually enrolled and picked a plan either do not appear on the federal Web site's database, or they do not show up in the insurer's database. This could cause a consumer to appear as though they are uninsured when trying to access health care.
- **The federal Web site has displayed incorrect plan information.** Consumers have been shown plans on the federal Web site that were described inaccurately. In some cases, the Web site may have displayed no deductible for the plan they bought when in fact there is a deductible tied to that plan. This was not the fault of the insurer but rather the fault of the federal Web site. If errors were displayed at the fault of the insurer, OCI would require the insurer to honor what was displayed. Unfortunately, because the errors were the fault of the federal Web site, consumers will have to satisfy the deductible or choose another plan which could result in a higher premium.

Updated: March 14, 2014

- **Some insurers have to process enrollment manually due to the federal Web site's back-end system problems.** Consumers might experience delays in receiving their insurance ID cards and booklets as the federal Web site delays have caused a backlog for insurers processing such applications.

3. What advice do you have for consumers facing these problems?

The most important step a consumer can take is to verify their insurance purchase. If the consumer has not received any confirmation from the insurer, they should verify that the insurer has the consumer's enrollment information. If the consumer has received ID cards and an insurance certificate, they should verify it matches what they think they purchased. If anything doesn't match up, contact the insurer as soon as possible.

4. How many consumers have enrolled in coverage through the federal exchange? How many consumers have paid their premium?

- Total federal exchange enrollment into plans with a January 1 effective date: 34,329. Insurers received premium for 28,178 of these plans (unpaid 18%).
- Total federal exchange enrollment into plans with a February 1 effective date: 12,733. Insurers received premium for 9,604 of these plans (unpaid 25%).
- Total federal exchange enrollment into plans with January 1 and February 1 effective dates: 47,062. Insurers received premium for 37,782 of these plans (unpaid 20%).

5. How many consumers enrolled in a plan in the individual market outside of the federal exchange?

Total enrollment, outside of the federal exchange, into plans with January 1 and February 1 effective dates: 7,885.

6. What should a consumer do if they have enrolled and have not paid their premium?

First, contact the insurer. If the consumer has not paid January's premium by now, they will not have coverage for January, even if they try to pay their premium. Health insurance purchases historically are always paid in advance of the month of coverage. Many insurers did make exceptions throughout January but in most cases insurers do not accept late premium payments due to adverse selection problems (for example people who only pay when their claims exceed their premium). If the consumer has no coverage, they should sign up for a new plan as soon as possible.

7. What consumer problems have been caused when a consumer has been allowed to pay their premiums late?

As highlighted above, there are concerns with consumers losing coverage. Consumers should also be aware that while HHS required insurers to accept late payments for the first month, the second and subsequent payments to insurers will always be due before the month of coverage. Therefore, we are now seeing consumers receiving a bill for two months of coverage, making it difficult for those consumers to catch up with their late payments.

8. **Some consumers received their enrollment materials very late. Why?**
This happened for a variety of reasons. In most cases, insurers never received premiums until much later (as described above). An insurer does not issue insurance ID cards and booklets until they receive the first month's premium payment. In other cases, the electronic data transmissions between the federal government and insurers had glitches.

9. **What has the Wisconsin OCI done to correct all of these problems?**
OCI has brought the information to the attention of the federal Department of Health and Human Services (HHS), escalated issues to HHS leadership, and worked to ensure consumers are protected. We have ordered insurers to take specific actions to protect consumers. It's important to note that when problems have occurred that were the fault of HHS, there is little OCI can do to penalize HHS for their errors but we have worked to ensure other entities are not held accountable for HHS's mistakes.

10. **How is the federal SHOP exchange working?**
It is not. Functionally, small businesses can compare prices but plans must be purchased through licensed agents or directly from an insurer.

11. **Are any Wisconsin laws compromised due to functionality limitations of the federal exchange?**
Yes, due to system limitations, the federal exchange Web site is not allowing consumers to shop for health insurance the way state law contemplates. For example, Wisconsin law requires a "free look" period allowing consumers to terminate coverage and receive a refund. That is a Wisconsin consumer protection law. Unfortunately, that functionality has not been built into the federal exchange and, as of now, those individuals cannot shop for a new plan through the federal exchange without filing an appeal. Consumers unhappy with a federal exchange plan also do not appear to be allowed to switch plans due to functionality problems.

12. **Who regulates the Wisconsin health insurance market, the state or federal government?**
OCI remains the primary regulator of the entire health insurance market in Wisconsin, regardless of whether insurers are selling policies on or off the federal exchange. All insurers must be licensed in Wisconsin and meet state marketing and financial standards. OCI regulates all rate and form filings, performs financial and market conduct examinations and responds to consumer complaints. Despite our strong state regulatory authority, we continue to be concerned with the federal government's standardized approach to problem solving and the impact that has on Wisconsin's market.

    In addition to OCI's regulatory authority over insurers, we also continue to regulate licensed health insurance agents, licensed navigators, and other registered assisters.

13. Despite problems with the federal Web site, how did Wisconsin get relatively high enrollment into the federal exchange?

This is a reflection of the way Wisconsin pursued consumer outreach. Both OCI and the Department of Health Services (DHS) focused on a grassroots effort and engaged stakeholders into what we called "regional enrollment networks." By linking county personnel, insurance agents, health provider systems and navigators, we were able to make most consumers aware of the options they had for insurance coverage (in the federal exchange, Medicaid, or in Wisconsin's market). Specific OCI and DHS efforts include: (1) held 16 town hall sessions across the state where we invited the public to listen to an ACA presentation and ask questions; (2) working on state legislation to ensure navigators and other "assisters" obtain state licensure/registration; (3) hosted free, in-person state training sessions for 578 individuals interested in becoming navigators or certified application counselors; and (4) requested that agents interested in helping individuals who are subsidy-eligible complete a 4-hour Medicaid-related continuing education course.

14. Wisconsin has a law requiring state licensure for navigators. Is that law in conflict with federal law?

No. Wisconsin law includes training and examination requirements, licensure and a background check. After some of the high profile incidents in other states, we continue to feel it is appropriate to require licensure and background checks. For example, one state with similar requirements stopped an individual with outstanding warrants and another stopped an individual who was a convicted terrorist from serving as navigators, despite HHS approval.

15. Have health insurance rates increased?

Yes. In early September, OCI released data that highlights the differences in pre-ACA and post-ACA policies. As we stated at that time, the increase is going to vary significantly depending on your region and age. Here is a link to the press release: http://oci.wi.gov/pressrel/0913rateinfo.htm.

16. Why did Wisconsin delay changes to Medicaid and the high-risk pool?

With the problems previously discussed with the federal exchange, it was difficult for consumers to sign up for a plan before January 1. As a result, Governor Walker and the legislature delayed the changes to Medicaid and the state's high-risk pool program (HIRSP) until March 31.

17. What is changing in Medicaid?

The biggest change is the expansion of Badgercare to childless adults. This means that for the first time, every Wisconsinite under 100% of poverty will be eligible for Medicaid. Children and pregnant women up to 300% of poverty will continue to be eligible for Badgercare as well. Medicaid eligibility does not change for blind, elderly and disabled individuals. Finally, those with incomes over 100% of poverty (and not eligible under other programs) will be eligible for subsidized private health insurance coverage in the federal exchange. These changes are expected to cut Wisconsin's already low uninsured rate in half.

18. Wisconsin had a very successful high-risk pool. What is happening with the high-risk pool members?

The state's high-risk pool (HIRSP) will cease operations on March 31, 2014. The reason for this transition has a lot to do with the ACA requiring health insurers to sell a policy to any person who applies for coverage, except in cases where fraudulent information is provided by the applicant. Additionally, HHS decided to nationalize the risk adjustment programs (reinsurance, risk adjustment, risk corridors) meaning Wisconsin insurers would be paying to cover high-risk individuals in HIRSP and paying into a separate national program to cover risks in other states. From both an access and cost perspective, it made sense to cease high-risk pool operations.

Depending on their income, former HIRSP members may be eligible for Medicaid under the new expansion or will have the option to purchase coverage through the federal exchange using federal subsidies to offset the cost of their premium. All HIRSP members will also have the option to purchase coverage off the federal exchange. Finally, for those on a Medicare plan, they will have a new right to gain coverage in the private market.

19. The Wisconsin high-risk pool served numerous members who were also on Medicare. Has that process been seamless?

As part of the legislation ending HIRSP, those individuals were given a guaranteed issue right into the Medicare Supplement market. However, many of the under 65 Medicare population have serious health conditions and utilize costly medications. Medicare drug programs have very high cost-sharing arrangements for specialty drugs. The federal government has also determined those individuals are not eligible for subsidized coverage in the federal exchange. There is little we can do at the state level to fix this issue. Here is a link to a HHS FAQ: http://www.cms.gov/Medicare/Health-Plans/Medigap/Downloads/High-Risk-Pool-FAQs.pdf.

20. When will open enrollment end?

It is scheduled to end March 31.

21. Will those losing coverage because of HIRSP closing and the changes to Badgercare be able to get coverage?

Yes. Those individuals have a special enrollment period for 60 days following their loss of coverage.

22. Will the federal exchange operate more smoothly in 2015?

At this point, we do not know. The federal government has given itself more time to fix problems, but that time has come at the expense of the state's ability to review rates and forms. States will have less time to conduct their reviews than in the past. Also, since much of the back-end operations of the federal exchange are still in the development phase, we may see the same problems during open enrollment next year.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Theodore K. Nickel*, Commissioner*

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Federal Health Care Law
Frequently Asked Questions for Insurers

Disclaimer:
Many of the responses to these questions are based on information currently available from the federal government. Federal guidance on the Affordable Care Act changes often and the Office of the Commissioner of Insurance (OCI) will update this document as new information becomes available.

1. **When are insurers selling individual plans required to make their rate and form filings?**
   For insurers selling individual plans only outside of the federal exchange, Wisconsin requires that all rates and forms be filed with the Office of Commissioner of Insurance at least 30 days prior to the effective date. Under federal law, insurers selling plans in the individual market must submit each year a single risk pool rate filing effective January 1 and may only introduce new plans and revise rates effective January 1 for the following calendar year.

   For insurers selling plans on the federal exchange only or both on and off the federal exchange, the Office of the Commissioner of Insurance is required to complete its rate and form filing reviews by July 31, 2014. Therefore, Wisconsin requires that insurers selling plans on the federal exchange file forms with the Office of the Commissioner of Insurance by June 30, 2014. Per federal exchange guidance, insurers selling plans on the federal exchange must file rates with the Office of the Commissioner of Insurance by June 27, 2014.

   Following is the timeline for individual market rate filings:

Individual Market	
Rate Filing Deadline (for companies seeking QHP certification)	June 27, 2014* * **OCI's review of annual SRP filings is generally complete within 60 days of receipt. Filings are reviewed in order of receipt. ERRP program requirements provide that OCI rate review findings be reported to the federal exchange by July 31, 2014.**
Rate Filing Deadline (for companies with plans subject to open enrollment)	November 14, 2014
Rate Filing Deadline (for companies with all plans guaranteed available for all of 2015)	December 1, 2014

Updated: March 10, 2014

2. When are insurers selling small group plans in 2014 and/or 2015 required to make their rate and form filings?

For insurers selling small group plans only outside of the federal exchange, Wisconsin requires that all rates and forms be filed with the Office of Commissioner of Insurance at least 30 days prior to the effective date. Under federal law, insurers selling plans in the small group market must submit each year a single risk pool rate filing effective January 1. Insurers selling plans in the small group market may introduce new plans and revise rates each calendar year quarter following the January 1 submission (April 1, July 1, October 1).

For insurers selling plans on the federal exchange only or both on and off the federal exchange in 2015, the Office of the Commissioner of Insurance is required to complete its rate and form filing reviews by July 31, 2014. Therefore, Wisconsin requires that insurers selling plans on the federal exchange in 2015 file forms with the Office of the Commissioner of Insurance by June 30, 2014. Per federal exchange guidance, insurers selling plans on the federal exchange must file rates with the Office of the Commissioner of Insurance by June 27, 2014.

Following is the timeline for small group market rate filings:

Small Group Market		
Type of Rate Filing	Possible Effective Dates	Rate Filing Deadline
Quarterly	July 1, 2014 October 1, 2014	30 days prior to rate change effective date***** *** OCI's review of quarterly SRP filings is generally complete within 45 days of receipt. Filings are reviewed in order of receipt. Federal exchange requirements provide that changes to the QHP Rate Data Template be submitted 45 days before the filing effective date. The federal exchange will not accept a revised Template until the OCI review is complete.**
Annual (for companies seeking QHP certification)	January 1, 2015	June 27, 2014***** *** OCI's review of annual SRP filings is generally complete within 60 days of receipt. Filings are reviewed in order of receipt. ERRP program requirements provide that OCI rate review findings be reported to the federal exchange by July 31, 2014.**
Annual (for companies offering plans off-exchange only)	January 1, 2015	December 1, 2014

3. **If an insurer files an application for QHP (qualified health plan) certification, is the insurer required to participate in the federal exchange?**
   No. A qualified health plan designation is required to participate in the federal exchange, but it does NOT commit an insurer to participate in the federal exchange. CCIIO has indicated that an insurer will not be committed to participate on the federal exchange until they sign a contract to participate in fall 2014.

4. **What is the deadline for an insurer to decide to participate (or not participate) in the federal exchange?**
   An insurer who wishes to participate in the federal exchange must file their rates with OCI by June 27 and have their forms reviewed by July 31. An insurer is NOT committed to participate in the federal exchange until a contract is signed with the federal government in fall 2014.

   An insurer that has filed rates and forms to participate in the federal exchange and subsequently decides not to participate may re-file their rates and forms with OCI as long as the filing meets the December 1 deadline.

5. **Does the private health insurance market have the same open enrollment time frame as the federal health insurance exchange?**
   Yes. Initial open enrollment period – October 1, 2013, through March 31, 2014. Annual enrollment period – November 15, 2014, through February 15, 2015.

   Minimally, insurers must meet the open enrollment time frames required by the law. Insurers may add additional open enrollment time frames for products sold off the federal exchange if done on a non-discriminatory basis.

   There are also special enrollment periods for an individual or family if they experience a "triggering event." Examples of common triggering events include: (1) loss of minimum essential coverage; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 60 days from the time of a triggering event to enroll in new or different health insurance coverage.

6. **What are Wisconsin's essential health benefits requirements?**
   The federal government has established the essential health benefits requirements on behalf of the state. Wisconsin information can be found here: http://cciio.cms.gov/resources/data/ehb.html#wisconsin

   The plan language is located here:
   http://oci.wi.gov/healthcare_reform.htm

7. **Will OCI follow the process outlined in the final essential health benefits (EHBs) regulation that allows actuarial equivalent substitutions within a benefit category?**
   Yes. Insurers are allowed to substitute actuarial equivalent benefits. However, insurers are reminded that those substitutions must be non-discriminatory.

8. **Recognizing that federal law prohibits annual or lifetime dollar limits on essential health benefits, can insurers replace dollar limits with other limitations, such as actuarially equivalent visit limits?**
   Yes. Insurers may make actuarially equivalent substitutions, in some cases, if the substitution falls within the rules of the essential health benefits. It is also important to note that, in some cases, there may be no actuarially equivalent substitution.

9. **Are large group plans required to cover essential health benefits (EHBs)?**
   No, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits. Plans may impose non-dollar limits that are at least actuarially equivalent to any annual dollar limits contained in the benchmark plan. Imposing visit limitations is an example.

10. **How does an insurer know whether its large group plan offerings contain EHBs?**
    Insurers may refer to <u>any</u> state's EHB benchmark plan when identifying whether its large group plans contain EHBs. As stated in the response to question 9, large group plans are not required to cover EHBs. However, if a large group plan provides coverage for any EHBs, the plan is prohibited from imposing annual or lifetime dollar limits on those benefits.

    There is no requirement for large group plans to cover benefits at the level provided in the benchmark plan or add benefits not currently covered by the large group plan.

    Any large group insurance plan choosing another state's benchmark plan must continue to cover Wisconsin state mandated benefits in accordance with state law. A large group plan may continue to impose dollar limits on a state mandated benefit if the chosen EHB Benchmark plan does not include the <u>Wisconsin</u> mandated benefits.

    Individual and small group health plans <u>must</u> provide benefits contained in the Wisconsin benchmark plan and <u>do not</u> have the option to choose a different state's benchmark plan.

11. **How will pediatric dental work?**
    The U. S. Department of Health and Human Services (HHS) provided guidance regarding coverage of pediatric dental services in the preamble of its final rule, "Patient Protection and Affordable Care Act, Standards Related to Essential Health Benefits, Actuarial Value and Accreditation," stating:

    > Plans outside of the Exchange may offer EHB that exclude pediatric dental benefits if they are 'reasonably assured' that such coverage is sold only to individuals who purchase Exchange-certified stand-alone dental plans.

    OCI is concerned that this inconsistent treatment may result in consumer harm, create confusion within Wisconsin's competitive health insurance market,

and create an unfair competitive advantage for health insurance plans operating inside of the federal exchange. Specifically, OCI is concerned that consumers may be harmed by purchasing a product they thought contained all EHBs.

Therefore, to ensure that consumer choice is not adversely impacted for those purchasing health insurance outside of the federal exchange and to ensure a competitive marketplace for insurers offering health insurance policies inside and outside the federal exchange, all insurers offering comprehensive individual or small group health insurance plans in Wisconsin must disclose, prior to the sale of the policy, whether the plan covers pediatric dental benefits.

Providing this notice with all health insurance policies sold inside the federal exchange or in the outside market will provide reasonable assurance for health insurers that consumers are obtaining the coverage they need and want.

For more information, please see our bulletin:

http://oci.wi.gov/bulletin/0413peddental.htm

12. How will habilitative services be defined?

The benchmark plan selected for Wisconsin does not include a definition of or coverage for habilitative services. In accordance with 45 C.F.R. §156.115 (a) (5) (i) and (ii), insurers may either: (i) provide parity by covering habilitative services that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (ii) report to HHS its definition of habilitative services.

When defining "habilitative services" insurers should consider that insureds are provided the Glossary of Health Insurance and Medical Terms as part of the Summary of Coverage and Benefits (as required by §2714 of the ACA), that defines "habilitative services" as:

> Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

For more information, please consult our bulletin on the issue:

http://oci.wi.gov/bulletin/0413habilitativeserv.htm

13. What are the requirements for a prescription drug formulary?

CCIO requires that insurers cover prescription drugs in at least each pharmaceutical class, but that insurers must match the same number of drugs available in each class as the benchmark plan.

14. **Will the state review policy language or rely on certification of compliance?**
    Wisconsin will continue to require insurers to certify compliance with key aspects of Wisconsin and federal law. We are not anticipating changing from our "file and use" approach to an approach that will require prior approval. However, we will continue to verify compliance through an analysis of complaints, market conduct examinations, and targeted market conduct examinations.

15. **Is there potential that additional rate review will be done at the federal level even though Wisconsin has an effective rate review program?**
    No. Wisconsin now has an effective rate review process for all markets including association group coverage.

16. **Will policy language variables be allowed as long as the policy also includes the EHB?**
    We do not anticipate any change to our requirements that allow these variables provided the variables meet all the requirements of state and federal law.

17. **What are options for insurers who unexpectedly attract a substantial portion of the market and find that they cannot financially sustain additional members?**
    Federal law requires insurers to accept every employer and individual in the state that applies for coverage, subject to certain exceptions. These exceptions allow issuers to restrict enrollment in coverage: (1) to open and special enrollment periods; (2) to employers with eligible individuals who live, work or reside in the service area of a network plan; (3) in certain situations involving limited network capacity and limited financial capacity.

18. **Are agents required to be appointed with all of the health insurers selling products on the federal exchange?**
    No. Agents need to be appointed with insurers whose products they plan to sell. All state appointment laws remain in effect.

19. **Are small employers required to purchase health insurance for their employees? Are there penalties for not offering coverage?**
    Employers with fewer than 50 employees are not required to purchase health insurance for their employees. There are no penalties for not offering coverage.

20. **Are large employers required to offer health insurance to their employees? Are there penalties for not offering coverage?**
    Federal law requires employers with 50 or more employees who work the equivalent of 30 or more hours per week to offer affordable health insurance to their employees. The federal government refers to this as "shared responsibility for employers."

    The health insurance offered must cover at least 60% of expected claims costs. Additionally, an employee's share of the premium for self-only coverage should not exceed 9.5% of the employee's income.

Employers, with 50 or more full-time equivalent employees, who do not offer their employees health insurance coverage could face a penalty of $2,000 per employee (but the employer is exempt from penalties on the first 30 employees). If an employer offers coverage but the coverage is not deemed "affordable" (the employee's share of the health insurance premium exceeds 9.5% of the employee's income for self-only coverage), employers may face a penalty of $3,000 for each employee that accesses subsidized coverage through the federal exchange. The total penalties for not offering affordable coverage cannot exceed the penalty for not offering insurance coverage at all.

While the effective date for the penalties associated with the shared responsibility requirement was previously expected to be January 1, 2014, the federal government announced that it will phase in this requirement as follows:

- Employers with 100 or more employees that offer coverage to at least 70% of its employees in 2015, and any calendar months during the 2015 plan year that fall in 2016, will not be subject to the $2,000 penalty referenced above. They may still be subject to the $3,000 penalty for not offering affordable coverage. For the 2016 plan year, employers must offer coverage to 95% of its employees.

- Employers with 50 to 99 employees are not subject to the shared responsibility penalties in 2015 or any calendar month during the portion of the 2015 plan year that falls in 2016.

The determination of whether an employer is subject to the federal requirement to offer health insurance and the extent to which any penalties apply is very complex. It is recommended that employers contact a tax professional to understand these issues. Licensed health insurance agents can also be helpful.

Below is a link to the final IRS regulation on employer requirements: Shared Responsibility for Employers Regarding Health Coverage.

https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage

21. Will small employers be able to purchase health insurance at any time throughout the year?

Yes. Health insurers must allow an employer to purchase health insurance coverage at any point during the year.

However, in the private health insurance market, if a small employer is unable to comply with employer contribution or group participation rules, health insurers may choose to limit enrollment of that employer to an annual enrollment period that begins November 15 and extends through December 15 of each year. SHOP will limit enrollment to that same time frame for employers who are unable to meet the SHOP participation requirement of 70%.

22. Are <u>all</u> small employers eligible for the federal small business tax credits?
No. The following requirements must be met for an employer to qualify for the federal small business tax credits: (1) the employer must have fewer than 25 full-time employees; (2) the average annual wages of employees must be less than $50,000; and (3) the employer must pay at least half of the insurance premiums.

The tax credit is worth **up to** 50% of the employer's contribution toward employees' premium costs (up to 35% for tax-exempt employers). The tax credit is highest for companies with fewer than 10 employees who are paid an average of $25,000 or less. Additionally, the credit is only available to small employers purchasing health insurance through SHOP. Today, to purchase a plan offered on the SHOP, an employer must work directly with a licensed health insurance agent or an insurer.

Below is a link to Internal Revenue Service FAQs on the small business tax credit. OCI is not responsible for the accuracy of the information provided at that site.
http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Calculating-the-Credit

23. If employees have access to health insurance coverage through their employer, are they eligible for federal health care premium tax credits?
No, unless the employee's share of the premium is more than 9.5% of their household income or the coverage does not meet minimum requirements.

24. Are there participation rates that must be met as a condition of purchasing small group coverage in either the private health insurance market or SHOP?
Insurers offering coverage in the private health insurance market may impose participation rates consistent with state law.

State law does not allow a small employer insurer to impose more stringent requirements than the following:

- For a small employer with more than 10 eligible employees, 70% of the group.
- For a small employer with 10 eligible employees, 6 eligible employees.
- For a small employer with 8 or 9 eligible employees, 5 eligible employees.
- For a small employer with 7 eligible employees, 4 eligible employees.
- For a small employer with 5 or 6 eligible employees, 3 eligible employees.
- For a small employer with 2 to 4 eligible employees, 2 eligible employees.

The federal Center for Consumer Information and Insurance Oversight (CCIIO) has indicated the federal SHOP will use a participation rate of 70%.

25. Will individuals and families be able to use navigators to purchase health insurance?

No. Navigators, by law, are prohibited from selling health insurance. They are available to help individuals check for eligibility into public assistance programs through the federal exchange and help individuals interested in purchasing health insurance view plan options displayed on healthcare.gov, the federal exchange Web site.

Even for consumers interested in purchasing health insurance through the federal exchange, navigators are not permitted, by law, to assess whether one plan may be better for a consumer than another. Only state-licensed health insurance agents can provide advice and sell health insurance.

For a list of permitted and prohibited activities related to navigators, review the July 26, 2013, bulletin posted to the OCI Web site at http://oci.wi.gov/bulletin/0713navigator.htm.

26. What are "application counselors" and "assisters"? Can they sell health insurance?

CACs, like navigators, help individuals check their eligibility for public assistance programs. CACs also help consumers sort through the health insurance plans that display on the federal exchange Web site after consumers enter their preferences.

CACs are not federally funded but must work for an organization designated by the federal government as a CAC entity. CACs must complete both state and federal training as well as pass state and federal examinations. State training and examination requirements for CACs are the same as navigator requirements. CACs are registered with the Office of the Commissioner of Insurance and are listed on the OCI Web site at http://oci.wi.gov/navigator/cac-registered.htm.

If you have concerns with a CAC's conduct, please complete a consumer complaint form located at https://ociaccess.oci.wi.gov/complaints-public/.

Under state and federal law, CACs and navigators are <u>not</u> qualified to and cannot legally sell health insurance or provide advice to consumers about which health insurance plan best meets their needs. Only state-licensed health insurance agents may sell and provide advice about health insurance coverage.

27. Can small employers purchase health insurance from the private health insurance market? Can they still use agents?

Yes, small employers can purchase health insurance from the private health insurance market either directly from an insurer or with the help of a licensed health insurance agent.

28. Can sole proprietors purchase group health insurance in the outside market?

No. Neither federal nor state law allow insurers to sell small group health insurance plans to sole proprietors. This is the case whether coverage is purchased through the private health insurance market or SHOP.

29. When are policies sold to individuals and groups required to be compliant with ACA provisions?

Insurers have some discretion. Insurers selling plans with an effective date on or after January 1, 2014, must ensure those plans are compliant. State and federal law allowed insurers to renew non-ACA compliant plans in 2013, with a plan year that began in 2013 and ends in 2014. An OCI bulletin is available on this issue at http://oci.wi.gov/bulletin/1113healthplans.htm.

30. Are insurers allowed to have renewal dates that are shorter than one year? Longer than one year?

Prior to January 1, 2014, insurers were allowed to offer early renewals to policyholders. Federal law specifies that insurers are not allowed to offer renewal periods longer than one year. However, non-ACA compliant plans are not subject to this rule.

31. If a consumer has a renewal date after the open enrollment period, will they be allowed their own special enrollment period?

Yes, if their current plan is no longer available for renewal.

32. Who is eligible for federal premium tax credits?

Iindividuals and families with incomes between 100% and 400% of the poverty level, or $11,670 to $46,680 for individuals and $23,850 to $95,400 for a family of four.

The premium tax credit is refundable so taxpayers who have little or no income tax liability can still receive the tax benefit.

Below is a link to a premium tax credit calculator available on the Kaiser Family Foundation Web site. OCI is not responsible for the accuracy of the information provided at that site.

http://healthreform.kff.org/subsidycalculator.aspx

33. Are consumers who purchase health insurance in the outside market eligible for federal premium tax credits?

No. The federal government only offers premium tax credits if health insurance *is* purchased through the federal exchange.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
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Frequently Asked Questions Regarding Certified Application Counselor Entities (Organizations)

(Updated 09/24/2013)

1. What are certified application counselor (CAC) entities?
2. My organization is interested in becoming a CAC entity (organization), how do we start this process?
3. Do the individuals employed by or working on behalf of my organization need to take any special training or get licensed?
4. Where can I find information on the requirements for individual certified application counselors?
5. Are there any state registration requirements for CAC entities?
6. Once my organization is registered with OCI, are there any ongoing reporting requirements?
7. Is there a fee for registering with or submitting changes to OCI?
8. Are CAC entities responsible for the acts of the CACs it employs or is affiliated with?
9. Does the organization need to furnish a bond to serve as a CAC organization?

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1. What are certified application counselor (CAC) entities?

CAC entities in a federal exchange will be federally Qualified Health Centers, hospitals, health care providers, social service agencies, local health departments and Indian Health Services.

CAC entities, with the help of individual CACs, will:

- Help consumers fill out electronic and paper applications to establish eligibility for the federal exchange and public assistance programs; and
- Help consumers enroll in coverage on the federal exchange.

Unlike navigator entities, CAC entities are not federally funded and are not responsible for education and outreach to raise awareness about the federal exchange.

CAC entities are not permitted to provide advice to consumers or employers about which health insurance plan offered on the federal exchange best meets their needs. Only a licensed health insurance agent may offer such advice. Additionally, CAC entities are not permitted to assist consumers in comparing health insurance plans offered off the federal exchange.

2. My organization is interested in becoming a CAC entity (organization), how do we start this process?

Your organization must submit an application to the federal exchange. Information on becoming a CAC organization and a link to the application is available online at http://marketplace.cms.gov/help-us/cac.html.

Once the application is approved, the organization will enter into an agreement with the federal exchange to certify its staff or volunteers to act as certified CACs who perform the duties and meet the requirements for CACs.

3. Do the individuals employed by or working on behalf of my organization need to take any special training or get licensed?

Yes, individuals serving as certified application counselors (CACs) are required to complete the federal training requirement and receive a passing score on the federal examination. They are also required to complete the state training and examination requirements and be registered with the Office of the Commissioner of Insurance.

4. Where can I find information on the requirements for individual certified application counselors?

Information about the training and examination requirements is available in the FAQs for certified applications counselors, available on the OCI Web site at http://oci.wi.gov/navigator/cac-faq.pdf.

5. Are there any state registration requirements for CAC entities?

Yes, upon becoming authorized by the federal exchange to provide CAC assistance, the entity must register with the Office of the Commissioner of Insurance (OCI) and provide the office with a list of all the individual CACs and any other nonnavigator assisters it employs, supervises, or is affiliated with.

CAC entities register with OCI by using the Nonnavigator Business Entity Initial Registration/Updates (OCI 11-092) form. This form is available for download free of charge on the OCI Web site at http://oci.wi.gov/agentlic/forms-apps.htm. Completed forms should be e-mailed to ocialdocuments@wisconsin.gov.

NOTE: Any government entity is exempt from the state CAC registration requirements.

6. Once my organization is registered with OCI, are there any ongoing reporting requirements?

Yes, the entity must provide the Office of the Commissioner of Insurance (OCI) with any updates to the list of individual CACs and other nonnavigator assisters, including additions, deletions, or modifications within 30 days of the change. Changes must be reported to OCI using the Nonnavigator Business Entity Initial Registration/Updates (OCI 11-092) form. This form is available for download free of charge on the OCI Web site at http://oci.wi.gov/agentlic/forms-apps.htm. Completed forms should be e-mailed to ocialdocuments@wisconsin.gov.

7. Is there a fee for registering with or submitting changes to OCI?

No, there are no fees associated with the initial registration of a CAC entity or for reporting changes to the list of individual CACs and other nonnavigator assisters employed by, supervised by or affiliated with a CAC entity.

8. Are CAC entities responsible for the acts of the CACs it employs or is affiliated with?

Yes, a CAC entity assumes full legal responsibility for the acts of the individual CACs that it employs, supervises or is affiliated with that are performed in Wisconsin that are within the scope of the CAC's apparent authority to act as a CAC.

9. Does the organization need to furnish a bond to serve as a CAC organization?

No.

If you still have any questions regarding registration requirements for CAC entities, please contact the Agent Licensing Section at (608) 266-8699 or ociagentlicensing@wisconsin.gov.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Frequently Asked Questions For Insurance Agents Regarding Navigators, Certified Application Counselors, and Participating on the Federal Health Insurance Exchange

(Updated 09/24/2013)

1. What are navigators?
2. What are certified application counselors (CACs)?
3. I am a licensed health insurance agent; can I become a licensed navigator?
4. What federal and state training requirements do I have to complete to become a navigator?
5. Do I have to become a navigator or CAC to sell on the federal exchange?
6. I am a licensed agent; can I work for a nonnavigator entity as a certified application counselor?
7. Where can I get information about the federal exchange?
8. Do I have to register to sell individual plans offered on the federal exchange?
9. What do I need to do to sell on the SHOP exchange?
10. Where can I take the online federal exchange training?
11. As an agent, do I need to be appointed with the company and will I receive commission for business placed via the federal exchange?
12. I am interested in helping individuals who will lose their Medicaid eligibility and will be newly eligible for premium tax credits in the federal exchange. Do I need to complete any additional training?
13. How do I ensure local social services agencies or community organizations know I want to help enroll these individuals into private insurance coverage?
14. Does the four-hour Wisconsin-specific course relating to public assistance health care programs count toward my biennial continuing education requirement?
15. Where can I find information on courses relating to Wisconsin-specific public assistance health care programs that are approved for continuing education?
16. What companies are on the exchange?
17. How do I get appointed with the companies on the exchange?

These frequently asked questions are presented for information purpose only. The intent is to help agents with frequently asked questions about navigators, certified application counselors (CACs), and participating on the federal health insurance exchange.

1. What are navigators?

Navigators are federally funded individuals, employed by or affiliated with a federally funded navigator entity, and licensed by the Office of the Commissioner of Insurance, who:

- Educate consumers and help them fill out electronic or paper applications to establish eligibility for the federal exchange and public assistance programs;
- Help consumers enroll in coverage through the federal exchange; and
- Provide outreach and education to raise awareness about the federal exchange.

A list of entities awarded a navigator grant can be found on the OCI Web site at http://oci.wi.gov/healthcare_ref/grant_recipients.pdf.

Navigators are not permitted to provide advice to consumers or employers about which health insurance plan offered on the federal exchange best meets their needs. Only a licensed health insurance agent may offer such advice. Additionally, navigators have a responsibility to make consumers aware that health insurance plans are available for purchase off the federal exchange but are not permitted to assist consumers in comparing health insurance plans offered off the federal exchange.

2. What are certified application counselors (CACs)?

CACs in a federal exchange will be individuals working in settings such as federally qualified health centers, hospitals, health care providers, social service agencies, local health departments, and Indian Health Services.

CAC's duties are to:

- Help consumers fill out electronic and paper applications to establish eligibility for the federal exchange and public assistance programs; and
- Help consumers enroll in coverage on the federal exchange.

Unlike navigators, CACs are not federally funded and are not responsible for education and outreach to raise awareness about the federal exchange.

CACs are not permitted to provide advice to consumers or employers about which health insurance plan offered in the federal exchange best meets their needs. Only a licensed health insurance agent may offer such advice. Additionally, CACs have a responsibility to make consumers aware that health insurance plans are available for purchase off the federal exchange but are not permitted to assist consumers in comparing health insurance plans offered off the federal exchange.

3. I am a licensed health insurance agent; can I become a licensed navigator?

Yes. Agents that hold an active resident license with the accident and health line of authority and complete the state-specific and federal training required to be a navigator may apply to be licensed as a navigator.

However, agents will need to be certified by the federal exchange as a navigator or must be affiliated with one of the six entities that received a federal navigator grant. In addition, agents cannot be a licensed navigator if the agent has any active appointments with a health insurance company. As a licensed navigator, agents cannot receive commission from a health insurance company.

The navigator application can be found on the OCI Web site at http://oci.wi.gov/agentlic/forms-apps.htm.

4. **What federal and state training requirements do I have to complete to become a navigator?**

   - Federal Training/Examination Requirements:

     Agents must complete 20 hours of federal training and receive a passing score on a federal examination. There are no fees associated with the federal training. To register for the training, agents must provide their National Producer Number (NPN). For more information, please go to the CMS Web site at http://marketplace.cms.gov/training/get-training.html.

   - State Training/Examination Requirements

     Agents that hold an active resident license with the accident and health line of authority are required to complete 4 hours of navigator training specific to public assistance programs, including Medicaid, or complete 16 hours of Commissioner-approved navigator prelicensing training. No examination is required. They are also required to submit fingerprints and criminal history from the Wisconsin Department of Justice prior to applying for the license.

     Agents with an active resident license but do not have the accident and health line of authority are required to complete 16 hours of Commissioner-approved navigator prelicensing training and successfully complete the navigator examination. They are also required to submit fingerprints and criminal history from the Wisconsin Department of Justice prior to applying for the license.

5. **Do I have to become a navigator or CAC to sell on the federal exchange?**

   No. A licensed agent with the proper line of authority and appointments that has registered with the federal exchange and completed required federal training can sell, solicit or negotiate insurance business on the federal exchange.

6. **I am a licensed agent; can I work for a nonnavigator entity as a certified application counselor?**

   If the agent sells, solicits, or negotiates a particular contract of insurance on behalf of an insurance company, the agent must comply with all applicable state insurance laws and regulations. If that sale, solicitation or negotiation arises while holding himself or herself out as a CAC, then the agent must also comply with ss. Ins 6.91 to 6.99, Wis. Adm. Code.

   If the agent is acting as a CAC to provide information to consumers and help facilitate consumer enrollment in qualified health plans and insurance affordability programs, the agent must comply with all federal requirements set forth in 45 CFR 155.255. These requirements include, but are not limited to: successful training completion, registration with a designated organization, protection of privacy and security standards and disclosure of potential conflict of interest. For more information, please contact CMS at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html.

7. **Where can I get information about the federal exchange?**

   General information about the federal exchange is available at http://www.healthcare.gov.

   Federal exchange information specific to agents and brokers is available online on the "Resources for Agents and Brokers in the Health Insurance Marketplace" Web page on the Center for Consumer Information & Insurance Oversight's Web site at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html.

8. **Do I have to register to sell individual plans offered on the federal exchange?**

   Before selling health plans available on the federal individual exchange, an agent must register with the federal exchange. The registration is a two-part process. In completing the registration process, an agent will:

   Part I – Medicare Learning Network (MLN)
   - Register with the MLN at https://Marketplace.MedicareLearningNetworkLMS.com.
   - Successfully complete the required online training courses available via the MLN.
   - Read and accept the applicable exchange agreements.

   Part II – Federally-facilitated Marketplace (Exchange) User Account
   - At least two days after accepting the applicable exchange agreements, create a User Account.
   - Complete identity verification through the Enterprise Identity Management System.

   Information about the federal exchange and how an agent can register with the federal exchange is available online at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/agent-broker-training-webinar.pdf.

9. **What do I need to do to sell on the SHOP exchange?**

   Agents not planning to sell any individual plans through the federal exchange but interested in selling plans through the Small Business Health Options Programs (SHOP) are required to register with the MLN at https://Marketplace.MedicareLearningNetworkLMS.com. They are also required to read and accept the applicable exchange agreement. While agents selling on the SHOP exchange are encouraged to take the federal training, it is not required.

10. **Where can I take the online federal exchange training?**

    The federal government has developed a Web-based training for agents. The training is available at https://Marketplace.MedicareLearningNetworkLMS.com.

11. **As an agent, do I need to be appointed with the company and will I receive commission for business placed via the federal exchange?**

    Yes. State laws regarding appointments apply to both on- and off-exchange business. In addition, insurers are required to pay the same commission levels on and off the federal exchange.

12. **I am interested in helping individuals who will lose their Medicaid eligibility and will be newly eligible for premium tax credits in the federal exchange. Do I need to complete any additional training?**

    Agents assisting this population are strongly encouraged to complete a four-hour continuing education course relating to public assistance health care programs in Wisconsin. Agents can find a list of approved courses on Sircon at http://www.sircon.com. Select "Look Up Education Courses/Credit," follow the prompts and search for courses approved as Navigator CE.

13. **How do I ensure local social services agencies or community organizations know I want to help enroll these individuals into private insurance coverage?**

    Regional enrollment networks (RENs) have been established across the state to collaborate on the best way to ensure the smoothest transition possible for individuals leaving Medicaid and purchasing private insurance coverage. Agent names and contact information will be shared with the RENs after completing the four-hour continuing education course and OCI has verified the agent contact information. If you have taken the training and do not wish to add your name to the REN list, please contact OCI at ociagentlicensing@wisconsin.gov.

14. **Does the four-hour Wisconsin-specific course relating to public assistance health care programs count toward my biennial continuing education requirement?**

    Yes. Agents will receive four hours of continuing education credit. The credit is granted even if the agent elects not to be included on the REN list.

15. **Where can I find information on courses relating to Wisconsin-specific public assistance health care programs that are approved for continuing education?**

    A list of "CE Navigator" courses is available on Sircon at http://www.sircon.com. Select "Look Up Education Courses/Credit," follow the prompts and search for courses approved as Navigator CE.

16. **What companies are on the exchange?**

    A list of companies participating on the exchange and their county-by-county service areas for the individual exchange and the SHOP exchange is available on the OCI Web site at http://oci.wi.gov/pressrel/0913serviceareas.htm.

17. **How do I get appointed with the companies on the exchange?**

    Agents seeking new appointments with companies they are not currently appointed with should contact the company directly. Companies are permitted to make their own business decision regarding how many and which agents it chooses to do business with.

If you still have any questions regarding licensing requirements to participate in the federally facilitated exchange, please contact the Agent Licensing Section at (608) 266-8699 or ociagentlicensing@wisconsin.gov.

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Frequently Asked Questions For Navigators

(Updated 10/09/2013)

General

1. What are navigators?
2. Is there a list of permitted and prohibited activities for navigators?
3. Am I or is my organization required to be licensed or to submit an application to the Office of the Commissioner of Insurance (OCI) in order to assist consumers with the exchange?

Individual Navigators

4. What are the requirements to be licensed as an individual navigator in Wisconsin?
5. Do I have to take any training before I can become licensed as a navigator?
6. How do I find a list of approved prelicensing courses and information on how to register for a course?
7. Is there a fee for the prelicensing training?
8. Do I have to take a state licensing examination in order to become a licensed navigator?
9. Where can I find information on how to register for and where to take the examination?
10. I've taken the federal courses and passed the federal test; do I also need to take the state training and examination?
11. What information will the written navigator examination cover?
12. Should I study before taking the state examination?
13. How long are the written navigator examination scores valid?
14. How do I apply for a license?
15. How do I submit fingerprints?
16. After licensure, are navigators required to complete continuing education training?

Navigator Entities

17. How does the navigator entity register with OCI?
18. Are navigator entities legally responsible for the acts of the navigators that are employed, supervised or affiliated with the entity?
19. Are navigator entities responsible for filing with OCI a list of individual licensed navigators it employs, supervises or is affiliated with?
20. Where do I find information on what my employees need to do in order to become a licensed navigator?

General

1. **What are navigators?**

   A navigator can be an individual or an entity that supervises or employs an individual who performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange. An individual navigator does not include a person acting as an insurance intermediary; however, an insurance intermediary may apply to be licensed as a navigator provided the intermediary complies with federal restrictions.

2. **Is there a list of permitted and prohibited activities for navigators?**

   Yes, that list is available in the navigator and nonnavigator assisters bulletin the Office of the Commissioner (OCI) released on July 26, 2013. The bulletin is available on the OCI Web site at http://oci.wi.gov/bulletin/0713navigator.htm. This list is also available in the Navigator Study Guide, also available on the OCI Web site at http://oci.wi.gov/navigator/pi-230.pdf.

3. **Am I or is my organization required to be licensed or to submit an application to the Office of the Commissioner of Insurance (OCI) in order to assist consumers with the exchange?**

   Yes, prior to performing services on behalf of the federal exchange:

   - Individual navigators must be licensed with OCI.
   - Navigator organizations (i.e., business entity navigators) must register with OCI.

Individual Navigators

4. **What are the requirements to be licensed as an individual navigator in Wisconsin?**

   An individual must:
   - Have received a funding grant from the federal government or is affiliated with an entity that has received a navigator grant,
   - Be at least 18 years of age,
   - Be a Wisconsin resident or maintain his or her principal place of business in Wisconsin,
   - Have completed Wisconsin training and the training required by the federal exchange,
   - Have passed a written examination,
   - Have submitted a full set of fingerprints and successfully completed a regulatory and criminal history background investigation, and
   - Have paid the applicable fee.

5. **Do I have to take any training before I can become licensed as a navigator?**

   Yes. To become a licensed navigator you must complete 16 hours of approved prelicensing training and any federally mandated exchange training.

6. **How do I find a list of approved prelicensing courses and information on how to register for a course?**

   There are vendors offering training courses across the state. Fees and offerings may vary depending on the vendor. To view a list of approved courses visit www.sircon.com. Select "Look Up Education Course/Credits;" select "Approved Courses Inquiry;" select "Wisconsin;" click "Submit;" select an "Education Type" of "Pre-Licensing Education" and a "Course Category" of "Navigator PE;" and click "Submit." Information about the courses and how to register is available directly from the provider.

7. **Is there a fee for the prelicensing training?**

   Yes. The cost of the prelicensing training may vary based on the source of the training.

8. **Do I have to take a state licensing examination in order to become a licensed navigator?**

   Yes. You must successfully complete the navigator licensing examination prior to applying for a navigator license.

9. **Where can I find information on how to register for and where to take the examination?**

   Information on how to register for the examination and the examination process can be found in the Navigator Candidate Handbook available on the OCI Web site at http://oci.wi.gov/navigator/candidate-handbook.pdf. There is a $75.00 fee to take the examination and you must register in advance.

10. **I've taken the federal courses and passed the federal test; do I also need to take the state training and examination?**

    Yes.

11. **What information will the written navigator examination cover?**

    The written state examination will test applicants on their knowledge of the insurance laws and regulations of Wisconsin, the state's public assistance programs and eligibility, and the duties and responsibilities of a navigator. An overview of the topics upon which the examination is based is available in the Examination Content Outline available on the OCI Web site at http://oci.wi.gov/navigator/examoutline.pdf.

12. Should I study before taking the state examination?

Yes, you are encouraged to review the following materials prior to taking the state examination:

- Navigator Study Guide (http://oci.wi.gov/navigator/pi-230.pdf)
- State Public Assistance Programs (http://oci.wi.gov/navigator/healthcare-assistance.pdf)

OCI has assembled a variety of additional materials to assist individuals preparing for the examination. They are available for download – free of charge – at http://oci.wi.gov/navigator/navigator.htm.

13. How long are the written navigator examination scores valid?

Examination scores are valid for 180 days. If you do not apply for a navigator license within 180 days of taking the examination, you will be required to re-take the examination.

14. How do I apply for a license?

After completing the Wisconsin prelicensing training, the federally mandated exchange training, passing the written examination, and submitting a full set of fingerprints to OCI, individuals may apply for a navigator license by submitting a completed Application for Individual Navigator License (OCI 11-090) to OCI. The application is available on the OCI Web site at http://oci.wi.gov/agentlic/forms-apps.htm.

15. How do I submit fingerprints?

Information on submitting fingerprints is contained in the Navigator Candidate Handbook available on the OCI Web site at http://oci.wi.gov/navigator/candidate-handbook.pdf.

16. After licensure, are navigators required to complete continuing education training?

Yes. After licensure, an individual navigator shall complete a course study of at least eight hours of approved training every one-year period. Training must be completed prior to seeking annual renewal of a navigator license. Training required must be approved by the Commissioner and provided by an approved education provider. Navigators must also satisfy any federal exchange training requirements.

Navigators Entities

17. How does the navigator entity register with OCI?

To register as a navigator business entity, the entity must:

- Submit a properly completed registration form—Navigator Business Entity Registration Application (OCI 11-091)
- Pay the applicable non-refundable application fee of $100.00
- Submit evidence of financial responsibility

- Identify an individually licensed Designated Responsible Licensed Navigator
- Provide a list of all individual navigators that it employs, supervises, or is affiliated with

The Navigator Business Entity Registration Application License (OCI 11-091) is available on the OCI Web site at http://oci.wi.gov/agentlic/forms-apps.htm.

18. Are navigator entities legally responsible for the acts of the navigators that are employed, supervised or affiliated with the entity?

Yes. The entity legally responsibility for the acts of the individual navigators that it employs, supervises, or is affiliated with that are performed in this state and that are within the scope of the navigator's apparent authority.

19. Are navigator entities responsible for filing with OCI a list of individual licensed navigators it employs, supervises or is affiliated with?

Yes. A list of individual licensed navigators the entities employs, supervises or is affiliated with should accompany the registration form. After providing the initial list of navigators with the application form, the navigator entity shall report any updates to the list of navigators, including additions, deletions or modifications, within 30 days of the addition, deletion or modification to the list of navigators.

20. Where do I find information on what my employees need to do in order to become a licensed navigator?

Information on what must be done to become an individual licensed navigator is included in the Individual Navigators section of this document.

If you still have any questions regarding registration requirements for navigators, please contact the Agent Licensing Section at (608) 266-8699 or ociagentlicensing@wisconsin.gov.

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Frequently Asked Questions Regarding Certified Application Counselors

(Updated 10/09/2013)

1. What are certified application counselors (CACs)?
2. Is there a list of permitted and prohibited activities for CACs?
3. Are there certification or licensure requirements for CACs?
4. What state and federal training requirements must be met before someone can be certified as a CAC and registered with OCI?
5. I am interested in completing the state CAC training. Where can I find information on how to do this?
6. Where can I find information about the state examination that I need to take to be a CAC?
7. What material will I be tested on when taking the state examination?
8. Should I study before taking the state examination?
9. I have heard that some people may be exempt from the state training and examination requirements. Is that true?
10. Do I need to be fingerprinted to serve as a CAC?
11. Are there any additional training requirements after I am certified and registered as a CAC?
12. Is there an alternative to the state CAC training for individuals who are interested in understanding the basic concepts of insurance but who do not plan to become CACs?
13. Do I need to furnish a bond to serve as a CAC?
14. Where can I find more information about the requirements for certified application counselor (CAC) entities (organizations)?

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1. What are certified application counselors (CACs)?

Certified application counselors (CACs) in a federal exchange will be individuals working in settings such as federally qualified health centers, hospitals, health care providers, social service agencies, local health departments and Indian Health Services.

CAC's duties are to:

- Help consumers fill out electronic and paper applications to establish eligibility for the federal exchange and public assistance programs; and
- Help consumers enroll in coverage on the federal exchange.

Unlike navigators, CACs are not federally funded and are not responsible for education and outreach to raise awareness about the federal exchange.

CACs are not permitted to provide advice to consumers or employers about which health insurance plan offered on the federal exchange best meets their needs. Only a licensed health insurance agent may offer such advice. Additionally, CACs have a responsibility to make consumers aware that health insurance plans are available for purchase off the federal exchange but are not permitted to assist consumers in comparing health insurance plans offered off the federal exchange

2. Is there a list of permitted and prohibited activities for CACs?

Yes, that list is available in the navigator and nonnavigator assisters bulletin the Office of the Commissioner (OCI) released on July 26, 2013. The bulletin is available on the OCI Web site at http://oci.wi.gov/bulletin/0713navigator.htm. This list is also available in the Navigator Study Guide, also available on the OCI Web site at http://oci.wi.gov/navigator/pi-230.pdf.

3. Are there certification or licensure requirements for CACs?

There are no licensure requirements for CACs. However, individuals interested in serving as CACs must be certified by an organization (entity) designated by the federal exchange to act as a certified CAC. Additionally, there is a state requirement that CACs be registered with the Office of the Commissioner of Insurance (OCI). The CAC entity you are affiliated with submits your name to OCI. For more information about how a CAC entity registers with OCI, see the FAQs for Certified Application Counselors Entities (Organizations) available on the OCI Web site at http://oci.wi.gov/navigator/cacentity-faq.pdf.

Both the federal requirement to be certified as a CAC by an entity designated by the federal exchange and the requirement for registration with OCI must be done before an individual can use the title "CAC."

4. What state and federal training requirements must be met before someone can be certified as a CAC and registered with OCI?

- Federal Requirements

  Individuals must complete five hours of online federal training and receive a passing score on a federal examination. There are no fees associated with the federal training or examination.

  For more information on the federal training, please go to the CMS Web site at http://marketplace.cms.gov/training/get-training.html.

- State Requirements

  NOTE: Any government entity or any person acting on behalf of a government entity is exempt from the state CAC training, examination and registration requirements.

  Individuals must complete 16 hours of approved prelicensing training and successfully pass a written examination. The prelicensing training is the same training requirement

established for navigators. The cost of the prelicensing training may vary depending on the vendor. There is a $75.00 fee to take the examination.

The CAC entity you are affiliated with is responsible for registering you with the Office of the Commissioner of Insurance (OCI).

5. I am interested in completing the state CAC training. Where can I find information on how to do this?

There are vendors offering training courses across the state. Fees and offerings may vary depending on the vendor. To view a list of approved courses visit www.sircon.com. Select "Look Up Education Course/Credits;" select "Approved Courses Inquiry;" select "Wisconsin;" click "Submit;" select an "Education Type" of "Pre-Licensing Education" and a "Course Category" of "Navigator PE;" and click "Submit." Information about the courses and how to register is available directly from the provider.

The training required for CACs is the same as the training for navigators. That is why you will see reference to "navigator" in some of the materials.

NOTE: Governmental entities and anyone working on behalf of a governmental entity is exempt from the state training requirements.

6. Where can I find information about the state examination that I need to take to be a CAC?

Information on how to register for the examination and the examination process can be found in the Navigator Candidate Handbook available on the OCI Web site at http://oci.wi.gov/navigator/candidate-handbook.pdf.

There is a $75.00 fee to take the examination and you must register in advance.

The examination for CACs is the same as the one for navigators. That is why you are being referred to the "Navigator Candidate Handbook."

NOTE: Governmental entities and anyone working on behalf of a governmental entity is exempt from the state examination requirement.

7. What material will I be tested on when taking the state examination?

The written state examination will test applicants on their knowledge of the insurance laws and regulations of Wisconsin, the state's public assistance programs and eligibility, and the duties and responsibilities of a navigator. An overview of the topics upon which the examination is based is available in the Examination Content Outline available on the OCI Web site at http://oci.wi.gov/navigator/examoutline.pdf.

8. Should I study before taking the state examination?

Yes, you are encouraged to review the following materials prior to taking the state examination:

- Navigator Study Guide (http://oci.wi.gov/navigator/pi-230.pdf)

- State Public Assistance Programs (http://oci.wi.gov/navigator/healthcare-assistance.pdf)

Additional materials that you may find helpful in preparing for the examination can be found on the OCI Web site at http://oci.wi.gov/navigator/nonnavigator.htm#cac

9. I have heard that some people may be exempt from the state training and examination requirements. Is that true?

Yes, any government entity or any person acting on behalf of a governmental entity is exempt from the state CAC training, examination and registration requirements.

10. Do I need to be fingerprinted to serve as a CAC?

State law does not require that CACs be fingerprinted. However, the CAC entity you are affiliated with may have such a requirement. You should check with the CAC entity you are affiliated with to determine what requirements it may have.

11. Are there any additional training requirements after I am certified and registered as a CAC?

Yes, CACs must complete eight hours of state-approved training annually, in addition to any ongoing training requirement established by the federal exchange.

12. Is there an alternative to the state CAC training for individuals who are interested in understanding the basic concepts of insurance but who do not plan to become CACs?

Yes, the Office of the Commissioner of Insurance (OCI) has taped a training session that is posted to the Department of Health Services Web site and available to anyone who is interested. This training will be especially beneficial to income maintenance employees who are exempt from state CAC training requirements.

The presentation – Insurance 101 On-line training – is 55 minutes long and is available online at http://dhsmedia.wi.gov/main/Play/bf07076993cc4ee2a1298fa60636e52c1d

13. Do I need to furnish a bond to serve as a CAC?

No.

14. Where can I find more information about the requirements for certified application counselor (CAC) entities (organizations)?

Additional information about the requirements for CAC entities is available in the FAQs for certified application counselor entities (organizations) available on the OCI Web site at http://oci.wi.gov/navigator/cacentity-faq.pdf.

If you still have any questions regarding registration requirements for CAC, please contact the Agent Licensing Section at (608) 266-8699 or ociagentlicensing@wisconsin.gov.

Date: August 6, 2013
For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Wisconsin Completes Filing Reviews

Madison, WI—The Wisconsin Office of Commissioner of Insurance has completed its review of rates and forms filed by insurers wishing to participate in the federally facilitated exchange.

In order to be eligible for the federally facilitated exchange, insurers must meet all state standards and file their rates and forms with the state of Wisconsin. Insurers began filing insurance policies with the state in April. Wisconsin reviewed the rate and form filings to ensure the policies are in compliance with all laws and regulations.

"This is only the first step in the process," explained Insurance Commissioner Ted Nickel. "Insurers wishing to participate in the federal exchange will need to complete an additional federal review process and sign a contract to participate on the exchange."

OCI has reviewed filings from 13 insurers who have requested their plans to be certified as a qualified health plan (QHP) in the individual market and 9 insurers who have filed plans to participate in the SHOP exchange. The following is a list of all of the health insurers that have submitted rate and form filings to OCI:

Individual Market Insurance Companies

Common Ground Healthcare Cooperative
Compcare Health Services Insurance Corporation
Dean Health Plan, Inc.
Group Health Cooperative of South Central Wisconsin
Gundersen Health Plan, Inc.
Health Tradition Health Plan
Medica Health Plans of Wisconsin
MercyCare HMO, Inc.
Molina Healthcare of Wisconsin, Inc.
Physicians Plus Insurance Corporation
Security Health Plan of Wisconsin, Inc.
Unity Health Plans Insurance Corp.
Arise (WPS Health Plan, Inc.)

Small Employer Group Market Insurance Companies

Common Ground Healthcare Cooperative
Group Health Cooperative of South Central Wisconsin
Gundersen Health Plan, Inc.
Health Tradition Health Plan
Medica Insurance Company
MercyCare HMO

MercyCare Insurance Company
Security Health Plan of Wisconsin, Inc.
Arise (WPS Health Plan, Inc.)

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

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Date: September 3, 2013
For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Wisconsin Releases Information on Rate Filings

Madison, WI—The Wisconsin Office of Commissioner of Insurance (OCI) has completed its initial analysis of rate filings in the individual market.

"While the exchange in Wisconsin will be run by the federal government, insurers wanting to offer coverage in the exchange had to file their rates with OCI. With our review of the exchange rate filings completed, we have attempted to compare what Wisconsin consumers are paying today to what plans will cost post 2014 under the new federal health law," stated Commissioner Nickel. "The truth is that comparisons are difficult because rates are going to vary based on age and where you live."

The chart below compares the cost increases for a $2,000 deductible that included drug coverage in the individual insurance market. We examined plans for a 21-year-old, a 40-year-old, and a 63-year-old. The rates were examined separately for Milwaukee, Eau Claire, Green Bay, Madison, Appleton, Wausau, Kenosha, and LaCrosse. The pre-reform plans are based on quoted rates effective July 1, 2013. Post reform plans are limited to plans from companies who have filed to participate in the federal exchange, and the averages will change if some insurers modify their service areas.

Percent Increase From Pre to Post 2014, Average Per Area								
Age	Milwaukee	Eau Claire	Green Bay	Madison	Appleton	Wausau	Kenosha	LaCrosse
21	78.11	68.75	53.73	124.85	54.18	77.44	37.59	88.53
40	40.85	48.35	53.73	73.43	36.75	35.03	15.15	41.58
63	45.48	58.12	22.54	70.04	32.01	26.07	9.72	37.29

It is important to note that a number of factors will impact how much of an increase an individual consumer will pay. The best way to determine how much you will pay is to review the exchange when it goes live on October 1. It should be noted some consumers will be eligible for a taxpayer-funded subsidy, which will offset the actual premium being charged for low-income consumers.

"With that said, from our analysis, it appears premiums will increase for most consumers. And, while there is no question that some consumers will have subsidies and may not pay these higher rates," Commissioner Nickel continued, "someone will pay for the increased premiums whether it is the consumer or the federal government."

It is important to note that any increase will not impact every consumer or group in the same way. The increases vary significantly across the state with some regions seeing far higher increases and others potentially seeing lower increases. The chart only includes data for plans that have filed to

participate in the exchange. Comparisons for the group market are far more difficult to compare and therefore our office did not attempt to analyze rate comparisons for this market. Factors making this difficult include limited interest in the SHOP exchange by insurers, the interest in early renewals in the private market delaying increases until next year, and the tremendous variables in employer makeup and benefit differences.

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For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

OCI Provides Information on Federal Exchange Service Areas

Madison, WI—While the exchange in Wisconsin will be run by the federal government, the Wisconsin Office of Commissioner of Insurance has collected final service area information for insurers participating in the federal exchange. Prior to the finalization of the insurer contracts with the federal government, this information was not available.

"Wisconsin is not running the federal exchange," stated Insurance Commissioner Ted Nickel, "but this is information that consumers need to know in advance of the October 1 deadline. We felt it was important to provide the information to prevent consumer confusion."

The charts below show the county-by-county service areas for the individual exchange and the SHOP exchange.

County	Federally Facilitated Exchange (Individual Market)	SHOP Exchange (Small Group Market)
Adams	Dean Health Plan, Inc. Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Ashland	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Barron	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Medica Ins. Co. Security Health Plan of WI, Inc.
Bayfield	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Brown	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Buffalo	Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Burnett	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Calumet	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc.	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)

	WPS Health Plan, Inc. (Arise)	
Chippewa	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Medica Ins. Co. Security Health Plan of WI, Inc.
Clark	Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Columbia	Dean Health Plan, Inc. Group Health Coop. of South Central WI Unity Health Plans Ins. Corp.	Group Health Coop. of South Central WI
Crawford	Dean Health Plan, Inc. Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Dane	Dean Health Plan, Inc. Group Health Coop. of South Central WI Physicians Plus Ins. Corp. Unity Health Plans Ins. Corp.	Group Health Coop. of South Central WI
Dodge	Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Group Health Coop. of South Central WI Molina Healthcare of WI, Inc. Unity Health Plans Ins. Corp. WPS Health Plan, Inc. (Arise)	WPS Health Plan, Inc. (Arise)
Door	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Douglas	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Dunn	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Medica Ins. Co. Security Health Plan of WI, Inc.
Eau Claire	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Medica Ins. Co. Security Health Plan of WI, Inc.
Florence	Molina Healthcare of WI, Inc.	
Fond du Lac	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Forest	Molina Healthcare of WI, Inc. Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Grant	Dean Health Plan, Inc. Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Green	Dean Health Plan, Inc. Group Health Coop. of South Central WI MercyCare HMO, Inc.	MercyCare HMO, Inc. MercyCare Ins. Co.
Green Lake	Dean Health Plan, Inc.	
Iowa	Dean Health Plan, Inc. Group Health Coop. of South Central WI	Group Health Coop. of South Central WI

	Unity Health Plans Ins. Corp.	
Iron	Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Jackson	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.
Jefferson	Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Group Health Coop. of South Central WI MercyCare HMO, Inc. Molina Healthcare of WI, Inc. Unity Health Plans Ins. Corp.	MercyCare HMO, Inc. MercyCare Ins. Co.
Juneau	Dean Health Plan, Inc. Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.
Kenosha	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Kewaunee	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
La Crosse	Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Lafayette	Dean Health Plan, Inc. Group Health Coop. of South Central WI	
Langlade	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Lincoln	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Manitowoc	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Marathon	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Marinette	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Marquette	Dean Health Plan, Inc.	
Menominee	Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc.	
Milwaukee	Common Ground Healthcare Coop.	Common Ground Healthcare Coop.

	Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	WPS Health Plan, Inc. (Arise)
Monroe	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.
Oconto	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Oneida	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Outagamie	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Ozaukee	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Pepin	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Security Health Plan of WI, Inc.
Pierce	Health Tradition Health Plan Medica Health Plans of WI	Health Tradition Health Plan Medica Ins. Co.
Polk	Health Tradition Health Plan Medica Health Plans of WI	Health Tradition Health Plan Medica Ins. Co.
Portage	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Price	Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Racine	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Richland	Dean Health Plan, Inc. Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Rock	Dean Health Plan, Inc. Group Health Coop. of South Central WI MercyCare HMO, Inc.	MercyCare HMO, Inc. MercyCare Ins. Co.
Rusk	Health Tradition Health Plan Security Health Plan of WI, Inc.	Health Tradition Health Plan Security Health Plan of WI, Inc.
Sauk	Dean Health Plan, Inc. Group Health Coop. of South Central WI Gundersen Health Plan, Inc. Health Tradition Health Plan Unity Health Plans Ins. Corp.	Group Health Coop. of South Central WI Gundersen Health Plan, Inc. Health Tradition Health Plan
Sawyer	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Shawano	Common Ground Healthcare Coop.	Common Ground Healthcare Coop.

	Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Sheboygan	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
St. Croix	Health Tradition Health Plan Medica Health Plans of WI	Health Tradition Health Plan Medica Ins. Co.
Taylor	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Trempealeau	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.	Gundersen Health Plan, Inc. Health Tradition Health Plan Security Health Plan of WI, Inc.
Vernon	Dean Health Plan, Inc. Gundersen Health Plan, Inc. Health Tradition Health Plan	Gundersen Health Plan, Inc. Health Tradition Health Plan
Vilas	Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Walworth	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. MercyCare HMO, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. MercyCare HMO, Inc. MercyCare Ins. Co. WPS Health Plan, Inc. (Arise)
Washburn	Security Health Plan of WI, Inc.	Medica Ins. Co. Security Health Plan of WI, Inc.
Washington	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Waukesha	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Dean Health Plan, Inc. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Waupaca	Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)
Waushara	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc.	Security Health Plan of WI, Inc.
Winnebago	Common Ground Healthcare Coop. Compcare Health Services Ins. Corp. Molina Healthcare of WI, Inc. WPS Health Plan, Inc. (Arise)	Common Ground Healthcare Coop. WPS Health Plan, Inc. (Arise)
Wood	Compcare Health Services Ins. Corp. Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)	Security Health Plan of WI, Inc. WPS Health Plan, Inc. (Arise)

The charts only include data for plans that have filed to participate in the exchange. Consumers shopping in the off-exchange market may have different options.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

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For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Scammers Take Advantage of Health Reform Confusion
State Insurance Regulators Warn Consumers to Be On Alert

Madison, WI—Since the Affordable Care Act (ACA) was signed into law in March 2010, unscrupulous scammers have been creating ways to take advantage of consumers' uncertainty surrounding the law. Posing as insurance agents or representatives of the federal government, these scam artists try to sell fraudulent policies or obtain sensitive information like Social Security and bank account numbers. The National Association of Insurance Commissioners (NAIC) and the State of Wisconsin Office of the Commissioner of Insurance (OCI) are warning consumers about common red flags and providing tips on how to avoid being the victim of a scam.

Health Insurance Marketplaces
One of the largest components of the ACA is the creation of new health insurance exchanges. An exchange is a Web site that will allow consumers to shop for health insurance plans. These online portals ask consumers to enter personal information and select a benefit level to receive a list of approved plans.

Open enrollment in the exchange begins October 1. However, bogus Web sites that purport to be part of the exchanges have been appearing online for more than a year. Do not enter any personal or financial information into a Web site that says you can purchase a policy before the open enrollment period on October 1, 2013.

The federal government is running the exchange in Wisconsin and the link can be found on www.healthcare.gov.

New "Obamacare" Insurance or Medicare Cards
Another common ploy involves unsolicited calls from scammers who claim to have your new "Obamacare" insurance card—they just need to get some information before they can send it to you. The caller then asks for credit card numbers, bank account information or your Social Security number. A variation of this trick specifically targets seniors on Medicare; the caller claims that in order for them to get their new Medicare card and continue receiving their benefits, they must verify their bank account and routing numbers. In other cases callers ask for their Medicare numbers, which are identical to Social Security numbers.

You are not required to obtain a new insurance or Medicare card under the ACA. Also, anyone who is a legitimate representative of the federal government will already have your personal and financial information and should not ask you to provide it.

Don't Be Misled
Here are some other important "red flags" to watch out for:

- The salesperson says the premium offer is only good for a limited time.
  Enrollment in the exchanges will be open from October 1 to March 31, and rates for plans in the exchanges will have been approved for the entire enrollment period. Be skeptical of someone who is trying to pressure you into buying a policy because the rate is only good for a short time. Remember: if the offer sounds too good to be true, it probably is.
- The salesperson says you could go to jail for not having health insurance.
  Starting in 2014, all Americans will be required to have health insurance. You will not face jail time if you do not purchase health insurance. However, those who remain uninsured and do not qualify for any exemptions will face a penalty of $95 (for each adult) or 1% of family income, whichever is greater. (www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision)
- You receive an unsolicited phone call or e-mail from someone trying to sell insurance that you do not know. You may receive a phone call from an insurance agent or a navigator; however, always verify the identity of the person contacting you. Check with OCI and the exchange for the person's license number and ask for identification.

Protect Yourself

The best way to protect yourself from insurance fraud is to research the agent and company you're considering. Always **STOP** before writing a check, signing a contract or giving out personal information. **CALL** the Office of the Commissioner of Insurance and **CONFIRM** that the agent and company are licensed to write insurance in Wisconsin.

More Information

For more information on health care reform, visit www.healthcare.gov. You can find additional information on the ACA on the HHS Web site.

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For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

OCI Consumer Notice
Technical Problems Continue for the Federal Exchange Web site: Healthcare.gov

Madison, WI—While many Wisconsin consumers have purchased insurance coverage through the federal exchange Web site (healthcare.gov) without issue, it is imperative that OCI notify consumers of technical problems that continue to exist with the Web site that may affect them. Healthcare.gov is the federal government's health insurance exchange Web site which has experienced a myriad of technical problems since its launch on October 1, 2013. The purpose of this notice is to inform Wisconsin consumers of the issues so that they can be proactive and avoid problems down the road.

Inaccurate Plan Information Posted by Healthcare.gov
In some cases, healthcare.gov is displaying plan information that does not match the information the insurer submitted to healthcare.gov. This incorrect plan information is the direct result of technical problems with the federal Web site and not errors caused by the insurer. One of the chief errors is in the display of cost-sharing information. For example, some plans are listed without a deductible when in fact a deductible requirement is tied to the plan.

"The posting of inaccurate plan information is one of the more harmful consumer-facing 'glitches' to date," explained Commissioner Ted Nickel. "Consumers rely on the information posted to Healthcare.gov to choose a plan that meets their medical and financial needs. Access to accurate information is critical to their decision-making process." Specifically, some consumers who purchased a plan on healthcare.gov will not get the plan as described on the Web site due to a technical error by the federal Web site.

OCI strongly encourages consumers using healthcare.gov to verify plan information by reviewing any insurer materials that may be accessible through healthcare.gov. If there are discrepancies between the plan details in those documents and the summary information provided on healthcare.gov, consumers should contact the insurer directly to avoid purchasing a plan that is inaccurately displayed on the Web site.

For those who have already purchased a plan, OCI recommends reviewing the actual plan document (which shows up on the Web site as a pdf file). If the plan document is different than information summarized on the federal Web site, consumers should contact the insurer to find out what their options are. If the plan document is the same as the Web site's summary, consumers should feel confident that they purchased what they initially intended. OCI has contact information for all insurers selling health insurance in Wisconsin posted on their web site at: http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf.

Federal Government Enrollment Transfers to Insurers

The transfer of enrollment information is another area of concern. Enrollment information is sent from the federal government to insurers. OCI has learned that, in some cases, this information transfer is delayed or not occurring at all. It is extremely important to note that this error in transferring the information from the Web site to the insurer is a technical issue with the federal Web site and that the only way to ensure coverage has been secured is through confirmation from the insurer. "Consumers who enroll through healthcare.gov but do not receive correspondence from the insurer confirming enrollment should contact the insurer directly to verify they are enrolled and payment has been received," stated Commissioner Nickel. If consumers have received confirmation from the insurer, they should feel confident that coverage has been secured.

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For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Joint Release: State Warns Consumers to be on the Alert When Signing up for the Affordable Care Act

Madison, WI—The Affordable Care Act's first open enrollment period is set to end on March 31, 2014. As with any new, large-scale program, fraudsters and identity thieves may try to take advantage of consumers who may be unfamiliar with the specifics of the program. Since the enrollment period began in October of last year, the Wisconsin Department of Justice (DOJ), the Office of the Commissioner of Insurance (OCI), the Department of Agriculture, Trade, and Consumer Protection (DATCP), and the Department of Health Services (DHS) have been working together, and with other states and federal agencies, to identify fraudulent schemes and protect consumers from them. Of particular concern is the potential for fraudulent telemarketers and Web sites designed to obtain consumers' personal information or steal their money.

"Considering the scale of the Affordable Care Act rollout, the state's Bureau of Consumer Protection received few complaints about scams," said Sandy Chalmers, DATCP Administrator for Trade and Consumer Protection. "If Wisconsin consumers believe they have been targeted by a fraudulent health care pitch, file a complaint with DATCP so we can take immediate action."

"The best way to protect yourself from fraud is to be prepared," stated Insurance Commissioner Ted Nickel. "There are literally thousands of people who can help you in the final days of open enrollment, but you need to take the time to check them out. I urge you to take advantage of all the resources the state of Wisconsin has put together to help protect you."

"We suspect fraudsters may emerge in the final weeks of the Affordable Care Act's enrollment," Attorney General J.B. Van Hollen said. "My office stands ready to support local law enforcement agencies around the state to stop those who violate the law."

You can protect yourself by taking a few precautions:

- **Check with OCI.** The best way to protect yourself from insurance fraud is to research the agent and company you're considering. Always **STOP** before writing a check, signing a contract or giving out personal information. **CALL** the Office of the Commissioner of Insurance and **CONFIRM** that the agent and company are licensed to write insurance in Wisconsin. OCI's contact information is:
  Wisconsin Office of the Commissioner of Insurance
  Phone: (608) 266-3585, Madison
  (800) 236-8517, statewide
  Web site: http://oci.wi.gov
- **Verify the legitimacy of Web sites you visit.** Using search engines may lead you to fraudulent Web sites if you are not careful. A good practice is to type the name of the Web site you want

into your browser window rather than merely searching for information about the Affordable Care Act. The official site is www.healthcare.gov. Other federal and state governmental Web sites provide links to legitimate sites related to the ACA.

- **Keep good records.** Keep a record of everyone who assists you, for whom they work, their telephone number, address, e-mail address and Web site.
- **Think before signing.** Don't sign anything you don't fully understand.
- **Be suspicious.** Are you being asked to transact business in an unusual way—for example by using a money order or by buying a money card? Stop, call and confirm. Also note, insurance discount cards are not the same as insurance.
- **Don't give in to high pressure tactics.** Threats, limited time offers or misinformation about Medicare are "red flags." You cannot go to jail for failing to enroll in the Affordable Care Act. If you are on Medicare, you do not need to enroll in the ACA or re-apply for Medicare.

If you are unsure about the legitimacy of any entity attempting to assist with ACA enrollment, check with the Wisconsin Office of the Commissioner of Insurance (OCI). OCI licenses anyone authorized to engage in the business of insurance in Wisconsin, and OCI can verify the legitimacy of anyone purporting to be trained to help enroll people in the Affordable Care Act. And, as always, if you suspect criminal activity, contact local law enforcement or contact the Department of Agriculture, Trade, and Consumer Protection (DATCP) at 1-800-422-7128. The state—through the cooperation of the DOJ, OCI, DHS and DATCP—is committed to prosecuting fraud and will work to protect Wisconsin consumers.

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For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Reminder: Health Insurance Open Enrollment Deadlines Coming
Health Insurance Must Be Purchased Before March 31st

Madison, WI—Insurance Commissioner Ted Nickel is reminding consumers that there are two Affordable Care Act (ACA) deadlines coming in the next several weeks.

The first deadline is March 15, 2014. In order to have health insurance coverage effective by April 1, 2014, consumers must have their insurance applications completed and submitted to the federal exchange by Saturday, March 15, 2014. Applications can be completed in the following ways:

1. Work with a local insurance agent
2. Contact a navigator or certified application counselor (for a complete list visit oci.wi.gov)
3. Visit the federal Web site, www.healthcare.gov
4. Call 1-800-318-2596 to speak to an exchange official

The second deadline is March 31, 2014, which is when ACA open enrollment ends. Health insurance applications submitted between March 16, 2014, and March 31, 2014, will have an effective date of May 1, 2014. **If you don't enroll by March 31, 2014, you may not be able to purchase private health insurance until the next open enrollment period starts.** The only way you can buy a health plan outside open enrollment is if you qualify for a special enrollment period. The next open enrollment period will be November 15, 2014, to February 15, 2015.

The federal government requires all individuals and families to have health insurance, either through the federal marketplace or through an employer. If you do not have health insurance, a penalty may be assessed on your 2015 taxes by the Internal Revenue Service.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

Last Updated: March 10, 2014

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Date: March 14, 2014
For more information contact: Terri Carlson, Administrative Policy Advisor, (608) 264-6239 or terri.carlson@wisconsin.gov

Ensure You're Insured

Don't let healthcare.gov problems impact you.

Madison, WI—After numerous problems with the federal Web site, Commissioner Ted Nickel is encouraging consumers to double check the status of their health insurance.

According to federal reports, thousands of Wisconsinites took advantage of the open enrollment period to purchase coverage through healthcare.gov. But the problems of the Web site are not fully over. OCI has continued to receive reports of consumers enrolled in incorrect plans. This happened when consumers entered their zip codes to show plans and the federal Web site showed plans that should not have been available based on the county in which the consumer lives. Once a consumer enrolled in a plan, the information was sent to the insurer. In some cases, consumers are paying a different premium for the plan they selected because the zip code pulled premium rates for a different area. In other cases, consumers have enrolled in a plan with a network of medical providers that do not practice anywhere near them. This can require significant travel time or more expensive medical care. Consumers were also allowed to purchase a plan not available in their region which will result in having no medical providers in their area.

However, in the most serious cases, consumers were enrolled with an insurer that does not have any plans available in their region. Those cases were sent back to the exchange by the insurer but there is no confirmation that any of those consumers were ever contacted by the exchange. These consumers are left without coverage but may not have been made aware of the problem. OCI is in the process of assuring that those consumers are contacted and that their problem is fixed by the exchange.

"The best thing any consumer can do is be proactive," stated Insurance Commissioner Nickel. "You've shopped around to purchase the best plan for you. Now you should take the next step to verify your coverage. Protecting you and your family's health is paramount."

Commissioner Nickel recommends the following steps:

- If you haven't received your enrollment materials within the expected time frame, check with your agent or the insurer to make sure you have coverage.
- Check to make sure that you have received enrollment materials.
- Verify that you have actually paid for coverage. For example, if paying by automatic withdrawal, check to see that the insurance company has debited your account for the premium you expected.
- Read your policy documents and make sure your deductibles and copays match what you were expecting. Make sure your medical providers are in the insurer's network.
- If you see any discrepancies, immediately contact your insurer.

"We are here to help," continued Commissioner Nickel. "We have worked with insurers to make sure all consumers are being treated fairly. If you don't feel you are being treated fairly, contact our office and we'll see what we can do to help."

For more information see the Federal Health Care Law Frequently Asked Questions—Enrollment (opens in new window).

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

Last Updated: March 14, 2014 [Back to Top]

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel*, Commissioner*

Wisconsin.gov

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Web Address: oci.wi.gov

Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Thursday, April 28, 2011
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome and Introduction of Members
Sharon Brosnan, Co-Chair
Wendy Arnone, Co-Chair

II. Life Insurance
Sharon Brosnan, Co-Chair

- Life Settlement Rule Update

- NAIC STOA Insurer Bulletin
- NAIC Annuity Disclosure Model Reg
  Sue Ezalarab, OCI

III. Health Insurance
Wendy Arnone, Co-Chair

- Federal Health Care Technical Legislation
  Jennifer Stegall, OCI

- Rate Review Regulation and Grant Update
  Sue Ezalarab, OCI

- Draft Bulletin: Rate Increase and Disclosure Review
  Guenther Ruch, OCI

IV. Other Issues

- Administrative Rule Update
  Julie Walsh, OCI

  Mental Health Parity
  Colorectal Cancer

V. **Next Meeting**

VI. **Adjournment**

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Thursday, August 18, 2011
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome
Wendy Arnone, Co-Chair

II. Life Insurance
Sharon Brosnan, Co-Chair

- Life Settlement Rule Update
  Jim Guidry, OCI

III. Health Insurance
Wendy Arnone, Co-Chair

- Federal Health Care Technical Legislation
  Jennifer Stegall, OCI

- External Review Update
  Jennifer Stegall, OCI

- Office of Free Market Health Care Working Groups
  Jennifer Stegall, OCI

- Rate Review Regulation and Grant Update
  Sue Ezalarab, OCI

- Risk Adjustment Working Group
  Guenther Ruch, OCI

- Rate Increase and Disclosure Review Bulletin
  Guenther Ruch, OCI

IV. Other Issues

- OCI Consumer Complaint System
  Sue Ezalarab, OCI
  Amit Trivedi, OCI

V. Next Meeting

VI. Adjournment

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Thursday, January, 19, 2011
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome
Wendy Arnone, Co-Chair

II. Life Insurance
Sharon Brosnan, Co-Chair

- Life Settlement Rule Update

III. Health Insurance
Wendy Arnone, Co-Chair

- Health Insurance Issues Update
  J.P. Wieske, OCI

- External Review
  Julie Walsh, OCI

- Medical Loss Ratio Waiver
  J.P. Wieske, OCI

- Risk Adjustment Working Group
  Guenther Ruch, OCI

- Coverage of Dependents Bulletin
  Sue Ezalarab, OCI

IV. Other Issues

- OCI Consumer Complaint System
  Sue Ezalarab, OCI
  Amit Trivedi, OCI

- OCI Stakeholder Outreach
  Ashley Natysin, OCI

- Read to Lead
  J.P. Wieske, OCI

V. Next Meeting

VI. Adjournment

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Monday, March 11, 2013
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome and Introductions
Wendy Arnone, Co-Chair

II. Life Insurance
Sharon Brosnan, Co-Chair

- Life Claims Settlement Working Group
  Robin Jacobs, OCI

- Long Term Care Commissions Working Group
  J.P. Wieske, OCI

- Legislative Issues
  J.P. Wieske, OCI

- NAIC Issues
  J.P. Wieske, OCI

III. Health Insurance
Wendy Arnone, Co-Chair

- Health Insurance Issues
  J.P. Wieske, OCI

- External Review
  Julie Walsh, OCI

- Essential Health Benefits
  Mollie Zito, OCI

Rating Areas
Stephanie Cook, OCI

NAIC Issues
J.P. Wieske, OCI
-Excise Tax

Legislative Issues
J.P. Wieske, OCI
-Navigators
-HIRSP
-Stakeholder Outreach

IV. Other Issues

- Small Business Regulatory Review Board
  J.P. Wieske, OCI

- Service Fee and Billing and Collection Agreements
  Julie Walsh, OCI

- Publications
  J.P. Wieske, OCI

V. Adjournment

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Thursday, November, 1, 2012
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome
Wendy Arnone, Co-Chair

II. Life Insurance
Sharon Brosnan, Co-Chair

- Life Claims Settlement Working Group
  Gina Frank, OCI

- Long Term Care Commissions Working Group
  J.P. Wieske, OCI

III. Health Insurance
Wendy Arnone, Co-Chair

- Health Insurance Issues
  J.P. Wieske, OCI

- External Review
  Julie Walsh, OCI

- Essential Health Benefits
  J.P. Wieske, OCI

- Wellness Plans
  Sue Ezalarab, OCI

IV. Other Issues

- Small Business Regulatory Review Board
  J.P. Wieske, OCI

V. Adjournment

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Wednesday, July 17, 2013
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome and Introductions
Sharon Brosnan, Co-Chair

II. Life Insurance

- Life Claims Settlement
  Mollie Zito, OCI

- Long Term Care
  J.P. Wieske, OCI
  Mollie Zito, OCI

- Legislative Issues
  J.P. Wieske, OCI

- NAIC Issues
  Mollie Zito, OCI

III. Health Insurance

- Health Insurance Issues
  J.P. Wieske, OCI
  Mollie Zito, OCI

- Bulletins
  Mollie Zito, OCI

  -Small Group Deductible
  -Dental

- NAIC Issues
  J.P. Wieske, OCI
  -Excise Tax

- Legislative Issues
  J.P. Wieske, OCI
  -Navigators
  -HIRSP

IV. Other Issues

- Publications/FAQ's
  Terri Carlson, OCI

- Office of Business Development
  Department of Administration
  Joe Knilans, Director
  Nancy Mistele, Director

- Service Fee and Billing and Collection Agreements
  Julie Walsh, OCI

V. Adjourn

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Tuesday, November 5, 2013
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome and Introductions

Sharon Brosnan, Co-Chair

II. Life Insurance

- Life Claims Settlement
  Mollie Zito, OCI

- Long Term Care Commissions
  J.P. Wieske, OCI
  Mollie Zito, OCI

- Legislative Issues
  J.P. Wieske, OCI
  -Assembly Bill 373, relating to electronic delivery by property and casualty insurers of notices and documents.

- NAIC Issues
  Mollie Zito, OCI

III. Health Insurance

- ACA Discussion
  J.P. Wieske, OCI
  Mollie Zito, OCI
  -Navigators/CAC's
  Sue Ezalarab, OCI

- Health Insurance Issues
  J.P. Wieske, OCI

- NAIC Issues
  J.P. Wieske, OCI
  -Excise Tax

- Legislative Issues
  J.P. Wieske, OCI
  -Health Insurance Technical Legislation

IV. Other Issues

- Publications/FAQ's
  Roger Frings, OCI

- NAIC
  -Producer Licensing Working Group
  Nitza Pfaff, OCI

  -NARAB II
  J.P. Wieske, OCI

  -ORSA/Model Holding Company Act
  J.P. Wieske, OCI

- Web Portal
  Roger Frings, OCI

V. Adjourn

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Theodore K. Nickel*, Commissioner*

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Office of the Commissioner of Insurance
Health and Life Insurance Advisory Council

Agenda
Tuesday, February 18, 2014
10:00 a.m. – 11:30 a.m.
125 South Webster Street
Room 227 – The Spencer Kimball Conference Room
Madison, WI 53703

I. Welcome and Introductions
Wendy Arnone, Co-Chair
Sharon Brosnan, Co-Chair

II. Life Insurance
J.P. Wieske, OCI
Mollie Zito, OCI

- Life Claims Settlement
- Long-Term Care Commissions
  Assembly Bill 736/Senate Bill 581
- Legislative Issues
- NAIC Issues
- Annuity Mortality Table Rule
- Wisconsin Taxpayers Alliance Report on Economic Impact of Insurance Industry
- Federal Insurance Office Report
- Unclaimed Property

III. Health Insurance
J.P. Wieske, OCI
Mollie Zito, OCI

- Navigators/CACs

- Health Insurance Issues
  Federal Correspondence

- NAIC Issues
  Excise Tax
  Model Laws Update

- Legislative Issues

IV. Other Issues
J.P. Wieske, OCI

- NAIC
  NARAB II

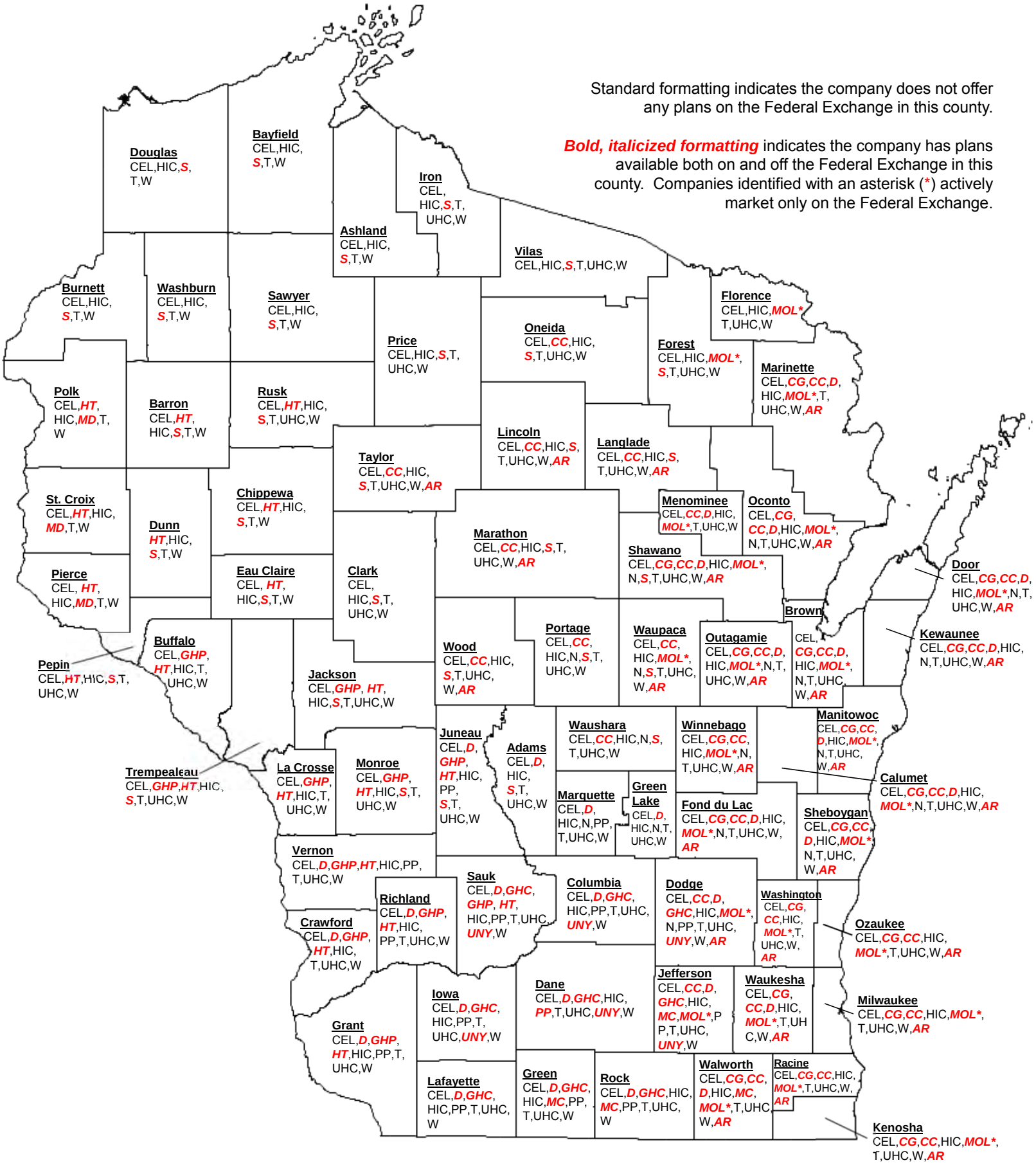
  ORSA/Model Holding Company Act
  Assembly Bill 735/Senate Bill 582

  NAIC Committee Assignments

- Web Portal

V. Adjourn

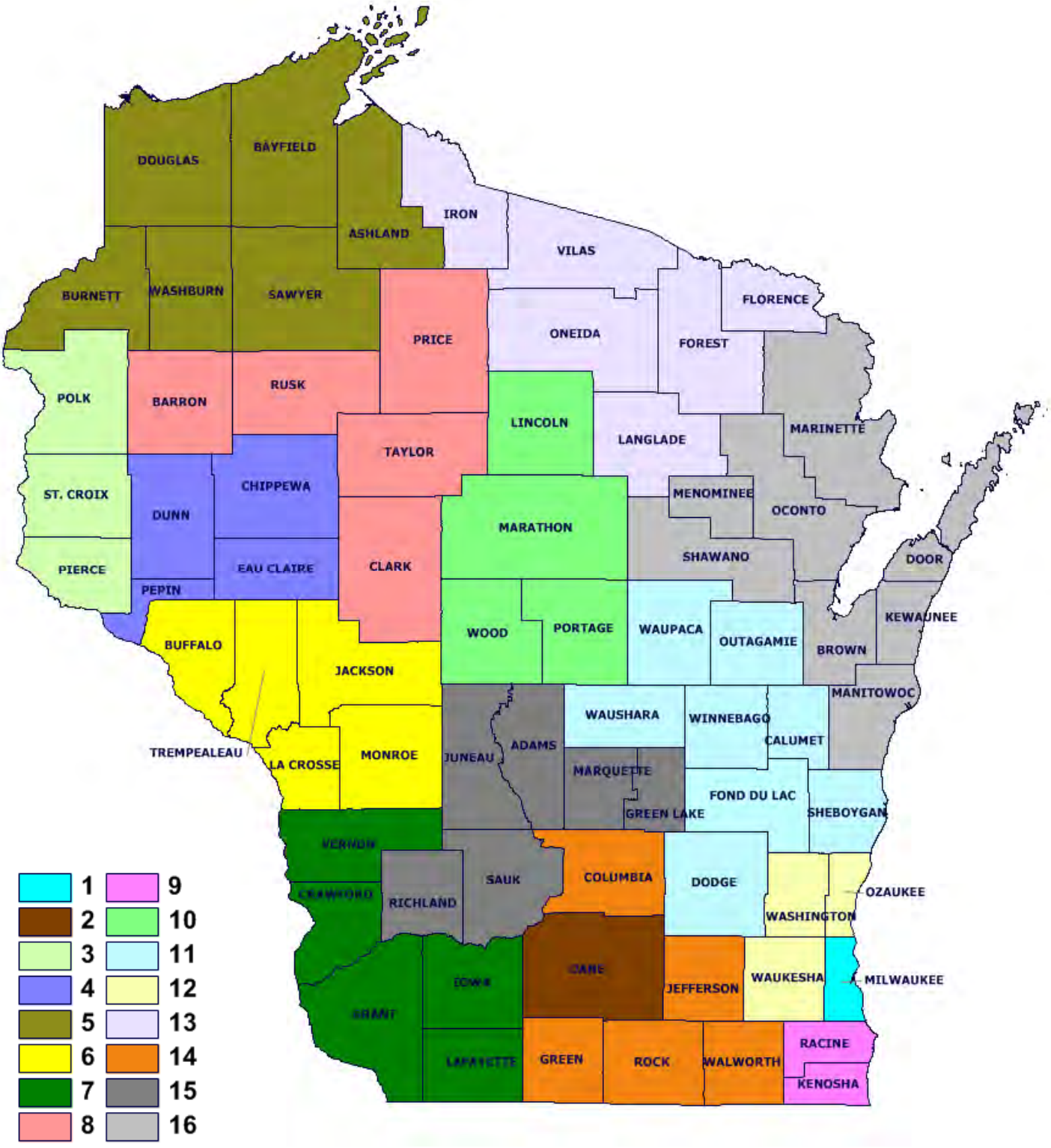
Individual Health Insurance Carriers in Wisconsin



	Company Name/Contact Information	Type(s) of Plans Offered
CEL	Celtic Insurance Company https://celtic.inshealth.com/ehi/ifp/individual-family-health-insurance;jsessionid=954838C06390AEC530986525B1EC14F5.prsvc02b?allid=Cel26959 1-800-779-7989	PPP
CG	Common Ground Healthcare Cooperative https://healthplans.commongroundhealthcare.org/ehp/eapp/ebuyer?execution=e1s1 1-855-494-2667	PPP
CC	Compcare Health Services Insurance Corporation https://www.anthem.com/health-insurance/wisconsin/health-plans/ 1-888-556-9098	POS, HMO, POS
D	Dean Health Plan, Inc. http://www.deancare.com/insurance/reform/ http://www.deancare.com/insurance/find-plan/quote/ 1-800-279-1301	HMO
GHC	Group Health Cooperative South Central WI https://hcr.ghcscw.com/ 608-828-4831	HMO
GHP	Gundersen Health Plan, Inc. https://www.gundersenhealthplan.org/PurchaseInsurance/IndividualFamily.aspx 1-855-685-6404	POS
HT	Health Tradition http://www.healthtradition.com/prospects/health-plans/health-tradition-individuals-overview/health-tradition-individuals http://www.healthtradition.com/prospects/contact-us 1-888-459-3020	HMO
HIC	Humana Insurance Company https://www.humana.com/individual-and-family/ 1-800-811-1670	PPP
MD	Medica Health Plans of WI http://www.medica.com/IFBCustomerService 1-888-592-8211	PPP

	Company Name/Contact Information	Type(s) of Plans Offered
MC	MercyCare HMO, Inc. http://www.mercycarehealthplans.com/members-find-insurance-now-mercycare-individual-health-plans 1-800-895-2421 Mary Hesse and Josh Mummery	HMO
MOL	Molina Healthcare of WI, Inc. http://www.molinahealthcare.com/members/wi/en-US/hp/marketplace/Pages/marketplace.aspx 1-855-542-1987	HMO
N	Network Health Plan http://www.networkhealth.com/ 1-855-275-1400	HMO
PP	Physicians Plus Insurance Corporation http://www.pplusic.com/home/buying-insurance/individual 608-282-8940	HMO
S	Security Health Plan of WI, Inc. https://www.securityhealth.org/ 1-800-472-2363	HMO
T	Time Insurance Company http://www.assuranthealth.com 1-800-394-4296	PPP
UHC	United Healthcare Life Insurance Corporation http://www.uhc.com/individuals_families.htm 1-888-545-5205	HMO
UNY	Unity Health Plans Insurance Corporation http://unityhealthexchange.com/ 1-800-362-3310	HMO
W	WI Physicians Service Insurance Corporation http://www.wpsic.com 1-800-351-9925	PPP, HMO
AR	WPS Health Plan, Inc. (Arise) http://www.wecareforwisconsin.com 1-866-841-6575	POS

Geographic Rating Areas



C. 3/18/2013

Appendix A

Wisconsin Geographic Rating Areas (Small and Individual Markets)

Rating Area ID (for federal systems)	County Name	3 Digit Zip Code (if applicable)
Rating Area 1	Milwaukee	
Rating Area 2	Dane	
Rating Area 3	Polk	
Rating Area 3	St. Croix	
Rating Area 3	Pierce	
Rating Area 4	Dunn	
Rating Area 4	Pepin	
Rating Area 4	Chippewa	
Rating Area 4	Eau Claire	
Rating Area 5	Douglas	
Rating Area 5	Bayfield	
Rating Area 5	Ashland	
Rating Area 5	Burnett	
Rating Area 5	Washburn	
Rating Area 5	Sawyer	
Rating Area 6	Buffalo	
Rating Area 6	Trempealeau	
Rating Area 6	Jackson	
Rating Area 6	La Crosse	
Rating Area 6	Monroe	
Rating Area 7	Vernon	
Rating Area 7	Crawford	
Rating Area 7	Grant	
Rating Area 7	Iowa	
Rating Area 7	LaFayette	
Rating Area 8	Barron	
Rating Area 8	Rusk	
Rating Area 8	Price	
Rating Area 8	Taylor	
Rating Area 8	Clark	
Rating Area 9	Racine	
Rating Area 9	Kenosha	
Rating Area 10	Lincoln	
Rating Area 10	Marathon	
Rating Area 10	Wood	
Rating Area 10	Portage	
Rating Area 11	Waupaca	
Rating Area 11	Outagamie	
Rating Area 11	Waushara	

Rating Area 11	Winnebago	
Rating Area 11	Calumet	
Rating Area 11	Fond du Lac	
Rating Area 11	Sheboygan	
Rating Area 11	Dodge	
Rating Area 12	Washington	
Rating Area 12	Ozaukee	
Rating Area 12	Waukesha	
Rating Area 13	Iron	
Rating Area 13	Vilas	
Rating Area 13	Oneida	
Rating Area 13	Forest	
Rating Area 13	Florence	
Rating Area 13	Langlade	
Rating Area 14	Green	
Rating Area 14	Rock	
Rating Area 14	Walworth	
Rating Area 14	Jefferson	
Rating Area 14	Columbia	
Rating Area 15	Juneau	
Rating Area 15	Adams	
Rating Area 15	Marquette	
Rating Area 15	Green Lake	
Rating Area 15	Richland	
Rating Area 15	Sauk	
Rating Area 16	Marinette	
Rating Area 16	Oconto	
Rating Area 16	Menominee	
Rating Area 16	Shawano	
Rating Area 16	Brown	
Rating Area 16	Manitowoc	
Rating Area 16	Kewaunee	
Rating Area 16	Door	

Date: November 21, 2013

To: All Insurers Authorized to Write Health Insurance in Wisconsin

From: Theodore K. Nickel, Commissioner of Insurance

Subject: Non-ACA Compliant Plans

On Thursday, November 14, 2013, Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight (CCIIO), sent a letter to state insurance commissioners. The letter provided options under which health insurance issuers may choose to renew between January 1, 2014, and October 1, 2014, individual and small group coverage that would otherwise terminate due to federal health insurance market reforms required under the Patient Protection and Affordable Care Act (ACA).

Consistent with state requirements and the Office of the Commissioner of Insurance's (OCI) enforcement power of state and federal law, OCI will allow carriers to renew at their option non-ACA compliant individual and small group coverage that was in effect on October 1, 2013, for a policy year starting between January 1, 2014, and October 1, 2014. Carriers may submit rate revisions for 2014 renewals within 30 days after the rates become effective using one of the following methods:

- If a rate filing was submitted for the affected product(s) in 2013 and the carrier wishes to change rates by an annualized trend amount equal to or less than the amount indicated in the 2013 filing, a simplified filing process may be used. Carriers electing this option must submit through a filing in SERFF a letter indicating (1) the affected products, (2) the annualized trend amount filed in 2013, (3) the trend change requested in 2014, and (4) the rate change effective date(s). The letter must reflect any incremental implementation of the annualized trend change.
- If no rate filing was submitted for the affected product(s) in 2013 or the company wishes to increase rates by an amount greater than the annual trend amount filed in 2013, a complete filing must be submitted. The filing must fulfill all requirements for 2013 Non-Grandfathered rate filings. Detailed filing requirements are available on the OCI Web site at http://oci.wi.gov/ociforms/comphealth-ratefilings-ngf.htm.

It is important to note that coverage must have been in force on October 1, 2013, and that this OCI guidance does not apply to "newly obtained coverage." "Newly obtained coverage" does NOT include normal enrollment changes (i.e., adding dependents or new employees) nor does it include coverage that has merely received a price change before OR after October 1, 2013. Consistent with Wisconsin Statutes related to plan changes, the small business or individual may change their plan options from one non-ACA compliant plan to another and renew that coverage in 2014 provided:

1. Coverage was in force for the individual or small employer before October 1, 2013; and
2. The new plan was available for purchase prior to October 1, 2013.

Carriers opting to renew non-ACA compliant plans must provide disclosure to their enrollees including notice that an enrollee's premium may be affected either on the date of renewal or the

date on which the premium will be affected. Since the letter was sent too late for some carriers to comply with notice provisions under Wisconsin law, the 60-day notice provision under s. 631.36 (5), Wis. Stat., will not be enforced for affected products from the date of this bulletin until March 1, 2014.

Many Wisconsin carriers have already offered their enrollees an early renewal option. OCI will continue to allow carriers to offer an early renewal for non-ACA compliant individual and small group coverage in 2014. As required under state law, renewals must be treated uniformly and without regard to health status.

For carriers that are transitioning individuals from an existing plan to a new plan, it is the position of OCI that nothing in the Wisconsin Statutes or regulations prohibits carriers from offering their enrollees auto-enrollment into a similar new plan. Auto-enrollment allows for minimal disruption to consumers as a result of changes required by the ACA. In communicating with enrollees regarding plan change options and auto-enrollment, insurers must inform them of their guaranteed issue right to choose any plan. While consumers have the right to choose any plan, the auto-enrollment feature helps ensure they are provided with the right to guaranteed renewable coverage afforded under Wisconsin law.

This bulletin applies to all insurers offering comprehensive individual and small group health insurance plans beginning November 21, 2013. Any questions concerning this bulletin should be directed to J. P. Wieske at jpwieske@wisconsin.gov or (608) 266-2493.

Last Updated: November 21, 2013

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Date: March 20, 2014

To: All Insurers Authorized to Write Health Insurance in Wisconsin

From: Theodore K. Nickel, Commissioner of Insurance

Subject: Guidance Regarding the U.S. Department of Health and Human Services Extended Transitional Policy

On March 5, 2014, the Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) issued an Insurance Standards Bulletin extending the transitional policy outlined in a letter to state insurance commissioners on November 13, 2013 (http://oci.wi.gov/bulletin/1113healthplans.htm).

Consistent with state requirements and the Office of the Commissioner of Insurance's (OCI) enforcement authority, OCI will allow carriers to renew, at their option, non-ACA compliant individual and small group coverage and coverage to large employers[1] if coverage was in effect on October 1, 2013. Policies may be renewed on or before October 1, 2016. Carriers electing to extend non-ACA compliant plans have the following options for individual and employer-sponsored group outreach and enrollment:

1. A carrier may permit individuals and employer-sponsored groups currently enrolled in the carrier's non-ACA compliant plan to continue to renew their coverage.
2. A carrier may provide an additional opportunity to renew coverage in its non-ACA compliant plan to an individual or employer-sponsored group who is currently enrolled in the carrier's non-ACA compliant plan but who has indicated their intent to nonrenew at the end of the plan year.
3. A carrier may issue a notice providing an opportunity to reinstate coverage to an individual or an employer-sponsored group who, at the last renewal date, chose not to renew their coverage under the carrier's non-ACA compliant plan that was in effect on October 1, 2013. The notice must also state that the carrier will not provide retroactive coverage and that the coverage is on a going-forward basis only.

Carriers may submit rate revisions for 2014, 2015, and 2016 renewals within 30 days after the rates become effective using one of the following methods:

- If a complete rate filing was submitted for the affected product(s) in 2013, 2014, or 2015 and the carrier wishes to change rates by an annualized trend amount equal to or less than the amount indicated in the 2013, 2014, or 2015 filing, a simplified filing process may generally be used. Carriers electing this option must submit through a filing in SERFF a letter indicating (1) the affected products, (2) the annualized trend amount filed in the complete rate filing, (3) the trend change requested, and (4) the rate change effective date(s). The letter must reflect any incremental implementation of the annualized trend change.
- If no rate filing was submitted for the affected product(s) in 2013, 2014, or 2015, or the company wishes to increase rates by an amount greater than the annualized trend amount filed in 2013, 2014, or 2015, a complete filing must be submitted. The filing must fulfill all requirements for transitional rate filings. Detailed filing requirements are available on the OCI Web site at

http://oci.wi.gov/ociforms/comphealth-ratefilings-ngf.htm.

It is important to note that coverage must have been in force on October 1, 2013. The guidance contained in this bulletin does not apply to "newly obtained coverage." "Newly obtained coverage" does NOT include normal enrollment changes (i.e., adding dependents or new employees) nor does it include coverage that has merely received a price change or plan changes such as modified copayments, coinsurance, deductibles or provider networks before or after October 1, 2013. Consistent with Wisconsin insurance laws and regulations, the individual, small or large business may change their plan options from one non-ACA compliant plan to another non-ACA compliant plan and renew that coverage provided:

1. Coverage was in force for the individual, small employer or large employer before October 1, 2013; and
2. The new plan was available for purchase prior to October 1, 2013.

Carriers opting to renew non-ACA compliant plans must provide disclosure to their enrollees including notice that an enrollee's premium may be affected either on the date of renewal or in advance of the date on which the premium change will be affected.

For carriers that are transitioning individuals from an existing plan to a new plan, it is the position of OCI that nothing in the Wisconsin Statutes or regulations prohibits carriers from offering their enrollees auto-enrollment into a similar new plan. Auto-enrollment allows for minimal disruption to consumers as a result of changes required by the ACA. Carriers choosing to offer individual and group insureds the option for auto-enrollment must provide the insured a notice at least 30 days in advance of the renewal date that the insured will be automatically renewed in the existing plan unless the insured exercises his or her right to choose any plan from any carrier and will receive coverage that is guaranteed. While consumers have the right to choose any plan from any carrier, the auto-enrollment option effectuates the right to guaranteed renewable coverage.

This bulletin applies to all insurers offering comprehensive individual and small and large group health insurance plans beginning November 21, 2013. Any questions concerning this bulletin should be directed to J. P. Wieske at jp.wieske@wisconsin.gov or (608) 266-2493.

[1] As defined in the March 5, 2014, guidance from CCIIO as "large businesses that currently purchase insurance in the large group market but that, as of January 1, 2016, will be redefined by section 1304(b) of the Affordable Care Act as small businesses purchasing insurance in the small group market."

Last Updated: March 20, 2014

[Back to Top]

State Plan Amendments 2014

First quarter 2014:

Amendment 14-001 — Presumptive eligibility for hospitals.
Hospitals will be determining eligibility (PE) for the various population groups. Wisconsin is implementing the Affordable Care Act (ACA) requirement that requires states to allow qualified hospitals to make presumptive eligibility (PE) determinations for certain populations (42 CFR 435.1110). Any Medicaid-enrolled hospital that agrees to the PE determination process set forth by ForwardHealth will be considered a qualified hospital.

Amendment 14-002 — Graduate Medical Education.
This amendment will facilitate the Department's expenditures of funds for graduate medical education.
Public notice: Wisconsin Administrative Register Volume 696b, December 31, 2013.

Amendment 14-003 — Inpatient Hospital Rates.
The Department will make changes and updates to inpatient hospital rates.
Public notice: Wisconsin Administrative Register Volume 696b, December 31, 2013.

Amendment 14-004 — Outpatient Hospital Rates.
The Department will make changes and updates to outpatient hospital rate methodologies.
Public notice: Wisconsin Administrative Register Volume 696b, December 31, 2013.

Amendment 14-005 — Medicaid MAGI Eligibility effective date change.
Changes effective date of eligibility groups whose status would change on January 1 to instead change effective April 1.

Amendment 14-006 — Single state agency.
This will change Wisconsin from a determination state to an assessment state effective January 1, 2014.

Amendment 14-007 — Cost of Living Adjustment (COLA).
This amendment will make changes to the Medicaid State Plan effective January 1, 2014 implementing annual cost of living adjustments to the SSI Benefit Amount. An amendment will not be needed to reflect the annual update to the Federal Poverty Level.

Amendment 14-008 — Changing Copayments For Children.
We will amend the state plan to charge copayments to Continuously Eligible Newborns with income between 150% and 200% of the FPL and to no longer collect copayments from children with incomes from 100% to 133% of the FPL.

Amendment 14-009 — Eliminate Premiums for Infants.
Premium requirements will be amended to stop charging premiums to infants under one year of age with incomes over 200% of the FPL, effective February 1, 2014.

Amendment 14-010 — End Interstate Residency Agreement with Florida.
Effective February 1, 2014, the State of Florida will end our interstate residency agreement, which dates back to April 1982. We will modify our state plan to show we no longer have the interstate agreement with Florida.

Amendment 14-011 — Medicaid MAGI Eligibility effective date change.
Companion amendment to 14-005, which changes effective date of eligibility groups whose status would change on January 1 to instead change effective April 1.

Amendment 14-012 — Deleting Reference to Copayments From Benchmark Plan Recipients.
We will remove references to Benchmark Plan copayment levels from the State Plan (since the benchmark plan is being terminated as of 04/01/2014.

Amendment 14-013 — CHIP eligibility processing.

We will complete the transition on the CHIP side from being a determination State, as we were in October, to become an assessment State effective January 1.

Affordable Care Act Amendments Which Have Been Submitted to Date
(and one which has not been submitted)

SPA	Scope/Objective	Status
	Medicaid MAGI Eligibility & Benefits Amendments.	
13-021	Group 1. WI MAGI-based eligibility groups. WI.0273 WI.04 S25, 28, 30, 32, 33, 50, 51, 52, 53, 54, 55, 57, 59, & 14.	Approved: 10/30/2013.
13-022	Group 2. WI eligibility process SPA. WI.0281 WI.05 S94.	Approved: 03/17/2014.
13-023	Group 3. MAGI income methodology. WI.0282 WI.07 S10.	Approved: 11/01/2013.
13-024	Group 4. Single state agency. WI.0284 WI.08 A1, 2, & 3.	01/27/2014: DHS response to request for additional information (RAI). 02/25/2014: Additional CMS comments.
13-025	Group 5. Residency. WI.0285 WI.09 S88.	Approved: 12/05/2013.
13-026	Group 6. Citizenship and immigration status. WI.0286 WI.10 S89.	Approved: 12/05/2013.
	Group 7. Hospital presumptive eligibility. S21.	Not yet submitted.

SPA	Scope/Objective	Status
	CHIP MAGI Eligibility Amendments.	
13-028	Group 1. WI CHIP MAGI Eligibility & Methods. WI.0287 WI.06 CS 7, 9, and 15.	02/20/2014: DHS response to CMS. 02/21/2014: CMS additional RAI.
13-029	Group 2. WI CHIP Medicaid Expansion. WI.0339 WI.14 CS3.	Approved: 10/23/2013.
13-030	Group 3. Establish 2101(f) Group. WI.0288 WI.11 CS14.	Approved: 10/23/2013.
13-031	Group 4. CHIP eligibility process. WI.0290 WI.13 CS24.	12/04/2013: RAI from CMS. 02/17/2014: DHS response to CMS. 02/18/2014: Stop the clock letter from CMS.
13-032	Group 5. CHIP non-financial eligibility. WI.0289 WI.12 CS17, 18, 19, 20, 21, & 23.	02/20/2014: DHS response to RAI. 02/21/2014: CMS additional RAI.

State Plan Amendments (SPA) Status Report

Amendments submitted in 2013

SPA	Scope/Objective	Date Submitted	Status	CMS due date	DHS due date
	Medicaid MAGI Eligibility & Benefits Amendments.				
13-021	Group 1. WI MAGI-based eligibility groups. WI.0273 WI.04 S25, 28, 30, 32, 33, 50, 51, 52, 53, 54, 55, 57, 59, & 14.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/19 and 23/2013: CMS "informal comments". 09/30/2013: Conference call w. CMS. 10/30/2013: CMS approval letter.	Approved	
13-022	Group 2. WI eligibility process SPA. WI.0281 WI.05 S94.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/24/2013: CMS request for conference call. 09/30/2013: Conference call w. CMS. 10/09/2013: Conference call w. CMS. 10/09/2013: Questions from CMS. 10/14/2013: Response by DHS. Undated: CMS "Coordination and Renewal Questions for States. 11/01/2013: Response by DHS. 11/06/2013: Discussion on SOTA call. 12/05/2013: RAI from CMS. 01/13/2014: DHS response to CMS. 02/17/2014: Additional DHS responses to CMS. 03/17/2014: CMS approval letter.	Approved	
13-023	Group 3. MAGI income methodology. WI.0282 WI.07 S10.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/20/2013: CMS informal questions. 10/09/2013: Conference call w. CMS. 11/01/2013: CMS approval letter.	Approved	

Amendments submitted in 2013, continued

SPA	Scope/Objective	Date Submitted	Status	CMS due date	DHS due date
	Medicaid MAGI Eligibility & Benefits Amendments.				
13-024	Group 4. Single state agency. WI.0284 WI.08 A1, 2, & 3.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/20/2013: CMS questions and conference call with CMS. 11/01/2013: CMS additional questions. 11/19/2013: CMS additional CMS questions. 12/02/2013: CMS additional question/request. 12/05/2013: RAI from CMS. 01/02/2014: CMS additional questions. 01/27/2014: DHS response to RAI. 02/25/2014: CMS additional comments.	04/27/2014	N/A
13-025	Group 5. Residency. WI.0285 WI.09 S88.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/30/2013: CMS informal questions. 10/09/2013: Conference call w. CMS. 11/25/2013: Conference call w. CMS. 12/05/2013: CMS approval letter.	Approved	
13-026	Group 6. Citizenship and immigration status. WI.0286 WI.10 S89.	09/13/2013 3rd Q 2013	Submitted 3rd quarter 2013. 09/30/2013: CMS informal questions. 10/09/2013: Conference call w. CMS. 11/21/2013: CMS questions. 11/25/2013: DHS response to CMS. 11/25/2013: Conference call w. CMS. 12/05/2013: CMS approval letter.	Approved	
	Group 7. Hospital presumptive eligibility. S21.		Not yet submitted.		

State Plan Amendments (SPA) Status Report

Amendments submitted in 2013, continued

SPA	Scope/Objective	Date Submitted	Status	CMS due date	DHS due date
	CHIP MAGI Eligibility Amendments.				
13-028	Group 1. WI CHIP MAGI Eligibility & Methods. WI.0287 WI.06 CS 7, 9, and 15.	09/27/2013 3rd Q 2013	Submitted 3rd quarter 2013. 10/08/2013: Conference call w. CMS. 11/27/2013: RAI from CMS. 02/20/2014: DHS response to CMS. 02/21/2014: CMS additional RAI. 02/24/2014: DHS response to CMS. 02/25/2014: CMS request for DHS to take the amendment off the clock. 02/25/2014: DHS agrees to CMS request to take the amendment off the clock.	05/25/2014	N/A
13-029	Group 2. WI CHIP Medicaid Expansion. WI.0339 WI.14 CS3.	09/27/2013 3rd Q 2013	Submitted 3rd quarter 2013. 10/08/2013: Conference call w. CMS. 10/23/2013: CMS approval letter.	Approved	
13-030	Group 3. Establish 2101(f) Group. WI.0288 WI.11 CS14.	09/27/2013 3rd Q 2013	Submitted 3rd quarter 2013. 10/08/2013: Conference call w. CMS. 10/23/2013: CMS approval letter.	Approved	
13-031	Group 4. CHIP eligibility process. WI.0290 WI.13 CS24.	09/27/2013 3rd Q 2013	Submitted 3rd quarter 2013. 12/04/2013: RAI from CMS. 02/17/2014: DHS response to CMS. 02/18/2014: Stop the clock letter from CMS. 03/18/2014: CMS additional letter.	05/18/2014	N/A
13-032	Group 5. CHIP non-financial eligibility. WI.0289 WI.12 CS17, 18, 19, 20, 21, & 23.	09/27/2013 3rd Q 2013	Submitted 3rd quarter 2013. 11/18/2013: CMS questions. 10/23/2013: DHS response to CMS. 11/27/2013: RAI from CMS. 02/20/2014: DHS response to CMS. 02/21/2014: CMS additional RAI. 02/24/2014: DHS response to CMS. 02/25/2014: CMS request for DHS to take the amendment off the clock. 02/25/2014: DHS agrees to CMS requrest to take the amendment off the clock.	05/25/2014	N/A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

Shawn Smith
CHIP Director
Division of Health Care Access and Accountability
1 Wilson Street, Room 365
P.O. Box 309
Madison, WI 53701-0309

OCT 2 3 2013

Dear Mr. Smith:

I am pleased to inform you that your Title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number WI-13-029, submitted on September 20, 2013, and SPA number WI-13-0030 submitted on September 6, 2013, both of which are related to Modified Adjusted Gross Income (MAGI) Eligibility, have been approved with an effective date of January 1, 2014.

Title XXI Medicaid Expansion:
SPA number WI-13-029 converts the state's existing income eligibility standards to modified adjusted gross income (MAGI) equivalent standards, by age group, for children covered in its title XXI-funded Medicaid program. A copy of the approved state plan page (CS3) is attached, and should be incorporated into the state's approved CHIP state plan. This page supersedes the current Medicaid expansion Section (4.0) of the current CHIP state plan.

Establish 2101(f) Group:
SPA number WI-13-0030 provides coverage in a separate CHIP, as specified in the state's submission of CS14: Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards. A copy of the approved state plan page (CS14) is attached and should be incorporated within a separate subsection under Section 4.1 of Maine's approved CHIP state plan.

Your Title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
Facsimile: (410) 786-5882
E-mail: Joyce. Jordan@ cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Ms. Verlon Johnson, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Region V, Division of Medicaid and Children's Health Operations. Ms. Johnson's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Office of the Regional Administrator
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

If you have additional questions, please contact Ms. Linda Nablo, Director, Division of Children's Health Insurance Programs, at (410) 786-5143. We look forward to continuing to work with you and your staff toward the approval of your remaining MAGI Eligibility SPAs.

Sincerely,

Eliot Fishman
Director

Enclosures
cc: Verlon Johnson, ARA, CMS Region V

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program	CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	6	19	101	151	X

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards **CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☑ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

○ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

◉ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

○ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

○ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

○ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

[ ] % FPL

○ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

◉ Other.

The state will identify children protected by Section 2101(f) and enroll such children in a separate CHIP based on the following methodology and procedures as approved by CMS.

Any child who is eligible for Medicaid at the time they are transitioned to a MAGI-based Medicaid determination, and who subsequently loses Medicaid eligibility in the transition due to excess income, will be put into the extension if the household had been paying any amount of child support prior to the transition.

Describe the benefits provided to this population:

CHIP Eligibility

- (●) This population will be provided the same benefits as are provided to children in the state's Medicaid program.
- ( ) This population will be provided the same benefits as are provided to children in the state's separate CHIP.
- ( ) Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

- ( ) Cost sharing is the same as for children in the Medicaid program.
- ( ) Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ( ) No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- (●) Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

Are Premiums required? No

Are copayments or other cost sharing required? Yes

Describe other cost sharing:

Copayments will be the same as for children in the Medicaid program.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

October 30, 2013

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following Wisconsin State Plan Amendment (SPA) 13-021-MM1, which was submitted to CMS on September 6, 2013. SPA 13-021-MM1 incorporates the MAGI-Based eligibility groups into Wisconsin's State Plan in accordance with the Affordable Care Act.

Transmittal #13-021 --MAGI-Based Eligibility Groups
--Effective January 1, 2014

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

November 1, 2013

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following Wisconsin State Plan Amendment (SPA) 13-021-MM3, which was submitted to CMS on September 6, 2013. SPA 13-023-MM3 incorporates the MAGI-Based Income Methodologies into Wisconsin's State Plan in accordance with the Affordable Care Act.

Transmittal #13-023 --MAGI-Based Income Methodologies
--Effective January 1, 2014

The financial eligibility methodologies described in SPA 13-023-MM3 will apply to all MAGI-based eligibility groups covered under Wisconsin's State Plan. The MAGI financial methodologies set forth in 42 CFR §435.603 apply to everyone except those individuals described at 42 CFR §435.603(j) for whom MAGI-based methods do not apply. This SPA supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/

Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 5, 2013

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following Wisconsin State Plan Amendment (SPA) 13-025-MM5, which was submitted to CMS on September 6, 2013. SPA 13-025-MM5 incorporates the Medicaid MAGI-related Residency Amendment 13-025 into Wisconsin's State Plan in accordance with the Affordable Care Act.

Transmittal #13-025	--Medicaid MAGI-related Residency SPA --Effective January 1, 2014

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 5, 2013

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed for your records is an approved copy of the following Wisconsin State Plan Amendment (SPA) 13-026-MM6, which was submitted to CMS on September 6, 2013. SPA 13-026 incorporates the Medicaid MAGI-related Citizenship and Immigration Status into Wisconsin's State Plan in accordance with the Affordable Care Act.

Transmittal #13-026 --Medicaid MAGI-related Citizenship and Immigration Status
--Effective January 1, 2014

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 442-9125 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

Table of Contents

State/Territory Name: WI

State Plan Amendment (SPA) #: 13-022-MM2

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) Approved SPA Pages
5) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
223 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 17, 2014

Brett Davis, Administrator and Medicaid Director
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Davis:

Enclosed is an approved copy of Wisconsin's state plan amendment (SPA) 13-022-MM2, which was submitted to CMS on September 6, 2013. SPA 13-022-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Wisconsin's Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

Until December 31, 2014, the state is using interim paper and online alternative single streamlined applications; both applications provide the option to apply for multiple human services programs. On or before December 31, 2014, the state will implement revised alternative single streamlined paper and online applications that address CMS concerns outlined in the companion letter issued with this SPA approval. Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the end of Wisconsin's approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 1 – Statement related to coordination of eligibility and enrollment
- Attachment 2– Statement of use with respect to the alternative single, streamlined online application
- Attachment 3 – Statement of use with respect to the alternative single, streamlined paper application

If you have any questions about the application, please contact Dena Greenblum at 410-786-8684, or by email at Dena.Greenblum@cms.hhs.gov. If you have any questions concerning this SPA, please contact Charles Friedrich at 608-442-9125, or by email at Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Al Matano, WI DHS

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

March 17, 2014

Brett Davis, Administrator
Division of Health Care Access and Accountability
Department of Health Services
1 West Wilson St., Room 350
Madison, WI 53701-0309

RE: Companion Letter for Wisconsin State Plan Amendment (SPA) Transmittal Number 13-022

Dear Mr. Davis:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) Transmittal Number 13-022-MM2, which was submitted to CMS on September 6, 2013. Our review of this submission included a review of the alternative single streamlined paper and online applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act. Both applications provide the option to apply for health coverage only or to apply for multiple human services programs.

Until December 31, 2014, the state is using interim alternative single streamlined paper and online applications. These interim applications need to be revised to reflect the following changes:

Necessary changes	**Completion Date**
The following questions will not appear on applications for health coverage only where the applicant has not indicated that he or she is aged, blind, or disabled:	
• Questions about absent parents, beyond an agreement to cooperate with child support (paper and online applications)	December 31, 2014

• Questions about non-MAGI income types such as SSI and Child Support (Receipt of SSI may be asked about as a non-MAGI screening question, but as below, that would only be for applicants, unlike other income questions) (paper and online applications)	May1, 2014
• Question about "support payments or obligations" (online application)	May 1, 2014
• Question about City/State/Country of birth (paper application)	May 1, 2014
• Has paternity been established? (paper application)	December 31, 2014
In the online application, the following questions will not appear for household members not seeking any benefits, and in the paper application, these questions will be designated for applicants only:	
• The non-MAGI screening questions related to disability, blindness and long term care need	May1, 2014
• Questions related to residency information.	December 31, 2014
• All citizenship and immigration questions, including request for Alien Registration Number.	December 31, 2014
Applicants will have the opportunity to identify themselves as American Indians and Alaska Natives for purposes of cost-sharing protections, and identify American Indian and Alaska Native income not countable for Medicaid and CHIP income determinations.	May 1, 2014
The state will integrate questions for Medicaid, CHIP and APTC into a single application. (This includes questions related to employer sponsored health coverage and annual income. For the online application, the system should use the income and	December 31, 2014

household attestation to trigger additional questions based on the program for which the applicant appears eligible.)	

Please submit the revised alternative paper and online applications to CMS for review no later than December 1, 2014 to ensure approval by December 31, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any questions about this letter, please contact Charles Friedrich, of my staff, at (608) 442-9125 or by e-mail at charles.friedrich@cms.hhs.gov.

Sincerely,

/s/

Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Al Matano, WI DHS

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Wisconsin

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.
WI-13-0022

Proposed Effective Date
10/01/2013

Federal Statute/Regulation Citation
42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment
Medicaid eligibility process

Governor's Office Review
Governor's office reported no comment
Comments of Governor's office received
Describe:

No reply received within 45 days of submittal
Other, as specified
Describe:

Signature of State Agency Official

Submitted By:	Alfred Matano
Last Revision Date:	Feb 20, 2014
Submit Date:	Sep 6, 2013

DATE RECEIVED: 9/6/2013	DATE APPROVED: 3/17/14
PLAN APPROVED -- ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2013	SIGNATURE OF REGIONAL OFFICIAL: /s/
TYPED NAME: Verlon Johnson	TITLE: Associate Regional Administrator
REMARKS:	

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process — **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

COORDINATION OF ELIGIBILITY AND ENROLLMENT	
TRANSMITTAL NUMBER: 13-022MM2	**STATE:** Wisconsin

Notwithstanding the final checked statement on page 2, the single state agency has not entered into an agreement with the Federally-facilitated Marketplace to date. The single state agency will make a good faith effort to enter into a memorandum of agreement with the Federally-facilitated Marketplace before April 1, 2014. At such time the agreement is signed, it will be incorporated by reference into this attachment

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: WI 13-022-MM2	**STATE:** Wisconsin

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER: 13-022 MM2	**STATE:** Wisconsin
Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

BADGERCARE+

Demonstration Project Waiver

Overview

The Wisconsin Department of Health Services is requesting a new five-year Section 1115 BadgerCare Plus Demonstration Project Waiver. The current BadgerCare Plus Core Plan for Adults Without Dependent Children Demonstration Project Waiver expires on December 31, 2013. The Department held three public information sessions in July 2013 to provide information about the waiver and to collect comments from the public regarding the waiver request. All public comments were due by **August 5, 2013**. The Department submitted the waiver to the federal Department of Health and Human Services (DHHS) on **August 9, 2013**.

Updated August 15, 2013: View Wisconsin's BadgerCare Plus Demonstration Project Waiver submitted to the federal government (PDF, 2.7 MB)

View the public notice about the BadgerCare Plus Demonstration Project Waiver. (PDF, 339 KB)

View Wisconsin's Proposed BadgerCare Plus Demonstration Project Waiver Request - Version Reviewed for Public Comment - July 2013. (PDF, 417 KB)

If Wisconsin's BadgerCare Plus Demonstration Project Waiver is approved by DHHS; effective January 1, 2014, Wisconsin will provide coverage to adults without dependent children who have attained the age of 19 and have not yet attained the age of 65 years with Medicaid coverage so long as their family income does not exceed 100% of the Federal Poverty Level (FPL). Additionally, Wisconsin will begin requiring a monthly premium for parents and caretakers relatives who qualify for transitional medical assistance (TMA).

Public Input

The Department held three (3) public hearings and one (1) tribal consultation around the State to solicit input on the BadgerCare Plus Demonstration Project Waiver request. Written or verbal statements were able to be made at the following public hearings:

- **Eau Claire** – July 10, 2013 – 11:00 am to 1:00 pm in the Room 115 of Chippewa Valley Technical College's Health Education Center at 615 W.

Clairemont Avenue, Eau Claire, WI 54701, view the presentation or join the meeting online.

- **Wausau** – Tribal Consultation – July 10, 2013 – 9:00 am to 1:00 pm at the Best Western – Midway at 2901 Hummingbird Road, Wausau, WI 54401.
- **Milwaukee** – July 11, 2013 – 11:00 am to 1:00 pm at the Radisson Milwaukee West at 2303 North Mayfair Road, Milwaukee, WI 53226, view the presentation or join the meeting online.
- **Green Bay** – July 11, 2013 – 11:00 am to 1:00 pm in the Walnut and Oak rooms of the Green Bay Kroc Center at 1315 Lime Kiln Road, Green Bay, WI 54311, view the presentation or Join the online meeting online.

In addition, written comments were able to be sent by fax, e-mail, regular mail to the Department or be submitted online. Comments were due no later than August 5, 2013.

Fax Number:	(608) 266-1096
Email Address:	DHSBCDemonstrationWaiver@dhs.wisconsin.gov
Mailing Address:	Al Matano Division of Health Care Access And Accountability P.O. Box 309 Madison, WI 53707-03091

Public comments will be included in the waiver request submitted to CMS on August 9, 2013.

Waiver Timeline

The Department submitted the BadgerCare Plus Demonstration Project Waiver to CMS on **August 9, 2013**.

Stay Informed

Sign up to receive email updates about BadgerCare Plus.

Email address:

(optional) Your name:

Subscribe

Accessibility

English
DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may

request assistance to participate by contacting Al Matano at (608)267-6848. You must make your request at least 7 days before the activity.

Spanish
DHS es una agencia que ofrece igualdad en las oportunidades de empleo y servicios. Si necesita algún tipo de acomodaciones debido a incapacidad o si necesita un interprete, traductor o esta información en su propio idioma o en un formato alterno, usted puede pedir asistencia para participar en los programas comunicándose con Kim Reniero al número (608)267-7939. Debe someter su petición por lo menos 7 días de antes de la actividad.

Hmong
DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm (608)267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

History of the Program

Wisconsin currently covers adults without dependent children (referred to as 'childless adults' throughout this notice) with incomes not exceeding 200% FPL, at the time of application or renewal, under the BadgerCare Plus Core Plan. Because of the federal budget neutrality requirements of the Core Plan waiver, enrollment has been capped since October 2009. As of April 2013 there were more than 145,000 individuals on a wait list. The limited benefit plan provided to this population does not meet either the federal creditable coverage requirement or the new Patient Protection and Affordable Care Act (PPACA)-mandated Essential Health Benefits requirements. The current BadgerCare Plus Core Plan for Adults Without Dependent Children demonstration project waiver expires on December 31, 2013.

The Department intends to submit a new demonstration project waiver to cover those childless adults, ages 19-64 years old, who meet Medicaid non-financial requirements (SSN, citizenship/identity, etc.); are not otherwise eligible for full-benefit Medicaid; are not entitled to Medicare; and have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology including a 5% disregard, not exceeding 100% of the FPL. Eligible individuals will no longer be required to pay an annual enrollment fee or a premium, and the program will not be subject to an enrollment cap. Eligible individuals will be enrolled in the BadgerCare Plus Standard Plan, which is the same plan provided to all beneficiaries enrolled in BadgerCare Plus.

The Department is also incorporating changes to the current Transitional Medicaid Assistance (TMA) Premium and Restrictive Re-Enrollment Period component of the Medicaid 2014 Demonstration Project Waiver into the new BadgerCare Plus Demonstration Project Waiver. TMA currently allows individuals to maintain their Medicaid coverage for 12 additional months if:

- They have received Medicaid as part of the Section 1931 coverage group for three of the last six months; and
- Their earnings have increased to a level that their total family income exceeds the Section 1931 coverage group eligibility income threshold. (In Wisconsin, the § 1931 eligibility income threshold is 100% of the federal

poverty level (FPL). TMA policy in Wisconsin has never been adjusted to reconcile expanded eligibility criteria for Medicaid).

As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), amending the BadgerCare and BadgerCare Plus for Childless Adults waivers, Wisconsin received waiver approval that allows us to require that non-pregnant, non-disabled adult individuals receiving Medicaid, including those on TMA with family incomes that exceed 133% of the FPL pay a monthly premium to maintain their Medicaid coverage. Those who either refuse to pay their monthly premium or who fail to pay a premium may be subject to a restrictive re-enrollment period, as currently applies.

If approved in the new BadgerCare Plus Demonstration Project Waiver, effective January 1, 2014, all adult parents and caretaker relatives who qualify for BadgerCare Plus coverage through TMA only, not just those with income not exceeding 133% FPL, will be required to pay the TMA premium. All other provisions of the current TMA policy remain the same. Individuals will continue to be covered under the BadgerCare Plus Standard Plan benefit plan with the same copayments and other cost sharing requirements as all other BadgerCare Plus beneficiaries, outside of the monthly premium.

Population and Numbers Served

If approved, the new BadgerCare Plus Demonstration Project Waiver would cover those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology including a 5% disregard, not exceeding 100% of the FPL;

The Department estimates that nearly 99,000 childless adults will enroll in BadgerCare Plus between January 1, 2014 and December 31, 2014.

The Department estimates that by January 1, 2014, when the change in TMA policies under this waiver is implemented, there will be 15,000 adult parents and caretaker relatives eligible under the TMA program. The new premium income limit of 100% of the FPL may result in 23% (3,450) reduction in the number of eligible adults.

Last Revised: January 09, 2014

The Official Internet site for the Wisconsin Department of Health Services

FOR IMMEDIATE RELEASE
July 1, 2013

CONTACT: Claire Smith, (608) 266-1683

DEPARTMENT OF HEALTH SERVICES TO HOLD TOWN HALL MEETINGS ON CHANGES TO BADGERCARE PLUS

MADISON—The Department of Health Services today announced town hall meetings that will be held around the state as part of the submission process for a new BadgerCare Plus Demonstration Project Waiver. The waiver is part of Governor Walker's entitlement reform initiative and will allow Wisconsin to provide health care coverage through BadgerCare Plus to all adults with no dependent children between ages 19 and 64 and who have incomes that do not exceed 100% of the federal poverty level.

"Governor Walker's entitlement reform initiative will be the first time that all Wisconsin citizens will have access to affordable health care," said Wisconsin Medicaid Director Brett Davis. "We expect a significant reduction in the number of uninsured adults in Wisconsin as a result of the Governor's efforts."

Governor Walker's entitlement reform plan was approved and signed into law on June 30, 2013 as part of 2013-2015 biennial budget. The Governor's plan is scheduled to be implemented at the same time that the federal health insurance exchanges and the majority of the PPACA-related changes are implemented. The Department of Health Services is working with the federal government to get the federal approval needed to make these changes.

Wisconsin's current BadgerCare Plus Core Plan for Adults Without Dependent Children Demonstration Project waiver expires on December 31, 2013. After it is approved by the federal government, the new BadgerCare Plus Demonstration Project Waiver will become effective January 1, 2014 and will provide coverage to individuals who:

- Are between ages 19 and 64 years old,
- Are not pregnant or parents or caretaker relatives of children under age 19,
- Are not otherwise eligible for full benefit BadgerCare Plus or Medicaid,
- Are not entitled to Medicare,
- Meet all Medicaid non-financial requirements like citizenship and identity, SSN, etc., and
- Have a gross income that is calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology that includes a 5% disregard and does not exceed 100% FPL.

The waiver will implement the following changes to BadgerCare Plus:

- All BadgerCare Plus members will receive health care coverage through the BadgerCare Plus Standard Plan,
- Eliminate the BadgerCare Plus Core Plan annual enrollment fee and monthly premiums,
- Remove the current enrollment cap for childless adults under 100% FPL, and
- Require all parents and caretaker relatives who qualify for transitional medical assistance (TMA) to pay a monthly premium.

The Department will hold three public information sessions to provide information about the BadgerCare Plus Demonstration Project Waiver and to collect comments from the public regarding the waiver request. All public comments will be communicated to the United States Department of Health and Human Services as part of the final waiver request. The Department intends to submit the waiver request to the Centers for Medicare and Medicaid Services (CMS) on August 9, 2013.

Eau Claire	
Wednesday July 10, 2013 11:00 a.m. to 1:00 p.m.	Chippewa Valley Technical College Health Education Center 615 W. Clairemont Avenue Eau Claire, WI
Milwaukee	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Radisson Milwaukee West 2303 North Mayfair Road Milwaukee, WI
Green Bay	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Green Bay Kroc Center Walnut and Oak Rooms 1315 Lime Kiln Road Green Bay, WI

***People needing special accommodations to attend or participate in the meeting should notify the Department of Health Services at 608-266-9622 (TTY 888-701-1250) by the day prior to the event.**

Individuals who are unable to attend the public information sessions but would like to provide comments will be able to submit comments directly to the department by fax, email, regular mail or online.

Online	http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
Fax	608-266-1096
Email Address	DHSBCDemonstrationWaiver@dhs.wisconsin.gov
Mailing Address	Al Matano Division of Health Care Access and Accountability P.O. Box 309 Madison, WI 53707-0309

All comments must be received by the Department no later than August 5, 2013.

# # #

Last Revised: July 08, 2013

PUBLIC NOTICE
Wisconsin Department of Health Services
(BadgerCare Plus Demonstration Project Waiver)

In accordance with federal law, the State of Wisconsin, Department of Health Services must notify the public of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) any new 1115 demonstration waiver project or extension of any previously approved demonstration waiver project, or ending of any previously approved expiring demonstration waiver projects and must provide an appropriate public comment period prior to submitting to CMS the new or extended 1115 demonstration waiver application.

This notice serves to meet these federal requirements and to notify the public that the State of Wisconsin intends to submit a request for a new BadgerCare Plus Demonstration Project Waiver to CMS on August 5, 2013. Two 1115 demonstration projects waivers: the BadgerCare and the BadgerCare Plus for Childless Adults Section 1115 Demonstrations, as amended by the Medicaid 2014 Demonstration Project Waiver on July 1, 2012, will expire on December 31, 2013. It is the Department's intent that the new BadgerCare Plus Demonstration Project Waiver will replace these expiring waivers. You can review the official waiver request and provide comments for the next 30 days (see below), as well as through written or verbal statements made at the following public hearings:

- Eau Claire – July 10 – 11:00 am to 1:00 pm in the Commons area of Chippewa Valley Technical College's Health Education Center at 615 W. Clairemont Avenue, Eau Claire, WI 54701
- Milwaukee – July 11 – 11:00 am to 1:00 pm at the Radisson Milwaukee West 2303 North Mayfair Road, Milwaukee, WI 53226
- Green Bay – July 11 – 11:00 am to 1:00 pm in the Walnut and Oak rooms of the Green Bay Kroc Center at 1315 Lime Kiln Rd, Green Bay, WI 54311

Your comments will be considered to determine if changes should be made to the waiver request, but will not impact proposed or enacted state and federal law. In addition, all public comments will be communicated to the U.S. Department of Health and Human Services (DHHS) as part of the final waiver request.

Accessibility

English

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may request assistance to participate by contacting Al Matano at (608)267-6848. You must make your request at least 7 days before the activity.

Spanish

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Hmong

DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm (608)267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

BACKGROUND

The State of Wisconsin reimburses providers for services provided to Medical Assistance recipients under the authority of Title XIX of the Social Security Act and Chapter 49 of the Wisconsin Statutes. This program, administered by the State's Department of Health Services, is called Medical Assistance (MA) or Medicaid. In addition, Wisconsin has expanded this program to create the BadgerCare and BadgerCare Plus programs under the authority of Title XIX and Title XXI of the Social Security Act and Chapter 49 of the Wisconsin Statutes. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services. A plan that describes the reimbursement system for the services (methods and standards for reimbursement) is now in effect.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize Research & Demonstration Projects, which are experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under §1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Wisconsin intends to seek approval of a demonstration project waiver under this federal authority.

If Wisconsin's BadgerCare Plus Demonstration Project Waiver is approved by the DHHS Secretary, effective January 1, 2014, Wisconsin will provide coverage to adults without dependent children who have attained the age of 19 and have not yet attained the age of 65 years with Medicaid coverage so long as their family income does not exceed 100% of the Federally Poverty Level (FPL). Additionally, Wisconsin will begin requiring a monthly premium for parents and caretakers relatives who qualify for transitional medical assistance (TMA).

PROJECT GOALS

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate
- Provide a standard set of comprehensive benefits that will lead to improved healthcare outcomes at no additional cost to state tax payers and the federal government
- Create a medical assistance program that is sustainable so our healthcare safety net is available to those who need it most

PROJECT DESCRIPTION

The Patient Protection and Affordable Care Act (PPACA) included provisions that will allow most individuals and families the opportunity to purchase private insurance through the Federally Facilitated

Marketplace. For those with incomes exceeding 100% FPL and not greater than 400% of the FPL, federal tax subsidies are available to help offset the cost of monthly premiums. Cost sharing limits and subsidies will also be available for many low-income individuals who purchase private insurance through the Federally Facilitated Marketplace.

Wisconsin is committed to ensuring that Wisconsin residents have access to affordable insurance. To coincide with the PPACA, the 2013-2015 biennial budget request includes a provision that would change the income eligibility threshold for adult parents and caretaker relatives from 200% of the Federal Poverty Limit (FPL) to 100% of the FPL. Similarly, childless adults, if this waiver request is approved, would be eligible for BadgerCare Plus Standard Plan benefits if their income does not exceed 100% of the FPL. Children and pregnant women will continue to be eligible for BadgerCare Plus so long as their incomes do not exceed 300% of the FPL and adults with incomes that do not exceed 100% FPL will be eligible to enroll in BadgerCare Plus. Adults with incomes above the poverty level will have access to private insurance coverage with assistance paying for their insurance in the new federal Marketplace starting on October 1, 2013 with coverage effective for January 1, 2014.

This waiver request also includes a change for adult parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA). TMA is a program which extends Medicaid for 12 months for certain individuals whose income has exceeded 100% of the FPL because of an increase in earnings. TMA also extends eligibility for 4 months for certain individuals whose income has exceeded 100% of the FPL because of an increase in child or spousal support. Under the new waiver, all non-disabled, non-pregnant parents and caretakers relatives who qualify for TMA will be required to pay a monthly premium. Those adults who refuse to pay or fail to pay the monthly premium will not be allowed to enroll in BadgerCare Plus for 12 months. Currently, the monthly premium only applies to those adult parents and caretaker relatives who have income exceeding 133% FPL. This waiver request asks the DHHS Secretary to approve a policy that would apply the TMA premium and restrictive reenrollment to all TMA adults and parents with incomes exceeding 100% FPL.

Below, this notice will briefly outline: 1) the current Medicaid eligibility and coverage standards for childless adults; and 2) the Transitional Medical Assistance Program, and describe the specific proposed changes sought to these programs through this waiver request.

1) Childless Adults Eligibility and Coverage

Current Program: Under the authority of an 1115(a) demonstration project waiver, Wisconsin currently covers adults without dependent children (referred to as 'childless adults' throughout this notice) with incomes not exceeding 200% FPL, at the time of application or renewal, under the BadgerCare Plus Core Plan. Because of the federal budget neutrality requirements of the Core Plan waiver, enrollment has been capped since October 2009. As of April 2013 there were more than 145,000 individuals on a wait list. The limited benefit plan provided to this population does not meet either the federal creditable coverage requirement or the new PPACA-mandated Essential Health Benefits requirements. The current BadgerCare Plus Core Plan for Adults Without Dependent Children demonstration project waiver expires on December 31, 2013. Historical enrollment and aggregate expenditures for childless adults under the current waiver by State Fiscal Years (SFYs) are as follows:

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,398	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,850	$106,538,654	$96,066,396

Wisconsin currently covers, under the BadgerCare Plus Core Plan for Adults Without Dependent Children, those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Do not have access to health insurance through a current employer in the month of application or in the subsequent three months, regardless of the amount of employer contribution toward the premium.
- Have not had access to health insurance through a current employer in the past 12 months, regardless of the amount of employer contribution toward the premium, unless there is a good reason for not signing up. (For example, circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.)
- Is not currently covered by a health insurance policy (through employer or individual policy) and has not been covered by a health insurance policy for the past 12 months, unless individual has a good cause reason for losing the coverage (loss of employment, etc.).
- Have a gross income below 200% of the FPL at the time of application or renewal
- Have completed a health needs assessment at application and annual renewal;
- Have paid the annual application fee of $60 (waived for individuals who are homeless);
- Have a premium requirement and a restrictive reenrollment period of 12 months if a premium is not paid;
- For continued eligibility, have had a physical exam within the first 12 month certification period.

Individuals who have met these eligibility requirements are enrolled in the Core Plan. The Core Plan covers basic health care services, including hospital inpatient and outpatient services, physician and clinic services and generic prescription drugs.

In May 2013, 18,253 individuals were enrolled in the Core Plan. This number has been limited by the agreement in the Core Plan waiver that imposed a federal budget neutrality cap on enrollment.

Waiver Proposal: Through a new demonstration project waiver, Wisconsin would cover those

individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology that does not exceed 100% of the FPL before application of a 5% disregard.

Eligible individuals will no longer be required to pay an annual enrollment fee or a premium, and the program will not be subject to an enrollment cap. Eligible individuals will also be enrolled in the BadgerCare Plus Standard Plan, which is the same plan provided to all beneficiaries enrolled in BadgerCare Plus.

We estimate that nearly 99,000 childless adults will enroll in BadgerCare Plus (an increase of approximately 82,000 individuals) between January 1, 2014 and December 31, 2014. We also estimate that nearly 5,000 childless adults will transition to the federal Marketplace and will be eligible for a federal tax subsidy.

We further project annual Medicaid enrollment and aggregate expenditures for childless adults is as follows:

	SFY 2014	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

2) Transitional Medical Assistance (TMA)

Current: TMA has existed in different forms since the enactment of the Omnibus Budget Reconciliation Act of 1981. It supports the transition from welfare to work by allowing individuals whose earnings have increased to continue to receive Medicaid for a period of time. In Wisconsin, TMA allows individuals to maintain their Medicaid coverage for 12 additional months if:

- They have received Medicaid as part of the Section 1931 coverage group for three of the last six months; and
- Their earnings have increased to a level that their total family income exceeds the Section 1931 coverage group eligibility income threshold. (In Wisconsin, the § 1931 eligibility income threshold is 100% of the federal poverty level (FPL).

As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), amending the BadgerCare and BadgerCare Plus for Childless Adults waivers, Wisconsin received

waiver approval that allows us to require that non-pregnant, non-disabled adult individuals receiving Medicaid, including those on TMA, with family incomes that exceed 133% of the FPL to pay a monthly premium to maintain their Medicaid coverage. As currently occurs, those who either refuse to pay their monthly premium or who fail to pay a premium may be subject to a restrictive re-enrollment period. A restrictive re-enrollment period (RRP) means the member cannot re-enroll in BC+ for twelve months from the termination date while their income remains high enough to owe a premium.

Historical enrollment and aggregate expenditures for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs) are as follows:

	SFY 2009	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013 Est.**
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

Waiver Proposal: We are incorporating the TMA Premium and Restrictive Re-enrollment Period component of the Medicaid 2014 Demonstration Project Waiver into the new BadgerCare Plus Demonstration Project Waiver with modifications. Beginning January 1, 2014, non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for Standard Plan BadgerCare Plus coverage through TMA only and whose income exceeds 100% of the FPL would be required to pay the TMA premium. Individuals will continue to be covered under the BadgerCare Plus Standard Plan benefit plan with the same copayments and other cost sharing requirements, other than the monthly premium, as all other BadgerCare Plus beneficiaries.

In May 2013, there were approximately 19,114 adults enrolled in BadgerCare Plus through TMA. The number of adults receiving coverage under the TMA program has steadily declined at a rate of 500 per month since the premium requirements included in the Medicaid 2014 Demonstration Project Waiver were implemented on July 1, 2012. We estimate that by January 1, 2014, when the policies under this waiver are implemented, there will be 15,000 adult parents and caretaker relatives eligible under the TMA program. Under the new premium income limit of 100% of the FPL, we estimate a reduction similar to when the premium requirement was implemented for adults with incomes exceeding 133% of the FPL, or 23% between July 2012 and December 2013. If this trend is indicative of the number of adults who will no longer be eligible for BadgerCare Plus under the TMA program, we estimate a further reduction of 3,450 adults by December 31, 2014, at which point the total number of adults eligible under the premium is expected to stabilize.

We further project annual Medicaid enrollment and aggregate expenditures for adults covered through Transitional Medical Assistance is as follows:

	SFY 2014	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**
Average Enrollment	15,000	11,550	11,550	11,550	11,550

Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

HYPOTHESIS AND EVALUATION PARAMETERS

To assess the demonstration, the State will conduct an evaluation. The demonstration evaluation will include an assessment of the following hypothesis:

1. By providing the standard Medical Assistance benefit plan to childless adults under poverty, the State will :
    - Improve health outcomes
    - Reduce the incidence of unnecessary services
    - Increase the cost effectiveness of Medical Assistance services
    - Increase the continuity of health coverage

Therefore, the evaluation will examine the demonstration across the spectrum of access, outcomes, and costs, with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other MA populations.

For the TMA demonstration we will continue to evaluate the impact of cost-sharing provisions on lower-income families above the poverty line. Questions the waiver evaluation will address will include whether or not participants will pay cost sharing, as well as whether or not the cost-sharing requirements will slow the growth of health care spending. The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the new federal Marketplace.

A detailed evaluation design will be developed for review and approval by the Centers for Medicare and Medicaid Services. The evaluator will use relevant data from the Medical Assistance program, and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter / utilization, chart reviews, and other administrative data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be performed to help inform the State, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be public and posted on the Department of Health Services website.

SPECIFIC WAIVER AND EXPENDITURE AUTHORITIES

Childless Adults: Wisconsin requests that DHHS waive § 1902(a)(34) and that, under authority of § 1115(a)(2) of the Act, expenditures identified for the demonstration population described below, which are not otherwise included as expenditures under§ 1903, be regarded as expenditures under Wisconsin's Medicaid State Plan.

Demonstration Population: Provide prospective Medicaid coverage to individuals between the ages of 19 and 64 with family income that does not exceed 100% of the FPL before applying the MAGI 5% disregard. Except for Wisconsin's Family Planning Services and Tuberculosis Medicaid, these individuals are not otherwise eligible for Medical Assistance or the State Children's Health Insurance Program (SCHIP).

TMA and RRP: Wisconsin requests that DHHS waive § 1902(a)(14) insofar as it incorporates section 1916, so that the demonstration population described below may be required to pay a monthly premium as a condition of continued TMA coverage and that those adults who refuse to pay or fail to pay are ineligible for the duration of the 12 month Restrictive Reenrollment Period.

Demonstration Population: Provide Medicaid coverage to non-disabled, non-pregnant adult parents and caretaker relatives who qualify for TMA because their total income, because of earnings or spousal support, exceeds Wisconsin's §1931 family income limit of 100% FPL.

COPIES OF DEMONSTRATION PROJECT WAIVER

Copies of Waiver Documents
A copy of waiver documents, including the waiver application once complete, may be obtained from the department at no charge by downloading the documents from http://dhs.wisconsin.gov/badgercareplus/waivers.htm or by contacting:

Regular Mail
Al Matano
Division of Health Care Access and Accountability
P.O. Box 309
Madison, WI 53707−0309
Phone
Al Matano
(608)267−6848
FAX
(608)261−7792
E−Mail
Alfred.Matano@dhs.wisconsin.gov

WRITTEN COMMENTS

Written comments are welcome and will be accepted through July 30, 2013. Written comments on the changes may be sent by FAX, e-mail, or regular mail to the Division of Health Care Access and Accountability. The FAX number is (608) 266-1096. The e-mail address is BCDemonstrationWaiver@dhs.wisconsin.gov.

Regular mail can be sent to the above address.

Public comments will be included in the waiver request submitted to CMS on August 5, 2013 and will be available on the department's web site at the address listed above.

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State of Wisconsin
BadgerCare Plus Demonstration Project Waiver

Coverage of Adults Without Dependent Children with Income At or Below 100% of the Federal Poverty Level and Requiring Monthly Premiums for Adult Parents and Caretaker Relatives for Transitional Medical Assistance (TMA)

Draft 1115 Demonstration Project Application

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Introduction

The State of Wisconsin has been a leader in Medicaid and CHIP program innovation for many years. We were one of the first states to streamline and simplify our programs for families, pregnant women and children and one of the few states that expanded Medicaid to cover adults without dependent children. It has always been our goal to provide quality health coverage for our citizens. With the implementation of the Patient Protection and Affordable Care Act (ACA) provisions that will provide federally-funded subsidies to help individuals and families purchase private health insurance and that place limits on the amount of cost sharing that can be required of certain individuals and families, Wisconsin sees an opportunity to both decrease the ranks of the uninsured in our State, but also to facilitate the transition of those adults who have incomes above the poverty line and who have been dependent upon Medicaid for health coverage onto private health insurance.

Background

Wisconsin has successfully achieved widespread health care access without a federal mandate. In 1999, the state implemented BadgerCare to provide a health care safety net for low-income families transitioning from welfare to work. BadgerCare Plus expanded coverage to families at higher income levels than had been covered under the Medicaid program.

Beginning in 2008, the following groups were eligible for coverage:

1) All uninsured children (birth through age 18)
2) Pregnant women with incomes at or below 300% of the FPL
3) Parents and caretaker relatives with incomes at or below 200% of the FPL

In 2009, childless adults with incomes at or below 200% FPL became eligible through the BadgerCare Plus Core Plan approved by an 1115 waiver.

Subsequently, in 2011, Wisconsin submitted the Medicaid 2014 Demonstration Project, amending the BadgerCare and BadgerCare Plus Core Plan demonstrations, to allow Wisconsin to require that non-pregnant, non-disabled adult parents and caretaker relatives whose incomes exceeds 133% FPL to pay a monthly premium.. This amendment was approved by the Center for Medicaid and Medicare Services (CMS) in April 2012 with an effective date of July 2012.

Demonstration Project Overview

PPACA included provisions that will allow most individuals and families the opportunity to purchase private insurance through the Federally Facilitated Marketplace (FFM). For those with incomes greater than 100% FPL and not greater than 400% of the FPL, federal tax subsidies are available to help offset the cost of monthly premiums. Limits on out of pocket spending and additional subsidies for cost-sharing may also be available for low-income individuals who purchase private insurance through the FFM.

Wisconsin is committed to ensuring that Wisconsin residents have access to affordable insurance. In conjunction with the PPACA, the Wisconsin 2013-2015 biennial budget includes a provision that will change the income eligibility threshold for adult parents and caretaker relatives from 200% of the Federal Poverty Limit (FPL) to 100% of the FPL. Children and pregnant women will continue to be eligible for BadgerCare Plus so long as their incomes do not exceed 300% of the FPL and childless adults with incomes at or below 100% FPL will be eligible to enroll in BadgerCare Plus. The budget also includes a provision that childless adults, if this waiver request is approved, will be eligible for BadgerCare Plus Standard Plan benefits if their income does not exceed 100% of the FPL. All adults not otherwise eligible for BadgerCare Plus with incomes above the poverty level will have access to subsidized private insurance coverage in the FFM starting on October 1, 2013 with coverage effective on January 1, 2014.

This waiver request also includes a change for adult parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA). TMA is a program which extends Medicaid for twelve months for certain individuals who, with the Medicaid eligibility changes approved in the 2013-2015 budget, have income exceeding 100% of the FPL due to an increase in earnings. TMA also extends eligibility for 4 months for certain individuals whose income has exceeded 100% of the FPL due to an increase in child or spousal support. Under the new waiver, all non-disabled, non-pregnant parents and caretaker relatives who quality for TMA will be required to pay a monthly premium. Those adults who refuse to pay or fail to pay the monthly premium will not be allowed to enroll in BadgerCare Plus for twelve months. Currently, the monthly premium only applies to those non-pregnant, non-disabled adult parents and caretaker relatives who have income greater than 133% FPL. This waiver request asks the Department of Health and Human Services (DHHS) Secretary to approve a policy that would apply the TMA premium and restrictive reenrollment to all non-pregnant, non-disabled TMA adults and parents with incomes greater than 100% FPL.

Project Objectives

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate
- Provide a standard set of comprehensive benefits that will lead to improved healthcare outcomes at no additional cost to state tax payers and the federal government
- Create a program that is sustainable so our healthcare safety net is available to those who need it most

Demonstration Populations

Demonstration Population 1: Childless adults eligible for coverage under this demonstration are defined as individuals between the ages of 19 and 64 years with income that does not exceed 100% of the FPL at the time of application or annual renewal. They are individuals who are not pregnant, or qualified for any other Medicaid, Medicare, or CHIP program. Childless adults may have children, but

either the minor children are not currently living with them or those children living with them are 19 years of age or older.

Wisconsin requests that DHHS waive § 1902(a)(34) and that, under authority of § 1115(a)(2) of the Act, expenditures identified for the demonstration population described below, which are not otherwise included as expenditures under§ 1903, be regarded as expenditures under Wisconsin's Medicaid State Plan.

Demonstration Population 2: Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act, who are non-pregnant, non-disabled, and whose countable family income is above 100% of the of the FPL.

Wisconsin requests that DHHS waive § 1902(a)(14) insofar as it incorporates section 1916, so that the demonstration population described below may be required to pay a monthly premium as a condition of continued TMA coverage and that those adults who refuse to pay or fail to pay are ineligible for the duration of the 12 month Restrictive Reenrollment Period (RRP).

Demonstration Project Description

Childless Adults Eligibility and Coverage

Since their inception, the Medicaid and CHIP programs have been focused on covering children, pregnant women, the parents and caretaker relatives of minor children, people with disabilities, elderly adults and others with medical needs because of specific health conditions (breast cancer, tuberculosis, need for long term care, etc.). Wisconsin was one of only a handful of states who expanded its Medicaid program to provide limited health coverage through Medicaid to childless adults. In 2009, when Wisconsin expanded Medicaid for childless adults there were few other health coverage alternatives available to this group even with incomes up to two times the poverty level. This will change with the enactment of the PPACA provisions that allow for the coverage of this group under Medicaid and provisions that provide federal funding to support premium and cost sharing obligations for private health insurance. With this in mind, Wisconsin is seeking this waiver to provide Medicaid coverage for childless adults with incomes that do not exceed 100% of the FPL, to allow those childless adults with higher incomes the opportunity to participate in the private insurance market (with federal financial supports) and to transition these individuals from dependency on public health coverage to independence through enrollment in private health insurance plans.

Current Program: Under the authority of an 1115(a) demonstration project waiver, Wisconsin currently covers adults without dependent children (referred to as 'childless adults' throughout this application) with incomes not exceeding 200% FPL, at the time of application or renewal, under the BadgerCare Plus Core Plan. Enrollment has been capped since October 2009 because of the federal budget neutrality requirements of the Core Plan waiver. As of April 2013 there are currently more than 145,000 individuals on a wait list. The limited benefit plan provided to this population does not meet either the federal creditable coverage requirement or the new PPACA-mandated Essential Health Benefits requirements. The current BadgerCare Plus Core Plan for Adults Without Dependent Children

Demonstration Project Waiver expires on December 31, 2013. Historical enrollment and aggregate expenditures (based on date of payment) for childless adults under the current waiver by State Fiscal Years (SFYs) are as follows:

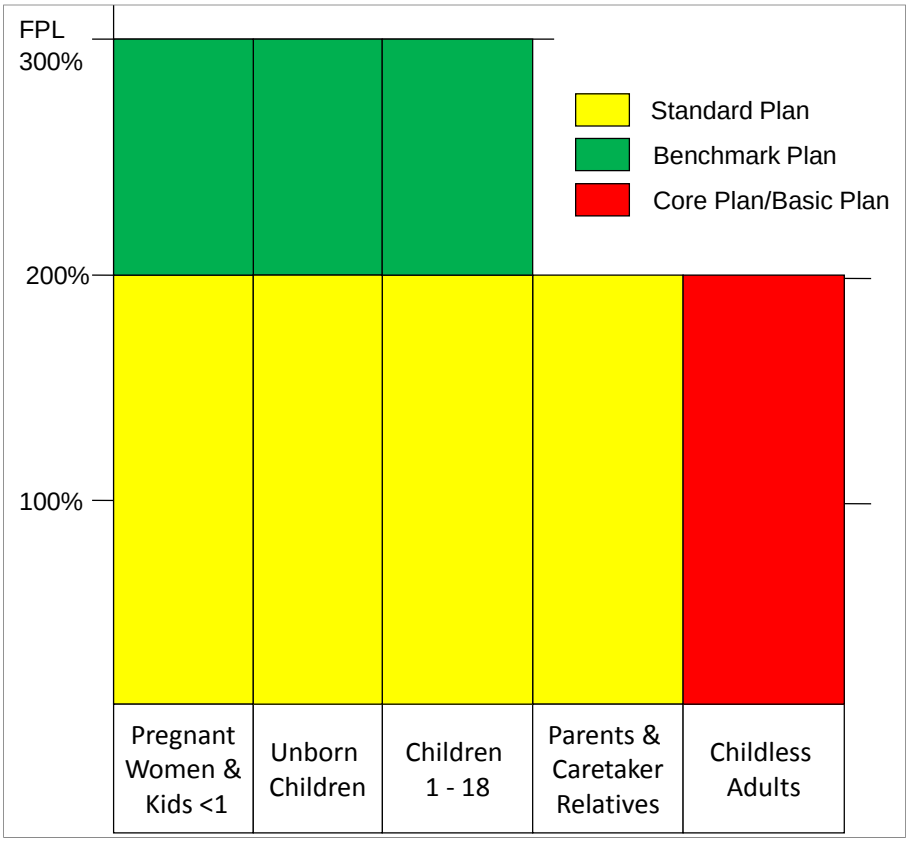
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,398	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,850	$106,538,654	$96,066,396

Wisconsin currently covers, under the BadgerCare Plus Core Plan for Adults Without Dependent Children, those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Do not have access to health insurance through a current employer in the month of application or in the subsequent three months, regardless of the amount of employer contribution toward the premium.
- Have not had access to health insurance through a current employer in the past twelve months, regardless of the amount of employer contribution toward the premium, unless there is a good reason for not signing up. (For example, circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.)
- Is not currently covered by a health insurance policy (through employer or individual policy) and has not been covered by a health insurance policy for the past twelve months, unless individual has a good cause reason for losing the coverage (loss of employment, etc.).
- Have a gross income that does not 200% of the FPL at the time of application or renewal;
- Have completed a health needs assessment at application and annual renewal;
- Have paid the annual application fee of $60 (waived for individuals who are homeless);
- Have a premium requirement and a restrictive reenrollment period of twelve months if a premium is not paid;
- For continued eligibility, have had a physical exam within the first twelve month certification period.

Individuals who have met these eligibility requirements are enrolled in the Core Plan or the Core Plan waitlist based on the plan's existing enrollment cap. Table 1 shows both the current eligibility limits for all children, pregnant women, adult parents and caretaker relatives and childless adults and the plans that cover each group.

Table 1 - Current BadgerCare Plus Eligibility Limits and Benefit Plans



The current Core Plan covers outpatient hospital and emergency room services, physician services, podiatry, reproductive health, smoking cessation services and emergency transportation. It has limited coverage of disposable medical supplies, generic and some brand name drugs, durable medical equipment, home care/personal care, inpatient hospital and speech, occupational and physical therapies. The copayments in the Core Plan are much higher than the Standard Plan and are mandatory. There are two different levels of copayments in the Core Plan with higher copayments for those with incomes above 100% of the FPL than for those whose income does not exceed 100% of the FPL.

Table 2 shows the discrepancies between the current Core Plan (childless adults), benchmark plan (pregnant women and children above 200% of the FPL) and the Standard Plan (pregnant women, children under 19, parents and caretaker relatives at or below 200% of the FPL).

Table 2 - Comparison of Core, Benchmark and Standard Plans

Full Coverage in All Plans – Chiropractic, Hospital OP & ED, Physician, Podiatry, Reproductive Health, and Emergency Transportation

Service	Standard Plan	Benchmark Plan	Core Plan
Dental			
DMS			
Drugs			
DME			
Hearing			
Home Care/Personal Care			
Hospital - IP			
Behavioral			
Nursing Home			
Therapies			
Vision			
Smoking Cessation			
NEMT			

Green = Full Coverage, Yellow = Limited Coverage, Red = No Coverage

As of May 2013, 18,253 individuals were enrolled in the Core Plan. As previously noted, enrollment has been limited by the agreement in the Core Plan waiver that imposed a federal budget neutrality cap on enrollment.

Waiver Proposal (Demonstration Population 1): Through a new demonstration project waiver, Wisconsin would cover those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit Medicaid/BadgerCare Plus;
- Are not entitled to Medicare; and
- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology, that does not exceed 100% of the FPL before application of a 5% disregard.

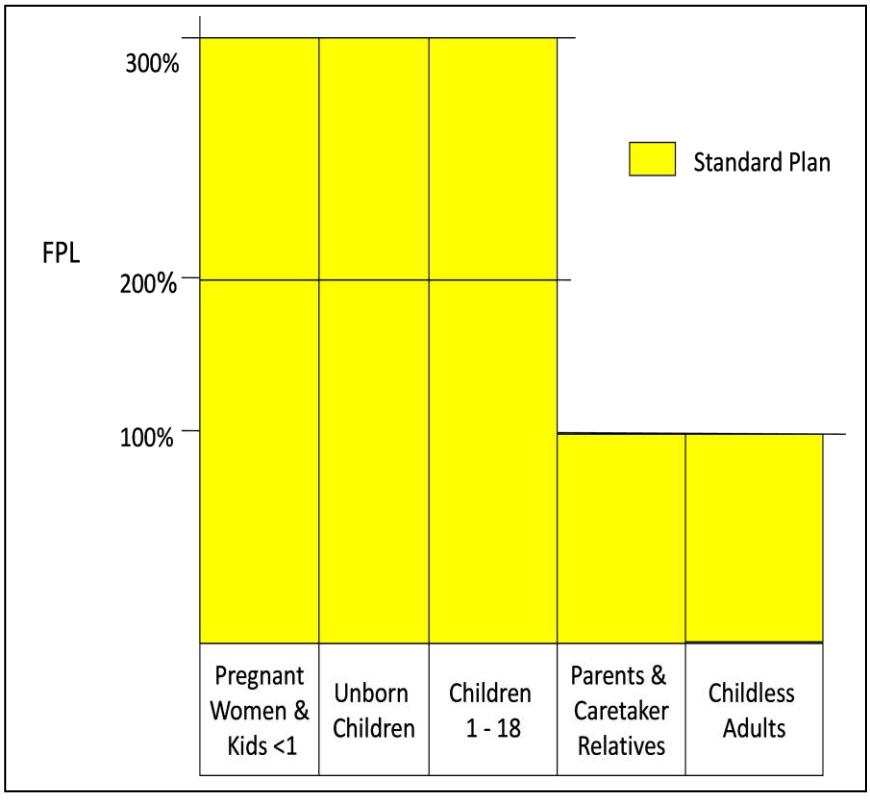
Eligible individuals will no longer be required to pay an annual enrollment fee or a premium, and the program will not be subject to an enrollment cap. Eligible individuals will also be enrolled in the BadgerCare Plus Standard Plan, which will be the same plan provided to all beneficiaries enrolled in BadgerCare Plus starting in 2014. Table 3 shows BadgerCare Plus eligibility limits and benefit plans effective January 1, 2014 with the approval of this waiver request.

For this proposed demonstration project, the projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for childless adults is as follows:

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

The BadgerCare Plus Standard Plan covers all of these services and charges nominal copayments. Consequently, the plan being offered under the new BadgerCare Plus Demonstration Project Waiver for childless adults will cover all of the services that had been covered under the Core Plan, however it removes limitations that had been imposed for DMS, drugs, DME, home care/personal care, inpatient hospital, and therapies and adds dental, hearing, behavioral health, long term care, vision and non-emergency medical transportation services. The cost sharing will be nominal, as is the cost sharing for the Standard Plan for all other populations.

Table 3 - BadgerCare Eligibility Limits and Benefit Plans 1/1/14



We estimate that nearly 99,000 childless adults will enroll in BadgerCare Plus between January 1, 2014 and December 31, 2014 (an increase of approximately 82,000 individuals). We also estimate that nearly 5,000 childless adults will transition to the FFM and will be eligible for a federal tax subsidy and reduced cost sharing.

Transitional Medical Assistance (TMA)

TMA has existed for many years to support the transition from welfare to work. TMA allows non-disabled, non-pregnant adult individuals to maintain their Medicaid coverage for twelve additional months once their income changes from an amount that would have qualified them for benefits under the former Aid to Families with Dependent Children (AFDC) cash assistance program to an amount above that income threshold. In Wisconsin, the AFDC income threshold is 100% of the FPL. This waiver is intended to align Wisconsin's TMA policy needs with both the new BadgerCare Plus eligibility limits for adult parents and caretaker relatives and the FFM with financial supports for qualifying individuals.

Current: TMA has existed in different forms since the enactment of the Omnibus Budget Reconciliation Act (OBRA 81). It supports the transition from welfare to work by allowing individuals whose earnings have increased to continue to receive Medicaid for a period of time. In Wisconsin, TMA allows individuals to maintain their Medicaid coverage for twelve additional months if:

- They have received Medicaid as part of the Section 1931 coverage group for three of the last six months; and
- Their earnings or spousal support has increased to a level that their total family income exceeds the Section 1931 coverage group eligibility income threshold. (In Wisconsin, the § 1931 eligibility income threshold is 100% of the federal poverty level (FPL).

As part of the Medicaid 2014 Demonstration Project, Wisconsin received a waiver that allows us to require non-pregnant, non-disabled adult individuals receiving Medicaid, including those on TMA, with family incomes that exceed 133% of the FPL to pay a monthly premium to maintain their Medicaid coverage. As currently occurs, those who either refuse to pay their monthly premium or who fail to pay a premium may be subject to a RRP. A RRP means the member cannot re-enroll in BadgerCare Plus for twelve months from the termination date while their income remains high enough to owe a premium.

Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs) are as follows:

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

Waiver Proposal: We are incorporating the TMA premium and RRP component of the Medicaid 2014 Demonstration Project (effective July 1, 2012) into the new BadgerCare Plus Demonstration Project Waiver with modifications. Beginning January 1, 2014, all non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, would be required to pay the TMA premium, not just those with income greater than 133% FPL. All other provisions of the current TMA policy remain the same. Individuals will continue to be covered under the BadgerCare Plus Standard Plan benefit plan with the same copayments and other cost sharing requirements as all other BadgerCare Plus beneficiaries, outside of the monthly premium.

The affected populations will be subject to monthly premiums based on the sliding scale as outlined below. Pre-payment of the first month's premium payment is required at time of enrollment. Demonstration participants are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled. Demonstration participants who fail to make a premium payment will be prohibited from re-enrolling into the Medicaid program for a period of twelve months.

Monthly Premium Amount based on FPL Percentage	Monthly Premium Amount as a Percentage of Income
100.01 – 119.99%	2.0%
120 – 132.99%	2.5%
133 – 139.99%	3.0%
140 – 149.99%	3.5%
150 – 159.99%	4.0%
160 – 169.99%	4.5%
170 – 179.99%	4.9%
180 – 189.99%	5.4%
190 – 199.99%	5.8%
200 – 209.99%	6.3%
210 – 219.99%	6.7%
220 – 229.99%	7.0%
230 – 239.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.1%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

As of May 2013, there were approximately 19,114 adults enrolled in BadgerCare Plus through TMA. The number of adults receiving coverage under the TMA program has steadily declined at a rate of 500 per month since the premium and RRP requirements included in the 2014 Medicaid Demonstration Project were approved and implemented on July 1, 2012. We estimate that by January 1, 2014, when the policies under this waiver are implemented, there will be 15,000 adult parents and caretaker relatives eligible under the TMA program. Under the new premium income limit of 100% of the FPL, we estimate a reduction similar to when the premium was implemented for adults with incomes greater than 133% of the FPL, which was -23% between July 2012 and December 2013. If this trend is indicative of the number of adults who will no longer be eligible for BadgerCare Plus under the TMA program starting in 2014, then we estimate a further reduction of 3,450 adults by December 31, 2014, at which point the total number of adults eligible under the premium is expected to stabilize.

For this proposed demonstration project, the projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance is as follows:

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

Budget and Cost Effectiveness Analysis

Approach to Ensuring Federal Budget Neutrality

Federal policy requires s. 1115 waiver demonstrations be budget neutral to the federal government. This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Particulars, including methodologies, are subject to negotiation between the State submitting the demonstration application and the federal Centers for Medicare and Medicaid Services (CMS).

To ensure budget neutrality for each federal fiscal year of this new, 5-year Demonstration, Wisconsin uses a per-member per-month (PMPM) based methodology specific to the Wisconsin childless adult population under 100% of FPL, in the context of current federal and state law, and with the appropriate, analytically sound baselines and adjustments. This includes:

- For an initial baseline figure for the average PMPM for a childless adult in 2013, use of most recent 12 months of expenditures for childless adults (HMO and fee-for-service), converted to an average PMPM, is the most accurate representation of the primary baseline costs associated with the current limited benefit package for this population and includes payments made under the actuarially sound, CMS-approved capitation rates.

- Adjustments to reflect, as appropriate:

    1. The incremental PMPM cost of the standard Medicaid services not covered under the current limited benefit package, most notably behavioral health services, pharmacy benefits, and non-emergency medical transportation.

    2. The lower cost sharing in the Medicaid standard benefit package.

    3. Use of Disproportionate Share Hospital (DSH) payments, expressed on a PMPM basis.

- Use of an analytically appropriate per capita trend factor. When demonstrating federal budget neutrality under a PMPM-based methodology, States typically use the national, Medicaid-specific per trends reflected in the President's most recent Proposed Budget.

- Multiplying aggregate average annual PMPM figures by the State's applicable Federal Medical Assistance Percentage (FMAP) for benefits.

- Conversion of figures from SFY or calendar year bases to a federal fiscal year basis.

With regards to budget neutrality for the Transitional Medical Assistance population, this proposal increases revenues that will offset expenditures. Therefore, budget neutrality will be achieved

Public Involvement and Public Comments

This section is reserved for completion following the public comment process on this draft application.

Following completion of the public comment period, this section will describe in detail the State's public comment process (including public notice, website, and public meetings) and describe the comments received through the various means offered.

Evaluation Activities and Findings

To assess the demonstration, the State will conduct an evaluation. The demonstration evaluation will include an assessment of the following hypotheses:

By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:

- Improve health outcomes
- Reduce the incidence of unnecessary services
- Increase the cost effectiveness of Medical Assistance services
- Increase the continuity of health coverage

Therefore, the evaluation will examine the demonstration across the spectrum of access, outcomes, and costs, with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

For the TMA demonstration we will continue to evaluate the impact of cost-sharing provisions on lower-income families above the poverty line. Questions the waiver evaluation will address will include whether or not participants will pay cost sharing, as well as whether or not the cost-sharing requirements will slow the growth of health care spending. The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the FFM.

A detailed evaluation design will be developed for review and approval by CMS. The evaluator will use relevant data from the BadgerCare Plus program, and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter / utilization, chart reviews, and other administrative

data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be conducted to help inform the State, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be made public and posted on the Wisconsin Department of Health Services website.

Wisconsin BadgerCare Plus Demonstration Project Waiver

Wisconsin Division of Health Care Access and Accountability

Public Hearing – Green Bay

July 11, 2013

1

Presentation Outline

- Wisconsin Vision and Commitment
- Program Background
- Waiver Request
- Demonstration
- Proposed Timeline
- Comments
- Questions

2

Wisconsin Vision and Commitment

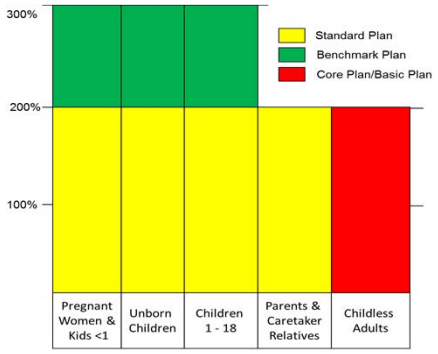
Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.

Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.

Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

3

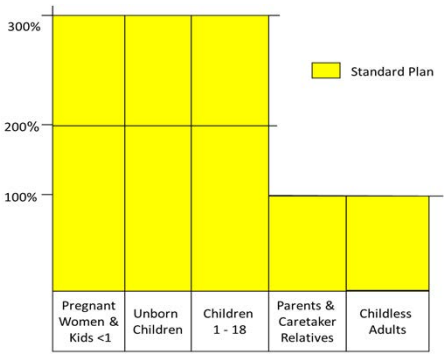
Current BadgerCare Plus Health Plans



BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	484,164	247,712	16,450	769,130

4

BadgerCare Plus Health Plan - 2014



BadgerCare Plus Enrollment - Projected in Budget				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	522,695	160,255	98,641	802,395

5

2013 Federal Poverty Levels

Monthly Income Levels by Family Size

Family size	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1	$957.50	$1,149.00	$1,273.48	$1,292.63	$1,436.25	$1,915.00	$2,393.75	$2,872.50
2	$1,292.50	$1,551.00	$1,719.03	$1,744.88	$1,938.75	$2,585.00	$3,231.25	$3,877.50
3	$1,627.50	$1,953.00	$2,164.58	$2,197.13	$2,441.25	$3,255.00	$4,068.75	$4,882.50
4	$1,962.50	$2,355.00	$2,610.13	$2,649.38	$2,943.75	$3,925.00	$4,906.25	$5,887.50

6

Existing Waivers

- Wisconsin currently has two existing waivers that authorize the BadgerCare Plus programs, the BadgerCare and BadgerCare Plus Childless Adult (Core Plan) Waivers.
- Both of these waivers will be expiring on December 31, 2013.
- The newly proposed BadgerCare Plus Demonstration Project Waiver will contain some elements of each of the existing waivers, as well as the new demonstration components discussed throughout this presentation.

7

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver
  - Program began in 2009.
  - Adults without dependent children (referred to as childless adults) with incomes up to 200% FPL.
  - Enrollment is capped and a waitlist is maintained.
  - Benefit plan is limited and does not comply with the Essential Health Benefits requirements of the federal government.
  - Waiver expires December 31, 2013.

8

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver members are:
  - 19 to 64 years of age;
  - Not pregnant or parents or caretaker relatives of children under age 19;
  - Not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
  - Not entitled to Medicare;
  - And meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.).

9

Core Plan Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for childless adults under the current waiver by State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,398	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,850	$106,538,654	$96,066,396

10

Transitional MA Background

Transitional Medical Assistance (TMA):

- TMA allows non-disabled, non-pregnant adults and children to maintain their Medicaid coverage for twelve months once their earning or spousal support rises above the amount that would have qualified them for benefits under the former Aid to Families with Dependent Children cash assistance program (100% FPL).
- As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), Wisconsin requires non-pregnant, non-disabled adults receiving Medicaid, including those on TMA, with family incomes above 133% of the FPL to pay a monthly premium. Those who do not pay a premium cannot re-enroll in BadgerCare Plus for twelve months while their income remains high enough to owe a premium.

11

Historical Transitional MA Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

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BadgerCare Plus Demonstration Project Waiver Request

- Cover all Wisconsin adult residents with incomes below the federal poverty line – 100% FPL.
- Simplify benefits design:
  - o One benefit package, the Standard Plan, for adults.
  - o Clearer for providers, less administratively cumbersome to manage, and more easily understood by the people served.
  - o More comprehensive set of services than was previously available under the Core Plan (mental/behavioral health, preventive dental, non-emergency medical transportation, etc.).

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Background - Comparing Current Plans

Service	Standard Plan	Benchmark Plan	Core Plan
Dental			
Durable Medical Equipment and Supplies			
Drugs			
Hearing			
Home Care/Personal Care			
Hospital - Inpatient			
Behavioral			
Nursing Home			
Therapies			
Vision			
Smoking Cessation			
Non-Emergency Medical Transportation			

Full Coverage in All Plans – Chiropractic, Hospital Outpatient & Emergency Department, Physician, Podiatry, Reproductive Health, and Emergency Transportation

Full Coverage Limited Coverage No Coverage

14

BadgerCare Plus Demonstration Project Waiver Request

Establish a new five-year waiver project that will:

- Allow for the coverage of adults without dependent children with incomes not to exceed 100% FPL.
- Require all non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, to pay ACA-level premiums beginning at 100% FPL.

15

Demonstration

- By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:
  - Improve health outcomes.
  - Increase the cost effectiveness of Medical Assistance services.
  - Reduce the incidence of unnecessary services.
  - Increase the continuity of health coverage.
- DHS will evaluate this hypothesis with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

16

Proposed Childless Adult Eligibility

If approved, effective Jan 1, 2014:

- Eligible individuals will no longer be required to pay an annual enrollment fee.
- Eligible childless adults will not be subject to an enrollment cap.
- Eligible individuals will be enrolled in the Standard Plan.

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Projected Childless Adult Enrollment & Expenditures

- Projected annual enrollment and aggregate expenditures (based on date of payment) for childless adults by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

18

Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Adult participants with income that exceeds 100% FPL are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled.
- Adult participants who fail to make a premium payment cannot re-enroll as a parent or caretaker relative into the Medicaid program for a period of twelve months.

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Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Affected eligible members will be subject to monthly premiums (between 2-9.5% of income) based on a sliding scale.
- Pre-payment of the first month's premium payment is required.

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Projected Transitional MA Enrollment & Expenditures

- Projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

21

Budget Neutrality

- Federal policy requires s. 1115 waiver demonstrations be budget neutral to the federal government.
- This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration.
- For the childless adults population, Wisconsin proposes to use a per-member per-month (PMPM) based methodology specific to the Wisconsin childless adult population under 100% of FPL to achieve budget neutrality.
- For transitional MA, budget neutrality will be demonstrated based on a reduction in aggregate expenditures or a reduction in the PMPM.

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Proposed Timeline

Major Milestones	Tentative Date
Public Notice Issued	July 1, 2013
Comment Period Closed	August 5, 2013
Waiver Submission	August 09, 2013
CMS Approval	Late September 2013
Benefits Effective Date	January 1, 2014

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Comments

Comments may be submitted by August 5, 2013 using the following methods:

- Online - http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
- Email - DHSBCDemonstrationWaiver@dhs.wisconsin.gov
- Fax - 608-266-1096
- Mail

  Al Matano
  Division of Health Care Access and Accountability
  P.O. Box 309
  Madison, WI 53707-0309

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Questions

25

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

For Immediate Release
August 9, 2013

Contact: Claire Smith
(608) 266-1683

DEPARTMENT OF HEALTH SERVICES SUBMITS BADGERCARE PLUS WAIVER TO CENTERS FOR MEDICARE AND MEDICAID SERVICES

Waiver will allow Department to provide access to health care for all adults living in poverty

MADISON— The Department of Health Services today announced that it has submitted a new BadgerCare Plus Demonstration Project Waiver to the Centers for Medicare and Medicaid Services (CMS). The waiver is part of Governor Walker's entitlement reform initiative and will allow Wisconsin to provide health care coverage through BadgerCare Plus to all childless adults between ages 19 and 64 and who have incomes that do not exceed 100% of the federal poverty level.

"Today's submission of the new BadgerCare Plus waiver takes us one step closer to realizing Governor Walker's goal of providing all Wisconsin citizens with access to affordable health care," said Wisconsin Medicaid Director Brett Davis. "We expect a significant reduction in the number of uninsured adults in Wisconsin as a result of the Governor's efforts."

Governor Walker's entitlement reform plan was approved and signed into law on June 30, 2013 as part of 2013-2015 biennial budget. The Department of Health Services is working with the federal government to get the federal approval needed to make these changes through the waiver request.

As part of the waiver submission process, the Department provided the opportunity for public comment on the proposed waiver through in person town hall meetings and an online submission form. Many of the comments that the Department received related to definitions and clarifications of certain terms used in the waiver application, questions on the benefits that members will receive, and questions on differences between the new waiver and the existing waivers. The waiver request includes all of the comments that the Department received.

In addition, the type of waiver that the Department is submitting allows states the flexibility to customize their Medicaid and Children's Health Insurance Program (CHIP) – called BadgerCare Plus in Wisconsin—programs to meet the needs of their citizens, as long as it is at no additional cost to taxpayers. Through this waiver, Wisconsin seeks to provide full Medicaid benefits through the Standard Plan, including enhanced mental health benefits and preventive benefits, to all adults in poverty who are enrolled in Medicaid and BadgerCare Plus. It is anticipated that offering the same benefits to all adults in poverty will lead to savings for Wisconsin taxpayers because helping individuals get access to these enhanced benefits in the primary care setting will help avoid costly and unnecessary emergency room and in-patient hospital stays.

Wisconsin's current BadgerCare Plus Childless Adults Demonstration Project waiver expires on December 31, 2013. Pending approval by the federal government, the new BadgerCare Plus Demonstration Project Waiver will become effective January 1, 2014 and will provide coverage to individuals who:

- Are between ages 19 and 64 years old,

- Are not pregnant or parents or caretaker relatives of children under age 19,
- Are not otherwise eligible for BadgerCare Plus for Families or Medicaid,
- Are not entitled to Medicare,
- Meet all Medicaid non-financial requirements like citizenship and identity, SSN, etc., and
- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology, that does not exceed 100% of the FPL before application of a 5% disregard.

The waiver will implement the following changes to BadgerCare Plus:

- Provide all BadgerCare Plus members with Standard Plan benefits,
- Eliminate the BadgerCare Plus Core Plan,
- Remove the current enrollment cap for childless adults under 100% FPL, and
- Require all parents and caretaker relatives who qualify for transitional medical assistance (TMA) to pay a monthly premium.

For additional information about the waiver, go to www.dhs.wisconsin.gov/badgercareplus/waivers.htm

# # #

State of Wisconsin
BadgerCare Plus Demonstration Project Waiver

Coverage of Adults Without Dependent Children with Income At or Below 100% of the Federal Poverty Level and Requiring Monthly Premiums for Adult Parents and Caretaker Relatives for Transitional Medical Assistance (TMA)

1115 Demonstration Project Application

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Introduction

The State of Wisconsin has been a leader in Medicaid and CHIP program innovation for many years. We were one of the first states to streamline and simplify our programs for families, pregnant women and children and have been one of the few states to provide coverage for adults without dependent children. It has always been our goal to provide quality health coverage for our citizens. With the implementation of the Patient Protection and Affordable Care Act (ACA) provisions that will provide federally-funded subsidies to help individuals and families purchase private health insurance, Wisconsin sees an opportunity to both reduce the uninsured rate and help people become less dependent on government. We see this as a means to facilitate the transition of those adults who have incomes above the poverty line and who have been dependent upon Medicaid for health coverage onto private health insurance. For the first time in our state history every Wisconsin resident will have access to affordable health insurance.

Background

Wisconsin has successfully achieved widespread health care access without a federal mandate. In 1999, the state implemented BadgerCare to provide a health care safety net for low-income families transitioning from welfare to work. Beginning in 2008, BadgerCare Plus expanded coverage to families at higher income levels than had been covered under the Medicaid program, making the following groups eligible for coverage:

1) All uninsured children (birth through age 18)
2) Pregnant women with incomes at or below 300% of the federal poverty limit (FPL)
3) Parents and caretaker relatives with incomes at or below 200% of the FPL

In 2009, childless adults with incomes at or below 200% FPL became eligible through the BadgerCare Plus Core Plan approved by an 1115 waiver.

More recently, in 2011, Wisconsin submitted the Medicaid 2014 Demonstration Project, amending the BadgerCare and BadgerCare Plus Childless Adult demonstrations, to allow Wisconsin to require that non-pregnant, non-disabled adult parents and caretaker relatives whose incomes exceed 133% FPL to pay a monthly premium, which aligned with the sliding scale premiums established under the ACA for private health insurance exchanges. This amendment was approved by the Center for Medicare and Medicaid Services (CMS) in April 2012 with an effective date of July 2012.

Project Objectives

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate
- Provide a standard set of comprehensive benefits that will lead to improved healthcare outcomes at no additional cost to state tax payers and the federal government
- Create a program that is sustainable so our healthcare safety net is available to those who need it most

Demonstration Project Overview

The ACA included provisions that will allow most individuals and families the opportunity to purchase private insurance through the Federally Facilitated Marketplace (FFM). For those with incomes greater than 100% FPL and not exceeding 400% FPL, federal tax subsidies are available to help offset the cost of monthly premiums. Limits on out of pocket spending and additional subsidies for cost-sharing may also be available for low-income individuals who purchase private insurance through the FFM.

Wisconsin is committed to ensuring that Wisconsin residents have access to affordable insurance. In conjunction with the ACA, the Wisconsin 2013-2015 biennial budget includes a provision that will change the income eligibility threshold for adult parents and caretaker relatives from 200% FPL to 100% FPL. Childless adults with incomes not exceeding 100% FPL will be eligible to enroll in BadgerCare Plus. Children and pregnant women will continue to be eligible for BadgerCare Plus as long as their income does not exceed 300% FPL. The budget also includes a provision that childless adults, if this waiver request is approved, will be eligible for BadgerCare Plus Standard Plan benefits if their income does not exceed 100% of the FPL. All adults not otherwise eligible for BadgerCare Plus with incomes above the poverty level will have access to subsidized private insurance coverage in the FFM starting on October 1, 2013 with coverage effective on January 1, 2014. Additionally, Wisconsin will provide the same Presumptive Eligibility (PE) path for childless adults that is provided for adult parents and caretakers.

This waiver request also includes a change for adult parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA). TMA is a program which extends Medicaid for a length of time specified in federal law for children, pregnant women, and adult parents/caretaker relatives who, with the Medicaid eligibility changes approved in the 2013-2015 budget, have income exceeding 100% of the FPL due to an increase in earnings or child/spousal support. Under the new waiver request, all non-disabled, non-pregnant parents and caretaker relatives who quality for TMA will be required to pay a monthly premium. Those adults who do not pay the monthly premium will not be allowed to enroll in BadgerCare Plus for twelve months. Currently, the monthly premium only applies to those non-pregnant, non-disabled adult parents and caretaker relatives who have income exceeding 133% FPL. This waiver request asks the United States Department of Health and Human Services (DHHS) Secretary to approve a policy that would apply the TMA premium and restrictive reenrollment to all non-pregnant, non-disabled TMA adults and parents with incomes exceeding 100% FPL.

Demonstration Populations

Demonstration Population 1: Childless adults eligible for coverage under this demonstration are defined as individuals between the ages of 19 and 64 years with income that does not exceed 100% FPL. They are individuals who are not pregnant, or do not qualify for any other Medicaid, Medicare, or CHIP program. Childless adults may have children, but either the minor children are not currently living with them or those children living with them are 19 years of age or older. Additionally, the childless adult population will also be provided with the same PE coverage afforded to adult parents and caretaker relatives:

- Wisconsin will allow presumptive eligibility for childless adults to be determined and certified by qualified hospitals, in the same way that this will be done for parents and caretaker relatives with incomes not exceeding 100% FPL.

Wisconsin requests that DHHS waive the applicable sections of §1902(a) to allow for the operation of this waiver. In addition, Wisconsin requests that, under authority of §1115(a)(2) of the Act, expenditures identified for the demonstration population described above, which are not otherwise included as expenditures under §1903, be regarded as expenditures under Wisconsin's Medicaid State Plan.

Demonstration Population 2: Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under §1925 of the Act, who are non-pregnant, non-disabled, and whose countable family income exceeds 100% FPL.

Wisconsin requests that DHHS waive §1902(a)(14) insofar as it incorporates §1916, so that the demonstration population described below may be required to pay a monthly premium as a condition of

continued TMA coverage and that those adults who do not pay are ineligible for the duration of the 12 month Restrictive Reenrollment Period (RRP).

Demonstration Project Description

Childless Adults Eligibility and Coverage

Since their inception, the Medicaid and CHIP programs have been focused on covering children, pregnant women, the parents and caretaker relatives of minor children, people with disabilities, elderly adults and others with medical needs because of specific health conditions (breast cancer, tuberculosis, need for long term care, etc.). Wisconsin was one of only a handful of states who expanded its Medicaid program to provide limited health coverage through Medicaid to childless adults. In 2009, when Wisconsin expanded Medicaid for childless adults there were few other health coverage alternatives available to this group even with incomes up to two times the poverty level. This will change with the enactment of the ACA provisions that allow for the coverage of this group under Medicaid and provisions that provide federal funding to support premium and cost sharing obligations for private health insurance. With this in mind, Wisconsin is seeking this waiver to provide Medicaid coverage for childless adults with incomes that do not exceed 100% FPL, to allow those childless adults with higher incomes the opportunity to participate in the private insurance market (with federal financial supports) and to transition these individuals from dependence on public health coverage to independence through enrollment in private health insurance plans.

Current Program: Under the authority of an 1115(a) demonstration project waiver, Wisconsin currently covers adults without dependent children (also referred to as 'childless adults' throughout this application) with incomes not exceeding 200% FPL, at the time of application or renewal, under the BadgerCare Plus Core Plan. Enrollment has been capped since October 2009 because of the federal budget neutrality requirements of the BadgerCare Plus Childless Adults Demonstration Waiver, which authorized the Core Plan. As of August 5, 2013 there were 157,259 individuals on the wait list for Core Plan coverage. The limited benefit plan provided to this population does not meet either the federal creditable coverage requirement or the new ACA-mandated Essential Health Benefits requirements. The current BadgerCare Plus Childless Adults Demonstration Project Waiver expires on December 31, 2013. Historical enrollment and aggregate expenditures (based on date of payment) for childless adults under the current waiver by State Fiscal Years (SFYs) are as follows:

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,398	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,850	$106,538,654	$96,066,396

Note: Historical waiver population income limit was 200% FPL with an enrollment cap beginning October 2009

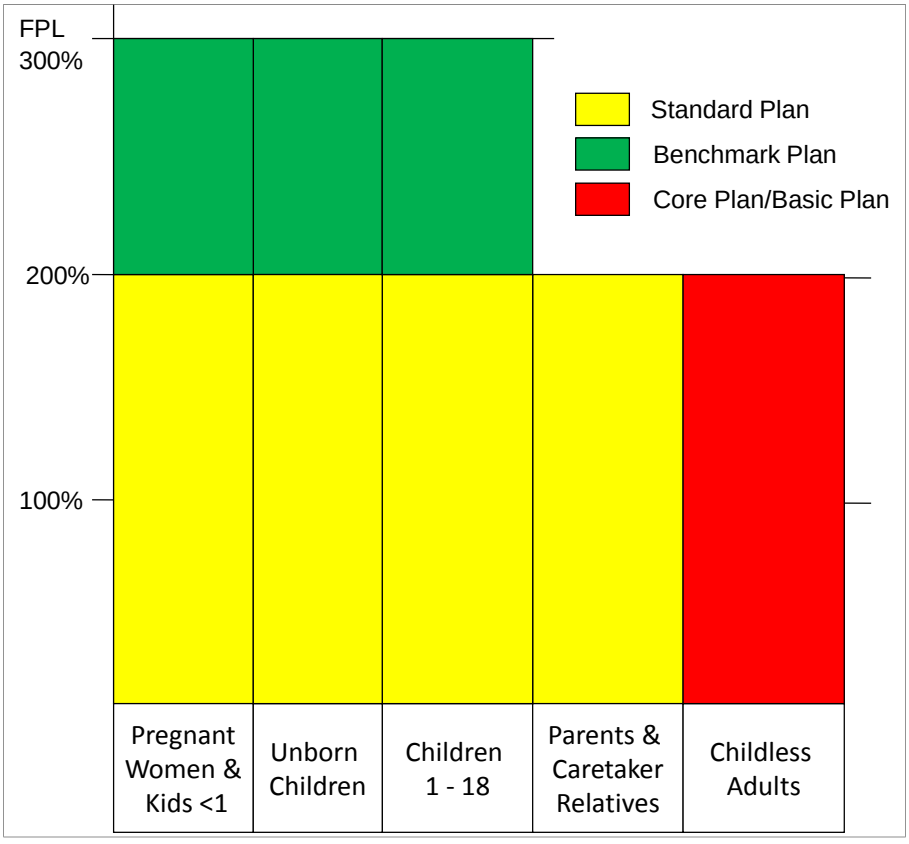
Wisconsin currently covers, under the BadgerCare Plus Core Plan, those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or custodial parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;

- Do not have access to health insurance through a current employer in the month of application or in the subsequent three months, regardless of the amount of employer contribution toward the premium;
- Have not had access to health insurance through a current employer in the past twelve months, regardless of the amount of employer contribution toward the premium, unless there is a good reason for not signing up (For example, circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support);
- Is not currently covered by a health insurance policy (through employer or individual policy) and has not been covered by a health insurance policy for the past twelve months, unless the individual has good cause for losing the coverage (loss of employment, etc.);
- Have a gross income that does not exceed 200% FPL at the time of application or renewal;
- Have completed a health needs assessment at application and annual renewal;
- Have paid the annual application fee of $60 (waived for individuals who are homeless);
- Have a premium requirement and a restrictive reenrollment period of twelve months if a premium is not paid; and
- For continued eligibility, have had a physical exam within the first twelve month certification period.

Individuals who have met these eligibility requirements are enrolled in the Core Plan or placed on the Core Plan waitlist based on the plan's existing enrollment cap. Table 1 shows both the current eligibility limits for all children, pregnant women, adult parents and caretaker relatives and childless adults and the plans that cover each group.

Table 1 - Current BadgerCare Plus Eligibility Limits and Benefit Plans

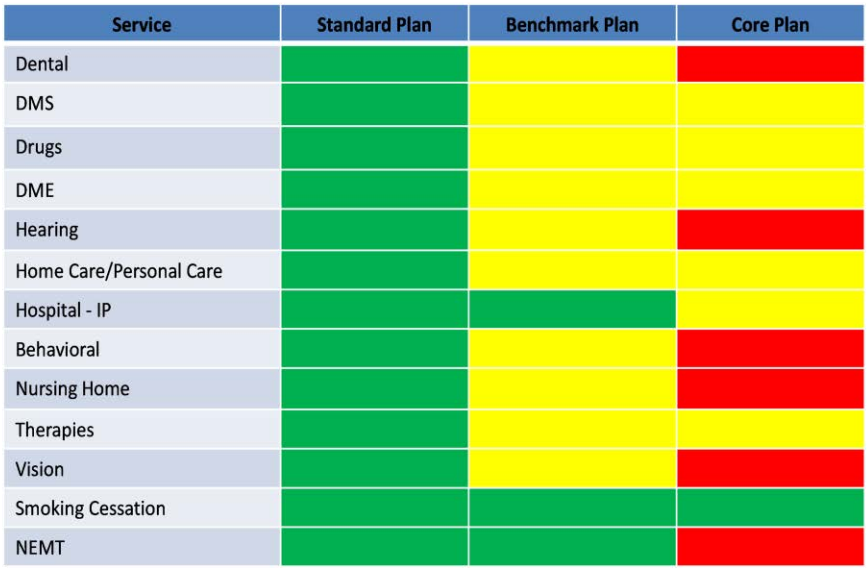


The current Core Plan covers outpatient hospital and emergency room services, physician services, podiatry, reproductive health, smoking cessation services and emergency transportation. It has limited coverage of disposable medical supplies, generic and some brand name drugs, durable medical equipment, home care/personal care, inpatient hospital and speech, occupational and physical therapies. The copayments in the Core Plan are much higher than the Standard Plan and are mandatory. There are two different levels of copayments in the Core Plan with higher copayments for those with incomes exceeding 100% FPL than for those whose income does not exceed 100% FPL.

Table 2 shows the discrepancies between the current Core Plan (childless adults), Benchmark Plan (pregnant women and children exceeding 200% FPL) and the Standard Plan (pregnant women, children under 19, parents and caretaker relatives at or not exceeding 200% FPL).

Table 2 - Comparison of Core, Benchmark and Standard Plans

Full Coverage in All Plans – Chiropractic, Hospital OP & ED, Physician, Podiatry, Reproductive Health, and Emergency Transportation



Service	Standard Plan	Benchmark Plan	Core Plan
Dental			
DMS			
Drugs			
DME			
Hearing			
Home Care/Personal Care			
Hospital - IP			
Behavioral			
Nursing Home			
Therapies			
Vision			
Smoking Cessation			
NEMT			

Green = Full Coverage, Yellow = Limited Coverage, Red = No Coverage

As of June 2013, 17,791 individuals were enrolled in the Core Plan. As previously noted, enrollment has been limited by the agreement in the Core Plan waiver that imposed a federal budget neutrality cap on enrollment.

Waiver Proposal (Demonstration Population 1): Through a new demonstration project waiver, Wisconsin would cover those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or custodial parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit Medicaid/BadgerCare Plus;
- Are not entitled to Medicare; and

- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology, that does not exceed 100% of the FPL before application of a 5% disregard.

Eligible individuals will no longer be required to pay an annual enrollment fee, and the program will not be subject to an enrollment cap. Eligible individuals will also be enrolled in the BadgerCare Plus Standard Plan, which will be the same plan provided to all beneficiaries enrolled in BadgerCare Plus starting in 2014. Table 3 shows BadgerCare Plus eligibility limits and benefit plans effective January 1, 2014 with the approval of this waiver request.

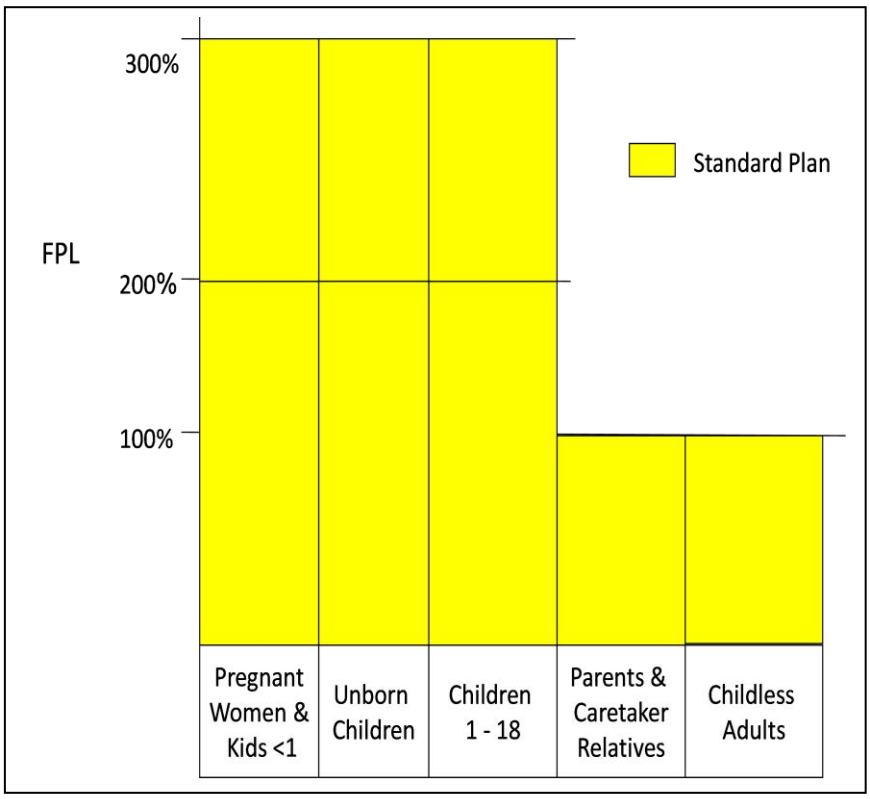
While eligible individuals will no longer be required to have completed a health needs assessment at application and annual renewal, the Wisconsin Department of Health Services will share data with the health plans to ensure that the health plans can effectively manage the new enrollee population.

For this proposed demonstration project, the projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for childless adults is as follows:

	SFY 2014	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

The BadgerCare Plus Standard Plan covers all of these services and charges nominal copayments. Consequently, the plan being offered under the new BadgerCare Plus Demonstration Project Waiver for childless adults will cover all of the services that had been covered under the Core Plan, however it removes limitations that had been imposed for DMS, drugs, DME, home care/personal care, inpatient hospital, and therapies and adds dental, hearing, behavioral health, long term care, vision and non-emergency medical transportation services. The cost sharing will be nominal, as is the cost sharing for the Standard Plan for all other populations.

Table 3 - BadgerCare Eligibility Limits and Benefit Plans 1/1/14



We estimate that nearly 99,000 childless adults will enroll in BadgerCare Plus between January 1, 2014 and December 31, 2014 (an increase of approximately 82,000 individuals). We also estimate that nearly 5,000 childless adults will transition to the FFM and will be eligible for a federal tax subsidy and reduced cost sharing.

Wisconsin Medicaid remains committed to Managed Care as the preferred service delivery model for serving all BadgerCare Plus and related populations in a manner that meets the financial requirements of our contracted MCOs, and satisfies the public policy health care goals and objectives of the Medicaid program. These goals and objectives include value-based purchasing, beneficiary access to care and services, continuous quality improvement and financial fairness for both the State and its health plan partners. However, we also recognize that Medicaid coverage for a new previously uninsured childless adult population may present actuarial challenges and introduce additional risk and new concerns for both the State and our health plan partners. Conversely, this potential uncertainty creates an opportunity for Wisconsin to consider and potentially demonstrate new innovative payment constructs for serving the newly covered beneficiaries.

In order to address these challenges we are currently poised to explore potential alternative payment constructs with our health plan partners for serving the childless adult population. Although, no additional waivers are anticipated, the consideration and potential implementation of these alternative payment constructs are included as a part of this waiver request and aimed at providing a fair and reasonable degree of protection against health plan medical losses that are not addressed through other currently employed risk mitigation methodological techniques, such as CDPS risk adjustment. Payment constructs being explored include Accountable Care-like payment mechanisms that mitigate risk while creating incentives for cost efficiency, contributing to budget neutrality and maintaining standards for access and

quality. While financial fairness, risk mitigation, and containing the rate of future cost increases are important objectives, the approach must also support the overarching goals to implement value based purchasing, maintain beneficiary access to care and services and promote continuous quality improvement through reporting and dissemination of health plan utilization and quality data.

Several Integrated Health Care Delivery Systems in Wisconsin have been operating within an ACO delivery model for some time. Some of these health systems have affiliations with health plans currently contracted to serve Medicaid beneficiaries. Wisconsin is assessing whether an ACO-like model, which has been promoted by CMS as an acceptable alternative delivery and payment construct for State Medicaid programs serving dual eligible beneficiaries, can be demonstrated as an effective payment construct for the childless adult waiver population.

Several key ACO concepts that will be addressed through any ACO-like payment construct demonstrated under the proposed waiver include:

- Shared savings
- Reducing costs
- Promoting evidence based medicine
- Engaging beneficiaries in their care
- Establishing and adhering to cost and quality metrics
- Coordinating care

A potential component of a Wisconsin ACO-like shared savings construct could include utilizing quality and efficiency measures and metrics to determine levels and thresholds of shared savings. Our model would strive to identify and partner with our contracted health plans to reduce inefficiency and waste in the delivery of services while promoting and incentivizing high quality effective care delivery. A plan could incorporate and achieve efficiencies by utilizing the 3M Health Information Systems products for identifying and classifying encounters/events in five major service areas that are *potentially preventable* and have the largest clinical and payment impact. These represent a combination of overtreatment, complications, unnecessary services, and inappropriate care.

Transitional Medical Assistance (TMA)

TMA has existed for many years to support the transition from welfare to work. Currently, TMA allows families to maintain their Medicaid coverage for twelve additional months once their income changes from an amount that would have qualified them for benefits under the former Aid to Families with Dependent Children (AFDC) cash assistance program to an amount above that income threshold. With the end of the AFDC program in 1996, TMA continued for families eligible under §1931 of the Social Security Act. In Wisconsin, the current §1931 income threshold is 100% FPL. This waiver is intended to align Wisconsin's TMA policy needs with both the new BadgerCare Plus eligibility limits for adult parents and caretaker relatives and the FFM with financial supports for qualifying individuals.

Current: TMA has existed in different forms since the enactment of the Omnibus Budget Reconciliation Act (OBRA 81). It supports the transition from welfare to work by allowing families whose earnings have increased to continue to receive Medicaid for a period of time. In Wisconsin, TMA allows families to maintain their Medicaid coverage for twelve additional months if:

- They have received Medicaid as part of the §1931 coverage group for three of the last six months; and

- Their earnings or child/spousal support has increased to a level that their total family income exceeds the §1931 coverage group eligibility income threshold.

As part of the Medicaid 2014 Demonstration Project, Wisconsin received a waiver that allows us to require non-pregnant, non-disabled adult parents and caretaker relatives receiving Medicaid, including those on TMA, with family incomes that exceed 133% FPL to pay a monthly premium to maintain their Medicaid coverage. As currently occurs, those who do not pay their monthly premium may be subject to a RRP. A RRP means the member cannot re-enroll in BadgerCare Plus for twelve months from the termination date while their income remains high enough to owe a premium.

Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs) are as follows:

	SFY 2009	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013 Est.**
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

Waiver Proposal: We are incorporating the TMA premium and RRP component of the Medicaid 2014 Demonstration Project (effective July 1, 2012) into the new BadgerCare Plus Demonstration Project Waiver with modifications. Beginning January 1, 2014, all non-disabled, non-pregnant, adult parents, and caretaker relatives excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, would be required to pay the TMA premium, not just those with income that exceeds 133% FPL. The length of the TMA extension will be based upon applicable federal law. All other provisions of the current TMA policy remain the same. Individuals will continue to be covered under the BadgerCare Plus Standard Plan benefit plan with the same copayments and other cost sharing requirements as all other BadgerCare Plus beneficiaries, outside of the monthly premium.

The affected populations will be subject to monthly premiums based on the sliding scale as outlined below. Pre-payment of the first month's premium is required at time of enrollment. Demonstration participants are responsible for making a monthly premium payment as a condition of continuing their eligibility and re-enrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled. Demonstration participants who fail to make a premium payment will be prohibited from re-enrolling into the Medicaid program for a period of twelve months.

Monthly Premium Amount based on FPL Percentage	**Monthly Premium Amount as a Percentage of Income**
100.01 – 119.99%	2.0%
120 – 132.99%	2.5%
133 – 139.99%	3.0%
140 – 149.99%	3.5%
150 – 159.99%	4.0%
160 – 169.99%	4.5%
170 – 179.99%	4.9%
180 – 189.99%	5.4%
190 – 199.99%	5.8%

200 – 209.99%	6.3%
210 – 219.99%	6.7%
220 – 229.99%	7.0%
230 – 239.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.1%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

As of May 2013, there were approximately 19,114 adults enrolled in BadgerCare Plus through TMA. Since the premium and RRP requirements included in the 2014 Medicaid Demonstration Project were approved and implemented on July 1, 2012, the length of time adults spend in TMA has become shorter, resulting in a monthly enrollment decline of approximately 500 per month. We estimate that by January 1, 2014, when the policies under this waiver are implemented, there will be 15,000 adult parents and caretaker relatives eligible under the TMA program. Under the new premium income limit of 100% FPL, we estimate that adults will transition from the program at a rate similar to when the premium was implemented for adults with incomes exceeding 133% FPL, which was -23% between July 2012 and December 2013. If this trend is indicative of the number of adults who will no longer choose to remain in BadgerCare Plus under the TMA program starting in 2014, we estimate a further enrollment decrease of 3,450 adults by December 31, 2014, at which point the total number of adults choosing to remain in the program is expected to stabilize.

For this proposed demonstration project, the projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance is as follows:

	SFY 2014	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

Budget Neutrality

Federal policy requires §1115 waiver demonstrations be budget neutral to the federal government. This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration. Determination of federal budget neutrality for purposes of a §1115 demonstration application must follow a unique process that is distinct from federal and state budgeting and health plan rate setting. The processes, methods, and calculations required to appropriately demonstrate federal budget neutrality are for that express purpose only. Therefore, the budget neutrality model shown here should not be construed as a substitute for budgeting and rate setting or imply any guarantee of any specific payment.

To ensure budget neutrality for each federal fiscal year of this new, 5-year demonstration, Wisconsin uses a per-member per-month (PMPM) based methodology specific to the two waiver populations, the childless adult population with incomes not exceeding 100% FPL and adult parents and caretaker relatives with incomes greater than 100% FPL. The per member per month calculation has been established in the context of current federal and state law, and with the appropriate, analytically sound baselines and adjustments. The following process shows that the federal cost of this Demonstration in each year are no greater than federal costs absent the new Demonstration and therefore the demonstration is budget neutral to the federal government.

Budget Neutrality for the Childless Adults Population Not Exceeding 100% FPL

Methodology for Without Waiver Calculation:

The Without Waiver (WOW) amounts are determined using the following steps

Step 1: Historical Baseline PMPM for Childless Adults with Limited Benefits

Step 1 is to determine an initial baseline PMPM figure for an average Wisconsin childless adult enrollee under the limited benefit package in CY 2013. The methodology and data for Step 1 are:

a. The most recent 12 months of expenditures for childless adults (HMO and FFS, all funds) for the period May 1, 2012 through April 30, 2013, converted to an average statewide PMPM figure.

b. The PMPM figure under (a) above is converted to a CY 2013 annualized basis using the applicable trend factor (described below in Step 3) for 2013 applied to months of May 2013 through December 2013.

The result is the most accurate baseline representation of the costs associated with this population for the limited benefit package in CY 2013. Based on the experience of the Core population, a baseline PMPM calculated on this basis is the most relevant data to use for the waiver budget neutrality. It includes payments made under the actuarially sound, CMS-approved capitation rates. Using a three-year average or some other approach would not provide an accurate or valid figure for the PMPM cost of an average childless adult enrollee with the current limited benefit package, nor would it reflect current market conditions for meeting HMO's financial requirements for continued participation in serving the childless adult population.

Step 2: Adjustments to Historical Baseline PMPM for Standard Benefit Package

Step 2 adjusts the initial baseline PMPM figure for childless adults with limited benefits in CY 2013 for standard Medicaid benefits not reflected in Step 1. The adjustments are the incremental, analytically sound PMPM cost for an average childless adult in CY 2013 for:

a. Medical costs of the standard Medicaid benefit package. That is, the incremental PMPM cost of the standard Medicaid services not covered under the limited package:

    1) Behavioral health, including mental health and substance abuse services now provided to childless adults not exceeding 100% FPL by counties with State and local funds.

    2) Pharmacy benefits not covered under the limited benefit, most notably brand drugs.

    3) Dental, hearing, chiropractic, and eyeglass benefits.

    4) Non-emergency medical transportation.

b. Cost sharing and cost sharing limitations. That is, the incremental PMPM cost of the lower cost sharing and fewer coverage or service limitations under the standard Medicaid benefit package.

The methodology and data sources for the PMPM adjustments are as follows:

Behavioral Health: The PMPM adjustment to reflect increased behavioral health benefits has two components:

1. Projected PMPM equivalent cost of county mental health services provided to uninsured childless adults not exceeding 100% FPL in CY 2013. This figure is derived from:

    - Actual county behavioral health spending in 2011 as reported to the state through the Wisconsin Human Services Revenue Reporting (HSRR) system. These are all non-federal dollars.

    - Applying applicable annual trend factors for 2012 and 2013. This results in a total of $457.7 million for CY 2013.

    - Adjusting for Wisconsin-specific population characteristics, chronicity, and insurance status using the most recent federal survey data. This results in the conservative projection that 33% of current county behavioral health spending ($151.04 million in CY 2013) is attributable to uninsured childless adults not exceeding 100% FPL.

    - Applying take-up rate of 65%. Since counties will have a strong incentive to assist newly eligible childless adults to enroll in Medicaid, this adjustment is highly conservative and may not be necessary.

    - Assuming that the effects of pent-up demand, HMO utilization management, and broader pharmacy benefits on behavioral health expenditures will net out.

    - The above results in a PMPM of $83.39 in CY 2013.

2. PMPM for behavioral health professional services covered under the standard Medicaid benefit but not provided under the limited benefit. This is $4.37 PMPM based on analysis of the CY 2013 portion of HMO statewide capitation rate applicable to adult men age 45-65. This is likely a conservative figure for childless adults.

Pharmacy Benefit: The PMPM adjustment for pharmacy benefits reflects the broader drug coverage under the standard benefit, specifically the much broader coverage of brand drugs, coverage of certain OTC drugs, and lower co-payments on scripts. These factors, coupled with expected increase in brand and generic utilization associated with increased behavioral health coverage under the standard benefit, are conservatively projected to increase PMPM pharmacy spend by childless adults by 32% or $90.24 on a 2013 basis.

Dental, Hearing, Chiropractic, and Eyeglass Benefits: This PMPM adjustment is based on analysis of CY 2013 HMO statewide capitation rates for adult men age 45-65 applicable to these individual services covered under the standard benefit but not under the limited benefit. Specifically, dental $4.45, hearing $0.50, chiropractic $1.10, and eyeglasses $0.50 for total projected PMPM of $6.55 for CY 2013.

Non-Emergency Medical Transportation (NEMT): This PMPM adjustment is based on our analysis of actual NEMT expenditures in 2011 for adult males covered under BadgerCare Plus, converted to a statewide weighted average, and adjusted for the higher service utilization of childless adults reflected in the post-adjusted PMPM baseline for CY 2013 (excluding NEMT itself). The result is a projected PMPM for NEMT for childless adults equal to 2.52% of the non-NEMT portion of the adjusted baseline PMPM for CY 2013.

Cost Sharing and Coverage Limitations: This adjustment adds the projected PMPM cost of (a) lower beneficiary cost sharing in the standard benefit package for services covered in both standard and limited package and (b) fewer service limitations in standard package (e.g., DME, home health). This is 1% of the adjusted baseline PMPM figure developed under Step 1 above.

Following these adjustments, we arrive at an analytically sound, cost-to-continue WOW PMPM baseline for a childless adult for CY 2013.

Step 3: Apply Trend

Under Step 3, we apply the annual trend factor to the adjusted baseline PMPM developed through Step 2 above. For the trend factor, the budget neutrality model uses the Society of Actuaries Long Term Healthcare Costs Trend Resource Model (SOA-Getzen Model), version 4.0 and updated November 2012.

The SOA-Getzen Model is widely used by health care actuaries in projecting annual health care cost increases. For purposes of determining budget neutrality, we use the default baseline assumptions that were approved by the Society of Actuaries Health and Pension Councils.

Step 4: WOW PMPM for Each Year of Proposed Demonstration

Following Step 3, we have an annual PMPM for an average childless adult not exceeding 100% FPL with the standard Medicaid benefit for each year of the demonstration. To show the federal share of the resulting PMPM figures, we will apply Wisconsin's regular benefit FMAP to the annual all-funds WOW PMPM figures.

Methodology for With Waiver Calculation:

Determining With Waiver (WW) budget neutrality under this demonstration is very straightforward as the process described above to develop annual WOW PMPM amounts and the process to project annual WW PMPM amounts are identical. That is, the population (average childless adult not exceeding 100% FPL), the standard benefit package, the model methodology and data sources, and trend factor are the same under both sides of the budget neutrality calculation. The result shows federal budget neutrality is met in each year of the demonstration.

Budget Neutrality Table for Childless Adults

For the base year and each year of the 5-year demonstration, the following tables show the PMPM budget neutrality figures:

WISCONSIN SECTION 1115 WAIVER FOR CHILDLESS ADULTS UNDER 100% OF FPL

Budget Neutrality

PMPM Method: Without Waiver (WOW)

	Base Year	Year 1	Year 2	Year 3	Year 4	Year 5
	5-1-12 to 4-30-13	1/1/14 - 12/31/14	1/1/15 - 12/31/15	1/1/16 - 12/31/16	1/1/17 - 12/31/17	1/1/18 - 12/31/18
	CY 2013 Comp	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Base PMPM	$ 406.29	$ 414.14	$ 589.90	$ 617.62	$ 650.35	$ 689.38
Adjustments for Standard Benefit:						
Behavioral Health		$ 87.76				
Pharmacy		$ 28.80				
Dental, Hearing, Chiropractic, Eyeglasses		$ 6.55				
Non-Emergency Medical Transporation		$ 13.54				
Cost Sharing and Coverage Limits		$ 4.14				
Adjusted Base PMPM	$ 406.29	$ 554.93	$ 589.90	$ 617.62	$ 650.35	$ 689.38
Trend Factor for Full Calendar Year	2.9%	6.3%	4.7%	5.3%	6.0%	5.9%
Total PMPM	**$ 414.14**	**$ 589.90**	**$ 617.62**	**$ 650.35**	**$ 689.38**	**$ 730.05**
Federal Medical Assistance Percentage (FMAP)		59.06%	59.19%	59.19%	59.19%	59.19%
State Share of Total PMPM		$ 241.50	$ 252.05	$ 265.41	$ 281.33	$ 297.93
Federal Share of Total PMPM		**$ 348.39**	**$ 365.57**	**$ 384.94**	**$ 408.04**	**$ 432.12**

PMPM Method: With Waiver (WW)

	Year 1	Year 2	Year 3	Year 4	Year 5
	1/1/14 - 12/31/14	1/1/15 - 12/31/15	1/1/16 - 12/31/16	1/1/17 - 12/31/17	1/1/18 - 12/31/18
	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Total PMPM	**$ 589.90**	**$ 617.62**	**$ 650.35**	**$ 689.38**	**$ 730.05**
Federal Medical Assistance Percentage (FMAP)	59.06%	59.19%	59.19%	59.19%	59.19%
State Share of Total PMPM	$ 241.50	$ 252.05	$ 265.41	$ 281.33	$ 297.93
Federal Share of PMPM	**$ 348.39**	**$ 365.57**	**$ 384.94**	**$ 408.04**	**$ 432.12**
Federal Share Difference WOW and WW	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) The increased federal expenditures associated with Section 1202 of the Affodable Care Act (the primary care rate icrease), are not included in budget neutrality since this will be reported separately on the CMS-64.

2) This exhibit is to demonstrate federal budget nuetrality as required under Section 1115 of the Social Security Act. It is not possible to derive specfic provider rate changes or state budget impacts from this illustration.

Budget Neutrality for Adult Parents and Caretaker Relatives with Incomes Exceeding 100% FPL

As described above, the demonstration includes continuation of Wisconsin's Transitional Medical Assistance (TMA) program, but with premiums for adult parents and caretaker relatives with incomes exceeding 100% FPL rather than the current premium level of 133% FPL. Budget neutrality is ensured by the facts themselves. Specifically, based on the following, the TMA portion of the demonstration is automatically, inherently budget neutral to the federal government:

1. The additional premium payments received will correspondingly reduce TMA program expenditures and the PMPM cost of the average TMA enrollee starting January 1, 2014. Given associated premiums from TMA enrollees between 100% and 133% FPL, the federal share of future With Waiver (WW) PMPM is no greater than the federal share of future Without Waiver (WOW) PMPM.

2. Under the new premium income limit of 100% FPL, adults are expected to transition from the program at a rate similar to when the premium was implemented for adults with incomes exceeding 133% of the FPL, which was -23% between July 2012 and December 2013. If this trend is indicative of the number of adults who will no longer choose to remain in BadgerCare Plus under the TMA program starting in 2014, we estimate a further enrollment decrease of 3,450 adults by December 31, 2014, at which point the total number of adults choosing to remain in the program is expected to stabilize.

3. All other factors affecting the federal WOW PMPM and federal WW PMPM for the 5-year demonstration are the same for each year (i.e., standard benefit package, other cost sharing, delivery system, enrollee income, and annual trend).

The new premium level of 100% FPL and the behavioral effect of the premium on enrollment are sufficient, whether considered separately or in combination, to ensure federal budget neutrality throughout the demonstration.

Public Involvement and Public Comments

Wisconsin State Budget for SFY 2013-2015: The policies and state finances underlying this Demonstration for Medicaid coverage of childless adults under poverty were proposed, considered, debated, and enacted as part of the public process for Wisconsin's biennial State Budget for SFY 2013-15. The public documents provided with web links below provide considerable background information related to this Demonstration and Medicaid coverage of childless adults, including State policy and budget development, deliberations, and budget and enrollment data:

- Governor Walker's announcement of reforms to Medicaid coverage of childless adults on February 13, 2013. The Governor's presentation is available on the web at http://www.wisgov.state.wi.us/Images/News/21313GovWalkerEntitlementReform.pdf. The Governor's press release on the reforms is on the web at http://www.wisgov.state.wi.us/Default.aspx?Page=891c1886-b72b-49a5-8505-c1d622886931

- Governor Walker's Executive Budget for 2013-15. Available on the web at http://www.doa.state.wi.us/debf/execbudget.asp?locid=166

- Analysis by the Wisconsin Legislative Fiscal Bureau (LFB), a nonpartisan service agency of the Wisconsin Legislature, resulting in a series of public reports posted on the LFB website at http://legis.wisconsin.gov/lfb/. LFB reports with detailed information related to Medicaid coverage of childless adults and policy and budget information related to this Demonstration include:

    - Summary of the Governor's 2013-15 Executive Budget for the Department of Health Services, including the Governor's proposal on Medicaid coverage of childless adults (March 2013). http://legis.wisconsin.gov/lfb/publications/budget/2013-15%20Budget/Documents/Governor/dhs.pdf

    - Medical Assistance (Medicaid) Cost-to-Continue Re-Estimate (May 30, 2013) http://legis.wisconsin.gov/lfb/publications/budget/2013-15%20Budget/Documents/Budget%20Papers/320.pdf

    - BadgerCare Plus Eligibility (May 20, 2013) http://legis.wisconsin.gov/lfb/publications/budget/2013-15%20Budget/Documents/Budget%20Papers/321.pdf

- Consideration by the Legislature's Joint Finance Committee and adoption by the Committee on June 4, 2013. Information about the Committee is on the web at http://legis.wisconsin.gov/lfb/jfc/Pages/default.aspx

- Adoption by the Wisconsin Legislature of Assembly Bill 40, the 2013-15 Wisconsin State budget bill. The Wisconsin Assembly adopted the final budget bill on June 18, 2013. The Wisconsin Senate adopted the final budget bill on June 21, 2013. Details on Assembly Bill 40, including legislative language, public hearings by the Joint Finance Committee, amendments, and votes, are available on the web at https://docs.legis.wisconsin.gov/2013/proposals/ab40

- Governor Walker's approval of Assembly Bill 40 as 2013 Wisconsin Act 20, with enactment on July 1, 2013. The Governor's message to the Legislature is available on the web at http://walker.wi.gov/Images/Documents/Final%20Veto%20Message%20-%20July%201.pdf. The

2013-15 budget as enacted (2013 Wisconsin Act 20) is available on the web at https://docs.legis.wisconsin.gov/2013/related/acts/20

Public Notice: On June 25, 2013, the Wisconsin Department of Health Services published a public notice seeking public input on the BadgerCare Plus Demonstration Project Waiver in numerous newspapers across Wisconsin. A copy of the public notice is available in Appendix A. The newspapers included:

- Milwaukee Journal Sentinel
- Appleton - The Post-Crescent
- Green Bay Press-Gazette
- The Janesville Gazette
- Kenosha News
- The La Crosse Tribune
- Wisconsin State Journal
- The Oshkosh Northwestern
- Racine - The Journal Times
- The Sheboygan Press
- Eau Claire - Leader-Telegram
- Fond du Lac - The Reporter

Web Page: Wisconsin DHS created a public web page, http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm, accessible from the Wisconsin DHS Home Page, which provided a summary of what was included in the waiver request and requested public comment. The web site included both the public notice and the draft waiver request documents and explained that they could be viewed or downloaded.

Public Hearings: There were three public hearings that included live webinar and telephone conference capabilities. An announcement regarding the hearings was provided to all media outlets in Wisconsin via a press release, http://www.dhs.wisconsin.gov/news/PressReleases/2013/070113.htm. Comments from those three public hearings relevant to this waiver request are listed in Appendix B and a copy of the presentation provided during the public hearings is available in Appendix D. Both the public notice and the web page announce that the public can review the official waiver request and provide comments for a 30 day period (see below), as well as through written or verbal statements made at the following public hearings:

- Eau Claire – July 10 – 11:00 am to 1:00 pm in the Commons area of Chippewa Valley Technical College's Health Education Center at 615 W. Clairemont Avenue, Eau Claire, WI 54701
- Milwaukee – July 11 – 11:00 am to 1:00 pm at the Radisson Milwaukee West 2303 North Mayfair Road, Milwaukee, WI 53226
- Green Bay – July 11 – 11:00 am to 1:00 pm in the Walnut and Oak rooms of the Green Bay Kroc Center at 1315 Lime Kiln Rd, Green Bay, WI 54311

Tribal Consultation: Additionally, the Department has met with representatives of the eleven federally recognized tribes located in Wisconsin during the regularly scheduled Wisconsin DHS/Tribal Consultation. That meeting was held on July 10th in Wausau, Wisconsin from 9:00 am to 1:00 pm at the Best Western – Midway at 2901 Hummingbird Road, Wausau, WI 54401. The BadgerCare Plus Demonstration Project Waiver was one of the topics on their meeting agenda. Comments from that meeting, and applicable

responses, are included in Appendices B and C. This meeting was also available via webinar and telephone for tribal representatives not on-site. A copy of the presentation as provided during the consultation is included in Appendix E.

Availability of Waiver Materials and Comment Mechanisms: The web site and public notice stated clearly that a copy of waiver documents, including the waiver application once complete, could be obtained from the Department at no charge by downloading the documents from http://dhs.wisconsin.gov/badgercareplus/waivers.htm or by contacting the Wisconsin DHS/DHCAA via regular mail, telephone, fax or e-mail. The web page and public notice further explained that public comments were welcome and were accepted for 30 days (until August 5th, 2013). Written comments on the changes could be sent by FAX, e-mail, or regular mail to the Division of Health Care Access and Accountability. The FAX number listed was (608) 266-1096 and the e-mail address was BCDemonstrationWaiver@dhs.wisconsin.gov.

Public Comment Availability: Public comments provided were posted on the web site, as described in the public notice and on the web page, and could have been viewed in-person at 1 West Wilson Street, Madison, WI or on the BadgerCare Plus public comment web site, as well as included in this waiver application (see Appendices B and C).

Consideration of Public Comments in Final Waiver:
Each comment that was submitted to the Department through either the public hearings, the Department website, or via mail was reviewed as the final waiver submission was developed.

Many of the comments that the Department received related to definitions and clarifications of certain terms used in the waiver application, questions on the benefits to be received under the new waiver proposal, questions on differences between the new waiver and existing waivers, and the identification and communication process for those who may be transitioning off of the program.

As a part of the final waiver application the following changes/clarifications were made in consideration of comments and suggestions received from the public:

- Presumptive eligibility for childless adults was added into the waiver request;
- The length of the Transitional Medical Assistance (TMA) extension will be based upon applicable federal law, rather than stating that it will be 12 months in length;
- Only children, pregnant women, and adult parents and caretaker relatives, not childless adults, may qualify for TMA;
- Clarified language related to the 5% income disregard to align with statutory language included in 2013 Wisconsin Act 20, §1097;
- Removed headings related to cost-effectiveness within the Budget Neutrality Section;
- Included additional information around the hypotheses and proposed evaluation of the demonstration; and
- Clarified language around the applicable income levels for eligibility.

The Department also received several comments that were outside the scope of the waiver proposal. Many commenters expressed disagreement with the decision to forego the adult group expansion, asked questions about what the Marketplace will do for them and inquired about changes to Medicaid unrelated to the waiver proposal. Because they were unrelated or requested action outside our statutory authority, we did not address them in finalizing this waiver proposal.

Full responses to the public comments can be found in Appendices B and C.

Evaluation Activities and Findings

To assess the demonstration, the State will conduct an evaluation. The demonstration evaluation will include an assessment of the following hypotheses:

By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:

- Improve health outcomes
- Reduce the incidence of unnecessary services
- Increase the cost effectiveness of Medical Assistance services
- Increase the continuity of health coverage

Therefore, the evaluation will examine the demonstration across the spectrum of access, outcomes, and costs, with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

For the TMA demonstration we will continue to evaluate the impact of cost-sharing provisions on lower-income families above the poverty line. Questions the waiver evaluation will address include whether or not participants will pay cost sharing, as well as whether or not the cost-sharing requirements will slow the growth of health care spending. The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the FFM.

A detailed evaluation design will be developed for review and approval by CMS. The evaluator will use relevant data from the BadgerCare Plus program, and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter / utilization, chart reviews, and other administrative data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be conducted to help inform the State, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be made public and posted on the Wisconsin Department of Health Services website.

Hypotheses and Evaluation Parameters

To assess the demonstration, the State will conduct an evaluation. In this section, we describe the hypotheses and evaluation parameters.

Childless Adult Coverage

Hypotheses: Regarding the childless adult population, the demonstration evaluation will include an assessment of the following hypotheses:

By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will: • Improve health outcomes • Reduce the incidence of unnecessary services • Increase the cost effectiveness of Medicaid services • Increase the continuity of health coverage

Evaluation Parameters: Consistent with the hypotheses, the evaluation will examine the demonstration across the spectrum of access, outcomes, and costs, with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

Transitional Medical Assistance:

Hypothesis: For the TMA portion of this demonstration, we will continue to evaluate the impact of cost-sharing provisions on lower-income families above the poverty line. In particular, we will test the following hypothesis:

TMA cost sharing provisions: • Reduce the incidence of unnecessary services • Slow the growth in health care spending • Increase the cost effectiveness of Medicaid services

Evaluation Parameters: Questions the waiver evaluation will address will include whether or not participants will pay cost sharing, as well as whether or not the cost-sharing requirements will slow the growth of health care spending. The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the FFM.

Evaluation Design Development:

Within 90 days following federal approval of the demonstration and associated waivers, the State will provide CMS with a detailed evaluation design for review and approval. Components of the evaluation design will include:

1. Brief description of demonstration, including objectives and demonstration interventions

2. Evaluation purpose and objectives

3. Research design for evaluation, including:
    - Demonstration hypotheses and related research questions
    - Demonstration populations
    - Data sources and uses, including relevant data from the BadgerCare Plus program and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter / utilization, chart reviews, and other administrative Wisconsin BadgerCare Plus data.
    - Research methodologies and related measures / metrics

4. Reporting and dissemination, including
    - Regular progress reporting
    - Reporting and resolution of issues encountered
    - Interim and final evaluation reports
    - Public release of evaluation reports and posting on the web

5. Evaluation management and schedule

Appendix A – Public Notice

PUBLIC NOTICE
Wisconsin Department of Health Services
(BadgerCare Plus Demonstration Project Waiver)

In accordance with federal law, the State of Wisconsin, Department of Health Services must notify the public of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) any new 1115 demonstration waiver project or extension of any previously approved demonstration waiver project, or ending of any previously approved expiring demonstration waiver projects and must provide an appropriate public comment period prior to submitting to CMS the new or extended 1115 demonstration waiver application.

This notice serves to meet these federal requirements and to notify the public that the State of Wisconsin intends to submit a request for a new BadgerCare Plus Demonstration Project Waiver to CMS on August 5, 2013. Two 1115 demonstration projects waivers: the BadgerCare and the BadgerCare Plus for Childless Adults Section 1115 Demonstrations, as amended by the Medicaid 2014 Demonstration Project Waiver on July 1, 2012, will expire on December 31, 2013. It is the Department's intent that the new BadgerCare Plus Demonstration Project Waiver will replace these expiring waivers. You can review the official waiver request and provide comments for the next 30 days (see below), as well as through written or verbal statements made at the following public hearings:

- Eau Claire – July 10 – 11:00 am to 1:00 pm in the Commons area of Chippewa Valley Technical College's Health Education Center at 615 W. Clairemont Avenue, Eau Claire, WI 54701
- Milwaukee – July 11 – 11:00 am to 1:00 pm at the Radisson Milwaukee West 2303 North Mayfair Road, Milwaukee, WI 53226
- Green Bay – July 11 – 11:00 am to 1:00 pm in the Walnut and Oak rooms of the Green Bay Kroc Center at 1315 Lime Kiln Rd, Green Bay, WI 54311

Your comments will be considered to determine if changes should be made to the waiver request, but will not impact proposed or enacted state and federal law. In addition, all public comments will be communicated to the U.S. Department of Health and Human Services (DHHS) as part of the final waiver request.

Accessibility

English

DHS is an equal opportunity employer and service provider. If you need accommodations because of a disability or need an interpreter or translator, or if you need this material in another language or in an alternate format, you may request assistance to participate by contacting Al Matano at (608)267-6848. You must make your request at least 7 days before the activity.

Spanish

DHS es una agencia que ofrece igualdad en las oportunidades de empleo y servicios. Si necesita algún tipo de acomodaciones debido a incapacidad o si necesita un interprete, traductor o esta información en su propio idioma o en un formato alterno, usted puede pedir asistencia para participar en los programas comunicándose con Kim Reniero al número (608)267-7939. Debe someter su petición por lo menos 7 días de antes de la actividad.

Hmong

DHS yog ib tus tswv hauj lwm thiab yog ib qhov chaw pab cuam uas muab vaj huam sib luag rau sawv daws. Yog koj xav tau kev pab vim muaj mob xiam oob qhab los yog xav tau ib tus neeg pab txhais lus los yog txhais ntaub ntawv, los yog koj xav tau cov ntaub ntawv no ua lwm hom lus los yog lwm hom ntawv, koj yuav tau thov kev pab uas yog hu rau Al Matano ntawm (608)267-6848. Koj yuav tsum thov qhov kev pab yam tsawg kawg 7 hnub ua ntej qhov hauj lwm ntawd.

BACKGROUND

The State of Wisconsin reimburses providers for services provided to Medical Assistance recipients under the authority of Title XIX of the Social Security Act and Chapter 49 of the Wisconsin Statutes. This program, administered by the State's Department of Health Services, is called Medical Assistance (MA) or Medicaid. In addition, Wisconsin has expanded this program to create the BadgerCare and BadgerCare Plus programs under the authority of Title XIX and Title XXI of the Social Security Act and Chapter 49 of the Wisconsin Statutes. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services. A plan that describes the reimbursement system for the services (methods and standards for reimbursement) is now in effect.

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize Research & Demonstration Projects, which are experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under §1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. Wisconsin intends to seek approval of a demonstration project waiver under this federal authority.

If Wisconsin's BadgerCare Plus Demonstration Project Waiver is approved by the DHHS Secretary, effective January 1, 2014, Wisconsin will provide coverage to adults without dependent children who have attained the age of 19 and have not yet attained the age of 65 years with Medicaid coverage so long as their family income does not exceed 100% of the Federally Poverty Level (FPL). Additionally, Wisconsin will begin requiring a monthly premium for parents and caretakers relatives who qualify for transitional medical assistance (TMA).

PROJECT GOALS

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate
- Provide a standard set of comprehensive benefits that will lead to improved healthcare outcomes at no additional cost to state tax payers and the federal government
- Create a medical assistance program that is sustainable so our healthcare safety net is available to those who need it most

PROJECT DESCRIPTION

The Patient Protection and Affordable Care Act (PPACA) included provisions that will allow most individuals and families the opportunity to purchase private insurance through the Federally Facilitated Marketplace. For those with incomes exceeding 100% FPL and not greater than 400% of the FPL, federal tax subsidies are available to help offset the cost of monthly premiums. Cost sharing limits and subsidies will also be available for many low-income individuals who purchase private insurance through the Federally Facilitated Marketplace.

Wisconsin is committed to ensuring that Wisconsin residents have access to affordable insurance. To coincide with the PPACA, the 2013-2015 biennial budget request includes a provision that would change the income eligibility threshold for adult parents and caretaker relatives from 200% of the Federal Poverty Limit (FPL) to 100% of the FPL. Similarly, childless adults, if this waiver request is approved, would be eligible for BadgerCare Plus Standard Plan benefits if their income does not exceed 100% of the FPL. Children and pregnant women will continue to be eligible for BadgerCare Plus so long as their incomes do not exceed 300% of the FPL and adults with incomes that do not exceed 100% FPL will be eligible to enroll in BadgerCare Plus. Adults with incomes above the poverty level will have access to private insurance coverage with assistance paying for their insurance in the new federal Marketplace starting on October 1, 2013 with coverage effective for January 1, 2014.

This waiver request also includes a change for adult parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA). TMA is a program which extends Medicaid for 12 months for certain individuals whose income has exceeded 100% of the FPL because of an increase in earnings. TMA also extends eligibility for 4 months for certain individuals whose income has exceeded 100% of the FPL because of an increase in child or spousal support. Under the new waiver, all non-disabled, non-pregnant parents and caretakers relatives who qualify for TMA will be required to pay a monthly premium. Those adults who refuse to pay or fail to pay the monthly premium will not be allowed to enroll in BadgerCare Plus for 12 months. Currently, the monthly premium only applies to those adult parents and caretaker relatives who have income exceeding 133% FPL. This waiver request asks the DHHS Secretary to approve a policy that would apply the TMA premium and restrictive reenrollment to all TMA adults and parents with incomes exceeding 100% FPL.

Below, this notice will briefly outline: 1) the current Medicaid eligibility and coverage standards for childless adults; and 2) the Transitional Medical Assistance Program, and describe the specific proposed changes sought to these programs through this waiver request.

1) Childless Adults Eligibility and Coverage

Current Program: Under the authority of an 1115(a) demonstration project waiver, Wisconsin currently covers adults without dependent children (referred to as 'childless adults' throughout this notice) with incomes not exceeding 200% FPL, at the time of application or renewal, under the BadgerCare Plus Core Plan. Because of the federal budget neutrality requirements of the Core Plan waiver, enrollment has been capped since October 2009. As of April 2013 there were more than 145,000 individuals on a wait list. The limited benefit plan provided to this population does not meet either the federal creditable coverage requirement or the new PPACA-mandated Essential Health Benefits requirements. The current BadgerCare Plus Childless Adult Demonstration Project waiver expires on December 31, 2013. Historical enrollment and aggregate expenditures for childless adults under the current waiver by State Fiscal Years (SFYs) are as follows:

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,398	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,850	$106,538,654	$96,066,396

Wisconsin currently covers, under the BadgerCare Plus Core Plan for Adults Without Dependent Children, those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Do not have access to health insurance through a current employer in the month of application or in the subsequent three months, regardless of the amount of employer contribution toward the premium.
- Have not had access to health insurance through a current employer in the past 12 months, regardless of the amount of employer contribution toward the premium, unless there is a good reason for not signing up. (For example, circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.)
- Is not currently covered by a health insurance policy (through employer or individual policy) and has not been covered by a health insurance policy for the past 12 months, unless individual has a good cause reason for losing the coverage (loss of employment, etc.).
- Have a gross income below 200% of the FPL at the time of application or renewal
- Have completed a health needs assessment at application and annual renewal;
- Have paid the annual application fee of $60 (waived for individuals who are homeless);
- Have a premium requirement and a restrictive reenrollment period of 12 months if a premium is not paid;
- For continued eligibility, have had a physical exam within the first 12 month certification period.

Individuals who have met these eligibility requirements are enrolled in the Core Plan. The Core Plan covers basic health care services, including hospital inpatient and outpatient services, physician and clinic services and generic prescription drugs.

In May 2013, 18,253 individuals were enrolled in the Core Plan. This number has been limited by the agreement in the Core Plan waiver that imposed a federal budget neutrality cap on enrollment.

Waiver Proposal: Through a new demonstration project waiver, Wisconsin would cover those individuals who:

- Are 19 to 64 years of age;
- Are not pregnant or parents or caretaker relatives of children under age 19;
- Meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.);
- Are not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
- Are not entitled to Medicare;
- Have a gross income, calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology that does not exceed 100% of the FPL before application of a 5% disregard.

Eligible individuals will no longer be required to pay an annual enrollment fee or a premium, and the program will not be subject to an enrollment cap. Eligible individuals will also be enrolled in the BadgerCare Plus Standard Plan, which is the same plan provided to all beneficiaries enrolled in BadgerCare Plus.

We estimate that nearly 99,000 childless adults will enroll in BadgerCare Plus (an increase of approximately 82,000 individuals) between January 1, 2014 and December 31, 2014. We also estimate that nearly 5,000 childless adults will transition to the federal Marketplace and will be eligible for a federal tax subsidy.

We further project annual Medicaid enrollment and aggregate expenditures for childless adults is as follows:

	SFY 2014	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

2) Transitional Medical Assistance (TMA)

Current: TMA has existed in different forms since the enactment of the Omnibus Budget Reconciliation Act of 1981. It supports the transition from welfare to work by allowing individuals whose earnings have increased to continue to receive Medicaid for a period of time. In Wisconsin, TMA allows individuals to maintain their Medicaid coverage for 12 additional months if:

- They have received Medicaid as part of the Section 1931 coverage group for three of the last six months; and
- Their earnings have increased to a level that their total family income exceeds the Section 1931 coverage group eligibility income threshold. (In Wisconsin, the § 1931 eligibility income threshold is 100% of the federal poverty level (FPL).

As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), amending the BadgerCare and BadgerCare Plus for Childless Adults waivers, Wisconsin received

waiver approval that allows us to require that non-pregnant, non-disabled adult individuals receiving Medicaid, including those on TMA, with family incomes that exceed 133% of the FPL to pay a monthly premium to maintain their Medicaid coverage. As currently occurs, those who either refuse to pay their monthly premium or who fail to pay a premium may be subject to a restrictive re-enrollment period. A restrictive re-enrollment period (RRP) means the member cannot re-enroll in BC+ for twelve months from the termination date while their income remains high enough to owe a premium.

Historical enrollment and aggregate expenditures for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs) are as follows:

	SFY 2009	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013 Est.**
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

Waiver Proposal: We are incorporating the TMA Premium and Restrictive Re-enrollment Period component of the Medicaid 2014 Demonstration Project Waiver into the new BadgerCare Plus Demonstration Project Waiver with modifications. Beginning January 1, 2014, non-disabled,
non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for Standard Plan BadgerCare Plus coverage through TMA only and whose income exceeds 100% of the FPL would be required to pay the TMA premium. Individuals will continue to be covered under the BadgerCare Plus Standard Plan benefit plan with the same copayments and other cost sharing requirements, other than the monthly premium, as all other BadgerCare Plus beneficiaries.

In May 2013, there were approximately 19,114 adults enrolled in BadgerCare Plus through TMA. The number of adults receiving coverage under the TMA program has steadily declined at a rate of 500 per month since the premium requirements included in the Medicaid 2014 Demonstration Project Waiver were implemented on July 1, 2012. We estimate that by January 1, 2014, when the policies under this waiver are implemented, there will be 15,000 adult parents and caretaker relatives eligible under the TMA program. Under the new premium income limit of 100% of the FPL, we estimate a reduction similar to when the premium requirement was implemented for adults with incomes exceeding 133% of the FPL, or 23% between July 2012 and December 2013. If this trend is indicative of the number of adults who will no longer be eligible for BadgerCare Plus under the TMA program, we estimate a further reduction of 3,450 adults by December 31, 2014, at which point the total number of adults eligible under the premium is expected to stabilize.

We further project annual Medicaid enrollment and aggregate expenditures for adults covered through Transitional Medical Assistance is as follows:

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

HYPOTHESIS AND EVALUATION PARAMETERS

To assess the demonstration, the State will conduct an evaluation. The demonstration evaluation will include an assessment of the following hypothesis:

1. By providing the standard Medical Assistance benefit plan to childless adults under poverty, the

State will:

- Improve health outcomes
- Reduce the incidence of unnecessary services
- Increase the cost effectiveness of Medical Assistance services
- Increase the continuity of health coverage

Therefore, the evaluation will examine the demonstration across the spectrum of access, outcomes, and costs, with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other MA populations.

For the TMA demonstration we will continue to evaluate the impact of cost-sharing provisions on lower- income families above the poverty line. Questions the waiver evaluation will address will include whether or not participants will pay cost sharing, as well as whether or not the cost-sharing requirements will slow the growth of health care spending. The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid and subsidized health insurance offered through the new federal Marketplace.

A detailed evaluation design will be developed for review and approval by the Centers for Medicare and Medicaid Services. The evaluator will use relevant data from the Medical Assistance program, and its managed care organizations. This may include eligibility, enrollment, claims, payment, encounter / utilization, chart reviews, and other administrative data. The evaluator may also conduct surveys and focus groups of beneficiaries and providers and other original data collection, as appropriate.

Both interim and final evaluations will be performed to help inform the State, CMS, stakeholders, and the general public about the performance of the demonstration. All evaluation reports will be public and posted on the Department of Health Services website.

SPECIFIC WAIVER AND EXPENDITURE AUTHORITIES

Childless Adults: Wisconsin requests that DHHS waive § 1902(a)(34) and that, under authority of § 1115(a)(2) of the Act, expenditures identified for the demonstration population described below, which are not otherwise included as expenditures under§ 1903, be regarded as expenditures under Wisconsin's Medicaid State Plan.

Demonstration Population: Provide prospective Medicaid coverage to individuals between the ages of 19 and 64 with family income that does not exceed 100% of the FPL before applying the MAGI 5% disregard. Except for Wisconsin's Family Planning Services and Tuberculosis Medicaid, these individuals are not otherwise eligible for Medical Assistance or the State Children's Health Insurance Program (SCHIP).

TMA and RRP: Wisconsin requests that DHHS waive § 1902(a)(14) insofar as it incorporates section 1916, so that the demonstration population described below may be required to pay a monthly premium as a condition of continued TMA coverage and that those adults who refuse to pay or fail to pay are ineligible for the duration of the 12 month Restrictive Reenrollment Period.

Demonstration Population: Provide Medicaid coverage to non-disabled, non-pregnant adult parents and caretaker relatives who qualify for TMA because their total income, because of earnings or spousal support, exceeds Wisconsin's §1931 family income limit of 100% FPL.

COPIES OF DEMONSTRATION PROJECT WAIVER

Copies of Waiver Documents
A copy of waiver documents, including the waiver application once complete, may be obtained from the department at no charge by downloading the documents from http://dhs.wisconsin.gov/badgercareplus/waivers.htm or by contacting:

Regular Mail
Al Matano
Division of Health Care Access and Accountability
P.O. Box 09
Madison, WI 53707−0309
Phone
Al Matano
(608)267−6848
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E−Mail
Alfred.Matano@dhs.wisconsin.gov

WRITTEN COMMENTS

Written comments are welcome and will be accepted through July 30, 2013. Written comments on the changes may be sent by FAX, e-mail, or regular mail to the Division of Health Care Access and Accountability. The FAX number is (608) 266-1096. The e-mail address is BCDemonstrationWaiver@dhs.wisconsin.gov.

Regular mail can be sent to the above address.

Public comments will be included in the waiver request submitted to CMS on August 5, 2013 and will be available on the department's web site at the address listed above.

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Appendix B –Public Comments Related to the Waiver Request

Where	Mode	Date Received	Comment Summary	Response
E-mail	E-Mail	7/8/2013	On the policy substance that guides the waiver request, you make two statements that are incorrect. The first is that Wisconsin has a commitment to providing health care to all of its citizens. If that were true, the state would have aggressively sought to implement the Affordable Care Act. Instead, it chose not to structure the exchanges, and it turned down funding that would have expanded BadgerCare coverage to tens of thousands. The policy that the state is following will insure man fewer people while costing the taxpayers at least $140 million more than was necessary. This is shear madness! The second statement is the characterization of the exchanges as providing an opportunity to meet the care needs of citizens through the private market. Twenty dollars a month may not be much to someone with a solid six-figure income, but to someone living on $12 to 14,000 per year, it is enormous. Those private policies will also carry with them co-pays that can add up to thousands per year, a figure that will be beyond anyone living just above the poverty line. And those "private" policies will require a government subsidy far greater than the cost of expanded BadgerCare. In short, the policy this waiver seeks to implement is health care mal-practice and fiscal insanity. The policy should be reversed!	Thank you for your comments, we will take them under consideration.
E-mail	E-Mail	7/8/2013	What are the federal limits and plus 100 percent more mean in actual income for a single male? How much can he make (maximum) and still qualify for this new badger care insurance?	Under the proposed waiver, a childless adult whose income does not exceed 100% of the federal poverty limit would qualify for BadgerCare Plus. Based on 2013 limits, this would be $11,490 for an individual. The federal government publishes these limits annually.
E-mail	E-Mail	7/9/2013	Thank you for the opportunity to comment on the proposed waiver. I'd like to begin with two comments on your process. First of all, a sincere public comment effort would have begun at a formative stage of the proposal, not after the legislature had implicitly approved the proposal though the state budget process. A sincere public involvement process would also provide the opportunity to comment closer to where the people live. More than one-third of the state's land area is North of Eau Claire	Thank you for your comments. The Department is holding 3 separate public hearings on the waiver application, one in Eau Claire, in in Green Bay and one in Milwaukee. We are also making every effort to ensure that there is reasonable access to both telephonic and web-based participation. The presentations will be available to the public on the WI DHS website as well.

			and more than a third is Southwest of Eau Claire. What is worse, those areas contain some of the places that most rely on the benefits of BadgerCare. Asking people to drive two to three hours for the opportunity for input does not demonstrate a sincere interest in their views. Second, by your numbers, which were conveniently withheld until after the budget discussions were complete, 1,017 people in my home county of Richland will be without health care because of the changes to BadgerCare. Four hundred twenty four will be kicked off the program; the balance will simply be denied care. These criteria have obviously been known for some time, but the people who will be impacted have not been informed. They need to know their status as soon as possible so that they can evaluate the meager options available to them and make sound decisions.	We are also working with community partners, health plans, counties, IM consortia, and several other stakeholders across the State to develop a comprehensive outreach and education strategy related to the eligibility changes in 2014. The Department will be proactively reaching out to those members who may be transitioning off of Medicaid in 2014 starting in September.
Eau Claire Public Hearing	In-Person	7/10/2013	How do you define income level?	The Affordable Care Act changes the definition of countable income so that it is now based on the Internal Revenue Code (with a few modifications). Countable income will now be defined as adjusted gross income from the tax code, except as it relates to social security benefits, earnings from a person working outside of the United States, etc.
E-mail	E-Mail	7/10/2013	I am attending the town hall meeting on-line. Please send me projected enrollment for Green County.	Projections for enrollment by county are available upon request.
E-mail	E-Mail	7/11/2013	I would like to know whether Forward Health intends to back-date effective dates for those residents who enroll for an Exchange after 12/31/2013, but before 3/31/2014, and have services between 1/1/2014 and the date of enrollment. Are we able to file claims for those services? Would there be a timely filing limitation that would result in denials?	There is no backdating for private health insurance coverage purchased through the Exchange. For example, if an individual enrolls in a QHP effective Feb 1, 2014, claims will only be reimbursed by the QHP for services received Feb 1 or after. BadgerCare Plus will continue to allow for three calendar months of backdated coverage for Medicaid eligible populations covered by the State Plan. This includes parents and caretakers with incomes that do not exceed 100% FPL; pregnant women with incomes that do not exceed 300% FPL; and children with incomes that do not exceed 300% FPL. Childless adults will be eligible for backdated coverage; however, the coverage cannot be backdated prior to January 1, 2014.

Eau Claire Public Hearing	In-Person	7/10/2013	Regarding TMA, please clarify for what period of time and for whom?	Currently TMA coverage lasts for 12 months – however, if the federal law governing TMA expires at the end of the year without extension by Congress, TMA will be 4 months. TMA extensions are provided to children, pregnant women, adult parents and adult caretaker relatives who have received BadgerCare Plus with income at or below 100% of the FPL for three of the last six months. If these individuals experience an increase in income due to earnings that puts their income above 100% FPL then they are granted a TMA extension. It doesn't apply to those parents/caretaker relatives who will be losing their eligibility on 12/31/13, but there are also parents/caretaker relatives who are already in a TMA extension, who, as long as they continue to meet all eligibility requirements, will remain covered by Medicaid for the duration of their TMA extension.
Eau Claire Public Hearing	In-Person	7/10/2013	Please make sure that health plans understand how TMA works.	We plan on meeting with and providing informational materials to the health plans on this program.
Eau Claire Public Hearing	In-Person	7/10/2013	Do you have a projected annual enrollment by county?	Yes, we will make this information available to the public upon request.
Eau Claire Public Hearing	In-Person	7/10/2013	Did the Legislature approve the enrollment estimates and budget described in the public notice and waiver request?	Yes, these projections were approved as a part of the 2013-2015 budget process.
Eau Claire Public Hearing	In-Person	7/10/2013	Are the premiums in the Federal Marketplace based on income? How about the premiums for TMA? Are the copayments the same as today?	The premiums themselves are set by the health plans, but there are federal premium tax credits available that will cover all but a % of the premium based on an individual's income and their choice of plan.
Eau Claire Public Hearing	In-Person	7/10/2013	Will copayments for childless adults be set at the same level they are set at today?	No, childless adults will receive Medicaid Standard Plan benefits. This plan has lower, nominal copayments. Additionally, DHS will be removing all copayments for preventive services.

Eau Claire Public Hearing	In-Person	7/10/2013	Will BadgerCare Plus CLA members be enrolled in HMOs?	Yes, that is the Department's vision. Everyone in BadgerCare Plus will receive the same Standard Plan benefits and cost-sharing. We are currently in the midst of contract negotiations with HMOs for 2014 and 2015. We don't foresee any changes in our current contracts that would exclude CLAs from HMO enrollment.
Eau Claire Public Hearing	In-Person	7/10/2013	Are either the Wisconsin Well Woman Program or the Family Planning Waiver program affected by these changes?	There are no changes in these programs, however, some of the women who would've only been able to access Medicaid services through the Wisconsin Well Woman Medicaid Program will now be able to access those services through the BadgerCare Plus, if they are childless adults with income not exceeding 100% of the FPL. The same is true for individuals who were eligible for the Family Planning program. Many will be eligible to receive family planning services as well as all other Medicaid services through the BadgerCare Plus program, if they are childless adults with incomes not exceeding 100% FPL.
Eau Claire Public Hearing	In-Person	7/10/2013	There are many childless adults who have been on the BadgerCare Plus Core Plan waiting list for a long time, including my brother. Will his in-kind income (he works as a resident manager of an apartment complex and is provided with an apartment) count in determining eligibility?	The Department plans to use the Core Plan wait list to do outreach for both those who would qualify for Medicaid as childless adults, but also to help persons to purchase their health insurance through the Federal Marketplace. Your brother's in-kind income would count in determining his eligibility for BadgerCare Plus (and for premium tax credits) under MAGI.
Eau Claire Public Hearing	On-Line	7/10/2013	Will adults who lose BadgerCare because they're over the 100% qualify for TMA?	Any child, pregnant woman or adult parent/caretaker relative who has income below 100% FPL, has been receiving BadgerCare Plus for three of the last six months, and whose earnings increase so that their total income is greater than 100% FPL will be eligible to receive the TMA extension. If this occurred prior to December 2013, they will remain on their extension until that extension period ends or they do not comply with the conditions of TMA eligibility. Adults not falling into the category above will be eligible for Qualified Health Plans in the Marketplace, but not BadgerCare Plus

Eau Claire Public Hearing	In-Person	7/10/2013	I'm worried about the 4,000 people who will be losing BadgerCare Plus in Eau Claire County, especially those persons with a mental illness. How will this affect people who are disabled, even those without the official disability finding by SSA or Medicaid? What about people who lose their supports?	Nothing is changing for the Elderly, Blind, and Disabled (EBD) population as currently covered under in the State. Additionally, childless adults with income that does not exceed 100% of the FPL will now be eligible, without an enrollment cap, for BadgerCare Plus. The program's benefits will be expanded beyond the Core Plan services, to include the full range of Medicaid Standard Plan services, including mental health and substance abuse services. Coverage through the Marketplace must provide coverage of mental health services as an essential health benefit. Once plans are available, consumers will be able to see exactly what benefits will be covered in the Marketplace.
Eau Claire Public Hearing	In-Person	7/10/2013	Does employer-sponsored health insurance access or coverage affect an adult's BadgerCare Plus eligibility?	It does not. However, it still may impact the eligibility of children with income greater than 200% of the FPL, who are applying for or receiving BadgerCare Plus.
Eau Claire Public Hearing	In-Person	7/10/2013	This is a demonstration project, right? If you can't prove that this is better, what if the federal government doesn't approve the waiver? Is there a Plan B?	Wisconsin has met and discussed this proposal with our colleagues at CMS, and we have been working collaboratively to receive approval for this waiver.
Eau Claire Public Hearing	In-Person	7/10/2013	I'm the guardian for my daughter who has a cognitive disability. Is there any impact on folks on Medicare?	No, there should be no impact on Medicare coverage.
Eau Claire Public Hearing	In-Person	7/10/2013	What is the impact on individuals who are eligible for both those Medicare and Medicaid?	There are no changes proposed as part of this waiver that would impact this group.
Eau Claire Public Hearing	In-Person	7/10/2013	Is there any impact on individuals enrolled in Family Care?	No, that is a long term support program that is not affected by the changes to BadgerCare Plus.

Eau Claire Public Hearing	In-Person	7/10/2013	Is there presumptive eligibility or backdating for those covered by the BadgerCare Plus Demonstration Project Waiver?	Upon reflection of the comments and suggestions received from the public, presumptive eligibility for childless adults is being included as part of the waiver request.
Eau Claire Public Hearing	In-Person	7/10/2013	How can this improve health outcomes? What does that mean when you're removing sick people from the program?	The part of this demonstration project waiver that proposes to evaluate health outcomes is specific to those childless adults covered by this waiver, those with incomes at or below 100% of the FPL. This project is not evaluating the impact of the changes in State law to BadgerCare Plus that will reduce the income eligibility for some adults.
Eau Claire Public Hearing	In-Person	7/10/2013	My daughter will qualify for this program. What if her income fluctuates? Will she lose her BadgerCare Plus coverage?	If you daughter meets all of the applicable eligibility criteria, she will qualify for BadgerCare Plus in 2014. If her income fluctuates above 100% FPL due to earnings, she may qualify for TMA, given that she meets the appropriate eligibility for this program as well. Childless adults will not qualify for TMA.
Eau Claire Public Hearing	In-Person	7/10/2013	It seems that the speed with which eligibility workers process these reported changes, particularly those that would allow an individual to retain their BadgerCare Plus and avoid any coverage gaps. Were there additional funds for eligibility processing to avoid eligibility gaps?	For those persons who experience gaps in coverage, our backdating policy and TMA coverage will help alleviate those gaps. The 2013-2015 budget also included additional funds for the IM consortia and MiLES for increased caseloads.
Eau Claire Public Hearing	In-Person	7/10/2013	For CLAs, when should they apply for BadgerCare Plus coverage?	They should apply on or after November 18, 2013.
Eau Claire Public Hearing	In-Person	7/10/2013	Where do they apply?	They can apply on-line using www.access.wisconsin.gov, in-person at their local county department of social or human service, through the mail or over the telephone.

Eau Claire Public Hearing	On-Line	7/10/2013	Can folks above 100% of the FPL choose between TMA and the Federal Marketplace?	It is our understanding that since TMA is technically considered Medicaid eligibility for the period in which the person is covered, that they would not be eligible for premium tax credits in the Marketplace while eligible for TMA.
Eau Claire Public Hearing	On-Line	7/10/2013	Will existing BadgerCare Plus childless adults with income at or below 100% of the FPL have to apply for the new BadgerCare Plus on 1/1/14?	No. They'll be transitioned to the new plan. They will renew their BadgerCare Plus eligibility at their scheduled annual renewal.
Eau Claire Public Hearing	In-Person	7/10/2013	In the case of someone who is over income, then loses income and re-qualifies, is there a wait list?	No, there will be no wait list.
Tribal Consultation Meeting	In-Person	7/10/2013	How will the change in eligibility affect our community? Can you (DHS) help tribes identify which members will be gain or lose eligibility when the waiver is implemented?	DHS needs help from tribes to identify members who will be affected by the change in eligibility. We need to share data so we can better identify tribal members. It is in tribal members' best interest to know who belongs to a tribe- especially for cost sharing reductions authorized through ACA.
Tribal Consultation Meeting	In-Person	7/10/2013	Can tribes have access to DHS eligibility data to identify tribal members?	DHS has pulled together some data by county and tribal IM agency on enrollment projections, however this information may not accurately reflect all eligible tribal member information. DHS is willing to do a data share with interested tribes to identify those BC+ members who may be affected by the 2014 eligibility changes.
Tribal Consultation Meeting	In-Person	7/10/2013	Will people on the waitlist for the current BadgerCare Plus waiver have to reapply to participate in the new waiver?	Yes, the waitlist may have outdated information, so individuals will need to reapply and update information.
Tribal Consultation Meeting	In-Person	7/10/2013	If enrollment in the new waiver exceeds estimates will a new waitlist be established?	If enrollment exceeds estimates, waiver design will be debated during the budget process.
Tribal Consultation Meeting	In-Person	7/10/2013	What will the amount of premium be for those individuals with incomes greater than 100% of the FPL?	Premiums will be in line with those established in the ACA - a sliding scale starting at 2% of income for those with income at 100% FPL and up to 9.5% of income for those up to 400% FPL.
Tribal Consultation Meeting	In-Person	7/10/2013	We understand that QHP will not provide dental coverage? The lack of dental coverage will impact tribe members and the provision of dental services at Tribal Health Centers.	Pediatric dental will be covered by QHPs. While adult dental coverage is not a required covered service under the EHB, most existing plans in Wisconsin offer some coverage of preventive and emergency dental services. Once the QHPs in the State are public, individuals will be able to review

				the full list of services that will be available to them.
E-Mail	E-Mail	7/11/2013	After leaving the waiver demonstration at the Kroc center in Green Bay, I need to share my disappointment in the number of attendees. As I scanned the room, there were approximately 25 people in attendance, most with notepads and name badges. Where was the publicity for this event? How was the information disseminated to reach the very people affected? Was there any effort made to make sure that the people impacted by this waiver would be able to attend? Was there public bus service out to the Kroc center? I again realized that if it isn't the rich affected we just need to go through the motions. I realize you met the requirements of public notice but didn't seem to go beyond that. Maybe it was good that the attendance was poor as the material presented was very slanted and offered no financial comparisons as to its cost in comparison to how it would have looked if federal monies would have been accepted. While I fully realize this was to explain the waiver it didn't in any way offer the citizens of Wisconsin any idea as to why this was better...or how much this waiver was costing...and how many people would not be eligible, An explanation of the poverty level would have been helpful to the average person (of course, there weren't many people there that would be directly affected). That explanation would have helped people figure out what they were eligible for. Seeing the narrow view presented I left with a heavy heart...one of those liberals who believes we should be helping our most vulnerable population...recognizing that again our Wisconsin values are being sacrificed at the expense of politicians that have forgotten to do their job. I truly believe that we are seeing at the state level the same attitude that we see at the federal level...if it is supported by Obama...be against it. Interesting that now the federal government should pick up the tab!	The public notice was published in 10 major newspapers throughout Wisconsin and a press release sent to major news outlets by the Department of Health Services. Each public hearing (3 were held across the state) allowed both telephonic and web-based participation as well. Additionally, we have created a web site specifically to solicit public comment, which will include the presentation provided during public hearings. An e-mail went out to the Department's list of Medicaid community partners. Anyone could comment through the mail, on the web site or through e-mail through August 5, 2013. Thank you for your other comments, we will take those into consideration.

E-mail	E-Mail	7/11/2013	I have the following suggestions that I would like you to consider as you are putting together this Demonstration Waiver. I am hoping that people who participate in this Demonstration Waiver program will have access to a wide range of services for care such as coverage for doctor's visits and prescriptions, and coverage for tests (i.e. blood work etc. and specific procedures). I am hoping that people who participate in this new waiver program will not be just given one (1) or two (2) options for coverage such as: this plan only covers family planning etc. I know that people with disabilities who will be eligible for this program will still have needs for specific disability related services. I am hopeful that this can be taken into consideration as this waiver program is designed for meeting the needs of these individuals. Thank you for considering my comments. If you have any questions, please let me know.	Thank you for your comments. The waiver intends to provide all childless adults with incomes not exceeding 100% FPL with a comprehensive set of benefits – including prescription drugs, mental health services, hospital and physician services.

Green Bay Public Hearing	In-Person	7/11/2013	With the decrease in the number of people who receive Medicaid/BadgerCare Plus, is there going to be adequate consumer navigation for the Federal Marketplace in order to assist these individuals?	There are federal navigator grants being issued for this express purpose.
Green Bay Public Hearing	In-Person	7/11/2013	Are there plans to help folks move to the Marketplace? This has to be more information than letters to alert people that they're losing Medicaid and need to purchase insurance.	The Department has a comprehensive to help people make this transition. We are working strategically to develop Regional Enrollment Networks with community partners for this purpose. Comments from these public hearings have been considered as a part of that plan development.
Green Bay Public Hearing	In-Person	7/11/2013	I'm assuming that the federal government will be providing funding for navigators to help people sign up through the Federal Marketplace. Will there be information included in the letter to those persons who will no longer be eligible for BadgerCare Plus?	Yes, we are working on the details of those notifications now.
Green Bay Public Hearing	In-Person	7/11/2013	Have there been any presentations that clearly lay out the costs of the program to Wisconsin citizens with and without the Medicaid Expansion? What is the cost differential? The cost of this program is $120 million more if the waiver is approved to provide care to 85,000 fewer people. The public is getting a choice between a stupid calamity and a stupid catastrophe. I've asked the DHS and my legislator to explain the Governor's comment that the reason that Wisconsin was not pursuing the Medicaid Expansion was that the federal government had not lived up to its financial commitments to the Medicaid program. I have received no answer.	The Legislature and Governor have enacted the 2013-2015 Biennial Budget that includes Medicaid coverage being pursued through this waiver request. Various presentations were prepared and disseminated to the public as part of the Biennial Budget process.

Green Bay Public Hearing	In-Person	7/11/2013	How was the public hearing and public notice disseminated? I'm disappointed with the way that the public hearing was publicized. Another gentleman commented that he heard about the public hearing through a local newscast. His local county DHS and the BadgerCare Plus hotline did not have any information about it. He agreed that it was poorly advertised.	The public notice was published in 10 major newspapers throughout Wisconsin and a press release sent to major news outlets by the Department of Health Services. Each public hearing (3 were held across the state) allowed both telephonic and web-based participation as well. Additionally, we have created a web site specifically to solicit public comment, which will include the presentation provided during public hearings. An e-mail also went out to the Department's list of Medicaid community partners to help disseminate the information. Anyone could comment through the mail, on the web site or through e-mail through August 5, 2013.
Green Bay Public Hearing	In-Person	7/11/2013	Do Social Security benefits count in determining eligibility for BadgerCare Plus?	Social Security income is counted as a part of MAGI for eligibility determination if it is taxable income.
Green Bay Public Hearing	In-Person	7/11/2013	Who were the community partners in Green Bay who were contacted? Was there an effort to reach out to the individuals who would be affected by this change?	The public notice was sent to 10 statewide newspapers, including the Green Bay Gazette. We also distribute all public notices to a large of community partners – and we will make this list available upon request. Individuals who will likely transition off of BadgerCare Plus starting in 2014 will be contacted in September.
Green Bay Public Hearing	In-Person	7/11/2013	Does this affect everyone in Wisconsin?	The waiver request is for a statewide implementation of the coverage of childless adults with incomes not exceeding 100% FPL. Other

				eligibility changes included in the 2013-2015 budget will impact some populations, but there are several who will not be impacted by any of the eligibility changes.
Green Bay Public Hearing	In-Person	7/11/2013	Some of the childless adults are on SSDI and don't have Medicare (yet). Those who are between 100 and 133% FPL will now lose their coverage. Does the budget and cost-effectiveness section of the waiver request include a cost-effectiveness analysis of the waiver versus the Medicaid Expansion included? This is confusing to many of the folks whose benefits will be lost who wonder how it can be more expensive to cover fewer people.	The waiver request does not include a cost-effectiveness analysis beyond an analysis of whether the demonstration project waiver will be budget neutral as it relates to federal funds provided under this waiver. We have clarified the headings within the application to remove the citation to cost-effectiveness.
Green Bay Public Hearing	In-Person	7/11/2013	If you have access to Medicare, can you qualify for BadgerCare Plus as a CLA under this waiver? I suggest that the waiver not include Medicare entitlement/receipt as an eligibility condition.	Currently, the waiver request would exclude someone from BadgerCare Plus eligibility who is eligible for Medicare, however these individuals could qualify under a different Medicaid eligibility category.
Green Bay Public Hearing	In-Person	7/11/2013	Does the current BadgerCare Plus demonstration project waiver have different cost sharing than the Core Plan?	Yes, the BadgerCare Plus waiver will have different cost sharing than the Core Plan. It will not have an enrollment fee and will have the same nominal cost-sharing as the Standard Plan, with no copayments for preventive services.
Green Bay Public Hearing	In-Person	7/11/2013	Is it possible to evaluate health outcomes for those who are losing BadgerCare Plus? For instance the group with incomes greater than 100, but not greater than 138% FPL.	We believe we can do so, but need to make sure that the federal government will allow it and that we'll have access to the data needed to evaluate those outcomes.
Green Bay Public Hearing	In-Person	7/11/2013	When we talk about budget neutrality is it federal budget neutrality or state budget neutrality? I suggest that the State compare the state budget impact with and without this waiver.	It's federal budget neutrality. The state budget impact has been reviewed as a part of the legislative budget process.
Green Bay Public Hearing	In-Person	7/11/2013	When you have the Medicaid transition numbers for 2014, it is interesting that they are higher in 2014 than in subsequent years. Why is that?	The reason for this reduction is that we are asking to impose a monthly premium for those with incomes greater than 100% FPL if they become eligible for TMA. We expect that this will decrease the number of individuals who will remain on the BC+ TMA if they do not pay the TMA premium and move into insurance in the Marketplace.

Green Bay Public Hearing	In-Person	7/11/2013	Will the waiver request include a request that would allow counties to ask for the federal Medicaid funds from the expansion directly? The state law doesn't restrict counties from doing this.	Without statutory approval, the Department of Health Services cannot request a waiver that would exceed the coverage granted under current statute. Furthermore, it is our understanding that the federal government would be unable to allow for county-specific Medicaid Expansion in a State. This has been discussed at length by other States and the answer has been that US DHHS will only approve statewide Medicaid Expansion through an amendment to the single state Medicaid agency's Medicaid State Plan.
Green Bay Public Hearing	In-Person	7/11/2013	How many people are participating in the public hearing in Eau Claire?	30+ people attended the session in-person with approximately 10 people participating via the webinar.
Green Bay Public Hearing	In-Person	7/11/2013	People have to go through a navigator to get private health care?	No, you do not need to go through a navigator to receive private health care. Individuals can go directly to the Federal Marketplace web portal or call the Federal Marketplace Call Center as examples of other resources.
Green Bay Public Hearing	In-Person	7/11/2013	Could the State look at holding public hearings in more places and in places with more people and provide flyers; to announce the public hearing?	The public notice was published in 10 major newspapers throughout Wisconsin and a press release sent to major news outlets by the Department of Health Services. Each public hearing (3 were held across the state in Eau Claire, Green Bay and Milwaukee) allowed both telephonic and web-based participation as well. Additionally, we have created a web site specifically to solicit public comment, which will include the presentation provided during public hearings. An e-mail also went out to the Department's list of Medicaid community partners to help disseminate the information. Anyone cound comment through the mail, on the web site or through e-mail through August 5, 2013. We will take into consideration comments related to this process for future public hearings and public notices.

Green Bay Public Hearing	In-Person	7/11/2013	If your income is below 100% of then FPL, then you could qualify for BadgerCare Plus program. If you're above 100% of the FPL, you can get help through the federal government, right?	Children and pregnant women with income no greater than 300% of the FPL are eligible for BadgerCare Plus. Adults will be BadgerCare Plus eligible if their income is no greater than 100% of the FPL. Premium tax credits are available for those individuals/families above 100% FPL who are not Medicaid eligible.
Green Bay Public Hearing	In-Person	7/11/2013	Will it help apply for BadgerCare Plus now, so that I'm on the system in October 2013?	Individuals can apply via ACCESS or through one of the regional Income Maintenance consortia offices, but between October 1 and December 31, 2014, we encourage individuals to apply through the Federally Facilitated Marketplace. We will continue to provide additional information on these options.
Green Bay Public Hearing	In-Person	7/11/2013	For the group with incomes between 100 to 133% of the FPL are the calculations based on the same MAGI methodology? Is there training for non-eligibility workers?	Based on tax rules, but there are different rules for individuals who are non-filers. We're doing extensive training in August and September 2013 on the new ACA rules for Medicaid for eligibility workers and community partners. Updates to the BadgerCare Plus handbook will be made in October 2013.
Green Bay Public Hearing	In-Person	7/11/2013	Is there a BadgerCare Plus Open Enrollment or Special Enrollment periods?	No. The federal law does not allow states to impose an open or special enrollment period.
Green Bay Public Hearing	In-Person	7/11/2013	If someone enrolls in BadgerCare Plus in November and December 2013, will they be enrolled by January 1, 2014?	Agencies have 30 days to process applications and many times, if the applicant is responsive to information and verification requests, and the workload is manageable, agencies may be able to provide an eligibility decision sooner than 30 days. Eligibility for childless adults will not begin prior to January 1, 2014
Green Bay Public Hearing	In-Person	7/11/2013	I'm aware of navigator funding from the federal government, will there be additional state funds and efforts? When will the state's outreach plan be published?	Yes, the State will be making a concerted effort to enroll individuals in the Marketplace. Our outreach plan will be published within the next month.

Green Bay Public Hearing	In-Person	7/11/2013	Please make sure that you include the Independence Centers in your distribution network, since they publish their own newsletters.	Thank you for the information and we have forwarded this on to our communications office
Milwaukee Public Meeting	In-Person	7/11/2013	What will happen to the Well-Women Medicaid Program? Will this waiver impact the Well-Women Medicaid Program?	This waiver does not change any program requirements for the Well-Women program. The program will continue to cover women according to the current eligibility requirements, even if they have incomes over 100% FPL.
Milwaukee Public Meeting	In-Person	7/11/2013	How will income eligibility be determined? What safeguards will be in place to make sure that those with incomes under 100% aren't kicked off of program? Does the eligibility rule take into account a person's monthly expenses? This waiver will hurt those that need coverage the most.	MAGI rules are being programmed into the eligibility and enrollment system to support ACA and waiver changes. We will know in September who will likely fall into a category that will need to purchase coverage on the Marketplace and will begin active outreach to do those members at that time. Eligibility rules are based on an individual's current gross monthly income.
Milwaukee Public Meeting	Online	7/11/2013	What outreach will DHS do to help those over 100% transition to exchange?	DHS believes that stakeholder organizations must play an active role in helping people transition to the Marketplace. Organizations need to work together to break down silos and work on hand-offs and transitions. In Southeastern Wisconsin for example, the Milwaukee Health Care Partnership is working in collaboration with other community partners to map out work flows to enroll people in the Marketplace. The Department is also working on a strategic plan to do an effective, targeted outreach.
Milwaukee Public Meeting	Online	7/11/2013	Will low-income residents who meet the new waiver eligibility requirements also get evaluated for disability coverage as well as waiver coverage?	Yes. It is standard to simultaneously evaluate enrollees for disability coverage.
Milwaukee Public Meeting	In-Person	7/11/2013	DHS should have structured a pilot program to test this waiver. Why implement this transition right now, with no mock up. DHS won't feel the consequences of an "oops". Why not pilot with the State Legislature and drop them from their current coverage and have them find coverage on the Marketplace?	Regarding the timing- DHS had to wait until the Legislature completed the budget process to obtain state authority to do this transition. Now we need to get federal approval and complete all the systems changes needed to support transition.

Milwaukee Public Meeting	In-Person	7/11/2013	Why aren't people who are eligible for BadgerCare now enrolled in the program?	Milwaukee enrollment staff will be able to do more outreach for SNAP now that there won't be an enrollment cap for BadgerCare Plus childless adults. We expect to see similar trends in other areas.
Milwaukee Public Meeting	In-Person	7/11/2013	How many of you (DHS staff representatives present at the public meeting) have had to go through the Medicaid eligibility process? Our family had to apply for Title 19 help for my parents. The process was not easy. When we opened state hospitals in the 1980s without a plan it was a disaster. Well-formed plans take time. What will happen to the people stuck in the middle of the transition? What will happen to the people you can't reach? How many people who are forced off of BadgerCare will not pay premiums? What about psych benefit?	On September 23rd we'll start targeted outreach and work with "regional partners" to notify people about the eligibility changes and assist to get people enrolled in private coverage. We'll send a letter to members and conduct outbound calls at this time. We have demonstrated outbound calling capability for a transition last fall when we moved 150K members from managed care to FFS. We will build on that model to support the implementation of this waiver. We estimate a 18-20% drop off when we put premiums into TMA. However, we believe that the transition to QHP will be better; we estimate 93% take up rate for those over 100% who moved to QHP coverage. Mental and behavioral health is a required covered category of service under the essential health benefits.
Milwaukee Public Meeting	In-Person	7/11/2013	This public outreach process is somewhat disingenuous. If this meeting was located in a different place, this room would be full of similar stories as the mother who spoke earlier. DHS should not wait until September to start outreach to those affected by the change in eligibility. I am convinced that using the ACA to pull back from what we've committed to already here in Wisconsin is a good idea. Nominal amounts actually matter to individuals--$5 a week can be a financial barrier to some individuals. DHS should do more outreach and let people ask and get their questions answered. On the mental health benefit demonstration evaluation- part of the evaluation should be to check with the criminal justice system to know if the mental health benefit expansion is working. There will be challenges with this transition. How do you make the system as responsive as possible during this transition? DHS must work with State Legislators' offices and community stakeholders to wrap around those affected by this transition.	Thanks for your comments, we will take them into consideration.

Milwaukee Public Meeting	In-Person	7/11/2013	Is the cost-share for coverage on the Marketplace amount a responsible amount? It would have been better to stagger the transition until after the Marketplace is established and we know what the QHP cost-share actually looks like. We don't know enough about the Marketplace to fully understand the implications of this waiver. Governor Walker should have taken the Expansion, even for just a year. DHS needs to be consistent with how it communicates the income eligibility for this waiver-- "at, below and exceeding 100% FPL". Is there any movement or thinking on the "alternative benchmark" plan?	Thank you for your comments. The State is not pursuing an alternative benchmark plan. DHS will provide the standard plan which is a more comprehensive set of benefits than offered to childless adults via the current waiver. We have clarified the language around the 100% FPL limit as a part of the waiver.
Milwaukee Public Meeting	Online	7/11/2013	Is there a chance that the bypass plan for cancer will be re-introduced?	Thank you for your suggestions, we will take this into consideration.
Milwaukee Public Meeting	In-Person	7/11/2013	What is the process to get on BadgerCare with disability?	The disability determination process will not be changed under this waiver.
E-mail	E-mail	7/12/2013	Thank you for affording the Wisconsin Nurses Association (WNA) the opportunity to provide comment on the Department of Health Services BadgerCare Plus Demonstration Project Waiver. WNA is the professional association for registered nurses in Wisconsin representing staff, advanced practice, managerial, educators and research nurses. We practice in a variety of settings that include acute care, primary, long-term care, public, community health and correctional facilities as examples. WNA provided comment on the portion of the Governor's budget bill that resulted in a number of formerly BadgerCare eligible recipients no longer eligible for health insurance. We view the lack of coverage for these individuals will result in utilization of	The Department thanks WNA for their comments and will take them under consideration as we the waiver.

			expensive health care and expensive settings. This is not the desired outcome we want to see happening in Wisconsin. WNA appreciates the Department's BadgerCare Plus Demonstration Project Waiver proposal and views it as an effort to obtain coverage for more of the uninsured. We do need to convey however that we support returning to the federal poverty level of 133% so that access to the Medicaid dollars that do not require a state match is captured and provides more coverage to more individuals and families. It is our understanding that this alternative remains an option. WNA has met with other groups to review the Department proposal and we probably have very similar concerns that have been expressed throughout your hearings. Most specifically, we find the proposal lacking detail in the important sections that describe the budget, cost-effectiveness and the evaluation activities. WNA would also like to comment on the other elements included in the proposal: The Defined Benefits Package plan (BadgerCare Plus Standard Plan), should be fully described and should include a commitment to the same plan, i.e. benefits and cost-sharing standard, that will exist for all the other enrollees in 2014 for the duration of the waiver. * Dual Eligible Medicare/Medicaid Individuals under this waiver who are enrolled in Medicare would not have access to Medicaid. Without this supplemented option, important support services would be missing. * Low-income individuals with income near the poverty line (100%) will need support transitioning between BadgerCare and subsidized Federal Marketplace coverage as their income fluctuates. In order to maintain high levels of coverage, the waiver language should ensure adequate, maintained support for consumer navigation and enrollment assistance in the Federal Marketplace and BadgerCare. * Enrollment of incarcerated persons, effective upon release, needs further explanation to include procedures to enable incarcerated individuals, prior to their scheduled release (parole) from prison, to enter the Health Insurance Marketplace's portal and enroll in either BadgerCare or Marketplace coverage effective upon their release date. Such procedures are necessary to increase the ability of such individuals to obtain, upon release,	

			treatment for addiction to drugs and alcohol and treatment for mental illnesses, thus helping to reduce recidivism. WNA also wants you to know that our members stand ready to assist the Department in any way we can to maximize the health care marketplace enrollment process. We have many access points to the 77,000 RNs and student nurses in Wisconsin. We are viewed as the most trusted profession and believe that we can offer education and encouragement to individuals to make the decision to enroll.	
E-mail	E-mail	7/12/2013	Dual-Eligibility: Clarification regarding BadgerCare specifically, and not all full-benefit Medicaid programs. For example, while the waiver proposal indicates that you cannot have Medicaid and BadgerCare; individuals may still obtain other Medicaid programs, if eligible, such as the Medicaid Purchase Plan (MAPP), to maintain dual-eligible status for the Medicare Part D Low Income Subsidy.	Eligibility for other programs such as long-term care programs are not impacted by this waiver or the 2013-2015 state budget.
Mail	Mail	7/23/2013	The state's existing EBD Medicaid plan will continue to support individuals who qualify for Medicaid due to the severity of their disabilities and low income level. The changes proposed in this application will impact individuals with chronic conditions or less severe disabilities who may struggle to afford the high costs of their health care which enables them to maintain their health and employment. These individuals will be acutely affected in various ways by the proposed changes to the BadgerCare Plus waiver and Transitional Medical Assistance (TMA). First of all, we recognize that this waiver request represents a significant commitment to address the uninsured population who are in extreme poverty. By creating an entitlement to coverage for all childless adults below 100% of the Federal Poverty Level (FPL), individuals affected by mental illness and other chronic conditions will have access to reliable and continuous health care. We estimate that approximately ¼ of the projected 82,000 who will gain coverage in this plan have chronic disabling conditions. We support the intent of this waiver application to expand coverage to these individuals.	Thank you for your comments and support, we will take this into consideration.

			In addition, we support the proposal to adopt the Standard Plan benefit which allows for enhanced coverage essential for people with disabilities including durable medical equipment, prescription drugs, personal care, behavioral/mental health care, therapies and non-emergency medical transportation. The elimination of annual enrollment fees or premiums and the enrollment cap are also significant positive changes. Therefore, we request that the waiver application indicate the Department's commitment to maintain the Standard Plan benefit package in its current form for the duration of the waiver. We request that the Medicare eligibility requirement for new enrollees be removed and an assurance that current Medicare-eligible individuals under 100% FPL accessing the Standard Plan will not experience a change in their benefit and can maintain this important wrap-around support. "Whether or not participants will pay cost will slow the growth of health care spending." Since data from the Medicaid 2014 Demonstration Project implemented in July 2012 shows a significant reduction in the ability of people above 133% FPL to pay a premium (-23% between July 2012 and December 2013), it appears the purpose of the current TMA demonstration applied to people at a lower poverty level is not valid. In addition, it is worth noting CMS' recent commentary on the issue of charging premiums to people explained that "the statute does not permit premiums for beneficiaries whose incomes below the poverty level." We do not support charging premiums for individuals in the TMA program below 133 % of FPL given the rapid rate at which DHS predicts people will lose coverage and the fact that increased cost-sharing in the Marketplace will make this coverage less affordable for low-income individuals with chronic conditions. The TMA portion of the waiver application, if not removed entirely as we suggest, should at the very least be updated to align appropriately with the expulsion provisions in the subsidized health insurance market, as is the waiver's stated intent. The waiver application does not directly address DHS' plans to eliminate BadgerCare coverage for this population, we feel the application falls short of the secondary goal by remaining silent, and we request that DHS improve the waiver plan to	

			protect and effectively transition beneficiaries. Federal HHS and various non-partisan groups have estimated that churning (movement between Medicaid and new health insurance exchanges) will be significant under the Affordable Care Act and particularly during the initial transition timeframe. This will be especially true in Wisconsin for the new population of individuals whose BadgerCare coverage will be terminated (eligibility reduced from 200% FPL to 100% FPL.) While our organization endorsed a plan which would have increased Medicaid coverage to 133% FPL in order to reduce the impact of churn and ensure coverage for this low-income population, we strongly suggest that the state's plan directly address this issue of transition within the waiver application. The Center for Medicare and Medicaid Services (CMS) has offered various transition strategies to states like Wisconsin that are using options in the Affordable Care Act to reform their systems to both enroll newly eligible low-income adults and ensure protections for beneficiaries as income and eligibility determinations change. CMS has outlined various options under section 1115 waiver authority which may be viable for Wisconsin. One option would be for Wisconsin to use its 1115 waiver authority to implement 12-month continuous eligibility for individuals at certain poverty levels to ensure a stable source of health insurance with no disruptions in necessary ongoing care. In addition, the waiver application should explain procedures it will establish to enable incarcerated individuals, prior to their scheduled release (parole) from prison, to enroll in either BadgerCare or the private insurance market to be effective upon their release date. This transition planning is essential for continuity of care for individuals who require treatment for drug and alcohol addiction and mental illness, to reduce the risk of recidivism. The waiver application presents an opportunity to implement a policy that can provide for continuity of care as consumers are required to change health plans and to prevent eligibility transitions from creating coverage gaps and losses. This is particularly important for people with chronic conditions, who	

			when they go without coverage, medication or therapies, even for a short period of time, can accrue significant public costs and detrimental human results.	
Letter to Secretary Rhodes		7/29/13	We, the below signed county leaders, are writing to you in regards to Wisconsin's waiver to the federal government to apply the BadgerCare changes approved in the 2013-15 state budget. With the federal Affordable Care Act encouraging innovation in states, provided the goal is to ensure a greater level of health coverage, we request a demonstration pilot project be included in the waiver request that would allow interested counties the opportunity to access these federal enhanced Medicaid funds. In 2014 thousands of Medicaid recipients will be placed in private health insurance exchanges and required to pay premiums. The transition from Medicaid to private insurance and the premium cost could result in the loss of health care due to confusion and inability to pay. Being underinsured and uninsured impacts County Human Services Departments because it can lead to untreated mental health or substance abuse, increases in uncompensated costs. Also leads to a lack of preventive health care that can lead to loss of jobs, the inability to function and loss of self-sufficiency. County boards in thirteen counties in Wisconsin have passed resolutions calling for accepting the federal funds at the state level, or, failing that, to allow for a mechanism for counties to access these federal funds in the interest of covering our citizens. Additional counties are currently considering resolutions in light of the availability of these federal funds in the future. Because the federal matching rate for Medicaid is 100% early on, we request that the waiver for BadgerCare include a provision for a demonstration project allowing counties who opt in to access these enhanced Medicaid funds through the Department of Health Services. If at which time this project is deemed unfeasible the opportunity would remain for counties to opt out, as is the ability of states to do under the full Medicaid expansion. Wisconsin already utilizes a Medicaid program that is administered on a county-by-county basis, FamilyCare, and could be a model for low income individuals slightly over the federal poverty line in need of affordable healthcare. This model could	Thank you for your comments Without statutory approval, the Department of Health Services cannot request a waiver that would exceed the coverage granted under current statute. Furthermore, it is our understanding that the federal government would be unable to allow for county-specific Medicaid Expansion in a State. This has been discussed at length by other States and the answer has been that US DHHS will only approve statewide Medicaid Expansion through an amendment to the single state Medicaid agency's Medicaid State Plan.

			be administered at a county level or through a consortium of interested counties. While this approach is, admittedly, a transition from the state's plan for BadgerCare, we believe it provides an additional opportunity to provide needed coverage to the individuals under 133% of the federal poverty line that are not eligible for Medicaid while seeking to gain full access to our tax dollars. A county-based waiver has been approved for Cuyahoga county in the state of Ohio in collaboration with their public hospital, a state that shares our Midwestern values and our economic strengths. The 1115 demonstration waiver, Cuyahoga county in Ohio was granted by CMS an early coverage Medicaid waiver demonstration expansion. The Patient Protection and Affordable Care Act (PPACA), which was signed into law in April 2010, allows states to cover uninsured individuals up to 133 percent of the Federal Poverty Level (FPL). The Medicaid Waiver Demonstration will cover uninsured adults, mainly individuals without dependent children, residing in Cuyahoga County with income up to 133 percent of the federal poverty line who are ineligible for Medicaid today. Because Ohio has not currently taken advantage of the federal enhanced Medicaid funding at a state level, this local effort will continue to provide access to care to an estimated 30,000 citizens. In light of this existing county waiver precedent, and the demonstrated actions and interests of numerous counties in Wisconsin, we request that the Department of Health Services' demonstration project allow counties to opt in to access federal Medicaid funds or that a similar alternative be included. Signed Supervisors from the following 20 Counties: • Dan Robinson, Brown County • Sue Bradley, Columbia County • Melissa Sargent, Dane County* • Tom Quinn, Dunn County* • Gerald Wilkie, Eau Claire County* • Tom DeLain, Iowa County*	

			• Jim Schroeder, Jefferson County* • Dayvin Hallmon, Kenosha County • Monica Kruse, La Crosse County* • Jim Alber, District 13, Lincoln County* • Rita Metzger, Manitowoc County* • John Robinson, Marathon County* • David Bowen, Milwaukee County* • Candy Sorensen, Oneida County* • Kathy Groat, Outagamie County • Ken Hall, Racine County • Tom Crofton, Richland County* • John Diets, Sauk County • Larry Lautenschlager, Winnebago County* • Jim Baumgart, Sheboygan County * - notes a county that has already voted in favor on a resolution in support accepting federal Medicaid funds	
Mail	Mail	7/29/13	Thank you for the opportunity to provide comments on the new BadgerCare Plus Demonstration Project Waiver. I urge the department to reconsider its current plan for BadgerCare Plus, which is essentially to spend more taxpayer money while providing health care coverage to fewer Wisconsinites. In the process, Wisconsin rejects billions of federal dollars that could be used to provide health care to thousands more hardworking Wisconsin families. It is important to note that Wisconsin is the only state in the nation attempting to obtain a federal waiver in order to provide less health care coverage then could be provided under Badgercare Plus and federal Medicaid guidelines. The states proposal adds about 80,000 childless adults to BadgerCare who are at or below 100 percent of the federal poverty level (FPL), which is $11,490 for an individual and $23,550 for a family of four. But does so by ending coverage for nearly 90,000 parents over the FPL, thousands of whom as still living in poverty and will struggle to purchase insurance in the private market. Many of these individuals and families will not be able to afford coverage even under the new health insurance exchange, where cost-sharing will be much higher (up to $2,100 per adult), leaving thousands of parents and single individuals without healthcare.	Thank you for your comments, we will take them under consideration.

			Additionally, the requested BadgerCare Plus Demonstration project would end the ability of families above 300% of the FPL to buy BadgerCare coverage for their children at full cost. There is no fiscal reason to preclude parents from purchasing, at full price, this coverage. Rather, the Department seeks to resurrect changes DHS proposed in 2011 that were rejected by the Obama Administration, and were anticipated to cause 29,000 kids to lose BadgerCare coverage. Thankfully for Wisconsin children, the Obama Administration would not allow the Walker Administration to kick off thousands of low-income children from the health care they need. A Fiscal Bureau analysis concluded that the alternative of providing BadgerCare to all adults below 133% of FPL would cover almost 85,000 more people and cost state taxpayers far less – nearly half a billion dollars less over the next seven years – by utilizing federal health care reform dollars. The waiver being sought by the Department of Health Services (DHS) adopts a more limited benefits package with higher cost-sharing for children and adults. Again, Wisconsin is the only state in the nation pursuing such an inexplicable approach. Why would Governor Walker spend more taxpayer money to cover less people? Wisconsin ranks 50th in short-term job growth according to the U.S. Chamber of Commerce and 42nd as best state for business. According to Forbes Magazine, Wisconsin will be 49th in job growth through 2016. The stagnate economic situation in Wisconsin demands that public officials do more, not less, in making sure our residents are healthy and have access to needed healthcare. But as important, we have a moral, ethical and legal obligation to pursue policies not to promote an archaic political ideology, but to implement policies that benefit the people of our state. The proposed BadgerCare Waiver Demonstration project is the antithesis of what the state should be pursuing, as in the end, it will result in less children and adults having access to health care, and curable diseases and ailments not being timely treated. Simply put, there are Wisconsinites who will die as the result of this Demonstration project and the reduction in health care coverage for children and adults that will result. I cannot think of	

			a more tragic approach than that which is being proposed in this Demonstration project. I urge the department to send its plan back to the drawing board and implement a plan that actually benefits the people of our great state. If not, I hope and pray the Obama Administration will reject such a misguided, harmful endeavor.	
E-mail	E-mail	7/30/13	I spoke at the public hearing regarding Badgercare in Milwaukee on July 11, 2013. I told the story of my family, which is that my husband works full-time for a small business and is offered employee-sponsored insurance for only himself, not the rest of our family of five. Therefore, the cost of the premium for just my husband and myself would be about $9,300, with a $3,000 deductible. We are currently at about 140% FPL – almost $40,000 for a family of five, and there would be no possible way we could afford this. We are very careful with our money, and we are just making ends meet (I had been employed part-time until my position was cut, but even still I was not offered insurance through my employer.) My story is not uncommon, as many working families do not have access to affordable insurance. We are trying to do our best, and we are even happy to pay more toward premiums for Badgercare. We just want to have access to affordable, reliable insurance. I was told by the panel at the hearing that I would be eligible for a subsidy through the insurance exchanges. However, after I spoke, I was approached in the hallway by several people, including someone from DHS and Senator Taylor's office, who expressed that they were not sure if I would be eligible for a subsidy through the exchanges. At this point I am very concerned about what will happen, since if I am not eligible for a subsidy; my costs for a premium could be very high. Then I would need to pay a high premium for myself, in addition to my husband's premium. (Currently my children do not need to pay a premium, but with all of the changes that are constantly happening, I would not be surprised if we would need to pay that also soon.) Adding all of these together could be completely unaffordable for us. Even if I am eligible for a subsidy, I have no idea what kind of insurance I may be able to obtain. It may have a high deductible, in which case my husband and I would both have very high	Thank you for reaching out to us. We will take your comments into consideration and reach out to you directly to discuss your family's situation.

			deductibles to meet, which again we could not afford. Or there may be lots of things that are not covered and we could accrue many expenses because of that. All of these expenses together could be very high and again unaffordable. My understanding is that if the federal government approves this waiver, we will not be eligible for Badgercare because our income will be too high, even though it is quite low for our family. Or I believe there is a clause stating that if your premium is less than 9.5% of your income, you do not qualify. This would apply to my husband and we could afford to pay for him, but if this then also applies to me we would not be able to afford the insurance through his employer for me. There are many questions and concerns regarding this waiver, and I'm very worried that many families like ours will fall through the cracks. From what I have learned, it doesn't sound to me that anyone is sure that a family like mine will be alright, since there a lot of contingencies and unknowns. Badgercare has been a lifeline for our family, and we would be very happy to pay more in premiums or deductibles to have something we know we could afford. For us, going without insurance is not an option in case anything bad were to happen, and I think it saves everyone money since otherwise if something were to happen we could not pay for it. My husband and I are very worried about what will happen and if and how we will be able to afford insurance. I urge you to consider families like ours. I know that by maintaining Badgercare coverage for us we would be insured and be able to afford it, again willingly paying more into it. Otherwise I don't know if we will be able to afford it. Please consider these choices carefully so that many families like ours will not be placed in these very difficult situations, either having to pay an extremely high percentage of their income toward insurance or choosing to go uninsured. Please consider the needs of those that are working hard and just trying to care for their families.	
E-mail	E-mail	8/2/13	Thank you for the opportunity to comment on Wisconsin's BadgerCare Plus Demonstration Project Waiver. The Wisconsin Alliance for Women's Health is dedicated to our mission of raising the status of Wisconsin women's health by engaging, educating, empowering and mobilizing individuals and organizations. Our vision is to create an environment in which all Wisconsin women at every age and stage of life can thrive through realizing their	Thank you for your comments, we will take them under consideration.

			optimal health, safety, well-being and economic security. WAWH has a broad and diverse support base of over four-dozen organizations, and over 1,000 individuals, including policy makers, health care providers and community members, and 180 health professionals throughout the state. Our organization has led numerous successful coalitions to further our impact on Wisconsin women's health and our numerous accomplishments are due to our incredible efficiency and strategic partnerships. While we appreciate the Wisconsin Department of Health Services' (DHS) commitment to ensuring that Wisconsin residents have access to affordable insurance, we believe that could have been better achieved by taking advantage of the budget opportunity to strengthen BadgerCare through the Affordable Care Act Medicaid Expansion enhanced federal funding. We continue to advocate for the preservation of current BadgerCare eligibility levels, and enhancing coverage to adults without dependent children to 133 percent of the poverty level with enhanced federal dollars. **However, knowing current state budget language, we support DHS' waiver request to provide BadgerCare full standard plan benefits as an entitlement to childless adults with incomes up to the poverty level. We do not support the requested change of charging premiums for parents and caretaker relatives on Transitional Medical Assistance (TMA).** More than one in ten non-elderly women currently get their health insurance through Medicaid, however, low-income women without dependent children still don't have access to health coverage. These women are likely to be poorer health, have difficulty accessing care, and are more likely to be racial and ethnic minorities than the general population. Medicaid coverage has led to higher utilization of services, and higher self-reported health status for these individuals. This is why we generally support the coverage of adults without dependent children as proposed in this waiver. Please accept these comments and requests for more information, so that we can work together to provide this coverage in the best way possible for low-income Wisconsin women.	

			· Plan Design: We request that the final waiver application provide assurance that the benefits and cost-sharing for the duration of the demonstration period will be the same as the current BadgerCare Plus Standard Plan design. · Budget and Cost Effectiveness: We request additional details on the general outline described in the draft waiver application. · Evaluation: We request additional details on the proposed evaluation activities, including the measures and data, and how it will be collected. · Medicare Wrap: We echo the comments of our colleagues at Disability Rights Wisconsin and recommend removing the Medicare eligibility exclusion from the waiver for the new demonstration population, and adding an assurance that current Medicare-eligible individuals under 100 percent of the federal poverty level accessing the Standard Plan will not experience a change in their benefits and can maintain this important wrap-around support. We do not support the Waiver proposal for Demonstration Population 2. Although Wisconsin's budget, 2013 Wisconsin Act 20, gives DHS the option to charge premiums to the individuals in TMA, it does not require that change. And based on the DHS evaluation of the effects of extending premiums to adults on BadgerCare Plus with incomes above 133 percent of the poverty level, we know that expanding those premiums will cause enrollees to fall off the program. Suppressing the participation of low-income adults is not a valid demonstration purpose for an 1115 Waiver. If the waiver proposal moves forward, we at least request the following changes: · Restrictive Reenrollment Period: The restrictive reenrollment period of 12 months proposed in this waiver for non-payment of premiums is unnecessarily long, and inconsistent with Medicaid, CHIP, and the new Health Insurance Marketplace regulations. All Wisconsin enrollees should be given at least a 90-day grace period to pay their premiums, and the restrictive reenrollment period should be limited to 60 days.	

			· Premium Consistency: DHS has made the argument that the intent of applying premiums is to remain consistent with the costs associated with the new health insurance marketplaces. The premium amount for those with income between 120 and 132.99 percent of the poverty level in the DHS draft waiver is 2.5 percent of income, whereas the premium for individuals with incomes under 133 percent of the poverty level who receive the advance premium tax credit is 2 percent of income. The Medicaid premium should not be more than the advance premium tax credit premium on the Marketplace for low-income individuals. We are concerned about the effect of these changes, as well as the elimination of BadgerCare coverage for many low-income Wisconsin women. To ensure that that DHS achieves the stated intent of decreasing the number of uninsured Wisconsinites, the Department must take responsibility for ensuring a smooth and sustained transition of low-income adults from BadgerCare into the subsidized federal Marketplace coverage. We appreciate the Department's early efforts at outreach, and look forward to seeing this work quickly accelerated in an accountable and transparent manner. We also hope that DHS will work with the federal government to ensure that the transition plan for these individuals also looks forward and ensures consistency between BadgerCare coverage and subsidized private plans in the Marketplace so that individuals are able to maintain coverage and access to care, to prevent unnecessary churn.	
E-mail	E-mail	8/5/13	Thank you for the opportunity to comment on Wisconsin's BadgerCare Plus Demonstration Project Waiver. The Wisconsin Council on Children and Families (WCCF) is a multi-issue child and family advocacy organization providing research, policy analysis, public education, and advocacy that lead to improved outcomes for children in the areas of health, economic security, safety and education. We are committed to BadgerCare Plus as a quality source of health insurance for Wisconsin's residents, and have worked over the years to strengthen and improve the program. We appreciate the Wisconsin Department of Health Services' (DHS) commitment to ensuring that Wisconsin residents have access to affordable insurance. The project objectives outlined in this waiver request align directly with our goals – reducing the	The Department thanks WCCF for their comments and will take them under consideration.

			number of uninsured, providing comprehensive benefits, and ensuring a sustainable health care safety net. In fact, those priorities led us to support the cost-saving alternative budget opportunity to maintain our current successful BadgerCare program for children and parents, while taking advantage of increased federal matching funds to provide insurance to childless adults with incomes up to 133 percent of the federal poverty level. In lieu of that preferred option, we support DHS' waiver request to provide BadgerCare full standard plan benefits as an entitlement to childless adults with incomes up to the poverty level. We do not support the requested change of charging premiums for parents and caretaker relatives on Transitional Medical Assistance (TMA). We also question why the state is using "expenditure authority" to cover childless adults. Expenditure authority was needed in the past because the Medicaid statute did not provide a pathway to coverage for this group. Now with the ACA, there is a pathway to coverage and we believe that Wisconsin should provide coverage through the new mandatory coverage group. Of course, the state would need to request a waiver to limit coverage to those with incomes below the poverty line, which would mean the state is not entitled to the enhanced match rate provided for new eligible under the ACA. With regard to the childless adults population, we appreciate that all eligible individuals will be enrolled in the BadgerCare Plus Standard Plan. We request that the final waiver application provide assurance that the benefits and cost-sharing for the duration of the demonstration period will be the same as the current BadgerCare Plus Standard Plan design. We also request additional details on the budget and cost effectiveness approach outlined in the draft waiver application. In particular, a more robust analysis and disclosure of the cost-projection figures, showing the cost-effectiveness for the federal government of this proposed waiver, should be made available for public comment. Because some of the adjustments the state will be able to make, like the Disproportionate Share Hospital payments, will change over the duration of this waiver, the budget contributions attributable to those adjustments should be made available to the public for analysis and comment.	

			We also request more details on the proposed evaluation activities, including the measures and data that will be collected to determine if the hypotheses prove correct. In addition, we would like to amplify the comments of our colleagues at Disability Rights Wisconsin regarding the fact that an individual is not eligible for the new childless adult waiver if they currently have access to Medicare. As they point out, parents/caretakers currently enrolled in the Standard Plan are allowed to supplement Medicare coverage with important Medicaid benefits, providing wraparound care. We recommend removing the Medicare eligibility exclusion from the waiver for the new demonstration population, and adding an assurance that current Medicare-eligible individuals under 100 percent of the federal poverty level accessing the Standard Plan will not experience a change in their benefits and can maintain this important wrap-around support. As noted above, we do not support the Waiver proposal for Demonstration Population 2. Although Wisconsin's budget, 2013 Wisconsin Act 20, gives DHS the option to charge premiums to the individuals in TMA, it does not require that change. Based on the DHS evaluation of the effects of extending premiums to adults on BadgerCare Plus with incomes above 133 percent of the poverty level, we know that expanding those premiums will cause enrollees to fall off the program. Focusing on the most comparable group – the 18,544 parents and caretakers on BadgerCare in July 2012 who had incomes between 133% and 150% of FPL, we find that only 31% were still on BadgerCare in December. Failure to pay a premium caused 21% of the original 18,544 to lose their coverage within six months; but among those who weren't disqualified for some other reason during the initial six months, 41% lost their coverage for failing to pay a premium. Suppressing the participation of low-income adults is not a valid demonstration purpose for an 1115 Waiver. Additionally, though Wisconsin is a state that has been granted a prior waiver of the Medicaid statute, which does not permit premiums for beneficiaries whose incomes are below 150 percent of the poverty level, premiums should not be allowed in 2014 when all individuals with incomes below 133 percent of the poverty level	

			have a pathway to coverage in the federal Medicaid statute. If DHS continues to pursue this 1115 waiver for the TMA population, we have additional concerns about the draft terms. The restrictive reenrollment period of 12 months proposed in this waiver for non-payment of premiums is unnecessarily long, and inconsistent with Medicaid, CHIP, and the new Health Insurance Marketplace regulations. Final federal regulations issued on July 5, 2013, clearly state that no further consequences can be applied for non-payment of Medicaid premiums, other than terminating eligibility if an individual fails to pay for 60 days [42 C.F.R. §447.551(b)(5), see page 550]. These final regulations also prohibit states from instituting a premium lock-out period in CHIP that exceeds 90 days. The Health Insurance Marketplace allows for a grace period to pay premiums of three consecutive months for individuals receiving the advance payment of the premium tax credit [45 C.F.R. §156.270(d)]. In light of those regulations and the department's goal of making TMA consistent with Marketplace coverage, all Wisconsin enrollees should be given a 90-day grace period to pay their premiums, and the restrictive reenrollment period should be limited to 90 days. When applying premiums to the TMA population with incomes above 133 percent of the poverty level, DHS stated that your intent is to mirror the premiums required under federal advance premium tax credits in the health insurance Marketplace. If premiums are applied to TMA participants below 133% of the poverty level, they should not exceed the Marketplace premiums for that population. The premium amount for those with income between 120 and 132.99 percent of the poverty level in the DHS draft waiver is 2.5 percent of income, whereas the premium for individuals with incomes under 133 percent of the poverty level who receive the advance premium tax credit is 2 percent of income. The Medicaid premium should not be more than the advance premium tax credit premium on the Marketplace for low-income individuals. In conclusion, to ensure that that DHS achieves the stated intent of decreasing the number of uninsured Wisconsinites, the Department must take responsibility for ensuring a smooth and sustained transition of low-income adults from BadgerCare into the subsidized federal Marketplace coverage. We appreciate the	

			Department's early efforts at outreach, and look forward to seeing this work quickly accelerated in an accountable and transparent manner.	
E-mail	E-mail	8/5/13	The Wisconsin Primary Health Care Association (WPHCA) represents the 17 Federally Qualified Health Centers (subsequently referred to as "Health Centers") across our state, and is pleased to respond to the above-cited request for comments from the Wisconsin Department of Health Services, Division of Health Care Access and Accountability. In 2012, Wisconsin's Health Centers saw 304,606 unique patients, approximately 60% of whom were insured through Medicaid, and approximately 23% of whom had no insurance coverage. Our Health Centers provide medical, dental, behavioral health and in house pharmacy across urban and rural areas. Wisconsin Health Centers play a critical role in the health care safety net and are a key partner in providing BadgerCare to low-income residents across the State of Wisconsin. We fully support the provision of BadgerCare Plus Standard Plan benefits for all adults living at or below 100% of the Federal Poverty Level, and for children and pregnant women living up to 300% of the Federal Poverty Level. As indicated in the Waiver application, the Primary Care Association and the Health Centers we represent are in full support of the Department's plan to provide Standard Plan level benefits to all adults living up to 100% FPL and to children and pregnant women living up to 300% FPL. Currently, only a small number of non-custodial adults in Wisconsin are insured through the BadgerCare Core program, a plan which was only open for a few months due to a cap on enrollment. In addition, the benefits provided under the Core plan are dramatically scaled back from the full benefits awarded under the Standard Plan. As primary providers of BadgerCare services, Wisconsin's Health Centers support the Department's intention to provide a wider array of coverage to low-income patients, including dental and mental health services. Wisconsin's Health Centers have made great strides to improve access to dental and mental health services over the past several years,	The Department thanks WPHCA for their comments and will take them under consideration.

			and this waiver represents additional access for a great number of Wisconsinites. If approved, this waiver would provide a quality level of benefits for nearly all Wisconsinites under 100% FPL. This is a great step forward to ensuring access to care and peace of mind for our fellow community members and neighbors. We also feel it is important to have continuity of benefits for those covered under this program and urge the department to clarify and maintain the commitment to the benefits and associated cost-sharing of the current BadgerCare Standard Plan for the duration of the waiver. While this plan provides unprecedented coverage for an entire population within a certain income bracket, it also reduces income eligibility levels, eliminating BadgerCare coverage for over 80,000 adults living between 100-200% FPL. It will be absolutely critical for the Department of Health Services to take responsibility for the successful transition of these individuals off of BadgerCare coverage and to secure enrollment in a Qualified Health Plan sold in the Marketplace. WPHCA and its members stand ready to be a partner in this effort to connect consumers with information and enrollment services for health care coverage. Thank you for your consideration.	

Appendix C – Public Comments Unrelated to the Waiver Request

Where	Mode	Date Received	Comment Summary	Response
E-Mail	E-Mail	7/8/2013	As a member of NAMI, the National Alliance on Mental Illness, I am dismayed that Wisconsin is passing up the best opportunity we have to address the shameful void in public mental health services. If we have learned anything at all over the past two years, it is that we must do what it takes to identify and treat mental illness early. Medicaid Expansion would have increased early identification and treatment for children who live with mental illness through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), a provision of federal Medicaid law. Medicaid Expansion would have filled critical gaps in access to care for the over 40,000 uninsured adults in Wisconsin who live with mental illness. That's 20% of all uninsured adults in Wisconsin. Those people have effectively been abandoned. As a person living with mental illness who was almost bankrupted by medical bills due to mental illness treatment needs, please work to provide parity in coverage for mental health AND support for those without insurance. Ignoring the mental health of our communities has broad financial implications that affect us all.	The eligibility changes authorized under the 2013-2015 budget do not impact Medicaid eligibility for children – children in the State will still have access to BadgerCare and all applicable benefits. One other important item to note is that as a part of the budget, Wisconsin's Standard Plan benefits will be expanded to all eligible Medicaid recipients. Mental health benefits are included as a part of this comprehensive benefits package – a benefit that has been limited in scope under the Benchmark and Core Plans.
E-Mail	E-Mail	7/8/2013	I am writing on behalf of the Wisconsin Breast Cancer Coalition. The WBCC is profoundly disappointed that Governor Walker and his colleagues have chosen to refuse the Medicaid Expansion funding. We fully expect that many low income women who will either be kicked off, or denied access to BadgerCare will go without insurance and will be less likely to discuss their breast health with a healthcare provider. Sadly, we also expect more of them to find tumors at later stages when they are less curable and more expensive to treat than if they'd been found early through regular screenings and clinical breast exams. It is even more disappointing because it is clear to us that the Republican leadership appears to have silenced their colleagues who have publicly, and in meetings with advocates, expressed concern about the Governor's rejection of federal funding to expand access to health care for low income residents in Wisconsin. This was a political move not in the least intended to expand access to health care for low income residents. We have been concerned from day one about the fate of the Wisconsin Well Woman Program's Medicaid component. It was reassuring to finally hear at a public hearing held by DHS on July 11, that there will be no changes to this program and that women will still be eligible up to 250%. We sincerely hope that bears out, as we expect many more women between 100% and 250% FPL will need the Well Woman Program and its Medicaid component.	Thank you for your comments. This reiterates that the eligibility changes as included under the 2013-2015 budget and this waiver request do not impact the existing Wisconsin Well Woman Program.

Where	Mode	Date Received	Comment Summary	Response
E-Mail	E-Mail	7/9/2013	First of all, a sincere public comment effort would have begun at a formative stage of this proposal, not after the Legislature had implicitly approved the proposal though the state budget process. A sincere public involvement process would also provide the opportunity to comment closer to where the people live. More than one-third of the state's land area is North of Eau Claire and more than a third is Southwest of Eau Claire. What is worse, those areas contain some of the places that most rely on the benefits of BadgerCare. Asking people to drive two to three hours for the opportunity for input does not demonstrate a sincere interest in their views. Second, by your numbers, which were conveniently withheld until after the budget discussions were complete, 1,017 people in my home county of Richland will be without health care because of the changes to BadgerCare? Four hundred twenty four will be kicked off the program; the balance will simply be denied care. These criteria have obviously been known for some time, but the people who will be impacted have not been informed. They need to know their status as soon as possible so that they can evaluate the meager options available to them and make sound decisions.	Thank you for your comments. The Department is holding 3 separate public hearings on the waiver application, one in Eau Claire, in in Green Bay and one in Milwaukee. We are also making every effort to ensure that there is reasonable access to both telephonic and web-based participation. We are also working with community partners, health plans, counties, IM consortia, and several other stakeholders across the State to develop a comprehensive outreach and education strategy related to the eligibility changes in 2014. In September, the Department will be proactively reaching out to those members who may be transitioning off of Medicaid in 2014.
Eau Claire Public Hearing	In-Person	7/10/2013	When will DHCAA notify existing BadgerCare Plus members that their eligibility will be ending due to the change in state law?	On September 23rd, DHCAA will begin mailing out a series of notifications to all members who are likely to transition off of BadgerCare Plus coverage on December 31, 2013.
Eau Claire Public Hearing	In-Person	7/10/2013	Where will the terminated BadgerCare Plus members be directed with their questions?	DCHAA is currently working on a plan for how best to transition members to the Federal Marketplace. Part of that plan will be a comprehensive description of where members will be directed to call with their questions, or to discuss options face-to-face.
Eau Claire Public Hearing	In-Person	7/10/2013	Individual from a health plan was worried that folks terminated from BadgerCare Plus will not find their way into private insurance, through the Federal Marketplace or otherwise.	The Department is collaborating closely with health plans, providers and community advocates on the development of an outreach and education strategy. A part of this strategy will involve training on where to send individuals with additional help on purchasing health coverage, either through the exchange or otherwise.

Where	Mode	Date Received	Comment Summary	Response
Eau Claire Public Hearing	In-Person	7/10/2013	An Eau Claire County Board Supervisor commented that the Eau Claire County Board of Supervisors had passed a resolution that urged Governor Walker and the Wisconsin Legislature to expand Medicaid under the ACA provision. The Board also requested that the State consider allowing counties to access the 100% FMAP and expand Medicaid for their county residents only. He asked if the State could do this as part of this demonstration project.	The Legislature and Governor enacted the biennial budget act that specified that parents, caretaker relatives and childless adults would be eligible so long as their income remained no greater than 100% of the FPL. Without statutory approval, the Department of Health Services cannot request a waiver that would exceed the coverage granted under current statute. Furthermore, it is our understanding that the federal government would be unable to allow for county-specific Medicaid Expansion in a State. This has been discussed at length by other States and the answer has been that US DHHS will only approve statewide Medicaid Expansion through an amendment to the single state Medicaid agency's Medicaid State Plan.
Eau Claire Public Hearing	In-Person	7/10/2013	How will the federal marketplace and the new insurance rules change things for me? I have a pre-existing condition and can't get insurance.	QHPs in a state or federal health insurance exchange will not be allowed to exclude individuals or increase the cost of health insurance for persons with pre-existing conditions. Additionally, individuals/families with income under 400% FPL may be eligible to receive premium tax credits through the Federal Marketplace that will help them pay for the cost of their health insurance.
Eau Claire Public Hearing	In-Person	7/10/2013	How will Wisconsin pay for health care coverage when we turned down $85 million in federal funds?	The 2013-2015 Biennial Budget enacted by the Legislature and Governor Walker relies on both federal and state funds to pay for the costs of the BadgerCare Plus program. Based on the State's projections, adequate funds have been appropriated to fund this program.
Eau Claire Public Hearing	In-Person	7/10/2013	The folks who supported the BadgerCare Plus changes in the state law aren't in this room.	Thank you for your comments.

Where	Mode	Date Received	Comment Summary	Response
Eau Claire Public Hearing	In-Person	7/10/2013	Any public hearings for Family Care program changes? I've asked DHS several times to have someone come to Eau Claire and do a presentation on Family Care changes?	We'll check on the Family Care public hearings and provide that information to you.
Eau Claire Public Hearing	In-Person	7/10/2013	I work for one of the few dental practices in the area that see Medicaid patients. Did the biennial budget include any increases in the reimbursement for dental services?	There was not a rate increase in the budget for fee-for-service dental services.
Tribal Consultation Meeting	In-Person	7/10/2013	Does the cost-sharing reduction for tribe member provided by ACA apply to descendants of members?	A tribal descendant may be exempt from the ACA individual mandate, but this is not an exemption from the cost sharing as far as the Department understands at this point in time, but we will research this and get back to the tribes with a response.
Tribal Consultation Meeting	In-Person	7/10/2013	Will tribe members be required to pay premium for coverage in the Federal Marketplace?	Members with incomes under 300% FPL are exempt from ACA cost sharing and premium requirements. Members 300-400% FPL must pay premiums, but it is our understanding that they would be eligible for the federal tax credits.
Green Bay Public Hearing	In-Person	7/11/2013	For those who don't know about this, State can always expand Medicaid even if we reject it now.	Thank you for your comments. The State understands that we do have the option to expand the program as defined under the ACA at a later point in time.
Green Bay Public Hearing	In-Person	7/11/2013	There is a great deal of frustration with not accepting the federal Medicaid Expansions. How much can you change the waiver that we're requesting?	We can change the waiver based upon comments received, so long as we comply with statutory requirements and meet federal law. Specific changes incorporated in response to public comments are included in the final waiver application.
Green Bay Public Hearing	In-Person	7/11/2013	The State should reconsider accepting the federal Medicaid Expansion funds.	Thank you for comments. The Legislature and Governor enacted the biennial budget act that specified that parents, caretaker relatives and childless adults would be eligible so long as their income remained no greater than 100% of the FPL.

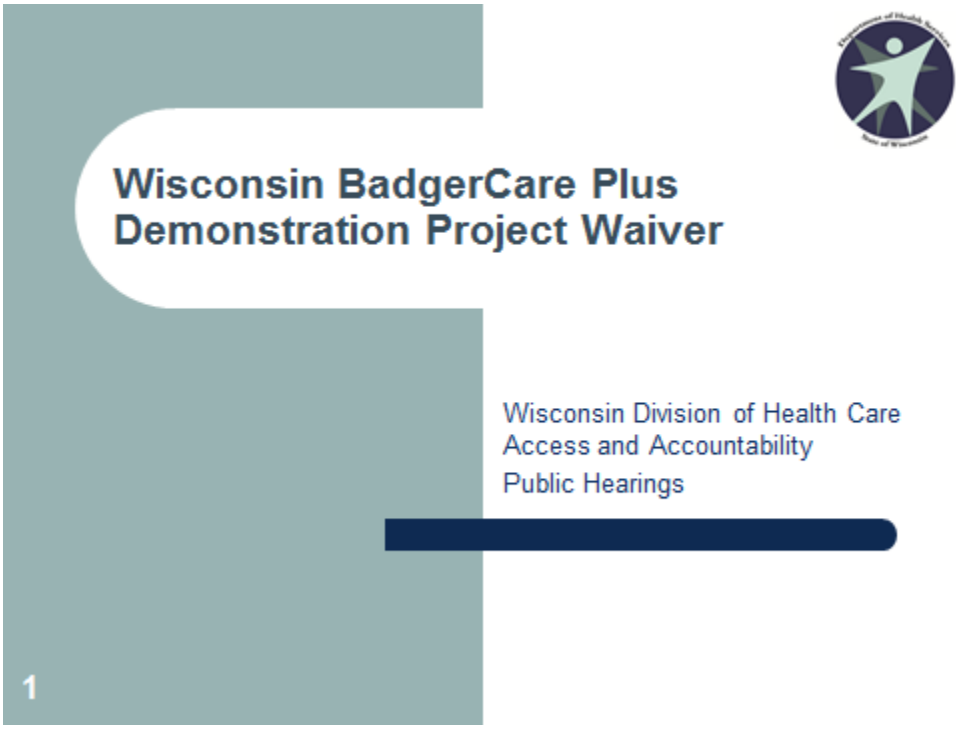
Where	Mode	Date Received	Comment Summary	Response
Green Bay Public Hearing	In-Person	7/11/2013	I'm a 38 year old CLA who has had 21 major surgeries. I don't look disabled and I've always worked. I'm being told by the Republican government that I'm worthless. I'm a self-taught IT professional. I know that you can get everyone's address who would be interested in this public hearing using Big Data. I'm unable to get this benefit because I'm educated. Disappointed in the communication about this public hearing, the only reason I found this was because I was on-line intensely.	The public notice was published in 10 major newspapers throughout Wisconsin and a press release sent to major news outlets by the Department of Health Services. Each public hearing (3 were held across the state in Eau Claire, Green Bay and Milwaukee) allowed both telephonic and web-based participation as well. Additionally, we have created a web site specifically to solicit public comment, which will include the presentation provided during public hearings. An e-mail also went out to the Department's list of Medicaid community partners to help disseminate the information. Anyone could comment through the mail, on the web site or through e-mail through August 5, 2013.
Green Bay Public Hearing	In-Person	7/11/2013	What are the amounts for the PTC for someone at 133% of the FPL?	The total amount of the premium tax credit (PTC) will be determined by the plans offered and by an individual's choice of plan. PTCs are based on the 2nd-lowest cost silver plan available to an individual. Individuals will be able to see the plans available to them starting in October.
Green Bay Public Hearing	In-Person	7/11/2013	An individual who is 62 to 65 and has social security benefits with 100 to 133% FPL, they will need to go through the Marketplace?	The 2013-2015 budget and the associated BadgerCare Plus changes in eligibility make no changes to our elderly, blind and disabled coverage. If an individual is currently eligible for EBD Medicaid, they will continue to be eligible in 2014 given that their status does not change.
Milwaukee Public Meeting	In-Person	7/11/2013	Why did DHS decide to spend all this effort pursuing a waiver when Medicaid Expansion is available? Why not accept the Medicaid Expansion funds? The Governor's decision to not accept Medicaid Expansion funds is illogical.	Governor Walker is investing in something historic for Wisconsin: An expansion of coverage to Childless Adults without a waiting list. This waiver will provide better benefits and access (than the current waivers) and provide a sustainable solution over time.

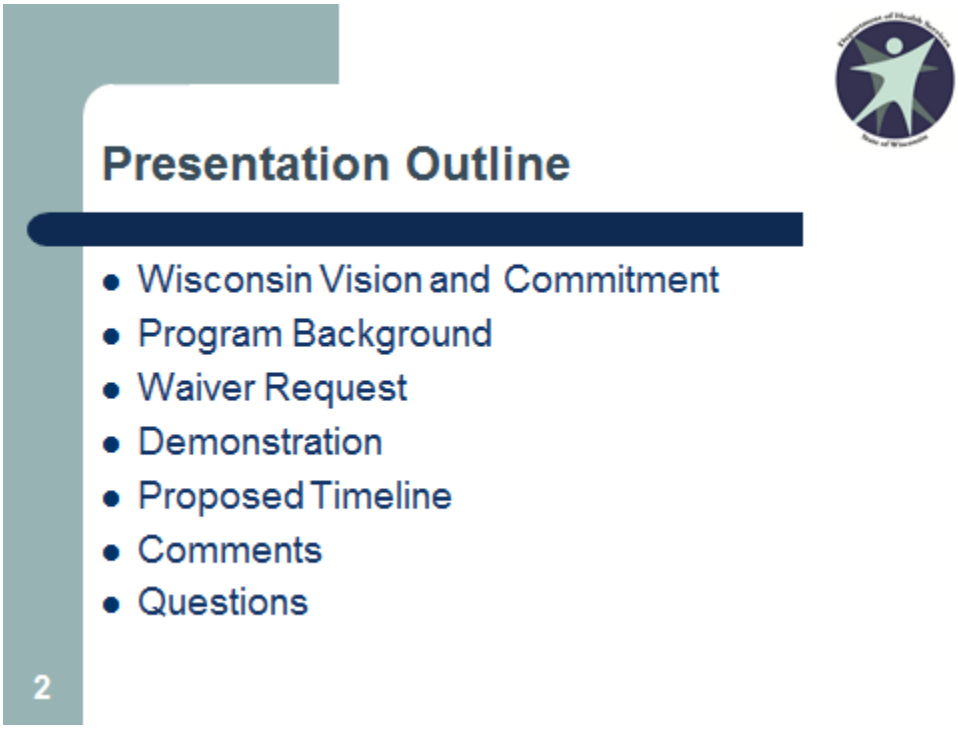
Where	Mode	Date Received	Comment Summary	Response
Milwaukee Public Meeting	In-Person	7/11/2013	Regarding Budget Neutrality, how do you (DHS) say that this waiver is budget neutral when the Legislature provided for a whole different budget to pay hospitals for increased ER utilization (implied- due to the change in BadgerCare eligibility)? What happens to those (over 100% FPL) who don't sign up for QHPs during the enrollment period? Wisconsin should pay a living wage if you want to get rid of entitlements. Why isn't DHS increasing BadgerCare eligibility to 160% FPL as has been approved for under other circumstances?	Thank you for your comments, we will take them under consideration as we review the waiver proposal.
Milwaukee Public Meeting	In-Person	7/11/2013	The State budgeted $73million in DSH payments for high levels of uncompensated care. Is there a backup plan if the allocation doesn't cover actual level of uncompensated care?	DHS is working with hospitals and community partners to reach out to state residents on health benefit enrollment. Hospitals are a partner in this process, and we are including a provision for Presumptive Eligibility for the waiver population to support the hospital role in enrolling eligible childless adults into Medicaid.
Milwaukee Public Meeting	In-Person	7/11/2013	We don't agree with eligibility reduction. The reduction is public health risk and a step backward. Cuts are shocking and will hurt families. Loss of coverage for current members devalues lives. Expanding coverage for some and denying coverage for others is wrong. Wisconsin should accept Medicaid Expansion.	DHS wants to get individuals covered but not only on government insurance. We will work with stakeholders aggressively to get individuals enrolled in QHPs so they have access to private health insurance.
Milwaukee Public Meeting	In-Person	7/11/2013	This waiver is propaganda. Dennis Smith convinced Governor Walker to opt out of Medicaid Expansion. Walker's ideology is forcing people into insurance they can't afford. Furthermore, the Governor's plan is a hidden tax on Wisconsin taxpayers. Governor's plan will cost the State $149 million more in upcoming budgets. The number of people who will be kicked off of BadgerCare is more than the published estimate. Walker should accept Medicaid Expansion like the other Republican Governors.	Thanks for your comments.

Where	Mode	Date Received	Comment Summary	Response
Milwaukee Public Meeting	In-Person	7/11/2013	Wisconsin is already damaged with large amounts of income disparity and financial risk for low-income people. DHS should be more concerned with what this waiver means for low-income people. The waiver design is totally different than BadgerCare. BadgerCare is what we know and are comfortable with. No one will pay the QHP premium.- people are already struggle and they won't pay a $5/week premium. Just stick with Badger Care, don't change anything. I don't trust this waiver. DHS should have talked to the community before making changes. It's not about personal responsibility- bad health is something that some people are born with. People know what they need- we should tell you what we need instead of you (DHS) deciding what co-pays and premiums we should have. Why can't we get a waiver for expanding BadgerCare (here in Milwaukee)? Why are you taking the needs of the community into mind when you figuring out policy. You're going about this all backward.	We think that there will be more people on BadgerCare Plus in 2014 than today and with more benefits- including mental health. We have a large waitlist right now, which includes some of the most vulnerable populations, such as the homeless who don't have access to healthcare services- removing the current enrollment cap is a huge first step.
Milwaukee Public Meeting	In-Person	7/11/2013	Will DHS make the BadgerCare Plus SPA available to the public?	Yes, the SPAs are on the website and we will make SPA changes available in the next quarter. The waiver application is also currently available in draft form on the DHS website, and will also be publically available once submitted.
Milwaukee Public Meeting	In-Person	7/11/2013	How will this waiver affect homestead act services? Will eligibility change for those who want to work on MAPP?	This waiver will not change homestead act services. The waiver will not change MAPP requirements.
Milwaukee Public Meeting	In-Person	7/11/2013	Governor Walker is going about this the wrong way. The Governor should have taken Expansion for at least a year. Ultimately, the State needs a single payer system.	Thank you for your comments.
Milwaukee Public Meeting	In-Person	7/11/2013	I absolutely disagree with Governor Walker's decision. If we are going this way (waiver) - we need to give people early notice so they can think about how to incorporate coverage changes into their lives. Dealing with insurers is difficult. DHS should go to sleep thinking about the people who are affected by your policies.	Beginning on September 23rd, DHCAA will begin mailing out a series of notifications to all members who are likely to transition off of BadgerCare Plus coverage on December 31, 2013.

Where	Mode	Date Received	Comment Summary	Response
Milwaukee Public Meeting	In-Person	7/11/2013	BadgerCare was a key factor to my ovarian survival. This policy change is short-sighted and illogical. Why didn't Governor Walker take the ACA Medicaid Expansion? DHS should at least notify people now so they can find other health care alternatives. Lawmakers know that people are going to fall through the crack so they have added DSH money to the budget for hospitals. This waiver is immoral.	Thank you for your comments.
Milwaukee Public Meeting	In-Person	7/11/2013	People have trouble finding providers who will take BadgerCare. Is the administration working with the federal government to increase reimbursement rates?	The 2013-2015 budget does include some funding to promote both dental and physician workforce development. In addition, the Department is implementing the Primary Care Rate increase as required by the ACA.
Milwaukee Public Meeting	In-Person	7/11/2013	We see healthcare issues come to us at the NAACP office as social justice issues. There used to be a cluster of community health centers to address community need. Now there aren't providers in the community and people go to the hospital for primary health care- especially the lack of emergency dental care. Without insurance, basic preventative care will be unavailable. This waiver is a step backward. We should not be cutting coverage in 2013.	Thank you for your comments. We will take access to community resources and preventive care into consideration as we develop our outreach and education strategies and other initiatives moving forward.
E-mail	E-mail	7/25/2013	I am a Registered Nurse, and have been since 1977. I am a member of Wisconsin Nurses Association, American Nurses Association, and American Public Health Association. I support Wisconsin Nurses Association regarding the Affordable Care act and BadgerCare/Medicaid positions. Refusing federal monies is shortsighted and not helpful for health outcomes of Wisconsin residents. In addition, my opinion is that what we really need is a system similar to that of Canada, and I believe that we should work toward that goal over the long run.	Thank you for your comments.

Appendix D – Public Hearing Presentation





Wisconsin Vision and Commitment

Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.

Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.

Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

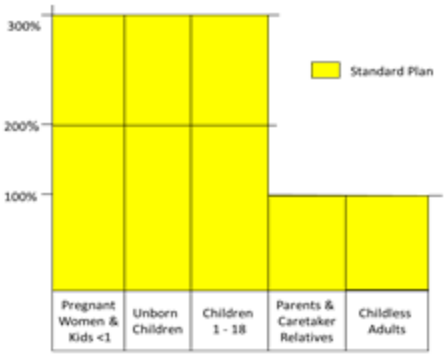
3

Current BadgerCare Plus Health Plans

BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	454,384	247,712	16,450	769,150

4

BadgerCare Plus Health Plan - 2014



BadgerCare Plus Enrollment - Projected in Budget				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,604	522,695	160,255	98,641	802,195

5

2013 Federal Poverty Levels

Monthly Income Levels by Family Size

Family size	100% FPL	120% FPL	133% FPL	136% FPL	160% FPL	200% FPL	250% FPL	300% FPL
1	$957.50	$1,149.00	$1,273.48	$1,292.63	$1,436.25	$1,915.00	$2,393.75	$2,872.50
2	$1,292.50	$1,551.00	$1,719.03	$1,744.88	$1,938.75	$2,585.00	$3,231.25	$3,877.50
3	$1,627.50	$1,953.00	$2,164.58	$2,197.13	$2,441.25	$3,255.00	$4,068.75	$4,882.50
4	$1,962.50	$2,355.00	$2,610.13	$2,649.38	$2,943.75	$3,925.00	$4,906.25	$5,887.50

6

Existing Waivers

- Wisconsin currently has two existing waivers that authorize the BadgerCare Plus programs, the BadgerCare and BadgerCare Plus Childless Adult (Core Plan) Waivers.
- Both of these waivers will be expiring on December 31, 2013.
- The newly proposed BadgerCare Plus Demonstration Project Waiver will contain some elements of each of the existing waivers, as well as the new demonstration components discussed throughout this presentation.

7

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver
  - Program began in 2009.
  - Adults without dependent children (referred to as childless adults) with incomes up to 200% FPL.
  - Enrollment is capped and a waitlist is maintained.
  - Benefit plan is limited and does not comply with the Essential Health Benefits requirements of the federal government.
  - Waiver expires December 31, 2013.

8

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver members are:
  - 19 to 64 years of age;
  - Not pregnant or parents or caretaker relatives of children under age 19;
  - Not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
  - Not entitled to Medicare;
  - And meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.).

9

Core Plan Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for childless adults under the current waiver by State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,595	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,650	$106,536,654	$96,066,596

10

Transitional MA Background

Transitional Medical Assistance (TMA):

- TMA allows non-disabled, non-pregnant adults and children to maintain their Medicaid coverage for twelve months once their earning or spousal support rises above the amount that would have qualified them for benefits under the former Aid to Families with Dependent Children cash assistance program (100% FPL).

- As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), Wisconsin requires non-pregnant, non-disabled adults receiving Medicaid, including those on TMA, with family incomes above 133% of the FPL to pay a monthly premium. Those who do not pay a premium cannot re-enroll in BadgerCare Plus for twelve months while their income remains high enough to owe a premium.

11

Historical Transitional MA Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	20,780	25,514	51,097	55,576	19,500
Aggregate Expenditures	$69,522,060	$85,114,704	$105,759,592	$111,542,556	$65,052,000

12

BadgerCare Plus Demonstration Project Waiver Request

- Cover all Wisconsin adult residents with incomes below the federal poverty line – 100% FPL.
- Simplify benefits design:
  - One benefit package, the Standard Plan, for adults.
  - Clearer for providers, less administratively cumbersome to manage, and more easily understood by the people served.
  - More comprehensive set of services than was previously available under the Core Plan (mental/behavioral health, preventive dental, non-emergency medical transportation, etc.).

13

Background - Comparing Current Plans

Full Coverage in All Plans – Chiropractic, Hospital Outpatient & Emergency Department, Physician, Podiatry, Reproductive Health, and Emergency Transportation

Full Coverage | Limited Coverage | No Coverage

14

BadgerCare Plus Demonstration Project Waiver Request

Establish a new five-year waiver project that will:

- Allow for the coverage of adults without dependent children with incomes not to exceed 100% FPL.
- Require all non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, to pay ACA-level premiums beginning at 100% FPL.

15

Demonstration

- By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:
  - Improve health outcomes.
  - Increase the cost effectiveness of Medical Assistance services.
  - Reduce the incidence of unnecessary services.
  - Increase the continuity of health coverage.
- DHS will evaluate this hypothesis with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

16

Proposed Childless Adult Eligibility

If approved, effective Jan 1, 2014:

- Eligible individuals will no longer be required to pay an annual enrollment fee.
- Eligible childless adults will not be subject to an enrollment cap.
- Eligible individuals will be enrolled in the Standard Plan.

17

Projected Childless Adult Enrollment & Expenditures

- Projected annual enrollment and aggregate expenditures (based on date of payment) for childless adults by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$356,759,524	$402,229,905	$416,319,101	$435,051,865

18

Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Adult participants with income that exceeds 100% FPL are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled.

- Adult participants who fail to make a premium payment cannot re-enroll as a parent or caretaker relative into the Medicaid program for a period of twelve months.

19

Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Affected eligible members will be subject to monthly premiums (between 2-9.5% of income) based on a sliding scale.

- Pre-payment of the first month's premium payment is required.

20

Projected Transitional MA Enrollment & Expenditures

- Projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$45,541,910

21

Budget Neutrality

- Federal policy requires s. 1115 waiver demonstrations be budget neutral to the federal government.
- This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration.
- For the childless adults population, Wisconsin proposes to use a per-member per-month (PMPM) based methodology specific to the Wisconsin childless adult population under 100% of FPL to achieve budget neutrality.
- For transitional MA, budget neutrality will be demonstrated based on a reduction in aggregate expenditures or a reduction in the PMPM.

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Proposed Timeline

Major Milestones	Tentative Date
Public Notice Issued	July 1, 2013
Comment Period Closed	August 5, 2013
Waiver Submission	August 09, 2013
CMS Approval	Late September 2013
Benefits Effective Date	January 1, 2014

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Comments

Comments may be submitted by August 5, 2013 using the following methods:

- Online - http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
- Email - DHSBCDemonstrationWaiver@dhs.wisconsin.gov
- Fax - 608-266-1096
- Mail

  Al Matano
  Division of Health Care Access and Accountability
  P.O. Box 309
  Madison, WI 53707-0309

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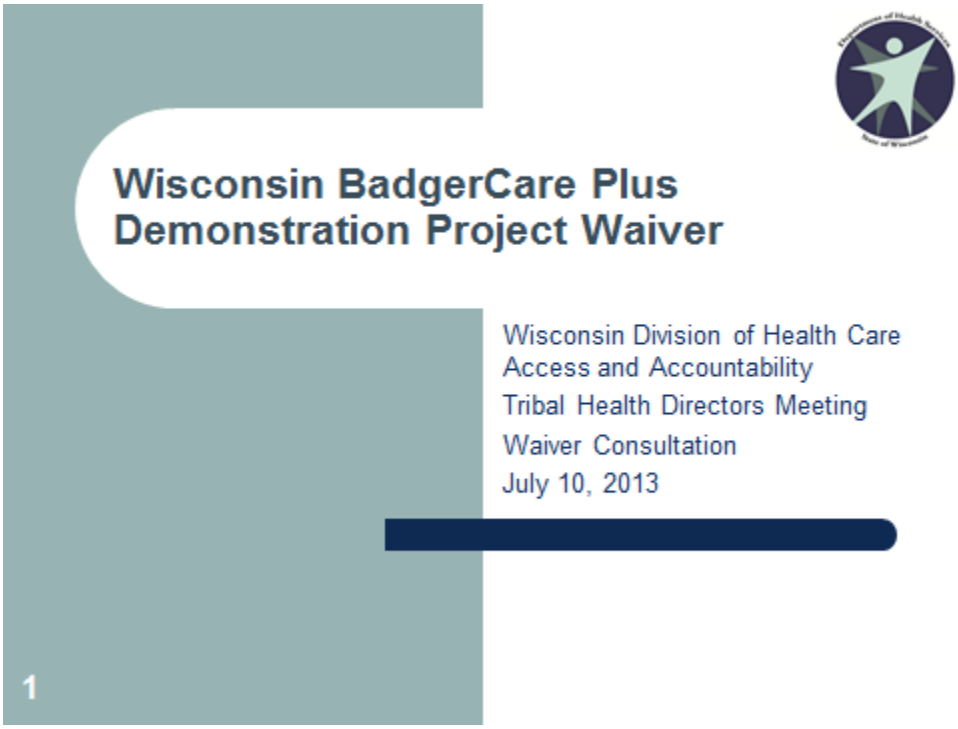
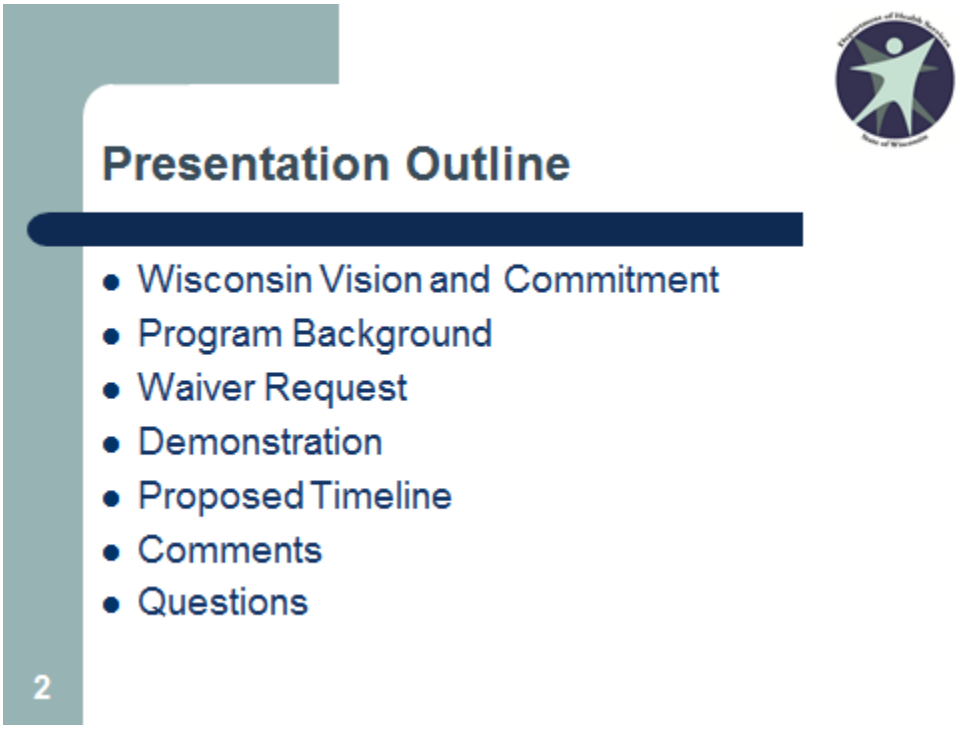
Questions

25

Appendix E – Tribal Consultation Presentation





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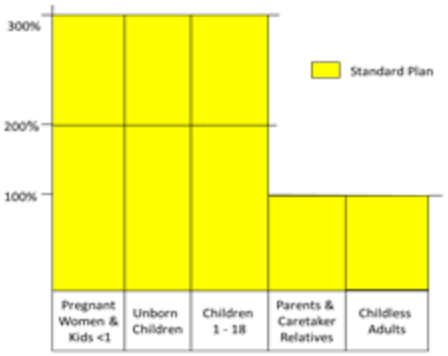

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2	$1,292.50	$1,551.00	$1,719.03	$1,744.88	$1,938.75	$2,585.00	$3,231.25	$3,877.50
3	$1,627.50	$1,953.00	$2,164.58	$2,197.13	$2,441.25	$3,255.00	$4,068.75	$4,882.50
4	$1,962.50	$2,355.00	$2,610.13	$2,649.38	$2,943.75	$3,925.00	$4,906.25	$5,887.50

6

Existing Waivers

- Wisconsin currently has two existing waivers that authorize the BadgerCare Plus programs, the BadgerCare and BadgerCare Plus Childless Adult (Core Plan) Waivers.
- Both of these waivers will be expiring on December 31, 2013.
- The newly proposed BadgerCare Plus Demonstration Project Waiver will contain some elements of each of the existing waivers, as well as the new demonstration components discussed throughout this presentation.

7

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver
  - Program began in 2009.
  - Adults without dependent children (referred to as childless adults) with incomes up to 200% FPL.
  - Enrollment is capped and a waitlist is maintained.
  - Benefit plan is limited and does not comply with the Essential Health Benefits requirements of the federal government.
  - Waiver expires December 31, 2013.

8

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver members are:
  - 19 to 64 years of age;
  - Not pregnant or parents or caretaker relatives of children under age 19;
  - Not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
  - Not entitled to Medicare;
  - And meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.).

9

Core Plan Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for childless adults under the current waiver by State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	12,595	50,627	45,349	28,991	21,016
Aggregate Expenditures	$51,075,005	$182,620,259	$144,075,650	$106,535,654	$96,066,596

10

BadgerCare Plus Tribal Impacts

- Parents/Caretaker relatives and childless adults under 100% FPL eligible for BadgerCare Plus.
- Parents/Caretaker relatives and childless adults over 100% FPL eligible for private coverage in the new federal Marketplace.
  - DHS can work with each tribe to produce tribe specific impacts via a member data match.
  - DHS will notify tribal members of potential changes in September and November 2013.
- Childless adults under 100% FPL covered by the BadgerCare Plus Standard Plan.

11

Transitional MA Background

Transitional Medical Assistance (TMA):

- TMA allows non-disabled, non-pregnant adults and children to maintain their Medicaid coverage for twelve months once their earning or spousal support rises above the amount that would have qualified them for benefits under the former Aid to Families with Dependent Children cash assistance program (100% FPL).

- As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), Wisconsin requires non-pregnant, non-disabled adults receiving Medicaid, including those on TMA, with family incomes above 133% of the FPL to pay a monthly premium. Those who do not pay a premium cannot re-enroll in BadgerCare Plus for twelve months while their income remains high enough to owe a premium.

12

Historical Transitional MA Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	20,780	25,514	51,097	55,576	19,500
Aggregate Expenditures	$69,522,060	$85,114,704	$105,759,592	$111,542,556	$65,052,000

13

BadgerCare Plus Demonstration Project Waiver Request

- Cover all Wisconsin adult residents with incomes below the federal poverty line – 100% FPL.
- Simplify benefits design:
  - One benefit package, the Standard Plan, for adults.
  - Clearer for providers, less administratively cumbersome to manage, and more easily understood by the people served.
  - More comprehensive set of services than was previously available under the Core Plan (mental/behavioral health, preventive dental, non-emergency medical transportation, etc.).

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Background - Comparing Current Plans

Service	Standard Plan	Benchmark Plan	Core Plan
Dental			
Durable Medical Equipment and Supplies			
Drugs			
Hearing			
Home Care/Personal Care			
Hospital - Inpatient			
Behavioral			
Nursing Home			
Therapies			
Vision			
Smoking Cessation			
Non-Emergency Medical Transportation			

Full Coverage in All Plans – Chiropractic, Hospital Outpatient & Emergency Department, Physician, Podiatry, Reproductive Health, and Emergency Transportation

Full Coverage Limited Coverage No Coverage

15

BadgerCare Plus Demonstration Project Waiver Request

Establish a new five-year waiver project that will:

- Allow for the coverage of adults without dependent children with incomes not to exceed 100% FPL.
- Require all non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, to pay ACA-level premiums beginning at 100% FPL.

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Demonstration

- By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:
  - Improve health outcomes.
  - Increase the cost effectiveness of Medical Assistance services.
  - Reduce the incidence of unnecessary services.
  - Increase the continuity of health coverage.
- DHS will evaluate this hypothesis with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

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Proposed Childless Adult Eligibility

If approved, effective Jan 1, 2014:

- Eligible individuals will no longer be required to pay an annual enrollment fee.
- Eligible childless adults will not be subject to an enrollment cap.
- Eligible individuals will be enrolled in the Standard Plan.

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Projected Childless Adult Enrollment & Expenditures

- Projected annual enrollment and aggregate expenditures (based on date of payment) for childless adults by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	47,552	95,641	95,641	95,641	95,641
Aggregate Expenditures	$199,145,069	$356,759,524	$402,229,905	$416,519,101	$435,051,665

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Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Adult participants with income that exceeds 100% FPL are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled.

- Adult participants who fail to make a premium payment cannot re-enroll as a parent or caretaker relative into the Medicaid program for a period of twelve months.

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Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Affected eligible members will be subject to monthly premiums (between 2-9.5% of income) based on a sliding scale.
- Pre-payment of the first month's premium payment is required.

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Projected Transitional MA Enrollment & Expenditures

- Projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$45,541,910

22

Budget Neutrality

- Federal policy requires s. 1115 waiver demonstrations be budget neutral to the federal government.
- This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration.
- For the childless adults population, Wisconsin proposes to use a per-member per-month (PMPM) based methodology specific to the Wisconsin childless adult population under 100% of FPL to achieve budget neutrality.
- For transitional MA, budget neutrality will be demonstrated based on a reduction in aggregate expenditures or a reduction in the PMPM.

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Proposed Timeline

Major Milestones	Tentative Date
Public Notice Issued	July 1, 2013
Comment Period Closed	August 5, 2013
Waiver Submission	August 09, 2013
CMS Approval	Late September 2013
Benefits Effective Date	January 1, 2014

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Comments

Comments may be submitted by August 5, 2013 using the following methods:

- Online - http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
- Email - DHSBCDemonstrationWaiver@dhs.wisconsin.gov
- Fax - 608-266-1096
- Mail

  Al Matano
  Division of Health Care Access and Accountability
  P.O. Box 309
  Madison, WI 53707-0309

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Questions

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Appendix F – Eau Claire County Board Resolutions

Enrolled No. RESOLUTION File No. 13-14/017

-URGING WISCONSIN TO USE FEDERAL MEDICAID FUNDING TO IMPROVE BADGER CARE-

WHEREAS, the Governor has rejected billions of new federal dollars for Medicaid which would have improved the state's BadgerCare program; and

WHEREAS, the federal Affordable Care Act encourages innovation in states with the goal of a greater level of health care coverage; and

WHEREAS, the decision to turn down federal funding for the State of Wisconsin, will not increase health care coverage; it actually makes it harder for people to qualify for BadgerCare, with an estimated 88,000 adults who currently qualify for the program being dropped; and

WHEREAS, not only does the decision to reject federal Medicaid funding shrink the number of Wisconsin residents who have health care coverage, but it also increases the costs to the state for the program; and

WHEREAS, if Medicaid was fully expanded, Wisconsin would have received $4.4 billion in federal support over 6 years. However, according to the Legislative Fiscal Bureau, the state budget will require $100 million more this budget cycle by rejecting these federal funds; and

WHEREAS, in 2014 thousands of Medicaid recipients will be placed in private health insurance exchanges and required to pay premiums. The transition from Medicaid to private insurance and the premium cost could result in the loss of health care due to confusion and inability to pay; and

WHEREAS, being underinsured and uninsured impacts county human services departments because it can lead to untreated mental health or substance abuse and lack of preventive health care that can lead to loss of jobs, the inability to function and loss of self-sufficiency; and

WHEREAS, Wisconsin Assembly Bill 53, and its companion, Senate Bill 38, requires the state to take action to qualify for enhanced Medicaid funding.

NOW THEREFORE BE IT RESOLVED, the Eau Claire County Board of Supervisors urges the Wisconsin Legislature to support Assembly Bill 53 and Senate Bill 38 and accept enhanced federal Medicaid funding to improve the state's BadgerCare program.

BE IT FURTHER RESOLVED, that as an alternative, the Eau Claire County Board of Supervisors encourages the Governor and the Wisconsin Legislature to authorize and enable counties to enhance Medicaid funding at the county level, thereby ensuring that citizens in participating counties have access to affordable health coverage.

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BE IT FURTHER RESOLVED, that the county clerk is directed to send a copy of this resolution to the Governor of the State of Wisconsin, Wisconsin Department of Health Services Secretary Kitty Rhoades, U.S. Department of Human Services Secretary, The Wisconsin Counties Association, and State Senators and Assembly members representing Eau Claire County.

OFFERED BY:

Supervisor Colleen Bates, Distict12

Supervisor Nick Smiar, District 15

Supervisor Gerald "Jerry" Wilkie District 19

Dated this 16th day of April, 2013.

ORDINANC/13-14.017

REVIEWED BY
CORPORATION COUNSEL
AS TO FORM

FACT SHEET
TO FILE NO. 13-14/017

One of the most important ways the new health care reform law expands coverage is filling the gaping holes in state programs (BadgerCare in Wisconsin) providing coverage to low income adults. Currently there are over 140,000 low income Wisconsinites on a waiting list for BadgerCare who are falling between the cracks. However, the U.S. Supreme Court gave states the option of turning down the funding. Although a number of governors have said yes to the new Medicaid dollars, the Governor of the State of Wisconsin decided in February to reject the funding and offer an alternative plan which forces 88,000 people off BadgerCare, costs over $200 million more, and will cover fewer people. However, the decision is not final and Wisconsin can accept the funding at any time.

People who lack access to stable and affordable health coverage face a constant threat of having their lives and careers devastated by health disasters.

The role of government is to step in and fill the gaps when the private market fails to provide equal economic and social opportunity. Filling the holes in BadgerCare is essential because the health insurance market has failed to provide low-income Wisconsinites with affordable health insurance options, and low-wage jobs are far less likely to include affordable coverage.

The rejection of federal Medicaid funding, forces low income Wisconsinites on to health exchanges that were designed for people with higher incomes.

The Governor's alternative plan force's 88,000 people off BadgerCare, many of whom make too little money to afford the new health care exchanges in which the Governor assumes they will enroll. The plan costs $100 million more in the current state budget to cover fewer people. In addition, the plan costs over 5 times more over the next 6 years (Non-partisan Legislative Fiscal Bureau analysis).

If the Legislature reverses the Governor's decision and accepts the funding, Wisconsin will get $12 billion dollars to fill the holes in BadgerCare over the next 10 years (Kaiser Family Foundation).

If Wisconsin accepts the new federal funding it will extend BadgerCare to over 170,000 Wisconsinites who currently fall through the cracks in the program. Within 10 years 211,000 additional Wisconsinites will have access to BadgerCare (Legislative Fiscal Bureau, Kaiser Family Foundation). Of that, an estimated 1,200 uninsured veterans would be eligible, and roughly 500 military spouses (Robert Wood Johnson Foundation).

There are over 146,000 Wisconsinites on the BadgerCare waiting list (WI Department of Health and Family Services).

The Medicaid (BadgerCare) provisions of the national health care reform law guarantee's coverage to all citizens below 133% of the federal poverty level--$14,856 in annual income ($7.14 per hour) for a single individual and $20,123 ($9.67 per hour) for couples. (Wisconsin Council on Children and Families).

Wisconsin hospitals would lose out on revenues as uninsured individuals continue to incur ER bills and uncompensated costs, costs that would have been covered by BadgerCare. Hospitals will lose out on $3.7 billion in revenue over the next 10 years (Robert Wood Johnson Foundation).

- The Governor's Administration has incorrectly suggested that filling the holes in BadgerCare would be very costly for the state (Wisconsin State Journal). According to the most authoritative national research, Wisconsin would actually save a total of at least $495 million over the next ten years by accepting the federal funding to fill the holes in BadgerCare (Kaiser Family Foundation).

    - Wisconsin would save $248 million over the next ten years by accepting the increased Medicaid funding because the federal government would pay over 90% of the costs of coverage for many current BadgerCare recipients for which the feds currently pay only 60% of the costs (Kaiser Family Foundation).

    - Wisconsin would also save an additional $247 million in the cost of uncompensated medical care because more people would have health coverage (Kaiser Family Foundation).

    - Not taking the funding would be costly for Wisconsin business. According to a national study by Jackson Hewitt Tax Services, the Governors decision to turn down the new Medicaid dollars will lead to a $36 million business tax increase in Wisconsin, due to fines charged to employers whose employees buy insurance on the new health insurance exchanges.

The above information was provided by CITIZEN ACTION OF WISCONSIN.

Respectfully Submitted By,

Supervisor Colleen Bates

Supervisor Nick Smiar

Supervisor Gerald "Jerry" Wilkie

Appendix G – Standard vs. Core Plan Comparison

Service	Standard Plan	Core Plan (Income < 100% FPL)
Chiropractic Services	Full coverage	Full coverage
	Co-payment $50 to $3 per service (varies by service provided)	$0.50 to $3 per service
Dental	Full coverage of preventive, restorative and palliative services	Emergency dental only
	Co-payment $50 to $3 per service (varies by service provided)	No co-payment
Disposable Medical Supplies (DMS)	Full coverage	Limited to syringes, diabetic pens, ostomy supplies and items used with durable medical equipment
	$0.50 per item	Co-payment $0.50 to $3 per unit of item
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs	In most cases, generic drugs and some over-the-counter drugs are covered.
	Co-payments:	Co-payments:
	$0.50 for OTC Drugs	????
	$1 for Generic Drugs	$4 for Generic Drugs prescription drugs
	$3 for Prescription Drugs	$8 for brand name prescription drugs.
	Co-payments are limited to $12 per member, per provider, per month. OTCs are excluded from this $12 maximum.	Co-payments are limited to $24 per month per pharmacy provider
Durable Medical Equipment (DME)	Full coverage	Benefit limit of $2,500 per year; Rental items count towards the limit.
	Co-payment $0.50 to $3 per item (varies by item provided)	Co-payment $0.50 to $3 per item (varies by item provided)
	Rental items are not subject to a co-payment.	Rental items are not subject to a co-payment.

Health Screenings for Children	Full coverage of Health Check screenings and other services for individuals under age 21 years	Not applicable
	Co-payment $1 per screening for those 18, 19 and 20 years of age	
Hearing Services	Full coverage	Not covered
	Co-payment $50 to $3 per procedure	
	No co-payments for hearing aid batteries	
Home Care Services (home health, private duty nursing and personal care)	Full coverage	Home health services for 30-days following an inpatient hospital stay, if ordered by the doctor
	No co-payment	No co-payment
Hospice	Full coverage	Hospice services for members and their family members who are terminally ill
	No co-payment	No co-payment
Hospital - Inpatient	Full coverage	Covered, except that inpatient mental health services are not covered
	Co-payment $3 per day with a $75 cap per year	For inpatient visits $3 per day with a $75 co-pay cap per stay
Hospital - Outpatient	Full coverage	Coverage of "outpatient visit", which includes an appointment at a hospital or a University of Wisconsin (UW) clinic. Outpatient visits are limited to 25 visits per member per enrollment year.
	Co-payment $3 per visit	For outpatient visits, $3 per visit. You will not have to pay more than $300 per year in co-pays for all of your hospital services.

Hospital -	Full coverage	Emergency room visits

Outpatient Emergency Room	No co-payment	$3 co-pay; If admitted to the hospital, required to pay inpatient hospital co-payment, but emergency room co-payment will be waived.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board)	Not covered
	Co-payment $.50 to $3 per visit	
	Limited to the first 15 hours or $500 of services, whichever comes first, provided per calendar year	
	Co-payment not required when services are provided in a hospital setting	
Nursing Home	Full coverage	Not covered
	No co-payment	
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage	Physical therapy, occupational therapy, and speech therapy. There is a limit of 20 visits per year for each type of therapy. Cardiac rehabilitation counts toward the 20 visit limit for physical therapy.
	Co-payment $.50 to $3 per provider, per date of service	Co-payment $0.50 to $3 per service
	Co-payment obligation is limited to the first 30 hours or $1,500 whichever occurs first, during one calendar year (co-payment limits are calculated separately for each discipline.)	Co-pays will not be charged after the first 30 hours or $1,500 of each type of therapy, whichever occurs first, each calendar year.

Physician Visits	Full coverage, including laboratory and radiology	Coverage includes office visits, surgical procedures, radiology and laboratory services. Mental health visits are only covered when they are with a psychiatrist. For substance abuse, physician services are covered. Routine eye exams are not covered.
	Co-payment $50 to $3 co-payment per service (varies by service provided)	Co-payment $50 to $3 co-payment per service (varies by service provided)
	Co-payments are limited to $30 per provider per calendar month	Co-payments are limited to $30 per provider per calendar year
	No co-payment for emergency services, anesthesia or clozapine management	No co-pays for emergency services, preventive care, anesthesia, or clozapine management
Podiatric Services	Full coverage	Podiatry service for diagnosis and treatment of the feet and ankles
	Co-payment $.50 to $3 per service	Co-pay of $0.50 to $3 per service, per provider, per calendar year
Prenatal/Maternity Care	Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems	Not applicable to this population
	No co-payment	
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization	Not covered as part of the Core Plan, but covered under the Family Planning Services program
	No co-payment for family planning services	No co-payment
Routine Vision	Full coverage including coverage of eye glasses	Not covered
	Co-payment $.50 to $3 per service (varies by service provided)	

Smoking Cessation Services	Coverage includes prescription and over-the-counter tobacco cessation products	Not covered
	Co-payment (see drugs)	
Transportation	Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.	Full coverage of emergency transportation, but no coverage of non-emergency transportation
	Co-payments are:	
	$2 for non-emergency ambulance trips	
	$1 per trip for transportation by an SMV	
	No co-payment for transportation by common carrier or emergency ambulance	No co-payment for transportation by emergency ambulance

A BC+ member may be required to pay a part of the cost of a service. This payment is called a "co-payment" or "co-pay".

ACA PREPARATION TIMELINE
TRIBAL IM AGENCIES
JANUARY 2014

March 2013	Brett Davis and Craig Steele attend joint meeting of tribal health directors and tribal IM directors to present overview on WI entitlement reforms and PPACA overview. OCI representatives also present overview.
April 2013	Tribal IM directors meet. Debbie Waite presents timeline for implementation of ACA – also shares planning for tribal IM worker and supervisor trainings on ACA policy and systems changes. Encourages tribal IM directors to attend ACA Phase I training at Area Administration Regional meetings.
July 2013	Linda Auchue attends the July Tribal IM Directors meeting to present a detailed implementation overview and answer related questions (a version of Phase I training customized to tribes) Each tribal IM director is given their tribe's ACA case projection print-out to use for workload planning purposes
August 2013	Enhanced Tribal IM allocation amounts for ACA implementation are shared with tribal leaders
Aug-Sept 2013	Phase II trainings for IM workers and supervisors are held at numerous locations throughout the state. Trainings held on September 17 at Lac du Flambeau and August 21 at Shawano were targeted to the tribal IM agencies. The Phase II training included detailed information on the BC+ policy changes plus exercises on determining household composition and income calculation scenarios.
Sept 2013	Tribal IM directors meet. Debbie Waite provides progress update on ACA implementation and takes feedback on Phase II training. Directors share information from their internal discussion on how they plan to use ACA enhanced funding to meet increased workload expectations

Oct 2013	Tribal IM directors are sent password protected CD with information on their agency's BC+ transitioning members to use for outreach purposes.
Oct-Nov 2013	Phase III trainings for IM workers statewide are conducted via Adobe Connect. IM workers had the option of signing up for the Adobe Connect trainings or viewing the pre-recorded training. Records indicate that 11 tribal IM workers completed the live training, although registration was not required to view the recorded training. The Phase III training focused on the updates to the CWW pages and walked IM workers through what they will see in CWW when processing a case using MAGI rules.
Nov 2013	Tribal IM directors meet. Debbie Waite shares information on changes to implementation schedule as a result of Governor Walker's plan to delay to April 1 for BC+ transitioning members. IM directors provide feedback on how they used CD information – several used data to do proactive outreach.
Jan 2014	Tribal IM directors are sent password protected updated information on their agency's BC+ transitioning members to use for outreach purposes.

NOTE: Tribal IM agencies also received numerous forwarded messages from CMS and communications updates from DHS throughout the year as part of broader communication efforts to consortia and partners.

Wisconsin BadgerCare Plus Demonstration Project Waiver

Wisconsin Division of Health Care Access and Accountability

Tribal Health Directors Meeting

Waiver Consultation

July 10, 2013

Presentation Outline

- Wisconsin Vision and Commitment
- Program Background
- Waiver Request
- Demonstration
- Proposed Timeline
- Comments
- Questions

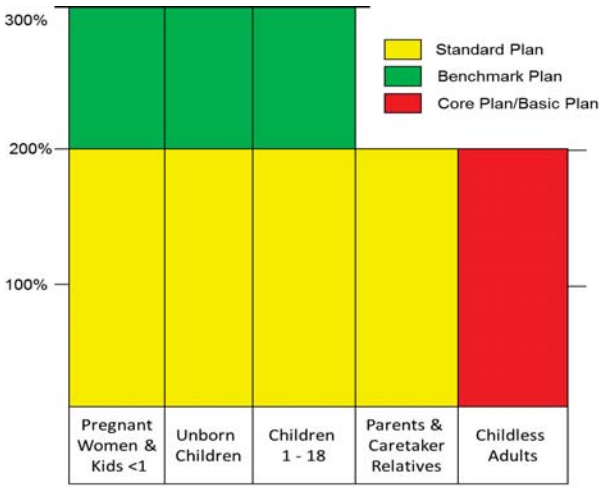
Wisconsin Vision and Commitment

Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.

Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.

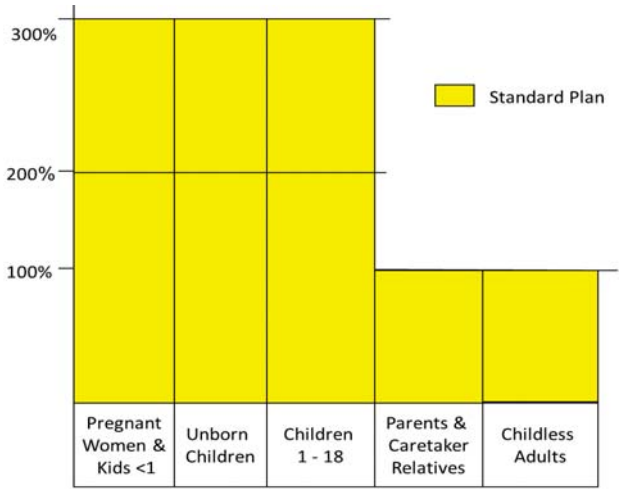
Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

Current BadgerCare Plus Health Plans



BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	484,164	247,712	16,450	769,130

BadgerCare Plus Health Plan - 2014



BadgerCare Plus Enrollment - Projected in Budget				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	522,695	160,255	98,641	802,395

2013 Federal Poverty Levels

Monthly Income Levels by Family Size

Family size	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1	$957.50	$1,149.00	$1,273.48	$1,292.63	$1,436.25	$1,915.00	$2,393.75	$2,872.50
2	$1,292.50	$1,551.00	$1,719.03	$1,744.88	$1,938.75	$2,585.00	$3,231.25	$3,877.50
3	$1,627.50	$1,953.00	$2,164.58	$2,197.13	$2,441.25	$3,255.00	$4,068.75	$4,882.50
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- Both of these waivers will be expiring on December 31, 2013.
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  - Enrollment is capped and a waitlist is maintained.
  - Benefit plan is limited and does not comply with the Essential Health Benefits requirements of the federal government.
  - Waiver expires December 31, 2013.

Core Plan Waiver Background

- Current BadgerCare Plus Core Plan Waiver members are:
  - 19 to 64 years of age;
  - Not pregnant or parents or caretaker relatives of children under age 19;
  - Not otherwise eligible for full-benefit or benchmark plan Medicaid/BadgerCare Plus;
  - Not entitled to Medicare;
  - And meet all Medicaid non-financial requirements (SSN, citizenship/identity, etc.).

Core Plan Enrollment & Expenditures

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- Parents/Caretaker relatives and childless adults under 100% FPL eligible for BadgerCare Plus.
- Parents/Caretaker relatives and childless adults over 100% FPL eligible for private coverage in the new federal Marketplace.
  - DHS can work with each tribe to produce tribe specific impacts via a member data match.
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- TMA allows non-disabled, non-pregnant adults and children to maintain their Medicaid coverage for twelve months once their earning or spousal support rises above the amount that would have qualified them for benefits under the former Aid to Families with Dependent Children cash assistance program (100% FPL).

- As part of the Medicaid 2014 Demonstration Project Waiver request (effective July 1, 2012), Wisconsin requires non-pregnant, non-disabled adults receiving Medicaid, including those on TMA, with family incomes above 133% of the FPL to pay a monthly premium. Those who do not pay a premium cannot re-enroll in BadgerCare Plus for twelve months while their income remains high enough to owe a premium.

Historical Transitional MA Enrollment & Expenditures

- Historical enrollment and aggregate expenditures (based on date of payment) for adults with Transitional Medical Assistance for the last four State Fiscal Years (SFYs).

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013 Est.
Average Enrollment	20,780	25,514	31,097	33,376	19,500
Aggregate Expenditures	$69,322,080	$85,114,704	$103,739,592	$111,342,336	$65,052,000

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- Cover all Wisconsin adult residents with incomes below the federal poverty line – 100% FPL.
- Simplify benefits design:
  - One benefit package, the Standard Plan, for adults.
  - Clearer for providers, less administratively cumbersome to manage, and more easily understood by the people served.
  - More comprehensive set of services than was previously available under the Core Plan (mental/behavioral health, preventive dental, non-emergency medical transportation, etc.).

Background - Comparing Current Plans

Service	Standard Plan	Benchmark Plan	Core Plan
Dental			
Durable Medical Equipment and Supplies			
Drugs			
Hearing			
Home Care/Personal Care			
Hospital - Inpatient			
Behavioral			
Nursing Home			
Therapies			
Vision			
Smoking Cessation			
Non-Emergency Medical Transportation			

Full Coverage in All Plans – Chiropractic, Hospital Outpatient & Emergency Department, Physician, Podiatry, Reproductive Health, and Emergency Transportation

Full Coverage Limited Coverage No Coverage

BadgerCare Plus Demonstration Project Waiver Request

Establish a new five-year waiver project that will:

- Allow for the coverage of adults without dependent children with incomes not to exceed 100% FPL.
- Require all non-disabled, non-pregnant adult parents and caretaker relatives, excluding tribal members, who qualify for BadgerCare Plus Standard Plan coverage through TMA only, to pay ACA-level premiums beginning at 100% FPL.

Demonstration

- By providing the BadgerCare Plus Standard Plan benefits to childless adults under poverty, the State will:
  - Improve health outcomes.
  - Increase the cost effectiveness of Medical Assistance services.
  - Reduce the incidence of unnecessary services.
  - Increase the continuity of health coverage.
- DHS will evaluate this hypothesis with an emphasis on the impact of the demonstration on the covered childless adult population in comparison to the prior waiver program and other BadgerCare Plus populations.

Proposed Childless Adult Eligibility

If approved, effective Jan 1, 2014:

- Eligible individuals will no longer be required to pay an annual enrollment fee.
- Eligible childless adults will not be subject to an enrollment cap.
- Eligible individuals will be enrolled in the Standard Plan.

Projected Childless Adult Enrollment & Expenditures

- Projected annual enrollment and aggregate expenditures (based on date of payment) for childless adults by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	47,882	98,641	98,641	98,641	98,641
Aggregate Expenditures	$199,145,069	$386,759,524	$402,229,905	$418,319,101	$435,051,865

Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Adult participants with income that exceeds 100% FPL are responsible for making a monthly premium payment as a condition of continuing their eligibility and reenrollment, and will have a 60-day grace period for non-payment of the monthly premium before being disenrolled.

- Adult participants who fail to make a premium payment cannot re-enroll as a parent or caretaker relative into the Medicaid program for a period of twelve months.

Proposed Transitional MA Changes

If approved, effective January 1, 2014:

- Affected eligible members will be subject to monthly premiums (between 2-9.5% of income) based on a sliding scale.

- Pre-payment of the first month's premium payment is required.

Projected Transitional MA Enrollment & Expenditures

- Projected annual Medicaid enrollment and aggregate expenditures (based on date of payment) for adults covered through Transitional Medical Assistance by SFY.

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Average Enrollment	15,000	11,550	11,550	11,550	11,550
Aggregate Expenditures	$50,040,000	$38,530,800	$40,072,032	$41,674,913	$43,341,910

Budget Neutrality

- Federal policy requires s. 1115 waiver demonstrations be budget neutral to the federal government.
- This means that a demonstration should not cost the federal government more than what would have otherwise been spent absent the demonstration.
- For the childless adults population, Wisconsin proposes to use a per-member per-month (PMPM) based methodology specific to the Wisconsin childless adult population under 100% of FPL to achieve budget neutrality.
- For transitional MA, budget neutrality will be demonstrated based on a reduction in aggregate expenditures or a reduction in the PMPM.

Proposed Timeline

Major Milestones	Tentative Date
Public Notice Issued	July 1, 2013
Comment Period Closed	August 5, 2013
Waiver Submission	August 09, 2013
CMS Approval	Late September 2013
Benefits Effective Date	January 1, 2014

Comments

Comments may be submitted by August 5, 2013 using the following methods:

- Online - http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
- Email - DHSBCDemonstrationWaiver@dhs.wisconsin.gov
- Fax - 608-266-1096
- Mail

  Al Matano
  Division of Health Care Access and Accountability
  P.O. Box 309
  Madison, WI 53707-0309

Questions

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel*, Commissioner*

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

July 3, 2013

Mr. Michael Allen, Executive Director
Great Lakes Inter-Tribal Council
P.O. Box 9
Lac du Flambeau, WI 54538

Dear Mr. Allen:

The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law on March 23, 2010. The law requires that the Health Insurance Marketplace, or Exchange, be ready soon. Open enrollment starts October 1, 2013 and coverage can start as soon as January 1, 2014.

The Office of the Commissioner of Insurance (OCI) has been working diligently to ensure that Wisconsin consumers are informed and have access to information. Various conference calls and committee meetings have been and continue between State and Federal contacts to ensure compliance with the federal healthcare reform laws.

Our Office recognizes that each of the Tribes in Wisconsin are sovereign with their own constitution and governing structure. We also recognize the impact that PPACA will have on Native communities, and have made inquiries regarding the education and outreach initiatives performed or planned by the federal government. It is our understanding that such education and outreach has been conducted on a regional basis, rather than state-specific.

OCI believes that Wisconsin is unique and the Tribes of Wisconsin deserve more personalized attention. Therefore, it is respectfully requested that the Tribes provide our Office with clarification regarding our level of involvement with education and outreach due to the unique relationship they have at the state and federal level.

The State of Wisconsin has been assigned specific contacts at the federal level, and those contacts have requested our Office facilitate a conference call with the Tribes to identify issues and answer questions related to PPACA. Our Office can 1) facilitate a call in which Tribal contacts present similar issues and advocate for themselves, or 2) gather issues and advocate on your behalf. We understand that each Tribe may have resources assigned to work on their specific issues, and need no interference from our Office. However, it is respectfully requested that Tribes provide input regarding our offer to assist them with conversations with federal personnel regarding the implementation of PPACA. Please contact me at your earliest convenience.

Best regards,

Ashley Natysin, ACS, AIRC, CICSR, CIE, HIA, MCM, MHP, MCPM
Education and Outreach Specialist
Office of the Commissioner of Insurance

July 8, 2013

REMINDER:

DEPARTMENT OF HEALTH SERVICES TO HOLD TOWN HALL MEETINGS

ON CHANGES TO BADGERCARE PLUS

MADISON—The Department of Health Services today announced town hall meetings that will be held around the state as part of the submission process for a new BadgerCare Plus Demonstration Project Waiver. The waiver is part of Governor Walker's entitlement reform initiative and will allow Wisconsin to provide health care coverage through BadgerCare Plus to all adults with no dependent children between ages 19 and 64 and who have incomes that do not exceed 100% of the federal poverty level.

“Governor Walker's entitlement reform initiative will be the first time that all Wisconsin citizens will have access to affordable health care," said Wisconsin Medicaid Director Brett Davis. “We expect a significant reduction in the number of uninsured adults in Wisconsin as a result of the Governor's efforts."

Governor Walker's entitlement reform plan was approved and signed into law on June 30, 2013 as part of 2013-2015 biennial budget. The Governor's plan is scheduled to be implemented at the same time that the federal health insurance exchanges and the majority of the PPACA-related changes are implemented. The Department of Health Services is working with the federal government to get the federal approval needed to make these changes.

Wisconsin's current BadgerCare Plus Core Plan for Adults Without Dependent Children Demonstration Project waiver expires on December 31, 2013. After it is approved by the federal government, the new BadgerCare Plus Demonstration Project Waiver will become effective January 1, 2014 and will provide coverage to individuals who:

- Are between ages 19 and 64 years old,
- Are not pregnant or parents or caretaker relatives of children under age 19,
- Are not otherwise eligible for full benefit BadgerCare Plus or Medicaid,
- Are not entitled to Medicare,
- Meet all Medicaid non-financial requirements like citizenship and identity, SSN, etc., and
- Have a gross income that is calculated using the federally-mandated Modified Adjusted Gross Income (MAGI) methodology that includes a 5% disregard and does not exceed 100% FPL.

The waiver will implement the following changes to BadgerCare Plus:

- All BadgerCare Plus members will receive health care coverage through the BadgerCare Plus Standard Plan,
- Eliminate the BadgerCare Plus Core Plan annual enrollment fee and monthly premiums,
- Remove the current enrollment cap for childless adults under 100% FPL, and
- Require all parents and caretaker relatives who qualify for transitional medical assistance (TMA) to pay a monthly premium.

The Department will hold three public information sessions to provide information about the BadgerCare Plus Demonstration Project Waiver and to collect comments from the public regarding the waiver request. All public comments will be communicated to the United States Department of Health and Human Services as part of the

final waiver request. The Department intends to submit the waiver request to the Centers for Medicare and Medicaid Services (CMS) on August 9, 2013.

Eau Claire	
Wednesday July 10, 2013 11:00 a.m. to 1:00 p.m.	Chippewa Valley Technical College Health Education Center 615 W. Clairemont Avenue Eau Claire, WI
Milwaukee	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Radisson Milwaukee West 2303 North Mayfair Road Milwaukee, WI
Green Bay	
Thursday, July 11, 2013 11:00 a.m. to 1:00 p.m.	Green Bay Kroc Center Walnut and Oak Rooms 1315 Lime Kiln Road Green Bay, WI

***People needing special accommodations to attend or participate in the meeting should notify the Department of Health Services at 608-266-9622 (TTY 888-701-1250) by the day prior to the event.**

Individuals who are unable to attend the public information sessions but would like to provide comments will be able to submit comments directly to the department by fax, email, regular mail or online.

Online	http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm
Fax	608-266-1096
Email Address	DHSBCDemonstrationWaiver@dhs.wisconsin.gov
Mailing Address	Al Matano Division of Health Care Access and Accountability P.O. Box 309 Madison, WI 53707-0309

All comments must be received by the Department no later than August 5, 2013.

July 31, 2013

Good afternoon,

I wanted to take this opportunity to share some important information with you about Wisconsin's plans for implementing the Patient Protection and Affordable Care Act and state Entitlement Reforms Initiative. Please feel free to pass along to your partners as well.

The Patient Protection and Affordable Care Act (PPACA) and state Entitlement Reforms present an opportunity to reduce Wisconsin's uninsured rate. We all share the goal of ensuring Wisconsin residents have access to affordable health care coverage. By working together we can achieve our shared goal of reducing Wisconsin's uninsured rate.

One of Wisconsin's most significant strategies to assist Wisconsin residents with enrolling in the appropriate public or private health care coverage will be through the recently announced Regional Enrollment Networks (RENs). The RENs will be comprised of various community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders like you. These RENs will be developed at the local level and may be different from each other depending on the needs of the local region.

On July 16, 2013, the Department of Health Services and the Office of the Commissioner of Insurance presented a proposed model for the RENs at the UW-Population Health Institute's Wisconsin Health Insurance Outreach & Enrollment Summit. The RENs were modeled after and leverage the current outreach and enrollment efforts underway in Milwaukee through the Milwaukee Enrollment Network. The presentation announcing the RENs is available online at http://www.dhs.wisconsin.gov/aboutdhs/initiatives/budget/initiatives/er/071613ren.pdf

Each REN will have dedicated facilitators that will lead each region's efforts of supporting partners and mobilizers.

Many partner organizations including public health departments, community based organizations, advocacy groups, Qualified Health Plans (QHPs), veterans groups, tribes and others have shown interest in collaborating to assist Wisconsin individuals and families navigate these new health care coverage changes.

As you know, we are faced with a very aggressive timeline to operationalize the RENs and begin the very important task of assisting Wisconsin individuals and families enroll in the appropriate public or private health care coverage. If you are interested in partnering with the Regional Enrollment Network in your area, please fill out the form at http://4.selectsurvey.net/dhs/TakeSurvey.aspx?PageNumber=1&SurveyID=m61L3895&Preview=true. The co-conveners of the RENs will contact you within the next couple of weeks to announce a REN kick-off meeting in each region.

For additional information, regionally based Department of Health Services staff listed below would be happy to assist you:

Region	Counties	Contact	Email address
Bay Lakes	Brown, Door, Marinette, Menominee Oconto, Shawano	Elizabeth Jungers	Elizabeth.jungers@dhs.wisconsin.gov
Capital	Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk	Amy Bell	Amy1.bell@dhs.wisconsin.gov

Central	Langlade, Marathon, Oneida, Portage	Bill Hanna	William.hanna@dhs.wisonsin.gov
East Central	Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago	Elizabeth Jungers	Elizabeth.jungers@dhs.wisconsin.gov
Great Rivers	Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, Washburn	Michelle Larson	Michelle.larson@dhs.wisconsin.gov
Milwaukee	Milwaukee	Sarah Fraley	Sarah.fraley@wisconsin.gov
Moraine Lakes	Fond du Lac, Ozaukee, Walworth, Washington, Waukesha	Angie Moran	Angela.moran@dhs.wisconsin.gov
Northern	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Melody Yeager	Melody.yeager@dhs.wisconsin.gov
Southern	Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock	Julie Milleson	Julie.milleson@dhs.wisconsin.gov
Western	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon	Jamie Fawcett	Jamie.fawcett@dhs.wisconsin.gov
WKRP	Kenosha, Racine	Sarah Fraley	Sarah.fraley@wisconsin.gov

In addition, DHS will be hosting Partner and Provider Medicaid policy overviews and trainings via webinar beginning in August 2013. The first webinar will be held Monday, August 12 from 10am to noon. Additional information, including how to participate in the webinar, will be available in the near future on the Department's website at www.dhs.wisconsin.gov.

Thank you,

Brett Davis

August 7, 2013

Good Morning,

I wanted to take the opportunity to provide additional details about the first BadgerCare Plus webcast training for partners, health care providers and other interested parties that will be held on Monday, August 12 at 10:00 a.m. The webcast will provide an overview of the 2014 BadgerCare Plus policy changes that were included as part of the biennial budget.

Here is the link to the webcast http://dhsmedia.wi.gov/main/Play/4fa6e1b7063a4753a8d56459ec69a9d11d that you can use to participate in the training on Monday. Please note that the webcast will also be taped and archived for individuals who are unable to tune in on Monday.

Please email me at Sarah.Fraley@Wisconsin.gov if you have any questions.

August 29, 2013

The Department of Health Services will be hosting three additional web based trainings for partners, providers, and those that support member and applicants with enrolling in and maintaining health care benefits.

The three trainings will be on these dates and cover the following topics:

- September 17, 2013, 10am - noon: General Modified Adjusted Gross Income (MAGI) Training and Overview of Upcoming BadgerCare Plus informational mailings to members that will likely transition to the Marketplace. This training can be accessed at www.dhs.wisconsin.gov/health-care
- October 14, 2013, 10am - noon: Information regarding current members that will be transitioning off BadgerCare Plus. The training will cover the timeline of transition, review of letters that will be received, and information on resources to assist with the transition process. The link to this training will be posted at www.dhs.wisconsin.gov/health-care closer to the actual date.
- November 11, 2013, 10am - noon: Policy Overview- Entitlement Reform, a more in-depth discussion of MAGI, and a demonstration of the updated ACCESS application/WI Streamline Application. The link to this training will be posted at www.dhs.wisconsin.gov/health-care closer to the actual date.

There is no need to RSVP to any of the trainings, please tune in live or feel free to watch the archived webinar version when it is convenient for you. We will continue to post frequently asked questions to the www.dhs.wisconsin.gov/health-care website, so please check the web page regularly. Any questions that you may have while watching an archived training can be sent to dhshealthcare@dhs.wisconsin.gov, and may be included in future FAQ documents.

This training series will culminate in the late fall with a series of in-person trainings throughout the state to offer general overview of BadgerCare Plus changes for 2014. Please stay tuned for those details at www.dhs.wisconsin.gov/health-care.

September 16, 2013

As a reminder:

Tomorrow, September 17, 2013, 10am – noon, DHS will be hosting a webinar for community partners, health care providers, public health departments and other interested stakeholders focusing on the General Modified

Adjusted Gross Income (MAGI) Training and Overview of Upcoming BadgerCare Plus informational mailings to members that will likely transition to the Marketplace. This training and the informational mailings can be accessed at www.dhs.wisconsin.gov/health-care/training/index.htm .

Please note there is no need to RSVP to any of the trainings, please tune in live or feel free to watch the archived webinar version when it is convenient for you. We will continue to post frequently asked questions to the www.dhs.wisconsin.gov/health-care website, so please check the web page regularly. Any questions that you may have while watching an archived training can be sent to dhshealthcare@dhs.wisconsin.gov, and may be included in future FAQ documents.

Thank you for your continued partnership !

October 11, 2013

On Monday, October 14th from 10am –12:00pm, DHS will be hosting the next in the series of training webinars for community partners, health care providers, public health departments and other interested stakeholders. This webinar training and all archived versions of earlier trainings can be accessed online at www.dhs.wisconsin.gov/health-care/training/index.htm<http://www.dhs.wisconsin.gov/health-care/training/index.htm>.

Please note, you do not need to RSVP any trainings. You can either watch the live training or view the archived webinar version when it is convenient for you.

DHS will continue to publish Frequently Asked Questions (FAQ) to the www.dhs.wisconsin.gov/health-care<http://www.dhs.wisconsin.gov/health-care> website, so check this website regularly.

If you have any questions viewing an archived training, that has not been previously asked and answered on the FAQ website, your question can be sent to dhshealthcare@dhs.wisconsin.gov<mailto:dhshealthcare@dhs.wisconsin.gov>,. The answer to your question will either be answered on the FAQ website or by email.

October 16, 2014

As of November 18th the ACCESS system will be updated to allow newly eligible BC+ members to apply directly for BadgerCare Plus coverage beginning on January 1, 2014. In an effort to continue to support and inform our partners, the Wisconsin Department of Health Services (DHS) in collaboration with Covering Kids and Families, the Wisconsin Primary Health Care Association and our local partners will be hosting a series of in person regional trainings to provide comprehensive overview of BC+ policies for 2014, and overview of the changes to the BC+ application, best practices when working with the Marketplace, and other key updates.

As space for each is limited, we ask that people please register for the training that they wish to attend. To register online, click the link below each training.

The following are the dates and times of the meetings:

Ashland – 10/28, 1:00-4:00pm
Wisconsin Indianhead Technical College
Conference Room 306-307

2100 Beaser Avenue, Ashland, WI 54806
To register: http://healthcare2014ashland.eventbrite.com/

Stevens Point – 10/29, 1:00-4:00pm
Portage County Public Library
Pinery Room
1001 Main Street, Stevens Point, WI 54481
To register: http://healthcare2014stevesnpt.eventbrite.com/

Chippewa Falls – 10/31, 1:00 – 4:00pm
Chippewa County Courthouse
711 N. Bridge Street, Room 001 & 003
Chippewa Falls, WI 54729
To register: http://healthcare2014chippewa.eventbrite.com/

LaCrosse – 11/5, 1:00-4:00pm
La Crosse County Health & Human Services Bldg
300 4th St N, La Crosse, WI 54601
To register: http://healthcare2014lacrossse.eventbrite.com/

Racine – 11/5, 10:00am-12:00pm
Gateway Technical College (iMET) Center
Auditorium
2320 Renaissance Blvd, Sturtevant, WI 53177-1763
To register: http://healthcare2014racine.eventbrite.com/

Madison – 11/6, 9:00am – 12:00pm
Goodman Community Center
Evjue Room D
149 Waubesa Street, Madison, WI 53704
To register: http://healthcare2014madison.eventbrite.com/

Milwaukee – 11/7 9:00am – 12:00pm
Medical College of Wisconsin
Auditorium, Room HRC H1400
8701 Watertown Plank Road, Milwaukee, WI 53226
To register: http://healthcare2014milwaukee.eventbrite.com/

Menasha – 11/7 2:30am – 5:30pm
UW-Fox Valley
James W. Perry Hall
1478 Midway Road, Menasha, WI 54952
To register: http://healthcare2014menasha.eventbrite.com/

Please help us spread the word about these events. Thank you for your assistance and collaboration.

October 21, 2013
As of November 18th the ACCESS system will be updated to allow newly eligible BC+ members to apply directly for BadgerCare Plus coverage beginning on January 1, 2014. In an effort to continue to support and inform our partners, the Wisconsin Department of Health Services (DHS) in collaboration with Covering Kids

and Families, the Wisconsin Primary Health Care Association and our local partners will be hosting a series of in person regional trainings to provide comprehensive overview of BC+ policies for 2014, and overview of the changes to the BC+ application, best practices when working with the Marketplace, and other key updates.

As space for each is limited, we ask that people please register for the training that they wish to attend. To register online, click the link below each training.

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Conference Room 306-307
2100 Beaser Avenue, Ashland, WI 54806
To register: http://healthcare2014ashland.eventbrite.com/

Stevens Point – 10/29, 1:00-4:00pm
Portage County Public Library
Pinery Room
1001 Main Street, Stevens Point, WI 54481
To register: http://healthcare2014stevesnpt.eventbrite.com/

Chippewa Falls – 10/31, 1:00 – 4:00pm
Chippewa County Courthouse
711 N. Bridge Street, Room 001 & 003
Chippewa Falls, WI 54729
To register: http://healthcare2014chippewa.eventbrite.com/

LaCrosse – 11/5, 1:00-4:00pm
La Crosse County Health & Human Services Bldg
300 4th St N, La Crosse, WI 54601
To register: http://healthcare2014lacrossse.eventbrite.com/

Racine – 11/5, 10:00am-12:00pm
Gateway Technical College (iMET) Center
Auditorium
2320 Renaissance Blvd, Sturtevant, WI 53177-1763
To register: http://healthcare2014racine.eventbrite.com/

Madison – 11/6, 9:00am – 12:00pm
Goodman Community Center
Evjue Room D
149 Waubesa Street, Madison, WI 53704
To register: http://healthcare2014madison.eventbrite.com/

Milwaukee – 11/7, 9:00am – 12:00pm
Medical College of Wisconsin
Auditorium, Room HRC H1400
8701 Watertown Plank Road, Milwaukee, WI 53226
To register: http://healthcare2014milwaukee.eventbrite.com/

Menasha – 11/7, 2:30 – 5:30pm

UW-Fox Valley
James W. Perry Hall
1478 Midway Road, Menasha, WI 54952
To register: http://healthcare2014menasha.eventbrite.com/

Please help us spread the word about these events. Thank you for your assistance and collaboration.

October 24, 2013

OCI CAC/Navigator In-Person Training

October 30 & 31, 2013- Milwaukee, WI

The Milwaukee Enrollment Network (MKEN) in collaboration with the Office of the Commissioner of Insurance (OCI) is pleased to host an in-person OCI training session for Navigators/CACs**.** There is **no charge** for this in-person training session.

This two-day Navigator/Certified Application Counselor (CAC) training will be held Wednesday, October 30, and Thursday, October 31, from 8:30 a.m. until 5:00 p.m. each day.

This training is intended for individuals who plan to work as a Navigator or CAC with an organization that received a federal Navigator grant or an organization that is a federally designated CAC organization. **You cannot serve as a CAC or use the title "CAC" without completing both the state and federal training and examination requirements.**

You must attend and complete both days of training and stay for the entire day to receive a certificate of completion. Identification will be required at check-in. You will receive a follow-up e-mail after registration with additional details and links to materials you will need for the training.

All individuals completing the state Navigator/CAC training and planning to serve as a Navigator or CAC must receive a passing score on the state and federal examinations. The state examination fee is $75.00. Advance registration is required for the state examination, which must be taken at a designated testing site. For more information about requirements for serving as a Navigator or CAC in Wisconsin, please see: oci.wi.gov/navigator/overview.htm.

The first day of training will be held:

Wednesday, October 30, 8:30-5:00
St. Joseph Hospital Auditorium (M101)
5000 W. Chambers St., Milwaukee, WI

The second day of training will be held:

Thursday, October 31, 8:30-5:00
Medical College of WI Kerrigan Auditorium (M1540)
8701 Watertown Plank Road, Wauwatosa, WI

Directions and parking instructions will be included in registration confirmation. There will be a 1-hour break for lunch. Participants are responsible for their own lunch and may eat at the training site cafeteria, go to a local establishment or bring a bag lunch.

This in-person OCI training option will cover the same material as the online version. The vendor offering online training has reduced the price for its course to $99.95. More information about the online course can be found on the OCI website: http://oci.wi.gov/navigator/nonnavigator.htm

Please note that state law exempts government entities or any person acting on behalf of a government entity from having to take the state CAC training and examination. Government employees interested in obtaining an understanding of general insurance concepts should access the insurance-specific training available on the DHS web site at http://dhsmedia.wi.gov/main/Play/bf07076993cc4ee2a1298fa60636e52c1d.

Any government employee planning to refer to themselves as a CAC must complete the federal training and examination requirements.

Attachment:

MILWAUKEE ENROLLMENT NETWORK

OCI Certified Application Counselor (CAC) / Navigator In-Person Training
October 30 & 31, 2013 – Milwaukee
Registration Form

Please complete one form per organization. *Please use a second sheet if you have more registrants. Note: This training is exclusively for those individuals who will function as CACs/Navigators for such entities.*

Has your organization completed the CMS CAC Organization Application? Yes / No
Any organization hosting a CAC must complete CMS CAC Organization Application.
See link for information and application: http://marketplace.cms.gov/help-us/cac.html

Has your organization completed the OCI CAC Organization Registration? Yes / No
Any organization hosting a CAC must complete OCI 'Nonnavigator Business Entity Initial Regisration/Updates' form. See link for registration form: http://marketplace.cms.gov/help-us/cac.html

Organization Contact Information
Name of Organization Employing /Hosting CACs/Navigators:
Name of CAC Organization Primary Contact for CACs/Navigators:
Title:
Work Address:

Email:
Phone:

CAC Training Attendees
Full Name (First, Middle, Last):
Work Address:
Email:
Phone:

Full Name:
Work Address:
Email:
Phone:

Full Name:
Work Address:
Email:
Phone:

Full Name:
Work Address:
Email:
Phone:

October 8, 2013
Thank you to all that have participated in our series of in-person trainings throughout the state. In light of all that we were able to cover and due to our intent to tape a final version of the in-person meeting presentation, DHS will no longer be hosting the previously scheduled webinar on Monday, November 11th. Please stay tuned to www.dhs.wisconsin.gov/health-care for information on the webcast of the presentation from the series of in-person partner trainings that DHS has been holding in collaboration with CKF, WPHCA and local partners. The content of the webinar training will be on the 2014 changes to BadgerCare Plus and best practices for the federal Health Insurance Marketplace.

This training and previous webcasts can also be accessed at www.dhs.wisconsin.gov/health-care/training/index.htm.

Please note, there is no need to RSVP for any of the web based trainings. Please tune in live or feel free to view the archived webinar version when it is convenient for you. We will continue to post frequently asked questions to the www.dhs.wisconsin.gov/health-care website, so please check the web page regularly. Any questions that you may have while watching an archived training can be sent to dhshealthcare@dhs.wisconsin.gov, and may be included in future FAQ documents.

Thank you for your continued partnership!

November 11, 2013

Today the Department will begin sending out an additional letter to the members that we have identified that may be transitioning from getting their health care through BadgerCare Plus to purchasing it through the Marketplace, also known as the Exchange. This was the group of individuals that were sent letter 1 in late September. You can see letter 1 at the following link: http://www.dhs.wisconsin.gov/em/CustomerHelp/bpcletters/Letter-1.pdf.

The Department is sending this additional letter to remind individuals who may be transitioning of the different ways that they can apply for health care coverage through the Marketplace – online, via phone or paper application. Each letter will contain a paper copy of the Marketplace application and instructions. Given the current technical issues with the Marketplace, the Department wants to make sure that transitioning members have the opportunity to apply and enroll by December 15, 2013 for benefits that begin January 1, 2014.

Here is a link to the reminder letter (what the Department is calling letter 9): http://www.dhs.wisconsin.gov/em/CustomerHelp/bpcletters/Letter-9.pdf

It is important to note that the reminder letter contains special instructions to members regarding how they should answer Question 1 in Step 4 (on page 6 of the paper Marketplace application). Please keep in mind that this question is asking whether the applicant(s) have BadgerCare Plus (Medicaid/CHIP) coverage as of January 1, 2014. This question states,

"Is anyone enrolled in health care coverage now for the following?

- *Yes. If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.*
- *No."*

Customers are being instructed to answer this question "No" so that the Marketplace will know that the customer's BadgerCare Plus coverage may be ending on December 31, 2013 and will move forward with processing the customer's Marketplace application.

Please email the Department at dhshealthcare@dhs.wisconsin.gov if you have any questions about this letter.

Thank you for your continued partnership and assistance.

November 14, 2014

Good Evening,

Below is a press release that was issued by Governor Walker early this afternoon calling for a special session of the Legislature to take up Legislation that would allow individuals currently enrolled in BadgerCare Plus more time to transition to the federal health insurance exchange. As a result the health care changes that were slated to be implemented on January 1, 2014 will now be effective April 1, 2014. All health care changes that were

included in the budget have been delayed, including changes to BadgerCare Plus eligibility and BadgerCare Plus plan design. All BadgerCare policies currently in effect remain until March 31, 2014.

I know many of you will have more specific questions about this announcement, especially regarding how this will impact systems and day-to-day operations.

The Department is currently working on a plan for the dates in which systems changes will be made and when the updated ACCESS application will be available. We will let you know as soon as we can what these details are. In the meantime, please send your questions to dhshealthcare@dhs.wisconsin.gov and we'll get them answered as soon as we work through the details.

Again thank you for your flexibility as well as your continued partnership and assistance as we enter 2014 and work together to achieve Governor Walker's goals of ensuring a smooth transition of BadgerCare Plus members to the federal exchange and reducing our uninsured rate in Wisconsin.

We could not do this without your help. You are a valuable partner in this process.

FOR IMMEDIATE RELEASE
November 14, 2013
Contact: Tom Evenson, (608) 267-7303

After Federal Government's Failed ACA Rollout, Governor Scott Walker to Call Special Session to Protect Wisconsin Citizens

Calls on President Barack Obama's Administration to Allow Wisconsinites to Use Subsidies in the Private Market to Work around Failed Federal Exchange

Madison—Due to the failed federal rollout of the Affordable Care Act (ACA), Governor Scott Walker announced he will be calling a special session of the Legislature to take up legislation to move forward with a three-month delay through March 31, 2014, in the implementation for people in Wisconsin moving into health care plans in the federal exchange. Governor Walker also announced a three-month extension for the state's high-risk insurance plan, known as the Health Insurance Risk-Sharing Plan (HIRSP), to provide a safety net during the transition for some of the state's most vulnerable.

"In Wisconsin, we are taking action to protect our citizens from the federal government's failure," said Governor Walker. "We will take care of the people of our state and not let them slip through the cracks. This delay will give Wisconsinites additional time, but the federal government must fix the issues with its health care exchange, so our people can make a logical transition."

After the difficulties many have experienced in using the federal exchange and seeing the dismal enrollment numbers from the federal government, it is necessary to protect Wisconsinites from the failure of the federal government's rollout of the Affordable Care Act.

In addition, Governor Walker called on President Barack Obama's Administration to open up Wisconsin's

competitive market to all consumers and allow those who qualify for subsidies to use them to purchase any qualified health plan, not just those listed in the exchange. Currently, those who qualify for subsidies can only use those subsidies on health plans listed on the federal exchange. By allowing people to use their subsidies in the private market and not just on the exchange, they will have more insurance provider options all offering ACA-qualified plans. Wisconsinites can access a full list of insurers offering health insurance plans in their counties at the following link<http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf>.

"Since the federal exchange is not working, it only makes sense to allow Wisconsinites, who are eligible for subsidies, to use those subsidies to access qualified health care plans in the private market," said Governor Walker. "In many counties, people will have more insurer options off the exchange than they do on it. Let people use their subsidies with the insurers of their choice."

The Wisconsin plan reforms the Medicaid entitlement to preserve it for the neediest, while protecting our taxpayers from uncertainty related to the federal government's funding. For the first time in our state, Wisconsin will provide health coverage for everyone living in poverty through Medicaid and allow those above that level to access health insurance through the exchanges or the private market. Governor Walker's reforms will not be changing, but will be delayed by three months to help ensure a smooth transition for the 77,000 Wisconsinites who will now be moving into health insurance plans through the exchanges.

Wisconsin was ready to move forward, but the federal government clearly was not. In Wisconsin, the Department of Health Services (DHS) and the Office of the Commissioner of Insurance (OCI) have implemented extensive outreach efforts to help those transitioning into health plans on the exchanges. DHS contacted those transitioning onto the exchange several times by mail and by phone to make sure they were aware of the changes in their eligibility and to provide them with information about how to enroll in health insurance in the exchanges. Just this week, DHS sent out letters to the approximately 77,000 individuals transitioning into the federal exchange with paper applications and directions about how to fill out the applications and turn them in.

October 18, 2013

Good Morning,

As you know, the BadgerCare Plus Reform changes scheduled for January 1, 2014 are being delayed until April 1, 2014. This means that non-pregnant adults between the ages of 19 and 64 who are 100% of the federal poverty level (FPL) and children over 300% FPL will remain on the BadgerCare Plus program until April 1, 2014. Additionally, we are delaying when childless adults below 100% FPL can begin applying for BadgerCare Plus, either through ACCESS.wisconsin.gov, phone, or paper application. We will provide additional details in the near future in regards to the new schedule for childless adults to begin applying for BadgerCare Plus coverage.

Guidance for completing a health care application – Childless Adults:
The best way for adults with no dependent children to apply for health care benefits right now is through the federal health insurance Marketplace (also called the Exchange). To apply through the Marketplace, go to healthcare.gov or call 1-800-318-2596 or 1-855-889-4325 (TTY). The Department will inform you as soon as

possible when ACCESS will be able to accept applications for adults between the ages of 19 and 64 who are not disabled, blind, pregnant, or living with and caring for a child under 19.

Guidance for completing a health care application – Recipients of Letter One (Currently enrolled Parents, caretaker relative, and adults with no dependent children with an income between 100-200% FPL and Children with incomes above 300% FPL):

We are working with the Centers for Medicaid and Medicare Services (CMS) to determine the impact to those current BadgerCare Plus members that are transitioning to the federal Marketplace. We are aware that some of these members have already received an eligibility determination and/or enrolled in a qualified health plan (QHP) at the federal Marketplace. We will provide additional information and guidance in the near future on how these members are impacted.

Thank you for your continued partnership, and if you have any questions please send them to dhshealthcare@dhs.wisconsin.gov.

November 26, 2013

My colleagues and I, at the Department of Health Services, want to thank you for being one of our valued partners who serve some of our state's most vulnerable residents. We also want to let you know that we very much appreciate your flexibility and patience as we collaborate to help Wisconsin residents understand the new private health care options available through the Affordable Care Act and the policy changes to BadgerCare Plus that will be effective in 2014.

Governor Walker has called for a special session of the Wisconsin State Legislature to take up legislation that would allow certain BadgerCare Plus members more time to transition to private health insurance through the federal Health Insurance Marketplace (also called the Exchange). **As a result, the health care changes that were to be implemented on January 1, 2014 will now be effective April 1, 2014.**

This means individuals who are enrolled in BadgerCare Plus, and continue to meet the current BadgerCare Plus rules, will not be affected by the BadgerCare Plus policy changes until April 1, 2014. In addition, childless adults with no dependent children who have income that is below 100% of the FPL will not be able to get health care through BadgerCare Plus until April 1, 2014.

In the meantime, adults, age 19 through 64, with no dependent children seeking BadgerCare Plus should apply through the Marketplace. To apply through the Marketplace, go to Healthcare.gov or call 1-800-318-2596 or 1-855-889-4325 (TTY). We will inform you when ACCESS will be able to accept applications for adults between the ages of 19 and 64 who are not disabled, blind, pregnant, or living with and caring for a child under 19.

Please note that for those that are seeking coverage through the federal Health Insurance Marketplace effective January 1, 2014 that CMS announced last week that the deadline to enroll and pay your first premium has been extended from December 15th to December 23rd.

The legislature announced last week that they will convene Session meetings on December 2nd. DHS continues ongoing communication with our federal partners, as we plan for the upcoming BadgerCare Plus policy changes and resolve other matters related to the delay. We will let you know as soon as we have an agreed upon transition plan with CMS and have finalized our operations plan. We expect to have plans finalized in the next few weeks. In the meantime, please continue to send any questions you have to dhshealthcare@dhs.wisconsin.gov. While we might not be able to answer your question right away, we will answer it as soon as we can.

Thank you for your continued partnership, and if you have any questions please send them to dhshealthcare@dhs.wisconsin.gov.

November 27, 2013

Good Afternoon,

I wanted to let you know about two new fact sheets that have been created for members that give information about the delay and what this means for them. I hope that you find these fact sheets helpful and that they can serve as a resource that you can give to members and other individuals and utilize to help answer their questions. Both fact sheets can be found online at http://www.dhs.wisconsin.gov/health-care/member/index.htm.

Thank you for your continued partnership, and if you have any questions please send them to dhshealthcare@dhs.wisconsin.gov.

December 12, 2013

Good Afternoon,

I wanted to take a minute provide you a brief update on a couple of items.

Attached is a call center script that the Department put together for the Consortia call centers. I believe you might also find this to be a valuable tool as you continue to answer many questions from current members and other individuals who are seeking health care through BadgerCare Plus or HealthCare.gov.

As you will see in the script, ACCESS will be updated as of February 3rd allowing childless adults to apply for health care benefits that begin on April 1, 2013.

Finally, last week, DHS sent letters to current basic plan members, informing them that they could continue to pay premiums and stay on the basic plan through March 31, 2014.

Here is a link to the letter: http://www.dhs.wisconsin.gov/em/CustomerHelp/bpcletters/Letter-4A.pdf.

Please note the quick turnaround time between the date the letter was received and the date the premium payment is requested. If members are not able to make their payment today, they should call the EM CAPO number included in the notice to discuss their situation. We also working on a plan for communication with transitioning members to inform them of the 3-month delay (pending final approval by the Senate and CMS).

Thank you for your continued partnership, and if you have any questions please send them to dhshealthcare@dhs.wisconsin.gov.

December 19, 2014

The special session bill to extend the Badger Care Plus Program through March 31, 2014 has been passed by the Wisconsin Senate and has now gone to Governor Walker to be signed. The bill delays changes to the program

that were to take effect January 1, 2014, to allow Wisconsin citizens more time to apply and purchase private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

The Department of Health Services is still working with the federal government to get approval to continue current program rules through March 31, 2014, and begin the new program rules on April 1, 2014. We are very close to the conclusion of this process and will let you know as soon as the waiver is finalized.

In addition, beginning Monday, December 23, 2013 the Department will begin sending three additional letters to members and applicants. Copies of the letters and information about the letters, as well as the letters that have been sent since late September, are available at http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm

Letter 1A will be sent to all BadgerCare Plus members that are anticipated to not meet the new BadgerCare Plus income limits and will need to apply at the federal Health Insurance Marketplace for April 1, 2014 coverage. This letter will:

- Inform these members that their BadgerCare Plus enrollment will be extended to March 31, 2014, and encourage them to purchase health insurance through the Marketplace and pay their first Qualified Health Plan premium by March 15, 2014 to ensure April 1, 2014 coverage.
- Include a form the member should complete and return to their income maintenance agency. This form collects tax filer and other relevant information which will be used to determine if the member(s) can remain enrolled in BadgerCare Plus after March 31, 2014, under the new program rules. For example, BadgerCare Plus households with child support will no longer have that type of income counted. Members must complete the form and return it by January 17, 2014. This information will also be sent to the Marketplace to simplify the affected members' Marketplace application and determine if the affected member(s) may be eligible for tax credits.
- The Department created a document for partners and the consortia that further explains the form and serves as a tool for when you are helping members fill out the form. The document is available at http://www.dhs.wisconsin.gov/forms/f0/f00914A.pdf.

Letter 3A will be sent to individuals who were on the BadgerCare Plus Core Plan waitlist.

- This letter informs the individual of the delay in implementation of BadgerCare Plus changes, and directs them to apply right now using the Marketplace application, or apply using ACCESS.wi.gov on or after February 3, 2014, for BadgerCare Plus coverage beginning April 1, 2014.
- It also informs the individual that if the Marketplace determines them eligible for private health insurance through a QHP before December 23, 2013, they are able to enroll in the QHP beginning January 1, 2014.

Finally, DHS has not yet received account transfers from the Marketplace. The Department has received a file which includes some contact information for applicants the Marketplace has determined eligible for BadgerCare Plus in 2014. DHS will send Letter 10 to the individuals that we receive on the flat file to clarify when their BadgerCare Plus coverage will begin and letting them know that we will process their application when we get it.

- The letter lets individuals with no dependent children under age 19 living in their home know they will not be enrolled in the BadgerCare Plus Standard Plan until April 1, 2014; they do not need to reapply or take any other action at this time; and they will get a letter in March with more information about their enrollment in BadgerCare Plus.

- The letter lets parents, caretaker relatives and children know that after the Marketplace sends their complete application for BadgerCare Plus, it will be processed and they will have BadgerCare Plus coverage that will be effective back to January 1, 2014; that depending on when they filed their application with the Marketplace, their coverage could be effective even earlier than January 1, 2014; that they do not need to reapply or take any other action at this time; and that they will get a letter with more information about their enrollment in BadgerCare Plus once we receive and process their application from the Marketplace.
- The letter also lets individuals who applied for coverage at the Marketplace and were referred to BadgerCare Plus because they may be eligible for services because you have special health care needs like needing help with daily living or having a disability, know that we will contact them after the Marketplace sends their complete information.

In the meantime, if you have any questions, please send them to dhshealthcare@dhs.wisconsin.gov.

Thank you for your continued partnership,

December 20, 2013

Good Evening,

The Department has updated the frequently asked questions document for partners to reflect the delay in program changes. You can view the document at dhs.wi.gov/health-care/faq.htm. In addition, attached is an updated copy of the call script that the Consortia and Member Services are using to answer questions from members and applicants.

One note about the email from yesterday current BadgerCare Plus members will receive Letter 1A, and not Letter 3A. It is important than only recipients of Letter 1A complete and return the form.

If you have any questions, please send them to dhshealthcare@dhs.wisconsin.gov.

Thank you for your continued partnership,

December 30, 2013

Good afternoon,

I wanted to take a few minutes to share an update with you about a couple of developments regarding BadgerCare Plus.

Since Governor Walker's announcement to delay implementation of the Medicaid reforms due to technical issues with Healthcare.gov, the Department of Health Services has been actively working with staff at the federal Centers for Medicare and Medicaid Services (CMS) to address the programmatic and system changes needed to meet the three month delay. Attached is an updated that the Department sent to legislative leaders this afternoon, along with our correspondence with CMS regarding these changes.

If you have any questions, please send them to dhshealthcare@dhs.wisconsin.gov.

Thank you for your continued partnership,

January 6, 2014

The Department of Health Services (DHS) will be hosting a webinar for partners to provide an update on the 2014 BadgerCare Plus policy changes, brief overview of the timeline and to provide information on the new BadgerCare Plus Tax Filer Information form that was recently sent to for current BadgerCare Plus members affected by the 2014 policy changes.

The BadgerCare Plus Tax Filer Information form is due by January 17th for members that choose to provide the additional information.

The webinar will be held:

Date: Wednesday, January 8th

Time: 10:30 am

Location: Can be viewed by going to :
http://dhsmedia.wi.gov/main/Play/902efb6b099d4742b8d7bdab61c485711d

January 9, 2014

I want to provide you with a brief status update regarding federal approval of Wisconsin's new BadgerCare Reform waiver. Please find attached correspondence between the Centers for Medicare and Medicaid Services (CMS) and the Wisconsin Department of Health Services (DHS) formally agreeing to a new Medicaid waiver to serve childless adults living in poverty.

Upon approval of the 2013-15 state budget, the Department began engaging in ongoing negotiations with CMS to develop the framework for delivering Medicaid benefits to Wisconsin's childless adult population who are below 100% of the federal poverty level (FPL). We greatly appreciate the work of our federal partners, state legislature, as well as the countless hours invested by Department staff who have successfully ensured that as of April 1, 2014, Governor Walker's entitlement reforms are fully implemented, and every Wisconsin resident will have access to affordable health insurance.

Attached is a copy of the letter from CMS Director Marilyn Tavenner approving the state's waiver. In addition, I have attached Wisconsin's response accepting the terms of the waiver. You can view the documents related to the submission and approval of the waiver at http://www.dhs.wisconsin.gov/badgercareplus/waivers.htm.

In addition, a press release will be issued by the Department later this morning announcing this agreement. You can view that release at http://www.dhs.wisconsin.gov/news/ Thank you for your time and attention to this important day for Wisconsin. If you have any questions, please send them to dhshealthcare@dhs.wisconsin.gov.

Thank you for your continued partnership,

January 9, 2014

The Department of Health Services will host a series of in-person meetings throughout the state, including a webinar that will be archived and made available for those that are not able to attend in person.

The trainings will provide an overview of the updated timeline of implementation for policy changes, what members and applicants can expect, the February 3, 2014, system updates for ACCESS.WI.GOV that will allow newly eligible BadgerCare Plus populations to apply for BadgerCare Plus coverage, and other relevant updates.

The dates and times of the meetings:

Milwaukee – January 22nd
9:00am – 12:00pm
Medical College of Wisconsin
Auditorium, Room HRC H1400
8701 Watertown Plank Road, Milwaukee, WI 53226
To register: http://wibadgercareplus2014updatemilw.eventbrite.com

Racine – January 23rd
9:00am-12:00pm
Gateway Technical College (iMET) Center Auditorium
2320 Renaissance Blvd, Sturtevant, WI 53177-1763
To register: https://wibadgercareplus2014updatewkrp.eventbrite.com

La Crosse - Monday, January 27, 2014
2:00 - 4:00pm
La Crosse County Health & Human Services Dept.
300 4th St N. Basement Auditorium
La Crosse WI 54601
To register: https://wibadgercareplus2014update.eventbrite.com

Ashland - Tuesday, January 28, 2014
1:00 - 3:30pm
Wisconsin Indianhead Technical College
2100 Beaser Ave
Ashland, WI 54806
To register: https://wibadgercareplus2014update.eventbrite.com

Stevens Point - Wednesday, January 29, 2014
2:00 - 4:00pm
Portage County Public Library

Pinery Room
1001 Main Street
Stevens Point, WI 54481
To register: https://wibadgercareplus2014update.eventbrite.com

Chippewa Falls - Thursday, January 30, 2014
10:00am - 12:00pm
Chippewa County Courthouse
Room 001 & 003
711 N. Bridge Street
Chippewa Falls, WI 54729
To register: https://wibadgercareplus2014update.eventbrite.com

Madison - Tuesday, February 4, 2014
10:00am - 12:00pm
Goodman Community Center
Evjue Room D
149 Waubesa Street
Madison, WI 53704
To register: https://wibadgercareplus2014update.eventbrite.com

Green Bay - Thursday, February 6, 2014
1:00 - 3:00pm
University Union – Phoenix A & B
University of Wisconsin-Green Bay
2420 Nicolet Drive
Green Bay, WI 54311-7001
To register: https://wibadgercareplus2014update.eventbrite.com

Please help us spread the word about these events. Thank you for your assistance and collaboration.

January 13, 2014

The Department of Health Services (DHS) hosted a webinar on January 8, 2014, for partners to provide an update on the 2014 BadgerCare Plus policy changes, a brief overview of the updated timeline and to provide information on the new BadgerCare Plus Tax Filer Information form that was recently sent to current BadgerCare Plus members affected by the 2014 policy changes.

The archived presentation and PowerPoint can be found at: http://www.dhs.wisconsin.gov/health-care/training/index.htm

The optional BadgerCare Plus Tax Filer Information form is due by January 17th

January 16, 2014
Good Evening,

We wanted to provide an update and a few reminders to our partners statewide regarding 2014 BadgerCare Plus policy changes:

Update on Technical Legislation:
Earlier this week both houses of the Wisconsin Legislature approved the 2014 BadgerCare Plus Policy technical change legislation to align Wisconsin law with the agreement with CMS and Governor Walker signed AB 610/SB 475 late this afternoon. The technical changes in this bill were needed to implement Modified Adjusted Gross Income (MAGI) beginning February 1, 2014. Beginning February 1, 2014, all new BadgerCare Plus applicants will be subject to MAGI rules. As part of this, the new income limit (100% FPL) will be applied to parents and caretaker relatives who are newly applying for BadgerCare Plus. Current BadgerCare Plus members between 100 % FPL and 200% FPL will remain enrolled through March 31st.

However, please note that although the new BadgerCare Plus income limit (100% FPL) will be applied to parents and caretakers that apply for coverage on or after February 1, 2014, newly eligible adults age 19-64 without dependent children living in the household cannot begin coverage until April 1, 2014 or later.

Stay tuned to http://www.dhs.wisconsin.gov/health-care/index.htm for DHS updates, materials, and information for partners.

Reminder about upcoming in-person trainings:
The Department of Health Services will host a series of in-person meetings throughout the state, including a webinar that will be archived and made available for those that are not able to attend in person.

The trainings will provide an overview of the updated timeline of implementation for policy changes, what members and applicants can expect, the February 3, 2014, system updates for ACCESS.WI.GOV that will allow newly eligible BadgerCare Plus populations to apply for BadgerCare Plus coverage, and other relevant updates.

The dates and times of the meetings:

Milwaukee – January 22nd
9:00am – 12:00pm
Medical College of Wisconsin
Auditorium, Room HRC H1400
8701 Watertown Plank Road, Milwaukee, WI 53226
To register: http://wibadgercareplus2014updatemilw.eventbrite.com

Racine – January 23rd
9:00am-12:00pm
Gateway Technical College (iMET) Center Auditorium
2320 Renaissance Blvd, Sturtevant, WI 53177-1763
To register: https://wibadgercareplus2014updatewkrp.eventbrite.com

La Crosse - Monday, January 27, 2014
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La Crosse County Health & Human Services Dept.
300 4th St N. Basement Auditorium
La Crosse WI 54601
To register: https://wibadgercareplus2014update.eventbrite.com

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1:00 - 3:30pm
Wisconsin Indianhead Technical College
2100 Beaser Ave
Ashland, WI 54806
To register: https://wibadgercareplus2014update.eventbrite.com

Stevens Point - Wednesday, January 29, 2014
2:00 - 4:00pm
Portage County Public Library
Pinery Room
1001 Main Street
Stevens Point, WI 54481
To register: https://wibadgercareplus2014update.eventbrite.com

Chippewa Falls - Thursday, January 30, 2014
10:00am - 12:00pm
Chippewa County Courthouse
Room 001 & 003
711 N. Bridge Street
Chippewa Falls, WI 54729
To register: https://wibadgercareplus2014update.eventbrite.com

Madison - Tuesday, February 4, 2014
10:00am - 12:00pm
Goodman Community Center
Evjue Room D
149 Waubesa Street
Madison, WI 53704
To register: https://wibadgercareplus2014update.eventbrite.com

Green Bay - Thursday, February 6, 2014
1:00 - 3:00pm
University Union – Phoenix A & B
University of Wisconsin-Green Bay
2420 Nicolet Drive

Green Bay, WI 54311-7001
To register: https://wibadgercareplus2014update.eventbrite.com

Please help us spread the word about these events. Thank you for your assistance and collaboration.

February 2, 2014

Reminder about upcoming in-person trainings – there is still time to register!
(PLEASE NOTE RESCHEDULED DATES AND REGISTRATION FOR THOSE CANCELED DUE TO INCLEMENT WEATHER)

The Department of Health Services is hosting a series of in-person meetings throughout the state, including a webinar that will be archived and made available for those that are not able to attend in person.

The trainings will provide an overview of the updated timeline of implementation for policy changes, what members and applicants can expect, the February 3, 2014, system updates for ACCESS.WI.GOV that will allow newly eligible BadgerCare Plus populations to apply for BadgerCare Plus coverage, and other relevant updates.

The dates and times of the upcoming meetings:

Madison - Tuesday, February 4, 2014
10:00am - 12:00pm
Goodman Community Center
Evjue Room D
149 Waubesa Street
Madison, WI 53704
To register: https://wibadgercareplus2014update.eventbrite.com

Green Bay - Thursday, February 6, 2014
1:00 - 3:00pm
University Union – Phoenix A & B
University of Wisconsin-Green Bay
2420 Nicolet Drive
Green Bay, WI 54311-7001
To register: https://wibadgercareplus2014update.eventbrite.com

Rescheduled to the following dates due to inclement weather the week of January 27th, 2014:

La Crosse - Wednesday, February 5, 2014
10:00am - 12:00pm
La Crosse County Health & Human Services Dept
300 4th St N. Basement Auditorium
La Crosse WI 54601
To register: http://bc2014update.eventbrite.com

Ashland - February 10, 2014
1:00 - 3:00pm
Wisconsin Indianhead Technical College
2100 Beaser Ave
Ashland, WI 54806
To register: http://bc2014update.eventbrite.com

Please help us spread the word about these events.

February 4, 2014

Good morning,

Thank you for your ongoing partnership and all of the hard work that you have done to assist Wisconsin residents learn about their health care options and to apply for benefits.

I appreciate your flexibility as key implementation dates have changed and for continuing to partner with the Department of Health Services (DHS). I am writing to provide a number of updates regarding BadgerCare Plus.

Topics that will be covered include:

1. Partner Trainings
2. ACCESS.wi.gov Updates
3. 2014 Federal Poverty Levels (FPLs)
4. Account Transfers – HealthCare.gov to Wisconsin
5. Guidance to Members Regarding Incorrect Determinations
6. Account Transfers – Wisconsin to HealthCare.gov
7. Members Who Will Be Transitioning From BadgerCare Plus to the Marketplace
8. Outbound Calls
9. Upcoming Key Dates

1. Partner Trainings

DHS is in the process of conducting in-person trainings to provide an overview of the updated timeline of implementation for BadgerCare Plus policy changes, what members and applicants can expect, and the February 3, 2014 system updates for ACCESS.WI.GOV that will allow childless adults to beginning applying directly for BadgerCare Plus coverage beginning as early as April 1, 2014. The Milwaukee, Racine, Stevens Point and Chippewa Falls trainings occurred in late January. The Madison and Green Bay trainings will be occurring this week. The training details are below. Please note that trainings in La Crosse and Ashland that were scheduled for last week were canceled due to the weather. These trainings have been rescheduled and details are noted below. A webcast of the Milwaukee training and a copy of the training materials are available online at http://www.dhs.wisconsin.gov/health-care/training/index.htm.

Madison - Tuesday, February 4, 2014
10:00am - 12:00pm

Goodman Community Center
Evjue Room D
149 Waubesa Street
Madison, WI 53704
To register: https://wibadgercareplus2014update.eventbrite.com

La Crosse - Wednesday, February 5, 2014
10:00am - 12:00pm
La Crosse County Health & Human Services Dept.
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Ashland - February 10, 2014
1:00 - 3:00pm
Wisconsin Indianhead Technical College
2100 Beaser Ave
Ashland, WI 54806
To register: http://bc2014update.eventbrite.com

2. ACCESS.wi.gov Updates

This past weekend (February 1, 2014) Wisconsin's online application tool, ACCESS, and eligibility determination system, CARES, were updated to include the new BadgerCare Plus program rules and to allow childless adults (adults age 19-64 with no dependent children living in the household) to begin submitting BadgerCare Plus applications.

As part of this update, beginning February 1, 2014, all new BadgerCare Plus applicants are subject to MAGI rules. As such, the new income limit (100% FPL) will be applied to parents and caretaker relatives who are newly applying for BadgerCare Plus. Current parent, caretaker relative, and childless adult BadgerCare Plus members with household incomes between 100 % FPL and 200% FPL will remain enrolled through March 31, 2014.

However, please note that although the new BadgerCare Plus income limit (100% FPL) will be applied to parents and caretakers that apply on or after February 1, 2014, newly eligible childless adults will not begin BadgerCare Plus coverage until April 1, 2014 or later.

Also included in the ACCESS.wi.gov updates was an update to the Am I Eligible screening tool to include the new BadgerCare Plus program rules. This can be an incredibly useful tool when assisting an adult whose

income is right around 100% FPL and you don't know where it would be best for them to apply for health care – through BadgerCare Plus or through the Marketplace. By entering a few pieces of information about the applicant and their household, you can get an overview of the Wisconsin public assistance programs the individual may be eligible for such as FoodShare and heating assistance. In addition, it will let you know if the person looks eligible for BadgerCare Plus or if they should apply for and purchase private health insurance through the Marketplace.

3. 2014 FPLs

ACCESS and CARES were updated January 31, 2014 to include the 2014 Federal Poverty Limits. You can view the new FPLs at http://badgercareplus.org/fpl.htm.

4. Account Transfers – HealthCare.gov to Wisconsin

HealthCare.gov has begun sending account transfers to Wisconsin. We anticipate that later this week DHS will be able to send small batches of the account transfers to the consortia for testing and initial processing. As this is a very new process, one which DHS has never previously done with the federal government, DHS is working to ensure the process goes as smoothly as possible as well as testing and validating the data Wisconsin receives through the account transfers to ensure it is accurate and complete.

The Centers for Medicare and Medicaid Services (CMS) has notified states that there have been issues with the data that they collected from applicants on HealthCare.gov and defects in the process by which they completed some determinations. Due to these known defects, as well as issues that DHS has since identified, we are working with the local agencies to complete further validation and testing of the data. Once we have completed this process, assuming there are no major issues detected, additional accounts will be sent to the local agencies for processing.

Please keep in mind that agencies may not receive a given account until mid-February or later so please allow the agencies ample time to receive and process the accounts. Once the agency has successfully processed an account, the applicant will be notified about their enrollment status through the mail via a notice of decision or a verification checklist.

In addition, when CMS notified states about the defects related to the HealthCare.gov applications and determinations, they also provided guidance regarding timeframes in which states are allowed to re-process determinations made by HealthCare.gov. Wisconsin is required by the federal government to accept the determination made by HealthCare.gov and enroll the individual in BadgerCare Plus even if the determination was incorrect. For more information about determinations made by the Marketplace, go to http://www.dhs.wisconsin.gov/publications/P0/P00594.pdf. Families will be enrolled for at least January and February 2014 and childless adults will be enrolled for at least April 2014. Wisconsin is allowed to re-process the applications after enrolling the member to determine if the member meets the BadgerCare Plus program rules and can continue to be enrolled in BadgerCare Plus.

Wisconsin will be re-running eligibility for individuals determined eligible for BadgerCare Plus by the Marketplace the weekend of March 22, 2014. If a member is found to be no longer eligible for BadgerCare Plus, they will receive a notice of decision the week of March 24, 2014 that lets them know that they are no

longer eligible for BadgerCare Plus as of May 1, 2014. This loss of insurance will qualify them for a special enrollment period allowing them to still enroll through the Marketplace. The member will get the standard notice of decision in the mail that includes a short message about why they are not eligible and what they should do (i.e. apply for and purchase private health insurance through the Marketplace). The notice will also include their hearing rights and the information used to make this determination. We will share with you a sample notice of decision in the near future.

Please Note: There are two primary reasons why individuals determined eligible for BadgerCare Plus by the Marketplace could be found to no longer be eligible for BadgerCare Plus:

- The Marketplace incorrectly applied MAGI rules. For example, the marketplace used household sizes that were too big or income amounts that were too low, or both.
- The member already has an open case with current income information, but they did not report that income to the Marketplace.

When eligibility is re-run on March 22, 2014, CARES will apply correct MAGI rules and will consider all current income information known to the case.

5. Guidance to Members Regarding Incorrect Determinations

If members believe that they have received an incorrect determination by the Marketplace, they may be able to remove their application from their Marketplace account and submit a new application. They also have the ability to appeal the Marketplace determination. Additional information about this process is available at https://www.healthcare.gov/can-i-appeal-a-marketplace-decision. If a member needs to update the information that they provided in their Marketplace application, they may be able to update this information by going to HealthCare.gov or by calling 1-800-318-2596.

6. Account Transfers – Wisconsin to HealthCare.gov

Wisconsin has confirmed with HealthCare.gov that we are able to successfully transfer the accounts of people who are no longer eligible for BadgerCare Plus back to the Marketplace. However, at this time, CMS has indicated that while they are able to receive the account transfers from states, the date in which they will begin processing these applications has not been decided. Until the point in time in which HealthCare.gov will be processing the accounts sent from states, Wisconsin will be directing individuals who are determined not be eligible for BadgerCare Plus to submit a new application directly with the Marketplace. At this time, this will be the easiest and most efficient way for individuals to apply for and purchase private health insurance through the Marketplace after they have been determined to not be eligible for BadgerCare Plus.

7. Members Who Will Be Transitioning from BadgerCare Plus to the Marketplace

On February 15, 2014, the new BadgerCare Plus income limits will be applied to the individuals who will likely be transitioning from BadgerCare Plus to the Marketplace (the current members who received Letters 1, 1A, 9). As a result, members who no longer meet BadgerCare Plus program rules will get a notice of decision letting them know that they will need to apply for and purchase private health insurance through the federal Health Insurance Marketplace. A sample notice of decision will be shared with partners in the near future.

Please Note: Through letter 1A, in late December, DHS sent the tax filing information (TFI) form to the members who will likely need to purchase private health insurance through the Marketplace in order to have health coverage beginning April 1, 2014. By filling out this form, members were able to request to be tested under the new MAGI rules to see if they can stay enrolled in BadgerCare Plus under the new program rules.

If members filled out the TFI form and it was determined that they will remain eligible under the new program rules, their enrollment will continue after April 1, 2014, as long as they continue to meet current program rules. These members will NOT be getting a follow-up notice of decision in the mail.

If the member filled out the TFI form and they were determined to not be eligible under the new program rules or if the member did not return the TFI form, the new BadgerCare Plus income limits will be applied to their case on February 15, 2014. If any of the members in the household are no longer eligible for BadgerCare Plus after March 31, 2014, they will get a notice of decision that will be mailed on Feb. 17, 2014 letting them know that they need to apply for and purchase private health insurance through the Marketplace.

Please Note: Individuals who filled out and returned the TFI form and were determined to not be able to stay enrolled in BadgerCare Plus under the new MAGI rules will still have their accounts transferred to the Marketplace. However, as discussed in update #6 above, we do not know when the Marketplace will begin processing these accounts, so the notice of decision will direct them to apply for and purchase private health insurance directly at the Marketplace.

8. Outbound Calls

Since October, DHS (through our vendors Automated Health Systems, Inc. and HP) has been making outbound calls to all households or individuals that received one of the informational notices to ensure that the letter was received, the member understood the letter, and that the member is taking action by either reporting a change with regard to their BadgerCare Plus case file or applying for coverage through the Marketplace. When DHS makes the outbound calls to individuals who were sent a letter we ask to the individual to verify the month they are born in.

If the individual is not comfortable verifying their birth month, they are advised to call their agency or member services, depending on whether the individual is currently enrolled in BadgerCare Plus or was on the Core Plan Waitlist.

Please Note: When members get one of these calls, they will see that the call is coming from (608) 729-0020 or (608) 221-4746.

The outbound calls are intended as additional outreach to make sure that members understand the three month delay and to communicate their health care coverage options during this time. While the correspondents are not able to answer questions about an individual's specific situation, they will be able to either provide the number of a local agency who can help with those questions or transfer the call directly, if that's requested.

9. Key Upcoming Dates

February 1, 2014

- MAGI rules will be implemented for all new applicants.
- FPLs updated in ACCESS and CARES.
- New income limits will be implemented for new parents and caretaker relative applicants.
    - Parents and caretakers with incomes from 100% to 200% FPL who are enrolled in BadgerCare Plus as of January 31, 2014 will remain eligible through March 31, 2014, as long as they continue to meet program rules.

February 3, 2014:

- Childless adults can begin submitting new applications via ACCESS, over the phone, or in person at their local agency. Please note that newly eligible childless adults will begin coverage no earlier than April 1, 2014.
- Am I Eligible will be updated with MAGI rules.

February 14, 2014:

- New FPLs will be applied to BadgerCare Plus members who pay premiums. Depending on the member's income, premium amounts may be reduced or some members may no longer be required to pay a monthly premium.

February 15, 2014:

- The new BadgerCare Plus income limits will be applied to the individuals who will likely be transitioning from BadgerCare Plus to the Marketplace (the current members who received Letters 1, 1A, 9).

Week of February 17, 2014:

- Notices will be mailed to members who have a change in eligibility or benefit plan effective April 1, 2014 because of income limit and benefit plan changes.
- Notices will be mailed to members who have a change in premium amount or are no longer required to pay a monthly premium.

March 15, 2014:

- Deadline for BadgerCare Plus members who are transitioning to purchasing private health insurance to pay their first month's premium so their private health insurance will begin April 1, 2014 they do not have a gap in health care coverage.
- Member update will be mailed to current Benchmark and Core Plan members who will continue to be enrolled in BadgerCare Plus after March 31, 2014 to let them know that they will be in the Standard Plan as of April 1, 2014.

March 22, 2014:

- DHS will re-run the eligibility of individuals determined eligible for BadgerCare Plus by the Marketplace.
- Members who were enrolled based on the Marketplace determination, but are identified to no longer be eligible for BadgerCare Plus through this process will have coverage through April 30, 2014.

March 24, 2014:

- Notices will begin to be mailed to members determined eligible for BadgerCare Plus through the Marketplace who will no longer be enrolled in BadgerCare Plus effective May 1, 2014.

April 1, 2014:

- Newly eligible childless adults begin coverage.

Again, thank you for your continued partnership. We will continue to be updating www.dhs.wisconsin.gov/health-care as information is available. Please continue to send any questions that you have to dhshealthcare@dhs.wisconsin.gov**.**

February 24, 2014

Good Morning,

Thank you for your continued assistance as we work together through this historic transition. Following is information regarding BadgerCare Plus changes that will become effective April 1, 2014.

Beginning Tuesday, February 18, 2014, BadgerCare Plus members who will no longer be eligible as of April 1, 2014, will begin receiving Adverse Action notices stating that they no longer meet the eligibility requirements for the program (See Appendix 27). These are the standard notices that are currently sent to members who no longer meet the eligibility criteria for a program. While previous informational mailings did not list which household members are affected by program changes, this notice will specifically list which household members will no longer be eligible. Households that have experienced a change in circumstance, such as a change in income, loss of job, change in family composition, or other unreported change that may affect their eligibility should contact their consortia immediately. Please note, the standard Department of Health Services (DHS) notice of decision has a 300 character limit to give specific, tailored messages regarding why someone will not continue coverage and what they should do next. Because of this, affected members are directed to the Marketplace or their local agency for additional assistance.

Members who receive this notice about their coverage ending should apply directly to the federal health insurance Marketplace, if they have not already done so, to purchase private health insurance. Please remind them they can take action now prior to actually losing their BC+ coverage. As a reminder, Wisconsin has confirmed with HealthCare.gov that DHS is able to successfully transfer the accounts of applicants who are no longer eligible for BadgerCare Plus to the Marketplace. However, at this time, the Centers for Medicare & Medicaid Services (CMS) has indicated that while they are able to receive the account transfers from states, the date in which they will begin processing these applications has not been decided. Until HealthCare.gov will be processing the accounts sent from states, individuals who are determined not be eligible for BadgerCare Plus should submit a new application directly with the Marketplace.

As a reminder, a new question has been added to the Marketplace application that allows applicants to attest that their local agency has found them to be ineligible for BadgerCare Plus since October 1, 2013. When an individual answers yes to this question, it will prevent the Marketplace from assessing them as Medicaid eligible. This question allows those individuals who have already been determined by Wisconsin to not be

eligible for BadgerCare Plus to bypass being assessed for Medicaid by the Marketplace. By answering yes to the question, they will only be assessed for an Advanced Premium Tax Credit (APTC), Cost Sharing Reduction (CSR) and Qualified Health Plan (QHP) coverage, and can then continue progressing through the private health insurance enrollment process so they can select and purchase their private health insurance plan. More information about this question and how consumers should answer it is available at https://www.healthcare.gov/help/found-not-eligible-for-medicaid/.

Another reminder, Wisconsin's online application tool, ACCESS, was updated to include the new BadgerCare Plus program rules and to allow childless adults (adults age 19-64 with no dependent children living in the household) to begin submitting BadgerCare Plus applications. Applications can also be done over the phone, on paper, or in person at their consortia. Newly eligible childless adults will not begin BadgerCare Plus coverage until April 1, 2014 or later.

Thank you again for your ongoing partnership and all of the hard work that you have done to assist Wisconsin residents in learning about their health care options and to apply for benefits. DHS will continue to update www.dhs.wisconsin.gov/health-care as information is available. Please continue to send any questions that you have to dhshealthcare@dhs.wisconsin.gov.

March 19, 2014

Good Afternoon

As the 2013-2014 federal Health Insurance Marketplace open enrollment period will be ending March 31, 2014, community partners and health care providers are encouraged to continue to assist Wisconsin residents understand their health care options and apply for and purchase private health insurance through the Marketplace before the end of March.

Here is a summary of key deadlines and when health insurance coverage will begin.

Individuals and Families who are Uninsured and Underinsured (not enrolled in BadgerCare Plus or HIRSP and do not qualify for a special enrollment period):

- March 15, 2014: Deadline to apply, select a qualified health plan and pay the initial premium to have coverage beginning April 1, 2014.
- March 31, 2014: The Federal Health Insurance Marketplace open enrollment period ends. March 31 is the deadline-to apply, select a qualified health plan and pay the initial monthly premium to have coverage through the Marketplace in 2014.

BadgerCare Plus and HIRSP members losing coverage effective April 1, 2014 :

- March 31, 2014: Deadline to apply, select a qualified health plan and pay the initial premium to have coverage beginning April 1, 2014.

Please note, as the individuals who were enrolled in BadgerCare Plus and HIRSP in February and/or March 2014 are losing their coverage because the health care program was ending (HIRSP) or they no longer meet

program rules (BadgerCare Plus) are experiencing a qualifying event that makes them subject to a special enrollment period through the Marketplace.

As a result, these individuals have 60 days from the date of the qualifying event to purchase health insurance through the Marketplace. However, in order for these transitioning members to not have a gap in health care coverage, it is important that they apply for and purchase private health insurance through the Marketplace by March 31, 2014. Additional information about the special enrollment period through the Marketplace is available at https://www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment/

In addition, it is important to note that individuals who are eligible for BadgerCare Plus or Medicaid can apply for these health care benefits at any time. Additional information is available at badgercareplus.org.

Here is chart that summarizes the information above

Who	**Deadline to Apply**	**Effective Date of Coverage**	**What happens if they do not apply**
Individuals and Families who are Uninsured and Underinsured (not enrolled in BadgerCare Plus or HIRSP and do not qualify for a special enrollment period)	March 31, 2014	May 1, 2014	• If they do not purchase private health insurance by the end of the federal open enrollment period, they will not be able to purchase private health insurance through the Marketplace until the 2015 open enrollment period. • They can purchase health insurance through the private market but will not be eligible for tax credits or subsidies. • They may be able to get care through free or reduced cost clinics. • Some individuals that do not obtain health insurance coverage may be

			subject to the individual mandate penalty.
BadgerCare Plus and HIRSP members losing coverage effective April 1, 2014	March 31, 2014 for no gap in coverage SEP ends May 30, 2014	April 1, 2014.	• If they do not purchase private health insurance by the end of the special enrollment period, they will not be able to purchase private health insurance through the Marketplace until the 2015 open enrollment period. • They can purchase health insurance through the private market but will not be eligible for tax credits or subsidies. • They could get care through free or reduced cost clinics. • Some individuals that do not obtain health insurance coverage may be subject to the individual mandate penalty.
BadgerCare Plus Standard Plan members losing coverage effective May1, 2014	April 30, 2014 for no gap in coverage SEP ends June 29, 2014	May 1, 2014	• If they do not purchase private health insurance by the end of the special enrollment period, they will not be able to purchase private health insurance through the Marketplace until the 2015 open

			enrollment period. • They can purchase health insurance through the private market but will not be eligible for tax credits or subsidies. They could get care through free or reduced cost clinics.
Pregnant women and Children with incomes up to 300% FPL; Adults with incomes up to 100% FPL	No Deadline: BadgerCare Plus does not have an open enrollment period	The month in which the application was filed.	Apply for BadgerCare Plus Coverage • Online at ACCESS • In-person at agency • Over the Phone • Through Mail with paper application

Local health care enrollment events

People needing assistance in applying for coverage at the federal Marketplace are encouraged to attend a local enrollment event where certified application counselors (CACs) and in-person assisters are available to help them complete an application. Enrollment for Health Wisconsin is keeping a list of all of the upcoming enrollment events:

- Milwaukee County Enrollment Events – http://e4healthwi.org/wp-content/uploads/MKEN_Calendar_March1.pdf
- Wisconsin Enrollment Events – http://e4healthwi.org/events/

People can also contact the federal Marketplace directly at www.healthcare.gov or by calling 1-800-318-2596. Additional resources may be found in the following enrollment directories that are available through Enrollment for Health Wisconsin.

- Milwaukee County Enrollment Directory - http://e4healthwi.org/wp-content/uploads/Milwaukee-County-Enrollment-Directory-Dec-2013.pdf
- Wisconsin Enrollment Directory - http://e4healthwi.org/wp-content/uploads/Enrollment-Directory_11_27_2013.pdf

March 19, 2014

I wanted to provide you a status update regarding account transfers and re-processing of federal Health Insurance Marketplace determinations that will be happening this coming weekend.

Processing Update: Account Transfers

Consortia statewide and MiLES began receiving and processing account transfers from HealthCare.gov in mid-February. While they have been working diligently since then to process them all, processing may not be complete until the end of March.

Once the agency has successfully processed an account, the applicant is notified about their enrollment status through the mail via a notice of decision or a verification checklist requesting they submit additional information. If a client is concerned that they have not received a notice of decision yet, they can contact their local consortia or MilES (for their contact information go to: http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm)

As previously noted, we are aware that some of the applications transferred from the federal Marketplace that were summited in October through December 2013 resulted in incorrect determinations. When CMS notified states in January 2014 about the defects related to the HealthCare.gov applications and determinations, they also provided guidance regarding timeframes in which states are allowed to re-process determinations made by HealthCare.gov. Wisconsin is required by the federal government to accept the determination made by HealthCare.gov and enroll the individual in BadgerCare Plus even if the determination was incorrect.

For more information about determinations made by the Marketplace, go to http://www.dhs.wisconsin.gov/publications/P0/P00594.pdf.

Re-processing of federal Health Insurance Marketplace Determinations

Wisconsin is allowed to re-process the applications *after* enrolling the member to determine if the member meets the BadgerCare Plus program rules and can continue to be enrolled in BadgerCare Plus, or if they qualify for a special enrollment period to enroll through the federal Marketplace.

Wisconsin will be re-running eligibility for individuals determined eligible for BadgerCare Plus by the Marketplace the weekend of March 22, 2014. If a member is found to be no longer eligible for BadgerCare Plus, they will receive a notice of decision the week of March 24, 2014 that lets them know that they are no longer eligible for BadgerCare Plus as of May 1, 2014. This loss of insurance will qualify them for a special enrollment period allowing them to still enroll through the Marketplace within 60 days of their disenrollment from BadgerCare Plus. The member will get the standard notice of decision in the mail that includes a short message about why they are not eligible and what they should do (i.e. that they need to purchase private health insurance through the Marketplace, that Wisconsin has sent their application to the Marketplace, and that they should contact the Marketplace to follow up).

Please Note: There are two primary reasons why individuals determined eligible for BadgerCare Plus by the federal Marketplace could be found to no longer be eligible for BadgerCare Plus:

- The federal Marketplace incorrectly applied MAGI rules. For example, the marketplace used household sizes that were too big or inaccurately disregarded income, or both.
- The member already has an open case with current income information, but they did not report that income to the federal Marketplace.

When eligibility is re-run on March 22, 2014, CARES will apply correct MAGI rules and will consider all current income information known to the case.

As noted, affected members will receive a notice of decision pertaining to their benefits beginning May 1st and they will be receiving an outreach call. We want to make sure they understand next steps, that they qualify for a special enrollment period and are aware that they should report any change in circumstances that may then result in their continued BadgerCare Plus eligibility.

Wisconsin has confirmed with HealthCare.gov that we are able to successfully transfer the accounts of people who are no longer eligible for BadgerCare Plus back to the Marketplace. However, at this time, CMS has indicated that while they are able to receive the account transfers from states, the timeframe in which they will begin processing these applications is unclear as they are beginning with applications first transitioned in October. Until the point in time in which HealthCare.gov will be processing the accounts sent from Wisconsin, individuals who are determined not be eligible for BadgerCare Plus should follow up directly with the federal Marketplace to complete the application process or file a new application if needed.

July 1, 2013

Dear Members and Staff –

As part of the Governor's Entitlement Reforms, the Department of Health Services will be holding town halls around the state. These town halls are part of the submission process for the BadgerCare Plus Project Demonstration Waiver. Once approved by CMS, the waiver will allow the state, for the first time, to cover childless adults whose income does not exceed 100% of the federal poverty level. Please find the schedule in the attached press release and as always, please let me know if you should have any questions.

September 27, 2013

Dear Members and Staff,

As we move closer toward the opening of the Marketplace/Exchange on October 1, I would like to make sure that you have some resources available to help answer questions from your constituents. Current BadgerCare Plus members and those on waiting lists already have or will be receiving letters explaining the changes that will take effect on January 1. The letters that were sent out can be viewed here: http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm.

In these letters, members are given notice that changes will be taking place and also provides helpful contacts for those individuals. The members will be directed to either their Income Maintenance Consortium or to Healthcare.gov. Other information can be found on the Department's website or through independent groups like E4Health.

For those who are interested in what options will be available to them in the Marketplace/Exchange, Healthcare.gov is the best resource. Starting October 1, individuals will be able to enter the required information to find out what health care options they may be eligible for. As always, please feel free to contact me if you should have any questions.

November 27, 2014

Dear Members and Staff –

I would like to take this opportunity to let you know about outreach materials that will be made available to Medicaid members, stakeholders, and advocates today. The additional outreach materials are fact sheets that provide answers to many of the questions that your constituents will be asking over the coming weeks. Both fact sheets can be found online at http://www.dhs.wisconsin.gov/health-care/member/index.htm.

Please continue to use me as a resource for any questions regarding Medicaid during the special session.

January 13, 2014

Dear Members and Staff -

I wanted to take this opportunity to share with you a brief paper that outlines the necessity for AB 610/SB 475. The paper is attached to this email.

Also, please find the attached letter that was shared with leadership on December 30 that explains the agreement that was reached with the Centers for Medicare and Medicaid Services (CMS).

As always, please feel free to contact me with any questions.

Entitlement Reform Delay
November 27, 2013

The Governor's 2013-15 budget made a number of changes to Wisconsin's Medicaid program. These entitlement reforms focused on reducing dependency on government programs, cutting the uninsured rate in half and restoring the Medicaid program to be a true safety net for all people living in poverty. However, these changes were contingent on people having access to affordable health care through the federal Health Insurance Exchange. Fewer than 900 Wisconsin residents were able to sign-up for private health insurance through the exchange through October. These issues have left the approximately 77,000 people who are anticipated to transition from Medicaid to the exchange with not enough time to sign-up for health insurance. In order to allow these individuals the opportunity to enroll and purchase health insurance through the exchange, the Governor has called for a special session to delay the implementation of his entitlement reforms by three months.

The problems at the federal level make it clear; Wisconsin must delay its reforms in order to ensure that these impacted populations do not fall through the cracks, but have an opportunity to successfully transition into private health insurance through the Marketplace.

The Governor's entitlement reforms will allow Wisconsin to maintain control of its Medicaid program. These changes will give people a path to independence while preserving a true safety net for individuals and families in poverty. These reforms protect Wisconsin taxpayers by not relying so heavily on the unpredictability of federal funding.

This delay will have the following impact on these populations:

- *Parents and Caretakers between 100%-200% FPL*
    - These individuals will continue to have Medicaid coverage through March 31, 2013
- *Childless Adults in Core Plan*
    - These individuals will continue to have Core Plan coverage through March 31, 2013
- *Members of the Basic Plan*
    - These individuals will continue to have the option to pay for the Basic Plan through March 31, 2013
- *Childless Adults under 100% FPL and Uninsured or Underinsured*
    - These individuals will now have access to Medicaid on April 1, 2014

After April 1, 2014, all individuals who are eligible for Medicaid will be on the Standard Plan and will receive the same level of benefits. The Standard Plan is a comprehensive plan that includes services previously not covered for some members:

- *Outpatient mental health and substance abuse services*
- *Dental services*
- *Generic and brand name prescription drugs*
- *Emergency and non-emergency medical transportation*

DRAFT

FAQ

Why did we end HIRSP in the first place?

HIRSP was created in Wisconsin in 1981 to ensure every citizen had guaranteed access to health insurance, since we allowed insurance carriers to underwrite based on health status and to reject applications if the risk was too high. After 1996, federal law required that every state had to either have a high risk pool like Wisconsin or require insurance carriers to guarantee issue and accept all risk. The new market rules under the ACA remove the option for states and now require every insurer – on or off the exchange – to provide guaranteed access coverage regardless of health status so there is no need for the high risk pools any longer.

Why did some states like Minnesota keep their high risk pool?

States can certainly keep their high risk pools if they like, but consumers with high risk pool coverage can now choose coverage from any insurer in the market and not just high risk pool coverage. With the available subsidies from the federal government, it is likely many consumers will pay less in the exchange – with the federal subsidy – than they will for their high risk pool coverage..

Would there be any benefit to Wisconsin consumers who are in HIRSP if we kept it place?

It is important to note that more than 70% of HIRSP members will have access to subsidized coverage or other government coverage under the ACA. This means that many HIRSP members would absolutely leave HIRSP for cheaper coverage in the exchange or other government programs. Therefore, even if someone who didn't qualify for a subsidy wanted to remain on HIRSP (and again, it is highly unlikely as they have more options in the open market) this would lead to far fewer HIRSP members and much higher administrative costs.

What is the risk if a state keeps a high risk pool?

First, for states that use taxpayer dollars to support the high risk pool, taxpayers will continue to subsidize the pool even though more affordable and federally subsidized coverage may be available outside the high risk pool. Again, it is important to remember that Wisconsin does not use taxpayer dollars to fund our high risk pool.

For Wisconsin consumers, they run the risk of higher premiums from keeping the pool open. This is because insurers in Wisconsin would be required to pay for HIRSP (including the administration of it) and pay into the ACA reinsurance pool to cover high risk individuals. The insurer will get a double hit and will simply pass those costs on to the consumer.

Why should HIRSP be extended past 12/31?

In short, the Governor was concerned about the slow pace of enrollments through the federal exchange. Only 877 Wisconsinites enrolled in coverage and that means there simply may not be enough time to process all the necessary applications in time. Since the report of only 877 consumers getting into the exchange, the numbers have more than doubled in the last week, so more folks are getting through the website or through the call center. In addition, we anticipate the federal government will continue to work on direct enrollment that allows consumers to sign up for subsidies directly from the insurers who are on the exchange. Just recently HHS approved a pilot direct enrollment for Florida, Ohio and Texas.

The 90-day extension will also allow individuals more time to shop and make decisions about their health care.

With federal government now allowing individuals to enroll until December 23rd for a January 1st effective date (it was Dec. 15th) will consumers have enough time to enroll in new coverage?

Maybe, but given the vulnerabilities in both of these populations, it makes sense to assure that they have enough time make the right decision for them. Given the anemic enrollment so far, there is no question more time will be better for these consumers, including the extra time needed for paper applications if that is how they try to obtain coverage.

Should HIRSP be extended longer than the 90 days?

No. First and foremost, there won't be a need for an extension longer than the 90 days since everyone in HIRSP who wants coverage is guaranteed to get coverage in the open market since the ACA requires guarantee issue now. If they want access to subsidies, as we stated before, they can and have been able to get through the website or call center. Because it has been so slow, HIRSP will now be sending any remaining HIRSP members after 1/1/14 a paper application to get into the exchange and obtain the subsidy. This 90 days is ample time for the paper applications if the website remains slow after 1/1/14.

Secondly, logistically, there is no way to keep HIRSP operating past March 31st. The authority and its board have been winding down for the past several months. Their lease expires at the end of February and the space is already leased. And, more importantly, the administrator for HIRSP has no ability to process claims or process premiums or any accounting function past October 1st, as their entire company went through a system conversation and did not include HIRSP in that conversation. The old system physically goes away on 10/1 and for them to convert the HIRSP data to the new system would cost millions.

Is the HIRSP delay revenue neutral?

Yes. For more than a decade HIRSP has not used taxpayer dollars. It is completely funded by the policyholders, insurers and providers. Any shortfall from reserves will be charged to insurers and providers, not policyholders.

Are childless adults left out in this delay?

No. Childless adults with medical conditions were not only eligible for subsidized coverage on HIRSP, but will continue to have both the coverage and the HIRSP subsidy during the 90 day extension. They will then be eligible for the expanded Medicaid after March 31st.

The bill requires that all surpluses be used before insurers are charged. Is that fair to policyholders?

The delay in HIRSP is intended to benefit policyholders by giving them more time. No matter how many claims occur during the 90 days, policyholders are protected from paying anything more than their current premium. However, insurers are at risk for covering unexpected high claims during this transition and run out. Because the policyholders are protected, and since insurers are subject to a number of ACA fees for high risk individuals in a national reinsurance pool, it is both fair and logical that we would spend down reserves first, before assessing insurers twice for the same high risk individuals.

Key Questions and Talking Points on Entitlement Reform Delay

1. How does the delay impact Wisconsin's Medicaid program?

The Governor's 2013-15 state budget made a number of changes to Wisconsin's Medicaid program. These entitlement reforms were aimed at reducing dependency on government programs, cutting the state's non-elderly uninsured rate by 50% and preserving Medicaid to be a true safety net for all people living in poverty.

The budget, as approved by the legislature and signed by the Governor, would make these changes to Wisconsin's Medicaid program on January 1, 2014. However, many of these changes were contingent on people having the opportunity to access and purchase affordable private health insurance through the federal health insurance exchange. Because of significant technical and governance issues related to the federal exchange, in October less than 900 Wisconsin residents were able to sign up for coverage through healthcare.gov, the toll-free number, with the paper application, or with the help of assisters.

While the federal government has announced that the issues with the exchange would be resolved by the November 30, 2013, this is not enough time for the approximately 77,000 current BadgerCare Plus members (the transition population) to navigate, select and purchase private health insurance through the exchange.

Through this one-time, 90 day delay, the federal government will have additional time to attempt to address the systemic issues in the exchange and will provide members of the transition population additional time to find coverage in the exchange.

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2. **What is the fiscal impact to the state because of this delay?**

The Governor's budget proposal was built on the assumption that the federal health insurance exchanges would be up and operational on October 1, 2013, that people in the transition populations would move from Medicaid into private coverage offered in the exchanges, and that new childless adults living in poverty would have access to Medicaid.

The state's Medicaid program currently has the funding to maintain the existing income eligibility levels for the next three months. According to the Department and the non-partisan Legislative Fiscal Bureau, Medicaid spending will be lowered by $23.1 million GPR in the next three months. This should not be considered "savings" to Medicaid, as the Department must identify additional spending reductions to offset a $52 million reduction in federal Medicaid funding as highlighted by the Legislative Fiscal Bureau on October 7th, 2013.

A decision to delay the transition population's move from Medicaid to the exchange for three months AND to still allow childless adults with incomes below 100% FPL to receive BadgerCare Plus benefits on January 1, 2014 would eliminate the estimated spending reduction and would require an additional $21.6 million in GPR to pay for the newly eligible childless adults.

There are some who continue to bring up policy debates and rehash decisions that were made in the 2013-15 budget and are urging the state to accept the Medicaid expansion in the Affordable Care Act by covering childless adults with incomes up to 133% FPL for three months. This option is problematic for a number of reasons.

First, the goal of the Governor's entitlement reforms was to reduce the dependency on government programs. Expanding Medicaid to people living above poverty creates new barriers for people to move away from government dependency. Second, the Department created its transition plan and supporting system changes based on the effective date of January 1, 2014. While the delay will cause some system changes, the majority of the operational issues will remain the same. Moving to expand Medicaid to 133% FPL on January 1, 2014 has not been part of the Department's operational plan and would require additional planning and resources in a limited timeframe. Even with increased financial and human resources, it is not possible to implement, test, communicate to members and provide training on the

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system changes needed for this option in within the next three months without severe disruptions to systems and operations.

It is also important to note this concept to "expand" Medicaid would still require the Department to transition people with incomes above 133% FPL from the current Medicaid program to the exchanges. In addition, under this model, people with incomes between 100% and 133% FPL would be covered under Medicaid even though the Affordable Care Act provides premium and cost sharing subsidies for this same population to purchase private insurance.

In April 2012, the Department of Health Services received approval from the Obama Administration's federal Centers for Medicare and Medicaid Services (CMS) to pilot a program within Medicaid to charge premiums to specific groups in July 2012. These premiums were modeled exactly off of the premium models in the Affordable Care Act and saw 77% of individuals pay the new premiums for their health coverage. This pilot showed that people are willing to pay the premiums outlined in the Affordable Care Act for their coverage.

The Governor's entitlement reforms will encourage people to move from dependency on the government's Medicaid program to private health insurance that allows for individuals and families to climb the economic ladder without worrying about losing their benefit due to an extra shift or a possible promotion.

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3. Who will be impacted by the delay?

Neither the delay, the entitlement reform provisions, nor the Affordable Care Act will affect the individuals who are enrolled in Medicaid for the Elderly, Blind or Disabled.

The delay will impact the following populations:

- **Parents, Caretakers, and Childless Adults between 100-200% FPL** – Known as the transition population, these 77,000 individuals will continue to be eligible for their existing BadgerCare Plus benefits until March 31, 2014. The state will also allow for parents and caretakers with incomes up to 200% of the federal poverty level and who meet current program rules to enroll in Medicaid through March 31, 2014.

  The Governor's decision to delay will give the transition population more time to find and purchase health insurance on the federal exchange. The Department intends to continue outreach and education to members of the transition population through the first three months of 2014. Effective April 1, 2014, the new eligibility standards will go into effect, and only parents and caretakers living in poverty (with incomes between 0-100% FPL) will have access to Medicaid coverage. Those with household incomes above 100% FPL will have access to affordable health insurance through the federal health insurance exchange.

- **Childless Adults in the BadgerCare Plus Core Plan** – The nearly 17,000 individuals who are currently in the BadgerCare Plus Core Plan will continue to receive coverage through the Core Plan until March 31, 2014. The Department will continue to keep the enrollment cap, originally placed on the program in 2009, in place for the next three months.

  Some of these adults, those with incomes above 100% FPL, are included in the transition population. For those individuals in the Core Plan who have incomes above 100% FPL, the Department intends to continue outreach and education to these members through the first three months of 2014 to encourage them to apply for private health insurance through the exchange.

  For those people who are living in poverty (under 100% FPL), the Department will transition them into the BadgerCare Plus Standard Plan for benefits beginning April 1, 2014. This will be a more comprehensive benefit than they have been receiving and it includes preventive dental care and comprehensive mental health and substance abuse treatment services.

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- **Members of the BadgerCare Basic Program** – The 1,200 people who are currently paying $325 for the limited Basic Plan benefit will continue to have the option to pay for the Basic benefit through March 31, 2014. The Basic Plan is not a Medicaid program and was created to provide a minimal level of services for people who were waiting for services through the Core Plan.

  For members of the Basic Plan who have income above 100% FPL, the Department intends to continue outreach and education about the federal health insurance exchange to these members through the first three months of 2014. However, Basic Plan members may find that the monthly premiums are cheaper in the private market than what they pay through the Basic Plan. They have the option to stop receiving health care through the Basic Plan and can begin purchasing private health insurance through the exchange as early as January 1, 2014.

  For members of the Basic Plan with incomes below 100% FPL who choose to remain enrolled in the Basic Plan through March 31, 2014, the Department will continue to process Basic payments. In order to have health care beginning April 1, 2014, all Basic Plan members will need to apply for health care benefits. The easiest way for Basic members to complete an application is through the exchange. If the exchange determines that the individual is eligible for BadgerCare Plus, then the exchange will send the application to Wisconsin and the member will be enrolled in BadgerCare Plus.

- **Childless Adults and Currently Uninsured or Underinsured with incomes under 100% FPL–** The 82,000 individuals who are living in poverty (under 100% FPL) and were anticipated to access Medicaid on January 1, 2014 will now have the effective date for their Medicaid coverage moved to April 1, 2014. To receive this new coverage, the individuals who are uninsured or underinsured will need to apply for Medicaid.

  The new benefit will cover new individuals who are not currently enrolled in the program, members who are in the current Core and Basic programs with incomes below 100% FPL, as well as individuals who are on the Core waiting list who are also under 100% FPL.

- **Children and Pregnant Women on Medicaid** – The 2013-15 state budget made no change to the Medicaid eligibility standards for children and pregnant women. The current income eligibility, which will not change in 2014, is 0-300% FPL for both groups.

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- **Children Above 300% FPL** – Under current law, children with incomes above 300% FPL can purchase health insurance through BadgerCare Plus. This option is not a Medicaid benefit because no state or federal dollars are used to pay for benefits for these children because either a parent or a caretaker must pay 100% of the premiums and out-of-pocket costs. The 2013-15 state budget eliminated the option for children with incomes above 300% FPL to purchase BadgerCare Plus coverage because of the new private health insurance options available in the insurance exchanges. However, because of the delay in implementing the Governor's reforms, children with incomes above 300% FPL will continue to have the option to purchase into BadgerCare Plus and pay 100% of all costs through March 31, 2014.

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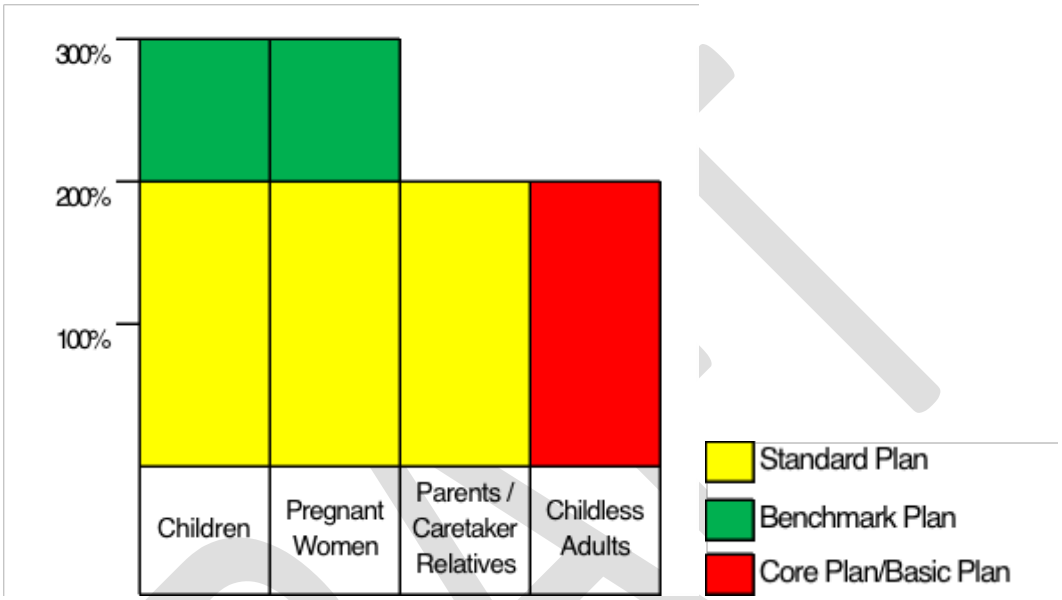
4. What are the <u>current</u> income eligibility limits under Medicaid?

The following are the current eligibility levels and corresponding benefits for children, pregnant women, parents and caretakers and childless adults that will remain in effect through March 31, 2014:



As of September 2013, the enrollment figures for these programs are as follows:

- Children – 428,277
- Pregnant Women – 18,512
- Parents and Caretaker Relatives – 222,060
- Childless Adults in the BadgerCare Plus Core Plan – 16,774
- **TOTAL: 685,623**

These eligibility limits and benefit plans will remain in place until March 31, 2014.

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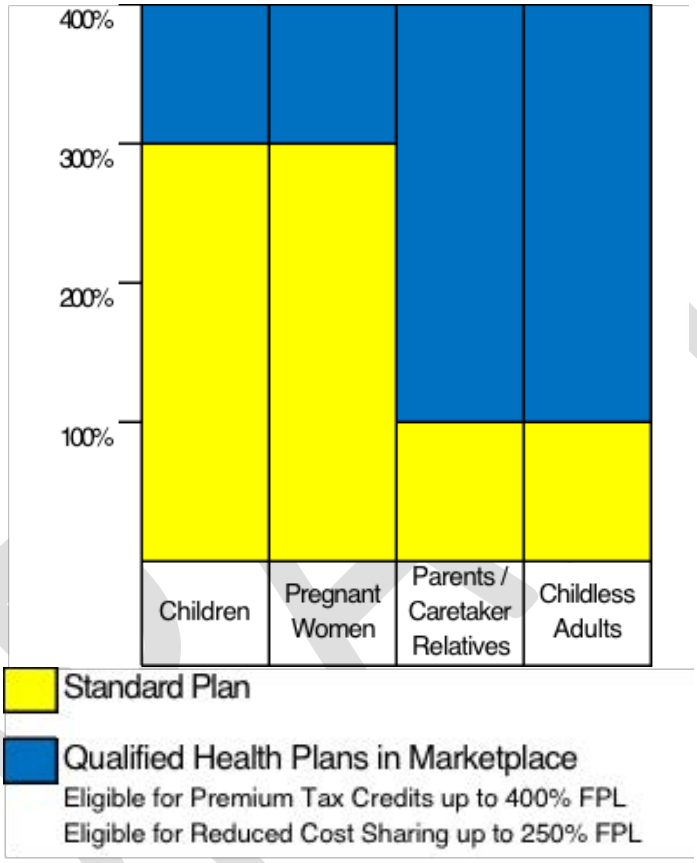
5. What are the <u>new</u> income eligibility limits under Medicaid effective April 1, 2014?

The following are the eligibility levels and corresponding benefits for children, pregnant women, parents and caretakers and childless adults that will be effective on April 1, 2014:



Based on the changes in eligibility and benefit plans that will be effective on April 1, 2014, the Department estimates the following enrollment figures for the 2013-15 biennium:

- Children – 466,808
- Pregnant Women – 20,804
- Parents and Caretaker Relatives – 142,009
- Childless Adults– 98,641
- **TOTAL: 728,262**

These eligibility limits and benefit plans will take effect on April 1, 2014.

Effective April 1st, Wisconsin will be the only state of the 26 that did not expand Medicaid to have no coverage gap. View the report.

6. **Why is the state delaying the new eligibility standards for childless adults below 100% FPL until April 1, 2014?**

   In building the 2013-15 state budget, the Governor highlighted that his entitlement reforms would cut the number of uninsured in Wisconsin by half while providing Medicaid coverage to all Wisconsin resident living in poverty. These reforms were dependent on the successful implementation of the federal health insurance exchange, which enrolled fewer than 900 Wisconsin residents in October.

   In addition, a key element in the Governor's entitlement reform plan was that it did not require any of the enhanced federal Medicaid dollars provided by the Affordable Care Act. Instead, the Governor's reforms allow Wisconsin to remain in control of its own Medicaid program.

   The decision to allow members above 100% FPL or the transition population, to remain on Medicaid means the state must continue to fund Medicaid benefits for these people for the next three months and keep the program operating as it is today through March 31, 2014. Under the state budget, the state savings from transitioning this population from Medicaid to private health insurance through the health insurance exchange was invested into new Medicaid benefits for the uninsured and underinsured childless adults who are living in poverty.

   If the state were to keep both the transition population on Medicaid AND bring on the new childless adult population, the Wisconsin Medicaid program would need an additional $21.6 million GPR to support both populations for the three month delay.

   Finally, as was discussed in a memo from Legislative Fiscal Bureau Director Bob Lang to the Co-Chairs of the Joint Committee on Finance, the Wisconsin Medicaid program is expected to lose $52 million in federal Medicaid matching funds in the current biennium. This loss of federal aid, compounded with ongoing health cost pressures, makes it fiscally irresponsible to bring on the new childless adult population until the transition population begins purchasing private health insurance through the exchange.

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Therefore, because of the problems at the federal level, Wisconsin needs the three month delay to allow for a successful transition and to not allow Wisconsin residents to fall through the cracks caused by the problems with the exchange rollout.

7. **Why does the state not accept the 100% federal funding for the childless adults for the next three months? Why not expand Medicaid immediately?**

The decision to delay the Governor's entitlement reforms was done due to the failure of the federal government to create a website that was able to help people access affordable health insurance. Throughout 2013, the Department, along with other state Medicaid agencies, asked the federal government for assurances that the exchanges would be operational on October 1, 2013. Because of the assurances from the federal government, the Department and the Office of the Commissioner of Insurance held outreach and training efforts throughout September.

With the failure of the exchange website to work, Wisconsin must modify its operational plan so Wisconsin families do not fall through the cracks created by Washington. The three month delay will give members of the transition population more time to purchase private health insurance and will provide the federal government with more time to address their operational failures.

As we move forward, Wisconsin's reasons for not expanding Medicaid remain the same. Wisconsin's reforms are about giving people a path to independence while establishing Medicaid as the true safety net for those people who are living in poverty.

Wisconsin built its budget to be sustainable by not relying on the promise of enhanced federal funding. Given the fiscal uncertainty highlighted by the federal shutdown, reliance on enhanced federal dollars to expand programs would be fiscally reckless and would move Wisconsin backward.

Wisconsin has seen firsthand the budget dangers when states accept enhanced federal funding for Medicaid. In October 2008 through June 2011, the federal government used the American Recovery and Reinvestment Act (ARRA) to provide states with enhanced federal matching funds. Normally Wisconsin's Federal Medical Assistance Percentage (FMAP) is approximately 60% and under ARRA the FMAP was increased to 70%, at its highest point. As a result, the 2009-11 biennial budget reduced GPR in the Medicaid base budget to reflect the temporary increase in federal funding.

In Wisconsin, the loss of enhanced federal funding contributed to a $1.8 billion hole in the Medicaid program in the 2011-13 state budget. With one-time federal dollars gone and federal law prohibiting states from making any changes to Medicaid eligibility

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rules, the Governor and the Legislature invested $1.3 billion in state GPR to fill the Medicaid hole created by the loss of federal funds. In addition, the Department was tasked with creating more than $500 million in efficiencies to cover the remainder of the funding loss.

The 2013-15 state budget was built with the expectation that federal funding for Medicaid would be cut $258.2 million GPR. Additional reductions to the state's federal match rate will increase state spending on Medicaid by an additional $52 million in the 2013-15 biennium. As a result, Wisconsin has had to fund the loss of federal dollars with GPR and will continue to work to meet the federal funding loss throughout the biennium.

Instead of being able to use these GPR resources to support and reform programs across state government, this money needed to be used to sustain Wisconsin's Medicaid program. Based on our experience of federal reductions, the Governor believes that Wisconsin should not rely on federal dollars to expand coverage.

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8. **Other than the changes to income eligibility, are there other changes occurring in the Medicaid program on April 1, 2014?**

In addition to ensuring that all Wisconsin residents who live in poverty have access to Medicaid, the Medicaid benefit plans will be changing on April 1, 2014.

The current BadgerCare Plus program consists of three separate benefit plans depending on the income of the child or adult. Children and pregnant women between 200% and 300% FPL have access to the Benchmark Plan, and not the standard Medicaid benefit, the Standard Plan. Childless adults in the Core Plan have coverage that has even fewer benefits than the Benchmark Plan. Adults in the Basic Plan have benefits that are severely limited and have a $7,500 deductible per year per individual.

Under the Governor's reforms, the current Medicaid program will move from four different benefit plans to the Standard Plan. This change will increase administrative efficiency for the state, and for insurers and for providers, while offering an improved benefit to those individuals and families on BadgerCare Plus.

For many of the members in Medicaid, there will be no change to their existing benefit plan. However, for children and pregnant women between 200-300% FPL and childless adults living in poverty, the new standard benefit will provide a broader array of services to address the health needs of these populations.

One reason for the decision to offer the Standard benefit plan is due to the underlying medical and general health issues facing individuals living in poverty. The Standard Plan will provide a more robust set of mental health, substance abuse treatment and dental services than the current Benchmark, Core or Basic plans. Through the mental health and substance abuse treatment benefits, many Wisconsin residents will have access to treatment services for the first time. The improved dental benefit will help thousands of people living in poverty improve their oral health.

Combined with other benefits offered in the Standard Plan, these changes will help improve the overall health of tens of thousands of Wisconsin citizens who are living in poverty and creates a Medicaid program that is truly fair for all people living in poverty.

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State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

December 30, 2013

Assembly Speaker Robin Vos
211 West
State Capitol
Madison WI, 53708

Senate Majority Leader Scott Fitzgerald
211 South
State Capitol
Madison, WI 53707

Senator Minority Leader Chris Larson
206 South
State Capitol
Madison, WI 53707

Assembly Minority Leader Peter Barca
Room 201 West
State Capitol
Madison, WI 53708

Dear Speaker Vos, Majority Leader Fitzgerald, Minority Leader Larson and Minority Leader Barca:

In the Department of Health Services' (DHS) ongoing efforts to provide the members of the Wisconsin Legislature with the most recent information on the implementation of Governor Walker's entitlement reforms, we are writing to provide an update on the state's negotiations with the Centers for Medicare and Medicaid Services (CMS).

As you are aware, the Department has focused on implementing the Governor's Medicaid reforms that will ensure every Wisconsin resident living in poverty has access to Medicaid while cutting the state's uninsured rate in half. Throughout the summer and fall, DHS and the Office of the Commissioner of Insurance initiated a comprehensive communication plan including hosting town hall meetings, meeting with editorial boards, and providing training for in-person assisters and insurance agents. DHS has also communicated with thousands of Wisconsin residents who will have access to Medicaid for the first time and those who have the opportunity to purchase private health insurance through the federal Healthcare.gov website.

As we know, due to significant technical issues that made it difficult for Wisconsin individuals to access Healthcare.gov, Wisconsin was in a challenging situation. Because the Wisconsin budget reforms were scheduled to take effect on January 1, 2014, many of the individuals who were transitioning from Medicaid into the insurance products offered through Healthcare.gov would have

less than one month to apply, select and pay for an insurance plan. Rather than allow these 77,000 individuals to fall through the cracks, the Governor announced a delay in the implementation of the

Wisconsin Medicaid reforms. After successful passage of the legislation this month, 2013 Act 116 moves the implementation of these reforms to April 1, 2014, providing 77,000 Wisconsin residents additional time to find insurance within the federal health insurance Marketplace.

Since the Governor's announcement, the Department has been actively working with staff at CMS to address the programmatic and system changes needed to meet the three month delay. Over the course of past weeks, DHS and CMS have had constructive and engaging discussions on how to operationalize the delay in Wisconsin in order to meet both the systems and policy needs of the state and CMS. In late December, CMS wrote to the state of Wisconsin confirming an agreement between the two entities related to the state's delay of entitlement reforms until April 1, 2014. The agreement outlined by CMS meets the key objectives of the state, while providing both the state and federal governments with systems flexibility to ensure a smooth transition.

Under the agreement, CMS agrees to the state's delay in implementing the entitlement reforms originally approved in the 2013-15 state budget and subsequently delayed under 2013 Wisconsin Act 116. The agreement addresses the following groups of individuals within Medicaid:

Parents and Caretakers:
Under the agreement, all enrolled BadgerCare parents and caretakers who have incomes between 100% and 200% of the Federal Poverty Level (FPL) will remain eligible for Wisconsin Medicaid until March 31, 2014. During this time, the Department will continue communication and outreach efforts to provide these individuals with the most up-to-date information about the federal health insurance exchange, or the Marketplace. In addition, DHS will continue to remind all populations that access to insurance coverage through the Marketplace's open enrollment period ends March 31, 2014 and that premiums are due March 15, 2014.

At the request of CMS, the agreement will make one modification to new parents and caretakers between 100% and 200% FPL. Under this provision, any new parent or caretaker who applies for Medicaid before February 1, 2014 will be eligible for Wisconsin Medicaid until March 31, 2014. While these individuals will be covered under Wisconsin Medicaid, the Department will continue to provide information on the Marketplace since Medicaid eligibility for these new individuals will end March 31, 2014. Eligibility for new parents and caretakers who apply for Medicaid coverage after February 1, 2014 will be run under the new Modified Adjusted Gross Income (MAGI) rules and new income eligibility standards. This will result in new parents and caretakers between 100% and 200% FPL seeking health coverage after February 1, 2014 being directed to the Marketplace for health coverage options.

This technical modification will allow Wisconsin to implement the entitlement reforms envisioned by the state budget on February 1, 2014 instead of April 1, 2014. As such, a technical bill will be required to bring Wisconsin statutes and the agreement between Wisconsin and CMS into compliance. The Department will forward proposed language in early 2014 for legislative consideration in the January floor period.

Letters to individuals impacted by these changes are attached available online at:
http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm

Childless Adults:
Under the agreement, Medicaid benefits for childless adults under 100% FPL that were slated to begin January 1, 2014 will be delayed until April 1, 2014. Childless adults seeking coverage through Wisconsin Medicaid will have MAGI-based eligibility determined in February of 2014. For those whose income is below 100% FPL, Wisconsin Medicaid benefits will begin April 1, 2014. For those childless adults with incomes greater than 100% FPL, their accounts will be transferred to the federal Marketplace to access affordable health insurance as well as apply for the Advance Premium Tax Credit (APTC).

For childless adults who have incomes between 100% and 200% FPL, and are currently enrolled in the BadgerCare Plus Core Plan, the agreement allows for them to remain on the program until March 31, 2014. At that time, childless adults in the Core Plan under 100% FPL will be automatically enrolled in the new Medicaid standard benefit. Childless adults in the Core Plan between 100% and 200% FPL who will be transitioning off of Medicaid on March 31, 2014 will continue to receive information on how to access health insurance options in the Marketplace prior to the March 31, 2014 open enrollment deadline.

Wisconsin and CMS are close to finalizing the state's 1115 demonstration waiver to provide standard Medicaid benefits to all childless adults living in poverty. As this waiver is finalized, the Department will provide the Legislature with the details of this agreement.

Communication and System Impacts:
As part of the agreement, the Department will provide a letter and questionnaire to existing BadgerCare Plus enrollees asking for information related to tax filing status and other information necessary to complete a MAGI-based redetermination. The Department is currently mailing this information to individuals. A copy of the questionnaire is available at:
http://www.dhs.wisconsin.gov/forms/f0/f00914.pdf

In addition, the Department intends on continuing our outreach efforts to both members of the transitioning population as well as those who are on the former Core Plan wait list. Over the past weeks, DHS has sent letters and made phone calls to provide members of the transition population and Core Plan wait list with information on pending eligibility changes as well as the option to access affordable health insurance through the Federal Marketplace. In early November, the state continued its communication efforts by mailing paper applications to individuals transition from Medicaid in an effort to provide another option to enroll other than the Healthcare.gov site and the call center toll free number.

Moving forward, the Department will continue outreach that includes letters, phone calls, targeted communication to individuals with chronic illnesses, as well as exploring the use of email and text messages to provide individuals with the most up-to-date information on the eligibility changes and options.

The agreement with CMS also modifies the current eligibility process and establishes Wisconsin as an assessment state starting January 1, 2014 rather than deferring to the federal Marketplace to make eligibility determinations. This change will greatly enhance program integrity related to Medicaid eligibility standards and will provide a more accurate and timely eligibility determination for members applying.

Thank you for the opportunity to update you and the members of the Wisconsin Legislature on the Department's ongoing efforts to implement Governor Walker's entitlement reforms. As always, should you have questions, please feel free to contact us.

Sincerely,

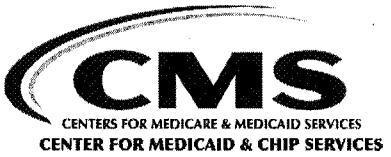
Kitty Rhoades
Secretary

CC: Members of the Wisconsin Legislature
Bob Lang, Director Wisconsin Legislative Fiscal Bureau

Attachments:

1. December 20, 2013 Correspondence from CMS to Department of Health Services
2. December 30, 2013 Response from Department of Health Services to CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



December 20, 2013

Mr. Brett Davis
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street, Room 350
PO Box 309
Madison, WI 53701-0309

Dear Brett:

I am writing to confirm our agreement regarding Wisconsin's plans for effectuating the transition of the BadgerCare and BadgerCare Plus Core Plan section 1115 demonstrations in light of the changes to the Medicaid program resulting from the Affordable Care Act. This agreement reflects a series of discussions over the past several months, including the exchange of written documents outlining the state's proposed mitigation strategies for transitioning the source of health coverage for 77,500 Wisconsin residents from Medicaid to the new health insurance Marketplace.

Eligibility and Waiver Authority

The state has proposed to delay the expiration date for two Wisconsin section 1115 demonstrations – BadgerCare and BadgerCare Plus – from December 31, 2013 until March 31, 2014 for parents and caretaker relatives and adults without dependent children.

The temporary extension of these demonstrations allows Wisconsin to continue to cover childless adults currently enrolled in the program up to 200% FPL through March 31, 2014; and to continue to cover parents and caretaker adults consistent with authorities currently provided under the waivers.

The state has indicated that it will not scale back eligibility levels as proposed, from 200 percent of the federal poverty level (FPL) to 100 percent of the FPL for adults without children as well as parents and caretaker relatives on December 31st, instead putting into place a temporary extension of coverage through the demonstrations and current state plan authority. Based on our agreement, the coverage levels and effective dates for the following populations will be as follows:

- **Parents and Caretaker Relatives.** Existing beneficiaries will remain eligible up to 200% of the FPL through March 31, 2014, at which point the Medicaid eligibility level will reduce to

100% of the FPL. New applicants will be enrolled based on 2013 (non-MAGI) rules until February 1st, at which point MAGI-based rules will be applied, along with the reduction in eligibility. Individuals who apply on or after February 1st will receive a MAGI-based eligibility determination and either be enrolled in Medicaid or be sent to the Marketplace via an account transfer for consideration for an advance premium tax credit (APTC). CMS will work with Wisconsin to provide the necessary 1115 waiver extensions and Medicaid state plan authorities.

The accounts for the parents/caretaker relatives who have applied at the FFM since October 1st, but have incomes up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard), will be transferred to the state in the very near future. Wisconsin will promptly contact these individuals upon receipt of the accounts to inform them that their coverage will begin on January 1, 2014.

Currently enrolled parents/caretakers will receive a form by mail from the state within the next few weeks asking them to provide information needed to complete a MAGI-based redetermination of eligibility before having their accounts either retained in Medicaid or transferred to the FFM. Beginning on February 17th the state will conduct redeterminations under the new eligibility levels and initiate account transfers to the Marketplace for consideration for APTC eligibility for individuals determined to have income above 100% of the FPL.

- **Adults without dependent children.** Pursuant to Wisconsin's direction to the FFM, individuals who are newly applying for coverage through the Marketplace are being screened and determined eligible for Medicaid if their income is up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard). If they have income above 100% of the FPL, these individuals have the opportunity to enroll in coverage in the Marketplace and receive an APTC to subsidize their premium costs. The accounts for the individuals who have applied at the FFM since October 1, but have incomes below 100% of the FPL, will be transferred to the state in the very near future. Wisconsin will promptly contact these individuals upon receipt of the accounts to inform them that their coverage will begin on April 1, 2014.

  Adults without dependent children who apply for coverage in Wisconsin will receive a MAGI-based eligibility determination once the MAGI-based rules are in place in February 2014. New applicants whose income is up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard) will be informed that their eligibility for BadgerCare coverage will take effect on April 1, 2014. Individuals whose income is over 100% of the FPL will have their accounts promptly transferred to the Marketplace for consideration for APTC eligibility.

  Adults without dependent children with incomes up to 200% of the FPL who are currently enrolled in the BadgerCare Plus Core Plan will continue to be eligible to receive these benefits through March 31, 2014.

Wisconsin residents with incomes above 100% of the FPL who have applied at the FFM during the fall of 2013 for coverage effective January 1st, 2014 will remain in Marketplace coverage.

Transitioning Populations and Implementation of MAGI-based Eligibility Rules

The state has adjusted its mitigation planning in order to implement MAGI-based eligibility rules on February 3, 2014 for new parent/family applicants; with full implementation of MAGI rules on February 17th to conduct redeterminations and account transfers for transitioning populations and for processing of all new applicants.

In order to minimize the impact of the delay in implementing MAGI rules, Wisconsin will send a letter and questionnaire to existing enrollees asking them to fill in information about their tax filing status and other information needed to complete a MAGI-based redetermination before the state transfers the accounts to the FFM. This document will be referred to as the Verification Check List (VCL). The individuals who return the information and whose incomes are above the reduced eligibility levels that Wisconsin is adopting will have their MAGI-based eligibility information transferred to the FFM beginning on February 17th.

CMS will continue to work with the state to establish acceptable mechanisms for tracking the individuals who do and do not successfully make the transition to coverage through the Marketplace, including the strategies discussed below.

Communication to Applicants

Because the FFM, at Wisconsin's instruction, is currently determining Medicaid eligibility for those Wisconsin applicants with incomes below up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard), messaging is needed to explain the delay in coverage until April 1, 2014 for adults without dependent children. It is our understanding (as noted above) that the state will enroll eligible parents/caretaker relatives promptly upon receipt of the account transfers from the FFM to effectuate January 1, 2014 coverage. The state can also conduct post-eligibility checks and, with proper notice and appeal rights, disenroll beneficiaries based on those results and transfer their cases back to the FFM for action. It is important to note that individuals applying at the FFM have already received a notice indicating that they are Medicaid eligible and that their coverage will take effect on January 1st.

The state will use the information provided in the enhanced weekly account transfer "flat files" and the formal Account Transfer files to develop telephone and written messages to families informing them of their eligibility determination and coverage start date. As part of the calls, beneficiaries will be asked whether they have completed an application at the FFM, enrolled in a QHP, and paid the initial premium, and these outcomes will be recorded and reported. These messages need to go out as soon as possible.

FFM Programming for Wisconsin

As noted above, as part of its mitigation strategy, Wisconsin agreed to delegate the authority for the FFM to make Medicaid eligibility determinations for individuals who apply through the Marketplace.

The FFM has been making those determinations for applicants with incomes below 100% of the FPL and will be transferring those accounts to the state shortly. As described above, Wisconsin will act on those determinations and enroll individuals for the appropriate coverage effective date depending on the eligibility group.

Wisconsin has indicated interest in changing the delegation of authority to permit the FFM to make assessments, rather than determinations, of eligibility beginning on January 1, 2014. CMS will approve that request provided the other elements of this agreement, in particular the execution of MAGI rules in February 2014, are in place. In addition, the enhanced maintenance and operations funding will become available in February, when all of the critical success factors have been met.

I hope this information is helpful in confirming our mutual understanding of how Wisconsin will proceed with implementation of the Medicaid eligibility changes included in the Affordable Care Act. Please do not hesitate to contact me with any questions or concerns and we look forward to your written confirmation of this agreement.

Sincerely,

Eliot Fishman
Director
Children and Adults Health Programs Group

Cc: Cindy Mann, Director, CMCS
Jennifer Ryan, Director, Intergovernmental and External Affairs Group, CMCS
Verlon Johnson, ARA for Medicaid, Chicago Regional Office

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Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin

Department of Health Services

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December 30, 2013

Eliot Fishman
Director
Children and Adults Health Programs Group
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Mr. Fishman:

Thank you for your December 20, 2013, letter regarding Wisconsin's plans for effectuating the transition of the BadgerCare and BadgerCare Plus Core Plan section 1115 demonstrations in light of changes to the Medicaid program resulting from the Affordable Care Act. I am writing to confirm our agreement as outlined in your letter.

Governor Walker's entitlement reforms mean that for the first time in state history all Wisconsin citizens will have access to affordable health care coverage. As noted in a recent report by the Kaiser Family Foundation, Wisconsin will have no gaps in coverage for our citizens. In addition, Governor Walker is investing in an enhanced set of benefits for people who need it.

Since these changes were signed into law in July we have implemented a very proactive and aggressive outreach plan, not only for current BadgerCare Plus members but also to those adults living in poverty who do not currently have access to coverage.

Beginning in July the Department of Health Services (DHS) partnered with the Wisconsin Primary Health Care Association (WPHCA), Covering Kids and Families (CKF), the University of Wisconsin's Population Health Institute, and the Milwaukee Health Care Partnership to create 11 regional enrollment networks (RENs) throughout the state. In September and October DHS co-sponsored kickoff meetings for over 1,500 individuals throughout the state and held trainings for almost 600 individuals. We currently have almost 800 individuals who have taken the state training, and nearly 400 individuals who have received state certification. We will continue to work with our partners throughout the state during the 3-month delay to continue to assist BadgerCare Plus members with their transition and provide in-person assistance to those applying and enrolling for health insurance.

From September through November DHS issued more than 250,000 letters and made 156,000 calls to current BadgerCare Plus families and individuals on the BadgerCare Plus Core Plan wait list to make them aware of the changes that were originally scheduled to take effect in January. DHS also provided the county Income Maintenance Consortia, BadgerCare Plus managed care

organizations and Medicaid providers lists of the current BadgerCare Plus members to coordinate outreach and provide consistent messaging regarding health coverage options in the federal Marketplace.

Following Governor Walker's announcement and request for a 3-month delay on November 14 DHS has developed a revised outreach plan. Last week DHS mailed over 200,000 letters to BadgerCare Plus members who will be able to maintain their coverage for the next three months as well as individuals on the Core Plan wait list. Additionally, last week DHS sent over 32,000 letters to those people who have already applied at the federal Marketplace and been determined eligible for BadgerCare Plus.

In addition to sending letters, we will proactively make phone calls to households that will likely transition to private insurance and to childless adults on the former Core Plan wait list starting in the New Year. We are putting special emphasis on assisting current members with higher risk conditions to make sure they are aware of all their coverage options.

In order to implement Wisconsin's agreement with the Centers for Medicare and Medicaid Services, it is our understanding that we will need to adjust the effective dates of several already approved MAGI state plan amendments (SPAs). Wisconsin will submit these SPAs early next quarter to effectuate these additional changes.

Thank you for working collaboratively to ensure our goal of ensuring every Wisconsin citizen has access to affordable health care becomes a reality. Please contact me if you have any questions at 608-266-8922 or Brett.Davis@wisconsin.gov.

Sincerely,

Brett Davis
Medicaid Director
State of Wisconsin

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

Technical Bill Summary
LRB 3908 and LRB 3896
January 9, 2014

The Centers for Medicare and Medicaid Services (CMS) recently approved Wisconsin's request to extend two existing federal waivers until March 31, 2014. This approval allows the Department of Health Services to move forward with Governor Walker's request to delay the entitlement reforms scheduled for January 1, 2014 to April 1, 2014 for transition population who are shopping for health insurance coverage on the Federal Exchange.

As part of negotiations, CMS is requiring Wisconsin to begin using the new Modified Adjusted Gross Income (MAGI) rules effective February 1, 2014 for all new parent and caretaker applicants as opposed to April 1, 2014, which was Wisconsin's original request. Starting February 1, 2014, Wisconsin is also required to complete a MAGI-based determination for any existing BadgerCare Plus members who lose eligibility.

What this means for new applicants:

- Parent and caretaker relatives who apply for BadgerCare Plus **before** February 1, 2014 will be enrolled using current BadgerCare Plus budgeting rules, program income limits (up to 200% FPL), and benefits (Benchmark and Standard).
- Parent and caretaker relatives who apply for BadgerCare Plus **on or after** February 1, 2014 will be enrolled using the new MAGI rules, program income limits (up to 100% FPL), and benefits (Standard).
- If a parent or caretaker relative applies for BadgerCare Plus **before** February 1, 2014 but reports a change during the transition period of February 1, 2014 to April 1, 2014:
    - They will be tested first as an existing member, with current BadgerCare Plus budgeting rules and program income limits (up to 200% FPL).
    - If they are above the current income limits, they will then be tested as a new applicant, using new MAGI rules and new program income limits (up to 100% FPL).
    - If they are found ineligible under new MAGI rules, they will be referred to the Marketplace.
- New income limits will be applied to all BadgerCare Plus members effective April 1, 2014, as required by ACT 116.

What this means for existing members:

- The Department of Health Services has sent a letter to members identified to be in the population transitioning to the Federal Exchange. The letter allows individuals the opportunity to see if they can stay enrolled in BadgerCare Plus after March 31, 2014, by filling out a new tax filer form which will allow their eligibility to be checked under the MAGI-based eligibility rules. A copy of Letter 1A and form can be found here: http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm

This technical modification will allow Wisconsin to begin implementing Governor Walker's entitlement reforms earlier than under current law. It will also align Wisconsin statutes with CMS requirements.

Finally, the technical bill would allow new applicants who are children and pregnant women with incomes between 200% and 300% FPL to receive the standard Medicaid benefit rather than the Benchmark Plan effective February 1, 2014. This change was originally scheduled to occur on April 1, 2014, however because of the system changes outlined above, the Benchmark Plan will not be offered for newly eligible individuals. This change brings Wisconsin's Medicaid in-line with state statutes and will accelerate the Governor's reforms for newly eligible children and pregnant women with incomes between 200-300% FPL.

The many policy impacts of the federal Patient Protection and Affordable Care Act (PPACA) are untested and unknown. When PPACA became law neither the federal government, nor the states fully understood the impact these changes would have on individuals and families as health care purchasers and consumers.

In March 2012, the Wisconsin Department of Health Services (DHS) received approval from the Centers for Medicare and Medicaid Services (CMS) to apply certain provisions of the federal Patient Protection and Affordable Care Act to its BadgerCare Plus program. Approval to apply these policy changes was granted through the amendment of Wisconsin's two existing 1115 demonstration waivers: (1) the BadgerCare Waiver and (2) the BadgerCare for Childless Adults Waiver. Federal authority was granted to Wisconsin to amend state eligibility standards, in conformance with PPACA provisions, which thereby provided Wisconsin a unique position to demonstrate certain impacts of impending PPACA changes affecting U.S. health care consumers.

For purposes of testing the effects of PPACA eligibility provisions, the CMS authorized a number of amendments to Wisconsin's Medicaid eligibility policies for non-pregnant and non-disabled adults, effective July 1, 2012. This report is intended to address early data related to the DHS premium policy reforms as authorized under the department's broader PPACA demonstration project. Notably, the premium reforms as implemented July 1, 2012, represent the greatest impact to demonstration project participants. It is with this in mind that the department endeavors to highlight early eligibility data that may signal to what degree health care will be viewed as affordable under PPACA. It is important to note that under PPACA, individuals will also be required to pay cost sharing for services. Additional, cost sharing is not a part of the Wisconsin waivers. Therefore, individuals will pay an even greater share of the total cost of this coverage under PPACA than under the Wisconsin demonstration.

PPACA and Affordable Healthcare

The legislative intent of PPACA is to decrease the number of uninsured Americans as well as reduce the cost of health care. In an effort to make mandatory health coverage affordable, PPACA provides federally subsidized premium contributions for adults with incomes greater than 100% of the federal poverty level (FPL). Specifically, individuals between 100%-400% of the FPL will qualify for premium tax credits structured to prevent individual health care costs from exceeding a certain percentage of household income, as detailed in the chart below.

Out of Pocket Premium Payments Under PPACA
For Individuals and Families

2012 FPL Level	Maximum Premium as a % of Income	Maximum Annual Premium by Family Size			
		1	2	3	4
100.0%	2.0%	$223	$303	$382	$461
133.0%	3.0%	$446	$604	$762	$920
150.0%	4.0%	$670	$908	$1,145	$1,383
200.0%	6.3%	$1,407	$1,906	$2,405	$2,904
250.0%	8.1%	$2,262	$3,072	$3,866	$4,668
300.0%	9.5%	$3,183	$4,312	$5,441	$6,569
400.0%	9.5%	$4,245	$5,749	$7,254	$8,759

Based on the premium of the second lowest cost silver plan available to the individual in the Exchange, qualifying individuals at or below 133% of the FPL would pay no more than 2% of income toward premiums, while individuals between 133% - 400% would incur premium costs ranging from 3% to 9.5% of income as provided in the schedule below.

Revised Policy for PPACA Alignment

Wisconsin proposed demonstrating the affordability of the PPACA premium contribution schedule, given that Wisconsin Medicaid covers similar adult populations and income levels that will be covered in the exchange beginning in January 2014. Prior to the implementation of the PPACA demonstration by DHS, adult parents and caretaker relatives eligible for BadgerCare Plus for Families were required to pay a monthly premium only if household income was at or above 150% of the FPL. The premiums were calculated on an individual basis and the total was capped at 5% of family income.

Under the former DHS premium policy, adult premium exemptions were granted for adults covered under other eligibility categories. Specifically, exemptions were extended to adults without dependent children (BadgerCare Plus Core) and adults in a transitional medical assistance group (BadgerCare Plus Extension). This latter group represents an eligibility category that applies to MA recipients whose income exceeds 100% of the FPL, either as a result of increased earned income or from additional child support. During their transitional MA eligibility period, participants have been exempt from premiums regardless of income level.

Effective July 1, 2012, non-pregnant, non-disabled BadgerCare Plus adults with household countable income at or above 133% are required to pay a single premium per household, calculated using household income according to the federal PPACA schedule noted above. Also, the premium policy under the demonstration project is in effect for all three types of adult eligibility groups to include non-pregnant and non-disabled adults that are provided Medicaid coverage through 1) BadgerCare Plus for Families, 2) BadgerCare Plus Core Plan, and 3) BadgerCare Plus Extension. Notably, the premium changes do not impact children or self-employed parents or caretaker relatives. Premiums for these individuals are calculated under former DHS policy.

The chart below compares the price impact of this demonstration for a family of 4 with household income of 133%, and alternatively 150% of the FPL. As shown, the 133% FPL family experiences a $77 monthly price increase while the family at 150% experiences an increase of $95 monthly.

Monthly Income and Federal Poverty Level	Prior Wisconsin Policy (Before July 2012)	PPACA Rate Schedule Implemented July 2012
133% FPL ($2,555/month)	$0	$77
150% FPL ($2,881/month)	$20	$115

Early Premium Impact Analysis

The following analysis represents premium payment statistics for the 3 months following demonstration implementation, July through September 2012. Given the limited amount of data, this analysis is not intended to estimate long-term premium impacts. This is because it is too soon in the demonstration to know how many members will continue to shoulder the cost of the demonstration premiums. Rather, this analysis provides a better view of economic decisions by Medicaid recipients who choose whether to purchase health care coverage at an initial price point.

The data collected for this analysis isolates adult premium payers in BadgerCare Plus (Parents / Caretakers), the Badger Care Plus Core Plan (Childless Adults) and the transitional medical assistance population (BadgerCare Plus - Extension) according to income level. The analysis demonstrates that the process of aligning state premium policies to PPACA parameters has had varying enrollment effects to the broader population now subject to the state's premium changes. This is partly due to implementation of a premium rate schedule that uses a wider range of rates with a more progressive sliding scale (compared to prior policy), and also because there are now individuals subject to premiums who were not previously. As a result, the marginal impact of premium charges varies substantially among population cohorts. For this reason, the analysis is organized in a way that distinguishes cohorts according to their lesser or greater response to the state's Medicaid premium changes.

In terms of data collection and methodology, DHS reviewed data from the state's CARES eligibility system to determine the number of adult members subject to a premium as well as the number that paid their premium for the month due. To get an accurate count of premium payers, the department waited until the option to make a late premium payment had passed and also allowed for administrative time to process payments. In addition, it is important to note that the household circumstances or income of a member may change and result in continued enrollment at a non-premium paying FPL level. The data analyzed accounts for these circumstances.

Baseline Premium Payers

Prior to implementing the July 2012 premium changes, the Wisconsin Medicaid program enrolled nearly 21,000 BadgerCare Plus parents and caretakers already subject to premiums. These members earned household incomes between 150% and 200% of the FPL, and experienced an average premium payment amount of just under $50 monthly. As shown in Table 1 below, monthly premium payers comprised approximately 17,500 ongoing premium payers and 3,100 individuals newly required to pay premiums. Those newly subject to premiums represent either new Medicaid applicants or ongoing members with increased income resulting in a premium requirement. In either case, the "newly subject" cohort represents a population who had newly engaged (that month) in the economic decision concerning whether to purchase Medicaid covered health care at a given cost, and, in fact, chose to purchase the Medicaid coverage. On average, 15% of total premium paying members were newly subject and chose to pay premiums during the baseline period.

Additionally, a monthly average of approximately 590 individuals disenrolled over the baseline period due to incomplete premium payments. This cohort represents 3% of the total monthly premium population, which includes both ongoing payers and those that are newly subject to premiums. Therefore, during the baseline period, 97% of those subject to premiums successfully completed payments for the premium month owed. This payment completion rate includes both on time and late payment.

Table 1
BadgerCare Plus for Families
(Parents and Caretakers Subject to Premiums)
Baseline Period

Adults Individuals with Income 150 to 200% FPL	May 2012	June 2012	Average Monthly Composition
Individuals Newly Subject to Premium Payments	3,155	3,101	15%
Members Subject to Premium Ongoing	17,524	17,578	85%
Total Population Subject to Premium	20,679	20,679	100%
Average Premium Cost per Member	$47	$48	
Non-Payment Eligibility Reduction	-509	-678	3%

Effective July 1, 2012, Wisconsin's PPACA demonstration project was implemented with premium reforms. As noted, this introduced premium changes that affected both the baseline population above, as well other adult Medicaid categories for whom premium requirements were newly expanded. As it relates strictly to the baseline population (i.e., BadgerCare Plus Parents & Caretakers with household income of 150%-200% FPL), the "newly subject" cohort faced a higher initial premium price, at approximately $100 monthly, compared to the average cost of nearly $50 per month prior to July 2012. The average impact to ongoing payers in July was a marginal rate increase of 100% by doubling the average payment of $48 per month in June 2012 to $96 by August and September.

As shown in Table 2 below, the higher premium rate for members newly subject to premiums resulted in an enrollment reduction of approximately 27%, as nearly 800 fewer individuals chose to purchase Medicaid coverage. This indicates that, compared to the baseline population level of 3,100 individuals that chose to pay the previous premium rates, approximately 73% of this cohort subsequently chose to pay premiums at the higher PPACA rate after July 2012. Also, given that the June-to-August population reduction remained roughly consistent through September, it is suggested that the enrollment reduction will likely stabilize at an estimated level of 800 fewer adults per month, compared to the baseline period.

Table 2
BadgerCare Plus for Families
(Parents and Caretakers Subject to Premiums)
May through September 2012

Adult Individuals with Income 150 to 200% FPL	May 2012	June 2012	July 2012	August 2012	September 2012	YTD % Change vs. Baseline (Ave)
Individuals Newly Subject to Premium Payments	3,155	3,101	2,592	2,280	2,299	-27%
Members Subject to Premium Ongoing	17,524	17,578	15,804	15,272	15,295	-13%
Total Population Subject to Premium	20,679	20,679	18,396	17,552	17,594	-15%
Average Premium Cost per Member	$47	$48	$93	$96	$96	99%
Non-Payment Eligibility Reduction	509	678	1,068	666	604	31%
Non-Payment Population as a % of Total Population Subject	3%	3%	6%	4%	3%	

For ongoing premium payers, the July changes resulted in a more modest enrollment reduction, presumably due to the more modest marginal premium change experienced by this group. Notably, ongoing premium payers experienced roughly half the marginal price impact experienced by the population newly subject to premiums, and, as a result, the ongoing payer group also experienced approximately half the enrollment reduction as a percentage of the baseline population. As indicated in Table 2, the price impact to the ongoing premium payer cohort reduced enrollment by 13%, compared to a 27% reduction experienced by those that were newly subjected to premiums and experienced premium prices double their ongoing payer counterparts. And, similar to those newly subject to premium payments, the enrollment reduction appears to have stabilized at approximately 15,300 compared to the baseline average of 17,550. This provides an estimated enrollment reduction of 2,250 individuals for this group compared to the baseline period.

The result of the combined price flows for both populations above (i.e., the newly subject and ongoing premium payers) is informative for measuring the effect of price on the demand for health care for

parents & caretaker adults with household income between 150%-200% of the FPL. Given the approximately 100% price increase for ongoing payers from $48 to $96 monthly, it was noted that ongoing payers declined by 13%, suggesting a demand and enrollment reduction of 1.3% for each incremental price change of 10%. Additionally, since the resulting rate of population decline for individuals newly subject to premiums approximately doubles in correlation with twice the marginal price impact for this group (as compared to the ongoing payer population), it is reasonable to conclude that the noted 1.3% reduction in demand will scale accurately for parent and caretaker households in this income bracket.

Early premium payment data also shows useful measures related to payment failure. While the rate of payment failure for the above population increases modestly in July to 6%, this rate reverted back to the baseline mean of 3% for the total population subject to premiums. Importantly, this suggests that payment compliance rates for this group are adversely affected in the very early stages of pricing changes, but do not persist at an increased level as the new equilibrium for those who choose to pay at the new price is quickly established.

Additional Premium Payers

As noted previously, the demonstration population for premiums expanded beyond the baseline population by including members previously exempt from premiums. Table 3 below shows that beginning July 2012 there were 48,835 total adults required to pay premiums compared to 21,000 baseline members. Also compared to baseline member premium costs, which averaged under $50 per month, Table 3 reflects the broader premium price increase associated with the PPACA income based sliding scale. This scale results in average premium payments that range from $57 per month for the lower income population to $499 per month on the higher end.

In terms of income composition, the largest segment of premium payers exists at 150% - 200% of the FPL, while a still sizable adult population makes up the 133% to 155% income bracket. Adults with incomes above 200% of the FPL made up only 6.5% of members subject to premiums. Notably, BadgerCare Plus for Families (Parents & Caretakers) is not included in this income group. Rather these individuals represent a portion of the BadgerCare Extension population and BadgerCare Plus Core enrollees only.

Table 3
July 2012 - Combined Adult Premium Programs
(Parents & Caretakers, CORE, and TMA)

Percent of Federal Poverty Level	Number of Individuals Subject	Average Premium Amount (July) Per Member	Percentage of Total Subject to Premiums in July
133 to <150	18,547	$57	38%
150 to <200	27,148	$92	55%
200 to <300	2,571	$207	5%
≥300	569	$499	1%
Total	48,835		

Given the substantial expansion of premiums, it is not surprising that premium prices had a broader effect on adult demand for Medicaid enrollment. As shown in Table 4 below, of the 48,800 individuals initially subject to premiums under the PPACA demonstration project, 7,656 opted to disenroll for premium reasons in the first month, a reduction of approximately 16%. The rate of enrollment reduction continued to decrease at a more moderated pace over the next two months by dropping an addition 1,858 members in August and another 1,648 in September. As of September 2012, the combined

enrollment decline was 11,162 adult Medicaid members, representing a 23% reduction to adult members subject to premiums as of July 2012.

Table 4
Premium – Enrollment Impact
Fiscal Year-to-Date through September 2012

Federal Poverty Level	Total Adults Subject to Premiums, July 2012	Adult Enrollment Reduction due to Non-Payment of July Premium	Adult Enrollment Reduction due to Non-Payment of August Premium	Adult Enrollment Reduction due to Non-Payment of September Premium	Adult Enrollment Reduction due to Non-Payment of Premium, YTD	Percentage Enrollment Reduction by FPL Group due to Non-Payment of Premium
133 to <150	18,547	3,237	719	612	4,568	-24%
150 to <200	27,148	3,021	979	893	4,893	-18%
200 to <300	2,571	1,085	126	119	1,330	-52%
>300	569	313	34	24	371	-65%
Total	48,835	7,656	1,858	1,648	11,162	-23%

When reviewing the rate of decline by income category in Table 4, it is clear that the rate of disenrollment is substantially higher for households earning greater than 200% of the FPL. Notably these individuals faced no premium prior to July 2012, but subsequently faced monthly premiums that averaged between $200 and $500 per month. While the size of these higher income groups is significantly smaller than other adult enrollees, it is worth noting that almost half of adults earning 200%-300% of the FPL chose not to continue coverage given the premium requirement, and over 60% of adults earning greater than 300% chose the same.

Additionally, a closer look at the enrollment impacts by income category indicates a divergence from the baseline population take-up trend that suggested a 1.3% change in quantity demanded for each incremental price change of 10%. Table 5 below helps explain this difference by comparing the take-up rates of the three adult premium populations at similar income levels (133%-150%), all of whom represent new premium payers as of July 2012.

Table 5
Premium Effects for Adults in BadgerCare Plus, All Programs
July 2012

Adult Individuals with Income 133% -150% FPL	Count of Adults Subject to Premiums	Ave. Premium Amount Per Individual	% Reduction in Enrollment due to Non-Payment	Take-up Rate
BadgerCare Plus for Families	13,242	$58	-16%	84%
BadgerCare Plus Extensions	4,044	$58	-25%	75%
BadgerCare Plus Core	1,261	$44	-5%	95%

The first category listed in Table 5, BadgerCare Plus for Families, represents an expansion to the same adult baseline population that represented parents and caretakers with household income between 150% and 200% of the FPL. This is the population that most accurately reflects a change in quantity demanded of 1.3% for each incremental price change of 10%. Where the marginal impact on the baseline population reduced eligibility by 13% when premiums increased for ongoing baseline premium payers by $48 monthly, the impact below demonstrates that a $10 increase to this baseline price reduced eligibility by an additional 2.6%, or approximately 16% total. In short, the 1.3% quantity demand change per 10% price increment continues to hold for BadgerCare Plus Families.

On the other hand, the two populations represented by BadgerCare Plus Extensions and the BadgerCare Plus Core population conform less to this model. First, the BadgerCare Plus extension population represents an adult population with a lower level of income stability. Also referred to as the Transitional Medical Assistance population, adults in the extension program initially entered Medicaid with income levels at or below 100% of the FPL. For Medicaid members with this history, it is reasonable to conclude that their experience in lower income brackets colors their economic decisions in a way that makes them more sensitive to price. As noted in Table 5, the take-up rate for this group was 75% compared to the higher 84% for their BadgerCare Plus for Family counterparts.

As it concerns the BadgerCare Plus Core population, this group represents a small number of Medicaid members with relatively high acuity levels compared to other BadgerCare Plus adults. This is evidenced by the dramatically higher per member per month health care cost to the Medicaid program for these individuals, which exceeds $400 monthly compared to approximately $275 in monthly costs for BadgerCare Plus parents and caretakers. The result of these higher acuity levels is a more inelastic response to price changes. As noted in Table 5, the take-up rate for Badger Care Plus Core members was 95%.

As shown, the demonstration population's response to price changes varies according to the unique characteristics of distinct adult population groups. The relative stability of the BadgerCare Plus Family population assists in modeling price impacts for this group as described. However, this group represents only 65% of the affected population. The remaining population is comprised of two groups, one highly sensitive to price, (TMA; 27%), and another represented by a high acuity population (CORE; 9%). For these groups, who represent 35% of the demonstration population, one's economic condition and health condition are more heavily weighted than what's been represented by the demonstration's baseline adult. Over the course of the remaining demonstration period, the Department of Health Services will further engage data in analysis of these economic and health factors to better understand how price influences the decision to own health coverage.

Wisconsin Department of Health Services
Division of Health Care Access and Accountability
P-00447 (12/12)

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BadgerCare Plus Program Rules — Updates

As of July 1, 2012, some of the BadgerCare Plus Program rules will change. The changes which may affect you and/or your family include:

- Monthly premiums (depending on your income)
- Rules for reporting and providing proof of income
- The rules regarding access to affordable employer-sponsored health insurance

If any of these changes affect you and/or your family, you will receive a letter in mid-June telling you of the changes, their impact on you and your right to appeal those changes.

Monthly Premiums

Certain adults will have to start paying monthly premiums or pay higher premiums. The amount will be based on your family's size and income.

Premiums will not change for members age 18 and under.

You will not pay a premium if you are:

- A pregnant woman
- A person with a disability (must be determined disabled by the Disability Determination Bureau or the Social Security Administration)
- An American Indian or child of an American Indian
- Age 18 through 21 years of age and were in foster care on your 18th birthday

If you are required to pay a monthly premium and you do not pay your premium, your benefits may end. Adults will not be able to receive health care benefits through BadgerCare Plus for 12 months and children for 6 months.

For more information about the monthly premiums.

Income Reporting Rules/Providing Proof

There are new rules for reporting changes in income and providing proof of changes in income. You must report, within 10 days if your income goes over the BadgerCare Plus Program rules. This amount will be listed on your Letters of Enrollment. You will also be required to send proof/verification of the change in income.

Access to Affordable Employer-Sponsored Health Insurance

If you are a parent or a person who cares for a child and you have access to an affordable employer-sponsored health insurance plan, you may not be able to get health care through BadgerCare Plus. This change will not impact children and will no longer affect people who have a disability (must be determined disabled by the Disability Determination Bureau or the Social Security Administration).

If you have access to affordable employer-sponsored health insurance, you will get a letter telling you this information. You may no longer be able to get health care through BadgerCare Plus.

This change, if it affects you and/or your family, will go into effect at your next regularly scheduled renewal or when you get a new job. Your agency will check to see if you have access to employer-sponsored health insurance.

Questions and Contacts

A letter and a fact sheet was mailed to members enrolled in BadgerCare Plus for Families and Core Plan explaining these changes. The letter and fact sheet can be viewed at:

- Update Letter (PDF, 121KB)
- Fact Sheet, P-00324 (PDF, 122KB)
- Partner Training Video
- Partner Training (PDF, 132KB)

The Department of Health Services will not know until the middle of June if these changes apply to you or what your premium amount will be. At that time, you will get a letter with additional information including your right to appeal.

If you have other questions about these changes, you can contact Member Services at 1-800-362-3002 or by email at memberservices@wisconsin.gov.

Last Revised: April 18, 2013

Community Partner Training

Federally Approved BadgerCare Plus Policy Changes for Non-Pregnant, Non-Disabled Adults

Effective July 1, 2012

July 1, 2012 Policy Changes Overview

The Centers for Medicare and Medicaid Services (CMS) approved the following BadgerCare Plus policy changes for non-disabled, non-pregnant adult BadgerCare Plus members above 133% of the federal poverty level as part of the Medicaid Savings Initiative.

These changes are one component of the Department's health care efficiencies package.

BadgerCare Plus eligibility and premiums for children are **NOT** impacted by these policy changes.

Policy Changes:

- Premium Reforms
- Failure to Pay Reforms (Restrictive Re-Enrollment)
- Access to Affordable Employer-Sponsored Health Insurance
- Backdating

Policy Effective Date : July 1, 2012

Communication Timeline

July 1, 2012 Policy Changes – Communication Timeline

- Existing BadgerCare Plus for Families and BadgerCare Plus Core Plan members above 100% FPL were sent a letter on May 1, 2012, of the upcoming policy changes (one time communication).
- Existing BadgerCare Plus for Families and BadgerCare Plus Core Plan non-pregnant, non-disabled adult members eligibility will be redetermined on June 9, 2012, to calculate new premium amounts based on the new premium policy changes.
- A Notice of Decision will be mailed to BadgerCare Plus for Families and BadgerCare Plus Core Plan members on June 11, 2012, with household-specific premium information, appeal rights and reporting requirements.
- Members required to pay a monthly premium in July will be mailed the premium coupon on June 11, 2012.
- BadgerCare Plus fact sheets and website, including the Enrollment and Benefits booklet and the Guide to Applying will be updated and available on July 1, 2012.

Premium Reforms

July 1, 2012 Policy Changes – Premium Reforms

The changes in premium will not impact:

- Children.
- Self-employed parents or caretakers who are eligible only after deducting depreciation expenses.

The changes do **NOT** affect members of EBD Medicaid.

July 1, 2012 Policy Changes – Premium Reforms

The following changes will be made as part of the premium reforms:

- Premiums will now be applied to **non-pregnant, non-disabled adult** BadgerCare Plus for Families and Core Plan members with household countable income above 133% FPL.
  - BadgerCare Plus for Families: Parents and caretakers, including parents and caretakers in a 12 or 4 month extension.
  - BadgerCare Plus Core Plan: Adults with no dependent children.

Additional Information for BadgerCare Plus Core Plan Members.

- Will still need to pay the annual $60 processing fee. If the member has a monthly premium, this fee will be used to pay their first monthly premium.
- If Core Plan members are required to pay a monthly premium and they do not pay their premium, their benefits could end.

July 1, 2012 Policy Changes – Premium Reforms

The following members will be exempt from paying new monthly premiums:

- American Indians exempt under Section 1916.
- Pregnant women.
- **Parents, caretakers, and Core Plan members who are determined blind or disabled by the Disability Determination Bureau or the Social Security Administration.**
- BadgerCare Plus members up to 21 years of age who on his/her 18th birthday were in foster care under the state's responsibility.

July 1, 2012 Policy Changes – Premium Reforms

- Premiums will be calculated based on a sliding scale, ranging from 3% of household countable income for individuals above 133% of the FPL to 9.5 % of household countable income for individuals above 300% FPL, as applicable.
- The chart on slide ten shows the premium members may be required to pay, depending on their family size and income.
- The chart was included in the member letter so members could estimate what their monthly premium may be.
  - This policy applies to both BadgerCare Plus for Families parents and caretaker relatives as well as BadgerCare Plus Core Plan members.
- **There is one single premium for all adults in the household.**

July 1, 2012 Policy Changes – Premium Reforms

Family Size of 1 Person			*Family Size of 2 People*	
Income Per Month	*Monthly Premium Range*		*Income Per Month*	*Monthly Premium Range*
$0.00 - $1,238.00	*No Premium*		*$0.00 - $1,676.90*	*No Premium*
$1,238.01 - 1,396.24	*$37 - 49*		*$1,676.91 - 1,891.24*	*$50 - 66*
$1,396.25 - 1,582.41	*$56 - 71*		*$1,891.25 - 2,143.41*	*$76 - 96*
$1,582.42 - 1,861.66	*$78 - 108*		*$2,143.42 - 2,521.66*	*$105 - 146*
$1,861.67 - 2,327.07	*$117 - 179*		*$2,521.67 - 3,152.07*	*$159 - 243*
$2,327.08 - 2,792.49	*$188 - 257*		*$3,152.08 - 3,782.49*	*$255 - 348*
$2,792.50 +	*$265 and up*		*$3,782.50 +*	*$359 and up*
Family Size of 3 People			*Family Size of 4 People*	
Income Per Month	*Monthly Premium Range*		*Income Per Month*	*Monthly Premium Range*
$0.00 - $2,115.80	*No Premium*		*$0.00 - $2,554.70*	*No Premium*
$2,115.81 - 2,386.24	*$63 - 84*		*$2,554.71 - 2,881.24*	*$77 - 101*
$2,386.25 - 2,704.41	*$95 - 122*		*$2,881.25 - 3,265.41*	*$115 - 147*
$2,704.42 - 3,181.66	*$133 - 185*		*$3,265.42 - 3,841.66*	*$160 - 223*
$3,181.67 - 3,977.07	*$200 - 306*		*$3,841.67 - 4,802.07*	*$242 - 370*
$3,977.08 - 4,772.49	*$322 - 439*		*$4,802.08 - 5,762.49*	*$389 - 530*
$4,772.50 +	*$453 and up*		*$5,762.50 +*	*$547 and up*

Failure to Pay Reforms (Restrictive Re-Enrollment)

July 1, 2012 Policy Changes – Failure to Pay Reforms (Restrictive Re-Enrollment)

- BadgerCare Plus and Core Plan eligible non-pregnant, non-disabled adult members having household income above 133% FPL who fail to pay a premium will be placed in a 12 month restrictive re-enrollment period (RRP).
    - The RRP will be lifted if the member pays the premium by the last day of the month following the month it was due.
    - **Coverage for children whose parents fail to pay the adult-related premium will be unaffected by the parents failure to pay.**
- For example:
    - Ed is enrolled in the BadgerCare Plus Core Plan and does not pay his monthly premium for August.
    - On September 1 Ed will enter a 12 month restrictive re-enrollment period.
    - If Ed pays the August premium as well as any current premiums due by the last day of September the RRP would be lifted.

July 1, 2012 Policy Changes – Failure to Pay Reforms (Restrictive Re-Enrollment)

- Members would become eligible during the RRP if the household income drops below 133%. If the income goes above 133% anytime during the RRP, the members under the RRP would become ineligible for the remainder of the RRP.
- For Example
  - Steve is enrolled in the BadgerCare Plus Core Plan and does not pay his monthly premium for August.
  - On September 1 Steve will enter a 12 month restrictive re-enrollment period.
  - Steve does not pay his August premium by the end of September and he continues the 12 month restrictive re-enrollment period.
  - In January, Steve's income reduces to 100% FPL and Steve re-applies for BadgerCare Plus and re-opens for benefits.
  - In May, Steve's income increases to 140% FPL making him ineligible due to the RRP. He will have to wait until September when the RRP ends to reapply for the BadgerCare Plus Core Plan by submitting a new application.

July 1, 2012 Policy Changes – Failure to Pay Reforms (Restrictive Re-Enrollment)

- The restrictive re-enrollment policy that applies to children – a 6 month restrictive re-enrollment period – will stay the same.
- Please note: if a non-pregnant, non-disabled adult with a household income is placed into an RRP and gets pregnant while on the RRP, the member will be able to begin receiving benefits through the BadgerCare Plus.

Access to Affordable Employer-Sponsored Health Insurance

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

Beginning July 1, 2012 there will be changes to how access to affordable employer-sponsored health insurance is determined for BadgerCare Plus non-pregnant, non-disabled parents and caretaker relatives with a household income above 133% FPL.

- BadgerCare Plus parents and caretaker relatives will be determined to have access to affordable employer-sponsored health insurance if they have **current access or past access** (in the last 12 months) to employer-sponsored health insurance where, for the employee-only plan, the premium does not exceed 9.5% of household income.
- BadgerCare Plus parents and caretaker relatives will be determined to have access to affordable employer-sponsored health insurance if they are **currently enrolled in** (in the last 3 calendar months) a employer-sponsored health insurance plan where the employee-only plan premium does not exceed 9.5% of the household income.

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

Example One:

- Joe and Mary are married and apply for BadgerCare Plus for themselves and their 3 children on July 2, 2012. Joe works for ABC Company. ABC Company offers an employee-only plan as well as a family plan. Joe's cost for the employee-only plan is less than 9.5% of the household's countable income.
- Joe and Mary are determined to have access to affordable health insurance because the cost of the employee-only plan is less than 9.5% of the household's countable income.
- Joe and Mary's children will be tested according to the 80% affordable test. If they are not determined to have access to affordable health insurance, they will be able to enroll in BadgerCare Plus.

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

Example Two:

- Gary and Cindy are married and apply for BadgerCare Plus for themselves and their 3 children on July 2, 2012. Gary works for Steve's Landscaping Company. Steve's Landscaping Company offers an employee-only plan and does not offer a family plan. Gary's cost for the employee-only plan is less than 9.5% of the household's countable income.
- Because Gary's employer does not offer a family plan, Cindy would be able to be covered by BadgerCare Plus. The children would also be eligible for BadgerCare Plus because Gary's employer does not offer a family plan.

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

- Members will be have their access to affordable employer-sponsored health insurance tested according to the new rules after July 1, 2012 when there is a:
  - new application or program request;
  - new employment; or
  - renewal.
- The Employer Verification of Health Insurance (EVHI) system will be used to verify the member's access to health insurance.

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

- The following members will be exempt from the new affordability test:
  - BadgerCare Plus for Families: parents and caretakers who are blind or disabled.
    - Disabled individuals must be determined disabled by the Disability Determination Bureau or the Social Security Administration.
  - BadgerCare Plus for Families: parents and caretakers in a 12 or 4 month extension.
- No changes will be made to the access and coverage policy for BadgerCare Plus Core Plan members.
  - An individual will continue to be ineligible for the Core Plan if he/she has current or past access to employer sponsored health insurance or is currently covered by a health insurance plan or has been covered by a health insurance plan in the past 12 months.

July 1, 2012 Policy Changes – Access to Affordable Employer-Sponsored Health Insurance

- Current Policy: Children's access to affordable employer-sponsored health insurance will continue to be based on whether or not the employer pays at least 80% of the premium or the access is to a State Employee's health care plan.
- However, effective July 1, 2012, the following groups of children will be no longer subjected to the access to affordable health insurance policy.
    - Infants less than 1 year old with household with household income between 150-300% of the FPL will no longer be subject to the access and coverage requirements.
    - Children ages 1 through 5 (up to age 6) with household income between 150-185% of the FPL will no longer be subject to the access and coverage requirements.

Backdating

July 1, 2012 Policy Changes – Backdating

- Current Policy: Children, parents and caretaker relatives may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application, for any of the months in which their family income was at or below 150% FPL.
- Beginning July 1, 2012: BadgerCare Plus non-pregnant, non-disabled adult members having household income above 133% FPL will not be eligible for backdated months.
- Please note, there is no backdating for BadgerCare Plus Core Plan members (current policy).

July 1, 2012 Policy Changes – Backdating

- As of July 1, 2012 BadgerCare Plus will allow backdating for the following members:
  - BadgerCare Plus non-pregnant, non-disabled adults and caretaker relatives with household countable income less than or equal to 133% FPL.
  - Infants less than 1 year old with household countable income less than or equal to 300% FPL.
    - Increase in FPL from 150% to 300%.
  - Children ages 1 – 5 (up to 6) with household countable income less than or equal to 185% FPL.
    - Increase in FPL from 150% to 185%.
  - Children ages 6 – 18 (up to 19) with household countable income less than or equal to 150% FPL (current policy).
  - All pregnant women, except those eligible under the BadgerCare Plus Prenatal program, may have their eligibility backdated (current policy).
  - Youth exiting out of home care (current policy).

Reporting Rules and Appeal Rights

July 1, 2012 Policy Changes – Reporting Rules

Member notices will list the required reporting rules

- BadgerCare Plus members must report the following non-financial changes within 10 days after occurrence (current rules):
  - Address.
  - Household composition, including pregnancy and changes to the pregnancy of a BadgerCare Plus member.
  - Living arrangement (e.g. institutionalization, incarceration, etc.).
- BadgerCare Plus members are only required to report income changes when their total monthly gross income exceeds the following percentages of the FPL for their group size. The income change must be reported by the 10th of the month, following the month, in which the total income exceeded the following thresholds:
  - 100% FPL (BC+ Families only)
  - 133% FPL
  - 150% FPL
  - 185% FPL
  - 200% FPL
  - 250% FPL
  - 300% FPL
  - 350% FPL
  - 400% FPL
- For example, the notice will say: Please report if your monthly income goes above $2,143.42.

July 1, 2012 Policy Changes – Reporting Rules

Changes to Reporting Rules

- BadgerCare Plus Core Plan:
  - Core Plan members will now be required to report and verify income changes during the 12 month certification period.
  - Changes in income do not affect a Core Plan member's eligibility during the 12 month certification period but the change may increase or decrease the premium amount.
  - Core members who fail to verify income changes during the 12 month certification period will have their eligibility terminated if requested verification is not submitted.
- BadgerCare Plus for Families:
  - Parents or caretakers in a 12 or 4 month extension who are required to pay a premium must also report and verify income changes during the extension certification period.
  - Eligibility for parents or caretakers in a 12 or 4 month extension who would be required to pay premiums will be terminated for failure to submit requested verification.

July 1, 2012 Policy Changes – Appeal Rights

- Currently, when an applicant or member disagrees with an agency's action (on his/her request for benefits, amount of benefits, overpayment or termination), an agreement is often reached through an adjustment of the benefit or explanation of the program rules by the agency.
- This will not change on July 1, 2012.

Future Implementation: Streamlined Eligibility Termination

Future Implementation: Streamlined Eligibility Termination

- This policy change allows the Department to terminate eligibility closer in time to the actual date of a member becoming ineligible for benefits.
- The current policy continues a member's coverage until the end of the month in which eligibility is lost.
- Implementation date: TBD.
- More information will be available as we get closer to implementation.

How Community Partners Can Help

How Community Partners Can Help

Using MyACCESS

- After completing the ACCESS application, the applicant will get notices in the mail with their case number on the top right corner of each notice.
- Using the “Create an Account” or “Login to Account” buttons on the ACCESS front page, the applicant can manage their benefits, complete reviews, submit change reports, and request benefits statements.
- After clicking one of these buttons the applicant must submit their Social Security Number, date of birth, and case number. This will link their ACCESS account login with their actual case.

Activating a Permanent MyACCESS Account

- Before the applicant can view ongoing benefit details, complete a change report, etc., the permanent MyACCESS account needs to be activated.
- After clicking “Create an Account” or “Login to Account,” the applicant must submit their Social Security Number, date of birth, and case number. This will link their ACCESS account login with their actual case.

Updating Mailing Addresses in ACCESS

- It is important to make sure that the member’s mailing address is accurate.
- The easiest way to check the member’s mailing address is to go into the member’s full MyACCESS account:
  - Once on the MyACCESS page, look for the section in the middle of the page that says “My Benefits.”
  - Click on the image in the details column to find out the review date for that program.
  - You will see information about when your benefits began, when your review is due, who is covered under the program, etc.
  - Click on the Third Tab – Contact Information. Listed at the bottom is the member’s current mailing address and phone number, in addition to information about how to contact the consortium.

How Community Partners Can Help

Submitting a Change Report in ACCESS

- The easiest way to report changes is to go to access.wisconsin.gov:
- If you already have a MyACCESS account:
  - Click on “Login to Account.”
  - Enter your User ID and Password and click the Login button.
  - Once on the “MyACCESS” page, look for the link on the left hand navigation bar that says “Report my changes.”
  - Click on Report my Changes to being reporting a change.
- If you do not have a MyACCESS account:
  - Click on “Create an Account” and follow the steps to set up an account.
  - Please note, in order to set up your account, you will need your social security number and your case number.
  - You will see a message that says “Congratulations! You have created your secure MyACCESS account”. Click on the “Click here” link to go to the MyACCESS page.
  - Enter your User ID and password and click the Login button.
  - Once on the “MyACCESS” page, look for the link on the left hand navigation bar that says “Report my changes.”
  - Click on Report my Changes to being reporting a change.
- Members can also call their consortium call/change center to report an income change.

How Community Partners Can Help

Checking the Member’s Next Review Date

- When is the member’s next review due?
  - Members will receive a notice in the mail 45 days before your review is due. You can also find your review date in your online access account.
- If you already have a MyACCESS account:
  - Click on “Login to Account.”
  - Enter your User ID and Password and click the Login button.
  - Once on the “MyACCESS” page, look for the section in the middle of the page that says “My Benefits.”
  - Click on the image in the details column to find out the review date for that program.
  - You will see information about when your benefits began, when your review is due, who is covered under the program, etc.
- If you do not have a MyACCESS account:
  - Click on “Create an Account” and follow the steps to set up an account.
  - Please note, in order to set up your account, you will need your social security number and your case number.
  - You will see a message that says “Congratulations! You have created your secure MyACCESS account”. Click on the “Click here” link to go the MyACCESS page.
  - Enter your User ID and password and click the Login button.
  - Once on the “MyACCESS” page, look for the section in the middle of the page that says “My Benefits.”
  - Click on the image in the details column to find out the review date for that program.
  - You will see information about when your benefits began, when your review is due, who is covered under the program, etc.

How Community Partners Can help

- Answer member's questions about the July 1, 2012 policy changes.
- Refer member to their consortium if they have case-specific questions.
  - Please urge members to wait to call their consortium after they receive the letter in mid-June as the consortium will not have case-specific information until that time.
  - If members want to discontinue their benefits before receiving the mid-June letter, please encourage them to wait until they receive the letter to make that decision.
- Help members update their address if it changes or report changes that are mandatory, if something has changed with their case.
- Help us get people enrolled in BadgerCare Plus before they get sick.

Resources

Medicaid Efficiencies Website

- http://www.dhs.wisconsin.gov/mareform/

Website explaining the July 1, 2012 policy changes

- badgercareplus.org/updates

ACCESS Handbook

- http://www.emhandbooks.wi.gov/ah

Questions, Comments?

If you have any further questions, contact:

Sarah Fraley

Sarah.Fraley@wi.gov

Phone: (414) 535-6556

FOR IMMEDIATE RELEASE
April 27, 2012

CONTACT: Stephanie Smiley, (608) 266-5862

OBAMA ADMINISTRATION APPROVES POLICY CHANGES TO BADGERCARE PLUS

MADISON—The Department of Health Services today received approval from the Obama Administration to amend BadgerCare Plus for Families and the BadgerCare Plus Core Plan. The changes were submitted to the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid Savings Initiative.

“These changes aim to preserve the core, safety-net functions of the program for low-income individuals and are necessary in order to keep the Medicaid program sustainable,” said Secretary Dennis G. Smith. “We would like to personally thank Secretary Sebelius and her staff in CMS in working with us to agree upon a commonsense plan that ensures individuals will continue to have access to affordable health insurance. This is an important step forward to help ensure equity among working families in Wisconsin as well.”

These federally approved program changes will only affect income-eligible non-pregnant, non-disabled adults above 133% of the Federal Poverty Level ($25,390 for a household size of three) and do not apply to children. Beginning July 1, 2012, there will be changes to:

- Monthly premiums (depending on income) – some members will be required to pay premiums and those who already do may see increases to their existing premiums; individuals who do not pay their premium will not be eligible for 12 months
- The rules regarding access to employer-sponsored health insurance – individuals described who have access to affordable health insurance through their employer will be asked to utilize that coverage rather than the publicly funded option
- Retroactive eligibility – members described above will no longer be eligible for three months of backdated eligibility

Individuals and families enrolled in the programs who may be affected by these policy changes will receive a general notice next week notifying them changes will be coming in July. The Department is currently in the process of determining how these changes impact each member and in mid-June will send letters about the changes specific to their situation.

The mission and cost of Medicaid in Wisconsin have expanded dramatically over the years. Medicaid serves one out of every five citizens and costs more than $7 billion in state and federal funding each year. Even after an infusion of $1.2 billion of additional state funding provided by Governor Walker and the Legislature for the

current budget cycle, the Department was tasked with finding savings to keep the Medicaid program in balance with the state budget. These policy changes are part of the Department's efforts to keep the Medicaid program sustainable now, and in the future.

The Department estimates $28.1 million in state funding will be saved annually as a result of these policy changes.

More information about the approved changes can be found at www.badgercareplus.org/updates/.

# # #

Last Revised: February 12, 2014

WI and CMS Correspondence
BadgerCare Reform Waiver Negotiations

Issue: Transition Plan and BadgerCare Reform Waiver

Email from CMS to WI: November 7, 2013

Brett,

The attached documents represent our proposed terms and conditions. CMS requests that the state review and consider acceptance of the following changes:

- In Sections II and IV of the STCs, the state is given authority to charge premiums to TMA adults with income above 133 percent starting from the date of enrollment. The state will have authority to charge premiums to TMA adults with income from 100-133 percent FPL starting 6 calendar months after the date of enrollment.

- Additionally, Section IV and VI of the STCs provide that termination of coverage will occur after a 90 day grace period for non-payment of a premium and that disenrollment will last for a 90 day period, after which time the individual must be immediately reenrolled upon request.

- The evaluation section of the STCs asks the state to test specific hypotheses around the impact of the premiums.

We hope that the state will be able to accept these terms and conditions in order to expedite approval by the state's requested date of November 18th.

Best regards,

Eliot

Eliot Fishman
Director, Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Email from WI to CMS: November 21, 2013

Jennifer,

Thank you for working with us through this transitional period for Wisconsin Medicaid. To clarify our conversations and hopefully assist with discussions within CMS, I am providing the attached document that includes additional details on our revised implementation plan.

My understanding is that you will provide us with guidance as soon as possible on how to proceed with getting the federal authority in place to implement an agreed upon transition plan, including public notice requirements.

In addition, attached is our response to the Standard Terms and Conditions (STCs) that were sent by CMS on November 7, 2013 for the BadgerCare Reform waiver. We are making progress and I believe are close to finalizing it. The primary issue remaining is related to the disenrollment and restrictive re-enrollment (RRP) policy for Transitional Medical Assistance (TMA) members who don't pay their premium. We are suggesting the same policy and timeframes be implemented for the adult TMA population that are in place for the CHIP population so children are not held to stricter standards for premium payment than adults.

Thank you again for your continued willingness to work with us on these issues and look forward to hearing from you very soon.

Sincerely,

Brett Davis

Medicaid Director

State of Wisconsin

Issue: Grace Periods and Restrictive Re-Enrollment Periods

Email from CMS to WI: December 13, 2013

Just seeking the answer to a question that has come up internally and I couldn't find any clues in the old BadgerCare STCs. We talked about notices in other contexts yesterday (the ten day notice for premium increases), but how will the state operationalize the 30-day grace period? When does the grace period start? How many days after the grace period is over do enrollees receive notice that they may be disenrolled? How much time does the notice allow for paying the missed premium, or to appeal? Thanks for the additional details!

Email from WI to CMS: December 16, 2013

Below is our response to your question:

The "30-day" grace period starts the first of the month after the benefit month for which a premium is due. For example, a premium is owed in January. The grace period starts February 1. We tell enrollees before the grace period begins that they will be disenrolled for failing to pay the premium. We allow them to pay the missed premium up to the end of the grace period

(February) to have their eligibility reinstated. Enrollees have 45 days after receiving the notice to file an appeal.

Please let us know if you need anything additional!

Email from CMS to WI: December 16, 2013

Thank you for this very helpful explanation. Just want to confirm my understanding of the hi-lighted portion. Do they have until the end of the February grace period to pay the missed premium in order to *avoid* disenrollment, or have they already been disenrolled. You said that they could pay during the grace month to "have their eligibility reinstated." Was it already terminated by that point? That would seem to contradict the fact that February is the grace month. Please clarify. Thanks!

Email from WI to CMS: December 17, 2013

Sorry for the delayed response on this - to clarify the previous example, the "30-day" grace period starts the first of the month for which a premium is due. In our example, the member receives their premium payment coupon in December and receives notice that they must pay the premium or their benefits will end. If the member fails to pay the premium by the "adverse action date", around the 17th or 18th of January in this example, we will send another notice at that time telling the member that his or her benefits will end at the end of January. If the member pays the premium by the end of January, the member maintains their enrollment and continues to receive benefits in February. If the premium is not paid, the member is disenrolled effective February 1 and starts their 3-month restrictive reenrollment period (RRP) at that time. At any point during that re-enrollment period, the member can pay the premiums they owe in order to re-enroll.

Wisconsin's policy is based on the premise of personal responsibility and fiscal responsibility to the taxpayers. We do not believe it is responsible to provide more than one month of benefits to someone who fails to pay premiums he or she owes. However, recognizing that personal circumstances may interfere with timely payment of premiums, Wisconsin agrees to implement a policy to maintain benefits for one month without premium payment, and to subsequently restore eligibility to an individual who pays his or her premium in the 3 months after the end of that grace period. We believe this policy is consistent with the federal concept of a grace period.

Please let us know if you have any additional questions related to this policy.
Thank you!

Email from CMS to WI: December 17, 2013

Thanks for your response. Are the procedures you described below consistent with how Wisconsin currently operates its 60-day grace period under BadgerCare? Obviously, it's longer by 30 days, but does it follow the same concept? For example, in current BadgerCare the

premium would be due on January 1, and if the enrollee misses the premium payment for that month, they get another thirty days, and then if the member has not paid by the end of February they are disenrolled by March 1? When in the current two-month timeframe is the “adverse action date?” We understand it’s a shorter timeframe under the new draft STCs for BadgerCare Reform, but just want to know if there are any other contrasts in procedure.

Email from WI to CMS: December 18, 2013

Other than the timeframe, the only other difference under the BadgerCare Reform waiver will be that a member's eligibility can be reinstated during the RRP if all back premiums are paid.

Wisconsin's Implementation Plan for 2014 by Population
DRAFT – 11/21/2014

This document outlines Wisconsin's planned implementation of the 3-month delay in BadgerCare Plus (BC+) changes announced by Governor Walker on November 14, 2013.

Below is a detailed description, by population, of when and how new benefit plans, income limits and MAGI-based determinations would take effect in 2014.

Additionally, Wisconsin will modify its SPA and request becoming an Assessment State immediately and process all account transfers received from the federal Marketplace, regardless of application/filing date, starting January 20, 2014. Given the delay in receiving the account transfers from the federal Marketplace and ongoing reports from Wisconsin regional enrollment networks and our county income maintenance agencies we are very concerned with the accuracy of the federal Marketplace determinations and BadgerCare Plus program integrity impacts that will result. This document also reflects this change.

1. **CURRENT BC+ MEMBERS**
    a. **Current members who will transition to the Marketplace (i.e. those who are over Wisconsin's new income limits):**
        - Will continue to remain eligible for BC+ until March 31, 2014, as long as they continue to meet current BC+ program rules.
        - Continue under their current benefit plan until March 31, 2014.
        - From January 1, 2014 to February 14, 2014 if a member loses eligibility under current BC+ program rules the applicant will receive a notice referring them to the Marketplace where they can receive a MAGI based assessment.
        - Starting February 17, 2014 if a member loses eligibility under current BC+ program rules they will be tested under MAGI rules prior to receiving a denial (if applicable) and being transferred to the Marketplace.
        - On February 15, 2014, Wisconsin will run a conversion similar to that planned for November 23, 2013, in which members are re-determined under current rules and notified if they are over the new income limits for April 1, 2014. Members that are determined ineligible during the conversion will be referred to the Marketplace where they can receive a MAGI based assessment.

    b. **Current members who will remain eligible under BC+ (i.e. those who are at or below Wisconsin's new income limits):**
        - Will continue to remain eligible for BC+ as long as they continue to meet current BC+ program rules.
        - Continue under their current benefit plan until March 31, 2014, at which point they will be transitioned to Standard Plan.
        - Will transition to MAGI on or after March 31, 2014 based on the date of their next regularly scheduled renewal.
        - From January 1, 2014 to February 14, 2014 if a member loses eligibility under current rules the applicant will receive a notice referring them to the Marketplace where they can receive a MAGI based assessment.

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- Starting February 17, 2014 if a member loses eligibility under current rules they will be tested under MAGI rules prior to receiving a denial (if applicable) and being transferred to the Marketplace.

2. NEW APPLICANTS WHO ARE PARENTS, CHILDREN or PREGNANT WOMEN:

- Starting on January 20, 2014 new applicants will be able to submit/complete a MAGI based application via paper, phone, and online via ACCESS.
- From January 1, 2014 to March 31, 2014 new applicants will first be tested under current income limits (200% FPL for parents/caretakers, 300% for children and pregnant women) and current budgeting methodologies.
  - This step maintains the comparability for those populations currently enrolled in BadgerCare Plus who are transitioning to the Marketplace.
- If the applicant is found eligible under current BC+ program rules, they will be enrolled under Standard or Benchmark Plan.
  - They will transition to MAGI on or after March 31, 2014 based on the date of their next regularly scheduled renewal.
  - Benchmark Plan members will transition to Standard Plan as of April 1, 2014.
- From January 1, 2014 to February 14, 2014 if the applicant is found ineligible under current BC+ program rules the applicant will receive a notice referring them to the Marketplace where they can receive a MAGI based assessment.
- Starting on February 17, 2014 if the applicant is found ineligible under current BC+ program rules they will be tested under MAGI rules prior to receiving a denial (if applicable) and being transferred to the Marketplace.
- Applicants who are not childless adults can apply through ACCESS at any time. ACCESS will be updated to reflect Single Streamlined Application requirements starting January 20, 2104, and Wisconsin's paper application form has already been updated to collect MAGI information.

3. NEW CHILDLESS ADULT APPLICANTS

- Applicants will be tested under the new income limit (100% FPL) and MAGI rules for coverage under the Standard Plan effective April 1, 2014.
  - There is currently an enrollment cap for the BadgerCare Plus Core Plan for childless adults.
- Starting on January 20, 2014 applicants will be able to apply via ACCESS (updated to reflect Single Streamlined Application requirements).
- Wisconsin's paper application form has already been updated to collect MAGI information.
- Starting on January 20, 2104 agencies can start processing applications from ACCESS and assessments from the federal Marketplace using new income limits and MAGI rules but would not be able to confirm April benefits until on or after February 17, 2014. Starting on February 17, 2014:
  - If the member is found eligible for BC+ using MAGI rules, they will be enrolled as of April 1, 2014.
  - If the member is found to be ineligible using MAGI rules, they will be transferred to the Marketplace.

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Regional Enrollment Network Strategic Planning Meeting
July 23, 2013 – 7:00am – 8:00am
1 West Wilson St.; DHS CR 350
1-877-402-9753 Access code: 1703775

Key Take Away Items to Note:

- Need to ensure all communications are clear and consistent – coordinated consumer outreach and education campaigns with different groups
- Identify co-conveners early on, understand CKF role
- Create simple charters to provide direction
- Identify roles and responsibilities
- This needs to be sustainable, role will not end in 2014 or 2015
- Feedback from Enrollment Summit shows there is demand/interest
- DHS should not be the convener but maintain a support role
- DHS area admin will begin meeting with county consortia supervisors and directors to share the presentation from the Summit
- Review HRSA grant to determine if dollars can support E4Health as a clearinghouse
- Health insurance literacy and education will be key
- Make sure to leverage ADRC's as well

Action Item	**Responsible**	**Due**	**Status**
Begin developing long term strategic plan	All		
Set up meeting every other week, Tuesday 7:00am – 8:30am	Tara	7/23/13	Complete
Create SharePoint Library for sharing documentation among Strategic Planning group members	Tara	7/25/13	Complete
Develop draft communication to be routed to partners as outreach	DHS	7/30/13	
Connect Joy Tapper with those working on insurance retention and supplemental help	Brett	7/30/13	
Set up meeting to meet AmeriCorps members		8/2/13	
Send agenda items for next meeting (8/6) to Craig and Tara	All	8/2/13	
Partner to discuss templates	Craig/Joy	8/6/2013	
Schedule AmeriCorp member meeting around 8/19 and have them analyze and identify gaps in each region	Bill	8/19/13	

Regional Enrollment Network Strategic Planning Meeting
August 6, 2013 – 7:00am – 8:30am
1 West Wilson St.; DHS CR B370
1-877-402-9753 Access code: 1703775

I. Regional Enrollment Network Identification
    a. Identify partners – assisters and mobilizers
    b. Kick-off Meeting
        i. Dates/Locations
        ii. Agenda review
        iii. Support
II. Regional Enrollment Network Planning
    a. Roles and responsibilities
    b. Communications arm
    c. Education and training needs
    d. Capacity
    e. Supporting materials
    f. Workflows
III. Regional Enrollment Network Operations
    a. Sustainability
    b. Continued outreach in 2014-2015 – most difficult to reach
    c. Periodic checkpoints
    d. Reporting
IV. Marketplace Updates
    a. Health Insurance Marketplace Training: Becoming a CAC Organization
        i. July 31st 1:30pm – 3:00pm EST
        ii. August 1st 1:30pm – 3:00pm EST
        iii. August 5th 1:30pm – 3:00pm EST
        iv. August 7th 1:30pm – 3:00pm EST
    b. Health Insurance Marketplace 101
        i. August 8th 1:00pm – 2:00pm EST
        ii. August 28th 1:00pm – 2:00pm EST
        iii. September 5th 1:00pm – 2:00pm EST
        iv. September 25th 1:00pm – 2:00pm EST
    c. Understanding the Health Insurance Marketplace
        i. August 14th 1:00pm – 2:30pm
        ii. September 11th 1:00pm – 2:30pm

Regional Enrollment Network Strategic Planning Meeting
August 14, 2013 – 7:00am – 8:30am

1 West Wilson St.; DHS CR 630
1-877-402-9753 Access code: 1703775

I. Regional Enrollment Network Kick-Off Meeting
    a. Dates/locations confirmed
    b. Who is attending
    c. Supporting materials review
    d. Workflows

Regional Enrollment Network Strategic Planning Meeting
September 3, 2013 – 7:00am – 8:30am
1 West Wilson St.; DHS CR B370
1-877-402-9753 Access code: 1703775

I. Welcome New Strategic Planning Members
II. Regional Enrollment Network Kick Off & MKEN Meetings Debrief
    a. Update from Joy/Sarah
    b. Discuss potential "do overs"
III. Regional Enrollment Network Planning – Next Steps
    a. Survey Completion
    b. REN Steering Support
        i. AmeriCorps Members
        ii. Outreach to "missing" partners
    c. Posting FAQs
    d. CAC Requirement Clarification & Training
        i. Regional/Remote Approach
    e. Mobilizer Scripts
    f. Education/Training/Supporting materials
        i. BadgerCare Plus
        ii. Marketplace
IV. Miscellaneous
    a. e4Heath web site
V. Marketplace Updates
    a. Health Insurance Marketplace 101
        i. September 5th 1:00pm – 2:00pm EST
        ii. September 25th 1:00pm – 2:00pm EST
    b. Understanding the Health Insurance Marketplace
        i. September 11th 1:00pm – 2:30pm

Regional Enrollment Network Strategic Planning Meeting
September 17, 2013 – 7:00am – 8:30am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 907179#

I. Welcome New Strategic Planning Members
II. Refining the role, scope and purpose of the REN Strategic Planning Committee
    a. Originally intended to serve as an advisory council to be able to relay issues and concerns in real time to people who could impact or resolve those issues.
    b. Recommend developing a scope and charter for the group that differentiates the strategic vision/planning and the tactical support needed to support the RENs, including an estimated duration for the engagement
    c. Recommend dividing the existing meeting or conducting separate meetings to accomplish the scope for each group.
    d. Discuss tactical team meeting more often to review and complete action items.
III. REN Open Action Items
    a. Federal/State Navigator/CAC Side-by-Side (Craig)
    b. REN Lead Follow-Up (Lisa)
        i. Request for them to host steering committee meeting
        ii. Template agendas
        iii. Notes from RENs
        iv. Contact information from RENs
    c. Sample Flow Charts (Joy)
    d. REN Lunch Reimbursement (Bill)
    e. Posting FAQs
        i. Compile lists (Bill)
        ii. Assign questions to appropriate group (Lisa and Marie)
        iii. Assign DHS questions to DHS staff (Bill)
        iv. Refer applicable questions to OCI (Craig)
IV. REN Support
    a. e4Heath web site
    b. DHS-OCI Training/Support
    c. BadgerCare Plus Training/Support
    d. Marketplace Training/Support

Regional Enrollment Network Strategic Planning Meeting
October 1st, 2013, 8:00am – 9:00am

1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 907179#

I. Navigator/CAC Trainings
    a. Debrief on September 17-18th and 24-25th Trainings
    b. Update on October 9th – 10th Trainings
II. REN Check In – October 7, 2013 @ 10:00 AM
III. Scope, role and work of the RENs – discuss reasonable expectations of the RENs
IV. Data Collection Requirements – discuss differences between federal and state requirements
V. REN Open Action Items
    a. Federal/State Navigator/CAC Side-by-Side (Jennifer)
    b. REN Lead Follow-Up (Lisa)
        i. Update on REN Steering Meetings
    c. Sample Flow Chart (Joy)
        i. Turning into scope document
    d. Posting FAQs
        i. Compile lists (Bill)
        ii. Assign questions to appropriate group (Lisa and Marie)
        iii. Assign DHS questions to DHS staff (Bill)
        iv. Refer applicable questions to OCI (Craig)
VI. REN Support
    a. e4Heath web site
    b. BadgerCare Plus Training/Support
    c. Marketplace Training/Support

Regional Enrollment Network Strategic Planning Meeting

October 15th, 2013, 8:00am – 9:00am

1 West Wilson St.; DHS CR B370

1-877-820-7831 Access code: 843470#

I. Navigator/CAC Trainings
    a. Debrief on October 9th – 10th Trainings
II. REN Check In Debrief – October 7, 2013 @ 10:00 AM
III. Medicaid Claiming for Marketplace Enrollment Assistance
IV. BadgerCare Plus One-Time Letters and Call Outreach Follow-Up
    a. Update on Status
    b. Provider Lists
V. Agent/Broker List Suggestions
VI. REN Open Action Items

a. Sample Flow Chart (Joy)
    i. Turning into scope document
b. Update on Posting FAQs

VII. REN Support
a. e4Heath web site
b. BadgerCare Plus Training/Support
c. Marketplace Training/Support

Regional Enrollment Network Strategic Planning Meeting
October 29th, 2013, 8:00am – 9:00am
1 West Wilson St.; DHS CR B155
1-877-820-7831 Access code: 843470#

I. Navigator/CAC 's
a. Debrief on trainings
b. Update on testing and certifications
II. REN Check In Debrief – October 21, 2013 @ 10:00 AM
a. Operational plan update
III. BadgerCare Plus One-Time Letters and Call Outreach Follow-Up
a. Update on Status
b. Provider Lists
IV. Update on OCI emergency rule
V. REN Open Action Items
a. Update on Posting FAQs
VI. REN Support
a. e4Heath web site
    i. Process for updating/changing contact information in directory
b. BadgerCare Plus Training/Support
c. Marketplace Training/Support

Regional Enrollment Network Strategic Planning Meeting
November 12, 2013, 8:00am – 9:00am
1 West Wilson St.; DHS CR B155
1-877-820-7831 Access code: 843470#

I. Navigator/CAC 's
a. Update on testing and certifications
II. REN Check In Debrief – November 4th @ 10:00 AM
III. BadgerCare Plus One-Time Letters and Call Outreach Follow-Up
a. Update on Status (See below)

b. Provider Lists (See below)

IV. REN Open Action Items

V. REN Support
   a. e4Heath web site
      i. Process for updating/changing contact information in directory
   b. BadgerCare Plus Training/Support
   c. Marketplace Training/Support

Regional Enrollment Network Strategic Planning Meeting
November 26, 2013, 8:00am – 9:00am
1 West Wilson St.; DHS CR B155
1-877-820-7831 Access code: 843470#

I. Navigator/CAC 's
   a. Update on testing and certifications (Jennifer)

II. BadgerCare Plus Delays (Craig)

III. Marketplace Updates (Craig)

IV. Cognosante (Lisa)

V. REN Check In Debrief – November 18th @ 10:00 AM (Lisa)

VI. REN Open Action Items

Regional Enrollment Network Strategic Planning Meeting
December 10 2013, 8:00am – 9:00am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 843470#

I. Marketplace Updates (Craig)

II. Cognosante (Lisa)

III. REN Check In Debrief –December 2nd @ 10:00 AM (Lisa)

IV. Navigator/CAC 's
   a. Update on testing and certifications (See below)
   b. Agent and Broker referrals (Lisa/Jennifer)

V. REN Open Action Items

Summary

CAC/Navigator Prelicensing Training	Completed As of 11/14/2013
OCI Sponsored Training (69102)	578
A.D. Banker & Company (69103)	90
Wick Insurance Services (69099)	122
Total	**790**

Certified Application Counselors	Registered
Entities	79
Individuals	393

Navigator Examinations	Examined	Passed	Failed	Passed Retest
Taken Through:				
Saturday, November 16, 2013	516	505	11	7

Navigator Licenses Issued	Count
Entities	4
Individuals	22

Registered CAC List: http://oci.wi.gov/navigator/cac-registered.htm

Registered Navigator List: http://www.oci.wi.gov/navigator/naventities-registered.htm

Regional Enrollment Network Strategic Planning Meeting
January 7, 2014, 8:00am – 9:00am
1 West Wilson St.; DHS CR 350
1-877-820-7831 Access code: 843470#

I. Marketplace Updates (All)
II. DHS Updates (Craig)
    a. 3-Month Delay Status
        i. State/Federal Approval
        ii. CMS MAGI requirement for February 1
        iii. Switch to Assessment State
    b. Communication & Outreach Updates
    c. Account Transfer Status
III. All REN Meeting Agenda – January 13, 2014
IV. Strategic Planning committee – Can we move from "emergency" mode to planning mode?
    a. Communications
        i. Suggestion for Gantt chart of DHS communications –what is going out when and to whom?
        ii. Need to better understand CMS plan for communications – who can take the lead on collecting this info?
            1. TV, print, radio?
            2. Target audience?
            3. SRA and Cognosante plans?
            4. Plan for updating notices?
    b. Promotions
        i. Concern with relying only on letters to members and provider lists
        ii. Recommendation for proactive publicity
            1. Subcommittee?
                a. PSAs
                b. Posters
                c. DHS website
V. REN Open Action Items

Regional Enrollment Network Strategic Planning Meeting
Monday, January 21, 2014 8:00am – 9:00am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 843470#

I. Marketplace Updates (All)
    a. 40,000 determined Medicaid eligible?
II. DHS Updates (Craig)
    a. Account Transfer Status
    b. DHS process and timing for verifying eligibility

c. for those who enrolled before Jan. (Assessment State)
d. for those enrolled after Jan 1 (Determination State)

III. Status of BC+ Communication / Outreach
a. Letters / Calls to Transitioners by acuity
b. Letters / CORE Wait List
c. Timing of updated patient lists for providers/Medicaid HMOs
d. Any TFI returns?

IV. Review DHS take-up / enrollment assumptions (have they changed given website issues and Medicaid reform delays)
a. Transitioners take-up rate in Marketplace (77,000)
b. Newly eligible childless adult take-up rate in BC+ (84,000)

V. OCI Updates (Jennifer)
a. Inaccurate plan information displayed on healthcare.gov
b. Update on non-navigator assistors in Wisconsin
c. Draft permanent rule overview.

VI. Strategic Planning committee
a. Communications Sub-Committee

VII. REN Open Action Items

Regional Enrollment Network Strategic Planning Meeting
Tuesday, February 4, 2014 8:00am – 9:00am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 843470#

I. Marketplace Updates (All)

II. DHS Updates (Craig)
a. Account Transfer Status
b. ACCESS go-live

III. OCI Updates (Jennifer)

IV. WPHCA RCHN Funding – new funding to support mobilizer/volunteer engagement, consumer enrollment education

V. Moraine Lakes REN Update

VI. Strategic Planning committee
a. Communications Sub-Committee Report

VII. REN Open Action Items
a. Flows for partner trainings
b. Send RENs “Final Notice”
c. New CACs/ACCESS Basics
d. New ID Cards
i. Milwaukee
e. Organization/RENS/Infrastructure

Regional Enrollment Network Strategic Planning Meeting
Tuesday, February 18, 2014 8:00 am – 9:00 am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 843470#

I. Marketplace Updates (All)
II. DHS Updates (Craig)
    a. Conversion Status
    b. Account Transfer Status
III. OCI Updates (Jennifer)
IV. Cognosante/SRA International Meeting
V. Strategic Planning committee
    a. Communications Sub-Committee Report
VI. REN Open Action Items
    a. Send RENs "Final Notice"
    b. New CACs/ACCESS Basics
    c. New ID Cards
        i. Milwaukee
    d. Ongoing REN Organization & Infrastructure Support

Regional Enrollment Network Strategic Planning Meeting
Tuesday, March 4, 2014 8:00 am – 9:00 am
1 West Wilson St.; DHS CR B370
1-877-820-7831 Access code: 843470#

II. Marketplace Updates (All)
    a. CMS Issues New Guidance on Retroactive QHP Coverage Options for Marketplaces Due to Exceptional Circumstances During Open Enrollment (**CCIIO Regulations and Guidance page**.)
    b. CMS Issues New FAQ Documents on Remote Identity Proofing and Resolution of Application Inconsistencies in the FFM (**FAQ document**)
    c. Healthcare.gov's Find Local Help Feature Updated (**Healthcare.gov's Find Local Help**)
    d. IRS Releases Health Care Tax Tips (**Health Care Tax Tips**)
III. DHS Updates (Craig)
    a. Potential Transition Issue/Workaround with FFM
    b. Account Transfer Processing Status
    c. March 22 – FFM Redeterminations
    d. Transitioning members update
IV. January 2014 CMS Medicaid/CHIP report: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/January-2014-Enrollment-Report.pdf.

V. OCI Updates (Jennifer)
    a. Free look back period during open enrollment
VI. Communications Sub-Committee Update
    a. Future letters to transitioning members
VII. REN Open Action Items
    a. Follow up on consumer complaint/consumer rights conversation from all REN call
    b. New ID Cards
        i. Milwaukee
    c. Ongoing REN Organization & Infrastructure Support – hold planning session in April to discuss:
        i. Current vs. future state of RENs
        ii. Roles and responsibilities
        iii. Infrastructure needs
        iv. Budget/financial needs

Alert: CMS Issues New Guidance on Retroactive QHP Coverage Options for Marketplaces Due to Exceptional Circumstances During Open Enrollment

On February 27, 2014, the Centers for Medicare & Medicaid Services (CMS) issued new guidance for Marketplaces that have experienced technical difficulties that have hindered their efforts to provide timely eligibility determinations to consumers during open enrollment. This guidance discusses the flexibilities that are available to Marketplaces to establish retroactive coverage effective dates in qualified health plans (QHPs) through the Marketplace for consumers in these exceptional circumstances once the Marketplace has made an eligibility determination for those consumers. The guidance also addresses the availability of premium tax credits (PTCs) and cost-sharing reductions (CSRs) on a retroactive basis to consumers in these exception circumstances once they have been determined by the Marketplace to be eligible for these subsidies. Accordingly, the guidance also describes the steps that CMS and Marketplaces need to take to ensure that payments of the PTCs and CSRs are appropriately applied based on the retroactive enrollment effective date established by the Marketplace in these exceptional circumstances. This guidance is posted on the **CCIIO Regulations and Guidance page**.

Alert: CMS Issues New FAQ Documents on Remote Identity Proofing and Resolution of Application Inconsistencies in the FFM

On February 24, 2014, CMS issued a new **FAQ document** addressing two aspects of verification of applicant information in the Federally-facilitated Marketplace (FFM). The first set of FAQs in the document describe the FFM's remote identity proofing process and describes the steps a consumer can take if he or she is not able to pass the FFM's remote identity proofing process when attempting to create an account on the FFM. The second set of FAQs describes the situation where inconsistencies occur when the information provided by a consumer on his or her application cannot be verified by the FFM, and how the consumer can provide and submit additional documentation to resolve any inconsistencies in his or her application for health coverage through the FFM.

Alert: Healthcare.gov's Find Local Help Feature Updated

In partnership with national and local agent-broker associations, CMS has updated **Healthcare.gov's Find Local Help** search feature to include local agent and broker associations from across the country. Now, individuals and small employers can use this feature to better locate agents and brokers in their areas. To find agent and broker associations near you, please visit **Healthcare.gov** and input your city and state or ZIP code.

In addition, national agent-broker associations can also help make connections to local assistance. Agents and brokers on the sites listed below are not endorsed by the Marketplace. To verify an agent or broker is registered with the Marketplace, licensed, and in good standing, please contact your state Department of Insurance (DOI).

- **National Association of Health Underwriters**
- **Independent Insurance Agents and Brokers of America**
- **National Association of Insurance and Financial Advisors**
- **Professional Insurance Agents**

Alert: IRS Releases Health Care Tax Tips

On February 25, 2014, the Internal Revenue Service (IRS) launched new **Health Care Tax Tips**, advice for consumers on how health insurance coverage can affect their taxes. The tips cover the following topics:

- **IRS Reminds Individuals of Health Care Choices for 2014** – Find out what you need to know about how health care choices you make for 2014 may affect your taxes.
- **The Health Insurance Marketplace: Learn About Your Health Insurance Coverage Options** – Find out about getting health care coverage through the Health Insurance Marketplace.
- **The Premium Tax Credit** – Learn the basics of the premium tax credit, including who might be eligible and how to get the credit.
- **The Individual Shared Responsibility Payment: An Overview** – Provides information about the types of qualifying coverage, exemptions from having coverage, and making a payment if you do not have qualifying coverage or an exemption.
- **Three Timely Tips about Taxes and the Health Care Law** – Provides tips that help with filing the 2013 tax return, including information about employment status, tax favored health plans, and itemized deductions.
- **Four Tax Facts about the Health Care Law for Individuals** – Offers basic tips to help people determine if the Affordable Care Act (ACA) affects them and their families, and where to find more information.
- **Changes in Circumstances Can Affect Your Premium Tax Credit** – Learn the importance of reporting any changes in circumstances that involve family size or income when advance payments of the premium tax credit are involved.

Regional Enrollment Network Strategic Planning Meeting

Tuesday, March 18, 2014 8:00 am – 9:00 am

1 West Wilson St.; DHS CR B370

1-877-820-7831 Access code: 843470#

I. Marketplace Updates (All)
   a. PCIP Coverage for April 2014 – see summary and link below. Trying to confirm impact in Wisconsin.
   b. CMS Issues New Guidance on "Implementing Health Reform: Exchange and Insurance Market Standards" proposed regulations. See summary and link to NPRM below.
   c. Interim Final Rule: Third Party Payment of Qualified Health Plan Premiums. See summary and link to interim final rule below.
   d. Retroactive Advance Payments FAQs – see summary and link below.

II. DHS Updates (Craig)
   a. Medicaid Enrollment Trends / FFM Enrollment for BC+ Transitions
   b. March 22 re-determinations and Consortia outreach
   c. Plan for post March 30th outreach

III. Communications Sub-Committee Update
   a. Future letters to transitioning members

IV. REN Open Action Items
   a. Follow up on consumer complaint/consumer rights conversation from all REN call
   b. New ID Cards
      i. Milwaukee

    ii. Tara is working with OCI to obtain copies of other QHPs

c. Ongoing REN Organization & Infrastructure Support – hold planning session in April to discuss: SEND OUT ADDITIONAL DATES APRIL 29th AND MAY
    i. Current vs. future state of RENs
    ii. Roles and responsibilities
    iii. Infrastructure needs
    iv. Budget/financial needs
d. Follow up on federal high risk pool end date (OCI)
e. Collective review of Interim Final Rule: Third Party Payment of QHP Premiums
f. Follow up on Basic and Core population – do they qualify for SEP by losing MEC or not (Craig)
    i. Chart of populations and key dates for enrollment/coverage
g. Send Craig bullet points or key messages to assist in drafting the post March 30th outreach no later than Friday, March 21st

Affordable Care Act Announcements (week of March 10)

PCIP Coverage for April 2014

Enrollees in the federally-run Pre-Existing Condition Insurance Plan (PCIP), who have not yet found new health insurance coverage through the Marketplace, can purchase an additional month of PCIP coverage through April 30, 2014, while they continue their search. Open enrollment through the Marketplace for this plan year ends on March 31. Enrollees will be notified by mail of this option to extend their PCIP plan through April, along with details about cost-sharing. Eligible enrollees can purchase PCIP transitional coverage by sending in an April premium payment; which will be the same monthly rate that they paid for January-March 2014. Click here for the 2014 Benefits Summary.

Interim Final Rule: Third Party Payment of Qualified Health Plan Premiums

This Interim Final Rule, with comment, that requires issuers to immediately begin accepting third party payments for enrollee premiums and cost sharing from Indian tribes, tribal organizations, urban Indian organizations, the Ryan White HIV/AIDS programs, and state and federal government programs for enrollees in the individual Marketplaces. This rule builds on previous guidance CMS issued that encouraged issuers and Marketplaces to accept these types of payments. The rule is effective today. The publication date will be **3/19/2014.** This ensures that consumers who rely on the specific third party payors identified in the rule to pay their premiums or cost-sharing payments can continue to access the care they need without delay. You can read more here.

Retroactive Advance Payments FAQs

This is a CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the Premium Tax Credit and Cost Sharing Reductions in 2014 Due to Exceptional Circumstances, and Related SHOP Issues. You can read the frequently asked questions and answers to retroactive advance payments here.

Market standards NPRM:

This proposed rule would update policy based on experience with initial open enrollment. Updates may include clarifying federally-managed services available for states in the second year of operations, expanding the use of data for efficient operations of the Exchange instead of minimum Exchange functions, developing privacy standards in the Exchange for the FFE and non-Exchange entities, implementing penalties related to false, fraudulent, or improper use of information, clarifying eligibility and appeals coordination responsibilities with state Medicaid agencies, and addressing treatment of retroactive eligibility from an appeal. This proposed rule would also establish requirements for Exchanges and QHPs to implement specific quality-related provisions of the Affordable Care Act. You can read more here.

Wisconsin Health Care Options in 2014

BadgerCare Plus Reforms Delayed Three Months Until April 1, 2014

On December 20, 2013, Governor Walker signed Special Session Assembly Bill 1 into law. This bill allows individuals currently enrolled in BadgerCare Plus who do not meet the new program rules more time to purchase private health insurance through the federal health insurance Marketplace. As a result, most of the BadgerCare Plus changes that were slated to be implemented on January 1, 2014 are not scheduled to take effect until April 1, 2014. Learn more about the delay.

Beginning in April 2014, all Wisconsin residents will have access to affordable health insurance. Some individuals and families will get health care through Wisconsin's public health care program, BadgerCare Plus, while others will purchase it through the private market, their employer, or through the federal Health Insurance Marketplace.

Information for Members about Wisconsin Health Care Options in 2014 and the three month delay

Estimated new Marketplace and BadgerCare Plus enrollees for January 2014-June 2015 (Excel, 62 KB)

Current Federal Poverty Levels

Questions can be emailed to the Department of Health Services at dhshealthcare@dhs.wisconsin.gov.

Health Insurance Marketplace

Learn about the Health Insurance Marketplace & your new coverage options. GET ANSWERS NOW

BadgerCare Plus Waiver Request	Partner with the Federal Marketplace	Wisconsin Regional Enrollment Networks
Frequently Asked Questions BadgerCare Plus 2014 Changes	Federal Marketplace Resources	Enrollment for Health Wisconsin (E4Health)
Training for Partners BadgerCare Plus 2014 Changes	Federal Marketplace Training	Wisconsin Office of Commissioner of Insurance Navigator/Nonnavigator/CAC Information
BadgerCare Plus Letters Regarding Health Care Options	CuidadoDeSalud.gov	Health Insurance 101 for Income Maintenance Workers
Income Maintenance (IM) Consortia Contact	Affordable Care Act	Two-Day Navigator/Certified Application

Information | Town Hall Meetings | Counselor Training

Last Revised: December 20, 2013

Protecting and promoting the health and safety of the people of Wisconsin

The Official Internet site of the Wisconsin Department of Health Services

Information for Members: Wisconsin Health Care Options in 2014

On April 1, 2014, changes will be made to the BadgerCare Plus program that include the adoption of new income limits and one benefit plan for all members. These changes were made because Wisconsin residents now have new options for purchasing affordable private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

Originally, these BadgerCare Plus policy changes were going to take effect on January 1, 2014; however, they will now take effect on April 1, 2014. The changes were delayed to allow Wisconsin residents more time to purchase private health insurance through the Marketplace due to technical problems with the Marketplace's website.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

The two fact sheets below provide additional information for BadgerCare Plus members about the health care options that will be available to them in 2014:

BadgerCare Plus Changes in 2014

BadgerCare Plus Changes and the Federal Health Insurance Marketplace

Last Revised: December 16, 2013

BadgerCare Plus Changes in 2014

Printable Version (PDF, 170 KB)

On April 1, 2014, changes will be made to the BadgerCare Plus program that include the adoption of new income limits and one benefit plan for all members. These changes were made because Wisconsin residents now have new options for purchasing affordable private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

Originally, these BadgerCare Plus policy changes were going to take effect on January 1, 2014; however, they will now take effect on April 1, 2014. The changes were delayed to allow Wisconsin residents more time to purchase private health insurance through the Marketplace due to technical problems with the Marketplace's website.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

Children, Parents and Caretakers Enrolled in BadgerCare Plus

As of April 1, 2014, due to changes in state law, non-pregnant adults with income above 100% of the Federal Poverty Level (FPL) will no longer be able to enroll in health care through BadgerCare Plus. Children with a household income above 300% of the FPL will no longer be able to enroll in health care through BadgerCare Plus, unless they meet a deductible. See the attached table for more information about BadgerCare Plus Income Limits.

Please Note: The new income limits do not affect pregnant women or people who are enrolled in EBD Medicaid.

Members who will be above the new income limits for BadgerCare Plus as of April 1, 2014, should apply for private health insurance through the federal Health Insurance Marketplace before March 31, 2014 (see "Applying Through the Marketplace").

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan is ending March 31, 2014. To continue receiving Core Plan benefits through March 31, 2014, members will need to continue to pay any required monthly premiums.

Core Plan members who are at or below the new income limit of 100% FPL for adults will be automatically enrolled in the BadgerCare Plus Standard Plan on April 1, 2014 and will get a better benefit package. See the attached table for more information about BadgerCare Plus Income Limits.

Members who are above the new income limits for BadgerCare Plus in 2014 should apply for private health insurance through the federal Health Insurance Marketplace before March 31, 2014 (see “Applying Through the Marketplace”).

BadgerCare Plus Core Plan Waitlist

Individuals on the Core Plan Waitlist should apply for health insurance through the Marketplace (see “Applying Through the Marketplace”). The Marketplace will let individuals know if they will be enrolled in BadgerCare Plus or if they should purchase private health insurance. If they will be enrolled in BadgerCare Plus, their coverage will begin April 1, 2014. If individuals should purchase private health insurance, the Marketplace will give them information about the private health insurance options that are available, what those plans cost, and if they can get any help paying for private health insurance. The private health insurance that individuals purchase through the Marketplace can begin as soon as January 1, 2014. However, their health insurance will not begin until they choose their plan and pay their first monthly premium by the date given by the health plan.

Please Note: The Marketplace Open Enrollment Period goes through March 31, 2014.

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is ending on March 31, 2014. If Basic Plan members continue to pay their monthly premiums, there will be no change in their Basic Plan enrollment until April 1, 2014.

Basic Plan members should apply for health care benefits through the Marketplace (see “Applying Through the Marketplace”). The Marketplace will let individuals know if they will be enrolled in BadgerCare Plus or if they should purchase private health insurance. If they will be enrolled in BadgerCare Plus, coverage will begin April 1, 2014. If individuals should purchase private health insurance, the Marketplace will give them information about the health insurance options that are available, what those plans cost, and if they can get any help paying for their private health insurance. The health insurance that individuals purchase through the Marketplace can begin as soon as January 1, 2014. However, their health insurance will not begin until they choose their plan and pay their first monthly premium by the date given by the health plan.

Please Note: The Marketplace Open Enrollment Period goes through March 31, 2014.

Applying Through the Marketplace

There are several ways individuals and families can apply for private health insurance through the federal Health Insurance Marketplace:

- Online at Healthcare.gov
- Phone: Call 1-800-318-2596, 24 hours a day, 7 days a week (TTY: 1-855-889-4325). A customer service representative can help complete the application
- Mail: Fill out a paper application. The application can be found online at Healthcare.gov.
- In Person: There are navigators, Certified Application Counselors (CACs), agents and brokers who can help individuals and families apply for health insurance through the Marketplace. Enrollment for Health Wisconsin has a list of certified navigators, CACs, agents, brokers, and other public benefits assisters on its website at e4healthwi.org.

BadgerCare Plus Standard Plan Benefits Beginning April 1, 2014

The BadgerCare Plus Benchmark and Core Plans are ending on March 31, 2014. Benchmark and Core Plan Members who meet the new BadgerCare Plus rules will be automatically enrolled in the BadgerCare Plus Standard Plan on April 1, 2014 and do not need to complete a new application to continue their BadgerCare Plus enrollment. More services are covered under the Standard Plan than the Benchmark Plan or Core Plan. Some of those services include:

- Generic and brand name prescription drugs and some over-the-counter (OTC) drugs.
- Outpatient mental health and substance abuse services.
- Dental services.
- Emergency and non-emergency medical transportation to and from a covered service.

The amount of member copays may also change. Copayments for the BadgerCare Plus Standard Plan range from $.50 to $3 per service.

BadgerCare Plus Income Limits

2013 Federal Poverty Level (FPL) Guidelines*

Family Size	Monthly Income Limit for Adults(100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

Last Revised: December 05, 2013

BadgerCare Plus Changes and the federal Health Insurance Marketplace

Why are BadgerCare Plus changes being delayed three months from January 1, 2014 to April 1, 2014?

The federal Health Insurance Marketplace (also called the Exchange) online application tool has had many problems since it launched on October 1, 2013. Due to these issues, many Wisconsin residents have not been able to purchase private health insurance through the Marketplace at Healthcare.gov. By extending the start date of the new BadgerCare Plus policy changes to April 1, 2014, BadgerCare Plus members will have extra time to apply for and purchase health insurance through the Marketplace. They will keep their BadgerCare Plus coverage through March 31, 2014, if they continue to meet all program rules.

How will I know if the BadgerCare Plus policy changes affect me?

The changes to BC+ rules will only affect non-pregnant adults who have income above 100% FPL. They also affect children with a household income above 300% FPL, unless they meet a deductible. These changes will not take effect until April 1, 2014. Members who continue to meet the current rules, including paying any required premium, will stay enrolled through March 31, 2014. The Department mailed letters in late September to BadgerCare Plus members who may be affected by these policy changes. This letter was titled “Important Information about Your BadgerCare Plus Enrollment.” Call your agency if you have any questions about staying enrolled in BadgerCare Plus after April 1, 2014.

I have already applied through the Marketplace. Do I need to do anything?

If you are enrolled in BadgerCare Plus, you will stay enrolled through March 31, 2014, as long as you meet the current BadgerCare Plus rules. If you are required to pay a monthly premium, you must keep paying the premium to stay enrolled.

If you are a BadgerCare Plus Standard, Benchmark or Core member: We are aware that you may already have an enrollment determination or have enrolled in a qualified health plan through the Marketplace. We are working to determine when you should pay your first monthly premium to enroll in a qualified health plan. We will know more in the near future about how you may be affected and if you need to do anything at this time.

If you are Basic Plan member: We are aware that you may already have an enrollment determination or have enrolled in a qualified health plan through the Marketplace but you have not paid your first premium to enroll. It is your choice

whether to continue to enroll in the qualified health plan or to remain enrolled in BadgerCare Plus through April 1, 2014. However, if your premiums for private health insurance are less than your Basic premiums, you can switch to private health insurance before March 31, 2014. However, to remain enrolled in the BadgerCare Plus Basic Plan through April 1, 2014, you must pay your monthly premium.

If I have already applied through the Marketplace and paid my first monthly premium, do I need to do anything?

If you are a BadgerCare Plus Standard, Benchmark or Core member: You do not need to do anything at this time. We are working to determine when your BadgerCare Plus enrollment will end and when you will begin getting health care services through the plan you selected at the Marketplace. You will be notified as soon as possible with further instructions.

If you are Basic Plan member: You should stop paying your Basic Plan premiums because you have private health insurance that begins January 1, 2014. Do not pay both premiums.

I have been trying to apply through the Marketplace online at Healthcare.gov, but I cannot get through. Are there other options to apply?

There are several ways you can apply for private health insurance through the Marketplace other than applying at Healthcare.gov. You can also apply by phone, mail, or in person:

- **Phone:** Call 1-800-318-2596, 24 hours a day, 7 days a week (TTY: 1-855-889-4325). A customer service representative can help you complete the application and enrollment process.
- **Mail:** You can also fill out a paper application. The application can be found online at Healthcare.gov.
- **In Person:** There are navigators, Certified Application Counselors (CACs), agents and brokers who can help you apply for health insurance through the Marketplace. Enrollment for Health Wisconsin has a list of certified navigators, CACs, agents, brokers, and other public benefits assisters on their website at e4healthwi.org.

I am between the ages of 19 and 64, and have no dependent children living in my home and I need health care right now. Is there anything I can do?

There are health care facilities in Wisconsin that provide services for people with little or no health insurance. These facilities provide primary care and preventive care, including health, oral, and mental health/substance abuse services to people of all ages, regardless of their ability to pay. They charge for services on a sliding-fee scale that is based on your family income and size.

You can get additional information about free and low cost health clinics in Wisconsin at dhs.wisconsin.gov/forwardhealth/clinics.htm.

You should also apply for health care benefits through the Marketplace. The Marketplace will let you know if you should enroll in BadgerCare Plus for coverage

starting April 1, 2014. If you do not meet the rules to enroll in BadgerCare Plus, the Marketplace will give you options for purchasing a health care plan and will also tell you if you qualify for lower costs on your monthly premiums and out-of-pocket costs.

Coverage through the Marketplace can begin as soon as January 1, 2014. Please note that the Marketplace Open Enrollment Period goes through March 31, 2014.

President Obama announced that I can keep my health plan. What does that mean for BadgerCare Plus?

The President's announcement regarding individuals and families keeping their current health insurance does not apply to BadgerCare Plus. It only applies to private health insurance purchased in the individual market.

Now that the Basic and Core Plans are continuing, can I apply for these plans?

The BadgerCare Plus Core and Basic Plans are ending on March 31, 2014. Neither plan is accepting new members. This will not be changing.

I am enrolled in the Core Plan and my renewal is in February. What do I need to do?

If you want to keep getting health care benefits through the Core Plan through March 31, 2014, you will need to complete your renewal if you have one between now and the end of March. You must continue to pay any monthly premiums that you owe.

Please keep in mind, the BadgerCare Plus Core Plan is ending March 31, 2014. If you are getting BadgerCare Plus Core Plan benefits and you meet the new BadgerCare Plus rules, you will be automatically enrolled in the BadgerCare Plus Standard Plan on April 1, 2014, and get a better benefit package.

I am enrolled in the Basic Plan. What do I need to do?

The BadgerCare Plus Basic Plan is ending on March 31, 2014. If you want to stay enrolled in the BadgerCare Basic Plan through March 31, 2014, you will need to keep paying your Basic Plan premiums.

You should **continue to pay your premiums** and stay enrolled in the BadgerCare Plus Basic Plan through March 31, 2014 if any of these apply to you:

- You applied through the Marketplace (also known as the Exchange) and they said you would be enrolled in the BadgerCare Plus Standard Plan starting January 1, 2014. Because these benefits will not start until April 1, 2014, you should stay enrolled in Basic through March 31, 2014.
- You applied through the Marketplace but you have not yet paid your first premium to enroll in a private health plan. However, if your premiums for private health insurance are less than your Basic premiums, you can to switch to private health insurance before March 31, 2014.
- You have not yet applied for private health insurance through the Marketplace.

You should **stop paying your Basic Plan premiums** only if you have already

signed up for private health insurance through the Marketplace AND you have paid your first premium for coverage starting January 1, 2014.

If you have not done so already, you should complete a health care application through the federal Health Insurance Marketplace by calling 1-800-318-2596 or TTY 1-855-889-4325 or going to http://www.healthcare.gov.

When you finish your application at the Marketplace, the Marketplace will let you know if you will be enrolled in BadgerCare Plus or if you should purchase private health insurance. If you will be enrolled in BadgerCare Plus, your coverage will begin April 1, 2014. If you should purchase private health insurance, the Marketplace will give you information about the health care plan options that are available to you, what those plans cost, and if you can get any help paying for your private health insurance.

Please note the health care coverage that you purchase through the Marketplace can begin as soon as January 1, 2014. Your health care coverage will not begin until you choose your plan and pay your first monthly premium by the date your health plan gives you. You need to apply for and purchase private health insurance through the Marketplace before March 31, 2014 in order to have health care coverage that begins on April 1, 2014.

When can I complete my application through ACCESS?

Children, parents and caretaker relatives can apply for BadgerCare Plus at any time online at ACCESS.wi.gov, by mail, phone or in person at their local agency.

Adults ages 19 through 64 who have no dependent children living with them can apply through the Marketplace at HealthCare.gov at any time.

Adults with no dependent children living with them cannot apply for BadgerCare Plus online using ACCESS right now but they will be able to sometime before April 1, 2014. This date has not yet been determined.

Last Revised: March 14, 2014

Home Page

Regional Enrollment Networks

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Regional Enrollment Networks

One of Wisconsin's most significant strategies to assist Wisconsin residents with enrolling in the appropriate public or private health insurance coverage is through 11 Regional Enrollment Networks (RENs). The RENs are comprised of various community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders. These RENs were developed at the local level and may be different from each other depending on the needs of the local region. Additional information about Wisconsin's RENs is available on the Enrollment for Health (E4Health) Wisconsin website.

On November 14, 2013, Governor Walker called for a special session of the Legislature to take up Legislation that would allow individuals currently enrolled in BadgerCare Plus more time to enroll in a private health insurance plan through the federal health insurance Marketplace. As a result, the BadgerCare Plus changes that were slated to be implemented on January 1, 2014 are not scheduled to take effect until April 1, 2014.

Due to the delay in implementation of the 2014 BadgerCare Plus policy changes, the presentations and other materials available on this page are currently out-of-date. While the policies being implemented remain the same, the implementation dates contained in presentations available on this page are not accurate. Updated information will be available in the near future.

Letters Mailed to BadgerCare Plus Members and Individuals Regarding Health Care Options in 2014

In late September and early November, the Department of Health Services sent letters to current BadgerCare Plus members, including individuals on the Core Plan Wait list, letting them know it appears that as of January 1, 2014, they may no longer be eligible for BadgerCare Plus due to changes in state law. Learn more about the letters being sent.

The letters state that beginning January 1, 2014, there will be changes to the BadgerCare Plus program rules. However, the Governor is delaying these changes for three months to allow people who are applying for private health insurance at the Marketplace additional time because there are issues with the online Marketplace/exchange. As a result of the delay, the changes to the BadgerCare Plus program rules will be effective April 1, 2014. These changes include new program income limits for BadgerCare Plus.

The letters that were sent to members in late September and early November have not been updated at this time to reflect the new effective date of the BadgerCare Plus program rules - April 1, 2014.

Two-Day Navigator/Certified Application Counselor (CAC)

Training

Any community partner, health care provider, or other stakeholder that plans to work as a Certified Application Counselor (CAC) or Navigator with an organization that received a federal Navigator grant or an organization that is a federally designated CAC organization must complete both the state and federal training and examination requirements. You cannot serve as a CAC or use the title “CAC” without completing both the state and federal training and examination requirements.

The Wisconsin Office of the Commissioner of Insurance has information for Navigators/Nonnavigator Assisters/Certified Application Counselors

View the Navigator/CAC Training Presentation (PDF, 1.35 MB)

Affordable Care Act Town Hall Meetings

The Wisconsin Office of the Commissioner of Insurance (OCI), in partnership with the Department of Health Services, held a series of town hall meetings across Wisconsin on September 3, 2013 through October 3, 2013 to provide information about the Affordable Care Act. View OCI's presentation (PDF, 1.35 MB). View DHS's presentation (PDF, 1.1 MB).

Creating Wisconsin's Regional Enrollment Networks

On July 16, 2013, the Department of Health Services and the Office of the Commissioner of Insurance presented a proposed model assisting Wisconsin residents with enrolling in the appropriate public or private health care coverage through RENs at the UW-Population Health Institute’s Wisconsin Health Insurance Outreach & Enrollment Summit. View the Department's REN presentation. (PDF, 448 KB)

- View the email announcing the creation of RENs (PDF, 90 KB)
- View the email announcing the REN kick-off meetings (PDF, 87 KB)

On August 30, 2013, Deputy Secretary Kevin Moore briefed legislative staff on the Department’s strategy for enrollment outreach. View the presentation (PDF, 1.1 MB).

Regional Enrollment Contacts

Each REN held a kick-off meeting in late August or early September. Community partners, health care providers, income maintenance consortia, managed care entities, and other key stakeholders were invited to attend the REN meeting in their area. Each meeting was hosted and facilitated by a regional host, in partnership with the Department of Health Services, Covering Kids and Families, and the Wisconsin Primary Health Care Association. If you are interested in learning more about the REN in your area, please email one of the REN contacts for you area which are listed in the chart below.

Estimated Marketplace and BadgerCare Plus enrollees for January 2014-June 2015 (PDF, 61 KB).

Region	Counties	Contact
		Abigail Lading

Bay Lake	Brown, Door, Marinette, Menominee Oconto, Shawano	Elizabeth Jungers
Southern	Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock	Lola Gregg Julie Milleson
East Central	Calumet, Green Lake, Kewaunee, Manitowoc, Marquette, Outagamie, Sheboygan, Waupaca, Waushara, Winnebago	Elizabeth Jungers
Great Rivers	Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, St. Croix, Washburn	Connor Neste Michelle Larson
Capital	Adams, Columbia, Dane, Dodge, Juneau, Richland, Sauk	Mai Houa Vue Amy Bell
Northern: Hayward	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Nichole Kunze Tamara Feest
Northern: Marshfield	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Nichole Kunze Tamara Feest
Northern: Crandon	Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, Wood	Nichole Kunze Tamara Feest
Central	Langlade, Marathon, Oneida, Portage	Mary Testin Gail Chapman
Moraine Lakes	Fond du Lac, Ozaukee, Walworth, Washington, Waukesha	Angie Moran
Western	Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin,	Jamie

	Trempealeau, Vernon	Fawcett
WKRP	Kenosha, Racine	Jennifer Wigh Sarah Fraley
Milwaukee	Milwaukee	Heather Dummer Combs Sarah Fraley

Last Revised: March 12, 2014

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WISCONSIN DEPARTMENT OF HEALTH SERVICES

Trainings About 2014 BadgerCare Plus Policy Changes

On December 20, 2013, Governor Walker signed Special Session Assembly Bill 1 into law. This bill allows individuals currently enrolled in BadgerCare Plus who do not meet the new program rules more time to purchase private health insurance through the federal health insurance Marketplace. As a result, most of the BadgerCare Plus changes that were slated to be implemented on January 1, 2014 are not scheduled to take effect until April 1, 2014

The Department of Health Services has put together a series of taped webcasts and in-person trainings for community partners, health care providers, public health departments and other interested stakeholders about the 2014 BadgerCare Plus Policy Changes. Due to the delay in implementation of the 2014 BadgerCare Plus policy changes, some of the partner materials available on this page are currently out-of-date. Updated information will be available in the near future. **For the most up-to-date information, view the materials associated with training number five.**

If you are viewing an archived webcast and you have questions, please go to the Frequently Asked Questions page to see if your question has already been answered. If you don't see an answer to your question, send it to dhshealthcare@dhs.wisconsin.gov so it can be answered and added to the Frequently Asked Questions page.

Webcast trainings

Training Number	Training Date	Topic	View Training	Presentation Materials	Follow-Up Questions
1	August 12, 2013 at 10:00 a.m.	High-level overview of upcoming 2014 BadgerCare Plus policy changes.	Archived Webcast	August 12, 2013 (PDF, 112 KB)	Q&A
		Overview of upcoming BadgerCare Plus mailings that will be sent to			

2	September 17, 2013 at 10:00 a.m.	members who will likely transition to the Marketplace and an overview of the Modified Adjusted Gross Income (MAGI) policy.	Archived Webcast	BadgerCare Plus Mailings September 17, 2013 (PDF, 510 KB)	Q&A
3	October 14, 2013 at 10:00 a.m.	Overview of the Modified Adjusted Gross Income (MAGI), including the specific MAGI questions that will be asked of individuals and families applying for BadgerCare Plus.	Archived Webcast	October 14, 2013 (PDF, 895 KB)	Q&A
4	January 8, 2014 at 10:30 a.m.	Update on the 2014 BadgerCare Plus policy changes, brief overview of the timeline and to provide information on the new BadgerCare Plus Tax Filer Information form that was recently sent to for current BadgerCare	Archived Webcast	January 8, 2014 (PDF, 479 KB)	N/A

		Plus members affected by the 2014 policy changes.			
5	January and February 2014	In-person training regarding the 2014 BadgerCare Plus policy changes and timeline of the changes.	Archived Webcast	Assessment vs. Determination Handout (PDF, 226 KB) January/February 2014 (PDF, 472 KB)	N/A

Other training resources

- Federal Marketplace (exit DHS)
- Wisconsin Office of Commissioner of Insurance (exit DHS)

Last Revised: January 30, 2014

Frequently Asked Questions About 2014 BadgerCare Plus Policy Changes

On December 20, 2013, Governor Walker signed Special Session Assembly Bill 1 into law. This bill allows individuals currently enrolled in BadgerCare Plus who do not meet the new program rules more time to purchase private health insurance through the federal health insurance Marketplace. As a result, most of the BadgerCare Plus changes that were slated to be implemented on January 1, 2014 are not scheduled to take effect until April 1, 2014. Click here to view information for members about Wisconsin Health Care Options in 2014 and the three month delay.

If you have a question about the 2014 BadgerCare Plus Policy Changes, please review the questions and answers on this page to see if your question has already been answered. If you don't see an answer to your question, send it to dhshealthcare@dhs.wisconsin.gov so it can be answered and added to this page.

BadgerCare Plus Eligibility	BadgerCare Plus Program Rules	Modified Adjusted Gross Income (MAGI) Questions	Effect of New BadgerCare Plus Rules on Other Programs
BadgerCare Plus Waiver	Applying for Health Care	BadgerCare Plus Outreach	Marketplace Questions

BadgerCare Plus Eligibility

Please Note: If you have case-specific questions on behalf of an individual or family, you should contact the local agency. Only income maintenance agencies are able to determine eligibility. In addition, the health care application (at HealthCare.gov or through BadgerCare Plus) will ask all relevant questions and the agency processing the application will determine the proper household size and income calculation. Each applicant's situation will be unique, so it is important that individuals file an application to receive the appropriate health care determination.

If a family applies through the Marketplace and the adults' household income is above 100% FPL, would the child's application be sent to BadgerCare Plus, or will the whole family stay in the Marketplace?

As of April 1, 2014, the following people are able to enroll in BadgerCare Plus:

- An adult with income at or below 100% of the Federal Poverty Level (FPL).
- A pregnant woman with income at or below 300% of the FPL.
- A child (under age 19) with household income at or below 300% of the FPL.
- Please note: a child or pregnant woman with a household income above 300% of the FPL may be able to enroll in BadgerCare Plus by meeting a deductible.

If a family with household income between 100% and 300% FPL submits an application for health insurance through the Marketplace, the adults in the household would purchase their health insurance through the Marketplace while the applications for the children will be transferred to BadgerCare Plus for enrollment. Please see Letter 10 for additional information that was mailed to individuals who applied for health care at the Marketplace and were determined eligible for BadgerCare Plus. (Updated 12/20/13)

If a single parent works and has income over the 200% of the Federal Poverty Level (FPL), can the parent enroll their child for BadgerCare Plus and buy insurance for themselves through their employer or the Marketplace? Or does the individual have to buy insurance from the employer for the both of them?

If the parent has employer-sponsored health insurance but wants to be covered under a private health insurance plan offered through the Marketplace, he or she must have the employer complete the Employer Coverage Tool Form to help figure out if the employer-sponsored health insurance is considered affordable according to the Marketplace.

If a parent decides to apply at the Marketplace, he or she will be notified if the child is eligible for BadgerCare Plus when the application is completed and assessed for a health insurance plan. If the child is found eligible for BadgerCare Plus, the Marketplace will send their information to DHS so the child can be enrolled in BadgerCare Plus. The parent does not need to purchase a Marketplace plan for that child. Keep in mind that the child may still be subject to the BadgerCare Plus health coverage and access tests if the parent has employer-sponsored health insurance that offers coverage for families. For more information on the BadgerCare Plus health care coverage rules, please see the ForwardHealth Enrollment and Benefits Handbook. (Updated 12/20/13)

Do all current BadgerCare Plus Core Plan and Basic Plan members have to re-apply?

Current BadgerCare Plus Core Plan members with income at or below 100% FPL will automatically transition into BadgerCare Plus Standard Plan for coverage as of April 1, 2014. Those BadgerCare Plus Core Plan members above 100% FPL can apply for and purchase private health insurance through the Marketplace at HealthCare.gov or by calling 1-800-318-2596 (TTY: 1-855-889-4325). To avoid a coverage gap they must apply and pay their first premium by March 15, 2014 for April 1, 2014 coverage.

Basic Plan members should apply for health care benefits through the Marketplace. When they finish their application at the Marketplace, the Marketplace will let then know if they will be enrolled in BadgerCare Plus or if they should purchase private health insurance. If they will be enrolled in BadgerCare Plus, their coverage will begin April 1, 2014. If they should purchase private health insurance, the Marketplace will give them information about the health care plan options that are available to them, what those plans cost, and if they can get any help paying for your private health insurance. The health insurance that individuals purchase through the Marketplace can begin as soon as January 1, 2014. However, their health insurance will not begin until they choose their plan and pay their first monthly premium by the date given by the health plan.

Please Note: The Marketplace Open Enrollment period goes through March 31, 2014.

(Updated 12/20/13)

Can childless adults apply for BadgerCare Plus coverage through the ACCESS online application tool right now?

Wisconsin's online ACCESS application tool is not currently accepting BadgerCare Plus applications for adults between the ages of 19 and 64 who are not disabled, blind, pregnant or living with and caring for a child under age 19. ACCESS will be available for childless adults starting February 3, 2014. (Updated 12/20/13)

Under the new BadgerCare Plus rules, can an adult living with dependent children still qualify for BadgerCare Plus even if he or she is on Medicare?

Parents and caretakers who are getting Medicare can still qualify for BadgerCare Plus and have dual eligibility under both programs if they meet all the BadgerCare Plus rules, including having an income at or below 100% FPL. Adults without dependent children will not be eligible for BadgerCare Plus if they are also getting Medicare. (Updated 12/20/13)

Will the changes to the BadgerCare Plus program affect documented or undocumented immigrants applying for Emergency Services?

Yes. Effective April 1, 2014, the income limit for parents and caretakers who are not pregnant applying for Emergency Services is 100% FPL. Adult immigrants without dependent children will be ineligible for Emergency Services. (Updated 12/20/13)

Will pregnant inmates or non-qualifying pregnant immigrants who meet the new BadgerCare Plus rules be enrolled in the Standard Plan as of April 1, 2014?

Yes. Effective April 1, 2014, all pregnant women enrolled in BadgerCare Plus, including pregnant inmates and non-qualifying pregnant immigrants on the BadgerCare Plus Prenatal Program, will be enrolled in the BadgerCare Plus Standard Plan. (Updated 12/20/13)

Can you please provide more details about the new requirement that a pregnancy test is not needed for BadgerCare Plus in 2014.

Beginning January 1, 2014, verification of pregnancy will no longer be required for BadgerCare Plus enrollment. (Updated 12/20/13)

Will newborns be considered "Continuously Eligible Newborns" if their mother was enrolled in the BadgerCare Plus Standard Plan as of April 1, 2014?

There are no changes to the policies around Continuously Eligible Newborns. If the mother is enrolled in BadgerCare Plus as of April 1, 2014, her newborn will be considered a Continuously Eligible Newborn and will also be covered under the BadgerCare Plus Standard Plan, unless the mother is incarcerated and delivers the child while she is incarcerated. (Updated 12/20/13)

Are adults on BadgerCare Plus obligated to enroll into an employer-sponsored insurance plan?

For adults who are interested in applying for BadgerCare Plus, as of April 1, 2014 there will no longer be a health insurance access test, but they must meet all other BadgerCare Plus requirements. However, some children may still need to meet the BadgerCare Plus health insurance access test depending on their household income and the health insurance coverage. (Updated 12/20/13)

BadgerCare Plus Program Rules

Will the BadgerCare Plus Benchmark, Core and Basic Programs end on December 31, 2013?

No. Due to changes in state law, the BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, and BadgerCare Plus Basic Plan will continue to be available to current enrollees until April 1, 2014. They were originally going to end on December 31, 2013 however, because of difficulties with HealthCare.gov, Governor Walker called for a special session of the Legislature to take up Legislation that would allow individuals currently enrolled in BadgerCare Plus more time to enroll in a health care plan through the federal health insurance Marketplace. On December 20, 2013, Governor Walker signed Special Session Assembly Bill 1 into law. This bill allows individuals currently enrolled in BadgerCare Plus who do not meet the new program rules more time to purchase private health insurance through the federal health insurance Marketplace. As a result, most of the BadgerCare Plus changes that were slated to be implemented on January 1, 2014 are not scheduled to take effect until April 1, 2014. Members currently enrolled in the BadgerCare Plus Benchmark Plan and Core Plan who meet the new BadgerCare Plus rules will be enrolled in the BadgerCare Plus Standard Plan as of April 1, 2014. DHS will contact current members who are affected by the change in program rules in early March. (Updated 12/20/13)

Will all members on BadgerCare Plus be required to pay a premium?

No. Beginning April 1, 2014, the following members will be required to pay a monthly premium:

- Parents and Caretaker Relatives of a dependent child under age 19 who are on a BadgerCare Plus Extension with income above 100% FPL.
- Children with household income between 200% and 300% FPL, except for children under age one or children who are tribal members. (Updated 12/20/13)

When should BadgerCare Plus parents and caretaker relatives and Core Plan members stop paying their monthly premiums?

BadgerCare Plus parents and caretaker relatives and Core Plan members, who owe a premium must continue to pay any monthly premiums that they owe. They must continue to pay until they receive a letter stating that they continue to be eligible but no longer have a premium, or until they get a letter saying that they are no longer eligible for BadgerCare Plus. (Updated 12/20/13)

If a BadgerCare Plus Core Plan member is enrolled in a BadgerCare Plus Core Plan HMO as of April 1, 2014, will that former Core member

be covered by BadgerCare Plus on a Fee-For-Service basis for the new BadgerCare Plus Standard coverage?

Benchmark Plan and Core Plan members who continue to meet the BadgerCare Plus rules and are being transitioned to the Standard Plan will continue to receive their care through an HMO if they live in an area that has HMO enrollment. If a BadgerCare Plus member has a question or concern about their HMO enrollment, they can reach the HMO Enrollment Specialist by calling 1-800-291-2002. (Updated 12/20/13)

What HMOs will serve BadgerCare Plus members in 2014?

DHS is currently working on HMO contracts for 2014, including finalizing the list of HMOs that will be serving BadgerCare Plus members. (Updated 12/20/13)

With the upcoming changes to BadgerCare Plus enrollment, after April 1, 2014, will BadgerCare Plus Standard Plan members be required to pay a copayment based on income?

Copayments for the Standard Plan are between $0.50 and $3.00 depending on the services. Members may be required to pay more than one copay if they get more than one service.

There are, however, copayment exemptions for certain BadgerCare Plus members. Health care providers are prohibited from collecting payments from the following BadgerCare Plus members:

- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Children who are American Indian or Alaska Natives who are enrolled in BadgerCare Plus.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.
- Children in the following categories:
  1. Children in foster care, regardless of age.
  2. Children in adoption assistance, regardless of age.
  3. Children in the Katie Beckett program, regardless of age.
  4. Children under age one with income up to 150% FPL.
  5. Children ages 1 through 5 with income up to 185% FPL.
  6. Children ages 6 through 18 years of age with incomes at or below 133% FPL. (Updated 12/20/13)

Will people applying for BadgerCare Plus in 2014 be able to backdate their eligibility?

Members may be able to backdate their BadgerCare Plus enrollment for up to three months prior to the month of their application if they meet the any of the following:

- Adults with income at or below 100% FPL. Note that BadgerCare Plus Standard Plan coverage for adults with no dependent children living in the home cannot begin earlier than April 1, 2014.
- A pregnant woman, unless she is in the BadgerCare Plus Prenatal Program.
- Some children can get backdated coverage:
  1. Infants less than 1 year old may get backdated coverage for any of the

months that their family income was at or below 300% FPL.
2. Children ages 1 through 5 may get backdated coverage for any of the months that their family income was at or below 185% FPL.
3. Children ages 6 through 18 may get backdated coverage for any of the months in which their family income was at or below 150% FPL. (Updated 12/20/13)

Can you explain more about the Transitional Medical Assistance or Extensions?

If a BadgerCare Plus parent, caretaker or pregnant woman has an increase in earnings or child/spousal support that puts them over 100% FPL, they will go into a four month period of continuous enrollment in BadgerCare Plus. In most cases, their children will also stay enrolled for this period. However, Congress has proposed extending the length of these extensions to 12 months, but just for those who have an increase in earnings. If that proposal is included in the federal budget deal, the length of the continuous enrollment will be 12 months. (Updated 12/20/13)

Can you explain how the restrictive re-enrollment period (RRP) will work under the new policy changes?

If a BadgerCare Plus member does not pay their required monthly premium, they will be placed in a restrictive re-enrollment period (RRP). A restrictive re-enrollment period is the period of time an individual is not eligible for BadgerCare Plus due to non-payment of a premium.

Beginning April 1, 2014, there are two groups subject to premiums and therefore to restrictive re-enrollment periods:

- Non-exempt children ages 1 to 18 with incomes over 200% of the Federal Poverty Level (FPL).
- BadgerCare Plus parents or caretakers who have an increase in earnings or spousal support that puts their income over 100% FPL and who receive a period of continuous enrollment in BadgerCare Plus as a result. This is called an extension, and is also known as Transitional Medical Assistance.

Both of these groups will be subject to a three month RRP for failure to pay a premium. At any time during the three month RRP, however, the unpaid premium(s) can be paid and the member can re-enroll in BadgerCare Plus. At the end of the three month RRP, the member can re-enroll without paying their unpaid premiums. (Updated 12/20/13)

Modified Gross Income (MAGI) Questions

Please note: The Income Maintenance (IM) agency will determine which income is counted for MAGI purposes. If you have questions about whether income is counted or how the MAGI rules will apply to a specific case, you could contact the IM agency.

How are household composition and income determined and will this be the same for BadgerCare Plus as it is for the Marketplace?

BadgerCare Plus eligibility determinations will use Modified Adjusted Gross Income (MAGI) rules. MAGI rules are based on the concept of an individual's tax household, not necessarily on the physical household or family relationships. This methodology

is designed to align with the MAGI rules used in the Marketplace.

Individuals who meet one of the exceptions to the MAGI tax filing rules or who are not tax filers or tax dependents will have their eligibility determined using relationship rules.

For more information on MAGI, view the partner trainings. (Updated 12/20/13)

Is Supplemental Security Income (SSI) no longer counted for parents or children?

Currently, Supplemental Security Income (SSI) is not counted as income for anyone applying for BadgerCare Plus and it will not be counted as income in 2014 either. (Updated 12/20/13)

Will child support be counted as income under MAGI ?

No, while it is currently counted as income, under the MAGI rules it will no longer be counted. (Updated 12/20/13)

Are Social Security Surviving Child Benefits counted towards household income for an adult when determining eligibility for BadgerCare Plus under Modified Adjusted Gross Income (MAGI) rules?

Although Social Security benefits are not taxable, under MAGI rules they must be counted as income. However, Social Security Benefits are not considered when determining if a child or tax dependent is “expected to be required” to file a tax return for the current year, which means that in most cases, a child’s Social Security benefits will not be counted. (Updated 12/20/13)

Will Family Planning Only Services (FPOS) applicants be counted as a group of one under MAGI rules, even if they are married?

Yes, for individuals whose eligibility for FPOS is determined under MAGI rules, the applicant’s group size will always be one. (Updated 12/20/13)

Effect of New BadgerCare Plus Rules on Other Programs

Will the new rules for BadgerCare Plus affect FoodShare members who are receiving both BadgerCare Plus and FoodShare benefits?

The new rules for BadgerCare Plus will not affect FoodShare. (Updated 12/20/13)

What will happen to the Medicaid Purchase Plan (MAPP)?

There are no changes to MAPP. (Updated 12/20/13)

Are Family Planning Only Services going to change?

Not at this time. After April 1, 2014, a few new income counting rules will apply the next time members renew their benefits. Only the member’s own income will count towards their Family Planning Only Services benefit. Because their group size will be

one, we will not ask any questions about tax filing. (Updated 12/20/13)

BadgerCare Plus Waiver

What is the timeline for DHS to be informed regarding the outcome of the BadgerCare Plus Demonstration Waiver?

The Department continues discussions with the Centers for Medicare and Medicaid Services (CMS) on the new BadgerCare Plus waiver. (Updated 12/20/13)

Applying for Health Care

If an adult with no dependent children is under 100% of the Federal Poverty Level, should he or she apply at the Marketplace as soon as possible or wait until ACCESS accepting applications for BadgerCare Plus for adults with no dependent children?

An adult with no dependent children can apply for health care benefits through the Marketplace. The Marketplace will let the member know if he or she will be enrolled in BadgerCare Plus or that his or her application has been transferred to the State for coverage starting April 1, 2014. If the member has income at or below 100% FPL, he or she can choose to wait to apply on ACCESS for BadgerCare Plus. Adults with no dependent children living with them can begin applying for BadgerCare Plus online at ACCESS.wi.gov as of February 3, 2014. (Updated 12/20/13)

When can Adults with no dependent children, otherwise known as Childless Adults, under 100% FPL start to apply on ACCESS?

February 3, 2014. In the meantime, they can apply through the Marketplace at Healthcare.gov at any time. (Updated 12/20/13)

Can applications for child care, Family Planning Only Services, and Food Share still be completed on ACCESS?

Wisconsin individuals and families can still use ACCESS to apply online for Child Care, Family Planning Only Services, and FoodShare. They will also be able to continue applying for these programs online after the new BadgerCare Plus policies are effective. (Updated 12/20/13)

Will Express Enrollment still be available after March 31, 2014?

Yes, express enrollment, also known as presumptive eligibility, will still be available for qualifying children and pregnant women after March 31, 2014. (Updated 12/20/13)

Will there be any changes to the Express Enrollment Process for pregnant women and children after March 31, 2014?

In general, the Express Enrollment process for pregnant women and children will not change. However, a few policy changes will take effect February 1, 2014 and will be reflected in the online express enrollment tool available on ACCESS at that time. These include Express Enrollment eligibility for legal residents as well as citizens,

limiting pregnant women to one period of eligibility under Express Enrollment per pregnancy, and no longer requiring verification of pregnancy for pregnant women. (Updated 12/20/13)

BadgerCare Plus Outreach

View information for members about Wisconsin Health Care Options in 2014 and the three month delay.

How many letters were sent out to Wisconsin residents regarding Health Care Options in 2014?

View the list of letters that were sent to BadgerCare Plus members and individuals on the BadgerCare Plus Core Plan Waitlist.

Below are the numbers of letters that were sent out:

- Letter 1: 56,246 letters were sent to 77,472 individual members
- Letter 1A: TBD – will have updated mailing numbers by 12/31/13
- Letter 2: 11,431 letters were sent to 14,932 individual members
- Letter 3: 163,808 individuals
- Letter 3A: 163,808 individuals
- Letter 4: 1,222 individuals
- Letter 4A: 1,222 individuals
- Letter 9: 56,246 letters were sent to 77,472 individual members
- Letter 10: TBD – will have updated mailing numbers by 12/31/13 (Updated 12/20/13)

How will Benchmark and Core Plan members know they are transitioning to the Standard Plan?

Benchmark Plan and Core Plan members who continue to meet the BadgerCare Plus rules and are being transitioned to the Standard Plan will receive two mailings. A letter about your enrollment and a ForwardHealth Member Update will be mailed by the end of March regarding this change. The ForwardHealth Member Update will explain the coverage for those enrolled in the BadgerCare Plus Standard Plan. (Updated 12/20/13)

What outreach is being done to educate members about these changes and the need of some members to transition to the Marketplace?

The Department sent out several mailings notifying our current members and individuals on the BadgerCare Plus Core Plan Wait list about the BadgerCare Plus changes. Additional mailings will be sent out in late-December and in early 2014. Generic versions of these letters have been posted to the Department's website. Please note: the letters sent in September, October and November were mailed before the delay was announced; therefore, the letters include January 1, 2014 as the effective date of the changes.

In addition, the Department will be offered a series of taped webcasts and in-person trainings community partners, health care providers, public health departments and other interested stakeholders about the 2014 BadgerCare Plus Policy Changes in September, October and November 2013. Due to the delay in implementation of the 2014 BadgerCare Plus policy changes, the partner materials available at dhs.wisconsin.gov/health-care/training/index.htm are currently out-of-date. While

the policies being implemented remain the same, the implementation dates contained within the videos and presentations are out-of-date. Updated information will be available in the near future. A webcast training that will be recorded and available online regarding this series of mailings. The same is true for the BadgerCare Plus handbook. While the policies outlined in the handbook are still correct, the implementation dates will be updated over the next several weeks.

These trainings for community partners tie into the Department's overall strategy of working with the Regional Enrollment Networks (RENs) to assist Wisconsin residents with enrolling in the appropriate public or private health care coverage. (Updated 12/20/13)

What outreach will be done to families with children on BadgerCare Plus that are currently over 300% FPL?

All BadgerCare Plus households that may be affected by policy changes should have received an informational mailing in late September. The informational mailings refer households with members who now need to purchase private health insurance through the Marketplace with information about how to contact the Marketplace. Any households that have members affected by changes will receive another letter in early March. (Updated 12/20/13)

What letter is being sent to BadgerCare Plus Standard Plan, Benchmark Plan, and Core Plan members who will be losing eligibility after March 31, 2014?

Members who are losing eligibility after March 31, 2014 will receive an enrollment letter (also called a Notice of Decision). They should receive this letter in mid-February to let them know that their benefits will be ending on March 31, 2014 and to remind them to apply at the Marketplace for health insurance (or, if they provided MAGI information via the form in letter 1A, we will let them know that we have transferred their application to the Marketplace). Most of these members would have received a letter indicating changes to the BadgerCare Plus program in late September or early October.

A letter was sent in September to allow current members to report any changes that may affect their eligibility and keep them enrolled in BadgerCare Plus as well as allow members whose income is greater than 100% FPL as much time as possible to research their health care options and apply for coverage through the Marketplace. Individuals who received letters that indicate their income may place them above the limits for BadgerCare Plus are encouraged to visit www.healthcare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325). If people have questions about these letters, they are encouraged to contact the local agency listed on the top of their letter. (Updated 12/20/13)

For the outbound telephone call campaign coordinated by DHS, will phone calls be made to BadgerCare Plus fee-for-service enrollees only or will phone calls also be made to BadgerCare Plus members who are enrolled in HMOs at the time of the call?

The outbound telephone call campaign was designed as another method of outreach to tell members about changes to the BadgerCare Plus program in 2014. Phone calls will be made to the following BadgerCare Plus members, whether they are enrolled in an HMO or not:

- BadgerCare Plus members who will need to purchase private health insurance through the Marketplace,
- Basic Plan members.
- Individuals on the Core Plan Waitlist.

Please note that when DHS contacts these members they may ask for the member's month of birth, but will not ask for any personally identifiable information or protected health information. (Updated 12/20/13)

Where should we go to look for updates and member materials?

Please visit dhs.wisconsin.gov/health-care/ or badgercareplus.org/ for information about BadgerCare Plus programs and healthcare.gov for information about the Marketplace. (Updated 12/20/13)

When will the DHS website have updated forms/publications available?

Updated form, publications, trainings, member fact sheets, and other information in early 2014. (Updated 12/20/13)

Marketplace Outreach

View Marketplace partner information and resources

When does open enrollment end?

The Marketplace Open Enrollment period goes through March 31, 2014. (Updated 12/20/13)

Will people still get to keep their same doctor once they are enrolled in the Marketplace, under any insurance that they pick?

For those individuals that have purchase private health insurance, each health insurance plan will have its own provider networks. Whether or not the individual's previous provider is within the private health insurance plan's network will depend on the plan's provider network and the individual's preferred doctor. Individuals and families can learn about the plans in their area, including costs and the provider network, by going to HealthCare.gov/find-premium-estimates. (Updated 12/20/13)

How is "affordable" defined for the employer provided insurance in the Marketplace?

See the Marketplace website for their definition of "affordable." (Updated 12/20/13)

What process will Wisconsin use for the Marketplace related appeals?

The Marketplace will be handling all Marketplace related appeals. For more information, go to the Marketplace. All eligibility determinations made by Wisconsin Income Maintenance (IM) agencies will continue to be handled by Wisconsin Division of Hearings and Appeals. (Updated 12/20/13)

Last Revised: December 20, 2013

Wisconsin Enrollment Directory

NOVEMBER 2013

ENROLLMENT *for Health* WISCONSIN

The Wisconsin Enrollment Directory was created to help individuals in Wisconsin to make appropriate referrals for enrollment services. Many thanks to each organization that contributed a listing to this directory, and to the Milwaukee Health Care Partnership for lending their template to this directory. The Partnership will continue to create the Milwaukee Enrollment Directory, and for this reason, Milwaukee locations do not appear in this directory.

Please note that the organizations listed below may change their information or services sooner than we can update the directory. Organizations which have been registered as Certified Application Counselor Organizations are marked with a star ✶. All other listings reflect organizations that are currently providing enrollment into public benefits only at this time.

Glossary of Health Care Programs Appearing in the Directory

BC+ BadgerCare Plus

CCC Child Care Coordination

Child Care Wisconsin's Child Care Subsidy Program

EE Express Enrollment

FPOS Family Planning Only Services via BadgerCare +

FS FoodShare

Katie Beckett

MA EBD Medicaid for the Elderly, Blind and Disabled

Marketplace

Medicare

PNCC Prenatal Care Coordination

SSDI Social Security Disability Insurance

SSI Supplemental Security Income

WIC Women Infant and Children Supplemental Nutrition Program

WWWP Wisconsin Well Woman Program

ADAMS COUNTY

Certified Application Counselors Open to the General Public

✯ Adams County Health and Human Services

108 E. North Street, Friendship, WI | 608-339-4379

Contact: Front Desk

- Monday – Friday, 8:00 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help stations/Computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | PNCC | CCC | WWWP | KATIE BECKETT | FS | CHILD CARE | SSI | SSDI | WIC

Public Benefits Only (until marketplace certification can be obtained)

Moundview Memorial Hospital & Clinics, Inc.

402 West Lake Street, Friendship, WI 53934 | 608-339-3331

- Monday – Friday, 8 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Polish, Language Line

HOSPITAL FINANCIAL AID

ASHLAND COUNTY

Certified Application Counselors Open to the General Public

✯ NorthLakes Community Clinic

Ashland Clinic | 719 Main St E, Ashland, WI 54806 | 888-834-4551

Contact: Rachel Coughtry

- Monday - Friday, 8:30 AM – 5 PM, extended hours available
- Call to schedule an appointment
- English, Sign Language
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | WWWP | FS | SSI | SSDI | WIC

BARRON COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Rice Lake Center | 1700 West Stout Street Rice Lake, WI 54868 | 800-442-4268, ext 3-8420

Contact: Patient Assistance Center

- Monday – Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Public Benefits Only

Barron County Department of Health and Human Services

335 E Monroe Ave, Barron, WI 54812 | 715-537-5691

Contact: Marie Berger

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Somalian, Language Line
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | FPOS | EE | PNCC | CCC | WWWP | FS | CHILD CARE | WIC

BAYFIELD COUNTY

Certified Application Counselors Open to the General Public

✯ NorthLakes Community Clinic

Iron River Clinic | 7665 US Hwy 2, Iron River, WI 54847 | 888-834-4551

Contact: Stephanie Fabiilli

- Monday - Friday, 8:30 AM – 5 PM
- Call to schedule an appointment
- English
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | WWWP | FS | SSI | SSDI | WIC

Certified Application Counselors Serving Target Populations

✯ Red Cliff Human Services [Focus on Tribal and surrounding community]

Red Cliff Administration Building | 88385 Pike Road, Bayfield, WI 54814 | 715-779-3706

Contact: Deb Morris

- Monday – Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English
- Self-help station/computer labs available

MARKETPLACE | BADGERCARE + | MA EBD | FPOS | CCC | FS | CHILD CARE | WIC

BROWN COUNTY

Certified Application Counselors Open to the General Public

✯ Hospital Sisters Health Systems [via HRS Erase]

St. Mary's Hospital | 1726 Shawano Avenue, Green Bay, WI 54303 | 920-433-8122

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English

MARKETPLACE

St. Vincent Hospital | 835 Van Buren Street, Green Bay WI | 920-433-8122

- Monday – Friday, 8 AM – 4:30 PM
- Call to schedule an appointment
- English

MARKETPLACE

N.E.W. Community Clinic

622 Bodart Street, Green Bay, WI | 920-437-9773

Contact: Tony Lee

- Monday and Thursday 8-5, Tuesday and Wednesday 8-6:30
- Call to schedule an appointment
- Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP | KATIE BECKETT | FS | WIC

Certified Application Counselors Serving Target Populations

✯ Oneida Tribe of Indians of Wisconsin [Focus on Native American Indians and Alaskan Natives]

Oneida Community Health Center | 425 Airport Drive, Oneida, WI 54155 | 920.869.2711

Contact: Margaret Valencia

- Monday – Friday, 7 AM – 6 PM
- Call to schedule an appointment; walk-in accepted
- English

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | PNCC | CCC | WWWP | CHILD CARE | SSI | SSDI | WIC

✯ Prevea Allouez Clinic [Prevea Health]

1821 S Webster Ave., Green Bay, WI 54301 | 920-405-1445

Contact: Amy McNally

- Monday, Tuesday, Friday 8 AM – 4:30 PM
- Call to schedule an appointment
- English, Spanish via

BADGERCARE+ | MA EBD | EE | WWWP

Public Benefits Only

Aging and Disability Resource Center of Brown County [Focus on individuals 60+ years, adults with physical or intellectual disabilities, mental health, AODA]

300 S. Adams St., Green Bay, WI 54301 | (920) 448-4300

Contact: Tina Brunner

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer labs available

BadgerCare+ | MA EBD | Medicare | FPOS | EE | FS | Child Care | SSI | SSDI

AIDS Resource Center of Wisconsin [Focus on existing clients and those at high risk for HIV and HCV]

445 S. Adams St. Green Bay, WI 54301 | 920-437-7400

Contact: Veralyn Prillaman

- Monday - Friday, 9 AM - 4 PM
- Call to schedule an appointment
- English, Spanish, Language Line

BadgerCare+ | MA EBD | Medicare | FS | Child Care | SSI | WIC

Brown County Human Services

111 N Jefferson St, Green Bay, WI 54305 | 888-794-5747

Contact: Jenny Hoffman

- Monday – Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line
- Self help stations/computer lab available

BadgerCare+ | MA EBD | FPOS | FS | Child Care | Energy Assistance

Planned Parenthood of Wisconsin [Focus on existing patients]

2605 S. Oneida Street, Suite 107 Green Bay, WI 54304 | 920-432-0031

Contact: Center Manager

- Monday, Wednesday 10 AM – 6 PM, Thursday 8 AM – 4 PM, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

BURNETT COUNTY

Certified Application Counselors Open to the General Public

✯ St. Croix Regional Medical Center

Ignalls Clinic | 7456 Main St. W, Webster, WI 54893 | 715-866-4271

Contact: Gail Johnson

- Monday - Friday 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | FPOS | EE | FS | SSDI

CALUMET COUNTY

Certified Application Counselors Open to the General Public

✯ Calumet Medical Center [Affinity Health System]

614 Memorial Drive | Chilton, WI 53014 | 920-849-7539 x2206 or 1-800-458-4042 x2206

Contact: Kelly Tasch

- Monday – Friday, 7:30 AM to 3:30 PM
- Call to Schedule an Appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP

CHIPPEWA COUNTY

Certified Application Counselors Open to the General Public

✯ Chippewa County Department of Human Services

711 North 4th Street | Chippewa Falls, WI 54017 | 715-726-7788

Contact: Lori Ploederer or Tammy Taylor

- Monday – Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE + | CCC | KATIE BECKETT | CHILD CARE

✯ Marshfield Clinic

Chippewa Falls Center | 2655 County Highway I Chippewa Falls, WI 54729 | 800-

924-8515, ext. 7-4825

Contact: Patient Assistance Center

- Monday – Friday 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Public Benefits Only

Open Door Clinic [Focus on existing patients]

130 W. Central St., Chippewa Falls, WI 54729 | 715-720-1443

Contact: Mary Meyers

- Monday 10 AM – 12 PM, Tuesday 4 PM – 8 PM
- Walk-in only
- English
- Self-help stations/computer lab available

BADGERCARE+

CLARK COUNTY

Certified Application Counselors Open to the General Public

✭ Clark County Department of Social Services

517 Court Street | Neillsville WI 54456-1976 | 715-743-5233

- Monday - Friday, 8 AM – 4:30 PM
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | BC+ |CCC | CHILD CARE | EE | FPOS | FS | KATIE BECKETT | MA EBD

Public Benefits Only

Clark County Health Department

517 Court Street Room 105, Neillsville, WI | 715-743-5105

Contact: Sabrina Meddaugh

- Monday – Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

BADGERCARE+ | FPOS | EE | PNCC | WWWP

COLUMBIA COUNTY

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

132 W. Cook Street, Portage, WI 53901 | 608-742-1551

Contact: Center Manager

- Tuesday 10 AM – 6 PM, Friday 9:30 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

DANE COUNTY

Certified Application Counselors Open to the General Public

✯ Dane County Human Services Job Center [via Access Community Health Center]

1819 Aberg Avenue, Madison 53704 | (888) 794-5556

- Monday – Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- Computers available
- English, Hmong, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

✯ Stoughton Hospital Association

900 Ridge Street, Stoughton, WI 53589 | 608-873-6611

Contact: Certified Application Counselors

- Monday - Friday, 7AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

MARKETPLACE

Certified Application Counselors Serving Target Populations

✯ HIV/AIDS Program – Division of Public Health [Focus on individuals with HIV/AIDS]

1 West Wilson Street Rm. 265 Madison, WI 53701 | 608-266-0463

Contact: Alison Meier

- Monday – Friday, 9 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | AIDS DRUG ASSISTANCE PROGRAM | HIV INS. PREMIUM SUBSIDY

Public Benefits Only (until marketplace certification can be obtained)

Journey Mental Health [Focus on existing patients]

625 West Washington Avenue Madison, WI 53703 | 608-280-2602

Contact: Linda Francis

- Monday – Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

BADGERCARE+ | MA EBD

St. Mary's Hospital

700 S. Park St Madison, WI 53715 | 608-251-6100

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line
- Self-help station/computer lab available

BADGERCARE+

UW Health

600 Highland Avenue | Madison, WI 53792 | 608-262-2221

Contact: Customer Service

- Monday - Friday, 8 AM – 5 PM
- Call to schedule appointment
- English, Spanish, Language Line
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | EE

Public Benefits Only

ARC Outpatient Services [Focus on existing clients]

1409 Emil Street, Madison, WI 53713 | 608-283-6426

Contact: Laura Fabick

- Monday – Friday 8 AM – 4:30 PM
- Call to schedule an appointment
- English

BADGERCARE+ | MA EBD | FPOS | EE | PNCC | FS | WIC

Planned Parenthood of Wisconsin [Focus on existing patients]

3706 Orin Road, Madison, WI 53704 | 608-241-3767

Contact: Center Manager

- Monday, Tuesday, Friday 9 AM – 5 PM, Wednesday, Thursday 8 AM – 6 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

2222 S. Park Street, Suite 210, Madison, WI 53713 | 608-251-6546

Contact: Center Manager

- Monday, Thursday 11 AM – 7 PM, Tuesday, Friday 9 AM – 5 PM, Wednesday 11 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

DODGE COUNTY

Certified Application Counselors Open to the General Public

✯ Dodge County Human Services and Health Department

199 County Hwy DF, Juneau, WI 53039 | 920-386-3500

Contact: Sheila Drays

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Translation Services, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | PNCC | CCC | WWWP | KATIE BECKETT | FS | CHILD CARE | SSI | SSDI | WIC

Certified Application Counselors Serving Target Populations

✯ Watertown Regional Medical Center [New or established patients/clients]

125 Hospital Drive, Watertown, WI | 920-262-4396

Contact: Brittany Grinker, Patient Financial Counselor

- Monday - Thursday, 7 AM - 5:30 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE

DOOR COUNTY

Certified Application Counselors Open to the General Public

✯ Ministry Door County Medical Center [Door County Memorial Hospital]

323 S 18th Ave Sturgeon Bay, WI 54235 | 920-743-5566

Contact: Keith Volkmann and Jason Pristelski

- Monday - Friday, 8 AM – 4 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MEDICARE

✭ Community Clinic of Door County, Inc.

Country Walk Shops, Country Walk Drive, Sister Bay, WI | 920-746-8989 ext 104

Contact: Jeanne Rabel

- Call to schedule an appointment
- English

MARKETPLACE | FPOS

1623 Rhode Island St., Sturgeon Bay Clinic | 920-746-8989 ext 104

Contact: Jeanne Rabel

- Call to schedule an appointment
- English

MARKETPLACE | FPOS

Computer Lab Only

We Are Hope Inc. /Door County Job Center

1300 Egg Harbor Road, Suite 124, Sturgeon Bay, WI | 920-743-6915

Contact: Kim Carley

- Monday – Friday, 8 AM to 4:30 PM
- Computer Lab Only

Public Benefits Only

Door County Department of Human Services

Government Center |421 Nebraska Street, Sturgeon Bay, WI 54235 | 920-746-2300

[Current BadgerCare recipients can call: 1-888-794-5747]

- Monday - Friday, 8AM to 4:30 PM
- Phone, Walk-in or appointment
- English, Spanish
- Self-help stations/computer lab availability

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

DOUGLAS COUNTY

Certified Application Counselors Open to the General Public

✯ Lake Superior Community Health Center

3600 Tower Ave Superior, WI 54880 | 715-392-1955

Contact: Paula Gayle, Nancianne Witt

- Monday - Friday, 8 AM – 5 PM
- Appointment Only
- English, Interpreter Services Available, Language Line

BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | FS

Public Benefits Only

Douglas County Department of Health & Human Services

1316 N. 14th Street, Suite 400, Superior, WI 54880 | 715-395-1304

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

BADGERCARE+ | PNCC

EAU CLAIRE COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Eau Claire Center | 2116 Craig Rd. Eau Claire, WI 54701 | 800-924-8515, ext. 7-4825

Contact: Patient Assistance Center

- Monday – Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Certified Application Counselors Serving Target Populations

✯ Chippewa Valley Free Clinic [via Chippewa Valley Health Clinic] [Focus on existing patients]

836 Richard Dr. Eau Claire, WI 54701 | 715-839-8477

Contact: Maribeth Woodford

- Call to schedule an appointment
- English, Spanish

MARKETPLACE

✯ AIDS Resource Center of Wisconsin[Focus on existing clients and those at high risk for HIV and HCV]

505 Dewey Street South, #107 Eau Claire, WI 54701 | 715-836-7710

Contact: Nichole Vesperman

- Monday – Friday, 9 AM - 4 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FS | CHILD CARE | SSI | WIC

Public Benefits Only

Eau Claire County Department of Health & Human Services

721 Oxford Avenue, Eau Claire, WI 54701 | 888-283-0012

Contact: Great Rivers Call Center

- Monday - Friday, 8:30 AM - 4:00 PM
- Call to schedule an appointment; walk-in accepted
- English, Hmong, Language Line

BADGERCARE+ | MA EBD | FPOS | CCC | FS | CHILD CARE

Eau Claire City-County Health Department

720 Second Avenue | Eau Claire, WI 54703| 715-839-4718

- Monday - Friday, 8:00 AM - 5:00 PM
- English, Spanish, Hmong, Language Line
- Self help station/computer lab avaiable for ACCESS only
- Phone line available for self-enrollment in Marketplace (no staff)

FPOS| EE | PNCC| WWWP | WIC

Planned Parenthood of Wisconsin [Focus on existing patients]

1231 Menomonie Street, Eau Claire, WI 54703 | 715-833-227

Contact: Center Manager

- Monday 11 AM – 7 PM, Wednesday 12 PM – 6 PM, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

Eau Claire County Veterans Services Office [Focus on existing clients and military veterans, dependents and survivors]

721 Oxford Ave, Suite 1015 Eau Claire WI 54701 | 715-839-4744

Contact: Debbie Waite

- Appointments Preferred
- English

VETERANS HEALTH BENEFITS | VETERANS BENEFITS AND SERVICES

Computer Lab Only

L.E. Phillips Memorial Public Library

400 Eau Claire Street, Eau Clarie, WI 54701 | 715-839-5004

Contact: Reference Staff

- Monday - Thursday 10 AM – 9 PM, Friday 10 AM – 6 PM, Saturday 10 AM – 5 PM, Sunday 1 PM – 5 PM September through May
- Walk-in
- English
- Self-help station/computer lab available

FOND DU LAC COUNTY

Certified Application Counselors Open to the General Public

✭ Agnesian HealthCare

430 E Division Street Fond du Lac, WI 54935 | 920-926-4788

Contact: Kathy Donahue

- Monday – Friday, 9 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP | KATIE BECKETT | FS

Certified Application Counselors Serving Target Populations

Waupun Memorial Hospital [Agnesian Health Care, Focus via on existing patients]

620 W. Brown St. Waupun, WI 53963 | 920-324-6540

Contact: Linda Nickel

- Monday - Thursday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

333 N. Peters Street, Suite 6, Fond du Lac, WI 54935 | 920-922-9884

Contact: Center Manager

- Tuesday 7 AM – 3 PM, Thursday 10 AM – 6 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

FLORENCE COUNTY

Certified Application Counselors Open to the General Public

Florence County Human Services [via Northern Health Centers]

501 Lake Avenue | Courthouse Lower Level | Florence, WI 54121 | 715-276-6321

Contact: Cory Ashbeck

- Every Other Wednesday, 9:30 AM - 3 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE

FOREST COUNTY

Certified Application Counselors Open to the General Public

✯ Forest County Potawatomi Insurance Department

Forest County Potawatomi Elderly Program | 5450 Kak Yot Lane, Crandon, WI 54520

715-478-4707

Contact: Natalyn Gardner

- Monday - Thursday, 7 AM – 5 PM
- Appointment Only
- English, Spanish

MARKETPLACE | MA EBD | MEDICARE | SSI | SSDI

Forest County Potawatomi Insurance Department | 5415 Everybody's Road, Crandon, WI 54520 | 715-478-4707

Contact: Natalyn Gardner

- Monday - Thursday, 7 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish

MARKETPLACE | MA EBD | MEDICARE

Forest County Potawatomi Health and Wellness Center | 8201 Mish ko swen, Crandon, Wisconsin 54520 | 715-478-4707

Contact: Natalyn Gardner

- Monday - Thursday, 7 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish

MARKETPLACE | MA EBD | MEDICARE• Call to schedule an appointment; walk-in accepted

Forest County Circuit Court [via Northern Health Centers]

200 E Madison Ave | Crandon Courthouse | Crandon, WI 54520 | 715-276-6321

Contact: Cory Ashbeck

- Every Other Wednesday, 9:00 AM - 4:00 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available
- Self-help station/computer lab available

MARKETPLACE

Certified Application Counselors Serving Target Populations

✯ Forest County Potawatomi Economic Support Department [Focus on residents of FC Potawatomi Reservation, residents of Forest County]

5415 Everybody's Rd. Crandon, WI 54520 | 715-478-4433

Contact: Nicole Anderson

- Monday - Thursday, 7 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | CCC | WORK PROGRAMS | CHILD SUPPORT | ICW | FS | CHILD CARE | SSDI | WIC

Public Benefits Only

Forest County Department of Social Services

Northern Income Maintenance Consortium | 200 East Madison Street, Crandon, WI 54520 | 715 478-3351

- Monday - Friday, 8:30 AM - 4:30 PM
- Appointment Only
- English, Language Line

BadgerCare+ | MA EBD | FS | Child Care

GRANT COUNTY

Public Benefits Only

Grant County Veteran Service Office [Focus on Veterans]

111 S. Jefferson Lancaster, WI 53813 | (608) 723-2756

- Contact: Tim Murphy
- Monday - Friday 8:30 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English

VA Health Care | VA Based Benefits

GREEN COUNTY

Public Benefits Only (until marketplace certification can be obtained)

Monroe Clinic

515 22nd Avenue, Monroe, WI 53566 | 608-324-2870

- Monday - Friday, 8 AM to 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

IOWA COUNTY

Certified Application Counselors Open to the General Public

✯ Community Connections Free Clinic

101 E. Fountain St., Dodgeville, WI 53533 | 608-930-2232

Contact: Molly Zuehlke

- Tuesday, Thursday, 4 PM – 8 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish
- Self-help station/computer lab available

Marketplace

JACKSON COUNTY

Public Benefits Only

Black River Memorial Hospital

711 W. Adams Street, Black River Falls, WI 54615 | 715-284-5361

Contact: Shirley Londre and Sherry Wilkins

• Monday - Friday, 7 AM – 6 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line

BADGERCARE+ | MA EBD | MEDICARE

JEFFERSON COUNTY

✯ Certified Application Counselors Open to the General Public

Jefferson County Human Services

Workforce Development Center | 874 Collins Road Jefferson, WI 53549 | 920-674-7500

• Monday - Friday 8 AM – 4:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | CCC | FS | CHILD CARE

JUNEAU COUNTY

Certified Application Counselors Open to the General Public

✯ Family Health /La Clinica [via La Clinica de los Campesinos]

Mauston Dental Center | 880 Herriot Drive | Mauston, WI 53948 | 608-847-6700

Contact: Angie Hinze
• Monday – Friday, 8AM – 5PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish
• Self-help station/computer lab available

MARKETPLACE | BADGERCARE + | MA EBD | MEDICARE | FPOS | EE | WWP | KATIE BECKETT | FHLC AFFORDABLE CARE PLAN |FS | CHILD CARE | SSI | SSDI | WIC | ENERGY ASSISTANCE

Mile Bluff Medical Center

1050 Division Street, Mauston, WI | 608-847-9796

Contact: Carol Thomas/CAC
• Monday - Friday, 8 AM - 4:30 PM
• Call to schedule an appointment
• English

MARKETPLACE

Certified Application Counselors Serving Target Populations

✯ Juneau County Department of Human Services [Focus on new or existing clients]

220 E. LaCrosse Street, Juneau, WI | 608-847-2400

Contact: Human Services

- Monday – Friday, 8 AM - 4:30 PM
- Call to Schedule an Appointment
- English

MARKETPLACE

✯ Juneau County Health Department [Focus on existing clients]

220 E. State Street, Room 104, Mauston, WI 53948 | 608-847-9373

- Monday – Friday, 8 AM – 12 PM, 12:30 PM – 4:30 PM
- Call to Schedule an Appointment
- English/Language Line

MARKETPLACE | BADGERCARE+ | EE | PNCC | WWWP | WIC

KENOSHA COUNTY

Certified Application Counselors Open to the General Public

✯ Kenosha Community Health Center, Inc.

Community Center | 1330 52nd Street Kenosha, WI 53140 | 262-656-0044

Contact: John Stuligross, Jessica Retzlaff

- Monday - Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | WIC

Dental Clinic | 6226 14th Avenue Kenosha, 53140 | 262-656-0044

Contact: John Stuligross

- Monday - Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | WIC

Medical Clinic | 4536 22nd Avenue Kenosha, WI 53140 | 262-656-0044

Contact: Jessica Retzlaff

- Monday - Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted

• English, Spanish
• Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | WIC

Certified Application Counselors Serving Target Populations

✯ Kenosha County Department of Health Services [Focus on existing clients]

8600 Sheridan Road Suite 600 Kenosha, WI 53143 | 262-605-6700

Contact: Stacey Wians

• Monday - Friday, 7 AM – 6 PM
• Walk-in Only
• English, Language Line

MARKETPLACE | BADGERCARE+ FPOS | EE | PNCC | WWWP | WIC

Aging and Disability Resource Center of Kenosha County

8600 Sheridan Road, Kenosha, WI 53143 | 262-605-6646

• Monday - Friday 9 AM - 4 PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish
• Self-help station/computer lab available

MARKETPLACE | MA EBD | MEDICARE | SSI | SSDI

Public Benefits Only (until marketplace certification can be obtained)

Kenosha Human Development Services Inc.

5407 8th Ave, Kenosha, WI 53140 | 262-657-7188

Contact: Susan Roknic

• Monday – Thursday, 9 AM – 5 PM, Friday 9 AM – 4 PM
• Appointment Only
• English, Spanish

BADGERCARE+ | MA EBD | FPOS | FS | SSI | SSDI

United Hospital System, Inc.

6308 Eighth Avenue, Kenosha WI 53143 | 262-656-2011

Contact: Angela Preston

• Monday - Friday, 9 AM – 4:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line
• Self-help station/computer lab available

BadgerCare+ | MA EBD | Medicare | FPOS | EE | SSDI

Public Benefits Only

AIDS Resource Center of Wisconsin [Focus on existing clients and those at high risk for HIV and HCV]

1212 57th Street, Kenosha WI 53140 | 262-657-6644

Contact: Caroline Akweyo

- Monday - Friday 9 AM - 4 PM
- Call to schedule an appointment
- English

BadgerCare+ | FS | Child Care | SSI | WIC

ELCA Outreach Center

2006 60th St., Kenosha, WI 53140 | 262-652-5545

Contact: Karl Erickson

- Monday - Friday, 9 AM – 4 PM
- Walk-in only
- English
- Self-help station/computer lab available

BadgerCare+

Kenosha County Department of Human Services [Focus on BadgerCare+ clients]

8600 Sheridan Rd. Kenosha, WI 53143 | 262-697-4500

Contact: Jesse Noyola

- Monday - Friday, 8 AM to 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line
- Self-help station/computer lab available

BadgerCare+ | MA EBD | Medicare | FPOS | EE | PNCC | CCC | WWWP | Child Support | FS | Child Care

Kenosha County Center | 19600 75th Street Kenosha, WI 53143 | 262-857-1967

Contact: Keli Pope

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

BadgerCare+ | MA EBD | FPOS | CCC | Child Support | FS | Child Care |

WIC

Planned Parenthood of Wisconsin [Focus on existing patients]

3601 Roosevelt Road, Kenosha, WI 53140 | 262-654-0491

Contact: Center Manager

- Monday 10:30 AM – 6:30 PM, Tuesday, Thursday, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

LACROSSE COUNTY

Certified Application Counselors Open to the General Public

✯ LaCrosse County Human Services

300 North Fourth Street, LaCrosse WI 54602-4002 | 608-784-HELP (4357)

- Monday - Friday, 8 AM – 4:30 PM
- Appointment recommended; walk-in accepted
- English, Hmong, Spanish, Language Line
- Self-help station/computer lab available

MARKETPLACE | CHILD CARE | FPOS | FS | MA EBD

Certified Application Counselors Open to the General Public

✯ Mayo Clinic Health System

Mayo Clinic | 191 Theater Road, Onalaska, WI 5460 | 866-789-4374

Contact: Certified Application Counselor

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English

MARKETPLACE

Franciscan Healthcare in La Crosse | 700 West Avenue South, La Crosse, WI 54601 | 800-362-5454

Contact: Certified Application Counselor

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE

Public Benefits Only

AIDS Resource Center of Wisconsin[Focus on existing clients and those at high risk for HIV and HCV

505 King Street #200, La Crosse, WI 54601 | 608-785-9866

Contact: Tressa Stroud Soressi

- Monday - Friday, 9 AM - 4 PM
- Call to schedule an appointment
- English

BADGERCARE+ | MA EBD | MEDICARE | FS | CHILD CARE | SSI | WIC

LAFAYETTE COUNTY

Public Benefits Only

Lafayette County Human Services

627 Main Street Darlington, WI 53530 | 608-776-4800

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | MEDICARE | FPOS | CCC | FS | CHILD CARE | SSI | SSDI

LANGLADE COUNTY

Certified Application Counselors Open to the General Public

UW-Extension [via Northern Health Centers**]**

837 Clermont St | Antigo, WI 54409 | 715-276-6321

Contact: Cory Ashbeck

- Thursdays 9:00 AM - 3:00 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE

Public Benefits Only

Langlade County Department of Social Services

1225 Langlade Road, Antigo, WI 54409 | 715-627-6500

- Monday - Friday, 8:30 AM - 4:30 PM
- Appointment Only
- English
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | FPOS | CCC | FS | CHILD CARE | SSDI

LINCOLN COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Merrill Center | 1205 O'Day St. Merrill, WI 54452 | 1-800-847-0016, ext. 7-3904

Contact: Patient Assistance Center

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

MANITOWOC COUNTY

Public Benefits Only

Aging and Disability Resource Center of the Lakeshore [Focus on individuals over age 60, individuals with disabilities over age 18, and caregivers]

4319 Expo Dr. P.O. Box 935, Manitowoc, WI 54221 | 920-683-4180 or 877-416-7083

Contact: Michelle Acevedo

- Monday - Friday, 8 AM to 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

FS

Planned Parenthood of Wisconsin [Focus on existing patients]

1100 S. 30th Street, Manitowoc, WI 54220 | 920-684-1332

Contact: Center Manager

- Tuesday 10 AM – 6 PM, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

MARATHON COUNTY

Certified Application Counselors Open to the General Public

✯ Bridge Community Health Clinic

1810 N. 2nd Street, Wausau 54403 | 715-848-4884 (voice)

Contact: Mary Testin

- Monday, Wednesday - Friday 8 AM – 5 PM, Tuesdays 8 AM - 7 PM

• Call to schedule an appointment; walk-in accepted
• English, Hmong, Laotian, Spanish

MARKETPLACE | BADGERCARE+ | MA EBD | WWWP

✯ Marshfield Clinic

Wausau Center | 2727 Plaza Dr. Wausau, WI 54401 | 800-847-0016, ext. 7-3904

Contact: Patient Assistance Center
• Monday - Friday, 8 AM – 5 PM
• Call to schedule an appointment
• English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Weston Center | 3501 Cranberry Blvd. Weston, WI 54476 | 800-847-0016, ext. 7-3904

Contact: Patient Assistance Center
• Monday - Friday, 8 AM – 5 PM
• Call to schedule an appointment
• English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Public Benefits Only

AIDS Resource Center of Wisconsin

1105 Grand Ave #1, Schofield, WI 54476 | 715-355-6867

Contact: Marcye Masis
• Monday - Friday, 9 AM - 4 PM
• Call to schedule an appointment
• English, Spanish

BADGERCARE+ | MA EBD | MEDICARE | FS | CHILD CARE | SSI | WIC

Aspirus Wausau Hospital

333 Pine Ridge Blvd. | Wausau, WI 54401 | 715-847-2121
• Monday – Friday, 9 AM - 5 PM
• Call to schedule an appointment
• English, Language Line

BADGERCARE + | MA EBD

Marathon County Department of Social Services

400 E Thomas St Wausau, WI 54403 | 888-445-1621
• Monday - Friday, 8 AM – 4:30 PM

• Call to schedule an appointment; walk-in accepted
• English, Spanish, Hmong, Language Line
• Self-help station/computer lab available
BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

MARINETTE COUNTY

Certified Application Counselors Open to the General Public

✯ Marinette County Public Health [via Northern Health Centers]

250 Hall Ave | Marinette, WI 54143 | 715-276-6321

Contact: Ashley Schneider
• Tuesdays 9:00 AM - 3:00 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line
• Self-help station/computer lab available
MARKETPLACE

✯ Bay Area Medical Center

3100 Shore Dr. | Marinette, WI 54143 | 715-735-4202
• Monday - Friday, 8 AM - 5 PM
• Call to schedule an appointment
• English, Language Line
• Self-help station/computer lab available
BADGERCARE+ | EE | FS

Public Benefits Only

Marinette County Health and Human Services Department

Wisconsin Job Center | 1605 University Drive, Ste. B, Marinette, WI 54143 | 715-735-4202
• Monday - Friday 8:30 AM - 4:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line
BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

MARQUETTE COUNTY

Public Benefits Only

Marquette County Human Services/East Central Consortium [Focus on Marquette County Residents]

428 Underwood Ave, Montello, WI 53949 | 608-297-3124

Contact: Diane Voth

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

BadgerCare+ | MA EBD | FPOS | CCC | Katie Beckett | FS | Child Care | SSI | SSDI

MENOMINEE COUNTY

Public Benefits Only

Menominee Indian Tribe of Wisconsin – Community Resource Center

W3236 Wolf River Drive, Keshena, WI 54135 | 715-799-5137

Contact: Sue Blodgett

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English
- Self-help station/computer lab available

BadgerCare+ | MA EBD | Medicare | FPOS | FS

MILWAUKEE COUNTY

The Milwaukee Health Care Partnership will be publishing the Milwaukee Enrollment Directory in the coming weeks.

MONROE COUNTY

✭ Certified Application Counselors Open to the General Public

Mayo Clinic Health System

Franciscan Healthcare in Sparta | 310 W Main St Sparta, WI 54656 | 866-789-4374

- Monday, Tuesday 8 AM - 4:30 PM
- Call to schedule an appointment
- English

Marketplace

Franciscan Healthcare in Tomah | 325 Butts Ave, Tomah, WI 54660 | 866-789-4374

Contact: Certified Application Counselor

- Thursday, Friday 8 AM - 4:30 PM
- Call to schedule an appointment
- English

✯ Scenic Bluffs Community Health Centers

238 Front Street, Cashton, WI | 608-654-5100 x283

Contact: Help Team Members

- Monday -Thursday 7:30 AM - 6 PM, Friday 7 AM – 5:30 PM
- Call to schedule an appointment; walk-in accepted
- Appointment preferred
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | PRESCRIPTION ASSISTANCE PROGRAM | SLIDING FEE APPLICATION

200 W North Street, Norwalk, WI | 608-654-5100 x283

Contact: Help Team Members

- Monday, Wednesday, Thursday 7 AM – 5 PM, Friday 7 AM – 3 PM
- Call to schedule an appointment; walk-in accepted
- Appointment preferred
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | PRESCRIPTION ASSISTANCE PROGRAM | SLIDING FEE APPLICATION

OCONTO COUNTY

Certified Application Counselors Open to the General Public

Aging and Disability Resource Center of the Wolf River Region [via Northern Health Centers]

229 Van Buren St | Oconto Falls, WI 54154 | 715-276-6321

Contact: **Ashley Schneider**

- Mondays 9 AM - 3 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE

✯ New Beginnings Work and Training Center

230 VanBuren Street, Oconto, WI | 920-846-0258

Contact: Dustin Coopman or Pat Preman

- Call to schedule an appointment
- English, Language Line
- Self-help station/ computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

✯ Oconto County Department of Health & Human Services

501 Park Avenue, Oconto, WI | 920-834-7159

Contact: Allison Rymer or Carla Ruechel

- Call to schedule an appointment
- English, Language Line
- Self-help station/ computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FS | CHILD CARE

✯ Northern Health Centers [Serves residents of Oconto, Marinette, Forest, Florence and Langlade counties]

15397 State Hwy 32, Lakewood, WI 54138 | (715) 276-6321

Contact: Rhonda Stuart

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | WWWP | FS | CHILD CARE | SSI | SSDI

ONEIDA COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Minocqua Center | 9601 Townline Rd. Minocqua, WI 54548 | 1-800-347-0673

Contact: Patient Assistance Center

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

OUTAGAMIE COUNTY

Certified Application Counselors Open to the General Public

✯ St. Elizabeth Hospital [via Affinity Health System]

1506 S. Oneida Street, Appleton, WI 54915 | 920-738-2000, 920-727-8065 or 1-877-928-5678

Contact: Nan Pierson

• Monday – Friday, 8:00 AM to 4:00 PM
• Call to Schedule an Appointment
• English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP

✯ Affinity Medical Group [via Affinity Health System]

1550 Midway Place, Menasha, WI 54952 | 920-727-8065 or 1-877-928-5678

Contact: Marie Kluck
• Monday – Friday, 8:00 AM to 4:00 PM
• Call to Schedule an Appointment
• English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients; abortion services only]

3800 N. Gilette Street, Appleton, WI 54912 | 920-731-9534
• Monday – Friday, 8 AM – 4 PM
• Call to schedule an appointment
• English, Spanish, Language Line

FPOS | EE

508 W. Wisconsin Ave, Appleton, WI 54911 | 920-731-6304

Contact: Center Manager
• Monday 9 AM – 5 PM, Tuesday 8 AM – 4 PM, Thursday 11 AM – 7 PM, Friday 9 AM – 5 PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish, Language Line

FPOS | EE

PIERCE COUNTY

Certified Application Counselors Open to the General Public

✯ Pierce County Public Health Department [Focus on residents of Pierce County]

412 W. Kinne St., Ellsworth, WI 54011 | 715-273-6755
• Monday - Friday, 8 AM – 5 PM
• Call to schedule an appointment
• English, Language Line

MARKETPLACE | BADGERCARE+ | FPOS | EE | PNCC | WWWP | WIC

POLK COUNTY

Certified Application Counselors Open to the General Public

✯ Polk County Health Department

100 Polk County Plaza, Suite 180, Balsam Lake, WI 54810 | 715-485-8500

Contact: Julie Baryluk or Certfied Applicaiton Counselor

- Monday - Friday 8:30 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

BadgerCare+ | MA EBD | FPOS | PNCC | CCC | WWWP | Katie Beckett | FS | Child Care | WIC | SSI for children only

✯ St. Croix Regional Medical Center

Frederic Clinic | 107 Oak Street East, Frederic WI 54837 | 715-327-5700

Contact: Patty Turner

- Monday – Friday 8 AM – 4 PM
- Call to schedule an appointment
- English, Spanish, Language Line
- Self-help station/computer lab available

Marketplace | BadgerCare+ | MA EBD | FPOS | EE | FS | SSDI

Unity Clinic | 1504 190th Ave, Balsam Lake, WI 54810 | 715-825-3278

Contact: Patty Turner

- Monday – Friday 8 AM – 4 PM
- Call to schedule an appointment
- English, Spanish, Language Line
- Self-help station/computer lab available

Marketplace | BadgerCare+ | MA EBD | FPOS | EE | FS | SSDI

Certified Application Counselors Serving Target Populations

✯ Polk County Jail [Focus on incarcerated population]

1005 W. Main Street, Suite 900, Balsam Lake, WI | 715-485-8379

Contact: Donna Johnson

- Monday - Friday 8 AM – 4 PM
- Appointment only
- English

Marketplace | BadgerCare+ | FS

PORTAGE COUNTY

Public Benefits Only

Aging and Disability Resource Center of Portage County [Focus on seniors, adults with disabilities, their families and caregivers]

1519 Water Street, Stevens Point, WI 54481 | 715-346-1401

- Monday - Friday 7:30 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

BadgerCare+ | MA EBD | Medicare | WWP | Long Term Care | FS | SSI | SSDI

Income Maintenance Central Consortium

(888) 445-1621

- Monday – Wednesday 8 AM – 4:30 PM, Thursday 10:15 AM - 4:15 PM Friday 8:15 AM - 4:15 PM
- Call Center
- English, Spanish, Hmong, Language Line

BadgerCare+ | MA EBD | FPOS | FS | Child Care

Portage County Health and Human Services

817 Whiting Ave., Stevens Point, WI 54481 | (715) 345-5350

- Monday, Thursday 8 AM - 4:30 PM, Wednesday 8 AM – 5 PM, Friday 8 AM - 3 PM
- Call to schedule an appointment
- English, Language Line

PNCC | WWWP | WIC

PRICE COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Park Falls Center | 50 Sherry Ave. Park Falls, WI 54552 | 800-347-0673, ext. 3-1131

Contact: Patient Assistance Center

- Monday - Friday 8 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

Marketplace | BadgerCare+ | MA EBD | FPOS

Public Benefits Only

Price County Department of Health and Human Services [Focus on existing clients]

104 South Eyder Avenue, Phillips, WI 54555 | 715-339-3054

Contact: Brenda Oswald

- Monday - Friday 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line
- Self-help station/computer lab available

BADGERCARE+ | FPOS | EE | PNCC | WWWP | WIC

RACINE COUNTY

Certified Application Counselors Open to the General Public

✯ Community Health Systems, Inc.

Racine Community Health Center | 2405 Northwestern Avenue, Racine, WI 53404 | 262-886-0474

Contact: Tom Dunkin

- Monday - Friday, 8 AM - 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | WWWP | DIABETIC HEALTH EDUCATION

✯ Racine County Human Services

1717 Taylor Ave., Racine, WI 53405 | 1-888-794-5820

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language line available
- Computer Lab/Self Help Station available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | CCC | FS | CHILD CARE

Western Racine County Human Services |209 N Main St., Burlington, WI | 888-794-5820

- Monday - Friday, 8 AM – 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Computer Lab/Self Help Station available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | CCC | FS | CHILD CARE

Public Benefits Only (until marketplace certification can be obtained)

Health Care Network, Inc [Focus on existing patients]

904 State Street Racine, WI 53404 | (262) 632-2400

Contact: Barb Tylenda and Regina Scott Brooks

- Monday - Friday 8:30 AM – 12 PM, 1 PM - 4:45 PM
- Call to schedule an appointment
- English, Spanish

BADGERCARE+

Wheaton Franciscan Healthcare All Saints [Focus on existing patients]

3807 Spring Street, Racine, WI 53405 | 1 866-972-4687

Contact: Michelle Jones

- Monday - Friday, 9 AM - 5:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

BADGERCARE+ | MA EBD | FPOS | PNCC | SSDI

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

834 S. Main Street, Racine, WI 53403 | 262-634-2060

Contact: Center Manager

- Monday 10:30 AM - 6:30 PM, Wednesday, Thursday, Friday 9 AM - 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

RICHLAND COUNTY

Certified Application Counselors Serving Target Populations

✭ Richland County Health and Human Services

221 West Seminary Street, Richland Center, WI 53581 | 608-647-8821

- Monday – Friday, 8 AM – 5 PM
- Assistance provided in-person and over phone
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self Help Stations/Computer Lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | PNCCC | CCC | WWWP | KATIE BECKETT | FS | CHILD CARE | SSI | SSDI

ROCK COUNTY

Certified Application Counselors Open to the General Public

✯ Community Health Systems, Inc.

Beloit Area Community Health Center | 74 Eclipse Center, Beloit, WI 53511-6214 | 608-361-0311

Contact: Lynn Larsen

- Monday - Friday, 8 AM - 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | PNCC | WWWP | DIABETIC HEALTH EDUCATION

Public Benefits Only

Rock County Health Department [Focus on pregnant women in need of express enrollment]

3328 Highway 51 N. Janesville, WI 53545 | 608-757-5440

Contact: Karen Cain

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

EE | PNCC | IMMUNIZATIONS

South Office | 61 Eclipse Center, Beloit, WI 53511 | 608-364-2010

Contact: Karen Cain, Health Officer

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

EE | PNCC

RUSK COUNTY

Certified Application Counselors Open to the General Public

✯ Marshfield Clinic

Ladysmith Center | 906 College Ave W Ladysmith, WI 54848 | 800-442-4268, ext 3-8420

Contact: Patient Assistance Center

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

SAUK COUNTY

Certified Application Counselors Open to the General Public

✯ Reedsburg Area Medical Center

2000 N. Dewey Avenue, Reedsburg, WI 53959 | 608-524-6487

Contact: Jan Brown

- Tuesday - Thursday, 8 AM - 4:30 PM, Friday 8 AM - 12 PM
- Assistance provided in-person and over phone
- Call to schedule an appointment; walk-in accepted
- English, Language Line

MARKETPLACE

Public Benefits Only

Sauk County Department of Human Services

505 Broadway, Baraboo, WI 53913 | 1-888-794-5556

- Contact: Receptionist
- Monday – Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line

BADGERCARE+ | MA EBD | FS | CHILD CARE

Sauk County Public Health Department

505 Broadway, Suite 372, Baraboo, WI 53913 | 608-355-3290

- Monday - Friday, 8 AM – 12 PM
- Walk-in Only
- English

EE | PNCC | WWWP | WIC

SAWYER COUNTY

Certified Application Counselors Open to the General Public

✯ NorthLakes Community Clinic

Hayward Dental Clinic | 15910 W Company Lake Rd, Hayward, WI 54843 | 715-934-2224

Contact: Hilary Neste

- Tuesday 8:30 AM – 5 PM, extended hours available
- Call to schedule an appointment
- English
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | FS | SSI | SSDI

Hayward Clinic | 11128 N Hwy 77, Hayward, WI 54843 | 715-634-2541

Contact: Stacy Kolkind

- Monday - Friday, 8:30 AM – 5 PM, extended hours available
- Call to schedule an appointment
- English
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | FS | SSI | SSDI

Public Benefits Only

Sawyer County Public Health

10610 Main Street Suite 224, Hayward, WI 54843 | 715-638-3423

Contact: Eileen Simak

- Monday - Friday, 8 AM to 4 PM, Wednesday 8 AM to 7 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

FPOS | EE | PNCC | WWWP | WIC

Aging and Disability Resource Center – North Sawyer County Branch [Focusing on Sawyer and Price county residents with disabilities ages 18-59]

10610 Main St. Ste. 224 Hayward, WI 54843 | 866-663-3607 ext. 207

Contact: Lauri Perlick DBS

- Monday - Friday, 8 AM – 4 PM
- Appointment Only
- English

BADGERCARE+ | MA EBD | MEDICARE | SSI | SSDI

Senior Resource Center of Sawyer County

15856 E. 5th Street, Hayward, WI 54843 | 715-934-2177

Contact: Linda Hand, benspec@cheqnet.net

- Monday - Friday, 8 AM – 4 PM
- Call or e-mail to schedule an appointment
- English
- Self-help stations/computer lab available

MA EBD | MEDICARE | SSI | SSDI | FOODSHARE | HOMESTEAD CREDIT | SAFELINK | SOCIAL SECURITY

SHEBOYGAN COUNTY

Certified Application Counselors Open to the General Public

✯ Hospital Sisters Health Systems

St. Nicholas Hospital | 3100 Superior Avenue, Sheboygan, WI 53081 | 920-433-8122

OR 800-211-2209

- Monday - Friday, 8 AM to 4:30 PM
- Call to schedule an appointment
- English

MARKETPLACE

✯ Lakeshore Community Health Center

510 South 8th Street, Sheboygan, WI | 920-783-6633 x207

Contact: Jennifer Schmidt

- Monday – Friday, 9 AM - 5 PM
- Call to schedule an appointment; walk-in accepted if available
- English, Language Line

MARKETPLACE, BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | PNCC | CCC | WWWP | KATIE BECKETT | FS | CHILD CARE | SSI | SSDI | WIC

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

2108 Kohler Memorial Drive, Sheboygan, WI 53081 | 920-458-9401

Contact: Center Manager

- Monday 8 AM – 4 PM, Wednesday 10 AM – 6 PM, Thursday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

ST. CROIX COUNTY

Certified Application Counselors Open to the General Public

✯ St. Croix Regional Medical Center

St. Croix Fall Clinic | 216 S Adams Street, St. Croix Falls, WI 54024 | 715-483-3221

Contact: Patty Turner

- Monday – Friday 8 AM – 6 PM, Saturday 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

MARKETPLACE

Public Benefits Only (until marketplace certification can be obtained)

Baldwin Area Medical Center

730 10th Avenue, Baldwin, WI 54002 | 715-684-3311

Contact: Scheduling

- Monday - Friday, 8 AM to 4 PM
- Call to schedule an appointment
- English, Spanish, Language Line

Public Benefits Only

St Croix County DHHS – Economic Support Unit

1445 N Fourth Street, New Richmond WI 54017 | 715-246-8257

Contact: Scheduling

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, interpreters made available as needed, Language Line
- One self-help computer station available

BadgerCare+ | MA EBD | FPOS | CCC | Caretaker Supplement | Long Term Care Programs | FS | Child Care

St. Croix County Public Health

1445 N 4th Street, New Richmond, WI 54017 | 715-246-8365

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line
- Self-help stations/computer lab available

BadgerCare+ | FPOS | EE | PNCC | WWWP | WIC

TREMPEALEAU COUNTY

Certified Application Counselors Open to the General Public

✭ Trempealeau County Human Services

36245 Main St., Whitehall, WI | 715-538-2311 ext. 290

- Monday – Friday 8 AM – 4:30 PM
- Walk-ins welcomed, appointments recommended
- English

MARKETPLACE

VERNON COUNTY

Certified Application Counselors Open to the General Public

✭ St Joseph's Health Services [Gundersen St. Joseph's Hospital and Clinics]

400 Water Avenue, PO Box 400 Hillsboro, WI 54634 | 608-489-8198

Contact: Christine Dean

- Monday – Friday, 8 AM - 4:30
- Call to schedule an appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MEDICARE | FS | WIC

Public Benefits Only

Vernon County Department of Human Services

318 Fairlane Drive, Suite 100 Viroqua, WI 54665 | 608-637-5210

Contact: Public Benefits Worker

- Monday - Friday, 8:30 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, interpreter available, Language Line
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | CCC | FS | CC

VILAS COUNTY

Public Benefits Only

Vilas County Department of Social Services

330 Court Street, Eagle River, WI | 715 479-3668

Contact: Sandra Hulce

- Monday - Friday, 8 AM – 4 PM
- Call to schedule an appointment; walk-in accepted
- English, interpreters available, Language Line
- Self-help stations/computer lab available

BADGERCARE+ | MA EBD | MEDICARE | FS | CHILD CARE

WALWORTH COUNTY

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

312 S. 7th Street, Delavan, WI 53115 | 262-728-1849

Contact: Center Manager

- Monday 10 AM - PM, Tuesday 11 AM – 7 PM, Thursday 9 AM – 5 PM

• Call to schedule an appointment; walk-in accepted
• English, Spanish, Language Line
FPOS | EE

WASHBURN COUNTY

Certified Application Counselors Open to the General Public

✯ NorthLakes Community Clinic

Minong Clinic | 600 Shell Creek Rd, Minong, WI 54859 | 715-466-2201

Contact: Hilary Neste
• Monday, Wednesday - Friday 8:30 AM – 5 PM, extended hours available
• Call to schedule an appointment
• English
• Self-help station/computer lab available
MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | FPOS | EE | FS | SSI | SSDI

Public Benefits Only

Washburn County Health Department

222 Oak Street, Spooner, WI 54801 | 715-635-4400

Contact: Dianna Stumph
• Monday - Friday, 8 AM - 12 PM, 1 PM - 4:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line
• Self-help-station/computer lab available
BADGERCARE+ | FPOS | EE | CCC | WWWP | FS | CHILD CARE | WIC

Washburn County Human Services

110 4th Avenue | Shell Lake WI 54871 | 715-468-4747
• Monday – Friday, 9 AM - 4:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Language Line
• Self-help station/computer lab available
BADGERCARE + | MA EBD | FPOS | FS | CHILD CARE

WASHINGTON COUNTY

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

532 Shepherds Drive, West Bend, WI 53090 | 262-338-1303

Contact: Center Manager

- Monday 10 AM – 6 PM, Wednesday 8 AM – 4 PM, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

Washington County Human Services

333 E Washington Street, Suite 3100, West Bend, WI 53095 | 1-888-446-1239

- Monday – Friday, 8 AM - 4:30 PM
- Call to schedule an appointment
- English, Language Line
- Self-help stations/Computer lab available

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE

WAUKESHA COUNTY

Public Benefits Only (until marketplace certification can be obtained)

✯ Waukesha Community Health Center [via Sixteenth Street Community Health Center]

309 E. North Ave. Waukesha, WI 53188 | 262-408-2989

- Monday - Friday, 8:30 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

BADGERCARE+ | EE

Public Benefits Only

Catholic Charities

717 N East Avenue, Waukesha, WI 53186 | 262-547-2463

Contact: Nancy Munoz

- Monday - Friday, 8:30 AM – 5 PM
- Call to Schedule an Appointment
- English, Spanish, Hmong, Burmese

BADGERCARE+ | FS | WIC

Planned Parenthood of Wisconsin [Focus on existing patients]

426 W. Main Street, Waukesha, WI 53186 | 262-544-0708

Contact: Center Manager

- Monday 11 AM – 7 PM, Tuesday 11 AM – 7 PM, Wednesday 9 AM – 5 PM, Thursday 11 AM – 7 PM, Friday 9 AM – 5 PM, second and fourth Saturday 10 AM – 2 PM
- Call to schedule an appointment; walk-in accepted

• English, Spanish, Language Line

FPOS | EE

312 S. 7th Street, Delavan, WI 53115 | 262-728-1849

• Monday 10 AM - PM, Tuesday 11 AM – 7 PM, Thursday 9 AM – 5 PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish, Language Line

FPOS | EE

St. Joseph's Medical Clinic, Inc.

826 N. East Ave., Waukesha, WI 53186 | 262-544-6777

Contact: Peggy Brown

• Monday – Friday 9 AM – 3 PM, Monday and Thursday 5 PM – 7:30 PM
• Call to schedule an appointment; walk-in accepted
• English, Spanish

SSDI

Waukesha County Department of Health and Human Services

514 Riverview Ave., Waukesha, WI 53188 | 888-446-1239

• Monday - Friday, 8 AM - 4:30 PM
• Call to schedule an appointment
• English, Spanish, Language Line
• One Self-help station/computer available

BADGERCARE+ | FPOS | FS | CHILD CARE

Waukesha Family Practice Center

210 NW Barstow St. Waukesha, 53188 | 262-548-6903

Contact: Ana DeJesus

• Monday, Wednesday, Friday 8 AM – 5 PM Tuesday, Thursday 8 AM - 8:30 PM
• Call to schedule an appointment
• English, Spanish, Language Line

PNCC | WWWP

WAUSHARA COUNTY

Certified Application Counselors Open to the General Public

Family Health/La Clinica [La Clinica de los Campesinos]

400 South Townline Road | Wautoma, WI 54982 | 920-787-5514

Contact: Heather Abbott

- Monday – Friday, 8AM – 5PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish
- Self-help station/computer lab available

MARKETPLACE | BADGERCARE + | MA EBD | MEDICARE | FPOS | EE | WWP | KATIE BECKETT | FS | CHILD CARE | SSI | SSDI | WIC | ENERGY ASSISTANCE

WINNEBAGO COUNTY

Certified Application Counselors Open to the General Public

Mercy Medical Center [via Affinity Health System]

500 S. Oakwood Road, Oshkosh, WI 54904 | 920-223-2000, 920-223-0484 or 1-877-928-5678

Contact: Lynn Michler

- Monday – Friday, 8:00 AM to 4:00 PM
- Call to Schedule an Appointment
- English, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS | EE | WWWP

Public Benefits Only (until marketplace certification can be obtained)

Northeast Regional Center for Children & Youth with Special Health Care Needs

325 N. Commercial St, Ste. 400 Neenah, WI 54956 | 960-969-5325

- Call to schedule an appointment; walk-in accepted
- English, translation services, Language Line

BADGERCARE+ | MA EBD | KATIE BECKETT

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

378 S. Koeller Avenue, Oshkosh, WI 54902 | 920-235-0115

Contact: Center Manager

- Monday 10 AM – 6 PM, Wednesday 7 AM – 3 PM, Friday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

WOOD COUNTY

Certified Application Counselors Open to the General Public

✯ Family Health Center of Marshfield, Inc.

1307 N. St. Joseph Avenue Marshfield, WI 54449 | 800-942-5420

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Language Line

MARKETPLACE

✯ Marshfield Clinic

Marshfield Center | 1000 N Oak Ave., Marshfield, WI 54449 | 800-782-8581 ext. 94475

Contact: Patient Assistance Center

- Monday - Friday, 8 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | FPOS

Public Benefits Only

Planned Parenthood of Wisconsin [Focus on existing patients]

1355 8th Street South, Wisconsin Rapids, WI 54494 | 715-423-9610

Contact: Center Manager

- Monday 9 AM – 5 PM, Wednesday 12 PM – 6 PM, Thursday 9 AM – 5 PM
- Call to schedule an appointment; walk-in accepted
- English, Spanish, Language Line

FPOS | EE

Wood County Human Services Department

220 3rd Ave S, Suite 4, Wisconsin Rapids, WI 54495 | 888-794-5722

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line
- Self-help station/computer lab available

BADGERCARE+ | MA EBD | FPOS | FS | CHILD CARE | SSDI | WIC | CARETAKER SUPPLEMENT | ENERGY ASSISTANCE | FSET |

630 S Central, Suite 404, Marshfield, WI 54449 | 888-794-5722

- Monday - Friday, 8 AM - 4:30 PM
- Call to schedule an appointment; walk-in accepted
- English, Language Line

BadgerCare+ | MA EBD | FPOS | FS | Child Care | WIC | Caretaker Supplement | Energy Assistance | FSET

NAVIGATORS

Navigators are organizations that are trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These organizations are required to be unbiased and their services are free to consumers.

Northwest Wisconsin Concentrated Employment Program, Inc. (NWCEP)

Ashland Job Center | 422 3rd Street West, Suite 200 Ashland, WI 54806 | 715-682-9141

Contact: Marcia Pratt [mpratt@nwcep.org]

- Monday - Friday 8 AM – 4:30 PM
- Call to schedule an appointment
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Barron County Job Center | 331 S. Main Street, Rice Lake, WI 54868 | 715-234-6302

Contact: Janis Ogren [ogrenj@workforceresource.org]

- Monday – Friday 8 AM – 4:30 PM
- English, Somali, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Chippewa County Job Center | 770 Scheidler Road, Suite 2, Chippewa Falls, WI 54729 |715-723-2248

Contact: Sue Lane [lanesm@workforceresource.org]

- Monday – Friday 8 AM – 4:30 PM
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Clark County Job Center | 501 Hewett St., Neillsville, WI 54456 | 715-723-2248

Contact: Sue Lane [lanesm@workforceresource.org]

- Monday - Friday 8 AM – 4:30 P M
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Dunn County Job Center | 401 Technology Drive E., Suite 200, Menomonie, WI 54751 | 715-232-7360

Contact: Julie Bruggenthies [bruggenthiesj@workforceresource.org]

- Monday - Friday 8 AM – 4:30 PM
- English, Hmong, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Eau Claire County Job Center | 221 W. Madison Street, Suite 140-A, Eau Claire, WI 54703 | 715-723-2248

Contact: Sue Lane [lanesm@workforceresource.org]

- Monday - Friday 8 AM – 4:30 PM
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Park Falls Job Center | 400 South 4th Street, Park Falls, WI 54552 | 715-762-2477

Contact: Sandra Behling

- Monday – Friday 8 AM to 4 PM
- Call to schedule an appointment
- English

MARKETPLACE

Pepin County Job Center | 316 W. Madison Street, Durand, WI 54736-1141 | 715-232-7360

Contact: Julie Bruggenthies [bruggenthiesj@workforceresource.org]

- Monday - Friday 8 AM – 4:30 PM
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Polk County Job Center | 404 Main Street, Balsam Lake WI 54810 | 715-234-6302

Contact: Janis Ogren [ogrenj@workforceresource.org]

- Monday – Friday 8 AM – 4:30 PM
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Spooner Job Center | 522 Service Road, Spooner, WI 54801 | 715-635-2175

Contact: Tasha Hagberg

- Monday - Friday 8 AM – 4 PM
- Call to schedule an appointment
- English
- Self-help stations/computer lab available

MARKETPLACE

St. Croix Valley Job Center |186 County Road U, Suite 205, River Falls, WI 54022 | 715-232-7360

Contact: Julie Bruggenthies [bruggenthiesj@workforceresource.org]

- Monday - Friday 8 AM – 4:30 PM
- English, Spanish, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP

Wisconsin Job Center - LaCrosse |402 N. 8th Street, LaCrosse, WI | 608-789-5645

Contacts: Wanda Palmer/Kelly Norsten/Carmin Trillo

- Call to schedule an appointment
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP | BADGERCARE + | MA EBD | MEDICARE

Wisconsin Job Center - Park Falls | City Hall, 400 South 4th Street, Park Falls, WI 54882 | 715-762-2477

- Self-help station/computer lab available

MARKETPLACE

Wisconsin Job Center | 522 Service Road, Spooner, WI 54801 | 715-635-2175

- Self-help station/computer lab available

MARKETPLACE | SHOP

Wisconsin Job Center – Tomah | 120 E. Milwaukee Street, Tomah, WI | 608-789-5645

Contacts: Wanda Palmer/Kelly Norsten/Carmin Trillo

- Call to schedule an appointment
- English, Language Line
- Self-help station/computer lab available

MARKETPLACE | SHOP | BADGERCARE + | MA EBD | MEDICARE | FPOS

Gerald L. Ignace Indian Health Center

1711 S. 11th St. | Milwaukee, WI 53204 | 414-383-9526

Contact: Lana Schocko

- Monday - Thursday 8 AM - 5 PM, Friday 8 AM - 4 PM
- Call to schedule an appointment
- Self-help stations/computer lab available

MARKETPLACE | BADGERCARE + | MA EBD | EE | FS |

Legal Action of Wisconsin, Inc.

230 West Wells St. Room 800 | Milwaukee, WI 53202 | 414-274-3455

Contact: Matt Hayes

- Monday - Friday 8 AM – 5 PM
- Call to schedule an appointment
- English, Spanish, Language Line

MARKETPLACE | BADGERCARE+ | MA EBD | MEDICARE | WWWP | FS | SSI | SSDI |

Partners for Community Development, Inc.

1407 South 13th Street, Sheboygan, WI 53081 | 920-459-2780

Contact: Jose Araujo

- Monday - Friday 8 AM – 4:30 PM.
- Call to schedule an appointment
- English, Spanish, and Hmong

MARKETPLACE | BADGERCARE+ | MA EBD | FS | WIC | ENERGY ASSISTANCE

Additionally, the Black Health Coalition of Wisconsin and R&B Receivables have been awarded Navigator grants in Wisconsin. Their information will be added as we are able to secure it.

Additional Resources

www.healthcare.gov

• Health Insurance Marketplace enrollment site, live chat feature, FAQs, general information. Healthcare.gov is the best starting place for individuals seeking insurance.

1-800-318-2596 (voice) or 1-855-889-4325 (TTY)

• Ask questions or apply via phone at this toll-free call center number operated by the Health Insurance Marketplace

www.access.wi.gov

• Online application and eligibility tool for public benefits in Wisconsin. For all benefits except health insurance, Access is the best place to start.

MARCH 2014

MILWAUKEE ENROLLMENT DIRECTORY

DEVELOPED BY

MILWAUKEE HEALTH CARE

PARTNERSHIP

FOR

MKEN Milwaukee Enrollment Network

Connecting Milwaukee to Health Care Coverage

This directory was developed as a referral guide for IMPACT 2-1-1, human service agencies, community health workers and other stakeholders to help Milwaukee County residents secure enrollment assistance in public health benefits or private health insurance through the Marketplace. The directory is updated on a routine basis. Please check www.mkehcp.org or dial 2-1-1 for the most recent enrollment site information.

The Milwaukee Health Care Partnership joins Covering Kids & Families Wisconsin and the Wisconsin Department of Health Services as co-conveners of the Milwaukee Enrollment Network, a public/private consortium organized to support Milwaukee County residents in securing adequate and affordable health insurance.

We are very grateful to the members of the Milwaukee Health Care Partnership, the Greater Milwaukee Foundation, the United Way of Greater Milwaukee and Milwaukee County for their funding support of enrollment outreach and education resources.

covering kids & families wisconsin

Wisconsin Department of Health Services

GREATER MILWAUKEE FOUNDATION

United Way of Greater Milwaukee

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Glossary of Terms

BC+ BadgerCare Plus

CCC The Child Care Coordination

Child Care Wisconsin's Child Care Subsidy Program

EE BC+ Express Enrollment

FPOS BC+ Family Planning Only Services

FS FoodShare Wisconsin

Katie Beckett The Katie Beckett Program

MA EBD Medicaid for Elderly, Blind and Disabled

MAPP The Medicaid Purchase Plan

Medicare Medicare

PNCC Prenatal Care Coordination

SSDI Social Security Disability Insurance

SSI The Supplemental Security Income

WIC The Special Supplemental Nutrition Program for Women, Infants, and Children

WWWP Wisconsin Well Woman Program

Additional Resources

www.access.wi.gov

Online application and eligibility tool for public benefits in Wisconsin. For all benefits except health insurance, Access is the best place to start.

www.healthcare.gov

Health Insurance Marketplace enrollment site, live chat feature, FAQs, general information. Healthcare.gov is the best starting place for individuals seeking insurance.

1-800-318-2596 (voice) or 1-855-889-4325 (TTY)

Ask questions or apply via phone at this toll-free call center number operated by the Health Insurance Marketplace.

Wisconsin HMO Enrollment Program for BadgerCare and SSI Members

- 1-800-291-2002
- Monday – Friday 7:00 a.m. – 6:00 p.m.
- English, Spanish, Language Line

Qualified Insurance Agents

Individuals needing assistance with enrollment in private insurance via the Health Insurance Marketplace may also contact an insurance agent and broker. A listing of qualified agents can be found at *mkehcp.org/mken/enrollment-assistance-toolkit*

Navigators

Gerald L. Ignace Indian Health Center

Open to the general public

1711 S. 11th St., 53204 | 414-383-9526

Contact: Lana Schocko

- Call to schedule an appointment
- Monday – Thursday 8:00 – 5:00, Friday 8:00 – 11:00
- English

BC+ | EE | FS | Marketplace | MA EBD

Legal Action of Wisconsin, Inc

Senior LAW – Serving individuals age 60 or over in these counties: Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, Washington, Walworth

230 West Wells Street, Room 800, 53203 | 414-274-3455

Contact: Navigator

- Monday - Friday 8:00 - 5:00
- Call to schedule an appointment
- English, Spanish, Language Line

BC+ | FS | Marketplace | MA EBD | Medicare | SSDI | SSI | WWWP

Black Health Coalition of Wisconsin

Serving Milwaukee County residents

3020 W. Vliet Street, 53208 | 414-933-0064

Contact: Dr. Patricia McManus

- Call to schedule an appointment
- Monday – Friday 9:00 – 5:00
- English

BC+ | Marketplace

Certified Application Counselors (CACs)

Open to the General Public

Catholic Charities of the Archdiocese of Milwaukee

2021 N. 60th St., 53208 | 414-771-2881

Contact: Community Outreach Case Managers

- Call for appointment
- Monday – Friday 8:30-5:00
- English, Spanish, Hmong

BC+ | Child Care | FS | Katie Beckett | Marketplace | MA EBD | Medicare | SSDI | SSI

City of Milwaukee Health Department

Contact: Community Healthcare Access Program (CHAP)

Keenan Health Center | 3200 N. 36th St., 53216 | 414-286-8620

- Walk in
- Monday – Friday 8:00 – 4:00
- English, Language Line

Northwest Health Center | 7630 W. Mill Rd., 53218 | 414-286-8620

- Walk in
- Monday – Friday 8:00 – 4:00
- English, Language Line

Southside Health Center | 1639 S. 23rd St., 53204 | 414-286-8620

- Walk in
- Monday – Friday 8:00 – 4:00
- English, Spanish, Language Line

BC+ | Child Care | EE | FPOS | FS | Marketplace | MA EBD | PNCC | WIC | WWWP (Southside location only)

Milwaukee Central Library | 814 W. Wiscsonsin Avenue, 53233 | 414-286-8620

- Walk-in
- Wednesday 3:00 – 5:00
- English
- Self-help computer lab with on-site assistance

Marketplace Only

IMPACT

611 W. National Avenue, Suite 230, 53204 | 414-649-4380

- **Contact:** Patricia Gutierrez
- Monday - Friday 8:00 - 4:40
- Walk-in with limited appointments
- English, Spanish, Language Line

BC+ | Marketplace

M&S Clinical Services

2821 N. 4th Street Suite 516, 53212 | 414-263-6000 ext. 16

- Contact: Mark Fossie, President
- Monday - Friday 8:00 - 4:30
- Call to schedule appointment; walk-in accepted
- English, Spanish

AODA/Substance Abuse Screening Referral | BC+ | Marketplace | MA EBD | Medicare | PNCC

Milwaukee Enrollment Services (MilES)

Coggs Center | 1220 W. Vliet St., 53205 | 888-947-6583 (voice) • 711(TTY)

Contact: Milwaukee Enrollment Services

- Monday – Friday 7:30-5:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Hmong, and more, Language Line

UMOS | 2701 S. Chase Ave., 53207 | 888-947-6583 (voice) • 711(TTY)

Contact: Milwaukee Enrollment Services

- Monday – Friday 8:00-5:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Hmong, and more, Language Line

BC+ | Child Care | FPOS | FS | Marketplace | MA EBD

Milwaukee Health Services

MLK Heritage Health Center | 2555 N. Dr. Martin Luther King Jr. Dr., 53212 | 414-372-8080

Contact: Enrollment and Outreach Specialist, Social Services Case Manager

- Monday – Friday 8:00am – 5:00pm
- Call to schedule appointment; walk-in accepted
- English, Language Line

BC+ | Child Care | EE | FPOS | FS | Marketplace | MA EBD

Outreach Community Health Centers

210 W. Capitol Dr., 53212 | 414-727-6320

Contact: Melissa Lawson, Lead Certified Application Counselor

- Call to schedule an appointment; walk-in accepted
- Monday – Friday 8:00-4:30
- English, Spanish, Hmong (limited hours for Hmong), Language Line

BC+ | EE | FPOS | FS | Marketplace | MA EBD | Medicare | PNCC | SSDI | SSI

Progressive Community Health Centers

Lisbon Avenue Health Center | 3522 W. Lisbon Ave., 53208 | 935-8000

Contact: Tina Chang, Outreach & Enrollment Coordinator

- Call to schedule appointment
- Monday – Friday 8:00-4:00
- English, Hmong, Language Line

Hillside Family Health Center | 1452 N. 7th St., 2nd floor, 53205 | 935-8000

Contact: Tina Chang, Outreach & Enrollment Coordinator

- Call to schedule appointment
- Monday – Friday 8:00 – 4:00
- English, Hmong, Language Line

BC+ | Child Care | EE | FPOS | FS | Marketplace | MA EBD

Certified Application Counselors (CACs)

Serving Target Populations

Angel of Hope / WFMG Orchard Street Clinic

Serving only clinic patients and Hope House Residents

Angel of Hope Clinic – Hope House
209 W. Orchard Street, 2nd floor, Milwaukee, WI 53204 | 414-385-5394

Contact: Linda Flores

- Monday – Friday 830am – 4pm
- Call for appointment
- English, Spanish. Language Line

BC+ | EE | Marketplace | MA EBD

Aurora Health Care

Serving only Aurora Health Care patients

Aurora hospitals, clinics and pharmacies in Milwaukee County
Enrollment Help Line: 877-732-6334 (toll free)

- Operator will assist them in scheduling an in-person enrollment assistance appointment
- Individual and Group enrollment sessions available
- Monday – Friday 10:00 – 4:00 (with after hours message)
- English, Language Line

BC+ | EE | FPOS | FS | Marketplace | MA EBD | WWWP

AIDS Resource Center of Wisconsin (ARCW)

Serving only people with HIV/AIDS

820 N. Plankinton Ave., 53203 | 414-225-1509

Contact: Ask for Case Manager on duty

- Call for appointment; walk-in accepted
- Monday – Friday 9:00 – 5:00
- English, Spanish, Language Line

BC+ | FS | Marketplace | MA EBD | Medicare | SSDI | SSI

Bread of Healing Clinic

Serving only clinic patients

Bread of Healing Clinic - Cross Lutheran Church
1821 N. 16th Street, 53205 | 414-977-0001

Contact: Barbara A. Horner-Ibler, MD. Medical Director

- Monday - Friday, 9:00 – 5:00
- Call for appointment; walk-in accepted
- English

Bread of Healing Clinic - Florist Ave Lutheran Church
4975 N. 40th St., 53209 | 414-466-3169

Contact: Barbara A. Horner-Ibler, MD. Medical Director

- Mondays 12:00 – 8:00, Wednesdays 1:30 – 8:00
- Call for appointment; walk-in accepted
- English

Bread of Healing Clinic - Eastbrook Church
5385 N. Green Bay Road, 53209 | 414-228-5220 Ext. 107

Contact: Barbara A. Horner-Ibler, MD. Medical Director

- Mondays 1:00 – 5:00, Thursdays 9:00 – 4:00
- Call for appointment; walk-in accepted
- English

BC+ | FS | Marketplace

Columbia St. Mary's

Serving only Columbia St. Mary's patients

Call the following number for an appointment at any of the following locations: 414-267-6570.

Contact: Certified Application Counselor

- By appointment only
- English and language line

Columbia St. Mary's – Milwaukee | 2301 N. Lake Dr., 53202
Monday, Tuesday and Friday 8:30 – 5:00

Prospect Medical Commons | 2311 N. Prospect Ave., 53202
Monday and Tuesday 9:00 – 5:30; Wednesday and Thursday 8:30 – 5:00

Heritage Center | 2320 N. Lake Dr. 53202
Monday 2:00 – 5:00; Friday 9:00 – 5:00

Family Health Center | 1121 E. North Ave
Tuesday, Wednesday and Friday: 8:30 – 12:30

This listing is continued on the next page

Ebenezer Church of God in Christ | 3132 N. Martin Luther King Dr. 53212

Thursday 9:00 – 5:00

Grafton Clinic | 2061 Cheyenne Ct., 53024

Wednesday 9:00 – 5:30

Glendale Clinic – Green Bay Rd. | 9233 N. Green Bay Rd., 53209

Thursday 9:00 – 5:30

Gateway Clinic | 801 S. 70th St., 53214

Friday 9:00 – 5:30

Marketplace

Diverse and Resilient

Serving only LGBT people

2439 N. Holton St., 53212 | 414-390-0444

Contact: Erin Moore or Anthony Harris

- Monday-Friday, 9:00 – 5:00
- Call for appointment; walk-in accepted
- English

Marketplace

Free & Community Clinic Collaborative (FC3)

Serving only FC3 clinic patients

Cross Lutheran Church, 1821 N. 16th St., 53205 | 414-465-8026

Contact: Erin Cohn

- Call to schedule an appointment
- Monday – Friday 9:00-4:00
- English

BC+ | FS | FPOS | Marketplace | MA EBD

Froedtert Hospital & Medical College of Wisconsin

Serving only Froedtert and Medical College patients

Froedtert Hospital | 9200 W. Wisconsin Ave., 53226 | 414-805-6206

Contact: Financial Counselor

- 7:00 - 4:30
- Call to schedule an appointment
- English, Spanish, Hmong, Russian, Language Line

Specialty Clinics Building, 1st Floor, Suite 1996 | 9200 W Wisconsin Ave., 53226 | 414-805-6206

Contact: Financial Counselor

- Monday – Friday 7:00 - 4:30
- Call for appointment; walk-in accepted
- English, Spanish

Froedtert Hospital, 2nd Floor | 9200 W Wisconsin Ave., 53226 | 414-805-6206

Contact: Financial Counselor

- Monday – Friday 8:15 - 4:45
- Call for appointment; walk-in accepted
- English, Spanish

Clinical Cancer Center | 9200 W Wisconsin Ave., 53226 | 414-805-6206

Contact: Financial Counselor

- 7:30 - 4:00
- Call for appointment; walk-in accepted
- English, Spanish

BC+ | EE | FPOS | FS | Marketplace | MA EBD | PNCC

Genesis Behavioral Services

Serving only clinic patients

Milwaukee Outpatient Clinic | 230 W. Wells Street, #312, 53203 | 414-344-3406

- **Contact:** Jennifer Lehnerz
- Monday - Friday 8:00 – 4:30
- Call for appointment
- English, Language Line

BC+ | FS | Marketplace

Milwaukee County Behavioral Health Division

Serving individuals with either a mental health or substance use disorder

Milwaukee County Behavioral Health Division | 9201 W. Watertown Plank Road, 53226 | 414-257-8085

- **Contact:** Janet Fleege
- Monday - Friday 8:00 - 4:30
- Call for appointment
- English, Language Line

BC+ | Child Care | Marketplace | MA EBD

Sixteenth Street Community Health Center

Serving established patients, with priority for those at or below 200% FPL, in zip codes: 53204, 53207, and 53215

Chavez Health Center | 1032 S. Cesar E. Chavez Dr. (16th St.), 53204 | 414-385-3363

Contact: Social Services Staff

- Call to schedule appointment
- Monday – Friday 8:00-5:00
- English, Spanish, Language Line

Parkway Health Center | 2906 S. 20th St., 53215 | 414-385-6274

Contact: Social Services Staff

- Call to schedule appointment
- Monday – Friday 8:00-5:00
- English, Spanish, Language Line

BC+ | EE | FS | Marketplace | TB Medicaid for patients only | WIC

Wheaton Franciscan HealthCare

Serving only Wheaton Franciscan patients

St. Joseph Hospital | 5000 W Chambers, 53210 | 866-972-4687

Contact: Financial Counselor

- Appointment preferable
- Monday – Friday 8:00-4:00
- English, Language Line

BC+ | EE | Marketplace | MA EBD | PNCC | SSDI

This listing is continued on the next page

Wheaton Franciscan Medical Group | 201 N. Mayfair Rd., Suite 200, 53226 | 866-972-4687

Contact: Financial Counselor

- 8:00 - 4:30
- Call for appointment; walk-in accepted
- English, Language Line

BC+ | EE | Marketplace | MA EBD | PNCC | SSDI

St Francis Hospital | 3237 S 16th Street, 53215 | 866-972-4687

Contact: Financial Counselor

- Monday – Friday 8:00 – 5:30
- Call for appointment; walk-in accepted
- English, Spanish, Language Line

BC+ | EE | Marketplace | MA EBD

Franklin/Midwest Orthopedic Specialty Hospital | 10101 S 27th Street, 53132 | 866-972-4687

Contact: Financial Counselor

- Monday – Friday 8:00 – 4:30
- Call for appointment; walk-in accepted
- English, Language Line

BC+ | EE | Marketplace | MA EBD

Wheaton Franciscan Medical Group - Metro | 2745 W Layton Ave., 53221 | 866-972-4687

Contact: Financial Counselor

- Monday – Friday 8:00 – 4:30
- Call for appointment; walk-in accepted
- English, Language Line

BC+ | EE | Marketplace | MA EBD

Winged Victory Project

Serving only Milwaukee County Behavioral Health (BHD) and Medical College of Wisconsin Tosa Clinic CCAPS patients; and BHD Community Support Program and TLS Behavioral Health clients.

Milwaukee County Behavioral Health Division | 9455 Watertown Plank Rd., 53226 | 414-257-4854

Contact: Julie Abramowski, Director, Winged Victory Project

- Call to schedule an appointment
- Requires a referral from BHD staff
- Monday – Friday 7:30-5:00
- English, Language Line

This listing is continued on the next page

MCW Campus Clinic Tosa (CCAPS) Center | 1155 N Mayfair Road; 3rd Floor, 53226 | 414-955-8917

Contact: Deanna Kloster, Benefits Specialist

- Monday – Friday, 8:00 - 4:30
- Call for appointment; walk-in accepted – with referral from CCAPS staff
- English, Language Line

MCFI - TLS Behavioral Health | 1040 S 70th Street, 53214 | 414-476-9675

Contact: Elizabeth Callahan

- Mondays & Wednesdays, 6:30 - 2:30
- Call for appointment; walk-in accepted – with referral from TLS staff
- English, Language Line

BC+ | FPOS | FS | Marketplace | MA EBD | Medicare | SSDI | SSI

Wisconsin Community Services (WCS)

Serving WCS clients, individuals with Occurring Disorders (Mental Health & Substance Abuse) and those involved with the Criminal Justice/Department of Corrections.

3732 W. Wisconsin Avenue, Suite 310, 53208 | 414-343-3569

Contact: Pauita Payton-Murphy, Program Director

- Wednesdays & Thursdays, 12:30 - 4:30
- Appointment
- English, Spanish

BC+ | FS | Marketplace

Wisconsin Jobs Now (WJN)

WJN works in low-income areas in central city Milwaukee, including zip codes: 53205,53206, 53204, 53212, 53213, 53233, 53208.

1862 West Fond du Lac Ave., 53205 | 414-395-5422

Contact: Karen Royster, Special Projects Coordinator

- Monday – Saturday 8:30 – 5:30
- Appointment or during scheduled group enrollment events
- English, Spanish

BC+ | Marketplace | SSI

Public Benefits Only

Open to the General Public

Aging Resource Center of Milwaukee County

Serving those who are age 60 years or older

Coggs Center | 1220 W Vliet Street, Suite 300, 53205 | 414-289-6874

Contact: Information and Assistance Call Center

- Monday – Friday, 7:00 - 5:30 pm
- Walk-in
- English, Spanish, Language Line

MA EBD applications for publicly-funded Long Term Care | SSI-E

Children's Hospital of Wisconsin

Children's Hospital | 9000 W. Wisconsin Ave., 53226 | 414-266-2588

Contact: Financial Counselor

- Monday – Friday 8:30-4:30
- Call for appointment
- English, Spanish, Language Line

Daniel M. Soref Family Resource Center | 9000 W. Wisconsin, 1st floor, 53226 | 414-266-3189

Contact: Brad Holman

- Walk in or referral from social workers
- Monday – Friday 9:00-5:00
- English, Language Line

BC+ | Child Care | EE | FS | Katie Beckett

Disability Resource Center of Milwaukee County

Serving residents ages 18-59 with a disability

Coggs Center | 1220 W. Vliet St., Suite 300, 53205 | 414-289-6660

Contact: Disability Benefit Specialist

- Call to schedule appointment; walk-in accepted
- Monday – Friday 8:00-4:30
- English, Language Line

MA EBD | SSI | SSDI

Hunger Task Force

Coggs Self-Service Center | 1220 W. Vliet St., 53205 | 414-588-7534

Contact: Erik Acevedo, ACCESS Project Manager

- Walk in for assistance
- Monday – Friday 8:00-5:00
- English, Spanish, Hmong, Burmese, Language Line

Independence First Self Service Center | 540 South First Street, 53204 | 414-588-7534

Contact: Peter Adamczak, EBD Benefit Specialist

- 8:00 - 4:30
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

Northwest Job Center | 6550 N. 76th Street, 53223 | 414-588-7534

Contact: Erik Acevedo, ACCESS Project Manager

- Walk in for assistance
- Monday – Friday 8:30-5:00
- English, Language Line

Robles Self Service Center | 910 W. Mitchell, 53204 | 414-384-6453

Contact: Erik Acevedo, ACCESS Project Manager

- Walk in for assistance
- Monday – Friday 8:00-4:30
- English, Spanish, Hmong, Burmese, Language Line

UMOS Self Service Center | 2701 S. Chase Ave., 53207 | 414-588-7534

Contact: Erik Acevedo, ACCESS Project Manager

- Walk in for assistance
- Monday – Friday 8:30-5:00
- English, Spanish, Burmese, Language Line

BC+ | Child Care | FS | MA EBD

Milwaukee Health Services

Isaac Coggs Heritage Health Center | 8200 W. Silver Spring Dr., 53218 | 414-760-3900

Contact: Benefits Coordinator

- Monday - Friday 8:00 - 4:30
- Call to schedule appointment; walk-in accepted
- English, Language Line

BC+ | Child Care | EE | FPOS | FS | MA EBD

Riverworks

526 E. Concordia Ave., 53212 | 414-906-9650

Contact: Financial Opportunity Center Program Assistant

- Call to schedule an appointment
- Monday – Thursday, 9:00-2:00
- English

BC+ | Child Care | FPOS | FS

Public Benefits Only

Serving Target Populations

The Cathedral Center, Inc.

Serving single women and families with children who are eligible for homeless services and referred by 211

845 N. Van Buren Street, 53202 | 414-831-0394, ext. 2153

Contact: Kristen Halula

- Monday – Friday, 9:00 – 4:00
- Call to schedule appointment
- English, Spanish, Language Line

BC+ | FS | Child Care

Columbia St. Mary's

Serving only Columbia St. Mary's patients

Columbia-St. Mary's Hospital | 2301 N. Lake Dr., 53202 | 414-291-1097, 414-291-1098 (ED)

Contact: Financial Counselor

- Monday – Friday 8:30 – 7:00; ED 9:00 – 5:30
- Call to schedule appointment
- English, Language Line

Prospect Medical Commons | 2311 N. Prospect Ave., 53202 | 414-319-3000

Contact: Financial Counselor

- Monday – Thursday 8:30 – 4:00; Friday 7:30 – Noon
- Call to schedule appointment
- English, Language Line

Gateway Medical Clinic | 801 S. 70th St., 53214 | 414-773-6600

Contact: Financial Counselor

- Thursday 10:00 – 3:00
- Call to schedule appointment
- English, Language Line

Water Tower Medical Commons | 2350 N. Lake Drive, 53202 | 414-291-1538

Contact: Financial Counselor

- Monday – Friday 8:00 – 4:30
- Call to schedule appointment
- English, Language Line

BC+ | MA EBD | Medicare | WWWP

Disability Rights Wisconsin

Serving EBD Medicaid recipients enrolled in the SSI-related Medicaid HMOs, and Medicare recipients under the age of 60 with Medicare Part D enrollment

6747 W. Washington St., Suite 3230, 53214 | 414-773-4646

Contact: Julie Dixon-Seidl, SSI Managed Care External Advocacy Project Coordinator
Ginger Rogers, Disability Drug Benefit Helpline Project Coordinator

- Monday – Friday, 9:00 – 5:00
- Call to schedule appointment; walk-in accepted
- English, Language Line

MA EBD | Medicare | Medicare Part D plan enrollment

The Guest House of Milwaukee, Inc.

Serving clients who are either currently housed in shelter, utilizing our clinic or residing in a permanent housing program

1216 N. 13th Street, 53205 | 414-345-3240

- Call to schedule appointment
- English

BC+ | FS | Medicare

Planned Parenthood of Wisconsin

Serving Planned Parenthood patients

Capitol Drive Health Center | 801 East Capitol Drive, 53212 | 414-967-4945

Contact: Center Manager

- Monday & Thursday 11:00 – 7:00; Wednesday & Friday 9:00 – 5:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

Jackson Street Health Center | 302 N Jackson St., 53202 | 414-276-8777

Contact: Center Manager

- Monday – Friday 8:30-4:30
- Call to schedule appointment, abortion services only
- English, Spanish, Language Line

Northwest Health Center | 5380 W Fond du Lac Avenue, 53216 | 414-536-6690

Contact: Center Manager

- Monday 11:00 – 7:00; Tuesday 10:00 – 6:00; Wednesday 11:00 – 5:00; Friday 9:00 – 5:00; Saturday 10:00 – 2:00
- CAC outstation hours: Monday 11:00 – 3:00; Tuesday 10:00 – 6:00; Friday 9:00 – 1:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

This listing is continued on the next page

Wisconsin Avenue Health Center | 2207 W. Wisconsin Ave., 53233 | 414-931-8181

Contact: Center Manager

- Monday & Tuesday 11:00 – 7:00; Wednesday 11:00 – 5:00; Thursday & Friday 9:00 – 5:00; Saturday 10:00 – 2:00
- CAC outstation hours: Monday 11:00 – 6:00; Tuesday 11:00 – 7:00; Friday 9:00 – 5:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

Mitchell Street Health Center | 1710 S. 7th St. Suite 300, 53204 | 414-645-8383

Contact: Center Manager

- Monday & Friday 9:00 – 5:00; Tuesday & Thursday 11:00 – 7:00; Wednesday 11:00 – 5:00; Saturday 9:00 – 3:00
- CAC outstation hours: Monday 9:00 – 5:00; Tuesday 11:00 – 7:00; Friday 9:00 – 5:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

Lincoln Plaza Health Center | 2239 S 108th Street, 53227 | 414-541-2772

Contact: Center Manager

- Monday & Thursday 11:00 – 7:00; Tuesday & Friday 9:00 – 5:00; Wednesday 12:00 – 5:00; Saturday 10:00 – 2:00
- Call to schedule appointment; walk-in accepted
- English, Spanish, Language Line

Health Center Services: EE | FPOS

CAC Outstation Services: BC+ | Child Care | FS | Marketplace | MA EBD

The Salvation Army Emergency Lodge

Serving those who are homeless

1730 North 7th Street, 53205 | 414-265-6360

Contact: Nancy Szudzik, Shelter Director

- Monday – Friday 8:30 – 12:30
- Call to schedule appointment
- English, Spanish

BC+ | FS

St. Ben's Clinic

Serving only clinic patients

1027 N. 9th St., 53233 | 414-765-0606

Contact: Bill Mullooly, Social Worker

- Call to schedule an appointment
- Monday, Wednesday, Thursday 9:00-3:00
- English, Language Line

BC+

West Allis Health Department

Serving only residents of West Allis or West Milwaukee

7120 W. National Ave., 53214 | 414-302-8600

- Monday – Friday 8:00-5:00
- Call to schedule appointment
- English, Language Line

BC+ | CCC | EE | PNCC | WIC | WWWP

Date: September 24, 2013
For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Janesville Affordable Care Act Town Hall Meeting

Madison, WI—The Wisconsin Office of the Commissioner of Insurance and the Department of Health Services will be hosting town hall meetings on the Affordable Care Act September 25 through October 3 throughout the state of Wisconsin.

A town hall meeting is scheduled in Janesville on Thursday, September 26, 2013. The meeting will be from 4:30 p.m. to 6:00 p.m. and will be held at UW-Rock County, 2909 Kellogg Avenue, Janesville, Wisconsin. The event will be in Allen Hall, Room AH106. This event is open to consumers, the general public and to press.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

Last Updated: September 24, 2013

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Date: August 27, 2013
For more information contact: J.P. Wieske, Public Information Officer, (608) 266-2493 or jp.wieske@wisconsin.gov

Office of the Commissioner of Insurance
Holding Statewide Federal Health Care Sessions for Consumers

Madison, WI—The Office of the Commissioner of Insurance (OCI) has long been committed to public education and serving as a resource for individuals, families and employers across the state. The agency has a responsibility to ensure consumers of health insurance are aware of state and federal laws that may impact them.

Many key provisions of the Patient Protection and Affordable Care Act (PPACA) become effective January 1, 2014, including the federal exchange which, according to the federal Department of Health and Human Services, will be available for enrollment beginning October 1 of this year.

As with any new law, there is always a certain level of confusion. While this is a federal law, it is OCI's role to protect and educate consumers about their responsibilities and how they may be impacted.

In an effort to provide a forum for citizens to gather unbiased information about PPACA, OCI and DHS are holding informational sessions across the state in the form of town hall meetings. These 90-minute meetings will be open to anyone who has an interest in learning more about PPACA.

Staff will be available to provide information highlighting the most important issues people should be aware of. They will also be available to answer questions. These meetings are informal and will be guided by the issues the people in attendance bring to the table.

Tuesday, September 3, 2013	Rhinelander, WI Oneida County Sheriff's Department Training Center 2000 East Winnebago Street 10:30 a.m. - 12:00 p.m.
Tuesday, September 3, 2013	Wausau, WI North Central Technical College 1000 West Campus Drive 3:00 p.m. - 4:30 p.m.
Tuesday, September 3, 2013	Eau Claire, WI LE Phillips Memorial Library 400 Eau Claire Street 10:00 a.m. - 11:30 a.m.
Tuesday, September 3, 2013	La Crosse, WI La Crosse Public Library 800 Main Street

	3:00 p.m. - 4:30 p.m.
Wednesday, September 4, 2013	West Allis, WI West Allis Public Library 7421 W. National Avenue 11:00 a.m. - 12:30 p.m.
Wednesday, September 4, 2013	Pewaukee, WI Pewaukee Public Library 210 Main Street 2:00 p.m. - 3:30 p.m.
Thursday, September 5, 2013	Kenosha, WI Kenosha Public Library 7979 39th Avenue 10:00 a.m. - 11:30 a.m.
Thursday, September 5, 2013	Green Bay, WI Northeastern Technical College 2740 West Mason Street 10:00 a.m. - 11:30 a.m.
Thursday, September 5, 2013	Appleton, WI Appleton Public Library 225 N. Oneida Street 2:00 p.m. - 3:30 p.m.
Friday, September 6, 2013	Madison, WI American Family Insurance Training Center 6000 American Family Drive 2:00 p.m. - 3:30 p.m.
Friday, September 6, 2013	Cleveland, WI Lakeshore Technical College Lake Michigan Conference Room 1290 North Avenue 3:00 p.m. - 4:30 p.m.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

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Milwaukee Affordable Care Act Town Hall Meetings

Madison, WI—The Wisconsin Office of the Commissioner of Insurance and the Department of Health Services will be hosting town hall meetings on the Affordable Care Act September 25 through October 3 throughout the state of Wisconsin.

Two town hall meetings have been scheduled in Milwaukee on Wednesday, September 25, 2013. The first town hall meeting will be from 2:30 p.m. to 4:00 p.m. and the second meeting will be from 5:30 p.m. to 7:00 p.m. The meetings will be held at the Milwaukee Area Technical College Auditorium, 1015 North 6th Street, Milwaukee, Wisconsin, in the Cooley Auditorium. The auditorium is located on the second floor of the main building. This event is open to the general public and to press.

Created by the Legislature in 1871, Wisconsin's Office of the Commissioner of Insurance (OCI) was vested with broad powers to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens. Today, OCI's mission is to lead the way in informing and protecting the public and responding to its insurance needs.

Last Updated: September 24, 2013

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Patient Protection and Affordable Care Act (PPACA)

Wisconsin Office of the Commissioner of Insurance
Wisconsin Department of Health Services
September 2013

What PPACA market reforms are in place today?

2010 PPACA Insurance Market Reforms

Effective September 23, 2010

- No lifetime dollar limits on coverage/limitations on annual dollar limits
- Dependent coverage to age 26
  - WI law in place prior to PPACA
- Coverage of preventive services without cost sharing
  - Most WI insurers had in place prior to PPACA
- Insurers are limited in the amount of administrative expenses they can fund with premium dollars
- No preexisting condition exclusions for children under age 19

What PPACA health insurance market reforms are coming in 2014?

2014 PPACA Market Reforms (Effective January 1st)

Guaranteed Issue

- Insurers must sell a health insurance policy to any person who applies for coverage except in cases of fraud.
- Individuals cannot be denied a policy due to a preexisting health condition.
- Insurers cannot exclude or limit coverage for a preexisting condition.
- The Health Insurance Risk-Sharing Plan (HIRSP) currently provides coverage to individuals who cannot obtain health insurance.
- HIRSP ends December 31, 2013, because all consumers, regardless of their health, have access to coverage in the private market.

2014 PPACA Market Reforms (Effective January 1st)

Individual and small group plans must cover essential health benefits (EHBs).

Ambulatory patient services	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Maternity and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services, including behavioral health treatment	Pediatric services, including oral and vision care

2014 PPACA Market Reforms (Effective January 1st)

Insurers in the individual and small group markets may only take the following into account when pricing their products:

- Individual or family coverage;
- The area of the state the policy is sold;
- Age; and
- Tobacco Use

2014 PPACA Market Reforms (Effective January 1st)

Limited Access to Catastrophic Plans

- What is catastrophic coverage?
  - Plans with high deductibles and lower premiums.
  - Includes coverage of 3 primary care visits and preventive services with no out-of-pocket costs.

- Who is eligible?
  - Young adults under 30 years of age.
  - Those who obtain a hardship waiver from the federal exchange.

2014 PPACA Market Reforms (Effective January 1st)

Individual and small group plans will be categorized into 1 of 4 different metal tiers.

The tiers represent the average portion of expected costs a plan will cover for an average population.

Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

2014 PPACA Market Reforms (Effective January 1st)

All plans will limit in-network, out-of-pocket expenses to $6,350 for self only coverage and $12,700 for family coverage.

- Out-of-network services do not count toward these limits.
- For 2014, out-of-pocket expenses tied to prescription drugs will not count toward these out-of-pocket maximums if the prescription drug plan is separate from the medical plan.

2014 PPACA Market Reforms (Effective January 1st)

Generally, plans in the small group market cannot have deductibles that exceed $2,000 for individual coverage or $4,000 for family coverage.

- A small group plan may exceed those limits if, for example, an employer's contribution to a health savings account is available to offset increases in excess of the $2,000/$4,000 limits.

What are the impacts of these changes on plans and consumers?

Impact of 2014 Market Reforms

Health insurance premiums will increase, on average, for the majority of people.

Many consumers in the individual market will be required to “buy up.”

Younger, healthier people will pay more and older individuals with greater health care needs will pay less.

Impact of 2014 Market Reforms

Few opportunities for consumers to keep their current health insurance plans.

- Insurers selling in certain areas of the state today will change their service areas in 2014, meaning their plans will not be available in the same areas of the state as they are today.

Impact of 2014 Market Reforms

Most consumers in the individual market will have one opportunity a year to purchase coverage, unless a special enrollment period is triggered.

- The initial open enrollment period begins on October 1, 2013, and ends March 31, 2014.
- Open enrollment is defined as the time when you can sign up for coverage, not when it is effective.
- If you want coverage effective on January 1, 2014, you must purchase health insurance by December 15, 2013.
- If you wait until you are sick to purchase coverage and the open enrollment period has ended, you will not be able to purchase a plan until open enrollment in the fall.

Impact of 2014 Market Reforms

Employers continue to be able to purchase health insurance at anytime during the year.

- Employers unable to meet contribution or participation requirements may need to wait to purchase coverage until a special enrollment period is available from November 15th through December 15th.

Is there a requirement to purchase health insurance?

Individual Mandate

Beginning January 1, 2014, federal law requires most individuals to have health insurance or pay a penalty.

- Those who do not have health insurance coverage, or fit within an exemption, will pay a federal tax penalty beginning in 2014.

Individual Mandate: Penalties

Year	Penalty
2014	Greater of $95 per adult, or 1% of taxable income.
2015	Greater of $325 per adult, or 2% of taxable income.
2016	Greater of $695 per adult, or 2.5% of taxable income.
Post 2016	Penalty increases annually based on a cost-of-living adjustment.

Are employers required to offer health insurance to their employees?

Employers: Offering Coverage to Full-Time Employees

If an employer offers coverage to its full-time employees, it must offer coverage to employees working at least 30 hours per week or face a penalty of $100 per day per member.

Employers: Fewer than 50 Employees

Employers with <u>fewer</u> than 50 full-time equivalent employees are <u>not</u> required to offer health insurance coverage to their employees.

Employer Shared Responsibility Mandate: Delayed

PPACA creates Employer Shared Responsibility requirements effective January 1, 2014.

The federal government delayed the requirements and associated penalties, without statutory authority, until 2015.

Employers: Shared Responsibility Mandate

In 2015, federal law requires employers with 50 or more employees who work the equivalent of 30 or more hours per week to offer affordable health insurance.

Penalty:

- Employers who do not offer their employees health insurance coverage face a penalty of $2,000 per employee (the employer can exempt the first 30 employees).

Employers Shared Responsibility Mandate

In 2015, employers with 50 or more employees who offer coverage to their employees must offer affordable coverage.

Penalty:

- Employers offering coverage that is not affordable face a penalty of $3,000 for each employee accessing subsidized coverage through the exchange.
- The total penalty for not offering affordable coverage cannot exceed the penalty for not offering insurance coverage at all.

Is there a notice employers are required to send employees about PPACA?

Employer Notice

Federal law requires all employers subject to the Fair Labor Standards Act to provide a notice to employees about PPACA by October 1, 2013.

The federal Department of Labor has released model notices on their Web site.
http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

What is the federal exchange?

Federal Exchange: A Web site

The federal exchange is a federal Web site that will allow consumers to:

- Check their eligibility for government assistance programs, including subsidies and premium tax credits available to help pay for private health insurance;
- Compare individual and small group health insurance plans; and
- Link consumers to insurers for the purchase of health insurance after they choose a plan they are interested in

The initial and annual enrollment periods are the same for the federal exchange as they are for the outside market (off exchange).

Federal Exchange: On vs. Off Exchange

Throughout this presentation, reference to "on exchange" means plans available for purchase through the federal exchange.

Reference to "off exchange" refers to the private health insurance market offering plans outside of the federal exchange that individuals or employers can purchase.

Federal Exchange: Not the Only Place to Purchase Coverage

Consumers have the right to purchase coverage either on exchange or from the market outside of the exchange (off exchange).

There are no penalties tied to where coverage is purchased.

Consumers are encouraged to research options off the exchange before committing to a purchase on the exchange.

What is the federal Health Insurance Premium Tax Credit?

Federal Health Insurance Premium Tax Credit (PTC)

The PTC is a public assistance provision in the law that artificially reduces the actual premium charged by insurers.

It does not reduce the premium. Rather, through tax dollars, it provides public assistance to offset the premium you will pay.

Eligibility:

- Income between 100% and 400% of the Federal Poverty Level (FPL)
  - $23,550 – $94,200 for a family of four in 2013.
- Must purchase a Qualified Health Plan (QHP) on the exchange.
  - All plans offered on the exchange are QHPs.
- Must be ineligible for government-sponsored coverage or affordable employer-sponsored insurance.

Federal Health Insurance Premium Tax Credits (PTC)

The PTC can be taken in advance or in the form of a refund at the end of the year.

If taking the tax credit in advance, there is a risk of having to re-pay any overpayments made to you.

Federal Health Insurance Premium Tax Credits (PTC)

Advanced PTC Example:

Monthly Premium	$300
Monthly Tax Credit	-240
New Monthly Cost	$ 60

Refundable PTC Example:

Yearly Tax Credit	$2,880 (*240 a month x 12)*
Tax Due	- 900
IRS Refund	$1,980

What are federal Cost-Sharing Subsidies?

Federal Cost-Sharing Subsidies

Federal Cost-Sharing Subsidies are a form of public assistance that artificially reduce the actual cost-sharing charged by insurers.

The subsidies do not reduce the out-of-pocket expenses required by the plan. Rather, through tax dollars, they provide public assistance to offset your out-of-pocket expenses, such as deductibles, copays and coinsurance.

Eligibility:

- Individuals must have income below 250% FPL; and
- Must purchase a silver level plan on exchange.

What is the SHOP?

SHOP: Web site

Like the federal exchange available to individuals, the Small Business Health Options Program (SHOP) is a federal Web site that will allow employers and employees to compare health insurance plans.

- Employers with between 2 and 50 full-time employees are eligible to purchase coverage on the SHOP.

SHOP

Nothing requires employers to purchase coverage on the SHOP and insurers are not required to sell on the SHOP.

Employers should compare plans on and off the SHOP.

Insurers must charge the same for similar plans whether they are sold on or off the SHOP.

SHOP: Employer Choice

Employer Choice:

- In 2014, a small employer choosing to purchase coverage on the SHOP will compare plans and choose a plan that meets their needs.
- The small employer will offer the plan to its employees, like it does today.

SHOP: Employee Choice Delayed

Employee Choice:

- PPACA requires an employee choice option for 2014, but the federal government has delayed its availability until 2015.
- Employee choice allows employees to compare and select a plan in the metal tier authorized by their employer.

SHOP: Participation Rate/Definition of Small Employer

Employers interested in purchasing coverage on the SHOP will need to meet a 70% participation rate.

In 2016, the definition of small employer includes employers with over 50 employees but fewer than 100.

Are the Small Business Health Care Tax Credits still available?

Small Business Tax Credit

Beginning in 2014, the small business health care tax credit available today is limited to employers purchasing coverage on the SHOP.

In 2014, the tax credit will increase from a maximum of 35% of an employer's qualified health expenses to a maximum of 50%.

- Employers with under 10 employees making less than $25,000 a year will reap most of the benefit from these tax credits.
- Employers are only eligible for the tax credit for 2 years.

Small Business Tax Credit

To qualify:

- The employer must have fewer than 25 full-time employees;
- The average annual wages of employees must be less than $50,000; and
- The employer must pay at least half of the insurance premiums.

What are Navigators and Certified Application Counselors?

Navigators

Navigators:

- Are funded by the federal government to help individuals apply for public assistance programs and compare health insurance plans sold on the exchange.
- They will also conduct consumer education and outreach activities.

Navigators

Navigators:

- Cannot legally provide advice to consumers about which health insurance plan to choose and are not permitted to sell insurance.
- Are to ensure consumers know there are plans available off exchange but are prohibited from helping consumers compare plans off exchange.
- Must be certified by the federal exchange and be licensed by the state.

Navigators

Federal grants awarded to six WI organizations totaling approximately $1.0 million.

- Partners for Community Development, Inc.
- Northwest WI Concentrated Employment Program, Inc.
- Legal Action of WI, Inc./SeniorLAW
- National Council of Urban Indian Health
- National Healthy Start Association
- R&B Receivables Management Corporation

Certified Application Counselors (CACs)

Certified Application Counselors:

- Help individuals apply for public assistance programs and compare health insurance plans sold on the exchange.
- Are not responsible for outreach and education activities.
- Are not federally funded.
- Will work in settings such as hospitals, local health departments, provider offices, etc.
- Must be affiliated with a CAC organization approved by the exchange and must be registered with the state.

Navigators/CACs

If you have any doubt or question about whether the person you are working with is a licensed navigator or registered CAC or you know they are but question their conduct, you should contact OCI.

To verify a navigator license, visit:
https://ociaccess.oci.wi.gov/ProducerInfo/PrdInfo.oci

To inquire about a CAC or report concerns about navigator or CAC conduct, e-mail OCI at:
ociagentlicensing@wisconsin.gov

Will health insurance agents still be available to help me?

Health Insurance Agents

Licensed health insurance agents will be available in 2014 to assist individuals and employers, like they do today.

- Unlike navigators and CACs, licensed agents are permitted to provide advice in helping individuals assess which health plan best suits their needs.

What is OCI's role now that PPACA is in place?

OCI

OCI was created in 1871 to ensure that the insurance industry responsibly and adequately met the insurance needs of Wisconsin citizens.

Even after the passage of PPACA, OCI's mission remains the same and OCI continues to be the primary regulator of the insurance industry in Wisconsin.

Consumers should continue to view OCI as a resource on any issue related to the WI insurance market.

Questions?

Wisconsin Regional Enrollment Outreach Strategy

Town Hall Meetings
September 2014

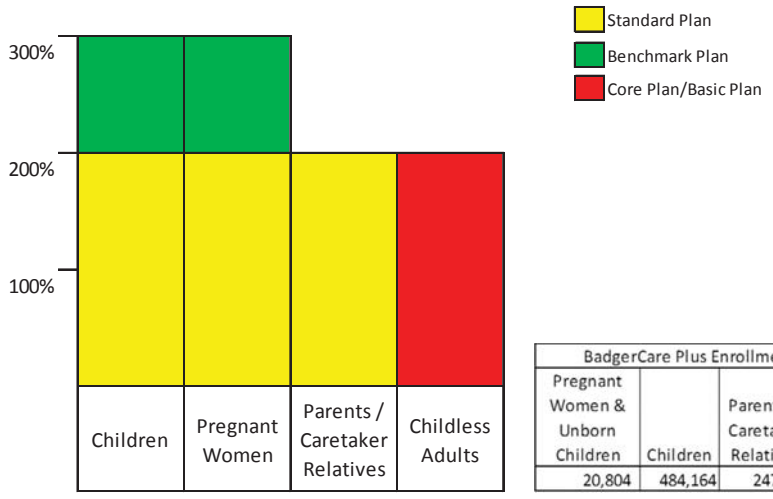
Outline

- Wisconsin Vision and Commitment
- Enrollment Background and Estimates
- Wisconsin Outreach Strategy; Regional Enrollment Networks
- Timeline
- Questions

Wisconsin Vision and Commitment

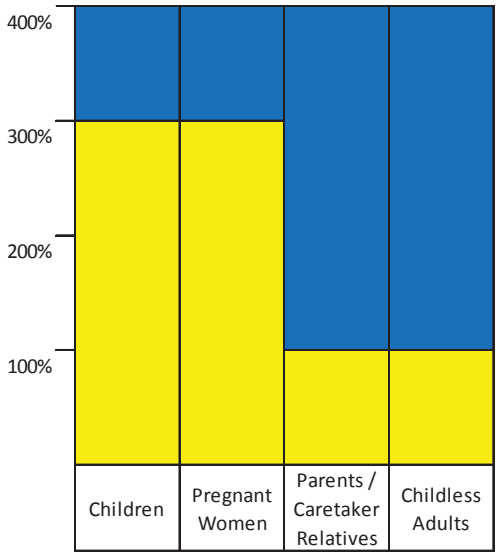
- Ensure that every resident has access to health insurance, create a Medicaid program that is sustainable, reduce reliance upon government health insurance, and maintain the health care safety net for those who need it the most.
- Reduce the number of uninsured non-elderly adults in our state and encourage consumers to be active participants in their healthcare.
- Simplify the Medicaid program by providing a standard set of comprehensive benefits that will lead to improved healthcare outcomes.

Current BadgerCare Plus Enrollment and Benefits



BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	484,164	247,712	16,450	769,130

Future BadgerCare Plus & Marketplace Enrollment and Benefits



Standard Plan

Qualified Health Plans in Marketplace
Eligible for Premium Tax Credits up to 400% FPL
Eligible for Reduced Cost Sharing up to 250% FPL

BadgerCare Plus Enrollment - Projected in Budget				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	522,695	160,255	98,641	802,395

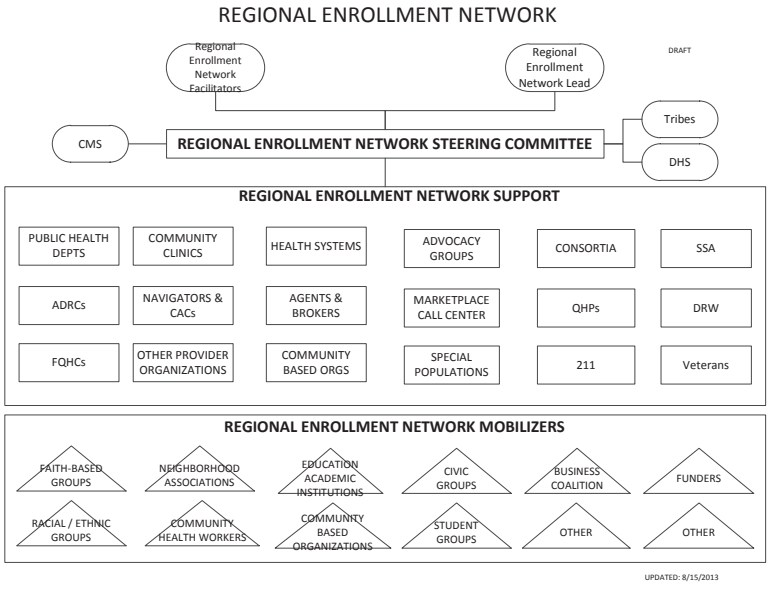
BadgerCare Plus & Marketplace Estimated Enrollment

	BadgerCare Plus	Marketplace
Children	522,695	No Estimate
Pregnant Women	20,804	No Estimate
Parents / Caretaker Relatives	160,255	232,551
Childless Adults	98,641	459,757

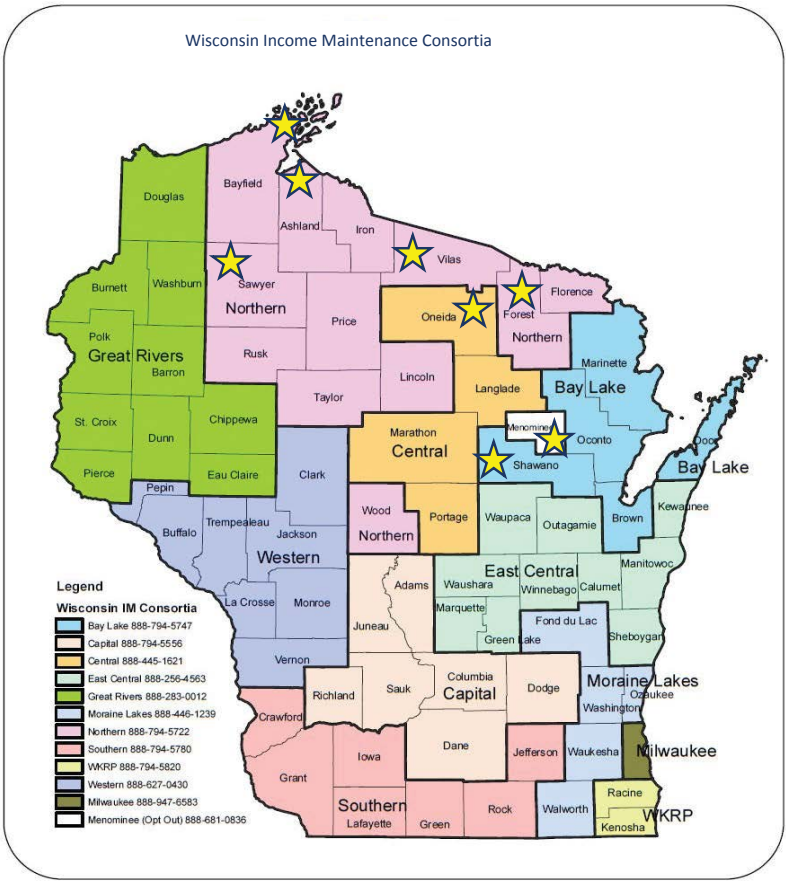
Wisconsin Outreach Strategy

- Leverage Milwaukee Enrollment Network effort currently underway.
- Create regional enrollment networks throughout the state with regional partners, including tribes.
  - Provide application and enrollment assistance.
  - Mobilize local grassroots resources to assist people in gaining healthcare coverage.

Sample Regional Enrollment Network



Wisconsin Regional Enrollment Networks



Wisconsin Outreach Strategy

- 11 Regional Enrollment Network kick-off meetings have been held across Wisconsin.
- Office of the Commissioner of Insurance (OCI), along with DHS, is hosting 11 town hall meetings across the state on ACA changes and impacts.
- Trainings for Certified Application Counselors are bring held across the state and online.

Outreach Timeline

Date	Milestone
07/16/2013	Begin establishing Regional Enrollment Networks
08/15/2013	Regional Enrollment Network Identification
09/16/2013	Regional Enrollment Network Operations Plan Complete
09/20/2013	Current BadgerCare Plus Members Notified of Potential Changes
09/29/2013	Core Plan Waitlist / Basic Plan Members Notified of Potential Changes
10/01/2013	DHS Targeted Call Outreach Begins for Transitioning Members
10/01/2013	Marketplace Open Enrollment Begins
11/18/2013	DHS Begins Processing BadgerCare Plus Applications Under New Eligibility Rules for January 1, 2014 Coverage
11/18/2013	DHS Begins Processing Applications Transferred from Marketplace
11/23/2013	DHS Notifies Members of Coverage Changes Effective January 1, 2014
12/15/2013	Marketplace Enrollment Deadline for Coverage Effective January 1, 2014
01/01/2014	New BadgerCare Plus Coverage Changes Effective
03/31/2014	Marketplace Open Enrollment Ends

For More Information…

Health Insurance Marketplace/Exchange:

www.healthcare.gov

1-800-318-2596

Wisconsin Health Care Options for 2014:

www.dhs.wisconsin.gov/health-care

Questions

DHS Speeches and Media Inquiries
Affordable Care Act and Entitlement Reform
July 1, 2013 through March 26, 2014

The Department of Health Services participated in approximately 60 different events and public meetings related to implementation of the Affordable Care Act and Entitlement Reform between July 1, 2013 and March 26, 2014.

In addition, the Department received approximately 300 media inquiries from more than 60 different Wisconsin and national media outlets regarding the Affordable Care Act and Entitlement Reform between July 1, 2013 and March 26, 2014.

Appleton Post Crescent	New York Times	WFRV-TV
Associated Press: National	NPR	Wisconsin Center for Investigative Journalism
Associated Press: Wisconsin	On the Record with Greta Van Susteren	Wisconsin Health News
Badger Herald	Oshkosh Northwestern	Wisconsin Public Radio
Bloomberg	Politico	Wisconsin Public Television
Capital Times	Racine Journal Times	Wisconsin Radio Network
CNN	Sawyer County Record	Wisconsin Reporter
CQ HealthBeat	Senior Beat	Wisconsin State Journal
Door County Daily news	Shepherd Express	Wisconsinfree.com
Duluth News	St. Paul Pioneer Press	Wisconsin Eye
Fox News Radio	Superior Daily News	WISC-TV
Gannett Newspapers	The Examiner	WISN-TV
Health Leaders	The Wheeler Report	WisPolitics
Insight on Business	Time	WITI-TV
Kaiser Family Foundation	Wall Street Journal	WKBT-TV
Kaiser Health News	Walworth County Sunday	WKOW-TV
La Crosse Tribune	WAOW-TV	WLUK-TV
MacIver Institute	Waukesha Freeman	WOSH Radio
BizTimes Milwaukee	Wausau Daily Herald	WSAU-TV
Milwaukee Business Journal	WBAY-TV	WTMJ-TV
Milwaukee Journal Sentinel	WDJT-TV	WUWM
Milwaukee Neighborhood News Service	WEAU-TV	
Modern Health Care	Weekly News Wire	

In September 2013, DHS and OCI met with the editorial boards of seven Wisconsin editorial boards. Those editorial boards include:

- Janesville Gazette
- Wisconsin State Journal
- Milwaukee Journal Sentinel
- Gannett – Eastern Wisconsin (Appleton Post Crescent, Green Bay Press-Gazette, Oshkosh Northwestern, Manitowoc Herald Times Reporter, Fond du Lac Reporter, and Sheboygan Press)
- Gannett – Central Wisconsin (Wausau Daily Herald, Wisconsin Rapids Daily Tribune, Marshfield News-Herald, Stevens Point Journal)
- La Crosse Tribune
- Eau Claire Leader Telegram

OCI Speeches and Media Interviews
April 24, 2013 through March 14, 2014

Start Date	Organization/Company	Title
4/24/2013	LOMA	2013 Conference on Health Insurance and Risk Assessment
5/7/2013	Greater Milwaukee Employee Benefits Council	Annual Update on Health Care Reform
8/8/2013	Portage Area Chamber of Commerce	Portage Area Chamber of Commerce Speech
9/3/2013	Milwaukee Journal Sentinel	Editorial Board
9/4/2013	Gannett: Eastern Wisconsin	Editorial Board
9/5/2013	Janesville Gazette	Editorial Board
9/5/2013	Wausau Daily Herald	Editorial Board
9/6/2013	La Crosse Tribune	Editorial Board
9/6/2013	Eau Claire Leader Telegram	Editorial Board
9/18/2013	DOR/DFI/OCI	2013 Tribal Consultation Meeting
9/20/2013	WFRV-TV	WFRV - TV Interview
9/23/2013	Madison Newspapers	Editorial Board
9/27/2013	WISN-TV	UpFront with Mike Gousha
10/2/2013	UW Platteville-ACA Town Hall	Editorial Board
10/14/2013	Wisconsin Eye	ACA-Panel Discussion
10/16/2013	St. Norbert College	CEO Breakfast Series
10/28/2013	Congressman Reid Ribble	Tele-Townhall Conference Call-14,000 attended
11/8/2013	Mgmt Resources Assn/Michael Best & Friedrich	MRA Labor Relations Information Exchange Mtg
11/18/2013	UW Madison	Inform students about ACA
11/22/2013	Wisconsin Public Television	Interview for "Hear and Now"
12/3/2013	National Federation of Independent Business	Speaking to Natl Federation ofIndependent Business
12/10/2013	WI Health News	WI Health News Lunch Briefing
1/30/2014	MEGA Wisconsin	2014 MEGA Healthcare Conference
2/6/2014	Medical College of Wisconsin	WI Winter Refresher Course
2/27/2014	Pharmacy Society of Wisconsin (PSW)	2014 PSW Legislative Day
2/28/2014	Alliance for Health Reform	Bipartisan Congressisonal Health Policy Conference
3/1/2014	Alliance for Health Reform	Bipartisan Congressisonal Health Policy Conference
3/12/2014	UWM-College of Health Sciences	2nd Annual Leadership Healthcare Forum
3/13/2014	Interview for 27 News	Interview with Greg Neuman of Channel 27 News
3/14/2014	Interview for "Hear and Now"	Wisconsin Public Television
3/14/2014	Upfront with Mike Gousha-WISN TV	Interview for "Upfront w Mike Gousha"

Wisconsin Navigator Grant Recipients

Navigators will serve as an in-person resource for Americans who want additional assistance in shopping for and enrolling in plans in the health insurance marketplace this fall.

Below are the recipients of navigator grants in federally-facilitated and state partnership marketplaces, grouped by state.

Recipients marked with an asterisk (*) are operating in more than one state. The anticipated grant amount listed in each case only applies to the amount going to that organization for that state's specific operations.

Partners for Community Development, Inc.
Anticipated grant amount: $315,720

Partners for Community Development will facilitate the enrollment of the uninsured with emphasis on reaching out to Hispanic and Hmong families and other hard-to-reach eligible consumers in Door, Kewaunee, Manitowoc, Ozaukee, and Sheboygan Counties in Wisconsin. It will focus outreach and enrollment efforts in its service area on hard-to-reach consumers and families with limited English proficiency.

Northwest Wisconsin Concentrated Employment Program, Inc.
Anticipated grant amount: $285,035

The Northwest Wisconsin Concentrated Employment Program will help lead a navigator project in their region to promote accessibility to the health insurance marketplace and the health care system in Wisconsin. The cooperative agreement will be used to provide marketplace navigator services at 21 Wisconsin job centers with outreach provided at libraries, senior centers and college campuses by existing staff that have experience working with diverse populations.

Legal Action of Wisconsin, Inc./SeniorLAW
Anticipated grant amount: $70,000

SeniorLAW is a community and consumer-focused nonprofit located in Milwaukee that provides a variety of services to individuals age 60 or over, mostly related to health insurance and public benefits. This group will conduct outreach to the 60-64 population in Wisconsin, using community education, client contacts and agency relationships that SeniorLAW has established throughout Southeastern Wisconsin.

National Council of Urban Indian Health*
Anticipated grant amount: $35,000

National Council of Urban Indian Health is the only national, membership-based organization dedicated to outreach and education on behalf of Urban Indian Health. It provides training, technical assistance, outreach, and education to Urban Indian Health Programs.

National Healthy Start Association
Anticipated grant amount: $191,667

The National Healthy Start Association is a nonprofit organization that works to improve birth outcomes and health disparities across the country through the federal Healthy Start programs. They will reach out to the uninsured population and provide education and assistance services for marketplace enrollment.

R&B Receivables Management Corporation DBA R&B Solutions
Anticipated grant amount: $104,520

R&B Receivables Management Corporation currently works to connect uninsured and underinsured individuals with coverage options to help them afford health care. They will expand their services to connect with a broader range of underserved populations, and leverage their experience screening people for eligibility for medical assistance programs to connect people with coverage.

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- Nonnavigator Assisters/Certified Application Counselors
- Prelicensing/Continuing Education Providers
- Registered Certified Application Counselors
- **Registered Navigator Entities**
- Applications
- Consent/Authorization Forms

Registered Navigator Entities and Affiliated Licensed Individual Navigators

A navigator can be an individual or an entity that supervises or employs an individual who performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange.

An individual who meets the definition of a navigator under the Wisconsin insurance law must obtain an individual navigator license. Entities functioning as, or intending to function as, navigators, supervising individual navigators or receiving funds to perform such activities must register with the Office of the Commissioner of Insurance (OCI).

On August 15, 2013, the Department of Health and Human Services announced the entities awarded navigator grants. Wisconsin Navigator Grant Recipients (opens in new window)

Disclaimer: As of the date of posting, the individual navigators or entities included on this list are licensed or have registered with the state of Wisconsin. The Wisconsin Office of the Commissioner of Insurance does not endorse any navigator or entity. To verify the license status, go to https://ociaccess.oci.wi.gov/ProducerInfo/PrdInfo.oci.

Registered Navigator Entities	Affiliated Licensed Navigators
BLACK HEALTH COALITION OF WISCONSIN, INC. 3020 W. VLIET ST. MILWAUKEE WI 53208 414-933-0064	MCMANUS, PATRICIA THOMAS-BOYD, TERESA TOWNSEND, LEOLIA WILLIAMS, BIANCA
LEGAL ACTION OF WISCONSIN, INC. 230 W. WELLS ST., ROOM 800 MILWAUKEE WI 53203 414-278-7777	KASDIN, PHOEBE A.
NORTHWEST WISCONSIN CONCENTRATED EMPLOYMENT PROGRAM, INC. 422 3RD ST. W, STE. 200 ASHLAND WI 54806-1574 715-682-9141	BEHLING, SANDRA K. BROWN, GINA MARIE BRUGGENTHIES, JULIE A. GINGRAS, BRADFORD ALLAN HAGBERG, TASHA MARIE LANE, SUSANN M. NORSTEN, KELLY MAE OGREN, JANIS LYNN PALMER, WANDA R. PRATT, MARCIA ANN STEPHENS, SUSAN J. TRILLO, CARMIN JEAN
PARTNERS FOR COMMUNITY	CHANG, MAI DER

DEVELOPMENT, INC. 1407 S. 13TH ST. SHEBOYGAN WI 53081 920-459-2780	PEREZ, MARY QUINO, VICTOR XIONG, YER
R & B RECEIVABLES MANAGEMENT CORPORATION 860 S. NORTHPOINT BLVD. WAUKEGAN IL 60085-8211 800-283-0310	JOHNSON, SHARLOTTE MASSETTI, TINA REMMEL, ROBIN R. SMITH, LINDA MARIE WALCZAK, SHAWNA

Last Updated: March 14, 2014

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WISCONSIN
Insurance Supplement

Examination Content Outlines

Effective Date: August 15, 2013

NAVIGATOR
CONTENT OUTLINE

(50 scoreable questions plus 5 pretest questions)

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E. Medicare supplement

Ref: s. 628.34, s. 632.84, s. Ins 3.27, s. Ins 3.39

F. Short-term medical policies

Ref: s. 632.7495(4)

Navigator Study Guide

State of Wisconsin
Office of the Commissioner of Insurance
P. O. Box 7873
Madison, WI 53707-7873

PI-230 (C 08/2013)

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Introduction

This guide is written for individuals who are preparing for the navigator examination. It is a brief summary of select laws and rules and is not a complete summary.

It is suggested that navigators obtain a complete copy of the Wisconsin Administrative Code and the Statutes from our Web site (oci.wi.gov) or from the Department of Administration, Document Sales and Distribution, 202 South Thornton Avenue, Madison, WI 53702, telephone (608) 266-3358. The Wisconsin Insurance Laws are also available from NILS Publishing Company, 20675 Bahama Street, P. O. Box 2507, Chatsworth, CA 91311. Information on the federal law and regulations is available on the Regulations and Guidance section of the Web site for The Center for Consumer Information & Insurance Oversight (www.cms.gov/cciio).

Applicants for a navigator license and certified application counselors have to take a prelicensing training course and pass a written examination. Navigator license applicants must also complete any exchange-related training mandated by the federal government.

Each person taking an examination will be responsible for knowing the material covered in this guide. The guide should be read carefully and completely. An effort has been made to simplify complex statutory language.

If an answer or example seems confusing, misleading, or incorrect, readers should consult the applicable statute or insurance rule. Most answers include numbers in brackets “[ ]” to a specific state statute and/or administrative rule.

A statute is a state law passed by the Wisconsin Legislature. In this guide, statutory references have an “s.” or a “ch.” before them, as in “s. 628.34” or “ch. 628.” This refers the reader to a particular section or chapter of the Wisconsin Statutes (Wis. Stat.). An insurance rule implements the general requirements of the law. In this guide, an insurance rule has an “s. Ins” before it, as in “s. Ins 3.27,” which refers the reader to s. Ins 3.27 of the Wisconsin Administrative Code (Wis. Adm. Code). The Commissioner promulgates insurance rules under authority delegated to the Commissioner by the Wisconsin Legislature.

OCI will update the guide periodically but readers should not rely solely on the material in this guide to stay informed of statute and rule changes. This guide is not intended to be a complete summary of the statutes and rules about which navigators should be aware. Navigators should also pay particular attention to the Wisconsin Insurance News, the quarterly newsletter available on the OCI Web site (oci.wi.gov). This is prepared by the Commissioner’s office. OCI also maintains several electronic mailing lists used to announce the issuance of bulletins to insurers, press releases, and/or the availability of the latest edition of the Wisconsin Insurance News. Readers may subscribe to one or more of OCI’s electronic mailing lists online at oci.wi.gov/listserv.htm.

I. Affordable Care Act

A. Intent of the Law

The federal Patient Protection and Affordable Care Act (P.L. 111-148), signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010, is also referred to as the Affordable Care Act (ACA), or simply as "federal health reform." The 900 plus page act contains many provisions, with various effective dates. Key provisions are intended to expand access to health insurance, increase consumer protections, emphasize prevention and wellness, improve health care quality and system performance, expand the health care workforce and curb rising health care costs.

B. Supreme Court Decision

On June 28, 2012, in a 5-4 decision the United States Supreme Court declared constitutional PPACA's individual mandate, which requires virtually all U.S. citizens to obtain health insurance coverage or pay a penalty (NFIB v. Sibelius, U.S., No. 11-393, 6/28/12).

In the other major holding, the Court declared the Medicaid provision constitutional, but only if the threat to the states for noncompliance is limited to loss of new funds provided under PPACA. States that choose to comply with the Medicaid expansion would receive regular Medicaid funding as well as the additional funding under PPACA. States that did not select Medicaid expansion would not get the additional funds. Wisconsin has chosen not take the Medicaid expansion.

C. Major Provisions

Some provisions of the Affordable Care Act are already in effect:

- No lifetime limits
- Limitations on annual limits for essential benefits
- Federal standards for internal and external review
- No preexisting condition limitations for children under 19
- Dependents are eligible for coverage to age 26
- Preventive services covered without cost sharing
- Rescissions prohibited
- Temporary high-risk pool
- Federal rate review standards
- Medical loss ratio standards and rebates if ratios are not met
- Uniform summary of benefits and coverage

Provisions regarding health insurance exchanges and market wide reforms are effective for policies issued on or after January 1, 2014. Health insurance exchanges are created for individual and small group health insurance. The health insurance market outside of the exchanges continues to function. Consumers can select health insurance plans during the annual open enrollment. The open enrollment for plans with effective dates on or after January 1, 2014, is October 1, 2013, to March 31, 2014. For coverage to be effective on January 1, 2014, an individual must enroll by December 15, 2013.

Some provisions apply to the entire market, both inside and outside the exchange:

- All plans must meet certain levels of coverage.

  Bronze level—The plan must cover 60% of expected costs across a standard population. This is the lowest level of coverage.

  Silver level—The plan must cover 70% of expected costs across a standard population.

  Gold level—The plan must cover 80% of expected costs across a standard population.

  Platinum level—The plan must cover 90% of expected costs across a standard population. This is the highest level of coverage.

  A catastrophic plan will be offered and will cover the same services. But its coverage will be slightly less generous than the bronze level plans. A catastrophic plan may be a less expensive option for those who are eligible; only young adults under 30 and individuals who have a hardship exemption from the individual mandate are allowed to purchase catastrophic plans.

- The metal levels are defined using the concept of "actuarial value." Actuarial value measures the percentage of total overall health care costs for the essential health benefits covered by a plan. This is the average share of medical spending that the plan pays, measured across a standard population. The percentage of total average costs the plan pays depends on the cost-sharing details—how much out-of-pocket the consumer pays for deductibles, coinsurance, and copayments and the out-of-pocket limits. A silver plan with a value of 70% means that, for a standard population, the plan will pay 70% of health care expenses through some combination of deductibles, copayments and coinsurance.

- All plans must cover essential health benefits.

- Single risk pool for individual and small group.

- Limited rating rules: only age, tobacco use, geography and family size.

Exchange Plans

Only qualified health plans will be offered on the individual and small group exchanges. An insurer must offer at least one gold and one silver plan and charge the same price inside and outside of the exchange. The plans must meet marketing requirements, network adequacy requirements, include access to essential community providers, be accredited, implement quality improvement strategies and use the uniform enrollment forms.

D. Essential Health Benefits

Beginning in 2014, the Affordable Care Act requires health plans to cover essential health benefits (EHB). Essential health benefits include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

The essential health benefits should be equal in scope to a typical employer health plan. Most health insurance plans already cover the essential health benefits with the exception of habilitative services and wellness services.

Habilitative services are services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces, including "participatory wellness programs" which generally are available without regard to an individual's health status. The rules also outline amended standards for nondiscriminatory "health-contingent wellness programs," which generally require individuals to meet a specific standard related to their health to obtain a reward. Examples of health-contingent wellness programs include programs that provide a reward to those who do not use, or decrease their use of, tobacco, or programs that provide a reward to those who achieve a specified cholesterol level or weight as well as to those who fail to meet that biometric target but take certain additional required actions.

Essential health benefits are defined by a benchmark plan in each state. Federal regulations set out standards for selecting the benchmark plan. The default plan is the largest product in the state's small group health insurance market by enrollment. All benefits in the Wisconsin benchmark plan are essential health benefits in this state and all plans in the individual and small group markets must offer, at a minimum, benefits that are substantially equal to the essential health benefits benchmark plan. There are standards for determining if the benefits are substantially equal. More information on the benchmark plan is available on the OCI Health Care Reform Web site. The federal government plans to assess the benchmark process for the year 2016.

E. Exemptions

In 2014, all individuals must maintain minimum essential coverage or pay a penalty. There are hardship exceptions. Examples are lack of affordable coverage, income below the tax filing threshold, ineligibility for Medicaid based on a state's decision not to expand Medicaid, self only coverage in an employer plan where cost for family exceeds 8% of household income and an individual is eligible for services through an Indian health care provider.

F. Financial Assistance Availability and Determination

1. The Affordable Care Act provides a new tax credit to help individuals afford health coverage purchased through the exchange. Advance payments of the tax credit can be used to lower monthly premium costs. If the consumer qualifies, he or she may decide how much advance credits to apply to the premium each month, up to a maximum amount. If the amount of the advance credit is less than the tax credit due, the consumer will get the difference as a refundable credit on the federal tax return. If the advance payments for the year are more than the amount of the tax credit, the consumer must repay the excess advance payments with the tax return.

2. Consumers may be eligible for public programs such as Medicaid or BadgerCare. These are discussed in greater detail in a separate section.

3. Small businesses with fewer than 25 full-time employees with wages less than $50,000 a year may be eligible for a tax credit if the employer pays at least half of the employee's premium. There is a small business health care tax credit estimator on the Internal Revenue Service Web site.

4. If a consumer has access to employer-sponsored coverage that is affordable and provides minimum value, the consumer will not qualify for the tax credits and cost-sharing reductions. Coverage is not

affordable if the cost of employee-only coverage under the employer plan costs the consumer more than 9.5% of the employee's annual household income. The plan does not provide minimum value if it pays for less than 60% of medical costs that the plan covers. The federal government has developed a minimum value calculator at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm.

An employer can provide a consumer with a minimum value written statement stating whether the plan is above or below the 60% threshold. Consumers will receive this information together with the Summary of Benefits and Coverages document when shopping for coverage through the exchange. A navigator, certified application counselor, or insurance agent also should be able to help.

G. Tax Penalties and Shared Responsibility

Individuals are required to have minimum essential coverage. Individuals must maintain minimum essential coverage or pay a tax penalty. Minimum essential coverage includes Medicare, Medicaid, and comprehensive health plans at least at the bronze level of coverage.

Employer plans must provide minimum value and premium must be affordable for employees or pay penalties, although the penalties are waived for 2014.

There are exceptions from the minimum essential coverage requirement based on employer size, income, religion, cost of insurance, and American Indian status.

H. Tribal Considerations

There are special provisions for American Indians and Alaska natives purchasing coverage through the health insurance exchange. These include:

- Eliminating cost sharing for Indians with household incomes under 300% of the federal poverty level who are enrolled in a qualified health plan through an individual market exchange.

- Elimination of cost sharing for Indians enrolled in a qualified health plan through an individual market exchange, regardless of income, when services are provided by the Indian Health Service or related providers.

- Exemption from the individual responsibility provisions and special monthly enrollment periods.

II. Basic Health Concepts

A. Health Care Options

1. Health maintenance organization plans are plans that may require selection of a primary care provider and require that consumers see plan providers for care.

2. Preferred provider organization plans provide an incentive to use providers who have a contract with the plan, but will provide coverage with increased cost sharing for non-plan providers.

3. Point-of-service plans are usually offered by health maintenance organization plans and permit the use of non-plan providers with increased cost sharing.

4. High-deductible health plans provide coverage after the deductible is satisfied.

5. Health savings accounts and health reimbursement accounts are pretax accounts established under Internal Revenue Service guidelines. A health savings account (HSA) is a tax-advantaged medical savings account available to taxpayers who are enrolled in a high-deductible health plan. The individual owns his or her own HSA and contributions can be made by the individual or an employer. Health reimbursement arrangements (HRA) are funded by employers and are an alternate tax-deductible source of funds paired with either high-deductible health plans or standard health plans. The funds contributed to an account are not subject to federal income tax at the time of deposit.

B. Cost, Premiums, Payments

1. A copayment is a fixed amount (for example, $15) a person pays for a covered health care service, usually when the person receives the service. The amount can vary by the type of covered health care service.

2. A deductible is the amount a person owes for health care services the health insurance plan covers before the health insurance begins to pay. For example, if the deductible is $1,000, the plan will not pay anything until the person meets the $1,000 deductible for covered health care services that are subject to the deductible.

3. Coinsurance is the share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The person pays coinsurance plus any deductibles. For example, if the health insurance plan's allowed amount for an office visit is $100 and the person has met the plan deductible, the coinsurance payment of 20% would be $20. The health insurance plan pays 80% of the allowed amount.

III. Health Insurance Exchanges

A. Federally Facilitated Exchange

States had the option to create health insurance exchanges or to defer to the federal government. Wisconsin does not have a state-based exchange. There will be a federally facilitated exchange managed by the federal government. The federal exchange provides for premium tax credits based on income; reduced cost sharing based on income if a silver plan is purchased; a federal exchange call center; comparison shopping tools on the exchange Web site; a single application; the opportunity to purchase coverage online, in person, by telephone or through the mail; and enrollment assistance through navigators.

B. Individual Exchange

The individual exchange allows individuals shopping for coverage one place to go to consider coverage choices, determine eligibility for public programs or tax credits, use tools to compare plans and receive help through the Web site, call center or from navigators trained to assist individuals. The exchange offers qualified health plans, provides information on premiums, deductibles, out-of-pocket costs, and tools to compare plans.

C. Small Business Health Options Program (SHOP) Exchange

The Small Business Health Options Program (SHOP) exchange provides small employers with 2 to 50 employees one place to go to sign up for coverage. For the 2014 plan year, employers will choose the plan for employees. Employers can define how much they will contribute toward coverage, and have access to a small business tax credit if they meet the requirements. Sole proprietors are not eligible for the SHOP exchange and will purchase coverage in the individual exchange.

IV. Navigators and Certified Application Counselors

A. Types

1. Navigators are funded through federal grants and have to maintain expertise in eligibility, enrollment and program specifications and conduct public education to increase awareness about the federal exchange. Additional duties include providing information in a fair, accurate and impartial manner, facilitating selection of a qualified health plan, providing referrals for enrollees with grievances or complaints, and providing information that is culturally and linguistically appropriate to the needs of the population being served. In addition, under Wisconsin law, navigators are required to complete 16 hours of prelicensing education, pass a written examination and obtain a navigator license.

2. Certified application counselors are a type of assistance personnel available to provide information to consumers and to help facilitate consumer enrollment into qualified health plans and insurance affordability programs. The federal exchange may designate organizations to certify staff or volunteers to perform these duties. In addition, under Wisconsin law, certified application counselors must complete 16 hours of prelicensing education and pass a written examination.

B. Roles and Responsibilities

Federal regulations set out the definition and eligible entities. Navigators are required to complete federal exchange training and certification. They are expected to provide fair, accurate and impartial information. They need to be familiar with plan eligibility criteria and plan enrollment procedures. Consumers can apply in person, over the telephone, on the Web site or through the mail. Navigators will need to assist consumers in making changes such as adding dependents or changes in income. They need to be aware that consumers on Medicare are not eligible for coverage through the individual exchange. In federal exchange states like Wisconsin, navigators are compensated through federal grant funds and do not receive compensation from insurers or the exchange. Federal regulations prohibit navigators from having conflicts of interest during their terms as navigators. Both navigators and certified application counselors must disclose potential conflicts of interest.

In Wisconsin, licensed navigators and registered certified application counselors are considered to be transacting the business of insurance when functioning within the scope of their license or registration. Activities permitted and prohibited for navigators and certified application counselors include the following:

Permitted Activities:

- Conduct public education activities to raise awareness of available Qualified Health Plans (QHP) within the federal exchange.

- Distribute fair and impartial information concerning enrollment in a QHP through the federal exchange and the availability of premium tax credits and cost-sharing reductions that may be available.

- Explain that consumers may purchase health plans through the federal exchange or off the exchange.

- Make consumers aware that plans are available in the outside market and that they may want to talk with a licensed health insurance agent about health insurance options.

- Facilitate enrollment in a QHP through the federal exchange. Outline information that a consumer will need to have available when applying for coverage through the federal exchange. Provide information that will allow the consumer to access the federal exchange either at their home or a computer terminal provided by the navigator.

- Explain to the consumer the following information: potential eligibility for public/governmental programs; how the federal health insurance premium tax credit and cost-sharing reductions work and risks, if any, for use of the federal health insurance premium tax credit.

- Describe the features and benefits of health coverage in general terms, including cost-sharing mechanisms like deductibles, copays or coinsurance and how these work or affect the consumer.

- Describe what a summary of benefits document is and where to locate a summary of benefits and relevant cost-sharing provisions within the information from QHPs.

- Explain how to find information about provider networks.

- Describe the different metal tiers (i.e., bronze, silver, gold and platinum) and how the benefits may change at different metal tiers based upon the consumer's income.

- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the federal exchange.

- Provide a referral for an individual to an appropriate state or federal agency who has a grievance, complaint or question regarding their health plan, coverage, or a determination under such plan or coverage.

Prohibited Activities:

- Receive compensation from an insurer, stop-loss insurance or a third-party administrator.

- Receive compensation that is dependent upon, in whole or in part, whether an individual enrolls in or renews coverage in a health benefit plan.

- Provide any information related to enrollment or other insurance products not offered in the federal exchange.

- Make or cause to be made false or misleading statements.

- Provide advice comparing health benefit plans that may be better or worse for the consumer or employer.

- Recommend a particular health benefit plan or insurer or advise consumers or employers regarding a particular insurer or health benefit plan selection.

- Engage in any fraudulent, deceptive or dishonest acts or unfair methods of competition.

- Receive consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employees into a QHP.

C. Privacy and Security of Health Information

The Health Insurance Portability and Accountability Act (HIPAA) privacy rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the privacy rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The security rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. If a covered entity engages a business associate to help it carry out its health care activities and functions, the covered entity must have a written business associate contract or other arrangement with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the rules' requirements to protect the privacy and security of protected health information. In addition to these contractual obligations, business associates are directly liable for compliance with certain provisions of the HIPAA rules.

If an entity does not meet the definition of a covered entity or business associate, it does not have to comply with the HIPAA rules. Covered entities include health care providers, health plans and health care clearinghouses.

Organizations designated by the federal exchange to provide navigator or certified application counselor services must agree that it and all of its staff members will comply with the privacy and security standards. For all exchanges, including the federally facilitated exchange, the definition for Personally Identifiable Information (PII) is information which can be used to distinguish or trace an individual's identity, alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual. Examples of PII include name, Social Security Number, address, e-mail, and date of birth.

There are two key points to remember about this definition:

1. This definition may be different from definitions provided under other laws. It is important to be familiar with this federal definition and how it applies to exchange information.

2. A key component to the definition is that PII involves information that is linked or linkable to a specific individual. Therefore, if it were possible to link information to an individual, this information would be considered PII, even if it has not yet been linked to that individual.

The key points on the privacy standards and issues are:

- In helping consumers obtain eligibility determinations, compare plans, and enroll in QHPs through the federally facilitated exchange, there may be access to PII.

- PII is information that can be used to distinguish or trace an individual's identity, alone, or when combined with other personal or identifying information that is linked or linkable to a specific individual.

- An exchange may only use or disclose PII as needed to carry out its required functions.

- Tax information is confidential and special rules apply to access and disclosure.

V. Brokers, Agents and Producers

Agents who receive compensation from insurers are not eligible to act as navigators or certified application counselors. Licensed agents can advise consumers and make recommendations regarding plan selection. Agents and brokers can enroll consumers in qualified health plans in the federal exchange if they have registered with the exchange and completed the federal training. Agents and brokers will receive compensation directly from the insurers with whom they have a contractual relationship.

VI. Outreach and Education

The federal exchange will use the marketplace Web site to provide education. There are publications, articles, multimedia presentations and materials in other languages available. There is also a Web site for businesses at business.usa.gov/healthcare.

VII. State Public Assistance Programs

A. State Health Care Assistance Programs

1. Medicaid
2. BadgerCare Plus

B. Eligibility

1. Financial requirements
2. Nonfinancial requirements

Additional information regarding State Public Assistance Programs is available on OCI's Web site (oci.wi.gov).

VIII. Wisconsin Statutes, Rules and Regulations Common to Life, Disability (A&H), Property and Casualty Insurance

A. Responsibilities of the Commissioner of Insurance

Powers and Duties of the Commissioner

Wisconsin statutory law vests the Commissioner with broad powers and duties to protect the public and to ensure that the insurance industry meets the insurance needs of Wisconsin citizens responsibly and adequately. These powers and duties are exercised in accordance with procedures designed to assure due process and judicial safeguards.

The Commissioner has broad rule-making authority, limited only by the proposed rule's relevance to the related statutes and by general legal and constitutional restraints. The Commissioner supplements statutory law by interpreting that law through the formal processes of rule-making and adjudication, and by informal executive decisions.

Rule-making builds up a body of insurance regulation which is a guide to regulated interests and the general public. The rule-making procedure includes the publishing of proposed rules and an invitation for comment at a scheduled hearing. This procedure permits people to express their opinions about the proposed rule's impact on their businesses, activities, and interests, and helps the Commissioner formulate rules based on sound public policy considerations.

The Commissioner has wide power to issue orders to enforce the statutes and rules. The existence of such enforcement powers enables the Commissioner to negotiate settlements and induce compliance in most instances without the necessity of taking formal disciplinary action. However, the Commissioner will use enforcement powers if the particular situation demands it.

The Commissioner has full administrative power of investigation, usually exercised through investigatory, educational, or multi-purpose hearings.

General Powers

WHAT ARE THE COMMISSIONER'S GENERAL DUTIES AND POWERS?

The Commissioner is responsible for administering and enforcing the insurance laws of Wisconsin. The Commissioner must act as promptly as possible on all matters placed before the office.

The Commissioner and the office possess all the powers specifically granted or reasonably implied by the statutes. This enables the office to perform the duties necessary to enforce the law, including adoption of rules.

[s. 601.41]

MAY THE COMMISSIONER ISSUE ORDERS?

The Commissioner is empowered to issue all prohibitory, mandatory, and other orders as are necessary to secure compliance with the law.

At the request of any person who would be affected by an order, the Commissioner may issue a declaratory order to clarify the person's rights and duties under Wisconsin law.

No rule or order may be issued as a result of a hearing unless the statutory requirements for administrative procedures are met.

[s. 601.41 (4)]

MAY THE COMMISSIONER REQUIRE PERSONS TO SUBMIT REPORTS AND OTHER MATERIAL?

(Persons as used in this context includes individuals, insurers, agencies, and other corporate entities.)

The Commissioner has the authority to require from any person subject to regulation under Wisconsin insurance law:

- Statements, reports, answers to questionnaires, and other information in whatever reasonable form the Commissioner designates and at such reasonable intervals as the Commissioner may choose; and

- Full explanation of the programming of any data processing system, computer, or any other information storage system or communication system in use.

[s. 601.42]

Examination Powers and Duties

WHAT POWER OF EXAMINATION DOES THE COMMISSIONER HAVE?

The Commissioner has the power to examine the affairs and condition of the persons listed below whenever the Commissioner deems it necessary to be informed about any matter related to the enforcement of the insurance laws. These persons include:

- Any licensee under insurance laws (including insurers, intermediaries, corporations, etc.);

- Any applicant for a license;

- Any person or organization transacting, or in the process of organizing to transact, the insurance business in this state;

- Any advisory organization serving any of the above in Wisconsin; and

- Any prelicensing school, continuing education provider, course, or instructor.

[s. 601.43, ss. Ins 26.10, 28.10]

Enforcement Procedures

WHEN ARE HEARINGS REQUIRED?

The Commissioner must hold a hearing before issuing an order or rule whenever the insurance laws or the administrative procedure requirements expressly provide for a hearing. Unless the insurance laws prescribe special procedures, all hearings must comply with the procedures set out in ch. 227, Wis. Stat., and ch. Ins 5, Wis. Adm. Code. The statutes do provide for the summary suspension of an intermediary's or navigator's license if the Commissioner finds that public health, safety, and welfare requires emergency action.

If the intermediary or navigator fails to pay a fee when due, the Commissioner may revoke the license without a hearing. If the Commissioner and the intermediary or navigator agree, an intermediary or navigator may consent to a revocation without a hearing. The Commissioner may revoke the license of a person who fails to comply with continuing education standards. Otherwise, the Commissioner may revoke, suspend, or limit a permanent license of an intermediary or navigator only after a hearing and an opportunity for judicial review.

The Commissioner must hold a public hearing before adopting any rule unless the rule is procedural rather than substantive, is an emergency rule, or is an exception listed under s. 227.02 of the Administrative Procedure Act.

The Commissioner may hold informal hearings and public meetings for the purposes of investigation, for ascertaining public sentiment, or to inform the public.

[ss. 601.41, 601.62, 628.10, 628.10 (2) (b), ch. 227]

DOES AN APPLICANT FOR AN INTERMEDIARY OR NAVIGATOR LICENSE HAVE A RIGHT TO A HEARING AFTER THE COMMISSIONER'S DECISION NOT TO ISSUE A LICENSE TO THE APPLICANT?

Before being granted an original license, the applicant must show the Commissioner that he or she is competent and trustworthy. Applicants have the right to a hearing to appeal the Commissioner's decision not to issue a license. Such hearing and appeal must comply with the procedures set forth in ch. 227, Wis. Stat.

When an order is issued without a hearing, any aggrieved person may demand a hearing within 30 days after the mailing of the order. Failure to demand a hearing within 30 days constitutes a waiver of the right to a hearing. The demand for a hearing must be made in writing and served on the Commissioner directly or left at the Commissioner's office. The Commissioner must hold the requested hearing not less than 10 days nor more than 60 days after delivery of the request for a hearing.

[s. 601.62, s. Ins 6.59]

WHAT ENFORCEMENT SANCTIONS ARE AVAILABLE TO THE COMMISSIONER?

Whenever a person fails to comply with an order, the Commissioner may start a legal action directing the person to comply with the Commissioner's order and restraining that person from further noncompliance. In addition, forfeitures, civil penalties, and criminal sanctions may be levied by the Commissioner.

[s. 601.64]

WHAT ABOUT FORFEITURES AND CIVIL PENALTIES?

Any person who violates an effective order or any insurance statute or rule may be required to forfeit to the state, in addition to any other forfeiture imposed, twice the amount of any profit gained from the violation.

Any person who violates an order after proper notice may be required to forfeit to the state not more than $1,000 for each violation. Each day the violation continues constitutes a separate offense.

Any person who violates an insurance statute or rule may be required to forfeit to the state not more than $1,000 for each violation. If the statute or rule imposes a duty to make a periodic or recurring report to the Commissioner, each week of delay in complying with the duty constitutes a new violation.

[s. 601.64 (3)]

A person who is ordered to pay a forfeiture may demand a hearing. If the person fails to request a hearing, the order is conclusive as to the person's liability. The scope of review for forfeitures is as specified under s. 227.57, Wis. Stat.

[s. 601.64 (3) (d)]

B. Licensing

Chapter 628, Wis. Stat., on insurance law has four main parts: the licensing of insurance intermediaries, regulation of insurance marketing practices, compensation of insurance intermediaries, and the licensing and regulation of navigators and nonnavigator assisters.

The licensing of intermediaries and navigators is concerned solely with the qualifications of the person applying for the insurance license. The essential requirement is that they be trustworthy and competent. The competence includes a basic understanding of fundamental insurance law as well as particular knowledge concerning specific statutes and rules.

Wisconsin insurance statutes outline and define the general requirements which the insurance intermediary must follow. In addition, the insurance intermediary must understand and follow the administrative code which has been adopted by the Commissioner. General statutory language is expanded and clarified—by rule in the administrative code—by describing for agents and companies the practices that are allowed and/or prohibited. The standards of professional conduct set out in the statutes and these rules will be strictly enforced by the Commissioner.

WHAT IS AN INTERMEDIARY?

"Intermediary" means an agent, broker or producer and any person, partnership or corporation requiring a license.

[ch. 628, Wis. Stat.]

A person is an "intermediary" if the person does or assists another in any of the following:

- Soliciting, negotiating, or placing insurance or annuities on behalf of an insurer or a person seeking insurance or annuities; or

- Advising other persons about insurance needs and coverages.

The following persons, however, are not considered "intermediaries" under Wisconsin law:

- A regular salaried officer, employee, or other representative of an insurer or licensed intermediary, who devotes substantially all working time to activities other than those listed immediately above and does not receive any compensation that is directly dependent upon the amount of insurance business obtained;

- A regular salaried officer or employee or a person seeking to procure insurance, who receives no compensation that is directly dependent upon the amount of insurance coverage procured;

- A person who gives incidental advice in the normal course of a business or professional activity other than insurance consulting. Neither the person nor the person's employer may receive compensation directly or indirectly on account of any insurance transaction that results from such advice;

- A person who, without special compensation, performs incidental services for another at another's request without providing advice or technical or professional services of the kind normally provided by an intermediary;

- A holder of a group insurance policy, or any other person involved in mass marketing, with respect to the person's administrative activities in connection with the policy. Such a person may not receive any compensation for the administrative work beyond actual expenses which can be estimated on a reasonable basis;

- A person who provides information, advice, or service for the principal purpose of reducing loss or risk;
- A person who gives advice or assistance without compensation; or
- A representative of a common carrier who sells only over-the-counter, short-term travel accident ticket policies and baggage insurance.

[s. 628.02 (1)]

What Are the Types of Intermediaries?

INTERMEDIARY-INSURANCE AGENT

An intermediary is an insurance agent if the intermediary acts as an intermediary other than as a broker.

[s. 628.02 (4)]

INTERMEDIARY-BROKER

An intermediary is an insurance broker if the intermediary acts in the procuring of insurance on behalf of an applicant for insurance or an insured. An insurance broker does not act on behalf of the insurer except by collecting premiums or performing other ministerial acts.

[s. 628.02 (3)]

WHAT IS A NAVIGATOR?

A navigator can be an individual or an entity that supervises or employs an individual who either performs any activities and duties related to the navigator program on behalf of the federal exchange and who receives funding to perform such functions on behalf of the federal exchange. An individual navigator does not include a person acting as an insurance intermediary.

[s. 628.90]

WHAT REQUIREMENTS MUST A PERSON MEET IN ORDER TO BE ISSUED A NAVIGATOR LICENSE?

Navigators must be licensed and complete 16 hours of prelicensing training, pass a written examination, and meet the following minimum requirements:

- Is at least 18 years of age.
- Resides in this state or maintains his or her principal place of business in this state.
- Has completed the training and course of study requirements and any training and course of study requirements mandated by the federal exchange.
- Has successfully passed a written examination approved by the Commissioner that test the applicant's knowledge concerning the duties and responsibilities of a navigator, the insurance laws and regulations of this state, and state public assistance programs and eligibility.
- Has submitted a full set of fingerprints to the Commissioner and successfully completed a regulatory and criminal history background investigation.

[ss. 628.92, 628.34]

WHAT ARE THE REQUIREMENTS FOR NAVIGATOR LICENSING EXAMINATIONS?

Individual navigator applicants must pass a written examination to become a navigator.

Sixteen hours of prelicensing education is required.

[s. 628.92 (7)]

An applicant who submits an application which meets the competence and trustworthiness standards, pays the required fee, completes the prelicensing education requirements and federal exchange training, and obtains a passing grade on the written examination will be issued a navigator license.

[s. 628.92]

ARE NAVIGATORS REQUIRED TO COMPLETE ANNUAL TRAINING?

Yes. All navigators holding a Wisconsin individual navigator license must complete 8 hours of approved training each year. All credits must be banked by the licensee's expiration date. A credit hour is defined as not less than 50 minutes of classroom instruction by an approved provider. Correspondence, self-study, and on-line courses may be completed if they are approved by meeting criteria under current law and include successful completion of a certified proctored examination.

[s. 628.92 (7)]

WHAT HAPPENS IF NAVIGATORS FAIL TO MEET THE ANNUAL TRAINING REQUIREMENTS?

The Commissioner will notify each individual navigator by mail at least 60 days prior to the reporting date if the navigator is lacking the necessary annual training requirement hours. If the required credit hours are not banked by the reporting date, the license of the navigator will be revoked with notice to the navigator by first class mail.

[s. 628.10 (2) (a)]

CAN A NAVIGATOR REAPPLY WITHOUT COMPLETING PRELICENSING EDUCATION AND TAKING AN EXAMINATION?

Yes. Any individual navigator whose license is revoked for failing to pay renewal fees, failing to complete the required annual training requirement or failing to pay delinquent taxes may, within 12 months, reinstate for the same license without completing prelicensing education or passing a written examination. The individual must have all previous annual training requirements met. If a license has been revoked for more than 12 months, the navigator shall, in order to be relicensed, satisfy the examination and licensing requirements.

[s. 628.10 (5), 628.097 (1m), (2m)]

WHAT IS A CERTIFIED APPLICATION COUNSELOR?

A certified application counselor is a nonnavigator assister who has been designated by or working on behalf of the federal exchange.

[s. 628.90 (4)]

WHAT REQUIREMENTS MUST A CERTIFIED APPLICATION COUNSELOR MEET?

Certified application counselors are required to meet the training and examination requirements established for navigators including the 16 hours of prelicensing training and successful passage of the written examination. This is in addition to any federal training requirements established at 45 CFR 155.225.

[s. 632.896 (2)]

ARE CERTIFIED APPLICATION COUNSELORS REQUIRED TO BE LICENSED?

No. Individuals who want to become certified application counselors do not need to be licensed. Entities employing one or more nonnavigator assisters are required to provide the Commissioner with a list of all certified application counselors that it employs, supervises or is affiliated with once the individuals are authorized by the federal exchange to provide assistance. Entities employing, supervising or affiliated with certified application counselors assume legal responsibility for the acts of the certified application counselors.

[s. 628.96 (1) (3)]

ARE CERTIFIED APPLICATION COUNSELORS REQUIRED TO COMPLETE ANNUAL TRAINING?

Yes. Certified application counselors are required to complete 8 hours of annual training.

[s. 628.96 (2)]

ARE THERE SPECIAL REQUIREMENTS FOR THE DISPOSAL OF PERSONAL MEDICAL INFORMATION?

Yes. Insurers and agents that obtain information from an insured or an individual seeking coverage, pertaining to the person's physical or mental health, medical history, or medical treatment, must take specific steps to ensure that personally identifiable information (PII) is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97]

WHAT IS HOME SOLICITATION SELLING?

Home solicitation selling means the solicitation or the offering for sale of insurance where the solicitation or sale is made by an agent at the residence or place of business or employment of the buyer or away from the agent's regular place of business. Home solicitation selling includes solicitations made directly or indirectly by telephone, person to person contact, or by written or printed communication, other than general advertising that indicates an intent to sell insurance or services at a regular place of business.

[s. Ins 20.01 (3) (c)]

ARE THERE CERTAIN DISCLOSURES THAT MUST BE MADE BY AN AGENT ENGAGED IN HOME SOLICITATION SELLING?

Yes. When engaged in home solicitation selling, every seller shall, at the time of initial contact or communication with an actual or prospective purchaser of insurance, clearly and expressly disclose the seller's individual name, the name of the business firm or organization represented, a statement that insurance is being sold or solicited, the identity of the insurer, if the solicitation is primarily for a single insurer, and the type of insurance being solicited.

A seller means a person, insurance agent, representative, insurance intermediary or organization engaged in home solicitation selling, advertising or offering services in home solicitation selling, or providing or exercising supervision, direction, or control over sales practices used in home solicitation sales.

A seller who receives a check or cash shall give the buyer a receipt or other document of the transaction which includes the date of the sale, a description of the type of policy applied for, price paid, the name of the seller, and the name and mailing address of the insurer issuing the policy.

Persons engaging in home solicitation selling shall not:

- Represent directly or by implication that the seller is making an offer to specially selected persons unless such representations are true and the specific basis for such representations is stated at the time the representation is made.

- Represent that the seller is conducting a survey, test or research project or engaged in a contest or other venture to win a cash award, scholarship, vacation, or similar prize when the principal objective is to make an insurance sale or obtain information to help identify sales prospects.

- Use any false, deceptive or misleading representations to induce a sale, or use any plan, scheme or ruse which misrepresents that the person making the call is selling insurance, or fail to leave the premises promptly when requested to do so.

[s. Ins 20 .01]

WHAT REGULATION CHARGES MUST A LICENSED NAVIGATOR PAY?

The annual regulation amount to be paid by each licensed individual navigator is $35.00. Notification of the annual regulation charge will be mailed by first class mail to the mailing address on file with the Commissioner at least 60 days prior to the due date. If the fee is not paid by the expiration date, the navigator's license is revoked.

[s. 601.31 (1) (n) (m), s. 628.10 (2) (a)]

HOW LONG DOES A NAVIGATOR LICENSE REMAIN IN EFFECT?

An navigator's license remains in effect until it is revoked, suspended, or limited by the Commissioner; until it is voluntarily surrendered by the navigator; until the death of the navigator; until a court's finding that the navigator is mentally incompetent; or until the Commissioner finds, after a hearing, that the person, corporation, or partnership is no longer qualified to act as an navigator.

[s. 628.10 (1)]

WHEN CAN A NAVIGATOR LICENSE BE REVOKED, SUSPENDED OR LIMITED?

The license of an individual navigator who fails to pay a fee or fails to complete the annual training requirements when due is revoked as of the date due if the Commissioner gave the navigator reasonable notice. The navigator may be relicensed only after satisfying all requirements under s. 628.92, Wis. Stat.

[s. 628.10 (2)]

IF A LICENSE HAS BEEN REVOKED, WHEN CAN THE NAVIGATOR REAPPLY?

If a license is revoked for nonpayment of fees or failure to comply with the annual training requirements, the individual navigator may reinstate immediately after paying the required fee and/or completing the annual training requirement.

When the Commissioner revokes an individual navigator license for any of the other reasons mentioned in the preceding section, the Commissioner may specify a time period of five years or less during which the navigator may not apply for a new license. If the Commissioner does not specify a time period, the navigator may not apply for five years.

[s. 628.10 (3)]

C. Marketing Practices

WHAT MARKETING PRACTICES ARE UNFAIR?

Unfair marketing practices include: misrepresentation; unfair inducements; unfair discrimination; restraint of competition, unfair restriction of contracting parties' choice of insurer; extra charges; attempt to unduly influence employers; and unfair use of official position.

[s. 628.34, ss. Ins 6.54, 6.55]

WHAT IS MISREPRESENTATION?

It is a violation for intermediaries and their employees or those acting on their behalf to make any written or oral communication about any insurance contract, the insurance business, any insurance company, or any agent which contains false or misleading information. This includes:

- Information which is misleading because of incompleteness;
- Filing a report with the intent to deceive the person examining that report;
- Making a false entry in a record;
- Failure to make a proper entry in a record for the purpose of concealing information; and
- Using the name, slogan, emblem, or related device which will or is likely to cause an intermediary to be mistaken for another intermediary in the insurance business. If an insurance intermediary distributes cards or documents, exhibits signs, or publishes advertisements which include misrepresentations and contain reference to a particular insurer that the person represents as agent, the intermediary's violation carries a presumption that the violation was also committed by the insurer.

[s. 628.34 (1)]

WHAT IS RESTRAINT OF COMPETITION?

It is illegal for any of the following persons to commit or agree to take part in any act of boycott, coercion, or intimidation which tends to unreasonably restrain the business of insurance, or which tends to create a monopoly in the insurance business:

- A person who is or should be licensed in Wisconsin;
- A person who is an employee or agent of the person who is or should be licensed in Wisconsin;
- A person whose main interest is to compete in the same business as those persons who are or should be licensed in Wisconsin;
- A person who acts on behalf of those persons mentioned in the preceding sections.

[s. 628.34 (4)]

MAY A PERSON'S CHOICE OF INSURER BE RESTRICTED BY ANOTHER?

No one who requires insurance coverage as a condition for concluding a contract or for exercising any right under a contract may restrict the choice of insurer of the person buying the coverage. The person who is requiring the coverage may reserve the right to disapprove, on reasonable grounds, the policy or insurance company selected. The form of the corporate organization of the insurance company is not a reasonable ground for disapproval.

[s. 628.34 (5)]

ARE THERE ADDITIONAL RULES DEFINING UNFAIR MARKETING PRACTICES?

Yes. The Commissioner may define by administrative rule specific unfair trade practices after a finding that the practices are misleading, deceptive, unfairly discriminatory, provide an unfair inducement, or restrain competition unreasonably.

[s. 628.34]

WHAT EFFECT DOES THE INTERMEDIARY'S APPOINTMENT HAVE ON THE INSURER?

Every insurer is bound by an act of its agent performed in Wisconsin that is within the scope of the agent's authority. The insurance company remains bound while the agency contract is in force or until the insurance company has made reasonable efforts to recover from the agent its policy forms and other indicia of the agency. Reasonable efforts shall include a formal demand in writing for return of the indicia, and notice to the Commissioner if the agent does not comply with the demand promptly.

[s. 628.40]

Compensation of Agents

MAY AN AGENT RECEIVE COMPENSATION FROM AN INSURED OR FROM AN INSURED AND ANOTHER SOURCE FOR THE PURCHASE OF INSURANCE OR FOR RENDERING ADVICE ON INSURANCE NEEDS AND COVERAGES?

Yes, an agent may accept compensation under these circumstances. However, the agent must disclose to the applicant in writing:

- The amount of compensation to be paid by the insured (other than a commission payment made by the insurer); and

- The fact, if applicable, that compensation will be paid by another source.

[s. 628.32]

WHAT ARE PROHIBITED PRACTICES FOR NAVIGATORS OR CERTIFIED APPLICATION COUNSELORS?

Licensed navigator and registered nonnavigator assisters are considered to be transacting the business of insurance when functioning within the scope of their license or registration. Activities permitted and prohibited for navigators and nonnavigator assisters include the following:

Permitted Activities:

- Conduct public education activities to raise awareness of available Qualified Health Plans (QHP) within the federal exchange.

- Distribute fair and impartial information concerning enrollment in a QHP through the federal exchange and the availability of premium tax credits and cost-sharing reductions that may be available.

- Explain that consumers may purchase health plans through the federal exchange or off the exchange.

- Make consumers aware that plans are available in the outside market and that they may want to talk with a licensed health insurance agent about health insurance options.

- Facilitate enrollment in a QHP through the federal exchange. Outline information that a consumer will need to have available when applying for coverage through the federal exchange. Provide information that will allow the consumer to access the federal exchange either at their home or a computer terminal provided by the navigator.

- Explain to the consumer the following information: potential eligibility for public/governmental programs; how the federal health insurance premium tax credit and cost-sharing reductions work and risks, if any, for use of the federal health insurance premium tax credit.

- Describe the features and benefits of health coverage in general terms, including cost-sharing mechanisms like deductibles, copays or coinsurance and how these work or affect the consumer.

- Describe what a summary of benefits document is and where to locate a summary of benefits and relevant cost-sharing provisions within the information from QHPs.

- Explain how to find information about provider networks.

- Describe the different metal tiers (i.e., bronze, silver, gold and platinum) and how the benefits may change at different metal tiers based upon the consumer's income.

- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the federal exchange.

- Provide a referral for an individual to an appropriate state or federal agency who has a grievance, complaint or question regarding their health plan, coverage, or a determination under such plan or coverage.

Prohibited Activities:

- Receive compensation from an insurer, stop-loss insurance or a third-party administrator.

- Receive compensation that is dependent upon, in whole or in part, whether an individual enrolls in or renews coverage in a health benefit plan.

- Provide any information related to enrollment or other insurance products not offered in the federal exchange.

- Make or cause to be made false or misleading statements.

- Provide advice comparing health benefit plans that may be better or worse for the consumer or employer.

- Recommend a particular health benefit plan or insurer or advise consumers or employers regarding a particular insurer or health benefit plan selection.

- Engage in any fraudulent, deceptive or dishonest acts or unfair methods of competition.

- Receive consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employees into a QHP.

Any individual or entity acting in violation of the newly enacted law provisions may be subject to an administrative action including restitution and limitation or revocation of licensure or registration.

[s. 628.95]

D. General Statutes, Rules, and Regulations Affecting Insurance Contracts

Insurance Contracts Generally

This section covers insurance contracts in general. The state statutes affecting this material (chs. 631 and 632, Wis. Stat.) set out minimal standards for regulating the terms of insurance contracts. Control over policy forms and provisions is necessary for the adequate protection of Wisconsin policyholders. The approach of these statutes is to establish explicit standards within which the intermediary and the insurer will have sufficient freedom to develop contract terms and alternatives that fill the needs of individual consumers.

General Rules

DO CHS. 631 AND 632, WIS. STAT. (the "Contracts" chapters), APPLY TO ALL KINDS OF INSURANCE?

The laws and regulations in these chapters apply to all insurance policies delivered or issued for delivery in this state on:

- Persons residing in Wisconsin when the policy is issued;
- Property ordinarily located in Wisconsin; or
- Business operations in Wisconsin.

[s. 631.01 (1)]

IS AN INSURANCE COMPANY RESPONSIBLE FOR INFORMATION KNOWN TO ITS AGENTS?

An insurance company is deemed to know any fact material to the risk or which violates a condition of the policy:

- If the insurance company's agent who bound the company, issued the policy or transmitted the application to the insurer knew the fact at the time he or she acted; or
- If afterwards any of the company's agents learned of the fact during the course of dealing with the policyholder as an agent and knew that the fact pertained to the policy.

[s. 631.09 (1)]

IS NOTICE TO AN AGENT NOTICE TO THE INSURANCE COMPANY?

Yes. The insurance company has been notified if the company's authorized agent has been notified by or on behalf of the policyholder or insured and provided with sufficient information to identify the policy in question.

[s. 631.09 (3)]

HOW IS THE INSURER PROTECTED FROM COLLUSION BETWEEN THE POLICYHOLDER AND AGENT?

If the agent and policyholder or insured acted together to deceive or defraud the insurance company, the sections on knowledge of the insurance company and acts of agents do not apply. The two sections also do not apply if the policyholder or the insured knew the agent was acting beyond the scope of the agent's authority.

[s. 631.09 (4)]

WHAT IS A REPRESENTATION BY AN APPLICANT?

Representations are oral or written statements made by an applicant. Insurance coverage is issued on the basis of the applicant's representations.

[Common Law, s. 631.11]

WHAT IS MISREPRESENTATION BY AN INTERMEDIARY?

Misrepresentation by an intermediary is the use of written or oral statements which incorrectly describe the terms or benefits of any policy.

[Common Law, s. 631.11]

WHAT IS A MATERIAL MISREPRESENTATION BY AN APPLICANT?

A material misrepresentation is an untrue statement made by an applicant that would influence a prudent insurer in determining whether to accept the risk or in fixing the amount of the premium in the event of such acceptance.

[Common Law, s. 631.11]

WHAT IS A WARRANTY?

A warranty is a statement made in an insurance contract by the insured when the validity of the insurance contract depends on the literal truth of the statement. The parties to the contract mutually intend that the policy will not be binding unless the statement is true.

[Common Law, s. 631.11]

WHAT IS AN AFFIRMATIVE WARRANTY?

An affirmative warranty is an express or implied positive representation in the policy which affirms an existence of a fact at the time the policy was entered into.

[Common Law, s. 631.11]

WHAT IS A PROMISSORY WARRANTY?

A promissory warranty is a warranty that certain things will be done or not be done after the policy has taken effect.

[Common Law, s. 631.11]

WHEN DOES A STATEMENT, REPRESENTATION, OR WARRANTY AFFECT THE INSURER'S OBLIGATIONS UNDER A POLICY?

No statement, representation, or warranty made by a person other than the insurer or an agent of the insurer in the negotiation for an insurance contract affects the insurance company's obligations under the policy unless it is stated in any of the following:

1. The policy.

2. A written application signed by the person provided that a copy of the written application is made a part of the policy by attachment or endorsement.

3. A written communication provided by the insurer to the insured within 60 days after the effective date of the policy.

[s. 631.11 (1) (a)]

MUST A COPY OF THE APPLICATION BE MADE AVAILABLE TO THE INSURED?

The policyholder under disability (health) insurance policy and any person whose health is insured under the policy may request in writing a copy of the application if he or she did not receive the policy or a copy of it. The request may also be made if the policy has been reinstated or renewed without attachment of a copy of the original application. If the insurance company does not deliver or mail a copy as requested within 15 working days after the company or its agent receives the request, nothing in the application may affect the insurance company's obligations under the policy to the person making the request. The same conditions and results apply where a group policy certificate holder is not informed by the insurer how such person may inspect the policy and application during normal business hours at a place reasonably convenient to the certificate holder.

[s. 631.11 (4m) (a)]

WHAT IS THE EFFECT OF A MISREPRESENTATION OR BREACH OF AN AFFIRMATIVE WARRANTY ON THE INSURER'S OBLIGATIONS?

No misrepresentation, and no breach of an affirmative warranty, that is made by a person other than the insurer or an agent of the insurer in the negotiation for or procurement of an insurance contract constitutes grounds for rescission of, or affects the insurer's obligations under, the policy unless, if a misrepresentation, the person knew or should have known that the representation was false, and unless any of the following applies:

- The insurer relies on the misrepresentation or affirmative warranty and the misrepresentation or affirmative warranty is either material or made with intent to deceive.

- The fact misrepresented or falsely warranted contributes to the loss.

[s. 631.11 (1) (b)]

WHAT EFFECT DOES THE INSURER'S KNOWLEDGE HAVE ON ITS OBLIGATIONS?

No misrepresentation made by or on the behalf of a policyholder and no breach of an affirmative warranty or failure of a condition constitutes grounds for rescission of, or affects an insurer's obligations under, an insurance policy if at the time the policy is issued the insurer has either constructive knowledge of the facts [under s. 631.09 (1), Wis. Stat.] or actual knowledge. If the application is in the handwriting of the applicant, the insurer does not have constructive knowledge under s. 631.09, Wis. Stat., merely because of the agent's knowledge.

[s. 631.11 (4) (a)]

If after issuance of an insurance policy an insurer acquires knowledge of sufficient facts to constitute grounds for rescission of the policy under this section or a general defense to all claims under the policy, the insurer may not rescind the policy and the defense is not available unless the insurer notifies the insured within 60 days after acquiring such knowledge of its intention to either rescind the policy or defend against a claim if one should arise, or within 120 days if the insurer determines that it is necessary to secure additional medical information.

[s. 631.11 (4) (b)]

WHAT ARE THE PRIVACY PROTECTIONS UNDER WISCONSIN INSURANCE LAW?

Wisconsin consumers are provided with privacy protection for medical and financial information. These laws correspond with the requirements under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Gramm-Leach-Bliley Act (GLB) enacted in 1999. Chapter Ins 25, Wis. Adm. Code, addresses insurance agents' responsibilities when sharing consumer and customer private personal financial and health information with third parties. The administrative code requires that a licensee provide written notice of its privacy policies and practices. It also establishes requirements for privacy

notices. Insurance agents may, for the most part, rely on the insurance companies with which they are listed to provide the required notices and disclosure. However, insurance agents who perform activities in addition to marketing products for insurance companies or who share client personal information may be responsible for obtaining authorization and providing notice to clients who meet the definition of consumers and customers.

[ch. Ins 25]

WHAT ARE THE MEDICAL RECORDS PRIVACY PROTECTIONS UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted a statute that regulates the disclosure of personal medical information. It places restrictions on both insurers and the persons that regularly assemble or collect personal medical information for the primary purpose of providing the personal medical information to insurers for the determination of an individual's eligibility for an insurance coverage, benefit or payment or for the servicing of an insurance application, policy or certificate. The law delineates the form that is to be used in obtaining authorization for release of personal medical information, the timeframe for which such information may be requested and maintained, how and to whom information may be released to other entities or health care providers, notice requirements to individuals or insureds and the right of the individual to request a correction, amendment or deletion of personal medical information that is in the insurer's possession.

[s. 610.70]

WHAT ARE THE PRIVACY PROTECTIONS REGARDING NONPUBLIC PERSONAL FINANCIAL INFORMATION UNDER WISCONSIN INSURANCE LAW?

Wisconsin enacted rules that require insurance companies and agents to provide written notice of its privacy policies and practices. The rule describes the conditions under which insurance companies and their agents may disclose nonpublic personal financial information. The rule also establishes requirements for privacy notices.

The rule also establishes restrictions on the sharing of health information. However, as Wisconsin has a separate statute regarding Medical Records Privacy, the provisions of the rule apply primarily to health information relating to claimants against worker's compensation or commercial liability insurance policies.

[ch. Ins 25]

WHEN ARE AGENTS REQUIRED TO PROVIDE PRIVACY NOTICES?

Agents can rely on the notice procedures of the insurance companies they represent as long as the agent does not share the nonpublic personal information as provided by the rule. If the agent shares the information with third parties in activities that are not excepted by the rule, the agent will be required to issue the same type of notices required of the insurer.

[ch. Ins 25]

DISPOSAL OF RECORDS CONTAINING PERSONAL INFORMATION

Wisconsin statutes include provisions regarding the proper disposal of personal medical information. The law is often referred to as the "dumpster diving law." It requires that insurers that obtain information from an insured, or an individual seeking coverage, pertaining to the individual's physical or mental health, medical history or medical treatment take specific steps to ensure that this personally identifiable information is shredded, erased, modified or otherwise handled so that no unauthorized person has access to the information.

[s. 134.97]

Use of Policy Forms

MAY ANY INSURANCE POLICY FORM BE USED IN WISCONSIN?

Unless specifically exempt under the statutes, no policy form may be used in Wisconsin unless it has been filed with the Commissioner.

[s. 631.20]

WHAT ARE THE READABILITY STANDARDS FOR INSURANCE POLICIES?

A rule relating to the readability of insurance policies went into effect in Wisconsin in 1980. The rule implements s. 631.22, Wis. Stat.

The rule applies to consumer insurance policies issued or delivered in Wisconsin. Consumer insurance policies are defined as life, disability (health), property or casualty policies and certificates or substitutes for certificates for group life, disability (health), property or casualty insurance coverage, issued for family, personal, or household purposes. There are some exemptions.

When policies subject to the rule are submitted for filing or approval, they must be accompanied by a certification stating that the policy meets the minimum standards.

[s. 631.22, s. Ins 6.07]

MUST INSURERS NOTIFY POLICYHOLDERS OF THEIR RIGHT TO FILE A COMPLAINT?

Yes. Insurers are required to notify their insureds of their right to file a complaint with the Office of the Commissioner of Insurance regarding problems they may have with their insurance. The notice is required once for each policy or certificate issued by an insurer.

[s. 631.28, s. Ins 6.85]

E. Regulation of Specific Clauses in Insurance Contracts

Insurance Claims

WHAT NOTICE AND PROOF OF LOSS REQUIREMENTS APPLY TO THE INSURED?

If a proof of loss is furnished to the insurer as soon as reasonably possible and within one year after the time it was required by the policy, failure to furnish such notice or proof within the time required by the policy does not invalidate or reduce a claim unless the insurer is harmed as a result and it was reasonably possible to meet the time limit.

The notice or proof of loss is sufficient if it is properly mailed to the insurer within the time prescribed. The Commissioner may expressly approve clauses requiring more prompt and efficient methods of notice where that is reasonable.

The acknowledgment by the insurer of the receipt of notice, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim is not alone sufficient to waive any of the rights of the insurer in defense of any claim arising under the insurance contract.

[s. 631.81]

ARE THERE STANDARDS FOR INSURANCE CLAIM SETTLEMENT PRACTICES?

Wisconsin law regulates insurance claim settlement practices in order to promote the fair and equitable treatment of policyholders, claimants, and insurers by defining certain claim adjustment practices as unfair business methods and practices in the insurance business.

[s. 628.46, s. Ins 6.11]

HOW PROMPTLY MUST CLAIMS BE PAID?

Unless otherwise provided by Wisconsin law, subject to interest payment, an insurer must promptly pay most insurance claims. A covered claim is overdue if not paid within 30 days after the insurer is furnished with a written notice of the fact of covered loss and the amount of loss.

If the written notice of the entire claim is not sent to the insurer, any partial amount supported by written notice is overdue if not paid within 30 days. A payment is not overdue if the insurer has reasonable proof to establish that the insurer is not responsible for the payment, even when written notice has been furnished to the insurer.

The date of payment is the date a check or payment was properly mailed or, if not mailed, the date of delivery of the payment. All overdue payments are charged simple interest at the rate of 12% per year.

The payment of a claim is not overdue until 30 days after the insurer receives the proof of loss required under the policy or equivalent evidence. Also, a delay in payment may be justified if the insurer cannot determine to whom the claim should be paid.

[s. 628.46]

WHAT ARE SOME EXAMPLES OF UNFAIR CLAIM SETTLEMENT METHODS AND PRACTICES?

Any of the following done without just cause and with such regularity as to indicate a general business practice, constitute an unfair method and practice:

[s. Ins 6.11 (3) for additional examples]

- Failure to promptly acknowledge pertinent communications with respect to claims arising under insurance policies;
- Failure to promptly provide the necessary claim forms, instructions, and reasonable assistance to insureds and claimants;
- Failure to attempt in good faith to effectuate fair and equitable settlements of claims in which liability has become reasonably clear;
- Knowingly misrepresenting to claimants pertinent facts or policy provisions.

[s. Ins 6.11]

IX. Wisconsin Statutes, Rules, and Regulations Pertinent to Disability (A&H) Insurance Only

Disability (Health) Insurance

Disability (health) insurance, previously labeled as “accident and health” insurance, is generally defined as any type of insurance that covers policy claims involving: (1) medical and surgical expenses; (2) indemnities for loss of income due to accident or health; (3) accidental death and disability (health); (4) hospital care; and (5) long-term care.

Most disability (health) policies offer a wide range of coverages and limits. The Commissioner has the authority to regulate the terms of insurance contracts to protect the policyholder. The insurance laws establish statutory standards, explicit enough to protect the insured and to give the Commissioner authority to set specific standards and provisions through rule-making powers.

A. Policy Provisions

DOES A POLICYHOLDER WITH AN INDIVIDUAL DISABILITY (HEALTH) INSURANCE CONTRACT HAVE A “RIGHT TO RETURN” THE POLICY ONCE IT HAS BEEN ISSUED?

A policyholder may return any individual disability (health) policy within 10 days after receiving it. If the policyholder returns the policy within the 10-day period, the insurance contract is invalid and all payments made under the contract must be refunded.

The “right to return” must be printed on or attached to the first page of each individual policy.

This “right to return” does not apply to single premium nonrenewable policies issued for terms not greater than six months or accident-only policies.

[s. 632.73]

MAY AN INSURER CONTEST A DISABILITY (HEALTH) POLICY ON THE GROUND THAT THE INSURED MADE A MISREPRESENTATION?

Disability (health) policies are incontestable once they have been in force for two years. This means that statements made by an applicant in an application attached to an individual disability (health) insurance policy may not be the basis for voiding a policy, or denying a claim for loss incurred or disability beginning after coverage has been in effect for two years. The contract may provide for a shorter period of contestability. Fraudulent misrepresentation constitutes a valid ground for voiding the policy, regardless of the length of time the policy has been in effect. The policy may provide for incontestability even with respect to fraudulent misstatements.

[s. 632.76 (1)]

WHAT IS PORTABILITY?

An insurer must reduce a preexisting condition waiting period under a group health benefit plan by the aggregate of an employee’s or dependent’s periods of creditable coverage on the individual’s enrollment date under the employer’s plan. Creditable coverage means coverage under a group health plan, health benefit plan, Medicare, Medicaid, a health plan offered under chapter 89 of title 5 or chapter 55 of title 10 of the United States Code, a state health benefits risk pool, a public health plan, a health plan under the federal Peace Corps Act, or a medical care program of the federal Indian health service or of an American Indian tribal organization. Periods of creditable coverage after which the individual was not covered under any creditable coverage for a period of at least 63 days before enrollment in the employer’s plan may not be

counted. Any waiting period or affiliation period for coverage under the employer's plan may not be counted in determining the period before enrollment in the employer's plan.

An insurer offering a group health benefit plan must count a period of creditable coverage without regard to the specific benefits for which the individual had coverage during the period, unless the insurer elects to reduce the preexisting condition waiting period by the amount of time the individual had prior creditable coverage within each of several classes or categories of benefits. These categories of benefits are limited to prescription drug, dental, vision, mental health, and substance abuse treatment.

This election must be made on a uniform basis for all individuals. Insurers electing the second option must count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category. Insurers must also prominently state in any disclosure statements concerning coverage and to each employer at the time of the offer or sale of coverage that the insurer has elected the second option and what the effect of that election will be.

[s. 632.746 (3)]

HOW DO INDIVIDUALS PROVE THEY HAVE CREDITABLE COVERAGE?

Insurers that provide health benefit plan coverage must provide a written certification of creditable coverage when an individual ceases to be covered under a health benefit plan, when an individual becomes covered under COBRA continuation coverage, and when an individual ceases to be covered under COBRA continuation. Insurers must also provide a certification upon the request of an individual that is made no later than 24 months after the date the individual's coverage ceases, or the date the individual's COBRA continuation begins or ceases, whichever is later. The certification must include information concerning the individual's period of creditable coverage; the coverage, if any, under COBRA; and the waiting period, if any, under the individual's health benefit plan.

[s. 632.746 (4)]

WHAT GRACE PERIODS ARE REQUIRED IN INDIVIDUAL DISABILITY (HEALTH) INSURANCE POLICIES FOR LATE PREMIUM PAYMENTS?

Every disability (health) insurance policy with weekly premiums must contain a provision for a grace period of at least 7 days. Policies with monthly premiums must provide for a grace period of at least 10 days. All other policies require a 31-day grace period. These grace periods apply only to the premiums that follow the initial premium payment. A policy continues in effect during the grace period.

[s. 632.78 (1)]

WHAT IS A GRIEVANCE?

A grievance is any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured including:

- Provision of services.
- Determination to reform or rescind a policy.
- Determination of diagnosis or level of service required for evidence-based treatment of autism spectrum disorders.
- Claim practices.

[s. Ins 18.01 (4)]

WHAT TYPE OF HEALTH POLICIES MUST DEVELOP AN INTERNAL GRIEVANCE PROCEDURE?

All insurers that issue health benefit plans must develop an internal grievance procedure. Health benefit plans do not include accident only or disability income insurance. Insurers are required to file with the OCI an annual grievance report.

[ss. 632.745 (11), 632.83, s. Ins 18.02 (1)]

WHAT IS AN INDEPENDENT REVIEW?

The independent review process provides an insured with an opportunity to have medical professionals who have no connection to their health plan review a dispute. The independent review organization (IRO) assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the disputed medical condition. The IRO has the authority to determine whether the treatment should be covered by the health plan.

[s. 632.835, s. Ins 18.01 (6)]

IS THERE A COST TO THE INSURED?

No, there is no cost to the insured. The health plan is required to pay the IRO's total fees.

[s. 632.835, s. Ins 18.11 (2) (a) 4.]

B. Coverages

MUST INSURERS PROVIDE COVERAGE FOR NURSE PRACTITIONERS?

Insurers or self-funded municipalities or self-funded school districts cannot refuse to provide coverage for certain specified tests, examinations, or associated laboratory fees when performed by a nurse practitioner if the policy would provide coverage for the same services when performed by a physician.

[s. 632.87 (5)]

MUST INSURERS PROVIDE COVERAGE FOR OPTOMETRISTS?

Insurers may not, under a contract or plan covering vision care services or procedures, refuse to provide coverage for such services provided by an optometrist if the contract or plan includes coverage for the same services or procedures when provided by another health care practitioner.

[s. 632.87 (2)]

MUST INSURERS PROVIDE COVERAGE FOR CHIROPRACTIC BENEFITS?

Insurers must include coverage of services by a licensed chiropractor for diagnosis and treatment of a condition or complaint within the scope of the chiropractor's professional license if the policy covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath. Medicare supplement policies cover the usual and customary expense for services provided by a chiropractor. This benefit is available even if Medicare does not cover the claim. Insurers are prohibited from:

- Restricting or terminating chiropractic coverage on the basis of an examination or evaluation other than by a chiropractor or peer review panel containing a chiropractor;
- Establishing underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers;
- Refusing to provide coverage to an individual because the individual has been treated by a chiropractor; or

- Excluding or restricting health care coverage of a health condition solely because the condition may be treated by a chiropractor.

Claims for chiropractic services must be paid within 30 days after the insurer receives clinical documentation from the chiropractor unless, on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for treatment.

[s. 632.87 (3)]

WHAT STANDARDS APPLY TO COVERAGE OF EMERGENCY MEDICAL SERVICES?

An insurer that provides coverage of any emergency medical services may not deny coverage for emergency services that a reasonably prudent person would consider an emergency, and that are required to evaluate or stabilize the patient. An insurer can also not require prior authorization for emergency services.

[s. 632.85]

WHAT RESTRICTIONS APPLY TO INSURERS WHO ONLY PROVIDE COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND DEVICES?

Insurers that use a formulary or other list of preapproved drugs and devices must have a process to permit a physician to request an individual exception for coverage of a drug or device not normally covered under the plan.

[s. 632.853, s. Ins 3.67 (2)]

WHAT REQUIREMENTS PERTAIN TO COVERAGE FOR EXPERIMENTAL TREATMENT?

Insurers that limit coverage for experimental treatment must disclose such limitations in its policies and certificates and have a procedure for handling requests for prior authorization of an experimental procedure. Insurers must issue a coverage decision on a request for experimental treatment within five working days of receiving the request. Insurers must also have a procedure to allow an insured to appeal a denial of coverage for an experimental treatment.

[s. 632.855, s. Ins 3.67 (3)]

ARE THERE SPECIAL RIGHTS FOR HANDICAPPED CHILDREN COVERED BY DISABILITY (HEALTH) POLICIES?

Hospital or medical expense policies that cover the dependent children of an insured may end coverage when the child reaches the age stated in the contract. However, coverage of a dependent child cannot be ended while the child continues to be both:

- Incapable of self-sustaining employment because of mental retardation or physical handicap; and

- Chiefly dependent upon the person insured under the policy for support and maintenance.

[s. 632.88]

WHAT COVERAGE MUST BE PROVIDED FOR DEPENDENTS OF AN APPLICANT OR INSURED?

Insurers or self-funded municipalities or self-funded school districts must offer and, if so requested by an applicant or an insured, provide coverage for an adult child as a dependent of the applicant or insured if the child is over 17 but less than 26 years of age.

The coverage requirement also applies to an adult child who is a full-time student and called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while attending an institution of higher education on a full-time basis, and under the age of 27 when called to federal active duty.

[s. 632.885]

WHAT BENEFITS ARE EMPLOYERS WITH FEWER THAN 10 EMPLOYEES THAT ELECT TO BE EXEMPT REQUIRED TO PROVIDE FOR ALCOHOLISM, DRUG ABUSE, AND MENTAL AND NERVOUS DISORDERS?

HMOs are required to provide certain benefits for outpatient treatment of nervous and mental disorders, alcoholism, and other drug abuse to a dependent student who is attending a school of higher education located in this state but outside the HMO's service area, if the HMO would have provided benefits for such services by a selected provider within the service area.

[ss. 609.05 (3), 609.655]

WHAT BENEFITS MUST BE PROVIDED FOR HOME CARE?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, providing coverage of expenses incurred for inpatient hospital care must provide coverage for no less than 40 home health care visits in any 12-month period for each person covered under the policy. Home health care means the care and treatment of an insured under a plan of care established by the attending physician, which may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies and medication prescribed under the home care plan, and nutrition counseling. If an insurer provides disability (health) insurance, or if two or more insurers jointly provide disability (health) insurance, to an insured under two or more policies, home health care coverage is required under only one of the policies.

Insurers may not deny coverage of a home health care claim based solely on Medicare's denial of benefits.

Insurers must disclose and clearly define the home care benefits and limitations in a disability (health) insurance policy, certificate, and outline of coverage.

[s. 632.895, s. Ins 3.54]

WHAT BENEFITS MUST BE PROVIDED FOR SKILLED NURSING CARE?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that covers hospital expenses must provide coverage for at least 30 days for skilled nursing care to patients who enter a licensed skilled nursing care facility. Coverage may be limited to care that is certified as medically necessary by the attending physician. A disability (health) insurance policy other than a Medicare supplement or Medicare replacement policy may limit coverage to patients who enter a licensed skilled nursing care facility within 24 hours after discharge from a hospital to receive continued care that is for the same condition as treated in the hospital.

[s. 632.895 (3)]

WHAT BENEFITS MUST BE PROVIDED FOR KIDNEY DISEASE TREATMENT?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that covers hospital expenses must provide coverage for hospital inpatient and outpatient treatment of kidney disease, which may be limited to dialysis, transplantation, and donor-related services. The coverage is not required to duplicate Medicare benefits and may be subject to the same limitations that apply to other covered health conditions.

[s. 632.895 (4)]

MUST A DISABILITY (HEALTH) INSURANCE POLICY PROVIDE COVERAGE FOR NEWBORN INFANTS?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, must provide coverage for a newly-born child of the insured from the moment of birth. The newborn has the same coverage as the policy provides for any children covered or eligible for coverage under the policy, except that waiting periods do not apply. If a person who is pregnant or whose spouse is pregnant makes application for a policy providing hospital and/or medical expense benefits, the insurer may not issue a policy that excludes or limits benefits for the expected child. The policy must be issued without the exclusion or limitation. Coverage for newly-born children must treat congenital defects and birth abnormalities as an injury or sickness under the policy. The disability (health) policy must cover functional repair or restoration of any body part when necessary to achieve normal body functioning. Coverage is not required for "cosmetic" surgery performed only to improve appearance.

[s. 632.895 (5), s. Ins 3.38]

WHAT IF AN ADDITIONAL PREMIUM IS REQUIRED TO PROVIDE COVERAGE FOR A NEWBORN INFANT?

If the payment of a specific premium or subscription fee is required to provide coverage for a child, the policy may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. The insurer may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes all past due payments with interest at the rate of 5 1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may request notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished.

[s. 632.895 (5)]

MUST A DISABILITY (HEALTH) INSURANCE POLICY PROVIDE COVERAGE FOR ADOPTED CHILDREN?

Yes. Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage for dependent children of the insured must provide coverage for children who are adopted or placed for adoption. This includes health maintenance organizations, preferred provider plans, and limited service health organizations.

[ss. 609.75, 631.07 (3) (a) 3. m., 632.896]

MUST GRANDCHILDREN BE COVERED?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage for a dependent child of the insured must provide the same coverage for children of the dependent child until the dependent child is age 18.

[s. 632.895 (5m)]

WHAT BENEFITS MUST BE PROVIDED FOR TREATMENT OF DIABETES?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides coverage of expenses incurred for treatment of diabetes must provide coverage for expenses incurred by the installation and use of an insulin infusion pump and provide coverage for all other equipment and supplies, including insulin or any other prescription medication, used in the treatment of diabetes. Policies must also provide coverage of diabetic self-management education programs.

Coverage may be subject to the same deductible and coinsurance as other covered expenses. Insulin infusion pump coverage may be limited to the purchase of one pump per year and the insurer may require the insured to use a pump for 30 days before purchase.

Prescription medication coverage for the treatment of diabetes is not available under a Medicare supplement policy or Medicare replacement policy issued after January 1, 2006, because the coverage is available under Medicare Part D.

[s. 632.895 (6)]

MUST MATERNITY BENEFITS BE PROVIDED FOR DEPENDENT CHILDREN?

Every group disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, that provides maternity coverage must provide maternity coverage for all persons covered under the policy. If a group policy provides maternity coverage for the insured or insured's spouse, the maternity coverage must also be provided for any dependent children covered under the policy.

[s. 632.895 (7)]

WHAT BENEFITS MUST BE PROVIDED FOR MAMMOGRAMS?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy that provides coverage for a woman age 45 or older, must provide coverage for periodic mammographies. Coverage is required regardless of whether the woman shows any symptoms of breast cancer. The policy may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy.

[ss. 609.80, 632.895 (8)]

WHAT BENEFITS MUST BE PROVIDED FOR LEAD POISONING SCREENING?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only policy, specified disease, Medicare supplement, Medicare replacement or long-term care policy, must provide coverage for blood lead tests for children under 6 years of age, which are conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and social services.

[s. 632.895 (10)]

WHAT BENEFITS MUST BE PROVIDED FOR TEMPOROMANDIBULAR JOINT DISORDERS?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only, dental, Medicare supplement and Medicare replacement policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle or tissue must provide coverage for diagnostic procedures and medically necessary surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

[s.632.895 (11)]

WHAT BENEFITS MUST BE PROVIDED FOR HOSPITAL AND AMBULATORY SURGERY CENTER CHARGES AND ANESTHETICS FOR DENTAL CARE?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only or dental policy, but including self-funded municipalities or self-funded school district plans, must cover hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if any of the following applies:

1. The individual is a child under the age of 5

2. The individual has a chronic disability that meets all the conditions in s. 230.04 (9r) (a) 2. a., b., and c., Wis. Stat.

3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

[s. 632.895 (12)]

WHAT BENEFITS MUST BE PROVIDED FOR BREAST RECONSTRUCTION?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but self-funded municipalities or self-funded school district plans, that provides coverage for a mastectomy must provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

[s. 632.895 (13)]

WHAT BENEFITS MUST BE PROVIDED FOR IMMUNIZATIONS FOR CHILDREN?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, hospital/surgical, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a dependent of an insured must provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments, or coinsurance under the policy or plan.

[s. 632.895 (14)]

WHAT BENEFITS MUST BE PROVIDED FOR TREATMENT FOR AUTISM SPECTRUM DISORDERS?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by a professional qualified to provide intensive-level services or nonintensive-level services.

[s. 632.895 (12m)]

WHAT BENEFITS MUST BE PROVIDED FOR A STUDENT ON MEDICAL LEAVE?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage for a person as a dependent of the insured because the person is a full-time student must continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student. The policy continuation is limited to one year from the date the person's coverage continuation began and the person has not returned to school full time. This statute is also known as Michele's Law.

[s. 632.895 (15)]

WHAT BENEFITS MUST BE PROVIDED FOR HEARING AIDS, COCHLEAR IMPLANTS, AND RELATED TREATMENT FOR INFANTS AND CHILDREN?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, must provide coverage of the cost of hearing aids and cochlear implants that are prescribed for a child covered under the policy who is under 18 years of age and who is certified as deaf or hearing impaired by a physician or by an audiologist.

[s. 632.895 (16)]

WHAT BENEFITS MUST BE PROVIDED FOR COLORECTAL CANCER SCREENING?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, or accident only policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of any diagnostic or surgical procedures must provide coverage of colorectal cancer examinations and laboratory tests for insureds and enrollees who are 50 years of age or older and for insureds or enrollees under age 50 and at high risk for colorectal cancer.

[s. 632.895 (16m)]

WHAT BENEFITS MUST BE PROVIDED FOR CONTRACEPTIVES AND SERVICES?

Every disability (health) insurance policy, other than a hospital indemnity, income continuation, accident only policy, specified disease, limited-scope dental or vision, Medicare supplement, Medicare replacement, or long-term care policy, but including self-funded municipalities or self-funded school district plans, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices must provide coverage of all of the following:

- Contraceptives prescribed by a health provider.

- Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if covered for any other drug benefits under the policy or plan.

[s. 632.895 (17)]

WHAT BENEFITS MUST BE PROVIDED FOR CANCER CLINICAL TRIALS?

No policy, plan or contract may exclude coverage for the cost of any routine patient care that is administered to an insured in an approved cancer clinical trial satisfying the specific criteria described in the regulation. The policy, plan, or contract is not required to reimburse services by a nonparticipating provider at the same rate as a participating provider.

[s. 632.87 (6)]

C. Marketing Methods and Practices

WHAT STANDARDS APPLY TO ADVERTISEMENTS FOR DISABILITY (HEALTH) INSURANCE?

Prospective buyers of disability (health) insurance must be provided with clear and unambiguous statements, explanations, advertisements, and written proposals concerning policies offered to them.

Section Ins 3.27, Wis. Adm. Code, outlines the minimum standards and guidelines for the advertising and selling of disability (health) insurance policies.

Advertisements and representations must be truthful, and not misleading, and must accurately describe the policy to which they apply.

In addition, the content, form, and method of dissemination of all advertisements, regardless by whom designed, created, written, printed, or used, are the responsibility of the insurer whose policy is advertised. Insurers must require agents to submit all proposed disability (health) advertising to them prior to use.

[s. 628.34, s. Ins 3.27]

WHAT IS AN ADVERTISEMENT?

An advertisement means printed as well as oral representations. This includes:

- Printed and published material, audio visual material, and descriptive material and literature of an insurer used in the media, including the internet and web pages, except for advertisements prepared for the sole purpose of obtaining employees, intermediaries, or agencies;

- Descriptive literature and sales aids of all kinds issued by an insurer or intermediary for presentation to members of the public;

- Prepared sales talks, presentations of material used by intermediaries and representations made by agents in accordance with these talks and presentations, except for materials to be used solely by the insurer for the training and education of its employees or intermediaries.

[s. 628.34, s. Ins 3.27 (5) (a)]

WHO IS RESPONSIBLE FOR DETERMINING THE "SUITABILITY" OF A POLICY FOR A PROSPECTIVE BUYER?

Before an intermediary or insurer can advise a prospective buyer to buy an individual policy, the agent or insurer must have reasonable grounds to believe that the recommendation is not unsuitable for the applicant.

The intermediary or insurer must ask such questions as are necessary to determine that the purchase of such insurance is not unsuitable for the prospective buyer.

This rule does not apply to an individual policy issued on a group basis.

[s. 628.34, s. Ins 3.27 (7)]

MUST AN ADVERTISEMENT IDENTIFY THE INSURANCE COMPANY?

The identity of the insurer must be made clear in all of its advertisements. An advertisement may not use a trade name, insurance group designation, name of the parent company of the insurer, name of a government agency or program, name of any other organization, service mark, slogan, or symbol or any device that has the capacity and tendency to mislead or deceive as to the identity of the insurer.

An advertisement may not use any combination of words, symbols, or materials that, by their content, phraseology, shape, color, nature, or other characteristics, is so similar to any materials used by federal, state, or local government agencies that it tends to confuse or mislead prospective buyers into believing that the solicitation is in some manner connected with the government agency.

[s. 628.34, s. Ins 3.27 (12)]

WHAT REQUIREMENTS MUST ADVERTISEMENTS MEET REGARDING TESTIMONIALS, ENDORSEMENTS, OR COMMENDATIONS BY THIRD PARTIES?

A testimonial means any statement made by a policyholder, or certificate holder that promotes the insurer and its policy by describing such person's benefits, favorable treatment, or other experience under the policy.

An endorsement means any statement promoting the insurer and its policy made by an individual, group of individuals, society, association, or other organization that makes no reference to the endorser's experience under the policy.

The testimonial or endorsement must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. An advertisement may not state or imply that an insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organization, unless it is a fact. An advertisement may not state or imply that a government publication has commended or recommended the insurer or its policy.

An advertisement may not contain a testimonial, endorsement, or other statement concerning the insurer, its policies, or activities by any person who receives direct or indirect compensation from the insurer in connection with the testimonial, endorsement, or statement, unless the advertisement discloses that the person giving the testimonial or endorsement is being paid. The rules of this paragraph do not apply if the person making the testimonial, endorsement, or statement holds a Wisconsin insurance intermediary license, or if the person is a radio or television announcer that is employed or compensated on a salaried or union wage scale basis.

[s. 628.34, ss. Ins 3.27 (5), (13)]

ARE ADVERTISEMENTS ALLOWED TO CONTAIN DISPARAGING COMPARISONS AND STATEMENTS?

An advertisement may not directly or indirectly make unfair or incomplete comparisons of policies or benefits. An advertisement may not falsely or unfairly disparage, discredit, or criticize competitors, their policies, services, or business methods or competing marketing methods.

[s. 628.34, s. Ins 3.27 (23)]

WHAT IS THE METHOD OF DISCLOSURE OF REQUIRED INFORMATION?

All information required to be disclosed to the prospective buyer by s. Ins 3.27, Wis. Adm. Code, must be set out clearly, conspicuously, and in close proximity to the statements to which such information relates. Required information can also be set out under appropriate captions of such prominence that it is readily noticed and not minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[s. 628.34, s. Ins 3.27 (24)]

WHAT OTHER STANDARDS MUST BE MET WHEN AN ADVERTISEMENT CONTAINS STATEMENTS ABOUT AN INSURER?

An advertisement may not contain statements that are untrue or are by implication misleading with respect to the insurer's assets, corporate structure, financial standing, age, experience, or relative position in the insurance business.

[s. 628.34, s. Ins 3.27 (22)]

D. Requirements for Group Health Policies

WHAT ARE THE CONTINUATION/CONVERSION PRIVILEGES OF INSUREDS UNDER GROUP AND INDIVIDUAL HEALTH INSURANCE POLICIES?

Wisconsin has a continuation/conversion law for both group and individual health insurance policies.

The major provisions are:

- Insurers must permit people who have been insured for at least three months under a group contract to continue group coverage or convert to an individual contract if the group coverage ends because of divorce, annulment, death or any other reason except discharge for misconduct.
- The rate for continued group coverage cannot be more than the group rate (including the employer's contribution).
- Employers must continue to accept premiums from these insureds.
- After 18 months, insurers can require those who elect continuation to switch to an individual conversion policy which has been filed with the Office of the Commissioner of Insurance.
- Insurers or group policyholders must notify insureds of their continuation/conversion options when their group coverage terminates.
- Individual policies under which coverage for dependent spouses and children is terminated after a divorce or annulment must provide a conversion option.
- Wisconsin continuation/conversion law also applies to group and individual long-term care insurance policies.

There is also a federal law relating to continuation. This law (COBRA) applies to most employers with 20 or more employees. There are some differences between the state and federal law. The federal Department of Labor enforces COBRA law.

[s. 632.897, ss. Ins 3.41, 3.42, 3.43, 3.44, 3.45, 3.455]

WHAT IS A SMALL EMPLOYER?

A small employer means an individual, firm, corporation, partnership, limited liability company, or association that is actively engaged in a business enterprise in Wisconsin, including a farm business, and that employs an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year and employs at least 2 employees on the first day of the plan year. All persons treated as a single employer under the Internal Revenue Code of 1986 must be treated as one employer.

[s. 635.02 (7)]

ARE THERE PROHIBITED COVERAGE PRACTICES RELATING TO EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. An insurer that offers a group health benefit plan to an employer must offer coverage to all of the employer's eligible employees and their dependents. Insurers may not offer coverage to only certain individuals in the group or to only part of the group, except for an eligible employee who has not yet satisfied a waiting period, if any.

An eligible employee means an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, including the owner of a farm business, a partner of a partnership and a member of a limited liability company if such a person is included as an employee under a health benefit plan of an employer. The term does not include an employee who works on a temporary or substitute basis.

An insurer that provides coverage under a group health benefit plan must provide coverage to eligible employees and their dependents who become eligible for coverage after the commencement of the employer's coverage, regardless of their health conditions or claims experience, if the employee has satisfied any applicable waiting period and the employer agrees to pay the premium required for coverage of the employee under the plan.

Rules for eligibility to enroll under a group health benefit plan include rules defining any applicable waiting periods for enrollment.

[ss. 632.746 (10), 632.747, 632.748]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF EMPLOYER GROUP HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that offers a group health benefit plan must renew such coverage or continue such coverage in force at the option of the employer and, if applicable, plan sponsor. An insurer may modify a group health benefit plan issued in the large group market at the time of renewal.

An insurer may nonrenew or discontinue a group health benefit plan only for the following reasons:

- Nonpayment of premium.
- Fraud.
- Failure to meet minimum participation or employer contribution requirements.
- The insurer ceases to offer coverage in the market in which the group health benefit plan is included.
- In the case of network plans, there is no longer an enrollee under the plan who resides, lives or works in the service area.
- In the case where coverage is provided through a bona fide association, the employer ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.

An insurer may discontinue offering a particular type of group health benefit plan in either the small or large group market if all the following apply:

1. The insurer provides notice of the discontinuance to each employer and plan sponsor and to the participants and beneficiaries who have such coverage at least 90 days before the date coverage will be discontinued.

2. The insurer offers to each employer or plan sponsor the option to purchase from among all of the other group health benefit plans that the insurer offers in the market in which the discontinued plan is included. However, in the large group market, the insurer must offer each employer or plan sponsor the option to purchase one other group health benefit plan that the insurer offers in the large group market.

3. The insurer must act uniformly without regard to any health status-related factor of any covered participants or beneficiaries who may become eligible for coverage.

An insurer may discontinue offering in this state all group health benefit plans in the large or small group market, or in both, only if all the following apply:

1. The insurer provides notice of the discontinuance to the Commissioner, to each employer and plan sponsor, and to the participants and beneficiaries who have such coverage in this state at least 180 days before the date coverage will be discontinued.

2. All group health benefit plans issued or delivered for issuance in this state in the affected market are discontinued and coverage under such plans is not renewed.

3. The insurer does not issue or deliver for issuance in this state any group health benefit plan in the affected market before 5 years after the day on which the last group health benefit plan is discontinued. [s. 632.749]

ARE THERE SPECIAL REGULATIONS REGARDING THE TERMINATION OR NONRENEWAL OF INDIVIDUAL HEALTH BENEFIT PLANS?

Yes. Except as otherwise permitted below, an insurer that provides individual health benefit plan coverage must renew such coverage or continue such coverage in force at the option of the insured individual and, if applicable, the association through which the individual has coverage. An insurer may modify an individual health benefit plan coverage policy form at the time of renewal, as long as the modification is consistent with state law and effective on a uniform basis among all individuals with coverage under that policy form.

An insurer may nonrenew or discontinue the individual health benefit plan coverage of an individual only for the following reasons:

- Nonpayment of premium.
- Fraud.
- The insurer ceases to offer individual health benefit plan coverage.
- In the case of network plans, the individual no longer resides, lives or works in service area. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- In the case where coverage is provided through a bona fide association, the individual ceases to be a member of the association on which the coverage is based. Coverage must be terminated uniformly without regard to any health status-related factor of any covered individual.
- The individual is eligible for Medicare and the Commissioner by rule permits coverage to be terminated.

An insurer may discontinue offering a particular type of individual health benefit plan coverage in this state if all the following apply:

1. The insurer provides notice of the discontinuance to each individual for whom the insurer provides coverage of this type and, if applicable, the association through which the individual has coverage at least 90 days before the date coverage will be discontinued.

2. The insurer offers to each individual for whom the insurer provides coverage of this type and, if applicable, the association through which the individual has coverage the option to purchase any other type of individual health insurance coverage that the insurer offers for individuals.

3. The insurer must act uniformly without regard to any health status-related factor of individuals who may become eligible for coverage.

An insurer may discontinue offering in this state individual health benefit plan coverage only if all the following apply:

1. The insurer provides notice of the discontinuance to the Commissioner and to each individual for whom the insurer provides individual health benefit plan coverage in this state and, if applicable, to the association through which the individual has coverage at least 180 days before the date coverage will be discontinued.

2. All individual health benefit plan coverage issued or delivered for issuance in this state is discontinued and coverage under such plans is not renewed.

3. The insurer does not issue or deliver for issuance in this state any individual health benefit plan coverage before 5 years after the day on which the last individual health benefit plan coverage is discontinued.

An insurer is not required to renew individual health benefit plan coverage that is marketed and designed to provide short-term coverage as a bridge between coverages.

[s. 632.7495]

ARE THERE SPECIAL REGULATIONS FOR MANAGED CARE PLANS?

Yes. A managed care plan is defined as any health benefit plan that requires or creates incentives for an enrollee to use providers that are owned, managed, or under contract with the insurer offering the health benefit plan.

Wisconsin statutes define three different types of managed care plans. They are health maintenance organizations, preferred provider plans, and limited service health organizations.

A “defined network plan” (managed care plan) is a health benefit plan that requires an enrollee or creates incentives for an enrollee to use providers that are managed, owned, under contract with or employed by the insurer.

A “health maintenance organization” is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

A “limited service health organization” is a health care plan that makes available to enrolled participants, in consideration for predetermined periodic fixed payments, a limited range of health care services performed by providers selected by the organization.

A “preferred provider plan” (PPP) is a health care plan that pays a specific level of benefits if plan providers are used and a lesser amount if non-plan providers are utilized. A PPP offers financial incentives to use network providers through the use of coinsurance and deductible amounts.

Except for an employer with fewer than 25 full-time employees, an employer that offers any of its employees a health maintenance organization or a comprehensive preferred provider plan must also offer employees a standard plan. Employers must give employees an annual opportunity to enroll in the plans provided. Employers must also give employees adequate notice of the opportunity to enroll in the health care plans and complete and understandable information concerning the differences between the plans offered.

[ch. 609, ch. Ins 9]

E. Medicare Supplement

WHAT ABOUT INSURANCE PLANS THAT "SUPPLEMENT" MEDICARE?

Medicare supplemental insurance, also known as Medigap, is designed to provide coverage for some of the "gaps" left by Medicare. Because Medicare may not cover all of the services needed and because Medicare requires recipients to pay deductibles, coinsurance, and copayments, many people purchase Medicare supplement policies to help pay for some of those extra services and costs. Medicare supplement policies are offered by private health insurance issuers. Medicare replacement policies also supplement Medicare benefits but are contracts between the federal government and qualified health maintenance organizations to provide health care benefits to persons eligible for Medicare.

Medicare select, which may be offered by insurance companies and health maintenance organizations (HMOs), is the same as standard Medicare supplement insurance in nearly all respects. The only difference between Medicare select and standard Medicare supplement insurance is that Medicare select policies will only pay full supplemental benefits if covered services are obtained through plan providers selected by the insurance company or HMO.

[ss. 628.34, 632.84, ss. Ins 3.27, 3.39]

F. Short-term Medical Policies

WHAT ARE SHORT-TERM MEDICAL POLICIES?

Short-term medical insurance is designed for healthy individuals and families who do not need coverage for preexisting conditions. Short-term medical policies are temporary solutions that can provide a low-cost safety net in case of illness or injury that might develop during the coverage period.

Most short-term policies limit the amount of time that the insured can keep the policy to 12 months or less. Short-term health insurance is typically bought in one-month increments that make it convenient to drop at the end of any month. Short-term medical policies are not renewable. The insured may apply for one additional policy. This second policy is not a continuation of the first. Insurers can refuse to issue a second policy if the insured filed any claims under the previous short-term policy. Others might offer the insured another policy, but they can treat any injuries or illnesses that occurred during the previous short-term policy as preexisting conditions and will not cover treatment related to such conditions.

Most insurers only sell short-term health policies to people under the age of 65. Each short-term health plan has its own application that contains a number of questions. Additionally, applicants must meet acceptance guidelines, usually including acceptable height and weight.

[s. 632.7495 (4)]

Examination and Licensing Procedures

Information on how to register for the navigator examination and apply for a navigator license is available on OCI's Web site (oci.wi.gov).

WISCONSIN
Insurance Supplement

Examination Content Outlines

Effective Date: August 15, 2013

NAVIGATOR
CONTENT OUTLINE

(50 scoreable questions plus 5 pretest questions)

I. AFFORDABLE CARE ACT(ACA)
- **A. Intent of the Law**
- **B. Supreme Court Decision**
- **C. Major Provisions**
- **D. Essential Health Benefits**
  1. Ambulatory patient services
  2. Emergency services
  3. Hospitalization
  4. Maternity and newborn care
  5. Mental health, substance use disorder services, behavioral health treatment
  6. Prescription drugs
  7. Rehabilitative and habilitative services and devices
  8. Laboratory services
  9. Preventive and wellness services and chronic disease management
  10. Pediatric services, including oral and vision care
- **E. Exemptions**
- **F. Financial assistance availability and determination**
  1. Individuals and families
  2. Public programs (i.e. Medicaid and BadgerCare)
  3. Subsidies and tax credits for small businesses
  4. Groups and financial subsidies
  5. Calculating the Advance Premium Tax Credit (APTC)
- **G. Tax Penalties and Shared Responsibility**
- **H. Tribal Considerations**
  1. Eligibility
  2. Enrollment options

II. Basic Health concepts
- **A. Health care options**
  1. Health Maintenance Organization (HMO) plans
  2. Preferred Provider Organization (PPO) plans
  3. Point of Service (POS) plans
  4. High Deductible Health Plans (HDHP)
  5. Health Savings Accounts (HSA)/ Health Reimbursement Accounts (HRA)
- **B. Cost, premiums, payments**
  1. Copayments
  2. Deductibles
  3. Coinsurance
  4. Low cost and no-cost care available in the Exchange

III. HEALTH INSURANCE EXCHANGES
- **A. Federally Facilitated Exchange**
  1. Eligibility and Enrollment
  2. Tax credits
  3. Call Center
  4. Navigator grant
- **B. Individual Exchange**
- **C. Small Business Health Options (SHOP) Exchange**
- **D. Qualified Health Plans (QHPs)**
  1. Essential Health Benefits
  2. Preventive Health Services
  3. Children's Coverage

IV. NAVIGATORS
- **A. Types**
  1. Navigators
  2. Certified Application Counselors
- **B. Roles and Responsibilities**
  1. Definition and eligible entities
  2. Training and certification of Navigators
  3. Provide fair, accurate and impartial information
  4. Plan eligibility and overview
  5. Plan enrollment procedures (signatures)
  6. Exchange eligibility and changes (individuals and families)
  7. Medicare disqualification
  8. Consumer questions
  9. Compensation
  10. QHP selection (referrals and information)
  11. Conflicts of interest
- **C. Privacy and security of health information**
  1. HIPAA
  2. Confidentiality, integrity and availability of Protected Health Information (PHI)
  3. Penalties for violations or noncompliance with HHS regulations
  4. Criminal acts

V. BROKERS, AGENTS AND PRODUCERS
- **A. Roles and responsibilities**
  1. Ineligibility as a Navigator or Assister due to compensation
  2. Producer licensing, certification and training
  3. Compensation by insurer

VI. OUTREACH AND EDUCATION
- **A. Identify goals (role of Producers, Navigators and Assisters)**
- **B. Medicare and Medicaid**
- **C. Employer-sponsored plans**
  1. Large group employers (51+ employees)
  2. Small group employers
  3. Self-employed business owners

VII. STATE PUBLIC ASSISTANCE PROGRAMS
- **A. State Health Care Assistance Programs**
  1. Medicaid
  2. BadgerCare Plus
- **B. Eligibility**
  1. Financial requirements

2. Nonfinancial requirements

VIII. WISCONSIN STATUTES, RULES, AND REGULATIONS COMMON TO LIFE, DISABILITY (A&H), PROPERTY AND CASUALTY INSURANCE

A. Responsibilities of the Commissioner of Insurance

1. Duties
   Ref: s. 601.41, s. 601.42
2. Examinations
   Ref: s. 601.43, s. 601.45, s. 601.49, s. Ins 16.01, s. Ins 26.10, s. Ins 28.10
3. Hearings
   Ref: ch. 227, s. 227.12, s. 601.41, s. 601.62, s. 601.64, s. 628.10, s. Ins 6.59
4. Penalties
   Ref: s. 601.64, s. 601.65

B. Licensing

1. Purpose
   Ref: ch. 628
2. Persons required to be licensed
   Ref: s. 618.41, ch. 628, s. 628.02-.04, s. 628.49, s. 628.92,s. 632.69, s. Ins 6.58,s. Ins 42.01, s. Ins 42.03, s. Ins 47
3. License requirements
   Ref: ch. 26, s. 628.03, s. 628.04, s. 628.34, s. 628.51, s. Ins 3.465, s. Ins 6.59

C. Marketing practices

1. Types of unfair practices
   Ref: ch. 20, s. 628.34, s. Ins 6.54, s. Ins 6.55, s. Ins 6.67, s. Ins 6.68
2. Responsibilities of the insurer
   Ref: s. 628.11, s. 628.40, s. Ins 6.57
3. Privacy
   Ref: s. 134.97, s. 610.70, s. Ins 25
4. Prohibited Practices for Navigators or nonnavigator assisters.
   Ref. s. 628.95

D. General statutes, rules, and regulations affecting insurance contracts

1. Definitions
   a. Specific knowledge
   Ref: ch. 631, ch. 632
   b. Misrepresentation/Warranties
   Ref: s. 628.34, s. 631.08, s. 631.11
2. Knowledge and acts of the agent
   Ref: s. 631.09, s. 631.11
3. Use of policy forms
   Ref: s. 631.20
4. Readability
   Ref: s. 631.22, s. Ins 6.07
5. Notice of right to file complaint
   Ref: s. 631.28, s. Ins 6.85

E. Regulation of specific clauses in insurance contracts

1. Cancellation
   Ref: s. 102.31,s. 102.315, s. 631.36, s. Ins 6.77, s. Ins 18.10, s. Ins 21.01
2. Renewal/Nonrenewal
   Ref: s. 102.31, s. 102.315, s. 631.36,s. Ins 21.01
3. Notice of proof of loss
   Ref: s. 631.43, s. 631.48, s. 631.81
4. Payment of claims
   Ref: s. 628.46, s. Ins 3.65, s. Ins 3.651, s. Ins 6.11
   a. Unfair claims, methods, and practices
   Ref: s. Ins 6.11, s. Ins 6.55,

IX. WISCONSIN STATUTES, RULES, AND REGULATIONS PERTINENT TO DISABILITY (A&H) INSURANCE ONLY

A. Policy provisions

1. Right to return a policy
   Ref: s. 632.73
2. Grace period
   Ref: s. 632.78(1)
3. Disclosure requirements
   Ref: s. 628.32, s. 635.11, s. Ins 3.60, s. Ins 8.48
4. Continuation and conversion privileges
   Ref: s. 632.897, s. 635.02(7), s. Ins 3.41 – s. Ins 3.45. s. Ins 8.49
5. Independent review
   Ref: s. 632.835, s. Ins 18.01(6), s. Ins 18.10-.11, s. Ins 18.105
6. Grievance
   Ref: s. 632.745(11), s. 632.83, s. Ins 18.01(4), s. Ins 18.02(1)

B. Coverages

1. Nurse practitioners
   Ref: s. 632.87
2. Optometrists
   Ref: s. 632.87(2)
3. Chiropractic benefits
   Ref: s. 632.87
4. Handicapped children
   Ref: s. 632.88
5. Alcohol, drug abuse, mental, and nervous disorders
   Ref: s. 609.05(3), s. 609.655, s. 632.89, s. 632.895(12m)
6. Home care
   Ref: s. 632.895, s. Ins 3.54
7. Skilled nursing facility
   Ref: s. 632.895(3)
8. Kidney disease
   Ref: s. 632.895(4)
9. Diabetes
   Ref: s. 632.895(6)
10. Newborn children
    Ref: s. 632.895(5), s. Ins 3.38
11. Maternity benefits for dependent children
    Ref: s. 632.895(7)
12. Adopted children
    Ref: s. 609.75, s. 631.07(3)(a)3.m, s. 632.896
13. Grandchildren
    Ref: s. 632.895(5m)
14. Mammograms

Ref: s. 609.80, s. 632.895(8)

15. Lead poisoning screening
    Ref: s. 632.895(10)
16. Temporomandibular joint disorders
    Ref: s. 632.895(11)
17. Hospital and ambulatory surgery
    Ref: s. 632.895(12)
18. Breast reconstruction
    Ref: s. 632.895(13)
19. Immunizations
    Ref: s. 632.895(14)
20. Emergency medical services
    Ref: s. 632.85
21. Prescription drugs and devices
    Ref: s. 632.853, s. Ins 3.67(2)
22. Experimental treatment
    Ref: s. 632.855, s. Ins. 3.67(3)
23. Requirements relating to AIDS
    Ref: s. 149.12(1), s. 631.90, s. 631.93, s. 632.895(9), s. Ins 3.53
24. Cancer clinical trials
    Ref: s. 628.34, 632.87(6), s. Ins 3.47

C. Marketing methods and practices

1. Advertising
   Ref: s. 628.34, s. Ins 3.27, s. Ins 3.39(15), s. Ins 3.46(22), s. Ins 6.90
2. Suitability
   Ref: s. 628.34, s. Ins 3.27(7), s. Ins 3.46

D. Requirements for group health policies

Ref: s. 632.746(9), ch. 635, s. 635(19), ch. Ins 8

1. Special provisions
   Ref: s. 600.03(35)(a), s. 625.13, s. 632.746, s. 632.747, s. 632.748, s. Ins 3.13(3)
2. Disclosure requirements
   Ref: s. 635.11, s. Ins 8.48
3. Termination/nonrenewal regulation
   Ref: s. 632.749, s. 632.7495

E. Medicare supplement

Ref: s. 628.34, s. 632.84, s. Ins 3.27, s. Ins 3.39

F. Short-term medical policies

Ref: s. 632.7495(4)

8-4-13

NAVIGATOR PRELICENSING COURSE OUTLINE

SECTION A and B – 8 hours

SECTION A

I. Principles of Insurance
   A. Health insurance terminology
   B. Definition of risk
   C. Pooling concept––law of large numbers
   D. Types of insurance companies (chs. 611, 613, 185, Wis. Stat.)

II. General Wisconsin Insurance Laws
   A. Duties and powers of Insurance Commissioner—statutory and rule−making
   B. Knowledge of administrative action process, including hearings and penalties
   C. Purpose of licensing, including procedures and who must be licensed/registered
   D. Record keeping and changes in navigator status, including change of name and address
   E. License expiration, revocation, suspension, and limitation
   F. General regulations regarding misrepresentation, knowledge of acts of agents, rebating
   G. Unfair claim methods and practices – timely payment of claims
   H. Home and telephone solicitation requirements
   I. Section 628.32, written disclosure of fees other than commissions
   J. Proper exchange of business
   K. Privacy of consumer financial and health information
   L. Unfair marketing practices
      1. Misrepresentation
      2. Unfair inducement
      3. Unfair discrimination
      4. Extra charges
      5. Influencing employers
      6. Unfair use of official position
      7. Restraint of competition
      8. Unfair restriction of contracting parties choice of insurer
   M. Insurance contracts in Wisconsin

SECTION B

III. Health Insurance
   A. Purpose of health insurance
   B. Types of policies
      1. Medical expense policies
         a. Basic hospital, medical, and surgical policies (excepted benefits policies)
         b. Comprehensive major medical policies
         c. Long Term Care
         d. Health Maintenance Organizations (HMO) policies
         e. Preferred Provider Organization (PPO) policies
         f. Service organizations (Blue Cross Plans)
      2. Group insurance
         a. General concepts
         b. Differences between individual and group contracts
         c. Small group and large group
         d. COBRA

3. Medicare supplement, Medicare select, and Medicare Advantage policies

C. Policy provisions, clauses, and riders
   1. Mandatory (uniform policy) provisions
      a. Entire contract
      b. Time limit on certain defenses (incontestable period)
      c. Grace period
      d. Notice of claim
      e. Claim forms
      f. Proof of loss
      g. Time of payment of claims
      h. Payment of claims
      i. Legal actions
   2. Other provisions and clauses
      a. Insuring clause
      b. Free look
      c. Consideration clause
      d. Probationary (waiting) period
      e. Elimination (waiting) period
      f. Exclusions
      g. Coinsurance
      h. Deductibles
      i. Nonduplication and coordination of benefits
   3. Rights of renewability
      a. Comprehensive health Plans subject to the ACA
      b. Other policies
         (a) Guaranteed renewable
         (b) Period of time

D. Contract law
   1. Requirements of a contract
   2. Warranties and representations
   3. Unique aspects of the health contract
      a. Conditional
      b. Unilateral
      c. Adhesion

IV. Wisconsin Health Insurance Law

A. General policy provisions
   1. Right of return
   2. Right of insurer to contest
   3. Grace periods

B. Mandated benefits
   1. Handicapped children
   2. Newborn children
   3. Alcoholism, drug abuse, and mental and nervous disorders
   4. Home health care
   5. Skilled nursing care
   6. Kidney disease treatment

7. Diabetes
8. Maternity benefits for dependent children
9. Nurse practitioners
10. Optometrists
11. Chiropractic
12. Adopted children
13. Grandchildren
14. Mammograms
15. Lead poisoning screening
16. Temporal mandibular joint disorders
17. Hospital/anesthesia coverage for dental care
18. Breast reconstruction
19. Immunizations
20. Emergency medical services
21. Prescription drugs and devices
22. Experimental treatment
23. Requirements relating to AIDS
24. Cancer clinical trials
25. Dependent children

C. Wisconsin Medicare supplement policies
D. Medicare
   1. Primary, secondary payor
   2. Medicare and Choice and Advantage
   3. Medicare Part D prescription drug
E. HIPAA (Health Insurance Portability and Accountability Act)
F. Continuation and conversion privileges
G. Marketing Methods and Practices
   1. Company approval of advertising
   2. Suitability
   3. Identification of insurer in advertising
   4. Testimonials, endorsements or commendations by third parties
   5. Disparaging comparisons and statements

SECTION C – 4 hours

V. Wisconsin Public Assistance Programs
   A. Medicaid-Elderly, Blind and Disabled
   B. Badger Care Plus
   C. Eligibility requirements
   D. Services Covered
   E. Copays and premiums
   F. Verification requirements
   G. Possible outcomes
   H. Rights and Responsibilities

NAVIGATOR PRELICENSING COURSE OUTLINE

Section D – 4 hours

VI. Affordable Care Act
- A. Intent of the Law
- B. Supreme Court Decision
- C. Major provisions
- D. Immediate Reforms
  1. No lifetime limits
  2. External review
  3. Coverage for preventive services
  4. Uniform summary of benefits and coverages
- E. Market-wide Reforms – January 1, 2014
  Guaranteed Issue
  1. No pre-existing condition limitations
  2. Rating rules
  3. Single Risk Pool
  4. Actuarial value – metal levels
  5. No annual limits for essential benefits
  6. Essential Benefits
     a. Ambulatory patient services
     b. Emergency services
     c. Hospitalization
     d. Maternity and newborn care
     e. Mental health, substance use disorder services, behavioral health treatment
     f. Prescription drugs
     g. Rehabilitative and habilitative services and devices
     h. Laboratory services
     i. Preventive and wellness services and chronic disease management
     j. Pediatric services, including oral and vision care
- F. Tax Penalties and Shared Responsibility
  1. Individuals – minimum essential coverage
  2. Employer plans provide minimum value and affordable premiums
  3. Exceptions
- G. Tribal Considerations
  1. Eligibility
  2. Enrollment options

VII. Health Insurance exchanges
- A. Federally Facilitated Exchange
  1. Eligibility and Enrollment
  2. Premium tax credits
  3. Reduced cost sharing
  4. Website and Call Center
  5. Comparison tools
  6. Enrollment assistance
     a. Navigators
     b. Certified application counselors

7. Qualified Health Plans
8. Stand-alone Dental Plans

B. Individual Exchange
C. Small Business Health Options (SHOP) Exchange

VIII. Other policies
- A. Grandfathered plans
- B. Student plans
- C. Expatriate plans
- D. Short term

IX. Navigators, certified application counselors
- A. Issuance of license and registration
  1. Navigators
     a. Prelicensing and examination
     b. Licensing
     c. Continuing education
  2. Certified Application Counselors
     a. Prelicensing and examination
     b. Registration
     c. Continuing education
- B. Roles and Responsibilities
  1. Prohibited activities
  2. Permitted activities
- C. Ethics
  1. Fiduciary duties and responsibilities
  2. Conflict of interest
  3. Ethical marketing practices, including fair and ethical treatment of policyholders
  4. Suitability of product to client
  5. Social responsibility of agents/navigators/certified application counselors
  6. Agent/company relationships
  7. Maintaining appropriate insurance expertise
- D. Definition and eligible entities
- E. Navigator Duties
  1. Plan eligibility and enrollment
  2. Conduct public education activities
  3. Provide fair, accurate and impartial information
  4. Provide information that is culturally and linguistically appropriate
  5. Facilitate QHP selection and acknowledge other health programs
- F. Privacy and security of health information
  1. HIPAA
  2. Confidentiality, integrity and availability of Protected Health Information (PHI)
  3. Penalties for violations or noncompliance with HHS regulations
  4. Criminal acts

Applying for Public Assistance Health Care Programs in Wisconsin

Overview for Navigators, Certified Application Counselors, Agents, and Brokers

GOALS

The goal of this training is to provide Navigators, Certified Application Counselors (CACs), Agents, and Brokers:

- An overview of public assistance health care program eligibility requirements with a focus on BadgerCare Plus and Elderly, Blind, and Disabled (EBD) Medicaid.

  and

- Information about the methods of applying for public health care programs in Wisconsin and what to expect throughout the application process.

PURPOSE

After taking this course, a Navigator, CAC, Agents, and Brokers should have a basic understanding of:

- General eligibility requirements
- Methods through which an applicant may apply for public health care assistance in Wisconsin
- What the applicant can expect throughout the process

This training, along with the separate training about the Health Insurance Marketplace, provides Navigators and CACs the knowledge to help a client enter the health care application process through the most appropriate route.

IM AGENCY ROLE

- This is a high level overview of BadgerCare Plus and Medicaid eligibility requirements relevant to applicants whose eligibility is being determined for January 1, 2014. This is **NOT** a training on determining eligibility. Only Income Maintenance (IM) agencies can determine eligibility.
- This training does not cover BadgerCare Plus benefits available *before* January 1, 2014.

****Note****: At any time policy and processes are subject to change. For updated public assistance health care benefits information please see http://www.dhs.wisconsin.gov/forwardhealth/

IM AGENCIES

- IM agencies are local county and tribal agencies that determine eligibility and issue benefits for the Wisconsin BadgerCare Plus and Medicaid programs.
- In Wisconsin, local IM agencies are organized in to 10 IM Consortia.
  - Menominee Tribal Agency is not within an IM Consortia
  - IM functions in Milwaukee are administered by the State of Wisconsin Department of Health Services through Milwaukee Enrollment Services (MilES).
- To see which IM agency services your client's geographic area visit:
  - http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

TRAINING OVERVIEW

An overview on the following will be provided:

- Wisconsin's Health Care Programs
- Eligibility Requirements
  - Non-Financial
  - Financial
- Guide to Applying
- Covered Services
- Verification Requirements
- What to Expect After an Application is Submitted
- Member Rights & Responsibilities

PROGRAMS AVAILABLE

Within this training, we will introduce you to various public assistance health care programs in Wisconsin. The programs we will discuss include:

- BadgerCare Plus,
- Medicaid for the Elderly, Blind, and Disabled (EBD), and
- Long Term Care Medicaid.

APPLICATION

It is important to understand that when a customer applies for a public assistance health care program through one of the methods described in this training, the following apply to each application:

- His/her eligibility will be determined by the Income Maintenance agency for the appropriate program based on his/her circumstance.
- An individual does not need to specify if they are applying for BadgerCare Plus or EBD Medicaid.
- One application will be used to determine his/her eligibility for the appropriate health care program.

Wisconsin's Health Care Programs

BADGERCARE PLUS

- BadgerCare Plus (BC+), including:
  - Coverage for eligible children, parents/caretakers, childless adults, and pregnant women
  - Family Planning Only Services (FPOS)
  - BC+ Prenatal Program

EBD MEDICAID

- Medicaid for the elderly, blind, and disabled (EBD), including the following programs:
  - Supplemental Security Income (SSI) Medicaid
  - SSI-Related Medicaid
  - Medicare Premium Assistance (QMB, SLMB, SLMB+)
  - Medicaid Purchase Plan (MAPP)

LONG TERM CARE MEDICAID

- Long Term Care Medicaid, including:
  - Institutional Medicaid
  - Family Care

Health Care Eligibility Requirements

BASIC ELIGIBILITY REQUIREMENTS

- Wisconsin resident
  - Physically present with an intent to reside in Wisconsin
- US Citizen or qualifying immigrant
- Provide social security number (with some exceptions)
- Supply required information and verification (proof) on time
- Monthly income must be below program limits
- When applicable
  - Payment of premium or deductible
  - Assets below program limits for Medicaid for elderly and/or disabled individuals

BadgerCare Plus (BC+)

BADGERCARE PLUS

BadgerCare Plus (BC+) is a State of Wisconsin health care program that provides health coverage for certain children, parents/caretakers, childless adults, and pregnant women residing in Wisconsin.

BC+ POPULATIONS

Populations Served **(effective January 1, 2014):**

BC+ Adults	BC+ Children	BC+ Pregnant Women
• Ages 19-64 • Non-disabled/Non-Pregnant • Household income at or below 100% of the FPL • Includes parents, caretakers, and adults without dependent children	• Children under 19 years old • Household income at or below 300% of the FPL • Children with household income over 200% will be required to pay a premium	• Household income at or below 300% of the FPL

BADGERCARE PLUS GROUPS

- BC+ financial eligibility determinations are based on an estimated projection of the household's current monthly income.
- Within a BC+ group ALL members' income is counted, with one exception:
  - Effective January 1, 2014, if a group member is a child or tax dependent of another group member, his or her income is only counted if he/she is 'expected to be required' to file a tax return for the current year.
- Only IM agencies can determine BC+ group size, income, and household member eligibility.

Financial Eligibility & Modified Adjusted Gross Income (MAGI)

BC+ FINANCIAL ELIGIBILITY

- Beginning January 1, 2014, the Marketplace will use tax rules to calculate income.
- Wisconsin will also use these same rules to determine eligibility for BC+ coverage that **begins on or after January 1, 2014**.
- These rules are known as the Modified Adjusted Gross Income, or MAGI, methodology.

BC+ INCOME

For BC+ coverage that begins on or after January 1, 2014, countable income for BC+ will consist of taxable income. Some types of countable income under MAGI methodology for BC+ will include:

- Taxable Gross Earned Income
- Taxable Self-Employment Income
- Unemployment Compensation
- Alimony/Spousal Maintenance
- Social Security Income

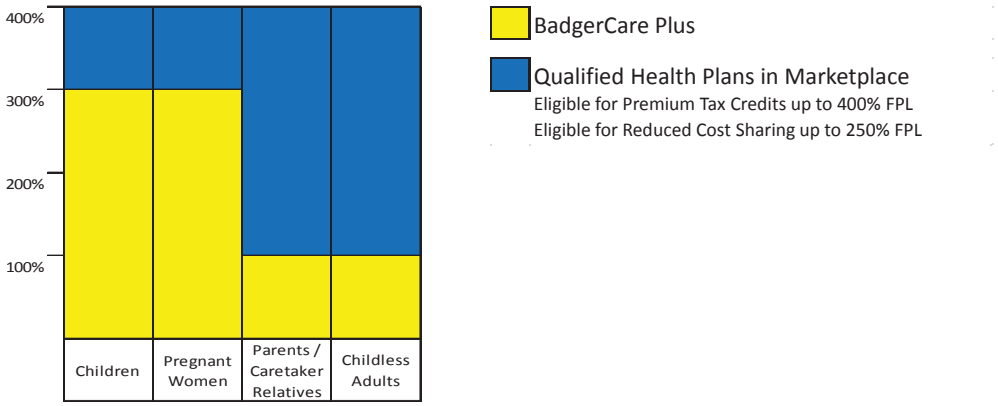
BC+ INCOME

Some common income types that will **NOT** be counted for BC+ eligibility include:

- Child Support
- Supplemental Security Income (SSI)
- Worker's Compensation
- Veteran's Benefits

BC+ FINANCIAL ELIGIBILITY SUMMARY CHART

The following chart displays the income limits for potential BC+ members as well as for the Qualified Health Plans in the Marketplace for coverage beginning on or after January 1, 2014:



FPL CHART

The Federal Poverty Level Chart can be found at the website below:

http://www.dhs.wisconsin.gov/badgercareplus/fpl.htm

Note: there is no maximum amount of available assets (such as savings accounts and real property) that a BC+ applicant or member is allowed to have.

BC+ MAGI GROUP

- Determining a BC+ MAGI group size is complex. A single BC+ application may result in one open BC+ case, with several different group sizes.
- BC+ MAGI groups will be person specific; therefore, IM agencies will have to determine group size one person at a time.
- Each group will be formed around an individual who is requesting assistance. The individual's group will be based on the:
    - Age,
    - Marital status,
    - Tax filing status, and
    - Tax relationships and/or family relationships.

BC+ MAGI GROUP

- Using MAGI methodology, each group will be formed using either tax rules or relationship rules.
- If the applicant is a tax filer and NOT also a tax dependent, the group will be formed using tax rules.
- If no one in the home will be filing taxes, the group will be formed using relationship rules.

BC+ MAGI GROUP – TAX FILING HOUSEHOLDS

- For tax filing households, most rules are based on, “what the household expects to do” with regard to filing taxes for the given year, with groups generally formed based on tax filing relationships.
- IM agencies determining MAGI groups will look at:
  - Who is filing taxes,
  - If the tax filer is being claimed as a tax dependent, and
  - If applicable, who the tax filer’s tax dependents are.

****Note**:** In order for a parent to request BC+ assistance for their child(ren), they must have physical placement of their child(ren) at least 40% of time each month.

BC+ MAGI GROUP – TAX FILING HOUSEHOLDS

If the applicant is a tax filer and NOT also a tax dependent, the applicant's group will be made up of:

- The applicant,
- The applicant’s spouse (included if they are living in the home and filing separately or if they’re filing jointly and living separately), and
- Any tax dependents the applicant expects to claim, including deceased individuals and individuals living outside of the home.

BC+ MAGI GROUP – NON-TAX FILING HOUSEHOLDS

If no one in the home will file taxes (and in certain other exception situations), IM agencies will use Relationship Rules to determine an individual's group size:

- If the applicant is age 19 or older, and relationship rules are being used, the group size will include:
  - Applicant,
  - Applicant's spouse, and
  - Applicant's children under age 19.
- If the applicant is under age 19 and relationship rules are being used, the group size will include:
  - Applicant,
  - Applicant's spouse,
  - Applicant's children under age 19,
  - Applicant's parents, and
  - Applicant's siblings (including half- and step-siblings) under age 19.

BC+ MAGI GROUP – DIVORCED

When parents are divorced:

- Only one parent can claim the child as their tax dependent in a given year.

If both parents are filing taxes:

- Only one parent will have the child included in his/her MAGI group.

If only one parent is filing taxes or if no parent is filing taxes:

- It is possible that both parents will have the child in their MAGI group.

****Note**:** If neither parent is filing taxes, and the child lives with both parents at least 40% of the time, the child may be put into both parents' MAGI groups due to relationship rules.

EXCEPTIONS AND OTHER SITUATIONS

There are many factors IM agencies consider when building household composition, as well as many special rules and exceptions under MAGI rules.

Individuals with the following complex household compositions should discuss their individual situation with their IM agency :

- situations of non-marital co-parents,
- married parents who file taxes separately, or
- situations where a child is being claimed as a tax dependent by a non-custodial parent.

BC+ GROUP SIZE – EXAMPLES

The following are a few examples to think about (for coverage beginning on or after January 1, 2014):

Example 1: A single mother with two children is applying for health insurance coverage. She works part time. Her income is at 70% of the FPL (below the 100% income limit for adults, and below the 300% income limit for children). She will likely be eligible for BC+/Medicaid, so it would be beneficial to apply directly for BC+/Medicaid.

Example 2: A single mother with two children is applying for health insurance coverage. She works full time. Her income is at 375% of the FPL (above the income limit for adults & children). She is not likely to be eligible for BC+/Medicaid, so would it be most beneficial to apply directly for health care through the Marketplace.

****NOTE** - ONLY IM AGENCIES CAN DETERMINE BC+ ELIGIBILITY**

BC+ OTHER POPULATIONS

Family Planning Only Services (FPOS) and Former Foster Care Youth

Family Planning Only Services	Former Foster Care Youth
• Provides limited benefits for men and women. • Income at or below 300% of the FPL. • 15 years of age or older • Not enrolled in BC+ without a premium or receiving other full benefit Medicaid .	• Full benefit Medicaid. • Any youth who were in foster care when they turned 18. • Are eligible for BC+ up to age 26 (beginning January 1, 2014). • No income limits for this population.

Medicaid for the Elderly, Blind, and Disabled (EBD)

MEDICAID INTRODUCTION

- Medicaid is a state/federal program that provides health coverage for Wisconsin residents that are elderly, blind, or disabled (EBD).
- Medicaid is commonly referred to as "Medical Assistance," "MA," and/or "Title 19."

****NOTE****: EBD Medicaid eligibility criteria is unaffected by the changes to BadgerCare Plus beginning January 1, 2014.

MEDICAID SUBPROGRAMS

Subprograms of Medicaid, include but are not limited to:

- Supplemental Security Income (SSI) Medicaid
  - IM agencies do not determine Medicaid eligibility for SSI recipients; eligibility is determined by the Social Security Administration.
- SSI-Related Medicaid
  - IM agencies determine eligibility for applicants.
- Medicaid Purchase Plan (MAPP)
- Medicare Premium Assistance (Medicare Savings Programs)
- Long Term Care Programs, including but not limited to:
  - Institutional Medicaid
  - Family Care

GENERAL EBD MEDICAID ELIGIBILITY CRITERIA

- To be non-financially eligible for EBD Medicaid, the applicant must be:
  - Elderly (65 years or older), or
  - Determined blind, and/or
  - Determined disabled.
- Meet the other general eligibility requirements, including:
  - Wisconsin resident
    - Physically present with an intent to reside in Wisconsin
  - US Citizen or qualifying immigrant
  - Provide social security number (with some exceptions)
  - Supply required information and verification (proof) on time
  - Pay any premiums or cost-sharing, if required.

EBD MEDICAID GROUPS

- Generally, an EBD Medicaid group includes the individual who is non-financially eligible for Medicaid and anyone who lives with them, and who is legally responsible for them.
  - This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses (this would be a group size of two).
  - There are some exceptions to this general rule, for example a blind or disabled minor living with their parents would be a group size of one.

EBD MEDICAID PROGRAM ELIGIBILITY

- An individual may fit into one (or more) EBD subprogram(s).
  - A person is eligible if she or he meets all program non-financial and financial requirements.
- Individuals who are not elderly, or determined blind or disabled (EBD) may be eligible for BC+.

SSI MEDICAID ELIGIBILITY

- SSI recipients are generally eligible for SSI Medicaid.
- Federal eligibility for SSI cash payment = eligibility for Wisconsin Medicaid and state supplemental payments.

SSI-RELATED EBD MEDICAID FINANCIAL CRITERIA

Individuals who are elderly, blind, and/or disabled may be eligible for SSI-Related Medicaid. **Note**: SSI payments are not required for this type of Medicaid.

- Unlike BC+, EBD Medicaid and subprograms generally include both income **and** asset tests.
- Income limit: up to $781.78 (single) and up to $1180.05 (married couple) per month. (**Note** that this income limit is not based on FPL).
- There are some income disregards that are taken into consideration. Details can be found in the Medicaid Eligibility Handbook (available at http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm in section 15).
- Countable assets below $2000 for a single individual, and $3000 for a married couple.
  - Common assets include cash, checking/savings accounts, some vehicles, non-home real property, some life insurance policies, burial assets, among others.

SSI-RELATED MEDICAID DEDUCTIBLES

- If household income exceeds the limit, a spend down is calculated. (Spend down amounts are calculated for a six month period by comparing the total countable monthly income to $591.67 and multiplying the difference by six.)
  - Unpaid and recently paid medical bills are used to "meet" the spend down. Proof is required.
  - Once the spend down is met, Medicaid pays for covered services until the end of the six month period.

MEDICAID PURCHASE PLAN ("MAPP")

- MAPP is for disabled individuals who are working or enrolled in a Health and Employment Counseling program.
- The program allows disabled people (who are working or want to work) to become or remain Medicaid eligible, even if employed, since MAPP has a higher income and asset limits.
  - Income limit is 250% FPL
    - There is a premium requirement if income exceeds 150% FPL
  - Asset limit is $15,000

MEDICARE PREMIUM ASSISTANCE (MSP)

- Medicare Premium Assistance is also commonly referred to as "Medicare Savings Program" or "MSP."
- Medicare generally charges beneficiaries coinsurance, deductibles, and monthly premiums, referred to as "Medicare cost-sharing."
- For certain Medicare beneficiaries, participating in a Medicare Premium Assistance program helps pay some of or the entire Medicare cost-sharing.

MEDICARE PREMIUM ASSISTANCE PROGRAMS

The following Medicare beneficiaries may be eligible for Medicare Premium Assistance:

- Qualified Medicare Beneficiary (QMB)
  - Medicaid pays Medicare Part A & B premiums and Medicare deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLMB)
  - Medicaid pays Medicare Part B premiums.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+)
  - Medicaid pays Medicare Part B premiums.
- Qualified Disabled and Working Adults (QDWI)
  - Medicaid pays Medicare Part A premiums.

MEDICARE PREMIUM ASSISTANCE INCOME & ASSET LIMITS

- QMB - 100% FPL
- SLMB - 120% FPL
- SLMB+ - 135% FPL
- QDWI - 200% FPL

Asset limits for QMB, SLMB, and SLMB+ are $6,940 (single) and $10,410 (married couple).

The asset limit for QDWI is $4,000 (single) and $6,000 (married couple).

Long Term Care (LTC) Medicaid

LONG TERM CARE (LTC) MEDICAID

Long-Term Care (LTC) Medicaid includes services and support that a person needs due to age, disability, or chronic illness which limits his/her ability to perform everyday tasks.

COMMON LTC PROGRAMS

- Institutional LTC Medicaid – for EBD individuals residing in a nursing home, hospital, or other medical institution.
- Family Care – enables EBD persons to live in community settings rather than medical institutions.
- Include, Respect, I Self-Direct (IRIS) – offered to individuals as an alternative to Family Care.

****Note****: Aging and Disability Resource Centers (ADRCs) serve as the access point for Family Care, IRIS, and other publicly funded long-term care programs and applications. However, persons interested in Institutional LTC Medicaid can apply on their own.

INSTITUTIONAL LTC MEDICAID

- An "institutionalized person" means someone who:
  - Has resided in medical institution for 30 or more consecutive days, or
  - Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.
- An "institution" means medical institution, including but not limited to hospitals, skilled nursing facilities, intermediate care facilities, and institutions for mental disease.

FAMILY CARE

- Family Care is a comprehensive and flexible LTC Medicaid program supporting adults with physical and developmental disabilities and frail elders.
- Family Care's goals:
  - Choice – give people better choices about the services and supports available to meet their needs.
  - Access – improve access to services.
  - Quality – improve quality through a focus on health and social outcomes.
  - Cost-effectiveness – create a cost-effective LTC system for the future.

FAMILY CARE FUNDING

- Managed Care Organizations (MCOs) get a payment for every member enrolled.
- MCOs provide members with:
  - The right service
  - In the right amount
  - At the right time
  - In the right setting
- There is no set budget for each member.

IRIS

- Serves same target groups as Family Care – adults with physical or developmental/intellectual disabilities and frail elders.
- People receive an individual budget to pay for needed services.
- Participants get support, as needed, from the IRIS Consultant Agency and Financial Services Agency.
- Encourages individualized and creative support opportunities.

IRIS

- IRIS is offered to individuals as an alternative to Family Care.
- Grounded in the principles of self-determination:
  - Freedom to decide how you want to live your life.
  - Authority over a determined budget amount.
  - Support to meaningfully organize and direct services.
  - Responsibility to use your public dollars wisely.
  - Confirmation of the individual's role in affecting change.

ADRCs

- ADRCs serve as a single access point for publicly funded LTC Medicaid programs (i.e. Family Care, IRIS), and provide eligibility determination and enrollment counseling.
- ADRCs are statewide and are a public service that anyone can use. Services are available regardless of income or eligibility for programs. Families, friends, caregivers, physicians, hospitals, and others use ADRCs.
- ADRCs provide:
  - Community Outreach
  - Information & Assistance
  - Long Term Care Options Counseling
  - Benefits Counseling
  - Pre-Admission Consultation/Nursing Home Relocations
  - Community Needs Identification
  - Access to Publicly Funded Long-Term Care Programs
  - Short Term Service Coordination
  - Transitional Services for Students and Youth
  - Prevention and Early Intervention Services
  - Client Advocacy

ADRCs

- Are welcoming and accessible places where older people and people with disabilities can obtain information, advice, and help in locating services or applying for benefits.
- Serve as a central source of reliable and objective information about a broad range programs and services.
- Help people learn how to conserve their personal resources, maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care.
- To find an ADRC in your area, click here: **http://www.dhs.wisconsin.gov/LTCare/adrc/customer/map/index.htm.**

Guide to Applying

GUIDE TO APPLYING

The Guide to Applying is a helpful resource that can be given to applicants or members. Click the link below to view:

http://www.dhs.wisconsin.gov/publications/p1/p16091.pdf

GUIDE TO APPLYING

The Guide to Applying provides information on:

- Who can Enroll
- How to Apply
- What Information Needs to be Provided
- What Information Needs to be Proved and How
- Benefits and Services Available
- Rights and Program Rules
- Fair Hearing Information

Contact Information

IM AGENCY INFORMATION

Throughout Wisconsin there are 10 Consortia, 11 tribal agencies and Milwaukee Enrollment Services (MilES). Click the link below to view a map and contact information for each consortia and tribal agency.

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Note: These IM agencies process applications and determine eligibility for BC+ and EBD Medicaid. ADRCs are the access point for Family Care and related Long Term Care application submission.

How To Apply

HOW TO APPLY

Individuals can request benefits and complete an application using a variety of methods. The business flow for each method varies from IM agency to IM agency.

HOW TO APPLY

A customer may use the following methods to contact or initiate an application:

Online through ACCESS.wi.gov

Walk-In (Face to Face)

Phone Call

Mail-In Application

ACCESS

ACCESS

- The ACCESS website is a fast, easy-to-use benefits application and maintenance tool. Potential and existing members can use it to perform a variety of functions anywhere at anytime.
- Please note that ACCESS works best with Internet Explorer 8 or 9.
- The ACCESS website can be accessed at **www.ACCESS.wi.gov**

ACCESS

ACCESS

- The ACCESS Home Page contains four buttons that you can click to use ACCESS:
  - **Am I Eligible** – find out what benefits you might be able to get (no login needed).
  - **Apply For Benefits** – apply for Child Care, FoodShare, Health Care or Family Planning Waiver benefits (login needed).
  - **Login to Account** – check benefits, renew benefits, report changes, and perform other functions.
  - **Create an Account** – link to create a new ACCESS account.
- When using ACCESS to perform benefit maintenance, members must input their case number, social security number, and birth date to link their case information to the myACCESS account.

ACCESS

All of the customer tools and ACCESS pages are available in Spanish by clicking the “Español” link at the top of each page.

Whenever using ACCESS, you can get help by clicking on the “Help” button in the upper right of your screen. This will explain more about what we are asking and how a customer should answer questions.

ACCESS Training Environment

The ACCESS Training Environment is also available where you can test drive the site without actually creating a valid application. It is a mock environment of the “live” ACCESS website.

ACCESS Training Environment

The ACCESS Training Environment does **NOT** create a valid application.

The ACCESS Training Environment can be accessed at **https://trn.access.wisconsin.gov/**

Note: This Website should only be used for testing and training.

Walk-In (Face To Face)

WALK-IN (FACE TO FACE)

A customer has the option to apply face-to-face at their local county agency office. To view the local county agency office locations, click the link below:

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

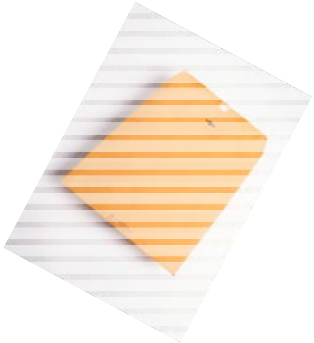
Telephone

TELEPHONE

Each consortium in Wisconsin has a Call Center available as one point of contact. The Call Center is the number a customer would call if they choose to apply by phone. To view the Call Center Information for each Consortium, click the link below:

http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Mail-In Application



MAIL-IN APPLICATION

A customer can choose to submit an application via mail. The application must be signed and dated. Click the link below to view a BadgerCare Plus Application Packet.

http://www.dhs.wisconsin.gov/forms/F1/F10182.pdf

Covered Services

COVERED SERVICES

To see a current listing of covered services, click the link below. The covered services listed below this link may change. To see if a service needed is covered, members should ask their health care provider.

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb48.htm

COVERED SERVICES

BC+ Standard Plan Covered Services may include:

- Ambulatory Surgical Centers
  - Certain surgical procedures and related lab services
- Chiropractic Services
- Dental Services
- Disposable Medical Supplies
- Prescription Medications
- End Stage Renal Disease
- Health Screenings for Children
- Hearing Services
- Home Care Services
  - Home Health, Private Duty Nursing and Personal Care

COVERED SERVICES

BC+ Standard Plan Covered Services may include (continued):

- Hospice
- Inpatient Hospital Services
- Mental Health and Substance Abuse Treatment
- Nursing Home Services
- Outpatient Hospital
  - Emergency Room
- Physician Services
- Podiatry Services
- Prenatal/Maternity Care

COVERED SERVICES

BC+ Standard Plan Covered Services may include (continued):

- Therapy
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech and Language Pathology (SLP)
- Transportation
  - Ambulance
  - Specialized Medical Vehicle (SMV)
  - Common Carrier
- Vision
  - Routine Services

COVERED SERVICES

Family Planning Only Covered Services may include:

- Reproductive Health Services — Family Planning Services
  - Excluding infertility treatments, surrogate parenting and the reversal of voluntary sterilization.

SERVICES COVERED

Some examples of EBD Medicaid covered services include:

- Chiropractic services
- Dental services
- Family planning services and supplies
- Home and community-based services authorized under a waiver
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease
- Laboratory and X-ray services

SERVICES COVERED

Some examples of EBD Medicaid covered services include (continued):

- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services
- Nursing services, including services performed by a nurse practitioner
- Optometric or optical services, including eyeglasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services

SERVICES COVERED

Some examples of EBD Medicaid covered services include (continued):

- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Respiratory care services for ventilator-dependent individuals
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other abuse services)
- TB (tuberculosis) services
- Transportation to obtain medical care

If members have additional questions about covered services or EBD Medicaid and BadgerCare Plus, they should contact Member Services at 1-800-362-3002.

COVERED SERVICES

Services NOT Covered Under Any Plan

Services or items not covered include (but are not limited to):

- Items such as televisions, radios, lift chairs, air conditioners, and exercise equipment (even if prescribed by a physician),
- Procedures considered experimental or cosmetic in nature, and
- Services that need approval (prior authorization) before a member gets them.

Copays and Premiums

COPAYS AND PREMIUMS

Copays:

Some services require members to pay a part of the cost of that service. This is called a copayment or copay. Co-pays range from $0.50 to $3.00. Providers are required to make a reasonable effort to collect the co-pays, but may not refuse services to a member who fails to make that payment. For more information about copays, go to the website below:

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb48.htm

COPAYS AND PREMIUMS

Premiums:

Some members may have to pay a monthly premium to enroll in BadgerCare Plus. The first monthly premium payment(s) must be paid to the local Income Maintenance agency before members can enroll. For more information on premiums, go to the website below:

http://www.dhs.wisconsin.gov/forwardhealth/EandB/eandb46c.htm

What to Expect after an Application is Filed

VERIFICATION REQUIREMENTS

Verification Requirements

Verification is part of determining eligibility for public assistance health care programs in Wisconsin. To verify means to establish the accuracy of verbal or written statements made about an individual's circumstances. Submitting proof is a method by which applicants and members accomplish verification.

The items required for verification will depend on the applicant's situation. The different mandatory verification items and sources of verification can be found in the respective program's handbook (BadgerCare Plus Handbook or Medicaid Eligibility Handbook), found by clicking on "*Handbooks and Manuals*" at the website below:

http://www.dhs.wisconsin.gov/em/index.htm

COMMON VERIFICATION ITEMS

Some commonly required verifications items are:

- Identity
- Earnings from a job
- Citizenship
- Assets, if applicable
- Out of State Unemployment Benefits

DATA EXCHANGE

The Wisconsin State Data Exchange can be used to verify information. If the worker is able to verify information through the Data Exchange, the customer does not have to provide proof. See below for information verified through Data Exchange:

- Wisconsin Unemployment Benefits
- Social Security
- Supplement Security Income

VERIFICATION CHECKLIST

If information is not able to be verified through the state's data exchange, the agency will issue the applicant a Verification Checklist (VCL).

VERIFICATION CHECKLIST

A verification checklist is sent to the applicant/member when a assistance program application is pending verification or other information.

VERIFICATION CHECKLIST

The verification notice:

- Includes verification requirements for BC+ and/or EBD Medicaid, as applicable.
- Provides the correct due dates according to program policy.
- Is divided into different sections based on what is pending on a particular case.
- Contains relevant, specific examples of documents that are needed.
- Includes a Document Tracking Sheet, which provides details on how the customer/member can submit their verifications.

VERIFICATION CHECKLIST EXAMPLE

The next two slides will show a sample of a Verification Checklist.

Notice of Proof Needed

To get or keep **BadgerCare Plus** benefits you need to provide proof of items and provide information by the due date listed below. The items that need proof we need you to provide are listed on the next few pages along with examples and instructions. If you do not provide the proof by the due date, benefits will be denied, decreased, or ended.

To make sure your benefits get processed as quickly as possible, use the **Document Tracking Sheet** at the end of this notice.

Program(s)	Due Date	Contact Information
BadgerCare Plus	Apr. 15, 2014	**Southern Consortium** Worker: [redacted] Phone #: [redacted] Fax #: [redacted] Use fax # to send verification.

VERIFICATION CHECKLIST

Proof Needed

This section lists items that we need proof of by the due date listed below. Contact us right away if you have questions or problems getting the proof and we will help you.

What?	Who?	Examples	Program(s)	Due Date
Employment at **WALMART** including : Expected monthly income before taxes or deductions and number of hours worked per pay period	[redacted]	Pay Stubs from the last 30 days; enclosed Employer Verification of Earnings Form filled out and signed by your employer; or Statement from your employer with the same information.	BadgerCare Plus	Apr. 15, 2014
Self-employment: **MICHAEL - BAKERY** Including : Expected monthly business income	[redacted]	Enclosed Self-Employment Income Report Form	BadgerCare Plus	Apr. 15, 2014

Possible Outcomes

NOTICES AND CHECKLISTS

After an applicant submits an application he/she will receive a letter (Notice of Decision (NOD) and/or Verification Checklist (VCL)) from the local agency to inform him/her of the status of their request and/or benefits. It's important that customers read the letter they receive in a timely manner as it will contain important information with possible deadlines.

NOTICES AND CHECKLISTS

These letters will inform customers if:

- Their benefits are being approved or denied, or
- The local agency needs additional information (or proof) from them in order to finish processing their request.

POSITIVE NOTICE OF DECISION

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice:

- **Summary:** This page gives a short review of the case as well as what benefits are approved and the contact information for the local agency.
- **Benefit Details:** This page will give details about benefits such as:
  - Who is enrolled
  - Dates enrolled
  - Who is not enrolled
  - If not enrolled, the reason(s) why

POSSIBLE OUTCOMES

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice (continued):

- **Household Income:** This section has a list of the income on file for the household. Members should check their letters to make sure all income information is correct.
- **Household Deductions:** This section has a list of deductions on file for the household.
- **How We Counted the Income:** This section has the amounts and limits that were used to decide whether the member is eligible.

POSITIVE NOTICE OF DECISION

If benefits are approved, the customer will receive a positive NOD. The following information will be on this notice (continued):

- **Reporting Rules:** This page has the reporting rules, which tell members what changes need to be reported to the local agency, and the timeframe.
- **Key Contacts:** This page has key contacts. The key contacts give information about who members should contact with questions.
- **Fair Hearing:** The last page of the letter has information about fair hearings. The date by which a hearing must be requested and how to ask for a fair hearing.

FAIR HEARING

- If benefits are denied, reduced or ended, and the customer believes the agency made a mistake, they should contact the agency
- If the applicant does not agree, the applicant can ask the agency worker to help in requesting a Fair Hearing.
- A Fair Hearing gives the applicant a chance to tell a hearing officer why they think the decision about their application or benefits was wrong.
  - At the hearing, a hearing officer will hear from the customer and the agency to find out if the decision was right or wrong, and inform the agency to take action as appropriate.

FORWARDHEALTH CARD

ForwardHealth Cards:

- Each person enrolled in BC+ will receive a ForwardHealth Card which should be shared with providers when services are requested.
- The ForwardHealth card does not show the dates that members are enrolled, but does have the customers name and ID number.
- Members will get an Enrollment Letter in the mail from the agency with the dates of enrollment.

The Right to Apply and Rights and Responsibilities

RIGHT TO APPLY

- All applicants have the right to file an application on the day of their first contact with a local IM agency.
- Local IM agencies may not refuse anyone the right or the opportunity to apply if s/he chooses to do so.
- S/he must be allowed to apply and set the filing date whether or not the person is in the correct office or region.

RIGHTS AND RESPONSIBILITIES

- Wisconsin Statute 49.81 is called the "Public Assistance Recipients' Bill of Rights."
  - This statute mandates that "…all public and relief granting agencies shall respect the rights for recipients of public assistance."
- These rights apply to anyone applying for or receiving BadgerCare Plus or Medicaid.

MEMBER RIGHTS

Everyone applying for or getting BadgerCare Plus and/or Medicaid has the right to:

- Be treated with respect by agency staff.
- Have their civil rights upheld.
- Have their private information kept private.
- Get an application or have the application mailed on the same day it is asked for.
- Have an application accepted right away by the agency.
- Get a decision about their application within 30 days of the day the agency gets the application.

MEMBER RESPONSIBILITIES

Everyone applying and/or receiving BadgerCare Plus and/or Medicaid has the responsibility to provide accurate answers as well as proof of their answers for BadgerCare Plus and Medicaid, when applying for benefits, renewing benefits or reporting changes.

For more information on customer rights and responsibilities, go to the Enrollment and Benefits Brochure, website below:

http://www.dhs.wisconsin.gov/publications/p0/p00079.pdf

ADDITIONAL RESOURCES

Additional Online Resources, including Policy Manuals, Operations Memos, fact sheets, directories, etc. can be found at the website below:

http://dhfs.wisconsin.gov/em/index.htm

Do & Don't Reminder

DO & DON'T LIST

As a Navigator or CAC, there are a few things to keep in mind as you assist customers:

Do:	Don't:
• Establish a relationship with local consortia • Learn how to navigate the ACCESS application • Learn how to access the Marketplace • Establish a relationship with ADRCs	• Attempt to answer questions about eligibility • Print out materials related to consortia contacts, Enrollment and Benefits or FPL income criteria; instead rely on accessing the information online to ensure that you have the most up-to-date information

Questions?

Please direct all questions related to Medicaid/BadgerCare Plus and this training to:

dhshealthcare@dhs.wisconsin.gov

Self Check

SELF CHECK

Who are the BC+ potential members?

A. Children under 19 years of age
B. Pregnant Women
C. Parents and caretakers
D. Young adults leaving foster care
E. Childless Adults
F. All of the above

F. All of the above

SELF CHECK

What is one income type NOT counted for BC+?

A. Earned Income
B. Child Support
C. Unemployment Compensation
D. Pension

B. Child Support

SELF CHECK

There is no asset limit for BC+.

True
False

True

SELF CHECK

An individual under 19 years old is considered a child for BC+.

True
False

True

SELF CHECK

A customer can submit a valid application at https://trn.access.wisconsin.gov/.

True
False

False *(A customer can submit a valid application at www.ACCESS.wi.gov.)*

SELF CHECK

On the ACCESS website, all of the customer tools and ACCESS pages are available in Spanish.

True
False

True

SELF CHECK

What are some conditions of eligibility that an individual must meet?

A. Be a Wisconsin Resident
B. Cooperate with verification requests on mandatory or questionable information
C. Prospective income must be below program limits
D. Be a US Citizen or qualifying immigrant
E. All of the above

E. All of the above

SELF CHECK

Fill in the blank:

"A _*Verification*_ _*Checklist*_ is sent to the applicant/member when a program of assistance is pending verification or other information."

SELF CHECK

The income limit for a Pregnant Women is at or below 300% of the FPL.

True
False

True

SELF CHECK

The income limit for a Parent or Caretaker is at or below 300% of the FPL.

True
False

False *(The income limit for a Parent or Caretaker is at or below 100% of the FPL.)*

SELF CHECK

Fill in the blank:

"Each person enrolled in BC+ will receive a ***Forward Health*** Card."

SELF CHECK

What are the methods of applying for Health Care assistance in Wisconsin?

A. ACCESS
B. Mail-In Application
C. Face to Face (Walk-In)
D. Telephone
E. All of the above

E. All of the above

Thank you for completing Applying for Public Health Care Assistance in Wisconsin: Overview for Navigators and Certified Application Counselors!

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

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Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

STATE OF WISCONSIN

OFFICE OF THE COMMISSIONER OF INSURANCE | SS

I, Theodore K. Nickel, Commissioner of Insurance and custodian of the official records, certify that the annexed emergency rule affecting sections Ins 6.91 to 6.98, Wis. Adm. Code, relating to navigators, nonnavigator assisters and related entities and affecting small business, is duly approved and adopted by this Office on September 4, 2013.

I further certify that I have compared this copy with the original on file in this Office and that it is a true copy of the original, and the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand at 125 South Webster Street, Madison, Wisconsin, on September 4, 2013.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN **OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedures set forth in under s. 227.24 (3), Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order affecting sections Ins 6.91 to 6.98, Wis. Adm. Code, relating to navigators, nonnavigator assisters and related entities and affecting small business.

HEARING INFORMATION

Date: September 27, 2013
Time: 9:30 a.m., or as soon thereafter as the matter may be reached
Place: OCI, Room 227, 125 South Webster St 2nd Floor, Madison, WI

Written comments can be mailed to:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 691
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Written comments can be hand delivered to:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule Ins 691
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Comments can be emailed to:

Julie E. Walsh
julie.walsh@wisconsin.gov

Comments submitted through the Wisconsin Administrative Rule Web site at: http://adminrules.wisconsin.gov on the proposed rule will be considered.

The deadline for submitting comments is 4:00 p.m. on October 11, 2013.

SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes, a summary of the changes and the fiscal estimate are attached to this Notice of Hearing.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

Notice is hereby further given that pursuant to s. 227.114, Stats., the proposed rule may have an effect on small businesses. The initial regulatory flexibility analysis is as follows:

a. Types of small businesses affected:

Insurance agents, community outreach organizations, consumer support organizations who are designated and under contract with the federally facilitated exchange as navigators, nonnavigator assisters or related entities. Governmental agencies are exempt from this rule.

b. Description of reporting and bookkeeping procedures required:

Navigator and nonnavigator assister entities, in addition to any federal requirements, will be required to maintain training records as well as current names and addresses of those who they employ, supervise or are affiliated with. Additionally, for entities handling consumer's money, and for navigators not affiliated with a navigator entity, proper financial accounts must be maintained.

c. Description of professional skills required:

Basic consumer, employee and business financial record keeping in addition to any requirements of the federal government.

OCI SMALL BUSINESS REGULATORY COORDINATOR

The OCI small business coordinator is Louie Cornelius and may be reached at phone number (608) 264-8113 or at email address louie.cornelius@wisconsin.gov

CONTACT PERSON

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the OCI internet Web site at **http://oci.wi.gov/ocirules.htm** or by contacting Inger Williams, Public Information and Communications, OCI, at: inger.williams@wisconsin.gov, (608) 264-8110, 125 South Webster Street – 2nd Floor, Madison WI or PO Box 7873, Madison WI 53707-7873.

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

Rule No. 145-____: To create Ins ch. 6 subch. II, subch. II (title), and Ins 6.91 to 6.98, Wis. Adm. Code.

Relating to: navigators, nonnavigator assisters and related entities and affecting small business.

The statement of scope for this rule SS 078-13, was approved by the Governor on July 1, 2013, published in Register No. 691, on July 15, 2013, and approved by the Commissioner on July 26, 2013. This emergency rule was approved by the Governor on August 30, 2013.

FINDING OF EMERGENCY

In accordance with s. 623.98, Stats., the commissioner may promulgate rules under ss. 227.24 (1) (a) and (3), Stats., without providing evidence that promulgating a rule is necessary for the preservation of the public peace, health, safety, or welfare and without a finding of emergency. The commissioner intends to publish the proposed rule sufficiently in advance of October 1, 2013 to permit proper licensing, certification and training of navigators and nonnavigator assisters and to permit proper registration of navigator and nonnavigator assister entities. The commissioner intends to promulgate permanent rules close in time to the emergency rules so not to create a gap in requirements.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. **Statutes interpreted:**

   Sections 601.31, 601.41, 601.62, 601.65, and ch. 628, 631, Stats.

2. **Statutory authority:**

   Sections 227.11, 601.41, 628.98, Stats.

3. **Explanation of OCI's authority to promulgate the proposed rule under these statutes:**

   The office has authority to promulgate rules interpreting ch. 628, Stats., as amended, relating to the oversight and licensing of navigators and registering navigator entities and nonnavigator assisters through the registration of nonnavigator assister entities. The commissioner has general authority to promulgate rules necessary to administer and enforce chs. 600 to 655, Stats., in accordance with ss. 227.11 (2) (a) and 601.41 (3), Stats. Further under s. 628.98, Stats., the commissioner is permitted to promulgate any rules necessary to carry out the purposes of subch. V. Additionally, the commissioner may promulgate rules under authority granted in ss. 601.42, and 628.34 (12), Stats.

general authority to promulgate rules necessary to administer and enforce chs. 600 to 655, Stats., in accordance with ss. 227.11 (2) (a) and 601.41 (3), Stats. Further under s. 628.98, Stats., the commissioner is permitted to promulgate any rules necessary to carry out the purposes of subch. V. Additionally, the commissioner may promulgate rules under authority granted in ss. 601.42, and 628.34 (12), Stats.

4. Related statutes or rules:

Ins chs. 6, 26 and 28, Wis. Admin. Code.

5. The plain language analysis and summary of the proposed rule:

The proposed rule establishes training and licensing requirements for navigators in accordance with state law and consistent with federal law. Navigators must have contracts with and grants from the federal government to assist consumers in enrolling in the federally facilitated health insurance exchange. When navigators provide facilitate enrollment of consumers into the federal exchange they are by law transacting an insurance business. As such, the office through this proposed rule sets forth basic requirements of licensure including fingerprinting, criminal background checks, consideration of prior personal and financial transactions that may provide insight to the individual's character. Since as navigators will have access to personal and financial information of the consumers they assist the proposed regulations includes requirements for record keeping in addition to the federally established privacy and security requirements. Further to ensure if a consumer were harmed by the acts of a navigator, the proposed rule implements the statutory requirement of financial responsibility for wrongful acts of a navigator.

Under the proposed rule nonnavigator assisters, navigator and nonnavigator assister entities are required to be registered with the Office. The nonnavigator assisters are registered with the commissioner through the nonnavigator assister entity with whom the nonnavigator assister is employed, supervised or affiliated with. Navigators, navigator entities and nonnavigator assister entities are designated by the federally facilitated exchange and navigators and navigator entities are under contract with the federally facilitated exchange to assist consumers enrolling in the exchange.

The state registration process will allow the office to ensure those persons and entities having direct contact with consumers have developed and implemented policies and procedures to ensure accurate guidance is given to consumers by properly trained persons. Through registration, the office will have current information for consumers of navigators and nonnavigator assisters who are compliant with training and knowledgeable of the exchange. The entities are legally responsible for the acts of the navigators or nonnavigator assisters that are employed, supervised or affiliated with the entities and are required to ensure the navigators and nonnavigator assisters are current in their training and of good character, competent and trustworthy.

Both navigators and nonnavigator assisters will be trained to understand not only the federal exchange health insurance products, but will also be familiar with public assistance programs and premium tax credits. The proposed rule requires initial and on-going training to ensure that the navigators and nonnavigator assisters who are providing assistance to Wisconsin consumers are providing the most recent and accurate information.

The proposed rule contains provisions intended to protect consumers from deceptive practices by restricting the use of terms, including navigator, nonnavigator assister, and certified application counselors, for use by only those persons who possess the proper training, licensure or registration status. The rule also delineates prohibited acts by navigators and nonnavigator assisters including making false or misleading statements, performing acts for which an insurance agent license is required, and receiving compensation from an insurer. Finally, the rule exempts governmental entities or persons acting on behalf of governmental entities from the regulations.

6. **Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:**

The proposed law dovetails with federal law and extends consumer protections through licensure, training and financial responsibility requirements. The federal law set forth in 45 CFR ch. 155, as amended, outlines federal training, grants, privacy and security and contracting requirements. The proposed rule ensures that persons assisting Wisconsin consumers are also

trained in Wisconsin insurance laws and public assistance programs available in this state. The proposed rules include financial responsibility for wrongful acts as a measure to provide greater protection to Wisconsin consumers. By requiring licensing or registration the proposed rule provides ready, verifiable information so consumers can be confident that the information and assistance they are provided by navigators and nonnavigator assisters are from persons of good character and who have successfully completed training.

7. **Comparison of similar rules in adjacent states as found by OCI:**

Illinois: 2013 SB 1194, passed by both houses June 2013, pending Governor signature. The Senate Bill proposes to clarify the roles of navigators from licensed insurance agents, establish requirements including licensing, training, and financial responsibility. The law as proposed is similar to the law passed in Wisconsin.

Iowa: Iowa Code § 522D (2013). The law establishes licensing requirements for navigators and navigator entities similar to the law passed in Wisconsin. The Insurance Division is in the process of promulgating administrative rules establishing training, licensing, fees and evidence of financial responsibility similar to this proposed rule.

Michigan: No similar laws or rules.

Minnesota: Minn. Stat. § 62V.05 (2013). Law was effective March 21, 2013 and requires the Minnesota exchange board to establish policies and procedures for the ongoing operation of a navigator program including in-person assisters. The law requires navigators and in-person assisters to have training and certified prior to selling for the exchange.

8. **A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:**

The Office considered federal law and laws of surrounding states to ensure the consumer safety and balance state oversight of navigators, nonnavigator assisters and related entities. The proposed regulations provide similar oversight for navigators, nonnavigator assisters and related

entities to that existing for insurance agents, brokers and managing agencies. The approach minimizes potential consumer harm by ensuring those serving the public meet basic qualifications and establish state regulation and control over the navigator and nonnavigator activities in the transaction of an insurance business.

9. **Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:**

The proposed rule may affect small businesses, however, the office has taken steps to minimize the impact of the rule by limiting the effect of the regulation to those navigators or nonnavigator assisters who are working on behalf of the federal government. For perspective, the federal government only awarded six navigator grants for the entire state of Wisconsin. The proposed rules and law impose no restrictions or regulations for governmental entities. There are many such entities already providing assistance to consumers with health insurance and public assistance concerns. By keeping the scope of the proposed rule very narrow, the impact on small businesses is significantly lessened.

The proposed rule fee amounts are consistent or lesser than similarly situated agents and managing broker agencies. Further, there is no imposition of fees for nonnavigator assisters or nonnavigator assister entities other than the cost of prelicensing training and examination costs. To further minimize the impact to navigators and nonnavigator assisters, the office provided and continues to provide some free prelicensing training to interested parties and in locations throughout the state in advance of the first open enrollment period.

10. **See the attached Private Sector Fiscal Analysis.**

11. **A description of the Effect on Small Business:**

This rule may have an effect on small businesses by requiring licensure or registration for navigators, nonnavigator assisters and related entities. However, the office minimized the impact by establishing less stringent requirements than those imposed on licensed insurance agents and

agencies. Further, the office provided, and continues to provide, some free prelicensing training to interested parties and in locations throughout the state in advance of the first open enrollment period. Additionally, the office approved licensed vendors to provide prelicensing training both in-person and on-line to reduce imposition on organizations. Finally the office imposed slightly lower fees than is required for licensed agents.

12. Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the Web site at: **http://oci.wi.gov/ocirules.htm**

or by contacting Inger Williams, OCI Services Section, at:

Phone:	(608) 264-8110
Email:	inger.williams@wisconsin.gov
Address:	125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail:	PO Box 7873, Madison, WI 53707-7873

13. Place where comments are to be submitted and deadline for submission:

The deadline for submitting comments is 4:00 p.m. on October 11, 2013.

Mailing address:

Julie E. Walsh

Legal Unit - OCI Rule Comment for Rule Ins 691

Office of the Commissioner of Insurance

PO Box 7873

Madison WI 53707-7873

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Web site: **http://oci.wi.gov/ocirules.htm**

The proposed rule changes are:

SECTION 1. Subchapter II and title are created to read:

SUBCHAPTER II -- NAVIGATORS, NONNAVIGATOR ASSISTERS AND RELATED ENTITIES.

SECTION 2. Ins 6.91 to 6.99 is created to read:

Ins 6.91 Definitions. In addition to the definitions in s. 628.90, Stats., which apply to this subchapter, in this subchapter:

(1) "Agent" means an agent as defined in s. 628.02, Stats.

(2) "Business checking account" means any account utilized by a navigator, navigator entity, nonnavigator assister or nonnavigator assister entity for insurance-related transactions.

(3) "Cash disbursed record" means a record showing all monies paid out by the navigator, navigator entity, nonnavigator assister or nonnavigator assister entity in transacting the business of insurance.

(4) "Cash receipts record" means a record showing all monies received by the navigator, navigator entity, nonnavigator assister or nonnavigator assister entity in transacting the business of insurance.

(5) "Certified application counselors" means a nonnavigator assister who is employed, supervised or affiliated with a registered nonnavigator assister entity as established by 45 CFR § 155.225, as amended, and who works for a nonnavigator assister entity that has been designated by and entered into an agreement with the exchange.

(6) "Commissioner" means the commissioner of insurance.

(7) "Formal administrative action" means consent decrees, cease and desist orders, stipulations, suspensions, revocations, license denials, fines, forfeitures, settlement agreements, navigator license restrictions or other actions limiting the navigator's method of transacting the business of insurance.

(8) "Navigator entity" means an entity or organization that employs, supervises or is affiliated with, one or more licensed navigators; is designated by the exchange as a navigator, works on behalf of the exchange and enters into an federal navigator grant funding agreement in accordance with 45 CFR § §155.210 (c), as amended; and is registered with the commissioner.

(9) "Nonnavigator assister entity" means entity or organization that employs, supervises or is affiliated with one or more nonnavigator assisters including certified application counselors; is designated by and works on behalf of the exchange and enters into an agreement with the exchange in accordance with 45 CFR § 155.225 (b) (1), as amended; and is registered with the commissioner.

(10) "Personnel records" means those records pertaining to anyone who is employed by, supervised by or affiliated with a navigator entity or nonnavigator assister entity including independent contractors.

(11) "Policyholder records" means all records, applications, request for changes, and complaints associated with a policy generated by or through the navigator, navigator entity, certified application counselor or nonnavigator assister entity.

Ins 6.92 Individual navigators. (1) PURPOSE. This section protects insurance consumers by establishing procedures for the licensing of navigators when transacting the business of insurance, prescribing minimum standards and requirements to ensure timely and reliable information will exist and be available to the commissioner. This section implements and interprets ss. 628.095, 628.097, 628.10, 628.90 to 628.93, Stats., as applicable.

(2) PROCEDURE. (a) *Application for navigator license.* An individual applying for a navigator license shall submit an application to the office in the form prescribed by the commissioner. A completed application consists of the navigator's name, the navigator's residence and mailing addresses, confirmation of successful completion of prelicensing training, fingerprints provided in a format specified by the commissioner to complete, an electronic confirmation of criminal history from the Wisconsin department of justice, crime information bureau, and the federal bureau of investigation completed not more than 180 days prior to the test date, payment of the nonrefundable fees to the testing vendor, an

electronic photograph of the applicant taken by the test service at the time of testing, confirmation of previous navigator licensure in another state, if applicable, and any documentation required in answer to questions on the application.

Note: A copy of the navigator license application form OCI 11-090, required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance at 125 S. Webster Street, Madison WI 53703, or at the Office's web address: oci.wi.gov.

(b) *Prelicensing Training.* An individual seeking a navigator license, in addition to any training requirements of the federal government, shall complete at least 16 hours of commissioner-approved navigator prelicensing training and pass with a satisfactory grade a commissioner-approved written navigator examination. Training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner.

(c) *Scheduling the navigator licensing examination.* An applicant shall notify the testing vendor, at least twenty-four hours prior to the desired navigator licensing examination date. The written examination will test the applicant's knowledge of the duties and responsibilities of a navigator; the insurance laws and regulations of this state; and the state's public assistance programs and eligibility. The written examination shall be commissioner approved offered through a commissioner-approved testing vendor.

(d) *Exception.* 1. An agent who holds an active resident license with the accident and health line of authority and is in compliance with continuing education requirements may apply to be licensed as a navigator if the currently licensed agent can meet all of the following:

a. Demonstrate compliance as set forth in s. 628.92 (1), Stats., including competence and trustworthiness.

b. Demonstrate satisfactory completion of 4 hours of navigator training specific to public assistance programs, including Medicaid, in addition to the completion of any federally required navigator training and compliance with federal restrictions and requirements including those set forth in 45 CFR §§ 155.205 (d), 155.210, 155.215 (b) and (c), and 155.260 (b), as amended. The state training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner.

2. A currently licensed agent that is in compliance with subd. 1. is exempt from passing the navigator examination and photograph requirements described in sub. (2) (a). The currently licensed agent will be required to obtain new fingerprints unless the office has received current, valid fingerprint results provided in a format specified by the commissioner and an electronic confirmation of criminal history from the Wisconsin department of justice, crime information bureau, and the federal bureau of investigation that were completed not more than 180 days from the date of the application:

(e) *Issuance of license.* An applicant for an original navigator license who completes and satisfies the requirements in pars. (a) and (b), in addition to any federal training or requirements including the requirements set forth in 45 CFR §§ 155.205 (d), 155.210, 155.215 (b) and (c), and 155.260 (b), as amended, and meets the standards of competence and trustworthiness as described in sub. (3), shall be issued a navigator license. Examination scores are valid for 180 days. Failure to apply for a license within 180 days will require the applicant to re-take the examination. Determination of the acceptance or rejection of a completed application shall be made within 90 days of receipt by the commissioner of the completed application including any documentation required.

(3) COMPETENCE AND TRUSTWORTHINESS. The following criteria may be used in assessing trustworthiness and competence:

(a) *Criminal record.* The conviction for crimes which are substantially related to the circumstances of holding an insurance or navigator license, including a felony or misdemeanor conviction that is significantly related to the circumstances of holding a navigator or insurance license.

(b) *Accuracy of information.* Any material misrepresentation in the information submitted on the application form.

(c) *Regulatory action.* Any formal regulatory action taken in any jurisdiction with regard to any occupational license held, such as insurance licenses in other states, real estate licenses and security licenses.

(d) *Other criteria.* Other criteria which the commissioner considers evidence of untrustworthiness or incompetence, including but not limited to:

1. Providing incorrect, misleading, incomplete or materially untrue information in the licensing application.

2. Violating any insurance laws, or violating any regulation, subpoena or order of the insurance commissioner or of another state's insurance commissioner, or of the federal government.

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any monies or properties received in the course of acting as a navigator or insurance agent.

5. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance.

6. Having admitted or been found to have committed any insurance unfair trade practice or fraud.

7. Using fraudulent, coercive, or dishonest practices in the conduct of business in this state or elsewhere.

8. Demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of personal financial transactions or professional business in this state or elsewhere.

9. Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory.

10. Forging another's name to an application for insurance or to any document related to an insurance transaction.

11. Improperly using notes or any other reference material to complete an examination for an insurance or navigator license.

12. Failing to comply with an administrative or court order imposing a child support obligation.

13. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(e) *Minimum Age and Residency.* An applicant for navigator licensure shall have attained at least eighteen (18) years of age and shall be a resident of this state or maintain his or her principal place of business in this state.

(f) *Proof of Financial Responsibility.* An applicant who is not affiliated with a navigator entity shall comply with the requirements of s. 628.92 (5) (b), Stats., or provide evidence of an equivalent coverage alternative subject to the commissioner's prior approval.

(4) CHANGE OF NAME OR ADDRESS. (a) Each navigator shall, within 30 days, notify the commissioner in writing of any change in the navigator's name, residence address, principal place of business, and mailing address.

(b) A navigator who is not employed or supervised by or affiliated with a navigator entity and changes residency to a location outside of this state or changes his or her principal place of business to an address outside this state and is not a resident of this state shall have his or her navigator license terminated effective 60 days after the change of address.

(c) Criteria used by the insurance commissioner to establish state residency shall include, but not be limited to:

1. Jurisdiction for payment of state taxes.
2. Jurisdiction for automobile driver's license and motor vehicle registration.
3. Location of voter registration.
4. Location of principal residence, such as owned or rented dwelling, condominium or apartment.
5. Location of principal place of business.

(5) APPLICABILITY OF OTHER LAWS. Licensed navigators are subject to the requirements contained at ss. 628.095, 628.097 and 628.10, Stats., as applicable to individual navigators.

(6) LICENSE RENEWALS. (a) The nonrefundable renewal fee of $35.00 is due before September 1 of each year. The commissioner shall send notice of the renewal fee by 1st-class mail at least 60 days prior to the fee due date to each navigator at the mailing address on file. Applications for navigator license renewal shall be submitted before the September 1 renewal deadline. The navigator shall provide proof of a bond in compliance with s. 628.92 (5) (b), or evidence of an equivalent coverage alternative subject to the commissioner's prior approval.

(b) An individual navigator is required to complete at least 8 hours of navigator continuing education training before September 1 of each year. Training must be completed prior seeking annual renewal of a navigator license. Recurring training shall be completed and reported at a rate of not less than 8 hours each 12 months of each compliance period. Training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner.

(c) Any navigator whose license is revoked for failing to pay renewal fees, failing to complete required annual navigator continuing education, or failing to pay delinquent taxes may, within 12 months from the revocation date, apply to reinstate for the same navigator license without completing prelicensing navigator training or passing a written examination. The navigator must satisfy the requirement of s. 628.10 (a), (am) or (cm), Stats., satisfactorily complete a reinstatement application and pay twice the amount of the license renewal fee under par. (a). If a navigator license has been revoked for more than 12 months, the navigator shall, in order to be relicensed, satisfy the examination and other licensing requirements established by subs. (2) to (6).

(7) FINANCIAL RESPONSIBILITY REQUIREMENTS. Each individual navigator not affiliated with a navigator entity shall comply with the requirements of s. 628.92 (5) (b), Stats., or provide evidence of an equivalent coverage alternative subject to the commissioner's prior approval.

Note: A copy of a sample navigator and navigator entity bond form OCI 11-093, required in sub. (7), may be obtained at no cost from the Office of the Commissioner of Insurance at 125 S. Webster Street, Madison WI 53703, or at the Office's web address: oci.wi.gov.

Ins 6.93 Registration of navigator entities. (1) (a) *Registration application for navigator entity.* An entity registering as a navigator entity shall submit an application to the commissioner in the form prescribed by the commissioner. A completed application consists of the navigator entity's name, the names of the entity's officers, the current mailing address, the name of at least one licensed designated responsible navigator, names and addresses for the navigators it employs, supervises or is affiliated with, and any documentation required to questions on the application. The navigator entity shall be designated by the exchange as a navigator entity, receive funding through a federal grant, and be in compliance s. 628.92 (2), Stats., and with applicable federal requirements including 45 CFR § 155.215 (a) (1), as amended.

Note: A copy of the navigator entity registration application form OCI 11-091, required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance at 125 S. Webster Street, Madison WI 53703, or at the Office's web address: oci.wi.gov.

(b) *Payment of fees.* An applicant for an original registration shall pay an initial, non-refundable, registration fee of $100.00 is due with submission of the application.

(c) *Acknowledgement of registration.* An applicant for an original registration who satisfies the requirements in pars. (a) and (b) shall be registered as a navigator entity. Determination of the acceptance or rejection of a completed application shall be made within 90 days of receipt by the commissioner of the completed application including any required or requested documentation.

(2) REGISTRATION RENEWALS. The renewal fee of $100.00 is due before September 1 of each year. The commissioner will send notice of the registration renewal fee by 1st-class mail at least 60 days prior to the fee due date to each navigator entity at the mailing address on file. The navigator entity shall provide proof of a current bond in compliance with s. 628.92 (5) (a), or evidence of an equivalent coverage alternative subject to the commissioner's prior approval.

(3) ENTITY REPORTING. A navigator entity shall comply with s. 628.92 (4), Stats., by filing with the commissioner the list of individual licensed navigators it employs, supervises or is affiliated with in a manner prescribed by the commissioner. After providing the commissioner with an initial notification of navigators in the application form, the navigator entity shall report any updates to the list of navigators, including additions, deletions or modifications, within 30 days of the addition, deletion or modification to the list of navigators.

(4) ENTITY LIABILITY. (a) A navigator entity assumes full legal responsibility for the acts of the navigators whom the entity employs, supervises or is formally affiliated with for acts that are performed in this state and that are within the scope of the apparent authority to act as a navigator on behalf of the entity.

(b) The entity shall provide evidence of financial responsibility consistent with s. 628.92 (5) (a), Stats., by submitting the original bond and form to the office in the form prescribed by the commissioner. Alternatively the navigator entity, subject to the commissioner's prior approval, may provide evidence of an equivalent coverage alternative.

Note: A copy of a sample navigator and navigator entity bond form OCI 11-093, required in sub. (5), may be obtained at no cost from the Office of the Commissioner of Insurance at 125 S. Webster Street, Madison WI 53703, or at the Office's web address: oci.wi.gov.

Ins 6.94 Registration of certified application counselors and other nonnavigator assisters. Certified application counselors and other nonnavigator assisters shall be employed or supervised by a registered nonnavigator assister entity, or be affiliated with a registered nonnavigator assister entity. To

be registered with a nonnavigator assister entity as a certified application counselor or other nonnavigator assister, the individual is required to comply with all of the following:

(1) PROCEDURE. (a) Certified application counselors and other nonnavigator assisters must be authorized by the exchange to provide consumer assistance and compliant with federal requirements set forth in 45 CFR § 155.225, as amended.

(b) Certified application counselors shall complete 16 hours of prelicensing navigator training, successfully pass a written examination, and annually thereafter complete 8 hours of navigator continuing education training that is approved by the commissioner, in addition to any federal training or other federal requirements. The state training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner.

(2) EXCEPTION. (a) An agent who holds an active resident license with the accident and health line of authority and is in compliance with continuing education requirements, may apply to be registered as a nonnavigator assister by a nonnavigator assister entity if the currently licensed agent can meet all of the following:

1. Demonstrate compliance as set forth in s. 628.96, Stats., including competence and trustworthiness.

2. Demonstrate satisfactory completion of 4 hours of navigator training specific to public assistance programs, including Medicaid, in addition to the completion of any federally required nonnavigator assister training and compliance with federal restrictions and requirements including those set forth in 45 CFR § 155.225, as amended. The state training required under this subsection must be approved by the commissioner and provided by an education provider that is approved by the commissioner.

(b) A currently licensed agent that is in compliance with par. (a) is exempt from taking prelicensing training and passing the written navigator examination.

(3) REFUSAL TO REGISTER NONNAVIGATOR ASSISTERS. The commissioner may refuse to register a nonnavigator assister for any of the following reasons:

(a) Failing to possess requisite character, integrity, competency and trustworthiness. In addition to the requirements set forth in s. 628.04, Stats., the commissioner may consider the criteria established in s. Ins 6.92 (3), in assessing trustworthiness and competence.

(b) Commission of any act that would warrant the denial, suspension, or revocation of an insurance license or registration including any of the acts delineated in s. Ins 6.92 (3).

Ins 6.95 Registration of nonnavigator assister entities. (1) ELECTRONIC REGISTRATION FOR A NONNAVIGATOR ASSISTER ENTITY. An entity registering as a nonnavigator assister entity shall provide all of the following information to the commissioner in the form prescribed by the commissioner:

(a) The nonnavigator assister entity's name and current mailing address.

(b) The name and contact information for the nonnavigator assister entity.

(c) The name, business address and type of nonnavigator assister for each nonnavigator assister it employs, supervises or is affiliated with.

(d) An attestation that each nonnavigator assister is in compliance with applicable state law including any nonnavigator assister who is a certified application counselor and who has complied with s. 628.96 (2), Stats.

(e) The nonnavigator assister entity's agreement to provide to the commissioner all supporting documents as requested by the commissioner.

(2) ENTITY REPORTING OF UPDATES. A nonnavigator assister entity shall comply with s. 628.96 (1), Stats., reporting in an electronic format as prescribed by the commissioner, any updates to the list of nonnavigator assisters that the nonnavigator assister entity provided when it first registered with the commissioner, including additions, deletions or modifications. The information shall be provided within 30 days of the addition, deletion or modification to the list of nonnavigator assisters.

(3) ENTITY LIABILITY. A nonnavigator assister entity assumes legal responsibility, in accordance with s. 628.95 (3), Stat., for the acts of the nonnavigator assisters, on behalf of the entity, that the entity employs, supervises or is formally affiliated with, that are performed in this state and that are within the scope of the apparent authority to act as a nonnavigator assister.

(4) REVOCATION OF ENTITY REGISTRATION. The commissioner may revoke a nonnavigator assister entity registration if the nonnavigator assisters it employs, supervises or is affiliated with, fail to comply with s. Ins 6.95 (3), or the nonnavigator assister entity fails to comply with any provision contained in this section or by failing to comply with requests of the commissioner.

Ins 6.96 Prohibited business practices. In addition to the prohibited acts contained in s. 628.95 (2), Stats., navigators and nonnavigator assisters are prohibited from all of the following:

(1) Receiving compensation from an insurer, stop-loss insurance or a third-party administrator.

(2) Receiving compensation that is dependent upon, in whole or in part, on whether an individual enrolls in or renews coverage in a health benefit plan.

(3) Providing any information related to enrollment or other insurance products not offered in the federal exchange.

(4) Making or causing to be made false or misleading statements.

(5) Providing advice comparing health benefit plans that may be better or worse for the consumer or employer.

(6) Recommending a particular health benefit plan or insurer or advising consumers or employers regarding a particular insurer or health benefit plan selection.

(7) Engaging in any fraudulent, deceptive or dishonest acts or unfair methods of competition.

(8) Receiving consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individual or employees into a qualified health plan as defined 45 CFR § 155.20, as amended.

6.97 Navigator, nonnavigator assister, navigator entity, and nonnavigator assister entity records. (1) PURPOSE. This section protects consumers by prescribing minimum standards and techniques of accounting and data handling of navigators, nonnavigator assisters, navigator entities and nonnavigator assister entities to ensure that timely and reliable information will exist, if applicable, and be available to the commissioner. This section implements and interprets ss. 601.42, and 628.34, Stats., by establishing the minimum records that are to be maintained.

(2) CASH DISBURSED RECORD. The cash disbursed record shall show the name of the party to whom the payment was made, date of payment, and reason for payment.

(3) CASH RECEIPTS RECORD. The cash receipts record shall show the name of the party who remitted the money, date of receipt, and reason for payment.

(4) PERSONNEL RECORDS. Personnel records shall include dates of employment, supervision or affiliation; position held; description of principal duties; name and last known address and telephone number of employee, supervisee or affiliated person.

(5) RECORDKEEPING REQUIREMENTS. Beginning October 1, 2013, each navigator, nonnavigator assister, navigator entity or nonnavigator assister entity shall maintain, for at least a 3-year period, unless a specific period is provided elsewhere, all of the following financial, consumer and employee records, as applicable:

(a) Business checking account.

(b) Cash disbursed records.

(c) Cash receipts records.

(d) Personnel records.

(e) Consumer or policyholder records.

(6) PLACE OF MAINTAINING RECORDS. (a) The navigator shall maintain records required by subs. (2) to (5), at the business address of the navigator or the navigator entity, or at another location only if the navigator provides written notice of the other location to the commissioner of insurance.

(b) The nonnavigator assister shall maintain records required by subs. (2) to (5), at the business address of the nonnavigator assister entity or at another location only if the nonnavigator assister entity provides written notice of the other location to the commissioner of insurance.

(7) UPDATING RECORDS. The navigator entities and nonnavigator assister entities shall maintain all financial records, records of compliance with prelicensing training completion, successful passage of the examination and continuing education completion, compliance with federal training and other federal requirements for the navigators and nonnavigator assisters it employs, supervises, or is affiliated with, as applicable for at least 3 years from the transaction of an insurance business.

Ins 6.98 Prohibition of uses of designations. (1) PROHIBITED USES OF DESIGNATIONS. It is an unfair and deceptive trade practice under s. 628.34 (12), Stats., for an agent to use terms including "navigator," "navigator entity," "nonnavigator assister," "certified application counselor," and "nonnavigator assister entity," in such a way as to mislead a purchaser or prospective purchaser that the agent has special certification or training in advising or providing services to consumers in connection with the advertising,

solicitation, sale, or purchase of a health insurance policy or in the provision of advice as to the advisability of purchasing a health insurance policy, either directly or indirectly, offered in the state either within or outside the exchange. The terms may not be used by an agent who is not licensed as a navigator or registered as a nonnavigator assister. The terms may not be used alone or be combined with one or more such terms as "certified," "licensed," "registered," or like words, in the name of the certification or professional designation that appears as a certification or professional designation.

(2) PENALTIES. A violation of this section is an unfair and deceptive trade practice under s. 628.34 (12), Stats., and shall subject the violator to ss. 601.41, 601.62, 601.64, 601.65 and 628.10, Stats.

Ins 6.99 Exemption. Governmental entities or any persons acting on behalf of a governmental entity are exempt from subch. II.

SECTION 3. These changes first apply to navigators, navigator entities, nonnavigator assisters and nonnavigator assister entities on the effective date of the emergency rule.

SECTION 4. This subchapter may be enforced under ss. 601.41, 601.64, 601.65, 628.095, 628.097, 628.10, and subch. V of ch. 628, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

SECTION 5. These emergency rule changes will take effect on day of publication as provided in s. 227.24(1)(c), Stats.

Dated at Madison, Wisconsin, this 4th day of September, 2013.

Theodore K. Nickel
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

Section Ins 6.91 relating to navigators and nonnavigator assisters and affecting small business.

The proposed rule will not have a significant effect on the private sector. With an exemption for governmental entities, there will be no effect on county, city, village, town, school district, technical college district and sewerage districts. Additionally the office will be able to manage any cost associated with maintaining the licensure and registration process without additional state funds being provided to the office during this current biennium.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-2049 (C04/2011)

DIVISION OF EXECUTIVE BUDGET AND FINANCE
101 EAST WILSON STREET, 10TH FLOOR
P.O. BOX 7864
MADISON, WI 53707-7864
FAX: (608) 267-0372

ADMINISTRATIVE RULES – FISCAL ESTIMATE

1. **Fiscal Estimate Version**
☒ Original ☐ Updated ☐ Corrected

2. Administrative Rule Chapter Title and Number
INS 691

3. Subject
navigators and nonnavigator assisters and affecting small business

4. **State Fiscal Effect:**

☒ No Fiscal Effect	☐ Increase Existing Revenues	☐ Increase Costs ☐ Yes ☒ No May be possible to absorb within agency's budget.
☐ Indeterminate	☐ Decrease Existing Revenues	☐ Decrease Costs

5. Fund Sources Affected: ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S	6. Affected Ch. 20, Stats. Appropriations:

7. **Local Government Fiscal Effect:**

☒ No Fiscal Effect	☐ Increase Revenues	☐ Increase Costs
☐ Indeterminate	☐ Decrease Revenues	☐ Decrease Costs

8. Local Government Units Affected:
☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ School Districts ☐ WTCS Districts ☐ Others: None

9. **Private Sector Fiscal Effect (small businesses only):**

☒ No Fiscal Effect	☐ Increase Revenues	☐ Increase Costs
☐ Indeterminate	☐ Decrease Revenues ☐ Yes ☒ No May have significant economic impact on a substantial number of small businesses	☐ Yes ☒ No May have significant economic impact on a substantial number of small businesses ☐ Decrease Costs

10. Types of Small Businesses Affected:

Individual licensed agents working as a navigator or nonnavigator assister, small organizations that work with consumers, and some surety bond issuers that may be considered a small business.

11. Fiscal Analysis Summary

The proposed rule may affect small businesses, however, the Office has taken steps to minimize the impact of the rule by limiting the effect of the regulation to those navigators or nonnavigator assisters who are working on behalf of the federal government. For perspective, the federal government only awarded six navigator grants for the entire state of Wisconsin. There are no restrictions or regulations for governmental entities or persons who work with such entities. These governmental entities currently assist consumers with health insurance and public assistance concerns and will not be impacted by this regulation. By keeping the scope of the proposed rule very narrow, the impact on small businesses is lessened. Further, the proposed rule limited the amount of fees navigator and navigator entities are required to pay annually and did not impose fees on nonnavigator assisters or nonnavigator assister entities other than the cost of prelicensing training and examination costs. The office minimized the impact by establishing less stringent requirements than those imposed on licensed insurance agents and agencies. Further, the office provided, and continues to provide, some free prelicensing training to interested parties and in locations throughout the state in advance of the first open enrollment period. Additionally, the office approved licensed vendors to provide prelicensing training both in-person and on-line to reduce imposition on organizations. Finally the office imposed slightly lower fees than is required for licensed agents.

12. Long-Range Fiscal Implications

None.

13. Name - Prepared by	Telephone Number	Date
Julie E. Walsh	(608) 264-8101	Aug. 26, 2013
14. Name – Analyst Reviewer	Telephone Number	Date
Signature – Secretary or Designee	Telephone Number	Date
		3 Sept 13

SCOTT WALKER
OFFICE OF THE GOVERNOR
STATE OF WISCONSIN

P.O. BOX 7863
MADISON, WI 53707

August 30, 2013

Ted Nickel
Commissioner of Insurance
125 South Webster Street
Madison, Wisconsin 53703-3474

RE: Emergency Rule modifying Chapter Ins 6 relating to navigators, nonnavigator assisters and related entities and affecting small business

Dear Commissioner Nickel,

I hereby approve the proposed emergency rule modifying Chapter Ins 6 submitted on August 27, 2013, pursuant to Wisconsin Statutes § 227.24. You may file the emergency rule for publication by the Legislative Reference Bureau pursuant to Wisconsin Statutes § 227.24(1)(e)1g.

Sincerely,

Scott Walker
Governor

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, *Governor*
Theodore K. Nickel*, Commissioner*

Wisconsin.gov

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Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

DATE: March 7, 2014

TO: Nonnavigator Assister Entities

FROM: Gina Frank, Administrator, Division of Regulation and Enforcement

SUBJECT: Guidance on Continuing Education Training Requirements

Under Wisconsin law, nonnavigator assisters, including certified application counselors, are required to complete 8 hours of health insurance continuing education training annually. Please note that a credit hour is equal to 50 minutes and training is in addition to any federal training or other federal requirements. This guidance does not apply to navigators.

The Office of the Commissioner of Insurance (OCI) does not require prior approval of the course content. Training that includes the following topics satisfies the requirement:

1. Principles of health insurance
2. Wisconsin health insurance laws and regulations
3. Public health program law, regulations and guidance including BadgerCare and Medicare
4. Federal Affordable Care Act law, regulations and guidance
5. Privacy and Security Guidelines - Personally Identifiable Information (PII)

Nonnavigator assisters may also complete health insurance courses approved for insurance agent continuing education credit to satisfy the requirement. A copy of the certificate of completion should be given to the nonnavigator assister entity to verify attendance.

By October 1 of each year, nonnavigator assister entities must attest to OCI that their nonnavigator assisters have completed the required training. OCI will provide the attestation form. Additionally, nonnavigator assister entities must maintain documentation verifying that the nonnavigator assisters working for or with the entity have completed the continuing education requirement.

This documentation shall consist of the following and is subject to audit by OCI:

- A summary record for each individual listing the course title, date of completion, course hours, mode of delivery (classroom, webinar, etc.) and location of class.

- Certificates of completion or verification of attendance for each course with a signature of the instructor or monitor verifying attendance.

- Course summary, outline or agenda describing the content of the course.

Questions may be e-mailed to ociagentlicensing@wisconsin.gov.

IMAC PPACA Subcommittees - Meeting Agenda

Date: 07/08/2013 **Note: This meeting is a conference call**

Location (room and dial-in): Conference Line: (888) 808-6929 / Access Code: 4685307

1 West Wilson Room 372

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
	Craig Steele – DHS	X	Joanne Ator – Bay Lake
	Angela Dombrowicki – DHS (PPACA)		Amy Mendel-Clemens – Capital
	Tricia Janssen – DHS		Sheila Drays – Capital
X	John Rathman – ES PAC		Amy Roland – East Central
X	Elizabeth Jungers – DHS	X	Liz Mahloch - East Central
	Carrie Schneck – DHS	X	Rhonda Brown-Anderson – Great Rivers
	Jamie Fawcett-Christianson – DHS	X	Linda Struck – Great Rivers
	Angela Moran – DHS	X	Jane Huebsch – IM Central
	Julie Milleson – DHS	X	Amy Mayo – IM Central
X	Shawn Smith – DHS	X	Danyel McNeil – MilES (PPACA)
X	Jen Mueller – DHS	X	Carol Wicklun – Moraine Lakes
X	Paul Michael – DHS	X	Luann Page – Moraine Lakes
	Adam VanSpankeren – DHS	X	Doreen Lang – Northern
X	Shantara Glenn – DHS	X	Hope Otto – WKRP (PPACA)
X	Bill Lien – DHS	X	Adelene Green- WKRP
X	Tricia LaPlant – DHS	X	Phil Boutwell – Southern
X	Cheryl Jatzcak – DHS	X	Carla Haigh – Southern
X	Doug Long – DHS	X	Jill Johnson-Southern
X	Kris Parkansky – Bay Lake	X	Lorie Graff – Western (PPACA)

Topics
Standing Agenda Items 1) Responses to Pending Questions Shawn has reviewed the CAP list, and it is not helpful. It is incredibly outdated. There are about 500 names on the list, and approximately 75% of those are individuals. Those individuals did not agree to have their names shared either. The list has hospitals and clinics, not the stakeholders you are looking for. Some consortiums

want to know the hospitals and clinics though.

The consortia want a list of big partners.

The consortia should have an idea of their stakeholders like W-2 programs and children's networks. The Salvation Army and food banks would be a good place to start.

Action Item: Adam will go through the list and pick out hospitals, clinics, and big partners.

Outreach groups are receiving money; however, some locations may not receive any.

All of the FHQCs in John's consortium have gotten funding. He is unsure of statewide funding.

2) Updates on New Development

3) Upcoming CMS Calls

CMS released their final regulations on 7/3/13.

We are going through the final regulations to see if there are any changes between our assumptions and their final guidelines. We will let you know if you if there are issues or changes.

CMS will conduct a webinar tomorrow, from 1:00pm-2:30pm, regarding the final regulations.

Action Item: If you would like to receive the webinar information, send an email to Gillian, and she will get the information to you.

Focus Agenda Items

2) Security Discussion — Tricia LaPlant

Tricia will send out the plan and spreadsheet with instructions after this meeting.

They encourage the use of a spreadsheet for five or more requests at a time. The spreadsheet contains all of the fields on the form. This has worked well for MilES in the past.

The turnaround time is currently five business days, but BITS has agreed to process the requests within 3 business days from July through September.

It is essential that they already have a WAMS ID in order to get access.

When you send the email, please put "Consortia Priority Access Request" as the subject line. This way they will know it is priority.

We will be using the same email address for these requests; that won't change.

Some think the spreadsheet should be by consortium instead of agency while the original plan was to do it by agency. The problem with it being by county is the person submitting the requests would have to know each county's information number and security/IT liaison. The entire consortium would have to agree to let someone request access for everyone within the consortium.

Action Item: If you would like to work as a consortium instead of as counties, please let Bill know.

Action Item: Bill will work with Tom Miller to get a process established, so he can submit requests for all of Western.

We will also process Partner Portal Access within three business days instead of the usual five during the implementation. You have to have a CARES ID before you can get a Partner Portal ID. Instead of denying it as usual, they will hold the application until there is a CARES ID. If there is a question about the access, they will hold it and send an email asking for clarification.

2) Introduction to Proposed Outreach Strategy for Transitioning BadgerCare Plus Groups to Marketplace. — Shawn Smith

This is a thread from the last IMAC meeting regarding the consortia filling the gaps in assisting the public as they apply to the Marketplace.

Brett will come to the next subcommittee meeting to discuss the vision.

The "Regional Enrollment Network" will be a coalition, lead by the area administrators, of stakeholders, partners, consortia, etc. It will discuss process points and how to get people enrolled into the Marketplace. How we facilitate the hand-off is the crucial piece for Brett, and he wants a forum to formalize ideas.

Brett realizes that processing applications will be very time consuming and the top priority, but he also wants to make it clear we do not turn people who want help applying to the FFM.

The FFM does have a role. We are trying to get information from them about what they envision that role to be, so we have a better idea of what is needed from our end.

You should come to the meeting ready to discuss how this could work for you. It would be helpful for Brett to hear what plans you already have in place regarding this. He wants to know how you are planning to fill that gap.

If you already have partners lined up, they should be involved in the meeting.

The consortia should reach out to the area administrators, specifically Elizabeth Jungers, if you have questions about this.

Potential July 17 Agenda Items

DHS Readiness (Note: These items will be discussed at PPACA Subcommittee meetings as plans become available.)

- CDPU Capacity
- CCA Capacity and Messaging
- Security
- Extended CARES Hours
- Extended CARES Call Center Hours

-Other?

Adjourn

IMAC PPACA Subcommittee - Meeting Agenda

Date: 07/17/2013

Location (room and dial-in): Ballroom, Dane County Job Center, 1801 Aberg Avenue, Madison, WI

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-12:00 noon

Individuals Invited/Attended (X=attended)			
X	Brett Davis – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
	Carrie Schneck – DHS	X	Amy Mendel-Clemens – Capital
X	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS	X	Tim Gessler – East Central
X	John Rathman – ES PAC	X	Liz Mahloch – East Central
X	Shawn Smith – DHS	X	Amy Roland – East Central
X	Elizabeth Jungers – DHS	X	Kristen Stacker – East Central
X	Julie Milleson – DHS	X	Linda Struck – Great Rivers
X	Tricia LaPlant – DHS	X	Ronda Brown-Anderson – Great Rivers
X	Bill Lien – DHS	X	Jane Huebsch – IM Central
X	Jamie Fawcett-Christianson – DHS	X	Amy Mayo – IM Central
	Angela Moran – DHS	X	Dana Thompson – MilES (PPACA)
	Gail Chapman – DHS	X	Carol Wicklund – Moraine Lakes
X	Tricia Janssen – DHS	X	Luann Page – Moraine Lakes
	Paul Michael – DHS	X	Doreen Lang – Northern
	Adam VanSpankeren-DHS	X	Hope Otto – WKRP (PPACA)
X	Michelle Ebert – DHS	X	Carla Haigh – Southern
		X	Phil Boutwell – Southern
X	Jill Johnson – Southern	X	Lorie Graff – Western (PPACA)

Topics
Standing Agenda Items 1) Responses to Pending Questions John would like something in writing regarding the use of PPACA funding for CAC work. They might have contractor staff do CAC work. 2) Updates on New Developments

3) Upcoming CMS Calls

You have to register for the CMS webinar on July 31st.

Focus Agenda Items

1) Regional Enrollment Centers/Outreach Brett Davis

Many of these slides have been discussed at other meetings, so it might not be all new information.

Our uninsured rate, for adults from 19-64, is 14%. Our goal is to cut that in half in two years.

Children at a 5% uninsured rate.

We are simplifying Medicaid by eliminating some BadgerCare plans, so there will only be one.

Everyone up to 400% of the FPL will have access to healthcare.

Some people believe that lowering the poverty level to 100% for eligibility will reduce the number of people on Medicaid. This is not accurate though since we anticipate more people will now be on Medicaid because childless adults will now be eligible.

We expect to have over one million full-benefit Medicaid members in 2014.

The "Leverage Milwaukee Enrollment Network" discussed on slide seven refers to the partnership. It is not MilES.

There will be difference by region, but this could be a structure to start with when creating your regional networks.

We have agreed to be one of six states working with CMS for reporting purposes to federal government. This should help be consistent.

Working with the Tribal IM agencies is important to us as well.

Slide eight is the purposed idea. It is not final. It is a virtual network, not an actual place to go.

The message we gave to the Steering Committee is to not wait for the State to take the lead on this but to take a leadership role yourself. You must be proactive.

You should pull proactive leaders as team members to get started. We cannot spin our wheels.

We made assumptions about the federal plans, and we will have to work out any differences.

Brett wants this to primarily a regional thing.

This plan is designed for the consortia to decide how they are involved, but the consortia will be integral since they are experts.

Medicaid must be done accurately and timely, and that is the top priority. Step two is to help the regional enrollment networks like assisting with CACs. If the bucket is too full to be able to help people enroll, you should reach out to partners to fill that gap.

DHS and Area Administrators will co-facilitate the start of this.

The "Regional Enrollment Network Lead" will pull together mentors and open doors. They will

lead the facilitators.

Joy S. is a good example of what the Lead should do. Brett thinks of her as an "Operational Director."

The "Regional Enrollment Network Facilitators" will be the glue that connects the dots and disperses information.

AmeriCorps has agreed to volunteer as the facilitators. They have nine, and they need one more. They will start on August 19th, and it will go for one year.

Based on the proposed networks, some providers are in three consortiums. We will have to work that out.

Example 1, on slide 10, shows how we need to make sure a hand-off occurs.

There could be non-profit volunteers in the county lobbies to help when the workers are busy with Medicaid applications.

Example 2, on slide 11, involves agents and brokers since you cannot steer someone to an insurance plan per federal law.

Some brokers have asked if the consortia would want them in their lobbies. This is a good sign they would be interested in helping, and it would strengthen that hand-off.

Linda Auchue is mapping out a tool for regional enrollment networks that delves deeper than these two examples. It will not be at the consortia operation level though.

Action Item: The consortia want both the overview map and a list of questions that they can ask and discuss with partners/stakeholders of how to make the network work in their consortia.

Area administration will start to compile a list of people to contact as enrollment assisters and mobilizers. AmeriCorps volunteers will start with them on 8/19/13.

Page 13 is a proposed template from DHS, but you should do whatever works for you.

In a perfect world, each consortium would have its own CAC unit. You can pull in community partners for this unit as well. Ed wants to train 50 people for this purpose

The consortia are exempt from the State's 16 hours of CAC training but not the federal training.

We are trying to get the consortia exempt from the federal training.

The OCI will do the State's training, but we do not know who is doing the federal training.

OCI released their dos and don'ts for CACs, and those are slides 21 and up.

We would like periodic checkpoints to occur with this network. We need to figure out the quickest way to get information out. Please think about how you would like to do this-calls, virtual conferences, virtual rooms, etc.

CMS continues to change their requirements which affect notices. The account transfer and State's responsibility is a hurdle.

Per CMS, we have to do account transfers by reaching out to the person, getting information, inputting it into the system, and then transferring the application to the Marketplace. We are trying to make them understand that this is not feasible.

We want to see if brokers can call the 92,000 current members that may be impacted by

coverage changes in order to enroll them; however, we do not know if that breaks HIPAA law. We can only share information with certain people.

We are going to try to identify veterans that may need assistance, and the VA will work with them. The VA is going to join forces with homeless shelters as well.

We do want your input on the notices. The first notice will go out on September 20th.

Brett is trying to find a way to let people who apply 10/1/13-11/17/13 to know we will not run their eligibility until 11/18/13. He is really worried about people calling or waiting in the lobby.

The timeline on slide 20 is good, but the consortia want a more in-depth timeline of the work and when things must be done by. Linda Auchue is creating one from the IM worker point of view.

If someone is on Medicaid now but losses it, there will be a hardship exemption period. We are trying to figure out how long the credible coverage will last.

There was a stakeholder training yesterday that was attended by many of the bigger, more popular institutes. The area administrators have the list of attendees. The consortia want that list even if there are more stakeholders not there.

IM workers will need to complete the first two bullet points of training on slide 21.

Slide 22 says the training is currently available. Some consortia are hiring staff now, and it would be good to get it out of the way if they can.

Action Item: We will follow-up on the link, so we can send it to them.

To get started on network formation, the area administrators will reach out to the different consortia. They will share the training attendance list and ask who the consortia are currently working with and how. They will then have mini-meetings within the group to come up with a plan.

Area administration will contact the consortia next week regarding the meetings. They do not want to add more meetings to anyone's calendars, so if you already have consortia meetings, they would like to attend those.

10/1/13-11/18/13 applications will be taken electronically not by paper. We will track the numbers daily, and we will tell you what is sitting in the inbox. We need to find a good way to dispense those reports weekly. Email or SharePoint could work, but they would want us to put it tomorrow they could find it if we put it on the SharePoint. They would also want the newest on top.

The FFM will only deal with healthcare applications, not other programs.

We do not know what the FFM application will tell us. We will receive them if they assess them to be eligible for Medicaid.

The consortia really need to know what information the FFM applications include since that will directly affect the work load.

CMS says the FFM application takes 20 minutes to complete. If this is accurate, it would mean more work on our side.

They say it will be ready on October 1st.

Shawn has been given a questionnaire to fill out regarding our Medicaid, so the FFM call center

has a script about our program.

We would like to know the customer service level of the FFM. We are trying to get their script, so we know what they will assist with. We do not know if they will help people apply to FFM. They will refer people to ACCESS, so they can apply for BadgerCare Plus.

If they take information over the phone, they just do assessments of the overall parameters.

We are working with CMS about verification, but they run it against the standard based on what the person says they make. We are using different verification methods than the FFM which will be a problem.

There will be an end to the back to back of the FFM sending an application to us because they think the person qualifies for BadgerCare Plus, but we send it back to the FFM because they do not qualify for BadgerCare Plus. We might have to enroll them in Medicaid if FFM determines they are eligible.

Since we are holding FFM online applications, the consortia would like to know if they could see the applications ahead of time. This way they could possibly, if they have time, contact the applicants ahead of time to get missing verification/pieces of information or establish interviews before the 30 day turnaround time starts.

The only unique identifier would be their Social Security number.

We need to share information with partners since they know less. We need to give them an outline of what we need like after X days, we need you to be a CAC.

The consortia needs to understand their role first since they are going to explain the different roles to the partners. We told them to talk and brainstorm locally first, and we are working on hand-outs for them to use.

Providers do not want to do CAC work in WKRP because of a conflict of interest. They have already told them that.

Medical providers are worried about the conflict of interest. Slides in this presentation include the dos and don'ts for CACs, and Sarah Fraley is looking at the rules.

CACs cannot give insurance plan advice or direct them to a plan.

Agents or brokers have to help in choosing a plan if the person would like assistance. This is not necessarily a needed step unless the person would like help.

We are doing data mapping to try to put the FFM application into an ACCESS application. This way we can find empty fields and hopefully be able to figure out what it is not asking that we do.

FFM applications that have been transferred will come into the consortia inboxes as an ACCESS application.

If members are denied through the FFM, they should get a notice from the FFM that they are denied, and we will then send them our letter letting them know that we will process it on 11/18/13. This will only be for childless adults since there is a program for families.

The exact filing date for the childless adult applications is something we need to ask Linda A.

If a childless adult applies through ACCESS before the new rules come into effect, what does the consortium do with them? Do they deny them and make them reapply?

2) Communications Update — Adam VanSpankeren

There is a batch of notices for people on BadgerCare Plus and a batch of notices for people who applied to the FFM.

Final language on notices was due to Deloitte on 7/15/13 for September notices.

We have until 7/30/13 for the language on one-time mailings, and we are still hoping to get your feedback on them.

We have not gotten them to you yet because we are waiting for CMS to tell us what we can say, have to say, and cannot say.

We will give the consortia a timeline on when the notices go out.

The one-time mailing's returned address mail will go to HP.

We will spread out the mailings by a day or two.

3) Highlights of Consortia Plans — Angie Dombrowicki

This topic will be moved to August's meeting.

We ask for a revised version of your plans by this meeting since the other was preliminary.

There is a question in the plan that relates to the Regional Enrollment Network, so you can add your plans for that there.

We could send back the summary we received from the consortium, and the consortium can correct anything if need be.

4) State Preparation

-Security –Questions on Process — Tricia LaPlant/Bill Lien

(materials emailed on July 10th)

The purpose of the spreadsheet is to submit mass (5+) requests at a time.

A signature would not be needed on the spreadsheet.

The standard form should be used for less than five requests.

We are going to cut the turnaround time from five to three business days for the PPACA implementation.

The consortia would like a prepopulated form for everything an ES employee would need, so they would just need to fill in the worker's information. Bill is worried about a form that would change with consortia permission level.

Action Item: Bill said to have the consortium/county call BITS, and they will walk through all of the roles for each role and explain what fits with each. The consortium/county could then hold

on to that as their template.

Some consortium already have something similar to the form others are requesting, so they will share with them.

If you would like to have one person be able to submit requests for the entire consortium, all of the partners simply have to agree to have one of the counties submit for everyone. Some would like to have flexibility though. For example, if Dodge has one person start, they would like to be able to submit that form instead of having to wait for Dane to do it.

Bill has worked with some consortium to get a plan going for total consortium submissions.

We will add a field to the spreadsheet for the security level, if it is a 25 or 50. The standard for a security level is 25.

Training IDs are granted with production IDs.

Everything has been processed, so we are up to date on Partner Portal security requests.

Partner Portal security requests will have a three day turnaround instead of five during the implementation as well.

We are holding requests without CARES IDs to see if we can get them instead of returning them.

If you need to cut someone's access off immediately, you can send an email to BITS, and they will cut it off instantly if you say the form is coming.

- Update on Extended hours for CARES — Angie Dombrowicki

Except for some sporadic times (adverse action, batch runs, etc.) when it will close early, the extended CARES hours will be: 7am-9pm Monday through Thursday, 7am-6pm Friday, and 9am-5pm Saturday.

There will be a calendar published on the website, and we will give advance warning if it will close early.

It might be closed some Saturdays.

We will keep this on the agenda.

The 11/15/13 through March of 2014 hours should be known by the next meeting.

The consortia would like us to add more weekday hours if CARES will be closed on Saturday.

- Training Update — Michelle Ebert

They did a dry run of the Phase II trainings, and they received a lot of good feedback and are making edits based on them.

It will be a full day training from 9am-4pm with a ½ hour lunch.

Registration was due on July 12th for the Phase II trainings, but we only received registration for 11 out of 21 sessions. We have extended registration because of this. There do not seem to be

barriers to registration.

The consortiums we need registration information from are: Capital's, both Moraine Lakes 8/2/13 and 8/8/13 trainings, both Southern's 8/29/13 and 9/20/13 trainings, and East Central's 9/9/13 training. Southern said they sent theirs in yesterday, but this was compiled before then which is why they were on the list.

We are recording all of the trainings, so we can collect all of the questions that arise.

If changes in policy come in between sessions, we will add those to the next session and final recording.

The Operations Memo will include policy changes.

Staff who takes earlier sessions should probably review the final recording to see if there are changes in policy or questions they have that might be in the Q&A.

If there is a huge policy change, we might cover it in Phase III trainings.

We will post the final training on the DHS Learning Center at the end of September. This will include all of the questions and answers compiled from all of the trainings and policy changes.

The consortia would like a separate section on the DHS Learning Center for the Q&A section as well as the changes in policy. This way staff could review it without having to sit through the entire training.

This will not be a part of the new worker training, so they will probably have to use the recording for the PPACA changes.

Phase III trainings will be Adobe Connect sessions from 10/22/13-11/15/13. They will be three hours, and there will be eight of them.

Sign-up for the Phase III trainings will be open in mid to late August as to not confuse it with the Phase II trainings.

- CDPU Capacity — Tricia Janssen

The fixes to the system will be done by August 17th, so we have time to assess the fixes to see if they worked and also correct them if need be.

Future Agenda Items:

We will look at which meeting each topic will be discussed in. The meeting listed after each topic is based on today's conversation and tentative; they might be covered in the other meeting based on timing and what is available at that time.

Linda A. to explain what the consortia are allowed to do with held applications. – In person

Linda A. discussion on the timeline of peaks in workflow. – In person

Can medical providers do CAC work or is it a conflict of interest? - Teleconference

Consortia Planning Review – In person

Notices Update – Teleconference

Regional Enrollment Networks – Standing agenda item on both Other Agency Concerns like Childcare or Fraud – Childcare could be done at the Program Connections Subcommittee meeting and Fraud at the Fraud Subcommittee meeting. Action Item: The PPACA Subcommittee teleconference and Steering Committee meeting needs to be moved to August 5th.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 08/05/2013

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
	Brett Davis – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
	Carrie Schneck – DHS	X	Amy Mendel-Clemens – Capital
	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS	X	Tim Gessler – East Central
X	John Rathman – ES PAC	X	Liz Mahloch – East Central
	Shawn Smith – DHS	X	Amy Roland – East Central
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
X	Julie Milleson – DHS	X	Amy Mayo – IM Central
	Tricia LaPlant – DHS	X	Jane Huebsch – IM Central
	Bill Lien – DHS	X	Dana Thompson – MilES (PPACA)
X	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Angela Moran – DHS	X	Luann Page – Moraine Lakes
	Gail Chapman – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
	Paul Michael – DHS	X	Adelene Green - WKRP
X	Adam VanSpankeren-DHS	X	Jill Johnson – Southern
X	Michelle Ebert – DHS	X	Carla Haigh – Southern
		X	Phil Boutwell – Southern
		X	Lorie Graff – Western (PPACA)

Topics

Standing Agenda Items

1) Responses to Pending Questions

Our current procedure is to respond to each policy question individually, and we will keep doing so. We are creating a FAQ document of all of these questions and will post it on our website when ready.

2) Updates on New Developments
3) Upcoming CMS Calls

Focus Agenda Items

4) Update on Regional Enrollment Networks — Bill Hanna

Most of the meetings are in the third week of August, and some will be in the fourth week.

They will be all day events from 9am to either 3pm or 4pm.

Northern and Western have yet to have their meetings established.

You will get an invite for the kick-off meetings this week. Agendas will go out with the invites.

A master list of when all of the meetings will be held will be put on the website.

It will be most beneficial for you to attend your region's meeting since part of it is strategizing with your partners face-to-face. If you cannot go to the meeting in your region, you can go to others to get a general idea of what is happening though.

Action Item: Please pass along Brett's email to any partners we may have missed.

We will be passing along information to anyone who is interested.

The URL for the REN website will be ready soon. There is a meeting regarding it tomorrow.

Medicaid information will be on DHS' website while all other information will be on the HMO's REN website.

The website will not be hosted by DHS but by a partner. We do not want to take charge of it. The negative side is that we then cannot control it.

We will hopefully have mock-ups of the website ready by IMAC since we want it for the kick-off meetings.

Action Item: We need to think about people without access to the internet. The letters give the REN website, but not everyone has the internet. There is not an actual REN department, so there is no number we can give for that.

Should it be 211 or Member Services' number that we give for the REN? 211 told us we could not give out their number when the ESC was implemented. If we give it to Member Services, it will affect them long-term, and we are unsure if it is in their scope. HP would probably want an updated resource estimate if that is the case as well.

Action Item: We need to follow-up at meetings tomorrow. We need to know by 9/3/13 because that is the last day for edits for the letters, so we need know what number to use.

5) Review of One-Time Member Mailings (Handouts of Letters 1, 2, 3, 4, 5, 7) — Adam VanSpankeren

There is one piece of language missing regarding the RENs. Some will have a referral link to the REN's URL, and that has a list of contacts that can help with FFM enrollment and a number they can call. The problem of not having a REN number emerges here.

The URL would have a list of regions, and people could click on their region, so the letters should have that static link. The language would say something like "for information or help, please see www. . . "

Letter 1 has the 12/15/13 date listed as the date for them to apply by instead of March because we did not want our customers to wait until March. If they see they have time, there is a good chance they will wait until it's too late plus there would be a lapse in coverage. The consortia want something like "for no lapse in coverage, apply by 12/15/13, but you still have until March" added.

We could possibly add something to CCA messaging in November regarding the March date, or we could send another letter in November. The consortia would like it in writing as to avoid undue calls.

Letter 5 will have the REN's website link where it says "Placeholder." We only give a FPL household size of one and two because it is Basic, so there are only family sizes of one or two.

Letter 6 is being reviewed today in a meeting which is why it is not included in this group of letters for the consortia's review.

Letter 7 will most likely not have REN information on it because calls should probably go to the consortia instead of RENs; however, the consortia think Member Services is the correct contact.

Action Item: The consortia should keep thinking about how we can handle the November 2013/March 2014 application deadline issue.

Action Item: Adam needs the letter feedback by COB Wednesday.

6) Consortia Work Plans — Debbie Waite

Action Item: We are hoping you can take a short time to look over the plans you submitted in June and make any changes that have come about. Please highlight the changes and send them to Gillian.

We are mainly focused on the staffing aspect.

We would want them by IMAC on August 15th.

Focus Agenda Items for the August 15th IMAC/PPACA Subcommittee Meeting

4) Requirements for Navigators and Certified Application Counselors (CACs)- Office of the Commissioner of Insurance (OCI) Staff

They will take us through the training requirements.

5) State Preparation
   a. Call Center Anywhere-Capacity and Messaging-Paul Michael and Adam VanSpankeren, DHS
6) Operational Readiness for Processing BadgerCare Plus Applications for 2014-Linda A

This will be a continuation of the verbal description of caseload activity that Linda Auchue presented at the June PPACA Subcommittee Meeting.

We will have hand-outs.

Other

John would like to know if the Workload and Finance training session will be held anytime soon. It will probably be a little bit before they are able to conduct it.

Action Item: We will follow-up on the Workload and Finance training at IMAC. Debbie has asked for a draft agenda from the BOC, so we can make sure everything the consortia needs is covered.

Note: There will not be a PPACA subcommittee meeting on August 14th. Instead the PPACA subcommittee meeting will be merged into the August 15th IMAC meeting.

It will start at 12:30pm and be held at the Alliant Energy Center.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 09/09/2013

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
	Brett Davis – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
X	Jen Mueller – DHS	X	Amy Mendel-Clemens – Capital
	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS		Tim Gessler – East Central
X	John Rathman – ES PAC		Liz Mahloch – East Central
X	Shawn Smith – DHS		Amy Roland – East Central
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
	Julie Milleson – DHS	X	Amy Mayo – IM Central
X	Linda Auchue – DHS	X	Jane Huebsch – IM Central
	Michelle Ebert – DHS		Dana Thompson – MilES (PPACA)
	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Angela Moran – DHS	X	Luann Page – Moraine Lakes
	Gail Chapman – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
	Paul Michael – DHS	X	Adelene Green - WKRP
	Adam VanSpankeren – DHS		Jill Johnson – Southern
X	Gillian Ward – DHS	X	Carla Haigh – Southern
		X	Lindsey Schwartz – Western
	Deb Morris – Redcliff	X	Lorie Graff – Western (PPACA)

Topics
Update on Applications Coming from the Marketplace Linda Auchue We will take the FFM determination between October 1st and December 31st. This affects those eligible in 2013 but will not be in 2014, and they apply through the FFM.

There are no changes to the process if the application did not come from the FFM.

The reason for this because MAGI changes will not be in CARES until November, and the BadgerCare Plus applications do not ask all of the questions that we need to for tax rules. Those questions will not be asked until March 2014. There are also system exchange issues. The FFM cannot receive our applications without the MAGI tax questions.

We will not be able to do a MAGI application until the new rules are in place.

We are in continuing talks with CMS, and they are worried there will be gaps in coverage. That is why we are going to be a determination state through the end of 2013.

We will send a letter to the applicant, if they come from the FFM, stating they will get BadgerCare Plus starting January 2014.

We are hoping this will reduce the call volume.

The worker will have to pull the application, but they will not have to gather further information because we are accepting the FFM verification.

Workers will not need to gather or verify information from any applications coming through the FFM from 10/1/13-12/31/13. The worker will not have to touch the case until their review date.

If there are discrepancies, the worker should make the update starting 1/1/14.

This should reduce the amount of time it takes to process the application.

We are currently defining what worker actions will be. They will have to pull the case and possibly add it to an open case. They will probably have to create the case and go through the intake driver flow. The whole process is finished once it is pulled from the inbox.

We will now hold family applications until 11/18/13 as well.

Family applications will have to be run using 2013 rules for the November to December timeframe. Starting in 2014, they will be run with MAGI rules.

We are holding applications until 11/18/13 because that is when the CARES changes and verification codes will be in place. We do not want workers to have to process the cases twice.

The question was posed of if we should send people to the FFM since that seems the best and quickest way for them to get coverage. Even though there is no “wrong door,” that seems to be the best door to go through.

Shawn responded that there is no harm in telling staff how the process will work, but we do not want to give out bad information since there is no documentation regarding this. We have to be careful with what we say. Our message has always been to go to the FFM, so that is not changing. We do not have to change the mailings because they already send people to the FFM.

It may appear to be better for the applicants to use the FFM since it is more expedited, but that might not be so if they are applying for more programs than just healthcare.

The September letters direct recipients to the FFM immediately.

The letter about the income-level changes will hopefully not cause as much confusion now since we will enroll them if they apply through the FFM.

Program integrity is our main concern with this.

Members will still have to report changes, and the agency workers have to process those

changes. They will still have renewals. We are hoping this will help with the integrity.

Second Party Review will be pulling cases to check on integrity as well.

We want an error code that the application came from the FFM, so we know it was verified by the Marketplace.

We will send out an Operations Memo with the process in the near future.

PPACA Workload Monitoring Linda Auchue

We are going to keep an eye on the workload for each consortium.

The determination change will help with this since it will make processing quicker and easier.

The workload monitoring procedure is part of the Operations Memo that was released last Tuesday.

The new applications received/processed daily report will help determine the status and needs.

There will be a spike on 11/18/13 of course.

We can view the balance on the document processing report too.

We will watch the dashboard for applications and SMRFs nearing the end of the review period.

We will contact the consortium leads if the case load is worrisome to see if there is a plan in place or if the consortium needs the State's help.

We are watching because we have to report to the Administrator's Office, Secretary's Office, and then to CMS.

We wanted better reporting than we had with the Core Plan.

Updates to Ongoing Topics

1) Regional Enrollment Networks Bill Hanna

The kick-off meetings have concluded.

Bill would like to thank the consortia for helping at the kick-offs.

The RENs wants one centralized location for all FFM and related information. The REN website will be used for this.

The website will include additional web-based trainings and the FAQ.

The OCI and DHS leadership are doing headboards, so it will hopefully be in the newspaper.

If people want standard FFM materials, CMS has those materials.

There were over 300 questions from the REN meetings we are trying to support.

There is healthy competition amongst the RENs.

Bill Hanna said the partners want a flowchart.

We will work on the flowchart.

The survey on enrollment inventory (who has CACs, locations, language, referrals, etc.) is going out, and we hope to have it published by the end of the month. This might be on e-health or have a link to our website.

2) HP Readiness Issues: Linda Auchue

- CDPU Capacity

We will be monitoring this as well.

The have updated their Kofax.

The CDPU is hiring 12 staff and will have them in place by the time the letters go out.

They will receive the returned mail.

- Member Services

They are adding additional phone lines.

They are hiring additional staff for the phones.

They will be using messaging similar to that of the consortia.

We will monitor the CCA for Member Services like we are for the consortia.

3) Communications Update

We wanted to have already sent out the mock-ups of the final mailings, but we are committed to doing it within the next few days. The letters are finalized.

CCA messaging feedback is finalized, and we are working on getting them approved. They will hopefully be ready by the time we send the letters out.

We will share Member Services scripting if that is helpful.

We are working on EM CAPO scripting now.

We have finished the vendor procurement process for the targeted outreach calls last week.

The vendor will make the outreach calls and have scripting for such. They will call people who received letters and refer them to the FFM.

Action Item: The outreach calls and the role of the callers will be added as an agenda item to the September in-person meeting.

Linda Struck informed us that the ADRC is sending out lots of information, and they are

contacting ES workers.

We wonder if they are sending people to ES workers because some might feel that since they got the money, it is their responsibility.

Action Item: Linda will send Debbie those emails.

Some ADRCs are planning on training for CACs, and they should be involved in the RENS if they are.

Action Item: If the ADRCs are involved with CAC work, they need to be added to the REN list.

Action Item: We will contact the DLTC about what they are sending out.

4) Updates to Consortia Work plans Debbie Waite

We heard from all consortiums except for WKRP and Western. It would be much appreciated if they could send us their plans or a note that there are no updates.

From the updates we received, it seems that there are four main themes: staffing updates, lobby activity and call center staffing, OT as a common strategy, and that the RENs have people reaching out to partners more.

Today's update might change this too.

5) Location and Date of Next In-Person Meeting Debbie Waite

There will only be one meeting because PPACA is being collapsed into the Thursday IMAC.

It will be at the usual 1pm IMAC time.

It will be at the Consumer and Protection Building on Agriculture Dr.

Today's IMAC Steering Committee at 11am is being cancelled.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 10/07/2013

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372A.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
x	Shawn Smith – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
X	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
X	Jen Mueller – DHS	X	Amy Mendel-Clemens – Capital
	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS	X	Tim Gessler – East Central
X	John Rathman – ES PAC	X	Liz Mahloch – East Central
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
X	Julie Milleson – DHS	X	Amy Mayo – IM Central
	Linda Auchue – DHS	X	Jane Huebsch – IM Central
X	Michelle Ebert – DHS		Dana Thompson – MilES (PPACA)
	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Sheila Kurt – DHS	X	Luann Page – Moraine Lakes
	Andre Small – DHS	X	Loraine ? – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
	Paul Michael – DHS	X	Adelene Green - WKRP
	Adam VanSpankeren – DHS	X	Jill Johnson – Southern
X	Gillian Ward – DHS	X	Carla Haigh – Southern
		X	Phil Boutwell – Southern
	Deb Morris – Redcliff		Lorie Graff – Western (PPACA)

Topics

1) Updates to Ongoing Topics Bill Hanna

Regional Enrollment Networks

Immediately following this call, there is a REN meeting with all of the REN members attending.

There are not many updates now because the meeting is after this.

Bill has received feedback about the FFM website not working.

Action Item: We will send out a brief account of the REN meeting to everyone after it is over.

2) Feedback on First Week of Marketplace Consortia

Bay Lake- The call center is getting calls from people coming through the FFM that are not in our consortium. They are getting a lot of misdirected calls. Workers have been asking where they are coming from. All of Door County's wrong calls have come from the FFM call center: two people from Milwaukee and one from Dane County. They have just started to print the paper applications since the website is down, but they have not heard of issues with the FFM call center number.

Capital- They had about 70 walk-ins, but they were mostly people seeing if they were still eligible for BadgerCare Plus. There were 31 the first day, 34 the second day, and less than 20 the next two days. People do not want to take the paper applications they have provided. Someone from the FFM told her the ID requested when you call is for them to use the backdoor to get to someone's account. There was an article in the paper that we will not process the applications until 11/18/13 which could cause issues.

East Central- Their navigator agency is reporting problems from the FFM sending Upper Peninsula residents to Sheboygan. One REN is holding paper applications until the website is up, and they can fill the application in online. Paying the premiums has become a problem because many do not have a checking account or want to give that information out. Someone is thinking of setting up a system where the customer can give them their money, and they give something like a money order to them.

Great Rivers- They are not having call center problems. The calls are basically busy work, but they are their constituents. There are multiple applications on the website, so they do not know which one to print. The other consortia are using the short form.

Action Item: Craig will ask CMS which application they should use.

IM Central- They do not have much to add. They have not had many walk-ins.

Moraine Lakes- They have also had the same experience as others. Not many walk-ins either.

Northern- The call volume is down; some calls are for PPACA.

WKRP- Racine has had 60 walk-ins, and they are giving out paper applications. Kenosha has had 25 walk-ins, but none have gotten into the website. Some have taken the paper applications. There has not been a lot of FFM traffic.

Southern- One person is monitoring the FFM functionality at different times throughout the day. They were able to apply at midnight on 10/4, and it took 30-45 minutes. It paused at the signature page before they could enroll in a plan. It timed out on then. When they tried accessing their account in order to enroll in morning, it said they did not have an account. Some people were frustrated that we could not give specific answers.

Western- Calls increased, but walk-ins are slow.

3) Update on CAC/Navigator Lists Craig Steele/Debbie Waite

The federal staff members responsible for fixing Find Local Help (FLP) were furloughed, so it is going to take longer to fix.

The FLH tool should be updated weekly if everything is going smoothly.

The FLH tool uses a 100 hundred mile radius when searching.

The consortia have been removed from the FLH listings.

Wisconsin is one of a few states with a regional model which is confusing for the FFM staff.

Craig will send out CAC information as he gets it.

Navigators are slowing down the process.

There is a REN meeting at 10am, so we might get more information then.

The message on the website has been changed; it is clearer.

Craig asked CMS to use the BadgerCare Plus language and not the CHIP/Medicaid language on the website since our customers are not used to that. CMS said there are 37 states that all use that same argot, so that will be at the bottom of the lists of fixes.

The Medicaid/CHIP link goes nowhere.

The CAC lists should get out sooner since that is not a coding fix.

There have not been many major difficulties with Forth Healthcare being listed within the Capital consortium.

4) Update on Functionality of Marketplace Craig Steele

Website and Self-Help Tool

Action Item: Craig will try to get the consortia coaching on what they should tell the customer to say when they call the FFM call center to make sure that they are not asked for a username or ID. Something like "enroll in the FFM," so the FFM worker does not think they are calling for another reason.

We cannot look at other states that have their own exchange because that would be anecdotal evidence. Some can enroll people, some cannot, and some can only enroll businesses. Kentucky has enrolled over 17,000 people.

One person was able to apply to see if they are eligible, but they could not enroll.

Craig suggests we keep printing the paper application since the FFM call center is giving it out.

Action Item: We will clarify if people can enroll over the phone.

They do not need an account to apply over the phone, so the FFM worker is wrong if they tell you that.

Action Item: We will forward the email from CMS that states that the customer does not need an account to apply over the phone. We will let them know this in the REN meeting as well.

Some tried using the phone when the website went down, but they needed the ID from the website. It was a catch-22.

Decision: Craig said to refer people to the phone, so they know which application to use. The FFM might have a backdoor that they can enroll people in too.

John Rathman has five CACs who had about 200 people come in to apply. They could not get through without an ID on the phone either. They found there are 86 healthcare options to enroll in which is overwhelming even for a person in a healthcare role.

We request that, as things get better, you funnel that information up, so we can understand what is working versus not working.

5) Call Center Outreach (walk-on item**)** Craig Steele

We are delaying the outreach until the FFM's website is fixed.

We are reviewing on a day-by-day basis to see if we will start the outreach.

Gillian sent an email regarding this this morning.

The targeted populations of the outreach are those who received letters 1, 2, 3, and 4.

Automated Health Services (AHS) are doing the calls.

AHS will have scripts on how to move forward. They will probably be generic. For example, if they call a Capital consortium member, they will probably not give out Capital's specific information since there are so many calls to make.

AHS will be able to transfer callers to the FFM.

We should add something for people who have been having problems, so we recognize their troubles.

We should give AHS more information, so they can be more helpful.

6) Feedback on Draft RMS Administrative Memo Debbie Waite

We sent out the draft memo with how to use the RMS code about ten days ago.

We will hopefully make Liz Mahloch's formatting suggestions since it makes it easier to read.

We will change the code reference to MPE 360 since it is now MPE 320.

The updated worker notification will be sent directly to the IM worker.

We answered individual questions directly.

If anyone has comments within 24 hours, please let us know.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 11/04/2013

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
X	Shawn Smith – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
X	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
X	Jen Mueller – DHS	X	Amy Mendel-Clemens – Capital
	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS	X	Tim Gessler – East Central
X	John Rathman – ES PAC	X	Liz Mahloch – East Central
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
X	Julie Milleson – DHS	X	Ronda Brown-Anderson – Great Rivers
X	Linda Auchue – DHS	X	Jane Huebsch – IM Central
X	Michelle Ebert – DHS		Dana Thompson – MilES (PPACA)
X	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Andre Small – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
	Paul Michael – DHS	X	Adelene Green - WKRP
X	Gillian Ward – DHS		Carla Haigh – Southern
	Deb Morris – Redcliff		Lorie Graff – Western (PPACA)

Agenda Items:

1) Updates-Craig Steele

- **Account Transfer Update**

We had a meeting with CMS on Friday, and they said the account transfers will not start before the end of the month.

We will have more meetings with CMS later in November.

Our initial testing is done, and we plan on testing cases determined eligible.

You cannot take action on the flat files.

We know there have been two incorrect determinations so far.

Some transfers could be kids already enrolled. We know there has already been one in fact.

- **Weekly Flat File**

This is intended to be a gage of what is being processed (the volume) by the FFM. They are those that the FFM determined eligible for BadgerCare Plus.

There are no numbers on how many applications are for Wisconsin.

We got them Tuesday, and there are 5289 applications representing 7248 individuals.

We expect these numbers to rise.

There are lots of duplicates, so we cannot say those number are exactly correct.

We may break the information down by county if the volume gets higher because we are saving Deloitte resources now.

The files come from the notices, so it is per household. The kids might be eligible for BadgerCare Plus while the parents are not.

- **CMS Desk Officer Operations**

Craig has a regional CMS contact.

We have discovered two issues so far. 1) There are two confirmed reports of CMS processing cases incorrectly. One was said to be eligible for BadgerCare Plus when they were not, and the other was a childless adult well below 100% determined to be part of the FFM. 2) The notice process from the FFM has incorrect consortium information. Craig is trying to figure out where they are getting their information from.

Amy's CACs are reporting issues.

Action Item: If you have issues, please let Craig know. If you send Debbie an email, she can forward it on to Craig too. He wants all issues even the small ones.

- **Number of Certified Application Counselors (CACs)**

As of last Thursday, 443 people had passed the State exam. We do not know how many passed the federal exam.

176 people are registered with OCI.

There are 13 navigators within two organizations registered with OCI.

- **Direct Call Process**

We started making calls to letter three and four recipients Thursday and stopped Friday.

We reached a little under 30% of letter one recipients. 80% of those people reported they received the letter. We are doing 2nd attempts now.

We made less than 10 transfers of the 56,000 we reached. It seems 99.9% of people understood the letter.

- **Status of Letter #9**

It will go to those we received letter one.

It will be a reminder letter with instructions and paper applications.

We put the mailing on hold last Friday.

The target mailing dates are from 11/7/13-11/15/13.

The consortia should receive a copy shortly. Gillian will send it to the PPACA subcommittee and ops leads while Linda will send it to the CARES/Policy teams.

CMS says the FFM will not improve by the end of the month which is why we are pushing the paper applications. Our goal is to make sure there is not a gap in coverage.

This is a very fluid situation.

- **CMS Notices to Members**

2) Operations Memos-Linda Auchue

We are working on the ops memos for how to process FFM applications. We are taking a little more time to ensure all of the information is correct. Since we are not receiving the account transfers yet, we have more time for this. Our new goal is to have it out the third week of November.

The FoodShare proposal was completed Friday.

The ops memo for presumptive eligibility should be out by the end of November; although, it will not be effective until 1/1/14.

The divestment ops memo will hopefully be out this week.

The BadgerCare Plus handbook with 2014 information was released last week.

We are trying to get the Q&A from the training sessions out this week. It is with the Secretary's Office now.

3) Other

The consortia would like to talk through how things will change processing wise and timelines. They would like to schedule a call for this.

The consortia would like to know if workers can have the week of Thanksgiving off. They probably can since we will not be receiving FFM applications until the end of November at the earliest.

It is the law that premium payments are due by 12/15/13, and CMS is not budging from that.

There are some issues with how to pay since there are different plans with different guidelines- Some won't take cash or credit cards, others want debit cards which is hard for our customers, etc.

Craig will follow-up with OCI on what they will/will not take.

At this time, we are not extending BadgerCare and HIRSP coverage. We are trying to stay the course since CMS says it will be fixed. From the State's standpoint, we are not changing direction right now. We are going to continue to monitor the situation.

People who have applied to the FFM are not hearing back from them like they said they would be. This is most likely a result of the 700,000 applications submitted that are stuck. Craig is confident 95% of the applications are stuck in the system which is why they are not hearing back.

We think CMS knows to expect lots of paper applications and are staffing up for it. We know they are expecting many duplicates.

CMS has changed their homepage to give other options for how to apply.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 11/20/2013

Location (room and dial-in): Aging and Disability Resource Center (ADRC) 2865 North Sherman Avenue, The ADRC is in the Northside Towne Center which is a shopping mall at the corner of Northport Drive (Highway 113) and North Sherman Avenue) Madison, WI

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-12:00 noon

Individuals Invited/Attended (X=attended)			
	Brett Davis – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
X	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
	Carrie Schneck – DHS	X	Amy Mendel-Clemens – Capital
X	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
	Bill Hanna – DHS	X	Tim Gessler – East Central
X	John Rathman – ES PAC	X	Liz Mahloch – East Central
X	Shawn Smith – DHS	X	Ronda Brown-Anderson – Great Rivers
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
X	Julie Milleson – DHS	X	Amy Mayo – IM Central
	Tricia LaPlant – DHS	X	Jane Huebsch – IM Central
X	Jen Mueller – DHS	X	Dana Thompson – MilES (PPACA)
	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Angela Moran – DHS	X	Luann Page – Moraine Lakes
	Gail Chapman – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
X	Paul Michael – DHS	X	Adelene Green - WKRP
	Adam VanSpankeren-DHS	X	Jill Johnson – Southern
	Michelle Ebert – DHS	X	Carla Haigh – Southern
			Phil Boutwell – Southern
		X	Lorie Graff – Western (PPACA)

Topics
1) Implementation Update **State Staff** The governor does not want transitioning members to lose coverage, so their BadgerCare Plus coverage/benefits will be extended to April 1, 2014. We know the special legislative session will be late November/early December.

The legislature may take the governor's proposal as is or modify it. We need CMS' approval as well. Once both are in place, we will have to quickly create a plan.

For childless adults below 100%, Craig says they should still apply to the FFM since they cannot in ACCESS yet.

Per the public report, there were 10,700 determinations made for Wisconsin. We had a little over 900 files the day before this announcement. The cause of the discrepancy could be the date the report was run.

What we do not yet know (dependent on the legislature and CMS):

6. If parents/caretakers and children currently eligible, but not enrolled, will be allowed to enroll past 1/1/14 if they are over the new income limits through March 31, 2014.
7. If CMS will extend the existing BadgerCare Plus waivers and allow Wisconsin to maintain the enrollment cap for the Core Plan. Basically, we will see if CMS allows us to maintain the Core plan for childless adults through 3/31/14.
8. The effective date of the new BadgerCare Plus Reform Waiver. Will all childless adults below 100% enrolled on 12/31/13 stay on to 3/31/13.
9. If the Core plan will end on 12/31/14
10. When we will implement and when the BadgerCare Plus Reform and ACA changes will be effective including:
    A. Will MAGI rules be effective 1/1/14?
    B. Will the new income limits be effective 1/1/14? Can new families join with the old FPL if not?
    C. Do the other benefit programs convert to the Standard Plan?
    D. The processing of account transfer for determinations made by the Marketplace
    E. Will the generation of account transfers to the Marketplace for those found ineligible for BadgerCare Plus be delayed until 4/1/14?
11. What happens to a transitioning BadgerCare Plus member that has already been determined eligible for BadgerCare Plus. If they are eligible to stay on until 3/31/13, what about the tax credit?
12. Will the Marketplace will make any changes (e.g. determinations, notices) to align with Wisconsin's delay? – We did have an initial conversation with CMS, but no answer yet.
13. What and when additional communication (e.g. letters, direct calls) is needed?

2) Group Discussion of Recent Developments All

Q=The question presented. A=The answer given at the time. Not all were answered there, so F/U means that is something that needs answering next session.

Q. Is basic continuing?

A. Basic will maintain to prevent a coverage gap because it is state controlled, and not part of the budget.

Q. Is that true for Core also?

A. We are unsure of what will happen with Core. F/U

Q. What about HIRSP?

A. HIRSP will be extended to 3/31/13 to allow for transitions.

Q. Is the governor getting questions on what his intent was so we can understand, and are you asking CMS what is allowable?

Q. What about childless adults that were told to apply to the FFM, then ACCESS, and not the FFM? When does their coverage begin? ACCESS will tell them they cannot even apply because they are ineligible, but the FFM will tell them they are eligible. What do we tell them? Plus, what do we tell the people who would have been eligible on 1/1/4? Can they get subsidies, so they can at least apply to the FFM and have coverage 1/1/14-3/31/14? F/U

Q. What about Core renewal and processing fees? We told them not to do them. Do we still do renewals and what fees do we take? F/U

Q. What about people who won't pay their benchmark fee? F/U We need to reach out to them.

Q. Do we tell transitioning members that are fully enrolled in the FFM to stay on that plan since they will have to do it all over again in April?

A. They will still be on BadgerCare Plus after 1/1/14, so it is their choice. They might have an IRS penalty, and we have asked CMS about it. If there is no way around the law, we might have to let the members know about it. F/U

Q. What do we tell people that the FFM told were eligible for BC+ when they are not? Some started with the consortium, were sent to the FFM, and are now back at the consortium.

A. Shawn suggested they get a denial from us to give to the FFM, but with CARES changes not going into effect, most cannot get through the application process. We will look into this more. F/U*

Q. Is there an expiration on FFM eligibility determinations? If they were determined eligible now but have not enrolled in a plan yet, can they use that determination come March?

A. Craig does not think there is since the FFM will do quarterly checks to see if the information is still accurate, so it should still be okay. Craig will ask though. F/U

Q. What about childless adults who use paper applications to apply for BC+ that would have been eligible before the extensions but are not now? What about when they appeal? F/U

Q. What about the waitlist applications (paper) we are still sitting on that would be eligible 1/1/14 if the changes didn't happen? We still have to process them within the 30 day timeframe, but what else do we do with them since we will now deny them? Call them, send a letter? There are hundreds if not a thousand applications statewide.

A. We will get direction on what to do with the paper applications. F/U*

Q. FFM paper applications are being mailed to the consortia, what do we do with them? Can we (the counties) send those to the FFM for them?

A. We think the consortia are able, but CACs are not. We will get clarification. F/U

Q. What are the chances that the law will say we have to give childless adults coverage 1/1/14? Do we tell them, as of today, childless adults will not have coverage until 4/1/14? F/U

Q. Can we get the old rule handbook back, so we can reference them?

A. There is a "history" tab you can click on to see the old rules.

Q. Do these changes affect funding? Some consortia are still in the hiring process. Can they make offers?

A. That has not come up yet, but the legislature is a different body. It might help to wait until after the 12/4/13 legislature session. F/U

Q. What about staff members who were trained in July/August and now won't use the new methods and rules until March? It will be hard for them to remember.

A. We are already putting together scenarios to take to the Training Subcommittee to discuss how we should handle this. The consortia do want refresher training with scenarios, but they think it is better if we do not require it. They can require it to their staff if need be.

Action Item: Southern will send the scenario training they created to us.

Q. What can the consortia's PPACA staff do to help? They hired them, but they do not have work to do because of the changes, and the consortia would like work for them.

A. We will let you know. We might pull back AHS from making the calls, so the PPACA staff can do it. F/U

We need to clarify FPL and MAGI changes happening at different times because it is confusing.

A problem is that we are trying to unravel the original release that had MAGI rules, FPL limits, childless adult eligibility, web changes, etc. all rolled into one. In the beginning of our meeting with CMS they were totally against changing anything, but they did pause later in the conversation when we explained all of this.

We need to know also explain the new date to apply for coverage for transitioning members.

Changes will remain in the UAT testing environment.

There are two consortium that have not accessed the SharePoint list of Letter 1 recipients, so we will ask Tara to leave them up for a little while longer.

John Rathman wants a list of waitlist members over 100% to start calling. This would be letter 3 recipients. There is not information on the waitlist member's income, but we could call them to get the information or get it from their FoodShare case if they have one. The consortia agree they want this information.

Core members that were on the transitioning members list would be a good population to reach out to.

Action Item: The consortia should prioritize the outbound calls they want to go out in this afternoon's meeting if they would like us to keep having AHS call. The timing of when they want to outbound calls to go out too.

The consortia would like refreshed lists run in December.

If we are going to send letters, the consortia really want to have input this time.

They would rather make the calls too.

Some members are now scared of phone calls through all of this.

Someone was asked, by the FFM, to provide proof to them that they were not eligible for BC+.

Action Item: Shawn would like all of that information forwarded to us.

The consortia have had people well over all income limits (500-600% FPL) coming to them saying that the FFM told them they are eligible for BadgerCare Plus.

Self-employment depreciation was a part of the FFM's incorrect determination.

The FFM is sending people they claim are eligible for BC+ (when they are not) without even allowing the person to complete the FFM application. We do not have a number to track it with then. A suggestion from Liz Jungers was to ask people to get the agent's full name, agent ID, and write down the time of the call. That is what the RENs/CACs are telling people to do. We can track it that way even though most people come to us after they have had the bad experience, and it is too late.

The consortia would like a script that hits actual points instead of a long summary.

The script is misleading too. On page two of the script, is says a childless adult should apply and will get coverage. No, it is not a lie because it does not give a date, but that is deceiving. We should say they will get coverage 4/1/14 and not mislead them.

The state would like a list of questions that the consortia have along with possible scenarios for different populations, so we can make sure to cover all bases and create a script.

Action Item: They will complete this in this afternoon's meeting.

Wisconsin Public Television is looking for a person who has successfully applied to the FFM.

The consortia have not opened up vacation time yet and will not until they know what needs to be done and what the workload will look like. Most are keeping it at about 90% coverage.

The consortia really want us to keep childless adults who want insurance in mind because some have not had coverage in years and need it. They will not care about tax credits and the like.

3) December Meetings

We are going to keep all of the December meetings as they are.

We will possibly meet the week of December 2nd if there are updates to share.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 12/9/2013

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
	Brett Davis – DHS	XY	Joanne Ator – Bay Lake
XY	Debbie Waite - DHS	XY	Jenny Hoffman – Bay Lake
X	Craig Steele – DHS	XY	Kris Parkansky – Bay Lake
	Carrie Schneck – DHS	XY	Amy Mendel-Clemens – Capital
XY	Angela Dombrowicki – DHS (PPACA)	XY	Sheila Drays – Capital
XY	Bill Hanna – DHS	XY	Tim Gessler – East Central
XY	John Rathman – ES PAC	XY	Liz Mahloch – East Central
XY	Shawn Smith – DHS	Y	Ronda Brown-Anderson – Great Rivers
XY	Elizabeth Jungers – DHS	XY	Linda Struck – Great Rivers
Y	Julie Milleson – DHS	XY	Amy Mayo – IM Central
	Tricia LaPlant – DHS	XY	Jane Huebsch – IM Central
XY	Jen Mueller – DHS	XY	Dana Thompson – MilES (PPACA)
XY	Jamie Fawcett-Christianson – DHS	XY	Carol Wicklund – Moraine Lakes
	Angela Moran – DHS	XY	Luann Page – Moraine Lakes
	Gail Chapman – DHS	XY	Doreen Lang – Northern
XY	Tricia Janssen – DHS	XY	Hope Otto – WKRP (PPACA)
XY	Paul Michael – DHS	Y	Adelene Green - WKRP
XY	Adam VanSpankeren-DHS	XY	Jill Johnson – Southern
XY	Michelle Ebert – DHS	XY	Carla Haigh – Southern
XY	Linda Auchue – DHS		Phil Boutwell – Southern
Y	Claire Smith – DHS		Lorie Graff – Western (PPACA)
		Y	Trisha Wavra – Western

X=Attended 9am-10am call

Y=Attended 11am-12pm call

Topics

I) 3-Month Delay — Craig Steele

A) State Authority

The assembly passed the bill for the three-month delay, so we are using that information for our planning.

The Senate will not take up the issue on 12/19/13 which extends the communication timeline.

B) Federal Authority

Things may still change until the point we get federal approval, and they agree to our plan.

The IRS will hold members harmless if people enrolled in a QHP. They will interpret BadgerCare Plus as "non-essential." We do not have anything in writing regarding this thus far.

C) Member Communications

3) Letter 1A

This letter went to transitioning members who appear to be over the FPL.

It is there to let people know it will be extended.

We cannot mail it until the Senate/government says it is okay. 12/20/13 is the target mail date.

CMS is requiring MAGI determinations, but our system will not be ready for it yet. Because of this, we are sending the form to these members to collect their tax information for use in the conversion process in February.

If we do the MAGI conversions, we can send the cases to the FFM as account transfers.

If they do not complete the form, they will not get a letter until March telling them to apply to the FFM.

Action Item: We need comments on the letter and checklist as soon as possible. There is not much time before we want to send it out. The consortia should discuss this from 10-11am, and we will reconvene at 11am to hear the feedback.

4) Basic Plan Update

We issued a letter to basic members and conducted follow-up calls to let them know the program is being extended.

We want them to know to keep paying their premiums, and we have updated AHS' scripts to include that point.

We gave them the option to stay on BadgerCare Plus or go to the FFM.

II) Federal Marketplace — Craig Steele

There were updates not on the blog. We will make sure to communicate that information to the consortia.

They are giving hidden directions to CACs.

F) New Updates

HHS and FFM said they have workarounds.

There is more robust window shopping. People can now put in their age, county, state, and wants in order to see their options without actually enrolling.

They have added an application where you can remove a problem application. If people have

applications that became stuck or they feel they received an incorrect determination, they can now remove that application.

If you think or have heard about issues regarding this, let us know, and we will escalate it. Someone had an issue, and we told CMS. They can help, or the FFM Help Desk is able to delete an application as well.

Direct enrollment is another function they are working on. They are working with carriers to create a system in which people can apply directly to the FFM on the carrier's website. Once the person has been deemed eligible for the FFM, they could enroll right into the plan they want. This is not working for Wisconsin.

They are also working on an advanced queuing system. It is basically an advanced parking lot. If the capacity has been exceeded (currently 50,000 concurrent lines), they will get a message that the system is full. It will say it is normal and not a bad sign.

G) Notices and Helpdesk

Craig would like Jenny Hoffman to let us know if Bay Lake is getting crushed. They are still part of the CMS messaging.

The FFM has started giving out Member Service's number when they should only use that number for the language line.

H) Premium Payments

The IRS is holding members harmless.

You should call each insurer to see what they will/will not accept to make sure you are giving correct information. It may change, so ask often.

There is no file containing information for all of the providers.

Federal regulations say they have to accept multiple forms of payment like checks and either credit/debit cards.

I) Paper Applications

There is a defect in the system for paper applications. The majority are not getting notices.

They say they will still process the applications within 3-5 days, but no notices are going out. If workers are getting that question, they should refer them to the FFM to search for the application. If the call center representative cannot find the application, the worker will help them fill out the application.

It is a good idea to refer to the tip document.

Remember to give it three to five days after it would have gotten there.

J) Federal Marketplace Determinations

The tips and tricks document is a little misleading.

The FFM says people can follow-up with the State regarding their application transfer, but that is not true. They might not be in the flat file. Even if they are in the flat file, they might not be eligible.

Someone may call and say the FFM said we have their information, but that may not be true. If you receive a call like this, please get the application ID, income source, and income amount. Do not include the name, and we will send the information to the FFM.

4) Weekly Flat File Applications

We may get the enhanced flat files tomorrow.

Identifiable information will now be included in the flat file.

Getting the identifiable information will require a waiver, and it will take additional work to get it in the system.

We would like to clean-up the file if possible.

We will break-out the information by county and send it out with a caveat that it will most likely be wrong and unhelpful. It will not have income or household make-up which makes it useless.

We have already found social security number mismatches, kids that are staying on BadgerCare Plus, duplicates, incorrect determinations, etc. in the flat file. It is bad data.

Without the account transfer piece, we do not have enough information to process the applications.

Question: Since we have very little intelligence on the quality of the files, do the consortia want the volume and/or details from the flat file?

Answer: Some might be parents with kids on BadgerCare Plus, so it would help to get them in the system. It would be like linking a case with a new application. It will be time saving to do those.

5) Determination Issues

Last Wednesday, CMS acknowledged there is an error in their determination algorithm.

They also said some errors were from entering incorrect data.

If you know the improper determination was not because of incorrectly entered data, get the application ID, income source, and income amount to Craig. He will escalate.

With the new delete option, if someone was incorrectly determined to be BadgerCare Plus eligible the first time, and then correctly determined to be FFM eligible, we still get the account transfer.

Most incorrect determinations are for childless adults.

6) Assessment vs. Determination State

We are concerned from a program integrity standpoint.

We have asked CMS to become an assessment state as soon as possible.

From a processing standpoint, we would have to use our regular verification which would mean more work.

If we became an assessment state, it would mean 1) different notices and 2) we would have to do something with the 20000 applications we already have.

We need to collect MAGI information to rerun applications which is also more work.

III) CARES Systems Update — Linda Auchue

We are working with Deloitte on business requirements.

There are three options.

It appears the 11/18/13 release date will probably now be in January.

We are working with CMS to see what they will allow.

Action Item: In the scenario spreadsheet, cut out the 1/18/14 date because it might be 2/1/14 for new applicants.

The MAGI provision is in law, so we cannot waive it. We want to find a way to process new applicants and keep transitioning members on.

The FFM has said they cannot support the old income limits, only the new income limits.

IV) CCA Messaging — Paul M./Adam V.

We are reviewing the messaging since it may be dated and too long.

We need a two-week turnaround.

The messages are stale from three months ago.

We can look at the messages.

ACA menus are business events that can be turned off by the consortia.

The consortia said something simple is all they need when we asked what they would like the messaging to say. They said two options would be all they need: 1) if they are on BadgerCare Plus and want to stay on or 2) if they would like to be on BadgerCare Plus. Those are the big groups calling in due to public notices.

Decision: The PPACA subcommittee should review the new messaging.

REN Update: Lisa Olson said the e4health website has been updated.

PPACA Subcommittee Continued: 11am-12pm

The consortia would like both the individual information and volume by county from the flat files.

People who can stay on BadgerCare Plus three additional months will not have premium tax credit issues. Childless adults on the waitlist may not be able to get the tax credit since the FFM system thinks they will be on BadgerCare Plus. It is only good for dual eligible people.

Adam and Paul will start on CCA messaging scripting.

Regarding the 1/18/14 vs. 2/1/14 date on the scenarios spreadsheet, the consortia want to use 2/1/14.

Action Item: Claire will change the scenario spreadsheet to reflect the 2/1/14 date and send it to the consortia.

The consortia would like a space for the person's case number on the MAGI tax form. The letter will have their case number, so they should be able to copy it from that.

They can search for the MAGI tax form in the ECF because it has been added as a document type.

The consortia would like a new timeline of the workload since there could be big implications with everything pushed back and together.

Capital has a lot of paper applications since they were collecting them. They want childless adults calling in under 100% FPL to be able to at least apply over the phone. With the MAGI tax form, they could collect that information at the same time. Those they can process, they will. If not, they will hold them until 2/1/14.

A signature is not needed for this form.

The counties can scan the forms. They would be seen as unprocessed documents, but we will waive timeliness for that.

The consortia would prefer people fill out the form and send it in without having to call in. They may process them after hours.

The consortia is okay with the language as is for calling for assistance.

The consortia would like the form PDF fillable, so they could easily fill it in while the person's on the phone.

We will try to create scripting for the consortia to help people fill out the form.

We took some of the form questions from the verification checklist.

It does not include pre-tax deductions. We assumed they did not have any since very few do. It would be on their paystub if they do.

We will not make a reference to their tax filings form because they use different forms, and they do not have this year's tax information yet.

The consortia thinks the form looks daunting. They think it would be best to remove some of the dependents and have a separate sheet if they need to add dependents to it.

Letter 1A will go out after adverse action. There will be about 58,000 letters mailed.

The consortia thinks it would be best to restate to do the form at the end of the letter.

The consortium can choose individually if they want to take the form information over the phone or have the person send it in. We will not add their information to the letter.

There will be a workload increase since three big events are colliding as once: processing childless adult applications, 2/1 being the first date to input information, and transitioning members.

We are trying to build MAGs, so once the system moves are in place, the consortia can process applications. The system will be able to pend/hold them and then activate them at the appropriate time. This way workers will not have to touch it twice.

We are working on Letter 10 now. It will be sent to anyone in the flat file (childless adults, parents, children, etc.), so we would prefer to have two different letters for the two different populations. We only have one letter planned for now. We need to let childless adults know they will not have coverage until 4/1/14 and let parents/caretakers know they will stay on until 4/1/14.

The consortia want call center messaging explaining Letter 10.

AHS is trying three times when they make their outbound calls. We will check, but we think their success rate is about 50%.

We do not know if the flat file includes email addresses.

The consortia would like to focus on workload and timing at the 12/18 PPACA Subcommittee meeting. The timeline does not have to be completely redone but at least revised. They want to understand the process.

If the consortia have any comments, questions, and/or concerns, let us know. We will plan for the 12/18 meeting with that.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 1/10/2014

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 8:30 a.m.-9:30 a.m.

Individuals Invited/Attended (X=attended)			
	Brett Davis – DHS	X	Joanne Ator – Bay Lake
X	Debbie Waite - DHS	X	Jenny Hoffman – Bay Lake
X	Craig Steele – DHS	X	Kris Parkansky – Bay Lake
	Carrie Schneck – DHS	X	Amy Mendel-Clemens – Capital
	Angela Dombrowicki – DHS (PPACA)	X	Sheila Drays – Capital
X	Bill Hanna – DHS	X	Tony Sis – Capital
X	John Rathman – ES PAC	X	Tim Gessler – East Central
X	Shawn Smith – DHS		Ronda Brown-Anderson – Great Rivers
X	Elizabeth Jungers – DHS	X	Linda Struck – Great Rivers
X	Julie Milleson – DHS	X	Amy Mayo – IM Central
	Tricia LaPlant – DHS		Jane Huebsch – IM Central
X	Jen Mueller – DHS		Dana Thompson – MilES (PPACA)
X	Jamie Fawcett-Christianson – DHS	X	Carol Wicklund – Moraine Lakes
	Angela Moran – DHS	X	Sandy Potter – Moraine Lakes
	Gail Chapman – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
X	Paul Michael – DHS		Adelene Green - WKRP
	Adam VanSpankeren-DHS	X	Jill Johnson – Southern
X	Michelle Ebert – DHS	X	Carla Haigh – Southern
X	Linda Auchue – DHS		Phil Boutwell – Southern
	Claire Smith – DHS		Lorie Graff – Western (PPACA)
		X	Trisha Wavra – Western

Topics	
1) January 3, 2013 Update Review (Attachment)	Craig Steele

CMS will not waive MAGI rules.

We will verify if “children over 300% FPL that apply for BadgerCare Plus on/after February 1,

2014 will be referred to the federal Marketplace" is in the bill.

HHS approved the BadgerCare Plus reforms on 12/30/13. We now have all the federal authority we need to move forward with our new plan.

The transitioning member number went down. It is about 75,000 now.

We will work on Letter 8 shortly.

Letter 10 goes to those in the weekly flat file. We will stop outreach when all account transfers are processed.

There are links under the Federal Marketplace that may be useful.

Bay Lake's contact information is still being used on FFM notices until 1/18/14.

We will send the flat files as soon as we get it, but it most likely will not be until Monday or Tuesday.

You may get requests from people who want to remove their application because they do not want BadgerCare or know they are not actually eligible and don't want to be penalized. Right now we are obligated (determination state) to put them on file, but we will come up with a policy decision. We will about what to do with them at a later time.

Member Services had a record-breaking number of calls recently. We are going to monitor their report on transfers coming in from the consortium that should not have been transferred like someone wanting to report changes.

We addressed the issue of the FFM Call Center erroneously advising childless adults to call their consortium and speak with a supervisor because we are out of compliance with CMS. They are going to update their scripts in the next couple of weeks, and they are going to let us review them.

The consortia would like something in writing regarding CMS' stance on premium payment assistance.

Craig will send out the updates we have discussed today.

Consortia Questions for Craig

We are not going to answer all of these since many will be answered in this call anyways.

Enhanced Flat File, Question 3: We want to be able to give you true referrals, but this is part of the missing or incomplete information issue.

Eligibility, Question 1: There is a chart in the implementation date Ops Memo that covers this. For parents and caretakers, it will be the file date to the FFM using regular rules for determinations.

The consortia would like to know what happens if someone like a child applies in October, is determined eligible, but does not ask for a back date.

The FFM can only make determinations starting 1/1/4, so we will use old rules for 10/1/13-12/31/13 eligibility.

Eligibility, Question 2: Yes, handle the same as usual. The FFM application will give instructions. It will explain how to process the FFM application.

Eligibility, Question 3: Yes. Some are referrals that we will not know about, so they will not.

Eligibility, Question 4: You should link to the open case like usual. It is described in the Ops Memo coming out.

Eligibility, Question 5: Yes. It will be identified as a FFM application in the inbox. Ops Memo 1328 explains the changes.

TFI Forms, Question 1: It is really a reported change, so a signature is not really needed.

TFI Forms, Question 2: We will have to take them forever since it is a change, and you cannot put a date on a change report.

We cannot guarantee we can process the change in time for the conversion if we do not receive the TFI form by 1/17/14.

We can start running childless adults and adults transitioning starting 2/3/14, so we can remove them.

We will hopefully have the Ops Memos at IMAC.

2) CARES Processing Discussion — Linda Auchue

We are pushing through two operations memos through the approval process now. We are aiming for a publication date of next Friday. There will be one for FFM application processing and one that covers the 2014 implementation dates for 2014 BadgerCare Plus.

Since we are a determination state for 10/1/13-12/31/13 applications, we have to make them eligible for at least one month. We can then test regularly like using income changes reported. This will be in the Ops Memo.

Example: If the FFM application has the father's income information, and we get a SWICA match for mom's income, you can add mom's income to the case, but you cannot change dad's income.

Applications coming in after 12/31/13 will be processed regularly.

We received over 200 applications this week.

If you have processing issues, you should work through your CARES Coordinator.

Starting 2/1/14 regular applications will have all new pages and policy changes.

Backdating rules are still the same. The FFM Application Processing Ops Memo states this.

We will put a new family with child.

On-going beneficiaries will stay on until 4/1/4.

The conversion that was originally scheduled for November will happen over this month's adverse action weekend.

You can start processing childless adult applications on 2/1/14. We will use MAGs, so once the conversion is done, the worker will only have to confirm it and not rerun it. It is up to the consortium how they manage their workload, but this should be a timesaver.

3) Flat File Use by Consortia — Consortia

There are lots of duplicates, so expect lots of duplicate account transfers.

We have no expectations on how you use them.

The only stance we have is that we are NOT enrolling people based on the flat file.

Decision: There will be an agenda item on next week's meeting for round robin sharing on how the consortium plan on using the flat file.

4) Status of Account Transfers — Craig Steele

The records are cleaner than after the initial look.

We now have 200 records in the testing environment. We have to do our own testing on the account transfers, and we haven't been able to do end to end validation. It will take approximately two weeks. We do not want to give bad data.

We don't know if they will trickle out as they are approved or come out in one big batch. It depends when we get the application production data.

5) Outreach Efforts — Craig Steele

Calls to the waitlist population started yesterday.

We will start calls for transitioning members next week.

We are asking them what they did and are recording that information.

We have no way of matching reports with the FFM.

Action Item: We will send call center scripts to the consortia after this meeting.

We have 54,000 cases (75,000 individuals) and will get the files to the counties next week.

6) Round Table Sessions — Gillian Ward

We will be holding individual round table discussions for each consortium the second week of February and again the last week of February. We want to support everyone as best as we can, so we will be taking any and all issues that arise in the initial processing as well as when we are in the weeds of processing.

The round tables will be two hours for each consortium on either 2/12/14, 2/13/14, or 2/14/14 and again on 2/26/14, 2/27/14, or 2/28/14.

Gillian will send out a preference sign-up sheet immediately after this meeting. There will be three slots for preferences for each round, and it will be on a first come, first served basis. We will try to get each consortium at least one of their picks, but that may not be possible.

7) 1/15/14 PPACA Subcommittee Agenda Items Input — Consortia

Amy thinks replicating today's agenda would suffice.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 1/15/2014

Location (room and dial-in): 1 W. Wilson St., DHS CR 630, Madison, WI

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-12:00 p.m.

Individuals Invited/Attended (X=attended)			
X	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
X	Shawn Smith – DHS	X	Kris Parkansky – Bay Lake
	Jennifer Mueller – DHS		Amy Mendel-Clemens – Capital
X	Elizabeth Jungers – DHS	X	Sheila Drays – Capital
	Angie Lueck – DHS	X	Tony Sis – Capital
	Bill Hanna – DHS	X	Tim Gessler – East Central
X	Julie Milleson – DHS	X	John Rathman – ES PAC
	Michelle Ebert – DHS	X	Ronda Brown-Anderson – Great Rivers
	Sabrina Fox – DHS	X	Linda Struck – Great Rivers
X	Paul Michael – DHS	X	Jane Huebsch – IM Central
	Adam VanSpankeren-DHS		Amy Mayo – IM Central
X	Gillian Ward – DHS	X	Dana Thompson – MilES (PPACA)
X	Linda Auchue – DHS	X	Carol Wicklund – Moraine Lakes
	Tricia Janssen – DHS		Sandy Potter – Moraine Lakes
X	Jamie Christian-Fawcett	X	Doreen Lang – Northern
		X	Hope Otto – WKRP (PPACA)
X	Cara – Capital	X	Carla Haigh – Southern
X	Ann Kriegal – East Central		Phil Boutwell – Southern
X	Claire Derconmatchu - WKRP	X	Jill Johnson – Southern
			Lorie Graff – Western (PPACA)
		X	Trish Wavra – Western

Topics

Focus Agenda Items

1) January 3, 2013 Update Review — Craig Steele

We just got the most current enhanced flat file last night. We are coding by county now, and we will get you the information shortly. We are hoping this week.

CMS has identified 10 big defects that are affecting determinations, and they are currently trying to work through them.

CMS only was able to explain two out of the ten defects in our call with them yesterday.

Childless adults are one of the defects.

Although CMS has fixed the defects in the FFM, they will not be fixing the account transfers. The account transfers will have the defects in them. They have given us the criteria to find the defects.

We are still obligated to enroll the applicants even with the defects, so we need to talk about a mitigation strategy. We have not figured out the best way of handling it. It may be quickest for the State to search through the entire file for them or for the processing staff to find them as they are processing the applications.

There are two things to note if a consortium want to pay a premium on for people enrolled in the FFM.

The first concern is the conflict of interest. CMS gave guidance that the HHS has regulation over the Marketplace, so anti-kickback laws may apply.

Craig suggests you call the plans in the area to make sure they will accept a payment from the consortium since HHS is discouraging health plans from accepting it.

If you are thinking about starting a fund, you should really consider the source. If it comes from a provider, there is a good chance it will be highly scrutinized. HHS has said they will be monitoring it.

Their second concern is one that they are not saying out loud, but it is a worry. CMS is worried that if non-profits are providing assistance, the FFM is going to lean towards lower-income residents which skews the cost sharing. They are nervous that the FFM will become a HIRSP.

CMS will not put out a direct answer about premium assistance, but they did send a memo in November on their view of it.

Action Item: We will send the premium assistance memo to the consortia.

Since CMW will not give a definitive answer, Craig suggests that your county board makes the decision. The State does not have a direct answer is CMS does not.

2) Status of Account Transfers — Craig Steele

We are in production.

We are still receiving a trickle, so we are waiting for CMS to ramp up and give us a large volume of applications.

A good portion will be workable, but there are a few issues to get to CMS.

We will provide regular updates.

3) Outreach Efforts — Craig Steele

We are continuing to call.

The next seven to ten days will be calls for the next round of letters.

4) Status of Operations Memo — Linda Auchue

The Secretary's Office gave edits last night, so we still have to make the edits. They will hopefully be sent out later today. We want to share them at IMAC.

We want to get them out today, so the consortia can review them, and we can answer questions

at IMAC.

We are trying to push them through publication. Once they are approved, we will send them to the consortia first.

The memo on timeline changes is approximately five pages, and the one on FFM application processing is 15 pages. We can go over that one more in depth.

The Q&A document will not be formally published, but Linda will send it to the Operations Leads and the CARES/Policy distribution list.

The Q&As came from questions asked during the Phase III training.

There has only been about 50 people who have taken the Phase IV training, so this is a polite reminder to do so.

5) Flat File Sharing — Consortia

Now that CMS is acknowledging the defects, it makes it that much worse.

It should provide and estimated workload.

It was said that the operational leads met last week, and most decided it will be primarily used for workload estimations. Great Rivers will only use it for that purpose.

Northern said they are going to use it to reach out to people with mandated services (e.g. mental health) that have tried getting help through the FFM. Linda Auchue said this would be a good use for it.

Linda Auchue said it could help if the consortia get a call from someone who says they have called the FFM but not heard back from them. They could check to see if the application is expected to come.

If you are having problems editing out information, let Craig know and he'll look into it.

Moraine Lakes does not plan on doing anything with it.

John Rathman said MIS is in works now. They are comparing to those losing Medicaid, getting the duplicates removed, and then reaching out to those members to suggest they apply to the FFM. They are going to keep track of the success rate weekly.

Capital is trying to do the same as John said. Someone is currently working through the file now to see if it is a manageable workload.

6) Round Table Sessions — Gillian Ward

We only have two sessions left to fill in the second round.

Once we know if Western or Southern will take the 8am slots on 2/26/14 or 2/27/14, it will be complete.

The invitations will hopefully go out today, but you will have them by the end of the week at the latest.

We are going to be offering a session for MilES and the tribes as well.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 1/29/2014

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room 372.

Conference Line: (877) 402-9757 / Access Code: 3208369

Time: 12:00 p.m.-1:00 p.m.

Individuals Invited/Attended (X=attended)			
X	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
X	Shawn Smith – DHS		Kris Parkansky – Bay Lake
X	Jennifer Mueller – DHS	X	Amy Mendel-Clemens – Capital
X	Elizabeth Jungers – DHS	X	Sheila Drays – Capital
	Angie Lueck – DHS	X	Tony Sis – Capital
	Bill Hanna – DHS	X	Tim Gessler – East Central
X	Julie Milleson – DHS	X	Amy Roland – East Central
	Michelle Ebert – DHS	X	John Rathman – ES PAC
	Sabrina Fox – DHS	X	Ronda Brown-Anderson – Great Rivers
	Paul Michael – DHS	X	Linda Struck – Great Rivers
	Adam VanSpankeren – DHS	X	Jane Huebsch – IM Central
X	Gillian Ward – DHS		Amy Mayo – IM Central
X	Linda Auchue – DHS		Dana Thompson – MilES (PPACA)
	Tricia Janssen – DHS	X	Carol Wicklund – Moraine Lakes
X	Jamie Christian-Fawcett – DHS	X	Sandy Potter – Moraine Lakes
X	Angela Stanford – DHS		Doreen Lang – Northern
X	Rebecca David – DHS	X	Hope Otto – WKRP (PPACA)
X	Autumn Arnold – DHS	X	Adelene Green - WKRP
			Carla Haigh – Southern
			Phil Boutwell – Southern
		X	Jill Johnson – Southern
		X	Lorie Graff – Western (PPACA)
		X	Trish Wavra – Western

Topics	
1) CMS Identified FFM Defects and Direction to States	**Craig Steele**
CMS admits that determinations have been made in error.	

On 1/14/14, CMS kicked-off a three part series that walked through the FFM defects. The third part is tomorrow.

Since CMS has recognized the errors, we are only a determination state for applications coming in between 10/1/14-12/31/14. We have to enroll them for at least one month, and we cannot follow-up during that month.

If they are enrolled in a QHP, they still have to be enrolled in BadgerCare.

We will provide details on how to evaluate erroneous information later, possibly in March.

We are aware you will get questions, so we wanted to document it for you.

Medicaid paying claims as the last resort will still be the same.

2) Approach to Releasing Account Transfers **Linda/Autumn**

We have received over 40,000 account transfers.

We have experienced mixed testing. Some of it is okay, but we have already found more errors than the 10 CMS has stated.

There are data mapping issues we are fixing now.

We will continue to find errors. We want to get these to you as soon as possible, but we do not want to give bad data. Once it is released to you, we cannot get them back.

We cannot fix them once they are in the consortium's inbox.

We are still working on kinks with the families.

Since we do not want to give accounts with errors, we are going to release them slowly. This will allow us to fix additional issues if they arise.

Our plan is to release a small sample (2500-3000) statewide to get started on 2/3/14. If that goes well, we will release another small sample (3500) on 2/6/14. If that goes well, we can release all of them on 2/10/14.

We will start with the childless adult applications since they are the cleanest.

It is up to the consortia if they would like the rest of the transfers on the 10th or if they would still like them staggered.

Our initial thought was to give them all at once, so the consortium can choose which they would like to process first.

The consortia would like to regroup next week to decide if they want all of the transfers on the 10th or stagger them.

One consortium would like all of transfers on 2/8/14, and we will ask Deloitte if it is possible.

Consortia could start on the paper applications and ACCESS applications they have since they will take time to process.

The account transfers will come interspersed as determination or assessment applications. The consortium will have to be aware of that when processing. CARES recognizes the differences, so it will show that way in the system.

John Rathman asks that CARES is open at 6am since it now opens at 7am.

Action Item: The State will talk to Deloitte of having it open starting at 6am.

3) Workarounds for Identified Defects **Linda/Autumn**

The key point to remember is that FFM applications with a file date of 1/1/14 or later are processed as

usual. We are an assessment state, so we should ask for verification like normal.

We are working on defects for the determination state applications.

We are not going to create a report of all of the cases with defects since almost every case would be listed on it. The worker will see a conflict message in CARES, and they can then refer to the matrix sheet.

The matrix outlines defects as of 1/28/2014.

We do not have figures for how often each defect occurs, but we realize it will be helpful to know if one happens in almost every case while one only happens once in a while. We will try to include those, but we are going to send out the matrix this afternoon without those. It is a work in progress; there have been already been updates in the last 24 hours. We want to get the information to you, so we will send out an updated matrix later with it. We can add a column of the frequency like "all applications" or "some." Amy suggested we can simply order the matrix by frequency. This would also help the worker since the issues they encounter most often would be at the top of the document, and they would not have to search through it.

We are amending Operations Memo 14-02. It will explain to look at the file date versus the processed date. If they get a new application with a later file date, we can use that as a reported change. It will come out as soon as possible, but we do not have an idea of the timing.

14-02 is for data not from the FFM.

We have delayed the annual FPL change to 3/22/14, so all members will go through the mass change. This will allow us to catch MAGI rule mistakes.

We do not want to add the matrix to Process Help since this should just impact 10/31/13-12/31/13 FFM applications. These are not on-going workarounds. The lingering issues will be added to Process Help.

These tips are just for determination applications. If you are missing information on assessment applications, you should get verification as normal.

If there is a case of a family being eligible for November, October, December, and February, the worker will have to override for January. We will add that to the ops memo.

Program request errors (#3) are a CMS defect. They say it changed from yes to no when it came to us. The problem is resolved, but they are still in the account transfers.

Driver flow issues (#4) are on all applications for the week of the third.

Incorrect application of MAGI rules (#5) has been corrected by CMS, but the defects will still be in the account transfers.

You may care about missing data from deceased individuals (#8) because they could be tax dependents or co-filers.

Incorrect data because of questions not asked by the FFM (#10) will most likely be an on-going issue.

Incorrect data from homeless living arrangements (#12) is a CMS issue based on the application submission date. Anything prior to 11/16/13 has them listed as homeless.

We know the relationships are not on the CARES list when there is an issue with incorrect data on incorrect relationships (#17).

The four additions from yesterday are:

1. The suffix is appended to the first name. You should just move that to the suffix field.
2. The self-employment page has the last tax filing date of 9/9/99. You should just delete it.
3. The start date of unearned income is missing. You should use the file date if it cannot be found in another system.
4. The FFM has a shorter list than our income types. When you see "other income" coming over,

check to see if it is an overlap. If it is, error on the side of the member and delete the income. If it is not a duplicate, keep the other income in the case.

4) Reporting Issues Associated with Determinations

Report issues to the CARES Call Center as usual.

Put "FFM Application Issue" as the subject line when contacting the CARES Call Center.

The call center will be in communication all of next week.

The call center will be staffed until 8pm starting next week.

The call center has set-up a method to quickly get issues to the systems staff for a speedy fix.

As more issues come in, we will update the matrix.

Round tables are another venue for discussing them.

5) Other Updates

The lists of EBD cases were sent out yesterday. You can use your judgment on how to use it.

If you request asset information, and you do not get it, they will get a BadgerCare Plus denial.

If someone is not eligible, ask them if they have other income. They may be able to be in MAPP.

You may want to reach out to help eliminate the workload after the conversion.

If it "Pending," it will be on the list.

It needs to be done before March adverse action.

We are putting together a list of the different reports coming out and what needs to be done with them.

Since we have run out of time, Craig will send out a written update.

Action Item: We will set-up a conference call for Wednesday afternoon.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 2/6/2014

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in Room B372.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 3:00 p.m.-4:00 p.m.

Individuals Invited/Attended (X=attended)			
X	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
	Shawn Smith – DHS	X	Kris Parkansky – Bay Lake
X	Jennifer Mueller – DHS	X	Amy Mendel-Clemens – Capital
	Elizabeth Jungers – DHS	X	Tony Sis – Capital
	Angie Lueck – DHS	X	Ann Kriegal – East Central
X	Bill Hanna – DHS	X	Tim Gessler – East Central
X	Julie Milleson – DHS	X	Amy Roland – East Central
	Michelle Ebert – DHS	X	Kelly McCarthy – East Central
	Sabrina Fox – DHS	X	John Rathman – ES PAC
	Paul Michael – DHS	X	Ronda Brown-Anderson – Great Rivers
	Adam VanSpankeren – DHS	X	Linda Struck – Great Rivers
X	Gillian Ward – DHS	X	Jane Huebsch – IM Central
X	Linda Auchue – DHS		Dana Thompson – MilES (PPACA)
	Tricia Janssen – DHS	X	Carol Wicklund – Moraine Lakes
	Jamie Christian-Fawcett – DHS	X	Sandy Potter – Moraine Lakes
	Angela Stanford – DHS	X	Doreen Lang – Northern
	Rebecca David – DHS	X	Hope Otto – WKRP (PPACA)
X	Autumn Arnold – DHS	X	Adelene Green - WKRP
		X	Kalie Poppy – WKRP
		X	Carla Haigh – Southern
		X	Jill Johnson – Southern
		X	Lorie Graff – Western (PPACA)
		X	Trish Wavra – Western

Topics	
1) CARES Implementation	**Jen/Linda**
All MAGI/ACA changes were made in CARES over the weekend.	

It seems that people are happy with the changes.

We are identifying issues and working with systems to get them fixed as soon as possible.

We are getting issues fixed quickly.

The fix for BadgerCare Plus cases with EBD Medicare choices will be made tonight.

The big issue is renewal functions. EBD/LTC cases cannot be put into renewal mode if it is in the month after the renewal is due. You can send the case to the CARES Call Center, and they will be able to put it in renewal mode. The fix for this will be done on Monday.

FFM applications were put in the consortium's inbox yesterday, and we have not had any reports of issues with them.

The counties do not have any issues to report at this time.

Continue to send issues to the call center.

The CARES Call Center is receiving three times the normal volume of emails and calls, so please be patient if your email is not answered immediately.

2) Consortia Feedback on Tuesday Account Transfers — Consortia

Bay Lake – They are almost done with everything.

Capital – They have completed all TFI forms. Things are going well with the FFM applications.

East Central – All TFI forms have been completed. FFM applications are being processed smoothly. There will be overtime on Saturday to catch up on the rest.

Great Rivers – Things are going smoothly for them and are not encountering problems.

IM Central – TFI forms are almost complete. They are almost done with the paper applications and are starting on FFM applications.

Moraine Lakes – They are seeing a lot more applications coming through ACCESS.

Northern – They closed their call center yesterday morning to get all of the TFI forms done. They had a few policy questions regarding FFM applications. They are seeing a lot more applications coming through ACCESS; many are childless adults.

Southern – They have completed all of the TFI forms and are working on applications now.

Western – Western has completed their FFM applications and is finishing up the TFI forms now.

WKRP – They are almost done with their TFI forms and approximately half-way done with the FFM applications.

We are asking for MAGI information during renewals, even those currently under 100%. Because CMS said they could not receive account transfers if this information was not included, we are asking for it from everyone.

The TFI form is like a change and not a SMRF. We will not be sending them out again.

No signature is required for the TFI form since it is similar to a change report.

A suggestion was made to go over the TFI form in the next Process Support meeting.

The TFI form mirrors questions asked on the verification checklist, in ACCESS, on paper applications, etc.

3) Account Transfers Discussion — Autumn/Linda

We are still doing testing and want to be thorough since we cannot pull them back to fix them

once they are in the consortium's inbox.

Taking extra time for testing also allows us to figure out and share the workarounds ahead of time.

On Saturday, the next batch of a little fewer than 2000 applications will be released. They will be single adults with a filing date on or after 1/1/14.

The next group released will be family applications. We would like to get them to you next Tuesday or Wednesday. We know it will not be on Monday. They are approximately 20% of the applications, around 8000-9000 applications, and we hope to get them all to you next week. These would be the ones that need a manual backdate for January. The systems team is still testing them. They have had the most testing problems with them.

The last you will see are individuals with a file date on or before 12/31/13 since they are more complicated.

We are releasing them from easiest to hardest.

We do not have an exact date for the big release. We are waiting until after conversion for 2013 single adults, so workers do not have to touch the case two times. They will still have over a month to process them.

There are over 55,000 applications in the enhanced flat files.

4) Miscellaneous Updates

The language has changed on the notice that said we were sending their application to the FFM. It is a temporary change. Since the FFM said they are not doing anything with our transfers to them, we do not want them thinking their application is being processed. That is why we changed the language to tell the customer to contact the FFM. We do not want them waiting and miss the opportunity for coverage.

They said they would start processing them soon, but they did not give us a time.

The FFM call center will do outreach calls with the account transfers.

The FFM adjusted their application to ask if they were denied Medicaid or CHIP. It should be in place now, but we are not sure it is retroactive for applications that have been started.

The partner update from Monday already needs to be changed.

We need to make clarifications to the partner trainings. They are under the impression they do not have to complete the TGI form that comes with the verification checklist since the first round was optional. They do have to complete the tax information forms that come with the verification checklist.

The consortia would like a printable form on tax deductions since the workers are unfamiliar with them. ACCESS has that information in the help section, so we will share the information. A good thing to remember is that if the person does not know what it is, there is a great chance they do not use it.

Action Item: We will reschedule the Monday PPACA call to Thursday at lunchtime.

Action Item: We are going to cancel the round tables next week since the account transfers were not released as expected.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 2/14/14

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in room 372A.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 2:00 p.m.-3:00 p.m.

Individuals Invited/Attended (X=attended)			
	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
X	Shawn Smith – DHS	X	Kris Parkansky – Bay Lake
X	Jennifer Mueller – DHS	X	Sheila Drays – Capital
X	Elizabeth Jungers – DHS	X	Tony Sis – Capital (+ a few sups)
	Angie Lueck – DHS	X	Ann Kriegel – East Central
	Bill Hanna – DHS	X	Tim Gessler – East Central
X	Julie Milleson – DHS	X	Amy Roland – East Central
	Michelle Ebert – DHS	X	Vicki Shaw – Great Rivers
	Sabrina Fox – DHS	X	Amy Mayo – IM Central
X	Paul Michael – DHS	X	Jane Huebsch – IM Central
	Adam VanSpankeren – DHS		Dana Thompson – MilES (PPACA)
X	Gillian Ward – DHS	X	Carol Wicklund – Moraine Lakes
X	Linda Auchue – DHS	X	Doreen Lang – Northern
	Tricia Janssen – DHS	X	Hope Otto – WKRP (PPACA)
	Jamie Christian-Fawcett – DHS	X	Adelene Green - WKRP
	Autumn Arnold – DHS	X	Jill Johnson – Southern
	Rebecca David – DHS	X	Trish Wavra – Western

Topics

1) Conversion — Linda

The new income limits go into CARES this weekend.

Depreciation being counted as an expense starting 4/1/14 will be put into effect.

A CARES email went out discussing the conversion.

CARES is shutting down at 5pm tonight.

You will not receive calls about the notices from this weekend's adverse action until Tuesday since the post office will be closed on Monday for President's Day.

SOLQI will be closed Monday as well due to the holiday.

A) Post Weekend Reports

The reports have to be run before March adverse action.

We will rerun the EBD reports.

You will have the regular 349 report.

People with social security numbers were removed from the flat file for conversion before adverse action. We will run it again in March for those that are still open on it.

With the new rules, people will fall off because of exceeding the income limits during adverse action.

2) Consortia Feedback on This Week's Account Transfers Consortia

Bay Lake: They are not having major problems. The cases are more involved and confusing. They were able to work through the questions. Their main question was from the CARES Call Center email today.

Today's CARES Call Center email explained that some RFAs were not updated with a county code, so workers could not pull the case in to work it. The worker does not need to create a RFA though. If a worker chooses the radio button at top of the screen, they will be able to bring the case into their processing view. This is actually a better way of doing it since the worker must process the case or it will fall off if there is an RFA.

Also, if a person was linked to a case incorrectly, let the CARES Call Center know. They will fix it on a case by case basis. It is important to make it a companion case instead of linking it.

Capital: It is moving a little slower than the first round since there are more questions with this batch. They have assigned most of the cases to workers.

East Central: There are some problems, and it is taking longer in general. They have completed about 60% of this morning's cases.

Great Rivers: It is slow and steady. They are researching issues as they appear. Their main problem is with educational aide while receiving child support. It pends the case until they hear back from the W2 agency.

IM Central: It is steady. They have ordered the cases by type for simplicity. This way workers are working on the same type of cases which will lead to less confusion. The hardest part for them is confirming cases when they know the person is not eligible.

Moraine Lakes: They have nothing to really report since they are slowly working through them.

Northern: Their big question is when they have applicants who are in system and receiving benefits, and they then get a duplicate application from the FFM. They were advised to reference Ops Memo 14-02 for these questions. They have an issue with some workers not being able to see the full dashboard; they can only see part of it.

Action Item: The State will check on what is happening with the dashboard.

Southern: They continue to process them slowly. The consortium trainer is collecting all questions from the counties and transmitting them with the answers to the rest of the consortium. She is figuring out some answers herself and asking the CARES Call Center the others. The CARES Call Center wants to be cc'd on all of the emails going to the entire consortium.

WKRP: They are seeing similar issues. They have lots of questions, but the help documents have been useful. They are about half-way done.

Decision: If someone says "yes" to long-term care help, they should be referred to the ADRC for a functional screening. We will keep in contact with the ADRC to see if they are getting many inaccurate referrals. If the consortia would like to reach out to the applicant, that is acceptable.

Western: Most FFM applications are completed except for the EBD cases.

3) Account Transfers Schedule Linda/Autumn

We will get them to the consortia next week.

We will most likely release the remainder of them Wednesday night. It will include all FFM applications we have in our inbox, individuals and multi-person applications.

There should be about 30,000 applications in the consortia's inbox Thursday morning. You will have 30 days from the 20th to complete them timely.

We have already released half of the family applications, so you have most of those done already. There will be about 5,000-5,500 family applications out of the 30,000 that will be released.

Most being released will be individuals with Marketplace determinations, so no verification will be needed.

We have not received any account transfers from the FFM after 1/17/14. If someone who applied to the FFM after 1/17/14, calls asking if we have received their application, you can let them know we do not have them yet.

We expect to get about 6,000 account transfers from the FFM in the next batch.

We will follow the same validation model, and we will let you know what the plan is going forward with the transfers.

4) Miscellaneous Updates

A) Update on New Marketplace Functionality

A partner email went out explaining the new Marketplace functionality. The two main updates are: 1) You can bypass the Medicaid assessment section, so people do not get stuck in the loop, and 2) you can report a life change; all different types of changes can be added. They can make changes that will affect their eligibility.

We will send the flat file through the end of the month. There will be one more county split and consortium distribution. We will then stop the flat file distribution process since CMS said we will be caught up at that point.

B) Reporting New Issues to CARES Call Center

C) Contingency Planning

D) CCA Messaging Progress

The messaging is old, so we have created new PPACA messages.

The Secretary's Office has approved them, and we will share them with the consortia today.

Action Item: Paul Michael will send out the new messages immediately after the meeting.

With message four, we were trying to let them know that we're working on their application.

Next week we will look at messaging for March. If you have any ideas for March messaging, let Paul and the CCA team know.

The messages will be loaded Monday.

ASK ABOUT IN-PERSON PPACA MEETING NEXT WEDNESDAY

People who answered said discussing PPACA-related matters at next week's IMAC is fine.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 3/3/14

Location (room and dial-in): This is a phone meeting. Note: State staff located at 1 West Wilson who are on the call should meet in room 372A.

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 9:00 a.m.-10:00 a.m.

Individuals Invited/Attended (X=attended)			
	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
	Shawn Smith – DHS	X	Kris Parkansky – Bay Lake
	Jennifer Mueller – DHS	X	Amy Mendel-Clemens – Capital
X	Elizabeth Jungers – DHS	X	Sheila Drays – Capital
	Angie Lueck – DHS	X	Tony Sis – Capital
	Bill Hanna – DHS	X	Tim Gessler – East Central
	Julie Milleson – DHS	X	Ann Kriegel – East Central
X	Michelle Ebert – DHS	X	John Rathman – ES PAC
	Sabrina Fox – DHS	X	Vicki Shaw – Great Rivers
	Paul Michael – DHS		Linda Struck – Great Rivers
	Adam VanSpankeren – DHS	X	Jane Huebsch – IM Central
X	Gillian Ward – DHS	X	Amy Mayo – IM Central
	Linda Auchue – DHS	X	Vanessa Robertson – MilES (PPACA)
	Tricia Janssen – DHS	X	Carol Wicklund – Moraine Lakes
	Jamie Christian-Fawcett – DHS	X	Sandy Potter – Moraine Lakes
X	Abby Abernathy – DHS	X	Doreen Lang – Northern
X	Rebecca David – DHS	X	Carla Haigh – Southern
X	Autumn Arnold – DHS		Lorie Graff – Western (PPACA)
		X	Trish Wavra – Western
			Hope Otto – WKRP (PPACA)
		X	Adelene Green - WKRP

Topics	
1) Evaluation of Round Tables	Consortia
Southern found theirs helpful.	
East Central thought it was a good opportunity to get answers and clarification.	
Bay Lake appreciated them.	

Northern echoes the sentiment of others.

All in all, the consortia found them helpful and liked them.

As of Friday, Capital is 36% done with their applications.

2) Policy/Systems Questions Consortia

Q: IM Central, East Central, and Northern have noticed new account transfers (dated 2/26/14 or later) are in their inbox. Does this mean the account transfers are coming in real time?

A: The spigot is on, but we did not know any had come in. We will check with Deloitte and send clarification.

Q: Can CARES/CWW be open on 3/22/14? Why was it down this Saturday, 3/1/14?

A: No, we cannot open CARES because of the mass change going into effect. It was down this Saturday because of system changes. There were almost six pages worth.

B) Correct Protocol for Referring to FFM/Consortia

The outstanding issue is that we do not know if the FFM is processing applications yet, so people may not hear responses from them.

Split families should start with ACCESS, so the children can be enrolled in BadgerCare Plus and the parents can go to the FFM and attest they were denied Medicaid.

Childless adults should go to ACCESS first.

You should really only refer people to the FFM who are obviously over 100%.

3) Single-Streamlined Applications Autumn Arnold

(Handouts)

We touched on this at IMAC, but this is a more detailed discussion.

This is planned to go into effect in late April/early May. There will be a second rollout of more changes in December.

These are all CMS or FNS required changes. CMS had two reasons to require the changes. They wanted to collect information they need for advance premium tax credits, and there were also questions (income types, EBD information) that they wanted removed. FNS wanted it to be easier to do a page one submission. They want it to be obvious that the applicant has the ability to only submit a one-page application. There was a question on tuberculosis they wanted to address as well.

These are all pretty set, but let us know if there are big concerns. You can send those to Autumn or discuss it at IMAC IT.

Amy wanted to know if the asset question on FoodShare will be changed since it causes problems by not showing Priority Service when it should be. It is on the list of to dos, but it may not be addressed in the deployment.

The CWW changes correspond directly with the changes in ACCESS.

The Yearly Income Details page was added purely for APTC reasons.

4) Outreach Calls to Members Transitioning after March Adverse Action Debbie Waite

We still do not know the actual number of people to call.

Capital would like to do their own outreach. Their customers feel better getting calls and help from them.

Outagamie would like to do their own too.

East Central has an interest too since customers feel comfortable with them, they have the case details which allows them to give the customer direct answers, and the last round generated more calls because people wanted to make sure the AHS calls were legitimate. They would need to know the numbers and due date before they made a commitment though.

There is not a hard timeframe for this, and there are two main purposes. The first is to try to alleviate customer confusion since they have received multiple letters/notices by this time. For this, it is best to reach the customer the week after March adverse action. The second reason is to encourage customers to apply to the FFM before they have a gap in coverage. There is almost five weeks to get this information to the customers before they experience a gap.

Our rough, ballpark number of people transitioning is about 25% of the determination cases (approximately 30,000), so we estimate the number to be between 5,000-10,000 calls. We will not know for sure until we run the numbers.

Action Item: Gillian will send an email to each consortium's operational lead asking if they would like to do their own outreach or would like us to call their consortium's members. The counties will have the option to decide for themselves if the consortium does not come to a consensus. We need to have the answers by Monday's PPACA call.

We will use HP or AHS if the counties do not want to do their own.

We probably will not do a follow-up letter since they have received so many already.

The State is planning on creating scripts and have started to develop language.

Capital is willing to do outreach for other counties/consortium.

CMS is now allowing people to pay their premiums at the end of the month and still get coverage at the beginning of the next month if they are in a SEP. This was part of the four part CMS update sent last week or the week before.

We will see if the outbound calls are IM funded since the consortia are not willing to do the outreach if not. Their eligibility has already been "determined" which was where the line was drawn before, so that would seem like a no. We are giving guidance and answering their BadgerCare Plus eligibility questions, so an argument could be made that it should be. We agree that it can be IM funded.

IMAC PPACA Subcommittee - Meeting Agenda

Date: 3/19/2014

Location (room and dial-in): Room 8; Dane County Job Center, 1801 Aberg Ave., Madison, WI

Conference Line: (888) 808-6929 / Access Code: 4685307

Time: 10:00 a.m.-11:30 a.m.

Individuals Invited/Attended (X=attended)			
X	Debbie Waite - DHS	X	Joanne Ator – Bay Lake
X	Craig Steele – DHS	X	Jenny Hoffman – Bay Lake
X	Shawn Smith – DHS	X	Kris Parkansky – Bay Lake
	Jennifer Mueller – DHS	X	Amy Mendel-Clemens – Capital
X	Elizabeth Jungers – DHS	X	Tony Sis – Capital
	Angie Lueck – DHS	X	Sheila Drays – Capital
	Bill Hanna – DHS	X	Tim Gessler – East Central
X	Julie Milleson – DHS	?	Amy Roland – East Central
	Michelle Ebert – DHS	?	Ann Kriegal – East Central
	Sabrina Fox – DHS	X	John Rathman – ES PAC
	Paul Michael – DHS	X	Ronda Brown-Anderson – Great Rivers
	Adam VanSpankeren – DHS	X	Linda Struck – Great Rivers
X	Gillian Ward – DHS	X	Jane Huebsch – IM Central
X	Linda Auchue – DHS	X	Amy Mayo – IM Central
	Tricia Janssen – DHS		Dana Thompson – MilES (PPACA)
	Jamie Christian-Fawcett – DHS	X	Carol Wicklund – Moraine Lakes
	Rebecca David – DHS	X	Sandy Potter – Moraine Lakes
	Autumn Arnold – DHS	X	Doreen Lang – Northern
		X	Carla Haigh – Southern
			Jill Johnson – Southern
		X	Lorie Graff – Western (PPACA)
		X	Trish Wavra – Western
		X	Adelene Green – WKRP
X	Cara Ponti – Capital	X	Hope Otto – WKRP

Topics
1) Update on Status of Daily FFM Transfers Craig Steele
The data on this handout was pulled March 11th.

The "Failed" number is the number of applications that we cannot import.

"Sprayed" means the table has been loaded with the data.

The 385 failed applications are in progress.

We will try to get this handout out weekly for a little while.

Action Item: Craig will send out the county specific numbers that comprised the pie chart today.

We have submitted some of the errors to CMS. The CARES Call Center is working them.

There seems to be a pattern of when the account transfers are released, and it appears to be on a Thursday, Friday, and Saturday basis.

We have asked CMS if they are going to start releasing them on a real-time basis.

There are approximately 3,000-6,000 applications coming in statewide weekly, but we have a very small sample size to use.

"Old" cases from 2013 from the FFM will probably still come in. They get retroactive coverage to back to the filing date. We are assuming it will be a low volume based on the difference between the flat file numbers and the account transfers we have received. There is a discrepancy of about 1,000 cases, and there is a strong chance there are duplicates with that number.

The consortia would like to discuss the number of old cases at the next meeting.

There were about 9,400 pending applications for Wisconsin in December.

2) Future ACA Workload – What's Next Linda/Craig

The FFM is still not processing our account transfers to them, and we have sent them almost 50,000 applications.

CMS has given us their work flow processes, and we are sorting through it now. We are trying to clean it up, so it is useful to you.

For the next three to six weeks, we anticipate you will receive calls from people displaced after this weekend's FPL changes and those who received incorrect determinations.

Change reports will be coming in.

There are some 2013 childless adult FFM applications pending verification when they should not be. The only cases that should be pending verification are 2014 assessment applications. We would like these cleaned up by this weekend. You can sort by the received date to find the cases you are looking for.

There are about 150 transitioning members left that have not been processed to close. We have to send a manual notice out by Friday. The CARES Call Center should be able to handle this.

With the FFM releasing the account transfers towards the end of the week, your already busiest days (Monday and Tuesday) will now have more work tied to them.

For the rest of the year, we should be prepared for problems with members transitioning at their renewals now that they are under the new MAGI rules. Members will be confused. It might help to have workers review the training if they have time.

3) Outreach Letter to Members Transitioning after March Adverse Action Craig Steele

The Secretary's Office decided last week to send another letter to transitioning members.

We plan to start sending it in mid-April.

The drafting hasn't started yet.

We want to keep it short, one page.

Our hope is to get a list from CMS of those who have enrolled in QHPs and compare it to those losing

coverage. This way we would only send the letter to those who have not taken action.

The RENs have asked partners to tell us what they feel should be included in the letter by the end of the week.

Action Item: If the consortia have messaging suggestions, please send them to Craig by the end of the week.

We are going to start the messaging with, "If you have already gotten coverage, you can ignore this message."

We are going to do outreach calls along with the letter.

We are going to create a script for the calls similar to the letter.

Most of those who lost coverage from us this year will qualify for a SEP. Because of this, they can apply through May. It also allows them to apply up until the end of the month. In order to be recognized as someone who is part of the SEP, they have to answer two questions on the FFM application accurately.

We will have to run a report using reason codes and the eligibility end date to see who we should reach out to. We do not want to send it to people the information will not apply to like those who lost eligibility in January.

The consortia would like consortium specific letters that include local help in their area. We cannot do this based on the way we are generating letters. We could possibly think about adding an insert to the envelopes.

4) Outreach Calls Debbie/Craig

There are two different transitioning groups we will reach out to.

There are those who received invalid determinations from the FFM and should never have been on BadgerCare in the first place for things like being over 100%. We are guessing there are 10,000 of those individuals based on taking 25% (error rate) of the 40,000 cases we received for them. These are all for determination model transfers.

The other group is all the members who have lost BadgerCare this year/since the end of January. There were 75,000 of those individuals as of November. They have already received notices. If we reached out to those who lost coverage in January, we would not have any real information for them since they would not qualify for SEP.

C) Members Transitioning after March Adverse Action

Monday's list is for those who received invalid determinations while the letter is for the larger population.

We are creating a script of general guidelines for the invalid determinations. It should be ready today or tomorrow. We will be telling them they have coverage now, but they will be losing it 4/30/14, so they may want to do something. The calls should probably be done after the notices are received.

Capital plans to do their calls 3/26/14.

We did not think the consortia had the bandwidth to do the transitioning member group of 75,000 which is why we had only asked about the invalid determination group. Some of the consortium would like to consider doing their own outreach to all of the transitioning members. The REN in Western is already doing outreach to their members.

We will look into the consortia doing the calls to the larger group and then follow-up to see if they would like to do them.

D) Ongoing

With RENs and partners pulling back, the consortia would like to know if someone will help CAC wise in April and May. With transitioning members in a SEP for those two months, it might be beneficial to still have them. Craig will ask SSIO to see if they can extend the assistance through the SEP period.

John Rathman would like a monthly list of those being transferred to the FFM for outreach purposes.

It would be nice to have a monthly report through 2014 at least since members will be losing eligibility at renewal time due to MAGI rules through this time period.

Counties would like the option to do their own ongoing outreach.

We need to decide what the IM agencies role is in the future, if this is the new normal.

Action Item: Linda will put this as a topic for the Process Support Subcommittee meeting. Our policy team will consider it as well.

5) Update on Premium Payments — Craig Steele

HHS issued the final rule last week. It says that the State, counties, local agencies, tribes, and non-profits can pay premiums on behalf of others as long as they are in no way affiliated with hospitals, providers, insurance carriers, etc., and the QHP has to accept it.

Craig will send the link to the new rule.

Q: Will insurance providers accept payments/applications after the 15th of the month for coverage starting the 1st?

A: Insurers have to accept backdate premiums/coverage for Marketplace errors, but providers will probably not make the exception like they did in December unless they lost coverage that month.

Those allowed to pay premiums/enroll by 3/31/14 for 4/1/14 coverage are for those who qualify for a SEP. Others had to pay by 3/15/14.

SEP is ongoing for BadgerCare Plus transitioning members, so they will have until the last day of the month to enroll. It is different for tribes as they have special rules.

Information regarding the SEP as it relates to BadgerCare Plus transitioning members was sent by Gillian in the third week of February. It contained four bulletins from the FFM.

The consortia think a SEP training would be very beneficial. Pa from Capital could probably get us screenshots of the two important questions on the FFM application for this.

6) Policy/Systems Questions — Consortia

Q: Where do we send people who are having a lot of problems with the FFM?

A: For now, send them to Craig. He will send them to the CARES Call Center to work it or a CMS' regional caseworker if needed. We will look into a plan for the future.

Q: Do you think CMS will continue to stop giving bad information to customers?

A: You should expect it through the end of the month, but they are conducting a training after open enrollment. That will hopefully help for the future.

Q: What about people who do not want BadgerCare Plus? What about those who do not want BadgerCare Plus but also want the tax credit?

A: If they are eligible for BadgerCare Plus, they cannot get the tax credit. They will have to go outside of the Marketplace to obtain private insurance or check "no" when it asks if they want financial assistance.

7) Consortia Sharing — Consortia

The RENs have helped the consortia meet and create relationships with their shareholders.

The consortia think it is a good idea to have a post-mortem discussion of what worked well and what did not. We will set a meeting up or use a future meeting for this purpose.

8) Carryover Items for IMAC

The two different outreach efforts should be explained to the larger group. The consortia would like a blurb describing the different outreach efforts. If the script is ready, they would like to see that as well.

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Scott Walker
Governor

Kitty Rhoades
Secretary

Telephone: 608-266-8922
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TTY: 711 or 800-947-3529
dhs.wisconsin.gov

State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC) MEETING

Thursday, July 18, 2013
1:00 – 3:30 p.m.
Dane County Job Center, 1801 Aberg Avenue - Ballroom, Madison, WI
Or online at https://connect.wisconsin.gov/imac/
For audio, dial 888-273-3658, then access code is 645-0020.

MINUTES

Non-State Attendees:

Jenny Hoffman, Bay Lake / Brown Co.	Joanne Ator, Bay Lake / Door Co.
Kris Parkansky, Bay Lake / Marinette Co.	Cindi Flynn , Capital / Adams Co.
Melissa Duane, Capital / Columbia Co.	Amy Mendel-Clemens, Capital / Dane Co.
Tony Sis, Capital / Dane Co.	Sheila Drays, Capital / Dodge Co.
Stephanie Ronnfeldt, Capital / Richland Co.	Liz Mahloch, East Central / Sheboygan Co.
John Rathman, East Central / Outagamie Co.	Lynn Brenner, East Central / Calumet Co.
Lori Garceau, East Central / Manitowoc Co.	Deb Williquette, East Central / Manitowoc Co.
Diane Voth, East Central /Marquette Co.	Amy Roland, East Central / Outagamie Co.
Linda Struck, Great Rivers / Eau Claire Co.	Ronda Brown-Anderson, Great Rivers / St. Croix Co.
Ruth Tveten, IM Central / Langlade Co.	Jane Huebsch, IM Central / Marathon Co.
Mandy Mayek, IM Central / Portage Co.	Rachel Pantaleo, Moraine Lakes / Ozaukee Co.
Doreen Lang, Northern / Wood Co.	Roby Fuller, Southern / Crawford Co.
CeCe Fishnick, Southern / Grant Co.	Marlin Harms, Southern / Iowa Co.
Jill Johnson, Southern / Jefferson Co.	Sandy Torgerson, Southern / Jefferson Co.
Carla Haigh, Southern / Rock Co.	Marjean Sutherland, Southern / Lafayette Co.
Lorie Graff, Western / LaCrosse Co.	Sue Kaufman, WKRP / Racine Co.
Hope Otto, WKRP / Racine Co.	Abbey Lukowski, Forest County Potawatomi Community
Elizabeth McDowell, Stockbridge-Munsee Tribe	Sarah Diedrick-Kasdorf, Wisconsin Counties Association
Linda Alexander, HP	

State Attendees:

Jamie Christianson-Fawcett, DHS	Sara Edmonds, DHS
Yolanda Evans, DHS	Brian Fangmeier, DHS
Bill Hanna, DHS	Elizabeth Jungers, DHS
Hannah Knouse, DHS / MilES	Christina Martin, DCF
Wendy Metcalf, DHS	Tiffany Orcholski, DHS
Carrie Schneck, DHS	Allison Shabino, DCF
Andre Small, DHS	Tony Trout, DHS
Debbie Waite, DHS	Jennifer Wickey, DHS
Pang Xiong, DHS	

1. Administrative Issues – Debbie Waite and John Rathman
   - All attendance to be emailed to Linda Alexander. (No on-site attendance sheet.)
   - CARS / RMS education sessions – will touch on this in sub-committee updates.

2. Approval of June 20, 2013 Minutes – Debbie Waite
   - Motion to approve 6/20/13 minutes. Motion seconded and passed by voice vote.

3. FNS Awards/Recognition – Sara Edmonds
   - FNS Local Agency awards – letters of recognition going to counties as well as heads of consortia. Plaques to be sent – payment accuracy from October, 2011 through September, 2012 rankings shared.

4. IMMR & Second Party Review Reports – Comparative Data – Sara Edmonds (Handouts)
   - Sara noted that production mode lags sometimes over the weekend. Workload Management Reports may not be available right away on Monday mornings, but are available within a couple of days.
   - Workload Management reports are now available for Tribal IM Agencies in IMMR.
   - In Performance Management Historical Reports, can choose a timeframe to review.
   - Monthly Consortia Report Handout and feedback, comments:
     - Consortia Application Timeliness (June 2013/new criteria) / IMMR Timeliness / Consortia Application Timeliness – Ad Hoc & IMMR. Suggested adding the roll-up of the old Executive Dashboard.
     - Consortia Churning Rate – a valuable tool to identify spikes during implementation of ACA – how it affects workload.
       Scan-First and Process-First Distribution (CDPU) – not currently a contract performance measure but it was considered. Enables consortia to evaluate best business practices.
     - Recommend adding counties and number of documents received to the report.
       Action Item: Sara Edmonds will adapt report to include counties and the number of documents received by each on this report.
       Other ideas: Send suggestions to Sara or give them to any member of the Performance Management sub-committee.
     - Active Error Rate by Consortia – this report will be posted to SharePoint but today is a preview. On report, non-consortium = tribal agencies. Again, feedback expressed was a preference for tracking by agency/county.
       Action Item: Sara Edmonds will bring the suggestion for county/agency error tracking to the next Performance Management sub-committee meeting. By then, will have six months of data to review.
     - Fair Hearings Decisions (Jan-Jun 2013) – Sara asked if this was useful information and the response was positive.
     - Percentage of Claims Dollars Establish to Potential Dollars – FNS recently visited Wisconsin and evaluated business efficacy. Being considered as a 2014 contract performance measure, potentially tied to the previous year's benchmark. FNS uses the overpayment error rate to identify "potential overpayment amounts." For

FFY 2012, FNS has identified 25.81% as the national average for claims established. All consortia met or were better than the national average.
    - Second Party Review Active Error Rate – number of cases in error; not comparable to FSQC (measures dollars involved). Second party review seeks to prevent the errors going forward, unlike FoodShare QC which uses the federal rules to review cases.
    - Six-Month Roll-up Reports – consortia have requested this for a long time. Shows multiple months (Jan-Jun) for key categories (caseload; % of applications processed timely; % of reviews processed timely; % of SMRFs processed timely; Consortia call center performance categories) on a two-page report. Sara complimented Tony Trout for his work on bringing this important information together in a very clear and concise way.
    - Sara will review comments, feedback and bring to Performance Management committee for consideration.
    - Debbie Waite recognized Sara, Tony Trout and Hannah Knouse for their efforts in developing / creating these measurement tools and continuing to improve them.

5. State Budget Wrap-up – Carrie Schneck (Handout)
    - At the last IMAC meeting, the State budget had not yet been finalized.
    - Handout is not comprehensive but intended to highlight the items relevant to IM.
    - BadgerCare Plus Eligibility changes – if the insurance exchanges / "Federal Marketplace" is not ready on 1/1/14, contingency plan is for BC+ to continue.
    - Funding to Income Maintenance Consortia for PPACA Workload - the $55.5 million increase (over two years) represents a change from the earlier documents based on an updated estimate of the BadgerCare Plus caseload and other changes. The Legislature routinely updates estimated BadgerCare Plus populations during the budget process.
    - Medicaid Divestment Policy – the Legislature added a requirement for the Department to request Joint Finance Council approval before implementing the policy. Question on target date for implementing / when will this go to Joint Finance. Uncertain – staff resources are currently directed to PPACA implementation.
    - FoodShare Able Bodied Adults without Dependent Children (ABAWD) Initiative – being piloted in Walworth, Racine and Kenosha Counties.

6. Farm Bill Update – Julie Zastrow
    - Two versions of the Farm Bill – House of Representatives' version failed. The Senate passed its own version on 7/11/13 which removed all SNAP provisions. May become a stand-alone bill. Next sent to conference committee where it will be reviewed and voted on; then it will be sent to President Obama for his signature. The President plans to veto a stand-alone SNAP bill.
    - At this time, DHS will continue to operate under the old Farm Bill law.
    - Provisions that have the biggest impact on IM:
        - $1 LEAP energy assistance which enables full household receipt of HUSA. Minimal energy assistance payment of $10.00 proposed.

- EBT replacement card recoupment – Senate version has additional language about the reason for replacements (vulnerable population exceptions – homeless, domestic violence, disabled); more reasons for replacement added.
- Bonus dollars received through QA program – Senate version requires that all dollars received would be reinvested in the FoodShare program.
- Convicted felons ineligible for SNAP for life for certain convictions/felonies.
- Funding levels for 2010-2012 were $8 million. Senate version has $12 million annual budget, now with significant amount to fund discovery and prevention of trafficking.

7. DHS IM Contract Performance Reports (Handout)
   - CDPU Performance – Sara Edmonds & Tony Trout
     - Report card for DHS/CDPU – timeliness, accuracy: contractual measures
     - Graphs for both measures; also shows 'scan-first' and 'process-first' categories.
     - Notes on report show trends and highlight changes.
   - BadgerCare Plus Premium Payment – Sara Edmonds
     - Performance measures of accuracy and timeliness as above. Exceptioned cases include *i)* payments written for the wrong amount; *ii)* payment unable to be posted because no matching record in interChange; *iii)* cases incorrectly keyed at US Bank (exceptioned for manual processing); *iv)* payment covers multiple months. Only US Bank incorrect keying is truly an error; therefore, the accuracy rate is lowered because the other reasons are counted as errors since the reasons are not identified in the reports.
   - Sara recommends posting to SharePoint but need a consistent consortia reporting date; suggests due date of 15th/middle of the month so that reporting is on the same timeframe.

8. PACA Issues & Planning Update – Debbie Waite & Amy Mendel-Clemens
   - Debbie Waite told about Brett Davis at 7/17/13 conference at the UW Health Population Institute. She also introduced Bill Hanna, Director of Area Administration, who will be working with the consortia on PPACA related issues along with the Area Admin staff with whom the consortia are already familiar.
   - Bill is also working with partner organizations as well as AmeriCorps to assist with the development of Regional Enrollment Networks in each consortia region. AmeriCorps staff is not scheduled to join until sometime in August. In the meantime, current Area Administrators will continue to be the contact for the consortia regarding Regional Enrollment Networks.
   - Bill talked about the presentation that Brett had delivered at the UW conference. It was a good opportunity for interaction between the AA's and the attendees from their respective areas. Will be holding meetings around the state and need consortia to identify other leaders, experts, stakeholders who should be included.
   - Ideas to assist in the implementation:
     - Streamlining processes, especially for security and for new employees;
     - Extended hours for CARES staff

- CDPU systems enhancements
- Volume projections for PPACA

- Announced Michelle Ebert as new section lead for training; will be developing Phase II training plans.
- PPACA Sub-committee meetings /update to be handed out today. Changes to sub-committee meeting dates: move next remote/conference call meeting to August 5th and the next face-to-face meeting to August 14th.

9. Sub-committee and Ad Hoc Group Reports - Debbie Waite / Leads (Handout)
   - PPACA – per John Rathman, concern that policy decisions that impact consortia's workload have not been fully defined. Debbie is researching the questions submitted; takes time to get the questions to the right resource and for a response to be developed. Debbie asked if Frequently Asked Questions (FAQs) could provide some level of information, especially if broken out by topic. Discussion led to how to incorporate the information/new policies, procedures into other platforms such as online or in handbooks.
   - Workload and Finance - What should be included in education / training? CARS? RMS (Random Moment Sampling)? Meeting scheduled for 7/31/13 at 1 W. Wilson (DHS – Conference Room B370). Bureau of Financial Services (BFS) wondering what questions financial managers would want them to address; suggest that those questions be collected and brought to the 7/31/13 meeting. Discussion that the education/training session should be postponed for another date and that the committee should focus on addressing its purpose.
     Action Item: Workload and Finance will address the purpose/direction/goals instead of having the training session previously scheduled for 7/31/13.
   - FSET – Amy Mendel-Clemens addressed #6 (Agency concerns around regionalizing FSET based on WDA boundaries), saying that the consortia were committed to getting more information about whether this was the best decision. The sub-committee members thought that Margaret Rosenthal was going to research, get more detail because the general language in the statute allows a choice among WDA, W2 and IM Regions. Thought that a position paper could be done.
     Action Item: Amy Mendel-Clemens will send a memo/message to Brett Davis that the consortia are strongly in favor of the IM Region model for FSET.

10. Operations Memos – Debbie Waite for Linda Auchue
    - The Child Support Operations Memo was sent out today.

11. Administrative Memos – Debbie Waite
    - 100% FSET Restoration Admin Memo is ready to be signed by Brett Davis

12. Other / Public Comment
    - N/A
13. August 15, 2013 Meeting Tentative Agenda Topics
    a. PPACA Update and Issues

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

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INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC) MEETING

Thursday, August 15, 2013
12:30 – 3:30 p.m.
Alliant Energy Center – Mendota 5 / 1919 Alliant Energy Center Way / Madison, WI 53713
Or online at https://connect.wisconsin.gov/imac/
For audio, dial 888-273-3658, then access code is 645-0020.

MINUTES

Non-State Attendees:

Jenny Hoffman, Bay Lake / Brown Co.	Kris Parkansky, Bay Lake / Marinette Co.
Mary Gruber, Capital / Adams Co.	Amy Mendel-Clemens, Capital / Dane Co.
Tony Sis, Capital / Dane Co.	Sheila Drays, Capital / Dodge Co.
Melissa Duane, Capital / Columbia Co.	Julie Arendsee, Capital / Sauk Co.
Liz Mahloch, East Central / Sheboygan Co.	John Rathman, East Central / Outagamie Co.
Shelby Jensen, East Central / Green Lake Co.	Lori Garceau, East Central / Manitowoc Co.
Deb Williquette, East Central / Manitowoc Co.	Amy Roland, East Central / Outagamie Co.
Chris Machamer, East Central / Waupaca Co.	Ann Kriegel, East Central / Winnebago Co.
Linda Struck, Great Rivers / Eau Claire Co.	Ronda Brown-Anderson, Great Rivers / St. Croix Co.
Jane Huebsch, IM Central / Marathon Co.	Amy Mayo, IM Central / Oneida Co.
Mandy Mayek, IM Central / Portage Co.	Rachel Pantaleo, Moraine Lakes / Ozaukee Co.
Carol Wicklun, Moraine Lakes / Walworth Co.	Sandy Potter, Moraine Lakes / Washington Co.
Luann Page, Moraine Lakes / Waukesha Co.	Doreen Lang, Northern / Wood Co.
CeCe Fishnick, Southern / Grant Co.	Marlin Harms, Southern / Iowa Co.
Marjean Sutherland, Southern / Lafayette Co.	Bill Boutwell, Southern / Rock Co.
Carla Haigh, Southern / Rock Co.	Lorie Graff, Western / LaCrosse Co.
Adelene Green, WKRP / Kenosha Co.	Hope Otto, WKRP / Racine Co.
Crystal Newaygo, Red Cliff Band	Linda Alexander, HP

State Attendees:

Linda Ashmore, DHS	Linda Auchue, DHS
Angie Dombrowicki, DHS	Michelle Ebert, DHS
Sara Edmonds, DHS	Bill Hanna, DHS
Lisa Hanson, DHS	Craig Hayes, DHS
Elizabeth Jungers, DHS	Ed Kamin, DHS / MilES
Hannah Knouse, DHS / MilES	Christina Martin, DCF
Wendy Metcalf, DHS	Paul Michael, DHS
Julie Milleson, DHS	Jennifer Mueller, DHS
Tiffany Orcholski, DHS	Shawn Smith, DHS
Jennifer Stegall, OCI	Tony Trout, DHS
Debbie Waite, DHS	JP Wieske, OCI
Pang Xiong, DHS	

1. Administrative Issues – Debbie Waite and John Rathman
   - Meeting attendance for on-site is sign-in sheet; if attending remotely, email Linda Alexander.
   - Heads up on September IMAC meeting location – sent previously but will be sent again with September meeting materials: Department of Agriculture, Trade and Consumer Protection / 2811 Agriculture Drive – Board Room / Madison WI 53708. Parking at no cost.
   - Follow up to State Budget Update from 7/19/13 IMAC Meeting– Angie Dombrowicki
     - As a follow-up to Carrie Schneck's presentation at the July meeting, update that divestment components of State Budget would need the Joint Finance Committee's approval before going into effect. No implementation date until the JFC approves.
       - Workload and Finance Sub-committee Meetings – an educational session on CARS and RMS, the 9/17/13 meeting has been moved to 9/24/13. Will be recorded and available through AdobeConnect.
     - Debbie Waite will send the tri-chairs and sub-committee the proposed agenda by 8/23/13.

2. Approval of July 18, 2013 Minutes – Debbie Waite
   - Changes made to the minutes sent on 8/15/13; copies of the corrected version available were brought to the meeting. Linda Alexander will forward a copy of the corrected version for review; defer approval of the July meeting minutes till the 9/19/13 IMAC meeting.

3. Training and Other Requirements for Navigators and Certified Application Counselors – Jennifer Stegall and J.P. Wieske, Office of the Commissioner of Insurance (Handout)
   - Topics to address: reason for legislation, overview of Federal rules, current status of efforts.
   - Marketplace requirements – WI collaborated with other states, Fed – whether the Federal government was best positioned to regulate, track, monitor and sanction navigators. Consensus that the states are better positioned to do this. Wisconsin provided guidance, input based on Wisconsin's successful (insurance) agent model, albeit with significant changes.
   - Navigators – Federal grant funds these positions. Must be appointed either by the Federal government or by a qualified entity. Careful selection and consideration due to the risk for targeting of vulnerable populations by unscrupulous practioners. Navigators have highest, most stringent level of requirements: fees, training, finger-printing, background checks, behavior monitoring, risk of corrective action, $100,000 of 'financial responsibility' / errors and omissions (under traditional insurance scenario, commonly covered by the insurance agents' companies). Cannot be paid by an insurer. Presents a potential risk for hospitals that own insurance providers; must provide disclosure and present unbiased advice/counsel. Cannot recommend a specific plan – only describe benefits, features. Must refer member to a licensed agent.

- Certified Application Counselors – must be hired by some type of approved entity who then pays them. Represent the exchanges and tasked with enrolling in the exchanges. The entity that hires the CAC is responsible for the financial responsibility (goal is making the consumer whole in the event of an error or mistake). CAC's required to take 16 hours of training, pass an exam and continuing education. (No finger-printing and background checks as with Navigators.) CAC's have registrations, not licensure. Update of status is due monthly to OCI. Cannot be paid by an insurer. (See additional comments in Navigator section above.)
- Training – Third party providers/private businesses do this for OCI, typically at a discount. Face-to-face training to be offered in October. OCI has scheduled training next week for 75 people. On-line training will be available within a few weeks. Exam fees range from $75.00 to $150.00 depending on provider and length of training.
- Agents – will enroll people. Paid same as outside of exchange. Training class for agents available on-line soon (4-hour class for about $40.00).
- Q&A's:
  - Q. Are government / county / consortia staff required to go through the training?
  - A. No; public entities (government and government contractors) are exempt from State training requirements, although there may be some Federal requirements.
  - Q. How will names of Navigators and CAC's be shared with the public?
  - A. Shared broadly within the state through various methods; likely will not share individual names w/the Feds.
  - Q. What are the training fees?
  - A. Private providers contracted by OCI typically offer a discount through OCI. Approximately $150 per person for a class/group. Pre-licensing training is another area of opportunity.
  - Q. Where are face-to-face training sessions being held?
  - A. Several 2-day sessions held in various locations: Stevens Point, Wausau, Sauk City, Madison.
  - Q. Is there value in having public employees go through the training even though they are exempt from the requirement?
  - A. Decision is "as needed" based on level of knowledge, experience as well as increase in consumer/members' knowledge and understanding. First day of training is focused on the nuts and bolts of health insurance. Then 4 hours spent on Affordable Care Act (ACA) and 4 hours on the Exchanges.
  - Q. Will CAC training be available without having to register the consortium or county as the sponsor?
  - A. Yes.
- Discussion on training IM workers to act as Certified Applications Counselors.
  - Advantage – familiarity with formularies, co-pays, deductibles, providers.
  - Disadvantage – workload volume for IM workers.
  - Recommendation – consortia might want to send a few IM workers through the training to become familiar with CAC role.

- Consortia concerned that IM workers who are qualified/trained in the CAC role will be asked to help members/applicants to complete the federal application / enrollment forms.
- CAC training - doesn't specify what CAC is prohibited from doing/addressing. Concern that without some direction, education, IM workers would send confused consumers to the Federal sites where they may become more confused.
- Will BadgerCare Plus applications be delayed if the IM workers are helping address members' questions?
- A suggestion about structuring future training for IM workers: more in-depth on the health insurance basics (not Medicare, Medicaid). OCI took the suggestion, will review and consider how to structure future training about this part.

4. Call Center Anywhere (CCA) Preparation for PPACA – Paul Michael, Linda Auchue and Jennifer Mueller
    a. Capacity –
        - Per Jen Mueller, outbound expansion complete by 9/20/13 before the first letter is sent.
        - For "Balance of State" (except MilES, which has its own parameters), can have 897 inbound calls with 299 concurrent conversations. Means 897 calls in queue until the 299th conversation ends/caller hangs up; then next call in queue moves to active conversation.
        - Capacity was determined by reviewing January-June for 15 minute timeframe (including queue and conversation), although no queuing the first thing in the morning. Staff increases also impacted performance/stats.

    b. Queuing Options -
        - Question: What happens on the 898th call? Answer: Exploring the options and contingencies for that situation. However, to date, have never come within 15% of maximum capacity. With capacity expanded by 33%, unlikely that maximum would be exceeded.
        - Hours of Operation – Consortia would like CCA support outside of the current operation/business hours. Jen suggested referring to the "Change" behaviors in the CCA training for background.

      Action Item: Consortia should alert CCA/Paul Michael to any changes in their hours of operation and their message will be changed in CCA.

    c. Messaging Content and Timeline –
        - Asked agencies for input on call flow, how to format the CCA menu, especially in the event that the caller wants specific ACA information.
        - Roll-out of PPACA changes on Friday, 9/13/13. Message crafting, approval, recording must be complete before then.
        - When call volumes increase, CCA option for a message to advise callers of status.

Action Item: Consortia should contact CCA / Paul Michael if they want options (standard or special messages) for high-volume and wait times messages.

- Question: What can we tell callers if they have Affordable Care Act questions?
  Answer: Need consortia feedback to develop a response that fits the needs of the balance of state (non-MilES). Should address a specific timeframe and message to be played over that timeframe will fit the need: e.g. message about appropriate topic from 9/1/13 to 10/18/13.
- Impact of the regional enrollment networks - accommodating numerous individual messages for each consortia/region would prevent DHS from providing at least one quality Balance-of-State solution.
- Per Paul Michael, as consortia develop CCA messages, should indicate the timeframe for which the message should be played (e.g., how long the message should remain in CCA; based on letters sent-dates).
- Question: When can agencies get copies of the letters?

Action Item: DHS to provide consortia / agencies with the letters just before they are scheduled to be sent.

- Question: Has the Health Insurance Risk Sharing Plan (HIRSP) letter been sent?
  Answer: Unknown.

Action Item: Linda Auchue will investigate whether the HIRSP letter has been sent and provide to CARES & Policy Coordinators, copying Operational Leads. (Note: Post IMAC meeting, HIRSP newsletter article was distributed to Operational Leads – HIRSP letters are going out in Sept/Oct time frame.)

- Need a letter for anyone who has applied to date; Linda Auchue will send. Content should be used to develop CCA message.
- Suggestion: In the letter and CCA message, contact should be a general number since consortia have no ACA-dedicated staff to address the questions.

Action Item: Jen Mueller and Paul Michael will investigate this suggestion.

- Concern - impacts to IM contract performance standards. Was discussed with Brett Davis at June IMAC meeting - contract language "beyond the consortia's control" addresses the issue. If further discussion is needed, Debbie Waite will convene a conference call with the tri-chairs.

5. Key Dates for IM PPACA Readiness – Linda Auchue (Handouts)
   - Handout "Key Dates for Income Maintenance Patient Protection and Affordable Care Act (PPAC) Readiness" addresses only what affects IM workers and consortia workload. Attempting to identify all impacts to capacity and workflow.
   - Caution: Everything is subject to change.
   - Processes under development with constant updates based on new directionfrom CMS. One element that is stable is the one-time letter to BC+ members potentially over the new income limits, extension to members between 100-133% of Federal

Poverty Limit/FPL, Core Plan Waitlist Members and Basic Members Mailings will impact staffing levels. C information in letters to existing members is the consortia.

- Ops Memo for Core Plan is under development now.
- Although Basic Plan is ending 12/31/13, should not result an increase in calls since these 1,300 members are used to calling the toll-free number; should not pose a burden to IM workload.
- Inbox and Dashboard will now show source of the application so agencies can identify which applications came from the Federally Facilitated Marketplace (FFM). This should assist agencies in assigning the cases and monitoring workload. The IMMR will also be enhanced to display separate counts for FFM applications as well as timeliness for applications received from FFM.
- Applications for Childless Adults will be held until 10/18/13 since no option is available for this group until 1/1/14.
- Another Ops Memo being developed on processing applications that are transferred to Wisconsin from the FFM.
- Linda Auchue reviewed dates and provided explanations, background for each.
- Feedback - very helpful, but still need a flowchart or better description for handing off (applications). DHS still waiting to get CMS' process (FFM ⇨ ACCESS ⇨ CARES WorkerWeb). Difficult to anticipate, staff lacking this information.
- Member Services will be getting returned mail for individuals on the Core Plan Waitlist, estimated at over 100,000 on list.
- Question: What is the new / location for Basic Plan Helpline?
  Answer: Goes to EM CAPO line.
  Action Item: Linda Auchue to supply the consortia with a copy of the Member Update letter.
- Request a 2014 calendar that shows which Saturdays CARES will be available. Also important that calendar shows any time during the week when CARES will NOT be available.
  Action Item: Jennifer Mueller will update and publish the CARES calendar, especially the days when CARES will not be available.
- Goal is to maximize CARES availability:
  Monday-Thursday: 6:30 a.m. to 9:00 p.m.
  Friday: 6:30 a.m. to 5:00 p.m.
  Saturday: 7:00 a.m. to 5:00 p.m. except when doing batch processing when adverse action is being run. Any last minute changes to calendar will be sent / communicated to CARES Coordinators, copied to Operational Leads.
- Will likely reassess calendar after June, 2014.

6. Regional Enrollment Network Update – Bill Hanna
   - As of 9:00 a.m. today (8/15/13), more than 600 people have registered for REN sessions. Deadline to register is 8/16/13.
   - New website is http://www.dhs.wisconsin.gov/health-care/
   - Session "Medicaid 101" taped – enables partners, others to learn about Wisconsin Medicaid.

- REN philosophy: No wrong door but there is a 'more right door.' Where does DHS want partners, providers to direct questions, consumers?
- Kick-off meetings are not training sessions. Goals for meetings: identify training needs for partners and providers; determine local direction/needs; discover capacity and identify regional resources for these needs. Collect input and formulate plans from the REN meetings.
- Recently, Brett Davis held meetings with various WI hospitals and many of the officials are opting for these instead of attending REN meetings.
- Question: Can the names of the AmeriCorps staff be posted when they are hired? Answer: AmeriCorps grant was for 9 slots. Agencies are doing the 'hiring;' this activity is being managed by the agencies and DHS does not have any control over the process. Suggest that at the REN Kick-off meetings, leaders/steering committee for the region are identified so that leadership and accountability are established by region (will vary by region).
- Further discussion about accountability and communication about REN's: DHS took lead, was the source of information; consortia want DHS to continue to actively communicate about the REN's.
- Kick-off meetings' outcomes – plan devised from feedback at meetings. Nothing consortia need to do other than provide input to models, share business practices in their offices that will or won't work.
- Consortia recommend that kick-off meeting agendas emphasize this is not a training session but rather a conversation, a collaboration, a chance to gather input. Not a lecture / training session.
- Consortia would like a list of all parties responding to the REN meetings
  Action Item: Bill Hanna and Jamie Christianson-Fawcett to provide lists of 600+ REN kick-off meeting responders / attendees to the consortia so they can use to encourage key players to attend. Jamie will email lists by COB today, 8/15/13.

7. PPACA Communications and Notices Update – Angie Dombrowicki
   - CCA Messages – being developed.
   - One-time Mailings – letter content stable.
   - Call Center Scripts – DHS working on these. Send any input / specific needs from questions consortia may have gotten from members to Adam Van Spankeren's email (DHS).
   - Partner FAQ's – On DHS website. Also send any ideas, input to Adam's email.

8. Consortia Feedback on Security Request Process – Debbie Waite and Tricia Janssen
   - How did the security expedited request process go?
   - Capital Consortia – OK/no issues
   - Rock County – worked OK.
   - St. Croix County – took 4 days to sign up new workers.

9. Consortia Feedback – John Rathman
    - DHS - Be sure to use appropriate and updated distribution lists when communicating with consortia.
    - Need an update on 2014 contract timeline.
    - DCF – O'Brien & Associates complaints on over-payment and collection language. Does DHS have concerns? Remember that Food & Nutrition Service (FNS) must approve notices language. Bring this up at Mike McKenzie's Fraud Sub-committee meeting tomorrow; may want to address at a future IMAC meeting as well.
    - Future IMAC IT meetings – continue; want to see the current roll-out schedule from Deloitte.
    - Requests from various audiences (boards, public health organizations, internal audiences) for consortia/county staff to address PPACA. Any materials that could be used to provide a consistent message and limit duplication of effort? Response - DHS handling a number of these speaking requests already. Existing PowerPoint material will be shared with consortia for their use. Brett Davis' "ACA 101" is one tool.

10. Administrative Memos – Debbie Waite
    N/A

11. Operations Memos – Linda Auchue
    - 3 FoodShare:
        1) Updated non-discrimination statements;
        2) Changing Child Support policy
        3) Federal Poverty Levels (FPL's) changes and standard utility allowances (allotments are decreasing)
    - FamilyCare Overpayments – recoup capitation payment from MCO (through DLTC)
    - Core Plan Changes
    - Dashboard / Inbox Searches
    - FFM Processing – may be split into two separate versions.

12. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    - No verbal needed; handout sufficient.

13. Other / Public Comment
    N/A

14. September 19, 2013 Meeting Tentative Agenda Topics
    a. PPACA Update and Issues
    b. Regional Enrollment Network Update

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State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC) MEETING

Thursday, September 19, 2013

1:00 – 3:30 p.m.

Department of Agriculture, Trade & Consumer Protection – Board Room

2811 Agriculture Drive / Madison, WI 53718

Or online at https://connect.wisconsin.gov/imac/

For audio, dial 888-273-3658, then access code is 645-0020.

MINUTES

Non-State Attendees:

Jenny Hoffman, Bay Lake / Brown Co.	Kris Parkansky, Bay Lake / Marinette Co.
Joanne Ator, Bay Lake / Door Co.	Melissa Duane, Capital / Columbia Co.
Amy Mendel-Clemens, Capital / Dane Co.	Tony Sis, Capital / Dane Co.
Cindi Flynn, Capital / Adams Co.	Sheila Drays, Capital / Dodge Co.
Stephanie Ronnfeldt, Capital / Richland Co.	Julie Arendsee, Capital / Sauk Co.
Liz Mahloch, East Central / Sheboygan Co.	Shelby Jensen, East Central / Green Lake Co.
Diane Voth, East Central / Marquette Co.	Amy Roland, East Central / Outagamie Co.
Amy Piotter, East Central / Outagamie Co.	Tim Gessler, East Central / Sheboygan Co.
Chris Machamer, East Central / Waupaca Co.	Stacy Engel, East Central / Waushara Co.
Ann Kriegel, East Central / Winnebago Co.	Linda Struck, Great Rivers / Eau Claire Co.
Ronda Brown-Anderson, Great Rivers / St. Croix Co.	Jane Huebsch, IM Central / Marathon Co.
Amy Mayo, IM Central / Oneida Co.	Mandy Mayek, IM Central / Portage Co.
Rachel Pantaleo, Moraine Lakes / Ozaukee Co.	Mia Inman-Anderson, Moraine Lakes, Walworth Co.
Sandy Potter, Moraine Lakes / Washington Co.	Luann Page, Moraine Lakes / Waukesha Co.
Doreen Lang, Northern / Wood Co.	Marlin Harms, Southern / Iowa Co.
Carla Haigh, Southern / Rock Co.	Adelene Green, WKRP / Kenosha Co.
Claribel Comacho, WKRP / Racine Co.	Jesse Noyola, WKRP / Kenosha Co.
Hope Otto, WKRP / Racine Co.	Linda Alexander, HP

State Attendees:

Linda Auchue, DHS	Angie Dombrowicki, DHS
Michelle Ebert, DHS	Sara Edmonds, DHS
Brian Fangmeier, DHS	Bill Hanna, DHS
Lisa Hanson, DHS	April Heim, DHS
Elizabeth Jungers, DHS	Donna King, DHS
Hannah Knouse, DHS / MilES	Christina Martin, DCF
Mike McKenzie, DHS	Eileen McRae, DHS
Fratney Miller, DHS	Julie Milleson, DHS
Jennifer Mueller, DHS	Tiffany Orcholski, DHS
Shawn Smith, DHS	Tony Trout, DHS
Debbie Waite, DHS	Angela Waltz, DHS
Pang Xiong, DHS	

1. Administrative Issues – Debbie Waite, Amy Mendel-Clemens, Liz Mahloch
   - Attendance should be e-mailed to Linda.Alexander@ Wisconsin.gov or noted on sign-in sheet at meeting location

2. Approval of July 18, 2013 and August 15, 2013 Minutes – Debbie Waite
   - Motion to approve, seconded and carried on voice vote for both months.

3. PPACA Preparation
   - **Applications Coming from Marketplace** (Handout) – Linda Auchue
     - Letters advising current enrollees they were no longer eligible and those on the BadgerCare waiting list scheduled to be sent beginning on 9/23/13.
     - No MAGI until 11/1/14. Cannot direct to Federally Facilitated Marketplace (FFM) till 1/1/14 due to system incompatibilities.
     - Method of tracking eligible people – see handout. Business requirements for processing into CARES are not yet developed. Must be sure CARES has functionality to support the differences in MAGI processes. Want to avoid having people calling agencies to check on status until 11/18/13. Update from CMS this morning: won't be able to accept the FFM applications for forwarding to DHS. DHS has agreed to use information submitted on FFM; no further verification required.
     - October 1 applications go into effect 1/1/14; DHS still needs to test CARES.
     - Until 1/1/14, ineligibility / lack of coverage only for death, moving out of state, failure to pay premium. After that, updates can be made for verification.
     - Operations Memo being developed and will be sent once background information, language is developed.
     - Medicaid Assister Line – Feds plan to set up a direct line available for state/agency workers. Requires names of those WI state and consortia workers who will use to verify person's role.

- Question: Could calls from an outbound CCA serve as verification that the caller is a state/agency employee? Waiting for response from CMS but they have denied this type of solution in other states.

- Question: Could consortia use the RMS lists (showing all staff members' names)? Concern about number of workers/names that would be involved - over 1,200.

- Question: Should consortia limit the number of staff members who have this access? This approach may eliminate confusion and minimize applicant getting caught in loop between the consortia and CMS.

- One Concept: Consortium could set up troubleshooting teams which would be the staff whose names and numbers are given to the feds.

Issues with *healthcare.com*. Craig Steele is working on messages on the site as well as sharing incorrect contact/referral information with CMS for correction. Bay Lake Consortium reported that tribes are showing up at the top of the list when someone accesses website and should be re-ordered to show consortia as the first choice.
Action Item: **Jenny Hoffman** to email Craig Steele, copying Debbie Waite, asking that CMS place the appropriate consortia at the top of the list of choices.

BC+ Notices Mailing. DHS Sent 55,885 letters to groups whose eligibility is likely to change due to Federal Poverty Limit changes or program elimination (BC+ extension, wait list, BC+ Basic). All returned mail going to CDPU. Returned mail @ approximately 25% per Alicia Hynes of CDPU. Essential that addresses are accurate before the October notice of decision (NOD).

CMS Reporting Requirements. Application processing must be reported to CMS daily and weekly. DHS will also be tracking. After 11/18/13, Linda Auchue will contact any consortia that look like there are issues with volumes or timeliness in processing applications, documents, SMRFs, etc.

PPACA Related Questions
Question: When will handbook be updated?
Answer: Will use BC+ through 2014 and then will add what is new/changed.

Question – What is impact on Family Planning Services?
Answer: Family Planning Services only – stays at 300% of FPL, so letters to this group are unnecessary. Consortia asked whether the FFM might provide broader/better coverage. DHS has no plans to send letters to this group.

- FFM turn-around time unknown; however, 30-day file date begins when agency receives. FFM applications identified so will not be counted in consortia performance statistics.

- Presumptive Eligibility – Eileen McRae

  What is changing?

  i. New "populations" being added (childless adults, patient care-takers). Because breast/cervical cancer patients are considered short-term, not being added.
  ii. Under PE, will be eligible for all services, except for pregnant women (only out-patient services).
  iii. New feature after 1/1/14: applicant will be asked if a resident of the U.S. and Wisconsin.

  What is process?

  i. ACCESS application is a two-step process. "Am I Eligible" feature in ACCESS. Results will show applicant if he/she can get benefits. Hospital worker then goes to ForwardHealth portal and asks applicant if he/she is eligible and whether truthful in statements.
  ii. Under PE, will be eligible for all services, except for pregnant women (only out-patient services).
  iii. Inmates of correctional institutions – Department of Corrections handling; hospitals will not make eligibility determination.
  iv. Only hospital staff (employed by hospital) can perform PE.
  v. DHS will be conducting audits to monitor patterns to insure integrity of process.

  Question: How will updates, new information be sent?
  Answer: Provider Updates to be sent electronically (approximately 6-8 weeks from now / mid-December), which will then be used to update the Provider Handbook.

- Regional Enrollment Networks / Next Steps (Handout) – Bill Hanna
  - Regional Enrollment Network Website is Wisconsin.gov/health-care/
  - Western Consortium has hired its own coordinator; other nine consortia staffed by the 9 AmeriCorps staff (see website).
  - Office of the Commissioner of Insurance (OCI), partnering with DHS, has conducted three training sessions (about 300 people) for Navigators / Certified Application Counselors (CAC). Must pass test but only 25 have done so to date. Sponsoring organizations are required to register with CMS but CMS has not been able to respond. Next session 9/24-25/13; remote sites (Iron River, Weston). Following the September training, next face-to-face training is 10/9-10/13 (Sturtevant, Rice Lake, Green Bay, Menasha & LaCrosse).
  - DO NOT send government employees to the training as non-profits need to avail themselves of this training first. OCI is developing a one-hour video training for government employees.
  - In all, seven face-to-face training sessions for partners and providers.

- Other outreach: Wisconsin Primary Health Care Association (WPHCA) sent "Enrollment Inventory Guide" in a survey with results due back 9/20/13. Will enable identification of CAC, how to refer people.
- If consortia need events scheduled, contact Area Admin.
- Consortia Question: Are the AmeriCorps staff being given direction, meeting together at all?
  Action Item: Bill Hanna will contact WPHCA to learn about plans for direction and whether the AmeriCorps staff is being fully supported; advise IMAC.
- Emergency medical services for illegals are still in force. Question if this should be referenced in the Health Insurance Flowchart (handout). No, since the chart addresses insurance, not healthcare policy.
- Communication: See DHS website (Wisconsin.gov/em/CustomerHelp/bcpletters) for summary of five letters regarding enrollment changes for specifics about audiences and mail/send dates. CARES and Policy Coordinators received scripts for CAC, Member Services.
- Question: Would Member Services scripts be helpful to consortia call centers?
  Answer: Yes – review, pick and choose what fits your consortium best.

- Direct Call Process Update – Angie Dombrowicki
  - Vendor (ASI – located in Milwaukee) outbound calls:
    1. Transitioning members above 100% of FPL; also includes 'extension' letters. Calls scheduled to begin week of 10/7/13, then through 11/15/13 (approximately 68,000 letters to be sent)
    2. Core Plan Wait List – 160,000 calls; will be very difficult to reach them so will make 3 attempts before abandoning the effort (approximately 160,000 letters to be sent). Calls scheduled to begin the week of 10/14/13.
    3. Basic Plan – begins/ends same as #2. (approximately 1,220 letters to be sent)
  - Consortia shared ideas on content for scripts #2 and 3. (E.g., "Did you get a letter? / What is the number on that letter?" "Any change in your income / eligibility?" Check comprehension, ability to refer to FFM.)
  - Consortia express concerns about consumers getting calls/contact from unscrupulous parties, especially since TV spots have said no calls from the government / "The government will not call you." How to overcome this obstacle - have vendor refer to the date of the letter and number (used to distinguish which audience got the letter). Include in script: "I will NOT ask for your Social Security number."

- Training Update – Michelle Ebert
  - BadgerCare Plus changes being presented in three phases:
    - Phase 1 – provided an overview; started in May 2013 and is complete.

    - Phase 2 – Policy Updates started 8/2/2013 and ends 9/29/13. Sessions will be on site but recorded session will be posted for future use on DHS website under "Instructional Resources" and include pdf's of materials.
    - Phase 3 – System Changes Related to Policy Changes. A 3-hour AdobeConnect session for up to 200 participants per session. Trainers will conduct 1-hour Q&A post segment. Also a pre-recorded session will be posted to "Instructional Resources," but will contain no post-session Q&A. Registration on-going; email sent on 9/14/13. Morning session is 9:00 a.m. to noon with Q&A from noon to 1:00 p.m.; afternoon session is 1:00 – 3:00 p.m. with Q&A from 3:00-4:00 p.m.
    - Q&A's to be handled by CARES Call Center.
  - OCI Webcast is "Basic Insurance Training for IM Workers," a 55-minute Insurance 101 course. Should be posted next week on DHS website under "Instructional Resources." Will send to consortia Training and Operational Coordinators.

- Miscellaneous Questions – Debbie Waite and Angie Dombrowicki
  - Goal: DHS staff will respond directly to questions received from consortia staff, but wanted to share answers on some key issues with broader group today.
  - Clarification of Roles and responsibilities of Navigators and CAC's – Bill Hanna working on informational piece.
  - Expensing / reimbursement of worker activity on Marketplace applications– DHS is awaiting CMS direction and will share in admin memo.
  - Impact of ACA on fraud (OIG) and Child Care (DCF) – will be addressed in upcoming Operations Memos
  - Are individuals @ 100-133 % of FPL eligible for tax credit? Yes, as long as not eligible for other coverage.
  - For third parties paying above 100% but below 200%, is it a tax event? No.
  - How will payment for members' insurance coverage through FFM be made? Individual insurance companies will determine this process.
  - Will BC+ families continue to be enrolled in an HMO? Yes.
  - Is returned mail going to CDPU? Yes, not to the consortia.
  - For the letter mailings mentioned previously, will the mailings be dropped at one time or staggered? Will be staggered starting the week of 9/23/13 – likely daily mailings.

4. ARRA and COLA Impact on FoodShare Benefits – Angela Waltz (Handouts)
   - Planning and Communication
     - Operations Memo sent 9/9/13 for changes taking effect October – November. Revised on 9/17/13 to avoid early notification when no way to advise of reason.
     - Stuffer mailing is starting 10/7/13 to be completed by 10/15/13. (Stuffer does not reference "Thrifty Food Plan.")

- CCA Call Flow message now being reviewed to determine where to position in order.
- Q&A Document – consortia encouraged to use this as background to respond to customer questions

5. Draft of Lobby Services Admin Memo – Lisa Hanson & Elizabeth Jungers (Handouts)
   - Draft amends current version of lobby services memo (12-02)
   - Cover email sent with draft explained the major changes, provided clarification of points, implications of marketplace activity. Interpretation services were not in the original Admin Memo and are now included.
   - Question: Must receptionist have to know all the answers for people who come into the lobby/welcome area? Could the receptionist/person greeting guests call an IM worker to address the guests' questions at the worker's desk? Answer: Yes.
     Consortia suggested re-working language to reference "someone," not necessarily a receptionist.
     Consortia raised issues about having limited lobby space and computer access available to support all IM programs. Enrolling through FFM is a lengthy process; could prevent someone from applying for or making changes to other programs, such as FoodShare. Response: intent of language is to comply with CMS' "no wrong door" strategy.

6. Consortia Feedback – All
   N/A

7. Operations Memos – Linda Auchue
   - Updates to Workload Dashboard, CARES Inbox Search and IM Management Reports – won't see changes until after 10/18/13 due to FFM applications.
     - Can search Inbox on an FFM application.
     - App Summary – an indicator showing Long Term Care need. Will have to work with Aging & Disability Resource Centers (ADRC's) to determine whether member has already been through an ADRC.
     - Changes to Core Plan – will no longer collect fees for renewal; all fees waived after 9/28/13. HP will issue refund if fee is received after 9/28/13.
   - Lobby Services – additional feedback will be taken on draft admin memo language.
   - BC+ Policy Changes and Systems Updates – targeting first week of October – memo is up to 45 pages in length.
   - Others – more Ops memos may be coming; IM workers should check any updates regularly.
   - CARES Issue in Bay Lake Consortium in which CARES was operational to 9:00 p.m. but ECF was not available after 8:00 p.m.
     Action Item: Jenny Hoffman to send issue for investigation to CARES Call Center to Linda Auchue's attention.

- Divestment Changes - On 9/18/13, Legislative Review Board looked at all divestment provisions except 1) changes to promissory note (to presumptive heir) and 2) transfer of homestead. Fratney Miller developed Operational Memo; now being routed for approval. User Acceptance Testing (UAT) next week, which will enable screen shots for illustrations. Ops Memo will contain effective date of changes.

8. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    a. IMAC IT Update – Review CARES Schedule – Tricia Janssen
    b. All other updates on handout
        - Fraud & Program Integrity – Mike McKenzie shared:
            - ChildCare Overpayment Letters / Notice – Department of Children & Families (DCF) alerted Mike to issues with notices issued by O'Brien & Associates. Contracts are between the agencies and O'Brien & Associates so OIG can only offer to assist agencies as it has successfully done in the past. Conflicting info coming from DCF about whether issue has been resolved.
            - 2014 FPI – published today; new fraud consortia will be formed as a result. Mike encouraged consortia to contact him or Wendy Metcalfe with any questions. They will work with consortia to help position the contract in each consortium.

9. Other / Public Comment
   N/A

10. October 17, 2013 Meeting Tentative Agenda Topics
    a. PPACA Update and Issues
    b. DDB Issues & Discussion (DDB Staff)

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

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INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC) MEETING

Thursday, October 17, 2013
12:30 – 3:30 p.m.
Central Wisconsin Center / 317 Knutson Dr. – Murphy Commons / Madison WI 53704
Or online at https://connect.wisconsin.gov/imac/
For audio, dial 888-273-3658, then access code is 645-0020.

MINUTES

Non-State Attendees:

Kris Parkansky, Bay Lake / Marinette Co.	Joanne Ator, Bay Lake / Door Co.
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Roby Fuller, Southern / Crawford Co.	Cece Fishnick, Southern / Grant Co.
Marlin Harms, Southern / Iowa Co.	Marjean Sutherland, Southern / Lafayette Co.
Carla Haigh, Southern / Rock Co.	Tricia Wavra, Western / LaCrosse Co
Adelene Green, WKRP / Kenosha Co.	Hope Otto, WKRP / Racine Co.
Linda Alexander, HP	Angie Dombrowicki, HP

State Attendees:

Linda Auchue, DHS	Kozue Bush, DHS
Dale Crapp, DHS	Sara Edmonds, DHS
Tricia Janssen, DHS	Cole Johnson, DFS
Elizabeth Jungers, DHS	April Heim, DHS
Hannah Knouse, DHS / MilES	Wendy Metcalfe, DHS
Tiffany Orcholski, DHS	Ed Ossman, DHS / DDB
Shawn Smith, DHS	Tony Trout, DHS
Debbie Waite, DHS	

1. Administrative Issues – Debbie Waite and John Rathman
   Per usual procedure, remote attendees email Linda Alexander of attendance.

2. Plan for Approval of September 19, 2013 Minutes – Debbie Waite
   September 19, 2013 meeting minutes have not been reviewed / approved by Secretary's Office yet. Will send September and October, 2013 minutes for review with the meeting materials for the November 21, 2013 meeting.

3. PPACA
   a. Marketplace Issues – Craig Steele
      Monitoring closely. PPACA team relies on consortia feedback. Pass along any feedback that you believe the PPACA team should be aware of/could use to provide marketplace information to CMS. Send to Craig Steele or Debbie Waite.
      Action Item: Consortia / staff to send Craig Steele an email to get direction on how to respond to any question they cannot answer.

      i. Update on Direct Call Process
         - Follow-up calls to confirm receipt and understanding of the four letters sent to the various segments/groups. Directing anyone who has had a life event change to call consortia.
         - Outreach Strategy:
           - Automated Health Systems, Inc. calls began to Letter 1 recipients. AHSI reported that in the first two days, 10,000 calls were made; 27% of calls answered; 20% confirmed receipt of letter.
           - Will make 3 attempts to reach; on third attempt, will leave a message (if possible), asking the member to call the consortia (county) to advise on BadgerCare Plus coverage.
           - Will complete Letter 1 calls before beginning calls to letter groups 2, 3 and 4.
         - Calls to Letter 2 recipients delayed from 10/1 to 10/15 until CMS approves waiver. (Meeting weekly with CMS and close to agreement.)
         - Feedback on calls thus far: Concern about tone of the messages, rude behavior, sound / 'speaker phone' quality of call.
         - Calls try to verify contact person's month of birth but not required to get it. Question: If primary person is unavailable, may the secondary person (in one case, the number called was wife's cell phone) provide the primary person's month of birth?
           Action Item: Craig Steele will investigate and advise.

      ii. Paper Applications
         1. Timing and Method of Processing – After application, CMS says member will receive notification "promptly and without undue delay." With the exception of fraud or ineligibility, in the first 3 months CMS will accept all applications; will not be held to MA or CHIP standards. Once entered,

member receives either a letter or a call. If no errors, member receives a letter; if any errors, questions, the member gets a letter and a phone call to follow-up. Member does *not* need to create an account if applying via paper or phone.

2. Which Version to Use – see links on CMS webpage
    a. Short form for single adults only (seeking financial assistance)
    b. Standard form for families
    c. Single adults not seeking financial assistance
    CMS had contracted with a third party dedicated to processing paper applications (entering into healthcare.gov).
    Action Item: Craig Steele will research what happens if applicant submits the wrong form and advise of findings.

3. Duplicate Applications
    CMS says no way to prevent duplicate apps (e.g., paper application and an on-line application). Uncertain how the paper application can be entered into the on-line system; if app is already present on-line, the application being entered by the third party or the member will not be accepted.
    Assume BadgerCare Plus eligibility has been determined through the Federally Facilitated Marketplace (FFM) – implementing two new codes.
    Process any application that comes through ACCESS (but need to check date of application to determine if any previous application date).
    Consortia reviews application dates (FFM sends to consortia's inboxes vs. ACCESS application date – which came first?)

4. Mailing Paper Applications
    CMS advises that consortia should not send the application for the member. Until change in direction, have the member mail his/her application.
    When group questioned about helping the member by mailing the form, Craig said he would check but he believed that CMS did not recommend it.
    Action Item: Craig Steele will follow-up and let the consortia know because the question was raised and consortia are used to helping the members.
    Later mentioned that CAC training emphasizes that the consortia staff should NOT mail for the member. (No action item necessary.)

iii. Update on CMS Website Local Help Feature
- Government shut-down delayed the loading of the contact information of the consortia.
- Zip codes of county agencies were used in a search function.
- Default search radius is 100 miles, which is challenging. Able to get access to test site to review and validate.

- State-specific language is not used on the CMS / FFM site. (E.g., if a WI Zip code entered, text does not reference Badger Care Plus.)

iv. Email Access in Lobby for Marketplace Accounts
- Consortia IT security protocols do not allow people who apply to set up email accounts or they block access to popular email sites.
- Healthcare.gov application requires applicant to either have an email account or set up one when they apply, using one of the links on the healthcare.gov page.
- CMS guidance from Jessica Kahn, Division of State Systems – if computers used to help people apply, they "should not block access to these email sites."
- Various situations in consortia offices – filters, blocking software, in some cases, had to be disabled. (All filters in Capitol Consortium had to be removed.)
- Only two sites allowed on the lobby-office computers are ACCESS and healthcare.gov.
  Action Item: Amy Mendel-Clemens will provide details to consortia about how Capital Consortium handled the blocking and filtering with its software to enable members to set up accounts.
- Discussion / ideas: Could texts to cellphones by used to send validation instead of establishing an email account? Suggestion to have consortia select one mail service and have members create their account in that mail service in order to get their validation email.
  Action Item: Craig Steele will send his email to consortia regarding requirements for ability to receive the verification.
- All action items and resolutions will be addressed at the November PPACA teleconference.

v. Marketplace Refusing to Accept Phone Applications
- Reporting just a few instances. CMS has no policy that forbids accepting another application even if one has already been submitted.
- Gather as much information as possible about the instance: Name, ID#
- Is it possible that the refusal was to create an account? It's not necessary to create an account if the application is paper or by phone.

b. Regional Enrollment Networks

i. Status of website: e4healthwi.org – Centralized information about Regional Enrollment Networks; setting up resources and news of events.
REN Directory has been pulled down for now. However, a "Contact" link is available that connects to Craig Steele.

ii. Other updates – Regional Enrollment plans are due tomorrow, 10/22/13. Not for approval, just in providing assistance from the Area Administrators.

Action Item: Consortia to email Craig Steele with ideas on how to improve the site.

- AmeriCorps staff in consortia has been charged with collecting the plans. See the website for contact information for them.
- Steering Committee – how involved have members been?

Action Item: Consortia to email Lisa Hanson with dates of events until she can create a button for posting to a calendar.

- Agents/brokers list will probably be available on the e4healthwi.org site next week.
- Office of Commissioner of Insurance (OCI) is updating broker/agent lists and will post to their website. Adding county information. Working with DHS and the staff updating e4healthwi.org to match up agents/brokers who have completed training.
- Capital Consortium has developed a web page showing what is going on in each of the counties in the consortium.
- AmeriCorps staff had varying start dates. Elizabeth Jungers (Area Admin) advised consortia to review the REN purpose for clarity on the AmeriCorps staff's roles. Consortia recommend that assessment of effectiveness be addressed at bi-weekly REN operational meetings. Consortia feel pressure from local media who are asking why the county human services staff is not taking the lead as is typically their role. Communication with AmeriCorps staff is key; remember to include them so that they can support more effectively.

  Action Item: Lisa Hanson will contact the any consortium that expresses a need and discuss how they could be best supported.

c. PPACA Operations Memos – Linda Auchue
   i. Ops Memo 13.32 - BadgerCare Plus Policy and Systems Changes. Error on page 26 – SSI eligibility. Have received 6 calls from advocates under the impression that DHS is disregarding all SSI income. Page screen print had error. Ops Memo being reissued.
   ii. FFM Application Processing – in work. Presumptive eligibility and adult/care-taker eligibility
   iii. Eligibility for children – making calls to parents of 26 children to advise them to apply through ACCESS in order to keep their needed prescriptions. Would be approved for BC+ for children at 300% Federal Poverty Level (FPL).
   iv. Walk-on hand-out advising of lock box closures – some counties are still sending Core plan premiums to the closed out lock box address. Lock box for Basic Plan premium also being closed 11/27/13. Any premium sent to the defunct address will be returned.

   Action Item: Linda Auchue will send remote attendees a copy of the handouts with the two lock box addresses being closed.

d. Roundtable – PPACA & Marketplace – Facilitated by Amy Mendel-Clemens & Debbie Waite
   - *Capital Consortium* – Quality Health Care (QHC) provided bank of phones and CAC's. Also Dane County United Way is providing help in subsidizing premium

payments. Since 10/1/13, consortium has had 230 customers. To date, seven customers have completed entire application process; have not yet selected QHC. Consortium staff has 65 names to call once the Federal website becomes more stable. Some members came to site to see if subsidized coverage was cheaper than private insurance. Word is out that the Federal website is not working. Holding enrollment fairs on Thursdays from 1-6 p.m. Richland County brokers have been contacted so that members can be forwarded to them.

- *Southern Consortium* –New REN / AmeriCorps staffer heading up Rock County providers' meeting. Iowa County holding two informational sessions on 10/21/13 and 10/30/12. Holding open lab to help people enroll as well as connect with insurance agents. Not experiencing much traffic or many phone calls. Lafayette County has a meeting scheduled this month at a high school.
- *Moraine Lakes Consortium* – not experiencing many phone calls or walk-in traffic. Fond du Lac County had about 30 people interested. In Washington County, not much interest in REN's; need to provide a list of agencies to invite to REN events. Email access in lobbies for establishing accounts is an issue for other counties.
- *Western Consortium* – Has a regional webpage. Counties opening doors for appointments. Insurance agents are assisting community members even when they will not necessarily be compensated. FFM (website) seems to be getting a little faster.
- *Bay Lake Consortium* – Steering Committee meets each Monday to discuss/share what works, what does not; using common materials and sharing best practices. In Door County, a coalition with libraries, non-profits, clinics, hospitals. Also have implemented a successful tracking system for each applicant. Rumors that BadgerCare was ending were dispelled. League of Women Voters facilitated an informational session about PPACA.
- *Great Rivers Consortium* – Coordinating locally with providers. No CAC's in 10 counties. Events being planned in conjunction with hospitals, clinics. Have handed out paper applications but now wonder if this is a good approach.
- *IM Central Consortium* – REN's working with 211 agencies (except Langlade County). Fairs and info sessions are posted on websites. Five more CAC's planned.
- *East Central Consortium* – Similar to Capital Consortium, subsidized funding being offered through United Way / a church group. REN meeting regionalized – eastern and western counties. Green Lake County has held 3 town hall meetings and one more scheduled. In this area, only one option for healthcare provider and one clinic that uses that provider. Invited 200 and only 4 attended. Marquette County has similar situation but no DeanCare providers in the county.

  <u>Action Item</u>: Craig Steele to investigate/research lack of providers and how to register concern about this situation and to whom.

  First meeting of REN is on Monday, 10/21/13. Winnebago County reports a trickle of activity.

  Rumor that Kaiser Family is advising that anyone at 100-138% FPL is no longer eligible for subsidies.

Action Item: Craig Steele will investigate the IRS ruling on this and clarify for the consortia.

- *Northern Consortium* – Three kick-off meetings held. To date, Steering Committee has not met. Have had very few calls. Community centers are assisting with questions, usually due to questions about FoodShare. Would like assistance with town hall meeting.
- *WKRP Consortium* – Have held five REN meetings with about 90 people attending. Interest dwindling. In Kenosha County, about 50 people have come in to try to get into the FFM website. Held a meeting with a panel of four providers; navigator introduced herself and offered her help. AmeriCorps staffer now part of scheduled events. In Racine County, similar experiences. Noted browsers Firefox and K-9 successful in being able to log into FFM.

e. IM Worker Process for Security Requests – Angie Dombrowicki, Debbie Waite
   - Per Debbie Waite, found through experience that it is easier and faster to process a large number of users/workers more quickly by using the previous process. As a result, changing back to the previous process; whole new set of security requirements received from CMS. Should experience a smaller volume of new workers now that most of the current workers are handled.
   - Feedback on the new forms – easier to use. Some people have found it valuable to save the .pdf's as a Word document for new requests; consortia/counties have created templates as well.

f. ACA Performance Reporting to CMS (Handout) – Sara Edmonds
   - High level overview of performance reporting.
   - See handout for details.

4. Impact of Federal Government Shutdown – Shawn Smith
   - Per Shawn, per FNS, FoodShare benefits were to have been withheld as of last Friday (10/11/13) but now that Federal government shut-down is over, status quo.
   - Heads up that in January, 2014, new debt ceiling deadline is looming. Could suspend payments, but not change eligibility.
   - Request from consortia: Could DHS craft a message of no changes to FoodShare? Worry about confusion especially with a decrease in some benefits in November, 2013.

5. Processing Discrepancies – Linda Auchue & Paul Michael
   - In reaction to review by Legislative Audit Bureau (LAB) of cases in which it could not be determined whether the issue had been resolved due to lack of worker comments on the case file.
   - Second Party Review staff will review cases for lack of worker comments and notify consortia of need for more detail. Discrepancies for cases with dual eligibility – send any to CARES Call Center.

6. Prisoner Match Cost Savings Results (Handout) – Tricia Janssen
   - Stats for January-June 2013.
   - See handout for details.

7. CARES Prioritization Process (Handout) – Tony Sis
   - "System Fixes and Enhancements" handout. Does not include CDPU (Centralized Data Processing Center) or CCA (Call Center Anywhere).
   - Updated issues and prioritized – Team reviewed and provided feedback at 10/13/13 meeting. Debbie Schwandt is the keeper of the document – made changes and sent to team members for distribution to the consortia IT contacts. Make sure to leave duplicates or completed projects on the report.
   - By 11/16/13 feedback is due; will then reprioritize based on input from consortia IT contacts.
   - Other data element that should be added: project size.
   - FamilyCare needs to be added.
   - Next step: Re-ranking based on overall feedback

8. Call Center Anywhere (CCA) Infrastructure Planning – Paul Michael
   - Department of Administration sent document about changing vendors.
   - DOA also sent an email asking for input/feedback on developing RFP for the call center application. "What is your wish list?"
   - An opportunity for consortia to provide needs, wishes. The email was sent to CCA Sub-committee members for discussion on 10/12/13.
   - Further input/discussion on what CCA features are popular/effective, which features were undesirable/unpopular. Consider everything 'in scope' at this point.
   - Please provide your feedback today, tomorrow or by Monday, 10/21/13.
   - Email sent to Operational Leads and CCA sub-committee members.

9. CARES Availability Update for Remainder of 2013 – Tricia Janssen
   - Schedule updated with expanded hours.
   - 11/16/13 – unavailable due to MAGI changes being implemented.
   - Monitoring closely, especially close to 11/18/13. Please report any issues as soon as possible in order to enable DHS to troubleshoot.
   - Close monitoring of batch processing. May need to adjust schedule based on outcomes from monitoring the batch performance.
   - Department of Workforce Development (DWD) sends DHS emails about any performance issues reported.

10. Disability Determination Bureau Issues / Discussion – Accessing ECF for Information – Ed Ossman, Debbie Waite and Tricia Janssen (Handout)
    - Defer to November.
    - Identifying any systems issues that should be addressed. Please review and bring any ideas, issues to next meeting.
    - Alternative: if a small group would like to propose solutions to identify issues, please advise Debbie Waite.
      Action Item: John Rathman, Capital Consortia rep and WKRP rep to identify group to work on this and email Debbie Waite with suggestions for other members of group.

11. Informational Handouts

    a. HIPP – Autumn Arnold is policy expert. Are these policy issues? Various questions have come from members; need assistance in addressing the member questions.
       Action Item: Amy Mendel-Clemens will email Linda Auchue to send a copy of the process to follow.

    b. HCTC

12. Consortia Feedback – All
    - Ops Memo on Lobby Services – still unresolved; either seventh or eighth draft. What are FNS issues/requirements about transferring calls? Very difficult for smaller agencies. OK to delay memo to next month, per Elizabeth Jungers.
      Action Item: Debbie Waite to provide the latest draft to consortia and to Area Admins.

    - Fair Hearings Decisions. Rachel Witthoft is contact for providing feedback on hearing administrative law judges. DHA issue – being billed for attorney time that was not allowable.
      Action Item: Consortia to send Rachel Witthoft recent examples of issues with administrative law judges.

    - FoodShare Bonus – Recommend that bonus goes into 2014 contract. Need a week for consortia to be able to communicate this to counties in their consortium.

    - FFM Website Performance – Implications for ending current BadgerCare coverage with issues preventing applying for PPACA. Can Wisconsin extend BadgerCare for a month or more? Any news on this? Options are being evaluated now.

13. Operations Memos – Linda Auchue
    - Child Support Deduction – BEPS supported policy but overruled by FNS. Make sure workers change amounts.
    - ECOW – Eligibility on Web
    - Divestment Changes – Elder law attorneys sent a communication to Aging & Disability Resource Centers (ADRC's) which caused questions from the ADRC's to the consortia. Effective 11/1/13, change to community spouse divestment within 5 years of institutionalized spouse. Also, no longer any partial payments from families. Able to pull in information Automated Verification System (AVS) from insurance agents, financial institutions. Requiring community spouse to sign application ameliorates the 'just say no' loop hole. Also addresses insurance riders added to face value to avoid qualification for higher amount. Promissory note issue did not pass with this law. Goal is to have this Operations Memo out next week.
    - CARES Correction – Part B added back in – will run a report of cases affected to help consortia identify those cases needed review, correction.

14. Administrative Memos – Debbie Waite
    - RMS during CAC training – "Ping" of RMS during 2-day CAC training. Portions of that time could still be subject to partial claiming.

15. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    a. IMAC IT Update – Tricia Janssen – Unable to provide due to length of meeting.
    b. All other updates on handout

16. Other / Public Comment
    N/A

17. November 21, 2013 Meeting Tentative Agenda Topics
    a. PPACA Update and Issues
    b. WFCAP Applications / Burial Information Tool/Template
    c. 2013 MER Results

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

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State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC) MEETING

Thursday, November 21, 2013

1:00 – 3:30 p.m.

Department of Agriculture, Trade & Consumer Protection – Board Room

2811 Agriculture Drive / Madison, WI 53718

Or online at https://connect.wisconsin.gov/imac/

For audio, dial 888-273-3658, then access code is 645-0020.

MINUTES

Non-State Attendees:

Jenny Hoffman, Bay Lake / Brown Co.	Joanne Ator, Bay Lake / Door Co.
Kris Parkansky, Bay Lake / Marinette Co.	Melissa Duane, Capital / Columbia Co.
Amy Mendel-Clemens, Capital / Dane Co.	Tony Sis, Capital / Dane Co.
Sheila Drays, Capital / Dodge Co.	Stephanie Ronnfeldt, Capital / Richland Co.
Liz Mahloch, East Central / Sheboygan Co.	John Rathman, East Central / Outagamie Co.
Lynn Brenner, East Central / Calumet Co.	Diane Voth, East Central / Marquette Co.
Tim Gessler, East Central / Sheboygan Co.	Chris Machamer, East Central / Waupaca Co.
Roxann Binkowski, East Central / Waushara Co.	Stacy Engel, East Central / Waushara Co.
Ann Kriegel, East Central / Winnebago Co.	Linda Struck, Great Rivers / Eau Claire Co.
Ronda Brown-Anderson, Great Rivers / St. Croix Co.	Jane Huebsch, IM Central / Marathon Co.
Amy Mayo, IM Central / Oneida Co.	Mandy Mayek, IM Central / Portage Co.
Rachel Pantaleo, Moraine Lakes / Ozaukee Co.	Sandy Potter, Moraine Lakes / Washington Co.
Luann Page, Moraine Lakes / Waukesha Co.	Doreen Lang, Northern / Wood Co.
Marlin Harms, Southern / Iowa Co.	Marjean Sutherland, Southern / Lafayette Co.
Carla Haigh, Southern / Rock Co.	Lori Graff, Western / LaCrosse Co.
Debbie Schwandt, WKRP / Kenosha Co.	Hope Otto, WKRP / Racine Co.
Nicole Brooks, WKRP / Racine Co.	Charles Friedrich, CMS
Roger Ingebritson, CMS	Audrey Mattison, CMS
Linda Alexander, HP	Angie Dombrowicki, HP
Sara Diedrick-Kasdorf, WI Counties Association	

State Attendees:

Abby Abernathy, DHS	Linda Auchue, DHS
Sara Edmonds, DHS	Brian Fangmeier, DHS
Bill Hanna, DHS	Lisa Hanson, DHS
Cole Johnson, DFS	Elizabeth Jungers, DHS
April Heim, DHS	Donna King, DHS
Hannah Knouse, DHS	Tiffany Orcholski, DHS
Allison Shabino, DFS	Shawn Smith, DHS
Tony Trout, DHS	Debbie Waite, DHS

1. Administrative Issues – Debbie Waite and John Rathman

   - Per usual procedure, remote attendees e-mail Linda Alexander of attendance.
   - Reminder that December 2013 ESPAC and IMAC meetings are at the Department of Agriculture, Trade and Consumer Protection.
   - Debbie Waite introduced Charles Friedrich of the CMS Chicago Regional Office located in Madison. Charles, in turn, introduced colleagues Roger Ingebritson and Audrey Mattison and gave a brief overview of the role of CMS in working with DHS in the common goal of serving citizens in need of assistance.

2. Approval of September 19th and October 17th Minutes – Debbie Waite

   - Debbie noted that recently, meeting minutes have been much more extensive and detailed, requiring more careful review and approvals. The October and November meeting minutes will be issued with the December meeting materials for the group's review and approval.

   - Linda Alexander noted a change to the September minutes (Federally **Facilitated** Marketplace, not "Funded"). Motion made to accept the September 19th meeting minutes with this change, seconded; approved by voice vote.

3. 2013 MER Results and 2014 Planning – Lisa Hanson, Elizabeth Jungers & Sara Edmonds (Handout)

   - Elizabeth Jungers walked through the presentation slides

   - Consortia had the following questions and feedback, from the ESPAC morning session regarding 2013 MER results:

     Question: How did the number of 2012 corrective actions compare with 2013?
     Answer: 2012 = 120 and 2013 = 154. (Same number of cases were reviewed)

     Question: Are errors being tracked by IM workers' length of experience or training received?
     Answer: Not at this time; only tracked by function title.
     Comment: If tracked, this could help evaluate effectiveness of new IM worker training. Per Sara Edmonds, great suggestion if possible to segment.

     Consortia would like more detail of results by county as well as overall consortium. This will help them address the specific areas where improvements are needed.

Best practices were not included in the MER results reports that the consortia received even though the presentation had a "Positives" page that mentioned a few. Why were consortia asked to share this if best practices were not included in the report?
DHS Response: MER assumes that if no comment / need for improvement, the consortia met the criteria.
Consortia Response: Then MER shows only negative items and no positives.

"Filing date" issue – even though workers explained the concept of a filing date, some may not have used that exact terminology with the customer.
Response: Best practice is to use the filing date terminology.

"Error prone profile" is a list of fraud prevention actions; confusion over the term.
Response: Best practice is to use the actual term.

Entrance meetings – consortia evaluated benefit of the meetings given the required travel and time; questioned if the entrance meetings were a good use of time, resources. DHS will reconsider for 2014.

Consortia noted discrepancies / inconsistencies among consortia in requirements for correcting issues, including the level of documentation required. DHS: Will be addressed for 2014 MER planning to insure consistency and adequate training.

- Lisa Hanson, Sara Edmonds and Elizabeth Jungers will incorporate this feedback into the 2014 MER planning. Goal is to streamline the 2014 MER process. Sara encouraged all to send additional feedback to Lisa, Elizabeth or herself.

- Consortia asked if timetable for MER visits could take into account anticipated heavy workloads during first part of 2014.

4. SNAP Funding Under Continuing Resolution – Sara Edmonds

- FNS has provided information about how SNAP benefits and the other categories of funding will be affected under the continuing resolution, should a funding lapse occur again on January 15, 2014. In accordance with the Continuing Resolution and OMB guidance on the funding provided, funding will be provided for each of the categories of SNAP funds as follows:

    - Benefits - through February 2014
    - SNAP-Ed - through February 2014
    - 100% E&T - through February 2014
    - 50/50 State Administrative Funding - through March 2014
    - 50/50 E&T - through March 2014

5. 349 Alert – Linda Auchue

- Linda noted that this was an important topic which would have been particularly critical this month had DHS proceeded with the November 18 scheduled batch processing for cases to implement the BC+ changes. Cases that had 'Exceptioned at Batch' (349 alert) then have to be run manually.

- Any case that is identified with a '349 alert' does not go through the batch process and remains open under the current program until eligibility is run by the worker. This means when DHS converts to MAGI next February, individuals will remain eligible under the old rules until the worker runs the case. If the case is not run, individuals will be incorrectly eligible for BC+ under the old rules, including the new income limits.

- Upcoming batch runs which will generate the alert:

  COLA Update – 1st week of December, 2014
  FPL Update – 1st week of February, 2014

- If no action is taken within six months, the alerts are no longer sent. As one example, a case continued to incorrectly receive FS benefits for 2 additional years because the case continued to exception at batch and eligibility was never run by the worker.

  Action Item: Consortia should remind IM workers to act on all 349 alerts prior to the next batch run or Adverse Action.

6. Medicaid QC Update – Brian Fangmeier (Handout)

- Brian reviewed high points of the CMS instructions on piloting the new Payment Error Rate Measurement (PERM) Pilots required for the implementation of the MAGI policies associated with ACA.

- The State's first PERM Pilot proposal is due to CMS by 12/31/13. The period of review will be for MAGI determinations made from October, 2013 through March, 2014. Samples of cases will be 85% Medicaid and 15% Children's Health Insurance Program (CHIP).

- Some expectations for the first pilot: Review a minimum of 200 cases. Determine error rate, analyze error rate data, develop corrective action strategies and report to CMS. Run 10 test cases provided by CMS through the CARES system. If no errors are found, no further action is required. If errors are found, make corrections to the CARES system and run through CARES again.

- CMS is due to publish national and state specific data on FFY 2012 PERM error rates in the next few weeks. Once that occurs, Wisconsin will submit its FFY 2012 PERM corrective action plan to CMS. The MAQC Section will analyze error data and provide consortia with break downs of error causes by elements of eligibility (e.g., income).

- Discussion and questions:
  Question: When can consortia expect to see FFY 2012 PERM reports?
  Answer: Probably sometime in December, 2013.

  Question from Charles Friedrich, CMS Office in Madison to Brian: What are your initial thoughts, reactions to the proposed pilots?
  Response: A good plan and MAQC will be anxious to get underway once Wisconsin's plan is approved by CMS.

7. PPACA – Remaining Issues from November 20, 2013 Sub-committee Meeting – Debbie Waite on behalf of Craig Steele

- What we know: Governor Walker does not want transitioning members to experience a coverage gap due to technical issues being experienced at healthcare.gov and will convene the legislature to act on a proposal to extend their coverage under BC+ until April 1, 2014. That triggers many questions to which the answers are not known at this time.

- DHS in continuous discussion with CMS about policy issues and Deloitte about technical and systems issues that must be addressed in order to be able to implement a delay.

- Special legislative session to vote on Governor Walker's proposal in December, 2013.

- DHS would like to hear from consortia about what tools would be helpful to them to support this change in plan.

- At PPACA sub-committee meeting, consortia identified some areas of interest which they discussed in more detail in a follow up meeting. Results of that discussion will be shared with DHS in written form in the next few days. Areas of interest were:

  (1) Consortia making outbound calls to groups most affected by the proposed changes. For purposes of identifying what data/member lists would be most useful for this purpose, consortia were asked to
  (a) Identify the groups
  (b) Prioritize order for contacting groups
  (2) Prioritizing the development of more targeted messaging to members affected by the change in plans.

(3) Having more and earlier input into the creation/development of member letters and notices.

- Consortia also asked to have more input into the overall communication plan

  - Charles Friedrich was asked about the expected timetable for resolution of remaining issues between DHS and CMS Response: Although the situation is still very fluid, he assured the group that all hands are on deck, working very hard to achieve the goal of insuring that coverage remains in effect without interruption.

  - A comment was made about the need to keep recent training fresh for IM workers. Response: Training Section is working on strategies for some updated scenarios and refresher training. Survey went to Training Leads for feedback on refresher training and mandatory/optional.

8. Consortia Feedback – All

- John Rathman shared these items from the 11/21/13 ESPAC Meeting:
  - Updates/status of 2014 FSET Contract – Very anxious to meet; December 11th meeting should not be cancelled.
  - Update/status of 2014 IM Contract – Question was asked about status of DHS responses on contract issues.
    Response: Official response shared with WCHSA attorney on November 1.
    Consortia response: Was not shared with negotiating committee.
    Follow up: DHS will distribute to negotiating committee members. (Note: This was done November 22)

  - Pilots for Random Moment Sampling (RMS) – Can RMS on-line roster update be used? Consortia received request from Kozu Busch asking for volunteers to participate in pilot; would like an overview of the pilot project before volunteering. RMS as possible December 2013 IMAC agenda topic.

  - Regional Enrollment Networks (RENs) – Need follow-up, especially in DHS outreach; improving but still need more attention and concerted effort.

9. Operations Memos – Linda Auchue

- FFM Application Processing – includes updates to policy. Will review and update content once new plan and process are clear given transition delay

- Paper Application Forms
  Action Item: Linda Auchue will re-send the communication referencing the paper application forms that the DHS Communications Coordinator had sent to the consortia leads, asking the leads to disseminate to the county contacts.

(NOTE: Additional communication regarding the forms has been sent since the meeting.)

Question: Which forms should the consortia use: new (which contain information the consortia still needs to collect) or can the old ones be used?
Answer: Old forms can be used

Action Item: DHS will check distribution lists to make sure each county has a forms coordinator. Consortia asked that forms be sent there instead of to operational leads.

(Note: Additional instructions for forms have been communicated since the meeting).

- Presumptive Eligibility Changes – also pending finalization

- Divestment (Community Spouse) – issued as Ops Memo 13-38. Forms and publications will be updated in the near future.

- Estate Recovery Program (ERP) – Ops Memo 13-39. This has been issued but does not go into effect/is not being implemented until July, 2014. ADRC's are asking for training from consortia. Refer requests to the Office of Resource Development in the Division of Long Term Care (DLTC).

10. Administrative Memos – Debbie Waite
    - No new at this time.

11. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    a. IMAC IT Update – Tricia Janssen
       Tricia Janssen was unable to attend/was not on the phone. Per Debbie Waite, the IT sub-committee is reviewing CARES priority list. Tony Sis confirmed that revised CARES Schedule was sent out, with a survey to follow, asking for feedback by 11/27-28/13.
    b. All other updates on handout

12. Other / Public Comment
    - None at this time.

13. December 19, 2013 Meeting Tentative Agenda Topics
    a. PPACA Update and Issues
    b. Fair Hearings
    c. Medicaid QC Information/Statistics
    d. RMS Pilots

Action Item: Consortia to send Debbie Waite names of staff that would be willing to work in a small group to address the DDB issues.

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Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC)
and
PPACA SUB-COMMITTEE MEETING

Thursday, December 19, 2013
1:00 – 3:30 p.m.
Department of Agriculture, Trade & Consumer Protection – Board Room
2811 Agriculture Drive / Madison, WI 53718
Or online at https://connect.wisconsin.gov/imac/
For audio, dial **877-402-9757**, then access code is **320-8369**.

MINUTES

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Rachel Pantaleo, Moraine Lakes / Ozaukee Co.	Carol Wicklun, Moraine Lakes / Walworth Co.
Luann Page, Moraine Lakes / Waukesha Co.	Sandy Potter, Moraine Lakes / Washington Co.
Doreen Lang, Northern / Wood Co.	Marjean Sutherland, Southern / Lafayette Co.
Carla Haigh, Southern / Rock Co.	Lori Graff, Western / LaCrosse Co.
Hope Otto, WKRP / Racine Co.	Charles Friedrich, CMS
Roger Ingebritson, CMS	Linda Alexander, HP

State Attendees:

Linda Auchue, DHS	Barbara Berlin, DCF
Jamie Christianson-Fawcett, DHS	Sara Edmonds, DHS
Brian Fangmeier, DHS	Bill Hanna, DHS
Elizabeth Jungers, DHS	Hannah Knouse, DHS
Wendy Metcalf, DHS	Julie Milleson, DHS
Jennifer Mueller, DHS	Tiffany Orcholski, DHS
Allison Shabino, DFS	Craig Steele, DHS
Tony Trout, DHS	Adam VanSpankeren, DHS
Debbie Waite, DHS	Pang Xiong, DHS
Julie Zastrow, DHS	

1. Administrative Issues – Debbie Waite and John Rathman
   - Recognized Liz Mahloch's pending retirement; today is her last IMAC meeting. All acknowledged Liz' accomplishments, dedication and sacrifices.
   - Per usual procedure, remote attendees e-mail Linda Alexander of attendance.
   - Reminder that January 2014 ESPAC and IMAC meetings are at the Department of Agriculture, Trade and Consumer Protection. Have also tentatively scheduled same location for February and March.

2. Approval of October 17th and November 21st Minutes – Debbie Waite
   - Motion to approve October minutes, seconded and approved by voice vote.
   - Motion to approve November minutes, seconded and approved by voice vote.

3. Patient Protection Affordable Care Act (PPACA) Sub-committee Update & Issues

   A. 3-Month Delay – Craig Steele
      - State Authority – Senate has convened but hasn't voted yet. Governor promises to sign immediately upon passage.

      - Federal Authority – Applied for extension of waivers; requesting approval of new waivers requires state plan amendment (SPA). Target is 12/20/13.

   B. Federal Marketplace Determinations
      - Enhanced Flat File – Initial file was provided to states in October, 2013. Received enhanced flat file last week. DHS will use only to generate letters – will distribute to consortia. Data in flat file continues to have some issues.
        Account transfers started Tuesday of this week; received six yesterday and one today. DHS is checking reliability of data and stability of transfer process.
        Will remain with the enhanced flat file until account transfer system is stable and reliable. Cumulative files are sent from FFM each Tuesday.

        Files coming from FFM also contain referrals, including anyone with a disability. Right now, it is difficult to interpret information in flat file – determinations versus referrals is an issue. Also cannot distinguish childless adults in flat file query necessary to determine reason for referral; not an issue for parents with children, which are clearly identified in the file.

        DHS is looking at way to share flat file information with consortia as they requested but need to work through PII issue.
        Question: Do consortia need social security number to adequately identify/match a case.
        Answer: Yes.
        DHS will continue to work on appropriate and protected methods to share flat file information with consortia.

- Assessment vs. Determination State
  DHS is still working with CMS on status and effective dates for being a determination or assessment state.
  Thus far, flat file shows approximately 23,000 Wisconsin applications.

  Some applicants say they are being asked to prove they're not eligible for BadgerCare. Document any cases of this, per Craig Steele. Example: Child support is largest part of income but it is not considered in determining eligibility.
  Some applicants are receiving notice from FFM indicating they are eligible for BC+ when they are clearly not. Advice: Make it clear to clients/applicants: "We are obligated to enroll you in BadgerCare if you applied between October 1 and December 31 and Marketplace determined you to be eligible – we have no flexibility to change that outcome."
  Also noted: in the flat file/account transfers, a referral is *not equivalent* to a determination.
  Question: What should consortia/counties do about applicants who are stopped before completing the process (before the eligibility screen/display) and told to contact their local agency?
  Answer: Please make a screen shot of these cases and send to Craig Steele for further investigation.
  Also noted: Applicants are getting a letter advising that the county/State cannot remove their application if it has been determined that the applicant is eligible.
  WI childless adults population concerned about lack of coverage for three months; all were expecting to be covered as of 1/1/14. To address, consortia want a script or help messaging to explain the situation.

  Action Item: Craig Steele will develop a script that the consortia can use with the childless adults which specifically addresses why this group cannot get coverage for 3 months.

  Consortia expressed confusion over terms "referrals," "assessment," "determination," "eligibility." Need a primer to explain so that consortia staff uses proper terms.

  Action Item: Craig Steele will provide a communication to the consortia with definitions and meanings of the terms most frequently confused; this will enable the consortia to communicate accurately and consistently.

  Consortia were thanked for working with the applicants that are being transferred. Many issues are surfacing: sometimes from a defect; other times, a user error – typically a combination of both.

C. Member Communications

- Letter 1A – "Member FYI Plus Tax Info Form" / Transitioning Members Letter; includes the Tax Info Form (enables a MAGI determination). If members complete and return the form, and are over income limit, DHS can do an automatic transfer to the Marketplace. Consortia can search on TFI code to address the cases that are in conflict; TFI code available after 2/15/14. This group has received two previous letters in late October/early November. The Consortia / counties can use this letter to contact members on the enhanced flat file.

- Letter 3A – Core Wait List Transition Letter. Reviewed and discussed draft of Letter 3A; consortia expressed concern about language in paragraph #2. Can this be changed? DHS staff will check if still timely.

- Letter 10 – This letter was generated directly from the enhanced flat file. Note that the language used in "Important Information about Your Application to the Federal Health Insurance Marketplace for BadgerCare Plus" is verbatim from the Federal Marketplace site.

- Additional Outreach Efforts
  AHSI, third party used for outreach calls previously, will renew efforts, contact members at the beginning of 2014. Identify transitioning members with moderate, high and very high morbidity scores and contact. AHSI also will continue with general calls for the first two weeks in January, 2014.
  AHSI will ask people contacted to verify month of birth. To date, 10% of those contacted refuse to verify.

- Other Communications Updates
  Charles Friedrich of CMS complimented Craig Steele about his ability to balance the expectations and requirements from CMS with needs of the consortia.

D. Federal Marketplace

- Notices and Help Desk
  FFM help is available through a URL, not a physical presence/desk.
  A temporary fix was installed to prevent Bay Lake Consortium phone number from showing on all notices. URL will replace the phone # for Bay Lake for about a month. Then, URL will be replaced by 1-800 numbers being developed by DHS which will give caller zip code option for transferring to appropriate consortia.
  Also noted: Marketplace Notices language change: "Department of Health Services / DHS" has been replaced with "BadgerCare Plus Program."

- Premium Payments
  Over time, insurers will improve and enhance their payment options. Some insurers are now working on systems that allow cash payments.

Question: Can a government entity pay the premium for a client? John Rathman shared that some counties may want to look at this option for certain populations like mental health clients.
Answer: Craig thought this was an acceptable practice but he will confirm.
Other examples of premium payment support: UW Health Foundation pays premium for those at 100-130% of FPL. Some providers providing premium payment through United Way.
Action Item: Craig Steele will research and report to consortia whether it is permissible for government agencies to pay members' premiums.

- In-Person Assisters
  Two companies contracted by CMS to help members in WI:
  Cognosante – has offices in Madison and Green Bay. Is looking for contacts at the Regional Enrollment Networks (RENs).
  SRA International – No offices in Milwaukee but does have an office in Janesville.
  Action Item: Carla Haigh will forward Craig Steele the contact information for SRA International.

  Another concern is that some insurance agents are charging to meet with members (rumor that the charges are $50-60).
  Action Item: Consortia to send Craig Steele any information, including as much detail as possible (case number, if known) about such instances or report directly to the Office of the Insurance Commissioner (OCI).

E. System Update – Linda Auchue
   - Original plan - PPACA effective 4/1/14. Negotiations with CMS resulted in MAGI and new income limits effective 4/1/14 for ongoing beneficiaries. New income limits and MAGI effective 2/1/14 for new applications for parents and caretakers. New applications on or after 2/1/14 will use MAGI rules but old income limits. Applicants can apply at the Marketplace and get coverage January 1st if application and premium paid by 12/31/13.

F. Work Timeline for Processing Applications – Linda Auchue (Handout)
   - See handout for detail.
   - After 1/3/14, all tax information will be in CARES (eligibility).
   - Childless who have been tested for March using MAGI rules, with income under 100% of FPL will be removed from files to prevent them from getting a letter telling them that they are not eligible.
   - Business requirements being developed now.
   - Elderly, Blind, Disabled (EBD) members removed from conversion file. Reports will be sent to the consortia after adverse action (AA) and the conversion is run of cases that have to be run and confirmed open for April.

G. Next Steps for Consortia

H. CCA Messaging – Paul Michael & Adam VanSpankeren (Handout)
- Discussed the handout; consortia would like Adam to update the document to include references to the specific letters (1A, 3A, 10)
  Action Item: Adam VanSpankeren will re-send the document today to all IMAC attendees/invitees, including the references to the mailed letters.
- Amy Mendel-Clemens strongly recommended that message #8 be moved to be heard first ("If you are calling for anything other than ACA, press ___.") Paul Michael will research how this change will affect the build of the system.
  Action Item: Paul Michael will research if it's possible to move message #8 to the first position in the call menu.
- Carla Haigh asked if any of the consortia had created an ACA-specific work group that addressed more focused training vs. overall general training in a larger group. No other consortia had created an ACA-focused training regimen or identified specific staff as ACA specialists. Calls answered in the order in which they come into the queue.
  Action Item: Consortia to provide any feedback/input to Adam VanSpankeren by noon on Friday, 12/20/13. (All changes must be interpreted and recorded, so this is a very tight timeline.)

4. Consortia Feedback - All
- January 2014 IMAC Meeting topics:
  - Random Moment Sampling (RMS) meeting w/DCF – outcomes, plans
  - Status of DDB Workgroup
- 2014 IM Contract – draft reviewed by tri-chairs; now in Bureau of Fiscal Services. After January, 2014, Brett Davis will sign and the contracts will be sent to the consortia signatories on file. Process improved by asking signatories to sign only page 2 of the contract, scan and email or fax back to DHS.
- 2014 FSET RFP was posted – FSET subcommittee meeting is on 1/7/14.
- Carry-over Funding for ACA and FoodShare – questioned whether consortia have to formally request a carry-over. Can it be carried over until it's spent?
  Action Item: DHS will provide clarification on carryover policy and process.

5. Operations Memos - Linda Auchue
- First Ops Memo on delaying system changes; however, policies behind the changes are effective 1/1/14. CARES and CARES Worker Web (CWW) will be updated 2/1/14 to reflect the changed policies. (Draft Ops Memo 13-43 handed out.)
  - No longer verifying pregnancy; don't need to ask questions about due date and number of fetuses.
  - Former foster care youth – upper limit is age 26

- Restrictive Re-enrollment Periods (RRP) for children who fail to pay a premium will now be for 3 months.
- Policies on WI residency, verification of citizenship/immigration status

- Second Ops Memo targeted to be issued in early January, 2014. Explains what will happen and when. Will include clarifications on policies. Also addresses what to do about extensions. As of 2/1/14, will use new rules (MAGI and income limits) for new applications. For continuing beneficiaries, use old rules and income limits. Some changes to continuing beneficiaries which causes the beneficiary to lose eligibility; must gather income / MAGI information to make a determination.

- Third Ops Memo scheduled for mid-January. Some of the same topics from Ops Memo #13-43. Includes Basic Plan member update effective 4/1/14. As of 4/1/14, everyone will be tested for eligibility using the new rules, income limits, MAGI. Also has instructions on how to complete verification form.

6. Administrative Memos – Debbie Waite
   - Two Admin Memos have been distributed to operational leads for comment - 2014 IM Consortia Administrative Allocation and 2014 FSET Admin Memo. Debbie Waite reported having received no feedback on either memo and asked if group was comfortable with DHS proceeding to publication. Was approved.
   - One Admin Memo is in development – 2014 ACA Administrative Funding. This memo will have similar language to the 2013 ACA Administrative Funding memo.

7. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
   - Additional update: Performance Management Sub-committee met yesterday (12/18/13). Discussed consortia's interest in having a forum for sharing Best Practices on how to use/interpret the management reports. Tony Sis and Hannah Knouse were asked to share some best practices at this forum which will likely be held in spring or summer.

8. Summary of Farm Bill Provisions (Handout)
   - Handout is a side-by-side comparison chart put together by the American Public Human Services Association which summarizes the key provisions of the pending Farm Bill.
   - Congress is still debating this bill in committee and no real movement has occurred on its provisions, including discussion of the Nutrition Title.
   - Per Julie Zastrow, expect more activity and discussion in mid-January.
   - Supplemental Nutrition Assistance Program (SNAP) proposals are stand-alone bills with House and Senate versions which vary in degree of funding cuts. These may be re-attached to the Farm bill but, for now, latest Continuing Resolution (CR) continues to fund under the old rules.
     Action Items: DHS staff asked to provide summary of House and Senate SNAP proposals.

9. Other / Public Comment
   N/A

10. January 16, 2014 Meeting Tentative Agenda Topics
    - PPACA Update and Issues
    - 2012 PERM Results
    - RMS Pilot Initiatives
    - Discrepancies and Alerts – Second Party Review Findings and Training Implications
    - Fair Hearings Process for Marketplace

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Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC)

Thursday, January 16, 2014
1:00 – 3:30 p.m.
Department of Agriculture, Trade & Consumer Protection – Board Room
2811 Agriculture Drive / Madison, WI 53718
Or online at https://connect.wisconsin.gov/imac/
For audio, dial 888-808-6929, access code 468-5307.

Non-State Attendees:

Jenny Hoffman, Bay Lake / Brown Co.	Joanne Ator, Bay Lake / Door Co.
Kris Parkansky, Bay Lake / Marinette Co.	Amy Mendel-Clemens, Capital / Dane Co.
Tony Sis, Capital / Dane Co.	Sheila Drays, Capital / Dodge Co.
Stephanie Ronnfeldt, Capital / Richland Co.	John Rathman, East Central / Outagamie Co.
Tim Gessler, East Central / Sheboygan Co.	Chris Machamer, East Central / Waupaca Co.
Kate Surprise, East Central / Waushara Co.	Ann Kriegel, East Central / Winnebago Co.
Linda Struck, Great Rivers / Eau Claire Co.	Ronda Brown-Anderson, Great Rivers / St. Croix Co.
Jane Huebsch, IM Central / Marathon Co.	Amy Mayo, IM Central / Oneida Co.
Mia Inman-Anderson, Moraine Lakes / Walworth Co.	Carol Wicklun, Moraine Lakes / Walworth Co.
Sandy Potter, Moraine Lakes / Washington Co.	Doreen Lang, Northern / Wood Co.
CeCe Fishnick, Southern / Grant Co.	Marlin Harms, Southern / Iowa Co.
Marjean Sutherland, Southern / Lafayette Co.	Carla Haigh, Southern / Rock Co.
Adelene Green, WKRP / Kenosha Co.	Hope Otto, WKRP / Racine Co.
Roger Ingebritson, CMS	Audrey Mattison, CMS
Linda Alexander, HP	

State Attendees:

Linda Auchue, DHS	Emily Campbell, DHS
Dale Crapp, DHS	Sara Edmonds, DHS
Brian Fangmeier, DHS	Lisa Hanson, DHS
April Heim, DHS	Elizabeth Jungers, DHS
Donna King, DHS	Hannah Knouse, DHS
Steve Martinelli, DCF	Mike McKenzie, DHS
Paul Michael, DHS	Julie Milleson, DHS
Tiffany Orcholski, DHS	Cherish Orozco, DCF
Melissa Pisczor, DHS	Allison Shabino, DCF
Craig Steele, DHS	Tony Trout, DHS
Debbie Waite, DHS	Jennifer Wickey, DHS

1. Administrative Issues – Debbie Waite & John Rathman
   Remote attendees:
   - Email Linda Alexander of attendance.
   - Another reminder: Please be sure phones are on 'mute,' not 'hold.'

   Agenda flexible due to Craig Steele's availability today.

   Welcome to CMS' Roger Ingebritson representing Charles Friedrich; Audrey Mattison attending by phone.

2. Approval of December 19, 2013 Minutes – Debbie Waite
   Motion to approve, seconded; passed by voice vote.

3. Department of Children & Families Update – Steve Martinelli, Cherish Orozco and Dale Crapp (Handout)
   a) RMS Roster Pilot Project
      - See handout "Random Moment Sample (RMS) Update" for details.
      - Previous RMS had been in place for more than 10 years and was becoming less effective; replacing color-coded Excel spreadsheets prone to mistakes.
      - Process staying the same but the tool has changed.
      - Enhancement - supervisors can now update their own employee rosters. More efficient than having a DCF unit updating more than 1,800 employees in all counties.
      - Out of 200 supervisors, 13 opted to participate in pilot.
      - Launched 12/19/13; new system up and running/live on 1/2/14. Over 70% of supervisors have logged into system; some have already used to make roster changes.

   b) Impact of New RMS System Changes to Supervisors
      - So far, very positive feedback.
      - Reminder emails to staff to update their activity response with a copy to supervisor. Results in supervisors getting a lot of emails; supervisors can encourage employees to be responsive to limit email reminders.
      - 'Help' text available for each activity, providing more detail to enable staff to enter most accurate choice. Reduces number of questions and promotes accuracy.
      - Ability to update 'expired samples' – for example, when a worker is out of the office in training. An 'out-of-office' email goes back to Steve Martinelli's staff so that a return date can be input if it is included in the 'out of office' message. Expired samples stay in the system till end of quarter. DFS staff does follow up with supervisor to address any outstanding expired samples.
      - Feedback: Would be helpful for DCF to send consortia a link to RMS.
      - Feedback from DHS / Dale Crapp: Very happy with results and the tool.

- Question & Answers:
  - What about staff with more than one supervisor / overlapping staff?
  - Reminders can be set by individual worker with name of his/her supervisor. Tony Sis process: added all his supervisors to system with WIEXT I.D. and then assigned workers' supervisors.
  - Can also work with DCF Help Desk with any questions, issues.

4. 2012 PERM Results & Next Steps – Brian Fangmeier, Melissa Pisczor & Donna King (Handout)
   - See "PERM FFY 2012 Data for T19 (Medicaid) and T21 (CHIP)" handout for details.
   - Discussion and clarifications:
     - T19 Active Error Data by Consortium page (4): "Number of error cases" column includes undetermined cases; must be included in total number of cases. Correction of WKRP's number of error cases from 2 to 0 which reduces the total number of error cases from 21 to 19.
     - T19 Active Errors by Element (page 9): By far, the highest percentage is due to wages and salaries. Also, unable to verify citizenship/I.D. with agency, so that is the next highest percentage of errors.
     - T19 Active Error Details (page 11): Highest percentage was for Liability Understated and second reason / next highest percentage was Ineligibility.
     - "Negative Cases" means denials and terminations. See T19 Negative Error Data by Consortia (page 25).
     - T19 Negative Error Types and Assistant Groups (page 28) – consortia would like to show data by county and by type of error. Consortia wanted to know when this detail would be available. Will email consortia by week of 1/20/14.
     - T21 Negative Error Data by Consortia (page 32) – consortia wanted to know why this error rate is so much higher than T19. Per Donna, at least 50% of the errors in Title 19 were because of Family Planning.
     - T19 and T21 National & State Findings (page 38) is CMS' report card / overall grade comparing Wisconsin to the national averages for eligibility error rates. National T19 estimated at 3.3%; Wisconsin's rate was 1.0%.
     - Next steps:
       - Corrective Action Plan (CAP) – requested after completion of the data analysis.
       - Regular PERM Cycles for 2014, 2015 and 2016 – on hold so that states and CMS can get a handle on MAGI. States are required to complete PERM Pilot Programs for 2014, 2015 and 2016. Wisconsin to complete three 6-month pilot projects followed by a one-year project. All cases reviewed will be MAGI determinations. Will pull 200 (MAGI) cases processed in February and March, 2014.
   - Consortia would like this detailed data regularly; very helpful. Should be sent to QA Contacts as well as the Operational Leads.

5. Disability Determination Bureau (DDB) Work Group Update – John Rathman & Debbie Waite –
   - Consortia had identified issues:
     - DDB was not sending initial notification of denials.
     - Also case documents were not appearing in the Electronic Case File (ECF).
   - DDB researched and found systems issue with document transfer to ECF.
   - Action Taken: DDB implemented a new form and a fix for system data transfer into ECF. Approximately 60 cases tested to insure accuracy.
   - If consortia find a case that is not included in ECF or a case without a notification, send it to DDB and copy CARES Call Center.

6. Patient Protection Affordable Care Act (PPACA) 1/15/14 Sub-committee Meeting Update & Issues – Craig Steele (Handout)
   - See "PPACA Subcommittee Update / New Developments – PPACA Implementation January 10, 2014" handout for details.
   - Governor will sign bill which was passed on Tuesday, 1/14/13.
   - Federal Marketplace Determinations – 6,000 of 43,000 cases in the enhanced file (account transfers).
     - Weekly Flat File Applications – DHS received flat file on 1/14/14; Tara will be sending to consortia.
     - John Rathman advised that members' names were not aligning with addresses on most recent flat file. Are all columns being sorted correctly?
       Action Item: John Rathman will send specific examples of the members with incorrect addresses for Craig to investigate.
   - Determination Issues – FFM new functionality will enable an applicant who received an incorrect determination for BadgerCare Plus to remove his/her application; DHS awaiting CMS verification this can be done.
     - Amy Mendel-Clemens has staff following up with people who fit this description and will advise Craig if the functionality works.
     - Using the flat file, cases can be identified as assessment/determined and which are cancellations. Use application date to determine:
       - Assessment = 1/1/14 or later
       - Determined = 10/1/13 through 10/31/13

       "Referral" page (from ACCESS) will show whether 'assessment 'or 'determined;' MAGI Eligibility = 'Y.' Linda Auchue noted this was part of a fourth quarter 2013 Ops Memo.

       No worker intervention required in CARES.
   - Miscellaneous Issues / Premium Assistance by Third Party Payers – Craig Steel confirmed that CMS has issued a memo stating that sponsorship of premium payments is not encouraged. CMS has also advised QHP's not to accept third party payments.

Action Item: Consortia should forward the CMS memo regarding third party payers on behalf of applicants, to their legal counsel for reaction / response per Craig Steele's recommendation.

- Health Insurance Risk-Sharing Program (HIRSP):
  - Federal program began in 2010; only about 2,000 people; will be extended temporarily.
  - Wisconsin HIRSP extended through 3/31/14.

7. Consortia Feedback –
   - See above for those related to PPACA.
   - Question related to Fair Hearings: What remedy or action is available for a Fair Hearings report containing criticisms of an individual worker? Answer: Report / forward to Debbie Waite or to Rachel Witthoft.

8. Operations Memos – Linda Auchue
   - All Ops Memos previously discussed at IMAC or PPACA Sub-committee meetings have been issued this week.
   - Operations Memo 14-01 – Describes the implementation dates for policy and system changes related to BadgerCare Plus and ACA, including when to apply the new income limits for ongoing members and new applicants, the start of the program for childless adults and how those will be processed after 2/1/14 when the system updates are in place.
     Linda reminded the group to leave the TFI forms in the document viewer and not to process them to the Electronic Case File (ECF) until after the system changes are made on February 1st.
   - Operations Memo 14-02 – Processing Applications Received from FFM. This memo contains information on how to process an application from the FFM. The language on Notices may be changing.
   - Discussion / questions:
     - For Ops Memo 14-02, what are the expectations for inputting applications by February cut-off? Since childless adults do not have a program until 4/1/14, this will take them out of the conversion process. Recommend looking at the application for families; could have eligibility back to October, 2013.
     - Pending disabilities – Will there be a reduction in the number of adults that will have to complete a Medicaid Disability Application (MADA) because they can be eligible for BadgerCare Plus? Workers should continue to fill out the MADA for anyone claiming they are disabled. CARES will 'pend' for the EBD MA and send the MADA even if MAGS opens. Despite the fact that many adults who file for disability are not approved, most prefer to complete an MADA. If coming from FFM, may still request a full determination.
     - Per Craig, account transfers do NOT equal referrals. See page 6 of Ops Memo 14-02 to clarify 'transfers process.'

- The FFM Referral page will be created in CARES Worker Web (CWW) once the application is processed through clearance.
- Confusion about closed case (for procedural reasons) text on page 16.
  Action Item: Linda Auchue will review language and make any corrections necessary to the Closed Cases/Procedural Reasons portion of the ops memo. // Subsequently, the memo was amended.
- Question: How long after a member loses eligibility for BadgerCare Plus before the member can get FFM coverage?
  Answer: Per Craig, 90 days to apply after a qualifying event.
- Per Doreen Lang, it was recommended previously that consortia hold paper applications because no program was available for some of the applicants.
  Question: When should consortia enter these paper applications into system?
  Answer: Process the held paper applications on 2/3/14.
- Discussion about applications for healthcare and FoodShare. The healthcare application kept; could be re-run for childless adults (after adverse action). Remember that tax information is now needed.
- BadgerCare Plus Phase 4 Training – now available. Also have published Q&A. Linda strongly recommends both. In Phase 2 and 3, workers can create a case and learn why something changed/happened to the case in the training. Great Rivers Consortium plans to block off time on Fridays for training – some in a group setting and some individual time.
- Reports:
  - Six reports will be out after January adverse action (1/17/14). John Rathman asked if the reports could be sorted by county. They can and DHS will do so.
  - HP will run reports with old med stat codes before March adverse action. These records will show an 'end date' in interChange (iC).
  - Amy Mendel-Clemens asked where to send Capital Consortia's reports.
    Response: Send to Angie Lueck, cc to Craig.
- Recommendation for future Ops Memos: include language directing comments or questions to the CARES Call Center. (Upcoming ops memo – presumptive eligibility and at least one more on another topic.)

9. Administrative Memos – Debbie Waite
   - Working on the Affordable Care Act (ACA) Contract – base contracts are still coming in to DHS. Once all received, contract addenda for ACA funding and FoodShare bonus will be issued.
     Action Item: DHS will follow-up with any consortia that have yet to respond or send contract.

10. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    a) FSET Sub-committee Report – While RFP remains open, DHS can share only limited information on upcoming changes. Margaret Rosenthal did send committee an email about Federal match.

11. Miscellaneous Updates – CCA Replacement System – Paul Michael
    - WI Department of Administration (DOA) is considering the Call Center Anywhere (CCA) replacement. Project is moving slowly.
    - Paul will advocate for representation on the Business Committee (the entity that considers the vendor/system/RFP); will facilitate consortia input and communication on developing requirements and vendor selection.
    - Will keep all stakeholders apprised.

12. Other / Public Comment
    N/A

13. February 20, 2014 Meeting Tentative Agenda Topics
    a. Fair Hearings Process for Marketplace - Rachel Witthoft
    b. Second Party Review Update – Paul Michael & Michelle Ebert
        - Discrepancies Project
        - General Update
        - Training Strategies

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INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC)

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John Rathman, East Central / Outagamie Co.	Shelby Jensen, East Central / Green Lake Co.
Amy Roland, East Central (Outagamie Co.	Tim Gessler, East Central / Sheboygan Co.
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Mandy Mayek, IM Central / Portage Co.	Rachel Pantaleo, Moraine Lakes / Ozaukee Co.
Carol Wicklun, Moraine Lakes / Walworth Co.	Doreen Lang, Northern / Wood Co.
Marlin Harms, Southern / Iowa Co.	Marjean Sutherland, Southern / Lafayette Co.
Carla Haigh, Southern / Rock Co.	Ali Pritchard, Southern / Rock Co.
Erin Davis, Western / LaCrosse Co.	Charles Friedrich, CMS
Audrey Mattison, CMS	Linda Alexander, HP

State Attendees:

Abby Abernathy, DHS	Linda Auchue, DHS
Jamie Christianson-Fawcett, DHS	Michelle Ebert, DHS
Sara Edmonds, DHS	Bill Hanna, DHS
Lisa Hanson, DHS	Craig Hayes, DHS
Elizabeth Jungers, DHS	Hannah Knouse, DHS
Sabrina Mandel, DHS	Paul Michael, DHS
Julie Milleson, DHS	Tiffany Orcholski, DHS
Shawn Smith, DHS	Craig Steele, DHS
Tony Trout, DHS	Debbie Waite, DHS
Rachel Witthoft, DHS	Pang Xiong, DHS

1. Administrative Issues – Debbie Waite & John Rathman
   Remote attendees, send Linda Alexander an email confirming your attendance.
   On-site, sign attendance sheet at handout table.
   Reminder that March, 2014 IMAC is again at Department of Agriculture, Trade and Consumer Protection but hoping to resume 2014 meetings at Dane County Job Center.
   a) FoodShare Bonus Update: CARS area in DHS reviewing a few days ago. Typically takes 10-20 days. Will send pages to consortia's signatories with copies to Operational Leads, attaching addendum to begin payments as quickly as possible.
   b) ACA Addendum: Same process being followed as with FS Bonus above. As soon as Brett Davis signs, will be sent out soon after the approval.
   c) FSET 50-50 Contract – All consortia but one have returned contract. Will follow up with the Bureau of Operational Coordination (BOC) to expedite.

2. Approval of January 16, 2014 Minutes – Debbie Waite
   Motion to accept the January 16, 2014 minutes; seconded and passed by a voice vote.

3. Second Party Review Update – Paul Michael & Michelle Ebert (Handout)
   a) Alerts Project
   b) General Update
   c) Training Implications

   Overview – see handout. Additional comments or explanations:
   - Second Party Review Staff – Amber Rahn and Craig Hayes – communication with consortia, especially the Quality Control and Operational Leads.
   - 2013 Review –
     - Completed 16,000 reviews (not including December), which is a very good sampling.
     - Steady increase in case level error rate. Paul attributed this to maturation and experience level of Second Party Review staff.
     - Trend upward can help focus training and improve QC processes.
     - Majority of errors due to being late (more than 45 days) and cryptic and/or lack of case comments.
     - Also see two handouts: Discrepancy Reporting and Error Detail Report Example
       - Found case history / comments are inadequate to explain how a discrepancy was handled.
       - Audit reports – also a tool for identifying areas of focus; DHS sometimes required to submit to audits by legislature.
   - The Future –
     - Consortia reached out to Second Party Review staff to help deal with or solve issues specific to their consortium. Paul encouraged more of the same for the future. The staff appreciates the opportunity to provide assistance and will fit in as appropriate.

Training –

- September, 2014 – first of refresher training released; five areas of focus.
  - Two of the first areas of focus:
    - When to send case summary
    - Prospective budgeting examples (e.g., semi-monthly budgeting)
- Experienced IM workers can log into DHS Training Center (through Captivate); records credit when completed.
- Future Goal: Five refresher training sessions per year. In 2014, will produce/make available one in September and one more before year-end.
- Source of Training Needs that Determine Development:
  1) Common errors from Second Party Review QC Reports
  2) Ideas from Training Sub-committee (March meeting)

Question / Answer:

Q. From Michelle Ebert, which consortia staff should receive announcements of training opportunities/events?
A. Operational Leads, Training Coordinators, Tribal/IM Coordinators

Q. Is Training staff looking at IT/systems issues in case summaries? (Tony Sis)
A. Yes; expensive to address.

Q. Is there a way to identify by consortia or county which staff has accessed the DHS training site?
A. Only through a labor-intensive /manual effort.

Q. Is there any way to determine the number or the percentage of cases done correctly?
A. The actual Rate Report (keep in mind the data shown is 3 months old) – shows the sample size (number of cases) and error rate which would enable consortia to calculate the number and/or the percentage of correct cases. One other source is the monthly Snapshot report.

Other Discussion:

- Will re-issue December, 2013 and January, 2014 reports.

4. 2014 Local MER Process and Timetable – Sara Edmonds (Handout)
   - Per Sara, the 2014 plans and process were based on experience and feedback from the previous Management Evaluation process while complying with Federal requirements and FNS reporting requirements.
   - Best Practices will be included this year.
   - Corrective Actions – now consistent across all consortia
   - Now have former "Negative Error Rate" report in place so no individual case reviews are necessary.
   - Entrance Conferences – Quality Control will provide all information known about the consortia as of the day of the meeting. This means the consortia will not be required

to complete spreadsheets or reports beforehand. A percentage of staff will be interviewed, taking into account years of experience. Will also use Call Interaction ID from recorded calls.

- See schedule as handout. Will begin with Capitol Consortium in April and end with MiLES in August. All consortia are scheduled; tried to accommodate consortia's preferences.
- Letter scheduling the MER will include the Federal requirements and areas of MER focus:
    1. Program access
    2. Program integrity
    3. FSET
    4. Negative reviews – hope to reduce current 15-18%

5. CMS 101 – Charles Friedrich, CMS (Handout)
    - Charles provided handouts that illustrate structure of Centers for Medicare & Medicaid Services (CMS), especially in Region 5 (Chicago) which includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin.
    - Charles, Audrey Mattison and Roger Ingebritson serve as the Medicare / Medicaid Wisconsin Liaisons.
    - CMS regional out-office is located in Madison, right behind the Kohl Center. Federal headquarters located in Baltimore, MD, which houses the CMS Administrator and about 3,200 staff.
    - Very close working relationship with WI Medicaid Director Brett Davis. Good examples of preserving Wisconsin's programs (e.g., SeniorCare waiver).
    - Also a good working relationship with Division of Long Term Care (DLTC) where Beth Wroblewski is the liaison with CMS.
    - Factoid: CMS pays 59% of the cost of MA; WI pays remainder.
    - FMAP payments – Wisconsin is in the middle of the pack with regard to payments. Because of the way payments are calculated (based on FPL as well as per capita income information /data), states like Mississippi are paid more and states like California are paid less. Not all states have the same kind of collaborative relationship with CMS that Wisconsin does.

6. Farm Bill Update – Sabrina Mandel & Julie Zastrow
    - Sabrina reported the Farm Bill was signed on February 7, 2014. Reporting on what is known today. More detail will be available and will be shared at future meetings with some documentation.
        - WHEAP Benefit – States may no longer pay $1.00. New minimum payment is now $20.01.
        - Employment and Training – FSET increase from $79 million to $90 million overall. $20 million increase for Able Bodied Adults w/o Dependents (ABAWD) effective 7/1/14. Also a Pilot Program in which FSET would be administered like W-2 (covering crisis, mental health and alcoholism).
        - Eligibility / Lottery & Gaming Winnings – ineligible until they meet income standards; more work needed.

- Convicted Felons – ineligible for FoodShare unless they comply with parole requirements.
- QC / Error Thresholds – Adjusting lower for error rate. As of October 1, adjusted downward from $50 to $37.
- Wage Verification / Data Matches – will match up with new hire wage database. Equifax work hub has work numbers.
- Funds for FNS Recruitment Activities – dollars spent to attract FoodShare enrollees. More to come.
- Farm Bill analysis is on-going; will continue to share with and update this group, releasing written updates when confirmed.

7. Upcoming Application Changes – Sabrina Mandel (Handout)
   - CMS-required Changes
     - Healthcare changes related to ACCESS and CARES Worker Web (CWW). Will be making more next month.
     - A single streamlined application – all questions asked to make a Medicare determination and for advanced premium tax credit. Two phases for implementation: one in late April and in December. Will share more information at March IMAC meeting.
     - Removing questions related to yearly income such as alimony, child care support and SSI payments (for BC+ applications only)
   - FNS-required Changes – see handout
     - Many of the changes were the result of feedback and input from 2013 statewide ME Reviews.
     - The handout was a mock-up of a screen shot; enabled feedback on how to improve; e.g., consider a check box for being considered for priority service.
     - Some questions/concerns: Is an applicant signed up/enrolled if he/she clicks 'sign' and submits the application without any financials? Is the agency / are consortia required to follow up?

     Action Item: Consortia to provide Sabrina Mandel with their feedback by 2/28/14.

8. Fair Hearings Process for Marketplace Applications – Rachel Witthoft
   - Lots of changes to BadgerCare Plus due to Affordable Care Act (ACA) and income requirements. DHS staff met with the Division of Hearings and Appeals (DHA) to identify possible impacts to the fair hearing process.
   - Discard the handout sent with the IMAC materials; will be replaced with Ops Memo with finalized information. Being reviewed at this moment and will be issued as soon as possible.
   - Working with consortia and the DHA to communicate any changes in the fair hearing process.
   - Anticipating that the consortia will see an increase in volume of fair hearings, much of which will likely be related to BC+ members whose BC+ benefits ended due to the change in the FPL eligibility level.

- Current fair hearing processes will continue as is; only change is the anticipated 'up-tick' in volume.
- For applications submitted through the Federally Facilitated Marketplace (FFM) from 10/1/13 through 12/31/13, the hearing defaults to the FFM unless the applicant chooses the state to hear the appeal.
- DHS will handle any appeals on FFM applications submitted from 10/1/13 through 12/31/13 where the applicant requests that the state hear the appeal. These appeals will not go through the Fair Hearings Tracking Tool.
- After 1/1/14, the consortia are making all eligibility determinations for BadgerCare, so appeals will follow the established process for BC+ fair hearings. The consortia are expected to follow the established process and timeline for submitting information to DHA and appearing at the hearing.
- Appeals related to private insurance or the Advanced Premium Tax Credit (APTC) must be handled by FFM or the health insurance company. IM consortia should not see these types of appeals.
- Main Take-away: If an IM consortium took the action to make a BC eligibility determination, should expect that the consortium will handle the appeals.

9. Patient Protection Affordable Care Act (PPACA) – Remaining Issues from 2/9/14 Sub-committee Meeting – Craig Steele
    - Linda Auchue – The FFM applications that were scheduled to be released to the agency inboxes was decreased by 20,000 applications. This was due to issues found when testing the applications. The applications will be released when the issues have been resolved. The issues include:

        - No FFM referral page generated when the application is processed; Deloitte has a fix. CARES Call Center has already manually added a referral page to 89 cases without one; may be more.
        - 41,000 FFM applications are still scheduled to be released. If these aren't released, do the consortia have a lull in workload? Per John Rathman, most consortia are caught up; will be getting pinched with the back log of the 41,000 applications.
        - CARES availability: one additional Saturday (3/8/14) will now be available. CARES has to be shut down the weekend of March 1st due to end-of-month processing. CARES cannot be up / functional on Sunday because of the various end-of-the-week updates. Confirmed CARES will be available / up the weekend of 3/15/14. CARES Calendar has been updated.
        - When will the 41,000 applications be sent to consortia? Tuesday or Wednesday; consortia prefer to receive on Wednesday morning, especially if this increases the accuracy of these applications.
        - Background: Problem did not surface during user acceptance testing (UAT) and only showed up as 'determination model' applications. First noticed on the multiple-person application and then it showed up on the single-person applications.

- EBD Reports and Workload – Need to be done in time for eligibility to be run. What is the status (by consortium)/have case updates been made?
  - WKRP – done with all applications from FFM
  - Great Rivers – will be done in time.
  - IM Central – still working on these. Approximately 30 cases are EBD.
  - Northern – have 30 apps from FFM.
  - Western – all caught up with FFM apps.
- CARES Call Center receiving 500-600 emails or calls over and above their regular volume. As a result, please give Call Center at least **3 business days** to respond to your question.
  - FAQ Document – The Call Center is sending updates on system issues, policy and process questions as they get them. Because this information needs to be communicated quickly we are not waiting to do an FAQ. Dane County staff has volunteered to put a document together with all of the updates that have been sent out.

- Craig Steele – update on other activities since 2/19/14 PPACA Sub-committee meeting and follow-up to January IMAC meeting.
  - FFM Notices – updated by CMS. Craig will send samples of three notices either today or tomorrow. (Post-meeting: Notices were sent to the PPACA Sub-committee.)
  - Third-Party Premium Payments – follow up to January IMAC meeting. CMS is discouraging third-party premium payments. CMS issued a memo outlining exemptions on 2/7/14. Refer to the memo for these. (Post-meeting: Memo was sent to the PPACA Sub-committee.)
  - Enrollment Terminations – CMS presentations summarizing five bulletins. One on Life Change Reporting is important to review, especially for policy on 'effective dates.' Craig had suggested to CMS that it could be more effective with screen shots. (Post-meeting: Bulletins sent to PPACA Sub-committee.)
  - Process of Retroactive Application & Enrollment – "stuck" in process since October. A huge document; will talk more about this at March IMAC meeting. (Post-meeting: Document distributed to PPACA Sub-committee.)
  - As of 3/22/14, will re-run FFM determinations. (Post-meeting: Scheduled for 3/22/14. People will begin to receive their notices the week of 3/24/14.)
  - Question: Any additional outreach to these people who were caught in the inappropriate determination? Should consortia do this? Do consortia want DHS to do this? Hard to tell until after 3/22/14 when the number affected is quantified. Ways to communicate: letter followed by a phone call? What other ideas? Feedback is that follow-up calls are more readily accepted and appreciated if they come from local agency. Could this be discussed at PPACA Sub-committee? Next meeting is too late; move up meeting to first week in March. (Post-meeting: This has been resolved and we have a plan in place to complete the outreach to those people that received erroneous FFM Determination. An update was sent to the PPACA Sub-committee.)

10. Consortia Feedback – All
    - Program Connections Sub-committee is exploring ways to make meetings more effective. Considering piggy-backing with ChildCare meetings on Wednesdays, per Jen Mueller.
    - Medical Transportation Management (MTM) Provider Concerns - documenting services received by members. Have an oversight committee and want to give them a response to their concerns, especially with regard to mental health patients/members.

11. Operations Memos – Linda Auchue
    Issued: BadgerCare Plus Extension – extensions could change.
    14-08 Filing Taxes / Deceased
    14-09 Presumptive Eligibility
    10-10 FPL Limits and Conversions
    In Development:
    Fair Hearings

12. Administrative Memos – Debbie Waite
    Lobby Services Admin Memo is ready for issuance.

13. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    N/A

14. Other / Public Comment
    N/A

15. March 20, 2014 Meeting Tentative Agenda Topics
    a. PPACA Issues
    b. FSET / ABAWD Process Update
    c. Incorporating ChildCare into CDPU

    If anyone has other topics to be considered, email Debbie Waite and John Rathman.

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Governor

Kitty Rhoades
Secretary

State of Wisconsin

Department of Health Services

INCOME MAINTENANCE ADVISORY COMMITTEE (IMAC)

Thursday, March 20, 2014

1:00 – 3:30 p.m.

Department of Agriculture, Trade & Consumer Protection – Board Room

2811 Agriculture Drive / Madison, WI 53718

Or online at https://connect.wisconsin.gov/imac/

For audio, dial 888-808-6929, access code 468-5307.

AGENDA

1. Administrative Issues – Debbie Waite & John Rathman
2. Approval of February 20, 2014 Minutes – Debbie Waite
3. Incorporating ChildCare into CDPU – Jennifer Mueller & Sue Pfeiffer, DCF
4. Consolidated Telephonic Signature – Julie Zastrow (Handout)
5. Farm Bill Update / LIHEAP Implications – Michelle Ebert (Handout)
    a) APHSA Summary
6. FSET / ABAWD Process Update – Angela Walz and Govinda Annyapu, Deloitte
7. CARES Schedule – Jennifer Mueller (Handout)
8. Patient Protection Affordable Care Act (PPACA) – Remaining Issues from 3/19/14 Sub-committee Meeting – Craig Steele
9. Consortia Feedback – All
10. Operations Memos – Linda Auchue
11. Administrative Memos – Debbie Waite
12. Sub-committee and Ad Hoc Group Reports – Debbie Waite / Leads (Handout)
    a) IMAC IT Sub-committee Update – Jennifer Mueller
13. Miscellaneous Updates / Other / Public Comment

14. April 17, 2014 Meeting Tentative Agenda Topics
    a. PPACA Issues

*If you wish to participate by phone, please call the teleconference number at **888-808-6929**. The access code is **468-5307**. If you want to participate by web meeting, you can follow along at your computer by logging into https://connect.wisconsin.gov/imac/ as a guest 5 minutes ahead of time and calling the above conference line for the audio.

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: 13-25

DATE: AUGUST 19, 2013

FS ☐	**MA** ☐	**BC+** ☐
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☒
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: Changes to the BadgerCare Plus Core Plan

CROSS REFERENCE: BadgerCare Plus Handbook Chptr 43; Process Help Chptr 4.7

EFFECTIVE DATE: September 28, 2013

PURPOSE:

The purpose of this memo is to announce changes to the BadgerCare Plus Core Plan. As of September 28, 2013, members completing renewals will no longer be required to pay a processing fee or complete a Health Needs Assessment (HNA) as a condition of eligibility. The Core Plan Waitlist will also be discontinued as of this date.

BACKGROUND:

Current policy requires a Core Plan member to pay an annual $60 processing fee and to complete a mandatory HNA before his or her annual renewal can be processed. As of January 1, 2014, the Core Plan will end. In place of the Core Plan, childless adults who meet all financial and non-financial eligibility requirements, including having household income at or below 100% of the Federal Poverty Level (FPL), will be eligible for regular BadgerCare Plus (BCP) Standard Plan. They will not need to reapply. Childless adults over the income limit for BCP will be able to purchase affordable insurance and apply for premium tax credits and reduced cost sharing through the Marketplace. As part of the transition from Core Plan to regular BCP the processing

fee and mandatory HNA requirements will be eliminated, for current Core Plan members effective September 28, 2013. In addition, the Core Plan Waitlist will be discontinued and Waitlist members will be advised of their new health care options.

Policy Change:

PROCESSING FEE

Effective September 28, 2013, Core Plan members will no longer be required to pay the $60 processing fee at renewal. A request for a processing fee will be sent to any member who starts his or her renewal prior to September 28th. Fees paid prior to September 28th will not be refunded. Any fees unpaid as of September 28th will be waived. Renewals that are pending for fee payment can be processed after September 28th with a waived fee. Core Plan members with income above 133% of the FPL will continue to be responsible for payment premiums through December 2013.

HNA

Effective September 28, 2013, Core Plan members will no longer be required to complete the HNA at renewal. A request to complete the HNA will be sent to any member who starts his or her renewal prior to September 28th. After September 28th, the requirement to complete the HNA will be waived. Renewals pending the HNA can be processed after September 28th without a completed HNA.

WAITLIST

Effective September 28, 2013, childless adults who apply for health care benefits will no longer be placed on the Waitlist. Existing Waitlist members will receive a letter shortly after the Waitlist is discontinued, letting them know about the options available via the Marketplace as well as through the BadgerCare Plus Standard Plan. They will be advised to reapply via the Marketplace as of October 1, 2013, or via their IM consortia as of November 18, 2013.

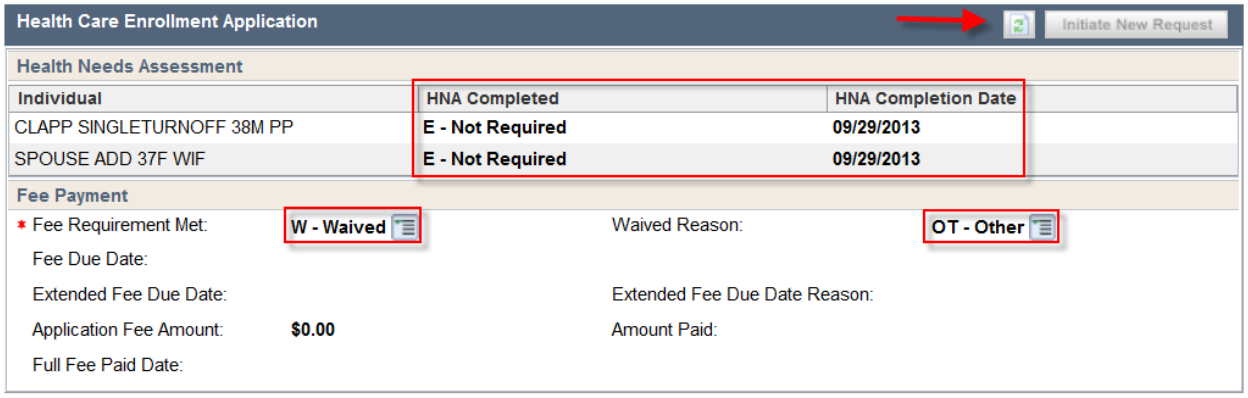
CARES:

BADGERCARE PLUS CORE PLAN FOR CHILDLESS ADULTS DETAILS PAGE

Effective September 28th, CARES will automatically populate the “Fee Requirement Met” field to “W-Waived” and the “Waived Reason” to “OT –Other”.

The “HNA Completed” field will be automatically updated to “E-Not Required” and the “HNA Completion Date” will be updated to the renewal date.

The “Initiate Request”, “Edit Request” and “Resume Request” buttons will be disabled.



WAITLIST

The option to add a person to the Waitlist through the CWW BadgerCare Plus Core Plan Potential Eligibility page or through the Waitlist Administration page will be disabled as of September 28th. Childless adults who apply in ACCESS "Apply for Benefits" between October 1, 2013 and November 16, 2013, will be advised to apply directly through the Marketplace. If the Marketplace determines the person's income is at or below 100% of the FPL, the account will be transferred back to Wisconsin for processing. More information on how to process an application referred from the Marketplace will be communicated in a separate Ops Memo.

Childless Adults can submit a regular ACCESS application after November 16, 2013.

NOTICES

BadgerCare Plus Core Plan members will now receive the regular BadgerCare Plus 45 Day Renewal Notice. Current language regarding fee payments and the completion of the HNA will not be included in the renewal notice. The notice will be updated to include a statement about gathering tax information and the tax information will be added to the "Proof Needed" section, for BadgerCare Plus Renewals.

Core Plan members who remain eligible for BCP will receive a notice after November 23, 2013, informing them about the change from Core to Standard Plan.

ACCESS:

In ACCESS "Renew My Benefits", payment of the fee and completion of the mandatory HNA will no longer be required, after September 28, 2013.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/LA

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: 13-28

DATE: 09/03/2013

FS ☐	**MA** ☒	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: Updates to the Workload Dashboard, CARES Inbox Search and the Income Maintenance Management Reports (IMMR)

CROSS REFERENCE: Process Help Chapters 66.1,53 and 3.15

EFFECTIVE DATE: September 28, 2013

PURPOSE:

The purpose of the memo is to announce changes to the Workload Dashboard, the CARES Inbox Search function, the Application Summary page and the Income Maintenance Management Reports (IMMR) that will allow Income Maintenance (IM) workers and managers to distribute and monitor applications transferred from the Federally Facilitated Marketplace, also referred to as the Exchange. A new 'Special Flag' will also be added to the Inbox Search Criteria, the Inbox Listing and the Application Summary pages to indicate an applicant is requesting Long Term Care (LTC) services.

BACKGROUND:

The federal Patient Protection and Affordable Care Act (PPACA) established the Federally Facilitated Marketplace (FFM) or Exchange as a resource for individuals and families to purchase affordable private health insurance and apply for Advanced Premium Tax Credits as

well as Cost-Sharing Reductions. The Marketplace/Exchange will begin taking applications on October 1, 2013. An application submitted to the Marketplace/Exchange is considered an application for BadgerCare Plus and Medicaid. If the Marketplace determines an individual or family has income within the income limits for BadgerCare Plus or Medicaid, the Marketplace will transfer the account to Wisconsin for processing. The application will be submitted to the IM Agency's inbox, through ACCESS, for processing.

The filing date for applications transferred from the Marketplace is the date the application was received by the Marketplace. That filing date will be preserved if the application is transferred to Wisconsin for processing. However, the IM agency will have 30 days from the date the application is submitted to the agency's inbox to process the application. The Workload Dashboard will be updated to hold the original filing date while using the inbox submission date to start the 30 day processing time frame. As with current ACCESS applications, if the application is transferred from the Marketplace outside of regular business hours, the 30 day processing time frame will begin on the next business day.

In order to identify these applications for workload assignment and to track the effects of these applications on performance measures, the CARES Inbox Search function, the Application Summary page, and the Workload Dashboard will be updated on September 28, 2013 to display and count applications referred from the Marketplace/Exchange.

No applications from the Marketplace will be submitted to the agency inboxes until November 18th so even though the new search functionality will be in place September 28th, no results will display until after November 18th. A PDF will be created for applications received from the Marketplace prior to November 18th with an LTC or Emergency Medicaid flag. A weekly report will be generated and sent to IM agencies with a list of these applications.

The IMMR will be updated in November 2013 to include reports identifying the source and program request type for received applications, daily monitoring of applications received and processed, and enhanced timeliness reports to separate performance monitoring for HC applications.

CARES:

WORKLOAD DASHBOARD

In order to allow IM agencies to identify and track applications received from the Marketplace, the following five new Work Item Types will be added to the Workload Dashboard.

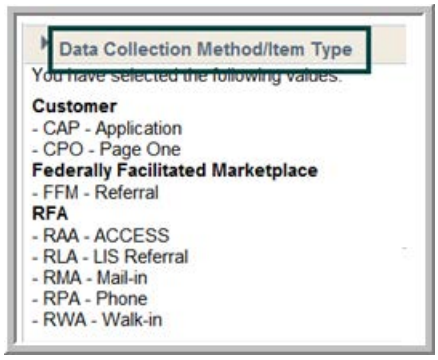
- BadgerCare Plus (FFM)
- BadgerCare Plus CLA (FFM)
- EBD Medicaid (FFM)
- Institutional (FFM)
- Health Care (FFM)

Work Items	Days Left to Complete					
Category	**Total**	**<1**	**1-7**	**8-14**	**15-30**	**>30**
Applications	1858	1735	47	22	53	1
Unassigned	417	329	20	19	49	
Health Care (FFM)	3		2	1		
Caretaker Supplement	1	1				
Case Processing	609	563	35	5	5	1
FoodShare Priority Service	148	148				
FoodShare	79	78	1			
BadgerCare Plus	14	13		1		
BadgerCare Plus (FFM)	2		2			
BadgerCare Plus CLA	4	3		1		
BadgerCare Plus CLA (FFM)	2		2			
EBD Medicaid	2	1	1			
EBD Medicaid (FFM)	2		1	1		
Medicare Premium Assistance	14	12	2			
Institution Medicaid (FFM)	2		2			

INBOX SEARCH CRITERIA-RFA/APPLICATIONS PAGE

Data Collection Method/Item Type

Workers will be able to search the inbox for applications referred from the Marketplace by checking the box for 'FFM-Referral' under the 'Data Collection Method/Item Type section.



To open the Data Collection section click on the section header. This will open the section and allow the worker to click on the data collection type to be used in the search, including the FFM-Referral types.

The FFM indicator will also appear on the inbox listing under 'Item Type'. This update will allow agencies to assign these applications to specific workers or teams.

Information on the Data Collection Method/Item Type' section is in Process Help Chapter 71.9.1.1.

LONG TERM CARE INDICATOR

Applications from the Marketplace may also include an indicator that the person has stated a need for Long Term Care (LTC) Services. Starting November 18th, ACCESS will also ask this

question when an individual is applying for benefits. A new 'Special Attention' flag will be added to the Inbox Search Criteria to allow workers to search specifically for cases with this flag. The LTC indicator will also display on the Inbox Listing page under the 'Special Attention' column. This will allow agencies easier access to find and distribute applications that must be processed by their Long Term Care and EBD workers or teams.

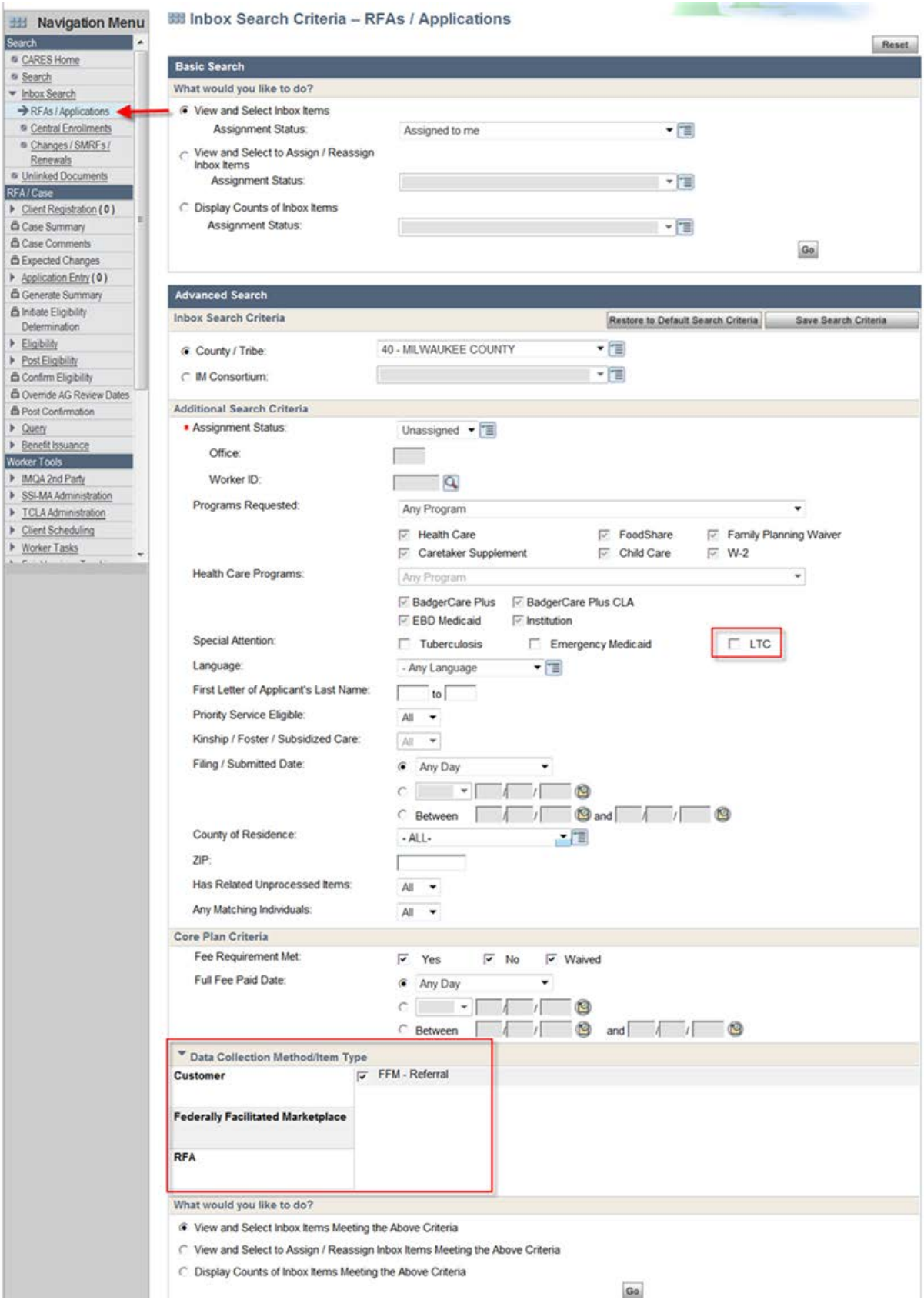
Aging and Disability Resource Center (ADRC) workers will be able to answer 'yes' to the question regarding the need for LTC services when submitting an ACCESS application without having to send an e-mail to the IM agency with the ACCESS tracking number.

IM agencies should communicate with their local ADRC regarding a referral process to the ADRC for applications with the LTC indicator that were not initiated by the ADRC. The ADRC remains responsible for completing the level of care screening, communicating the enrollment date with the Managed Care Organization and making referrals to the IRIS Consultant Agency.

IM Agencies in areas where Family Care expansion has not occurred should set up a similar communication process with the case managers in their agency who work with the LTC programs.

INBOX LISTING

The Inbox Listing Page will also display the new indicators. The LTC indicator will display under the 'Special Attention' column. The 'Item Type' 'FFM' will indicate that the application was referred from the Marketplace (FFM).


Navigation Menu
Search
CARES Home
Search
Inbox Search
RFAs / Applications
Central Enrollments
Changes / SMRFs / Renewals
Unlinked Documents
RFA / Case
Client Registration (0)
Case Summary
Case Comments
Expected Changes
Application Entry (0)
Generate Summary
Initiate Eligibility Determination
Eligibility
Post Eligibility
Confirm Eligibility
Override AG Review Dates
Post Confirmation
Query
Benefit Issuance
Worker Tools
IMQA 2nd Party
SSI-MA Administration
TCLA Administration
Client Scheduling
Worker Tasks
Inbox Search Criteria – RFAs / Applications
Reset
Basic Search
What would you like to do?
View and Select Inbox Items
Assignment Status: Assigned to me
View and Select to Assign / Reassign Inbox Items
Assignment Status:
Display Counts of Inbox Items
Assignment Status:
Go
Advanced Search
Inbox Search Criteria
Restore to Default Search Criteria
Save Search Criteria
County / Tribe: 40 - MILWAUKEE COUNTY
IM Consortium:
Additional Search Criteria
Assignment Status: Unassigned
Office:
Worker ID:
Programs Requested: Any Program
Health Care
FoodShare
Family Planning Waiver
Caretaker Supplement
Child Care
W-2
Health Care Programs: Any Program
BadgerCare Plus
BadgerCare Plus CLA
EBD Medicaid
Institution
Special Attention:
Tuberculosis
Emergency Medicaid
LTC
Language: - Any Language
First Letter of Applicant's Last Name: to
Priority Service Eligible: All
Kinship / Foster / Subsidized Care: All
Filing / Submitted Date: Any Day
Between and
County of Residence: - ALL -
ZIP:
Has Related Unprocessed Items: All
Any Matching Individuals: All
Core Plan Criteria
Fee Requirement Met:
Yes
No
Waived
Full Fee Paid Date: Any Day
Between and
Data Collection Method/Item Type
Customer
FFM - Referral
Federally Facilitated Marketplace
RFA
What would you like to do?
View and Select Inbox Items Meeting the Above Criteria
View and Select to Assign / Reassign Inbox Items Meeting the Above Criteria
Display Counts of Inbox Items Meeting the Above Criteria
Go

INBOX LISTING PAGE

Inbox Listing

1 of 3 Pages

Select	Cnty/Trb	Assigned Worker	Applicant Name	Filing Date	PS Elig	Programs Requested	HC Programs	Special Attention	Conf	Lang	Zip	Related Items	Ind Match	Item Type	Fee Paid Date	Fee
	Select Next Inbox Item Meeting the Above Criteria															
	40			08/07/2013	No	HC	FAM	LTC	No	E	53202	No	No	CAP	N/A	N/A
	40			08/12/2013	No	HC	FAM		No	E	53202	No	Yes	CAP	N/A	N/A
	40			08/12/2013	No	HC	FAM		No	E	53703	Yes	Yes	FFM	N/A	N/A
	40			08/09/2013	No	HC	FAM		No	E	53202	No	No	CAP	N/A	N/A
	40			08/09/2013	No	HC	FAM		No	E	53703	Yes	Yes	FFM	N/A	N/A
	40			08/09/2013	No	HC	FAM		No	E	53202	No	Yes	CAP	N/A	N/A

APPLICATION SUMMARY PAGE

The Application Summary Page will be update to display the Federally Facilitated Marketplace as a Data Collection Method. This will indicate to the worker processing this application that the application was referred from the Marketplace.

The page will also display the Long Term Care request under the 'Special Attention' section.

Application Information

ACCESS Application Number:	**7600633477** View	Status:	**Unassigned**
Filing Date:	**08/12/2013**	Community Access Point Number:	
Data Collection Method:	**Federally Facilitated Marketplace**	Item Type:	**Referral**
Phone/Mail Application Submitted Worker:			

Office Information

County / Tribe:	**MILWAUKEE COUNTY**	Office:	
Assigned Worker:		IM Consortium:	**STATE CONSORTIUM**

Contact Information

County of Residence:	**MILWAUKEE COUNTY**	Homeless:	**No**
Household Address:	**433 W WASHINGTON AVE SECOND LEVEL ADDRESS MADISON, WI 53703**		
Phone:			

App Summary with an LTC flag

Special Attention

Description
At least one person may qualify for Long Term Care
Signature matches name

INCOME MAINTENANCE MANAGEMENT REPORTS

The Income Maintenance Management Reports will be enhanced to display the application counts and timeliness for the applications referred from the FFM. A new report has also been created to track daily application received and daily applications processed. The IMMR changes

will not be implemented until November, but will contain historical information back to August, 2013.

DAILY REPORT OVERVIEW:

This report will monitor Received, Processed, and Pending Applications on a daily basis for the requested month and year. The Applications Daily Monitoring report contains the total count of applications received, processed, and pending in the report month it provides drill down functionality from 'Statewide' to 'Consortium / Tribal IM Agency' and to the 'Agency of Administration' level. This report also enables drill down functionality based on the Program request type (i.e. HealthCare, FoodShare and Caretaker Supplement). This report takes into account all application work items types on the Workload Dashboard; the report is based on the Agency of Administration.

APPLICATIONS DAILY MONITORING LANDING REPORT:

CARES **IM Management Reports**

Applications Daily Monitoring Landing Report (Includes Multiple Program Requests)

Last Database Refresh Date: 06/30/2103
Report Help

User Selections	
Year	2013
Month	June

Statewide Total Recieved / Processed / Pending Applications Count			
	Received Applications	Processed Applications	Pending Applications
Total Applictions Count	45,476	44,716	23,289

Statewide Received / Processed / Pending Applications Count by Date			
Date	Received Applications	Processed Applications	Pending Applications
Saturday, June 1, 2013	386	0	20922
Sunday, June 2, 2013	14	0	21121
Monday, June 3, 2013	3143	2564	21364
Tuesday, June 4, 2013	2363	2131	21528
Wednesday, June 5, 2013	2187	2352	22120
Thursday, June 6, 2013	2114	2273	22138
Friday, June 7, 2013	1846	2090	22058
Saturday, June 8, 2013	11	44	21797
Sunday, June 9, 2013	13	0	21977
Monday, June 10, 2013	2926	2641	22271
Tuesday, June 11, 2013	2218	2177	22179
Tuesday, June 11, 2013	2090	2177	22437
Thursday, June 13, 2013	2018	2175	22366

Consortium / Tribal IM Agency Drilldown Links
NORTHERN CONSORTIUM
WESTERN CONSORTIUM
BAY LAKE CONSORTIUM
GREAT RIVERS CONSORTIUM
SOUTHERN CONSORTIUM
MORAINE LAKES CONSORTIUM
EAST CENTRAL PARTNERSHIP
CAPITAL CONSORTIUM
CENTRAL CONSORTIUM
KENOSHA RACINE CONSORTIUM
STATE CONSORTIUM
TRIBAL IM AGENCIES

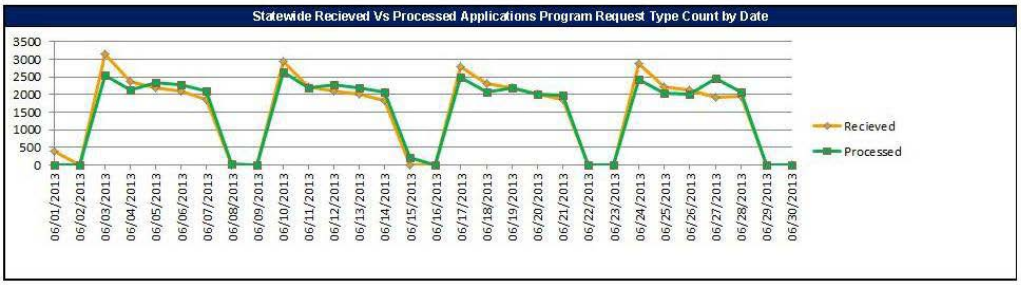
Program Request Drilldown Links
CARETAKER SUPPLEMENT
HEALTHCARE
FOODSHARE

CARES **IM Management Reports**

Applications Daily Monitoring Landing Report

Last Database Refresh Date: 06/30/2103
Report Help

User Selections	
Year	2013
Month	June



More information on the IMMR enhancements will be communicated through the IMAC Performance Monitoring subcommittee.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/LA

DEPARTMENT OF CHILDREN
AND FAMILIES
Secretary Eloise Anderson
201 East Washington Avenue, Room G200
P.O. Box 8916
Madison, WI 53708-8916
Telephone: 608-266-8684
Fax: 608-261-6972
www.dcf.wisconsin.gov

State of Wisconsin
Governor Scott Walker

DEPARTMENT OF HEALTH SERVICES
Secretary Kitty Rhoades
1 West Wilson Street
P.O. Box 7850
Madison, WI 53707-7850
Telephone: (608) 266-9622
FAX: (608) 266-7882
www.dhs.wisconsin.gov

TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: 13-32 Amended

DATE: 10/14/2013

FS ☐	**MA** ☐	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: BadgerCare Plus Policy and System Changes

CROSS REFERENCE: BadgerCare Plus Handbook

EFFECTIVE DATE: January 1, 2014

PURPOSE:

The purpose of this memo is to announce the changes to the BadgerCare Plus program resulting from changes in Federal laws and regulations governing Medicaid and the Children's Health Insurance Program (CHIP), as well as changes in State law.

BACKGROUND:

Provisions in the federal Patient Protection and Affordable Care Act (PPACA or ACA), signed into law in 2010, and in 2013 Wisconsin Act 20 (the State Biennial Budget) as well as major revisions to Federal Regulations governing the Medicaid and Children's Health Insurance Program (CHIP) require changes in the policies used to determine eligibility for the BadgerCare Plus (BC+) program. These changes go into effect for eligibility starting January 1, 2014.

PPACA established the Federally Facilitated Marketplace (also known as the federal Exchange or FFM). The Marketplace offers affordable private health insurance to individuals and families. Starting October 1, 2013, individuals will be able to use the Marketplace to shop for and purchase private health insurance with coverage beginning January 1, 2014. People can also use the Marketplace to apply for Advance Premium Tax Credits (APTCs). These tax credits will lower premium payments for people between 100% and 400% of the FPL, who are not eligible for BC+ or Medicaid (MA), if they purchase private health insurance through the Marketplace. Individuals with income under 250% of the FPL may also qualify for Cost-Sharing Reductions (CSRs) for their private insurance plan through the Marketplace.

An application to the Marketplace is also considered an application for BC+ and MA, if the applicant requests help paying for health insurance. When someone applies through the Marketplace and is determined to be eligible for BC+ or MA, the Marketplace will transfer their account to the state for processing.

Conversely, an application for BC+ is also considered an application to the Marketplace. Applications determined ineligible for BC+ by the State will be transferred to the Marketplace for APTCs and CSR determinations. This automatic transfer from the State to the Marketplace will be in place starting January 2014. Prior to January 2014, applicants who are determined ineligible for BC+ or MA will have to contact the Marketplace directly.

The Marketplace will use tax-based eligibility rules to determine if someone is eligible for assistance. States are required to align with the Marketplace by using the same tax-based rules to determine eligibility for BC+. Specifically, the Marketplace will determine income and household composition using the Modified Adjusted Gross Income, or MAGI, methodology. MAGI rules are based on tax rules and federal regulations published by the Centers for Medicare and Medicaid Services (CMS). Implementing MAGI rules for BC+ will introduce tax relationships into the process of determining household composition and income calculations for BC+.

CMS published new regulations in 2012 and 2013, to implement some of the provisions in PPACA. These regulations are effective January 1, 2014.

In addition to the changes introduced by PPACA and regulations, 2013 Wisconsin Act 20 (Act 20) includes changes to the income limits for BC+. These income limit changes are unrelated to the MAGI changes, and will affect all BC+ households, as of January 1, 2014.

This Operations Memo includes information on the following policy and system changes that will affect BC+ starting in 2014. The list below describes the sections within this memo and page that section begins.

- Policy changes that affect all BC+ populations starting January 1, 2014: These changes are not dependent on whether or not the household is being tested using MAGI rules. (Page 3).

- Modified Adjusted Gross Income (MAGI) Rules: This section outlines the changes that will affect BC+ households as they transition to the new MAGI rules. (Page 10.)

- CARES Worker Web (CWW) Changes: This section describes the new CWW pages as well as the new fields added to existing pages. (Page 33).

- New Medical Status Codes: New medical status codes have been created to accommodate the changes in benefit plans, funding sources and income limits. (Page 46).

- New Document Codes for Electronic Case File (ECF): ECF codes have been updated to include codes for verification of tax filing details and tax deductions. (Page 47).

- Correspondence Update: Notices, the verification checklist, case summary, etc. have all been updated. (Page 48).

- Cross Program Impacts: This section describes how the system changes will affect other programs of assistance. (Page 48).

POLICY CHANGES EFFECTIVE JANUARY 1, 2014:

The following policies are effective January 1, 2014. These changes in policy are not dependent on whether or not the individual or household is being tested using MAGI rules.

INCOME LIMIT CHANGES

2013 Wisconsin Act 20 includes changes to some of the income limits for BC+ starting January 1, 2014. The following new income limits will affect all BC+ members January 1st, regardless of when the individual transitions to the MAGI budgeting rules.

Adults: Non-pregnant adults age 19 or older must have income at or below 100% of the FPL to be eligible for BC+. This includes parents, caretakers and childless adults. The income limits have not changed for adults with a disability or adults 65 years of age or older who are being tested for Medicaid for the Elderly, Blind or Disabled (EBD MA).

Children: Children under 19 years of age must have income at or below 300% of the FPL to be eligible for BC+. Children with income over 300% of the FPL may become eligible by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150% FPL. Children with income over 150% of the FPL who are denied BC+ solely due to access to health insurance, may also become eligible for BC+ by meeting a deductible. The current process requiring a household to request a deductible for a child has not changed.

➢**NOTE:** Income limits have not changed for**:**

Pregnant Women: Pregnant women must have income at or below 300% of the FPL to be eligible for BC+. Pregnant women with income over 300% of the FPL may become eligible by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 300% FPL. The process for setting up a deductible for a pregnant woman has not changed.

Family Planning Only Services: BC+ Family Planning Only Services individuals must have income at or below 300% of the FPL.

The following table displays the new income limits for existing and potential BC+ members, effective January 1, 2014:

Coverage Group	**Income Limit**
Children (under 19 years old)	At or below 300% of the FPL
Pregnant Women	At or below 300% of the FPL
Parents & Caretakers	At or below 100% of the FPL
Childless Adults	At or below 100% of the FPL
Family Planning Only Services	At or below 300% of the FPL

In late September 2013, a letter was sent to all BC+ members with income over the new income limits notifying them of the upcoming change in the income limits. The letter contained information on the Marketplace and encouraged the members who appear to be over the new limits to go to the Marketplace and start the process for choosing an insurance plan and applying for tax credits and reduced cost sharing. This process must be completed by December 15th, to start coverage under the insurance plan on January 1st, and to avoid a gap in coverage.

CHILDLESS ADULTS

Wisconsin currently covers childless adults under the BC+ Core Plan through a waiver granted by the Federal Department of Health and Human Services (DHHS). Due to limited funding, the Core Plan has not been open to new enrollment since October 2009 when the Core Plan Waitlist was implemented. This waiver is ending December 31, 2013, and as described in Operations Memo 13-25, the Core Plan waitlist ended September 28th.

PPACA includes a provision that allows states to expand MA coverage to the childless adult population. Starting January 1, 2014, Wisconsin will provide MA coverage under the BC+ Standard Plan to any eligible childless adult. To be eligible, the childless adult must have income at or below 100% of the FPL and the following eligibility criteria:

- At least 19, but no more than 64 years of age,
- Not residing with any dependent children under age 19 who are qualifying relatives and under his/her care,
- Not pregnant,
- A U.S. citizen or qualifying immigrant,
- Provides an SSN, if not exempt from this requirement,
- Wisconsin resident,
- Ineligible for any full-benefit MA plan, and
- Not entitled to Medicare.

Childless adults will no longer be subject to:

- Health insurance access and coverage restrictions,
- Completing a health needs assessment as a condition of eligibility,
- Paying an annual application fee or premiums, or
- Obtaining a comprehensive physical exam.

There will no longer be enrollment caps or waitlists for anyone who meets the eligibility requirements. The change in the income limit for childless adults will mean those with incomes over 100% of the FPL will be terminated from the Core Plan effective December 31, 2013. Core Plan members with income over 100%, received a one-time letter in early October notifying them that it appears they will no longer be eligible for BC+ beginning January 1. The letter included information about the Marketplace. A Notice of Decision will be sent to all Core Plan members with income over 100% of the FPL in late November terminating their eligibility and advising them to go to the Marketplace. Core Plan members with incomes at or below 100% of the FPL will remain eligible for BC+ without having to file a new application.

Since Wisconsin will not have a program open to this population until January 1st, childless adults will not be able to apply for BC+ through ACCESS or their local IM agency until after November 18th, when CARES will determine January eligibility. Childless adults can apply for regular BC+ through their local IM agency prior to November 18th, but will be denied unless they are:

- A parent or caretaker,
- Under 19,
- Pregnant, or
- Eligible under an EBD MA or LTC MA program.

Childless adult applications submitted to the Marketplace will be referred to Wisconsin for processing, if the Marketplace determines the countable income to be at or under 100% of the FPL. Applications referred by the Marketplace between October 1st and November 16th will be submitted to the IM agency's inbox on November 18, 2013 for processing.

➢**NOTE:** Operations Memo 13-25 describes the changes to Core Plan renewal requirements and the waitlist process taking place in 2013.

BC+ BASIC PLAN:

The BC+ Basic Plan was implemented to provide limited coverage to individuals on the Core Plan Waitlist. As the Core Plan Waitlist will end and the childless adult population can now be eligible for BC+ or for assistance through the Marketplace, Act 20 ended the Basic Plan, effective January 1, 2014.

Basic Plan members received a one-time letter in early October notifying them of the program ending. The letter included information about the Marketplace, as well as the expansion of BC+ to cover childless adults who are within the new income limit. A termination notice will be sent to all Basic Plan members in late December. Basic Plan members must continue to pay their premiums to maintain coverage through December 31, 2013.

BENEFITS PLAN CHANGES:

Effective December 31, 2013, coverage under the Benchmark and the Core Plans ends. Starting January 1, 2014, all BC+ members, including childless adults, who meet the new program rules, will be enrolled in the Standard Plan. The Standard Plan is a more comprehensive benefit plan than the Benchmark and Core Plans. Children and pregnant women in the Benchmark Plan and Core Plan members who continue to qualify under the new income limits will transition to the Standard Plan effective January 1st and receive A Notice of Decision will be mailed in late November advising them of the change to their benefit plan.

HEALTH INSURANCE ACCESS AND COVERAGE:

Because of changes in the income thresholds at which parents, caretakers and childless adults will be eligible, no adult will be subject to the Health Insurance Access and Coverage tests. The 9.5% Past and Current Access/Coverage Tests for adults will be eliminated.

The current policy regarding the 80% Past Access and Current Access and Coverage Tests for children will continue to be applied to the following individuals:

- Children age 1 through 5 with AG income above 185% FPL and
- Children age 6 through 18 with AG income above 150% FPL.

If a child has current access, through the current employer of an adult family member who is currently living in the household, state health insurance, or employer-sponsored health insurance and the employer is paying at least 80% of the cost, the child will not be eligible for BC+, unless they meet a deductible.

If a child had past access to health insurance, including access due to a qualifying event in the twelve (12) months prior to the application or review date, they are not eligible for BC+ benefits, if the access was through the current employer of an adult family member who is currently living in the household and:

- The access was to a HIPAA health insurance plan through a current employer and the employer paid at least 80% of the premium, or through the State of Wisconsin's health care plan (regardless of plan type, or premium amount contributed by the employer); *and*
- The member is a child under age 19, is not exempt; and
- There is no good cause reason for not signing up for the coverage.

These conditions apply to both current and past access to health insurance.

The rules for health insurance coverage and access have not changed for the BC+ Prenatal Program.

PREGNANCY VERIFICATION:

Beginning January 1, 2014, verification of pregnancy, the due date, and the number of fetuses for BC+ or MA is no longer required. These items should not be questioned, unless there is other information that contradicts the applicant's statement deeming it questionable.

This new policy also applies to the BC+ Pre-natal Program (BC+PP). Eligibility for pregnant women under BC+PP will no longer be tied to the date pregnancy was verified. Instead, the eligibility effective date will be the first day of the month of application. Backdating of eligibility for BC+PP is still not allowed.

FORMER FOSTER CARE YOUTHS:

Formerly known as YEOHCs (Youth's Exiting Out-of-Home Care), youths who were in foster care, subsidized guardianships or court-ordered kinship care when they turned 18 will be eligible for BC+ up to age 26, starting January 1, 2014. It does not matter what state the youth

was residing in when the youth turned 18. Any former YEOHC whose case closed prior to January 1, 2014, due to turning 21, will have to reapply on or after November 18th, for eligibility beginning January 1st. CARES will not automatically re-establish eligibility for these individuals. The "out-of-home" status at the time the youth turned 18 does not have to be re-verified, if the youth re-requests benefits under this program starting January 1st.

Unlike YEOHC's who were required to have been born on or after January 1, 1990, Former Foster Care Youths born before that date are eligible, as long as they are under age 26. All other eligibility criteria for YEOHC's will continue to apply to Former Foster Care Youths. There will continue to be no income or asset test for this group as long as they are eligible under this status.

BACKDATED ELIGIBILITY:

The following individuals may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application:

- Parents/Caretakers with income at or below 100% of the FPL (for months prior to January 1, 2014, their income had to be at or below 200% of the FPL).
- Childless Adults with incomes at or below 100% of the FPL (excluding months prior to January 1, 2014).
- All pregnant women, except those eligible under the BC+ Prenatal Program, as long as their income was below 300% of the FPL in the backdated month, unless they are in a deductible.
- All Former Foster Care Youth.
- Children (unless they are in a deductible):
    - Infants less than 1 year old may have their eligibility backdated for any of the months in which their AG Income was at or below 300% of the FPL,
    - Children ages 1 through 5 may have their eligibility backdated for any of the months in which their AG income was at or below 185% of the FPL,
    - Children ages 6 through 18 may have their eligibility backdated for any of the months in which their AG income was at or below 150% of the FPL.

DEPENDENT 18 YEAR OLD:

Beginning January 1, 2014, for all BC+ members, an adult must be caring for a minor child or dependent 18 year old to be tested as a parent or caretaker. The definition of a dependent 18 year old is an 18 year old who is enrolled in school and expected to graduate before turning 19. School enrollment status and the expected date of high school graduation of an 18 year old should be verified, only if found questionable and the parent or caretaker's BC+ eligibility is being determined based on that child as a dependent 18 year old. The adult may be eligible as a childless adult if s/he is not caring for a minor, or if the only minor they are caring for is 18, but not a dependent 18 year old. The dependent status of an 18 year old will be captured on the "School Enrollment" screen.

The eligibility of the 18 year old will continue as a child, until s/he turns 19, and is not affected by dependent status.

The eligibility of parents and caretaker will not be affected by this change, until the next time a worker takes an action on the case. CARES will assume the 18 year old meets the dependent 18 year old status and continue to consider the adult(s) a parent or caretaker relative until the next time the worker runs eligibility on the case. At that point the worker should check the entries on the School Enrollment page if the Assistance Group (AG) changes for the parent or caretaker changes from a parent/caretaker AG to a childless adult AG.

SELF-EMPLOYMENT INCOME:

Starting January 1, 2014, depreciation and depletion will be allowable self-employment expenses and will be deducted from household income when determining BC+ eligibility for parents, caretakers, children, pregnant women and childless adults. These expenses will no longer be added back in to the self-employment income, when determining premium amounts for children.

ESSENTIAL PERSONS:

Starting January 1, 2014, individuals will no longer be eligible for BC+ as an Essential Person (BCP Eligibility Handbook, section 2.2.1.3).

EXTENSIONS:

Starting January 2014, ongoing BC+ members who are in 12-month earned income or 4-month child support Extension will remain in their Extension, until the end of their Extension certification period, as long as they continue to meet all other eligibility criteria. If the member in a child support or earned income Extension chooses to do their first MAGI renewal, prior to the end of the Extension, they will lose the Extension and go into a MAGI AG.

All BC+ Extensions that start in 2014 will be for 4 months regardless of whether the member is eligible under old BC+ rules or MAGI rules.

In general, the policies for becoming eligible for an Extension for BC+ families having their eligibility determined under the old BC+ rules are not changing in 2014. Families must have been eligible for BC+ with income at or below 100% of the FPL for 3 out of the last 6 months and had their income increase to over 100% FPL due to earnings and/or child support.

One exception to current rules is that currently, a child whose parents are counted but not eligible adults in the BC+ test group could become eligible in an Extension if a parent's earned income increased to put the group's income above 100% FPL. In 2014, a child can only become eligible for an extension if his or her parent becomes eligible for an extension.

Non-exempt adults with incomes above 133% of the FPL in an Extension will continue to be subject to premium requirements in 2014. However, starting January 1, 2014, non-exempt adults with incomes above 100% FPL will also be required to pay premiums. The premium cost for adults with incomes between 100% and 133% of the FPL will be 2% of the countable family income. They will also be required to report changes in income as it may affect the premium amount. The adult will close if the premium is not paid. Children will remain in the Extension, even if the parent closes for not paying a premium or verifying a change in income.

If a member's income drops to 100% of the FPL or lower, he/she will go out of the Extension and back into regular BC+.

Members eligible as a childless adult are not eligible for an Extension.

PREMIUMS:

Starting January 1, 2014, the following changes will be made to BC+ premium policies:

- All children under age one (1), not just Continuously Eligible Newborns (CENs) will be exempt from paying premiums.
- Children will be exempt from paying premiums if they are:
  - The grandchild or child of a tribal member or
  - Eligible to receive Indian Health Services
- Premium amounts for children in families with self-employment income will be based on net self-employment income, after depreciation is subtracted out.
- There will no longer be 5% premiums for families with self-employment income exceeding 200% of the FPL.
- Adults will no longer have to pay premiums, unless they are a parents or caretaker in an Extension.

BC+ premium payments will continue to be a non-financial condition of eligibility in 2014. Initial premium payments are required to be paid before eligibility is confirmed and the members are enrolled.

The first month is free if no one in the BC+ group was eligible for BC+ or MA in the previous month, and the BC+ AG has not received a free month in the previous 12 months.

Adults in an Extension are not given a free month.

The following individuals must pay a premium to become or remain eligible for BC+:

- Children with incomes above 200% FPL, unless they are:
  - Under age one (1) (this includes all infants, not just CENS)
  - Pregnant
  - Eligible in a BC+ Extension
  - Eligible in a met deductible
  - A Former Foster Care Youth (YEOHC)
  - The child of a parent in BC+ Extension and that parent is paying a premium
  - An American Indian or Alaska Native tribal member
  - The grandchild or child of a tribal member
  - Eligible to receive Indian Health Services
- Adults in a BC+ Extension, unless they are:
  - Pregnant
  - A Former Foster Care Youth (YEOHC)
  - Blind or disabled, or MAPP Disabled (includes presumptively disabled)
  - An American Indian or Alaska Native tribal member
  - The grandchild or child of a tribal member
  - Eligible to receive Indian Health Services

A 5% cap will continue to apply to children's premiums. In keeping with current policy, the household level premium amount must be paid in order for all children in the household to remain eligible.

Non-exempt adults in an Extension will be required to pay a premium. The premium will be calculated using a sliding scale from 2% up to 9.5%, based on the group's income.

If an adult in an Extension is required to pay a premium, no premiums will be required for any child in that household.

RESTRICTIVE RE-ENROLLMENT:

Starting January 1, 2014, Restrictive Re-enrollment Periods (RRPs) for children who fail to pay a premium will now be for 3 months. After the 3 month RRP is served, the arrears will be forgiven. Children will also have the option to re-enroll within the 3 month period as long as they pay all premiums due and request to re-enroll prior to the end of the RRP.

Example: Lucy's parents did not pay the June premium for Lucy's BC+. Lucy will be in a 3 month RRP for July, August & September. Lucy's mother contacted the IM agency in August and requested to have her BC+ re-instated. Lucy's mother will have to pay the June, July and August premiums in order to re-instate Lucy's BC+. If Lucy's mother had not contacted the IM agency until after September 30th, Lucy would not have been able to re-enroll for July, August or September. In that situation, the June premium would have been forgiven.

NOTE: If a parent reports in the third month of an RRP that a change occurred in the first month of the RRP that would make the child no longer subject to premiums, and the change is verified, apply the change retroactively and re-enroll the child without any arrears due as of the first month of the RRP.

An adult for whom a premium is owed for the current month who leaves BC+ by quitting or not paying the premium will be subject to a 12 month Restrictive Re-enrollment Period. Children are not subject to an RRP for quitting BC+.

Any children in a 6-month RRP or adult in a 12 month RRP on or before December 31, 2013, will continue with the existing RRP end date after January 1, 2014. Members whose income decreases to an amount that would not require a premium, will be removed from the RRP and re-enrolled in BC+.

RRPs in place for Core Plan members as of December 31, 2013 will end. No Core Plan members with income requiring a premium will remain eligible after January 1, 2014, due to the new income limits.

MODIFIED ADJUSTED GROSS INCOME (MAGI) RULES:

As described above, MAGI is a new methodology for determining BC+ eligibility, and it is distinct from the income limit changes that take effect for all BC+ members on January 1, 2014.

Use of MAGI rules will be effective for eligibility determinations for all new BC+ applications with a filing date of January 1, 2014, or later. BC+ members eligible for December 2013, who continue to be eligible under the new income limits in January 2014, are considered to be "ongoing beneficiaries", and they will transition to the new MAGI rules at their next scheduled renewal or March 31st, whichever is later. Applicants with a filing date in 2013, AND who are determined eligible for the month of December, will be considered "ongoing beneficiaries" and will continue to have their eligibility determined under the current BC+ rules ("old rules"), even if the application is processed in 2014.

Applicants with a filing date of January 1, 2014 through March 31, 2014, who request backdated benefits for a month in 2013, will have eligibility determined using the old rules for the backdated months in 2013. Even if they are determined eligible for December 2013, eligibility for any month in 2014, will be determined using MAGI rules because the application filing date is on or after January 1.

MAGI rules will be used for BC+ eligibility, Emergency Services MA for non-qualifying immigrants who would otherwise be eligible for BC+ and for Tuberculosis (TB) MA. The rules do not apply to:

- Eligibility for EBD or LTC programs. Individuals eligible as a Group A Waiver based on BC+ Standard Plan eligibility will have their BC+ eligibility tested using MAGI rules.
- Individuals over 65, unless the individual is a parent or caretaker being tested for BC+.
- Individuals receiving MA through another federal or state program such as SSI, Foster Care, Adoption Assistance or Well Woman MA.

CONVERSION OF ONGOING BENEFICIARIES TO MAGI RULES:

Ongoing beneficiaries who would lose eligibility for BC+ for excess income under the old rules must have their eligibility re-determined under MAGI rules at the time s/he is failing under the old rules.

Ongoing beneficiaries with a renewal in January or February will be tested first using the old BC+ rules. If eligible under the old rules, CARES will not test using MAGI rules. If the household is ineligible under the old rules, CARES will test using MAGI rules. If ineligible under both old and MAGI rules, CARES will terminate eligibility and send a case file (known as an "account") electronically to the Marketplace to expedite an application for private health insurance and APTC. The Notice of Decision will contain language notifying the applicant or member their account has been transferred to the Marketplace. The signature pages on the paper applications and ACCESS will be updated with language notifying the applicant their account will be transferred to the Marketplace, if they are found ineligible for BC+ and MA.

Ongoing beneficiaries with a January or February 2014 renewal who are found eligible under the old rules will transition to MAGI rules through a conversion batch run done on February 22, 2014. Ongoing members with renewal due in March 2014, or later will transition to MAGI rules at the next scheduled renewal, unless a change ends financial eligibility under old rules.

Workers must start to collect MAGI information on new applications and renewals starting November 18, 2013, to enable CARES to automatically test for eligibility under MAGI rules if anyone in the household loses eligibility for BC+ under the old rules. If MAGI information is not entered into CWW and someone loses financial eligibility under the old rules, workers must request MAGI information from the household and re-determine eligibility under MAGI rules before being able to confirm the termination of BC+.

Ongoing childless adult members will transition to MAGI rules at their next renewal on or after January 1, 2014. January and February reviews will not determine eligibility under the old rules for any childless adult.

For FPOS renewals, an ongoing beneficiary whose renewal is due in January or February will be tested under old rules and, if eligible, certified for 12 months of continuous eligibility. They will transition to MAGI rules at their next renewal. FPOS members with a renewal due in March 2014 will transition to MAGI at the next scheduled renewal.

While FPOS individuals will continue to have their eligibility for FPOS frozen for the 12-month certification period, an FPOS member eligible under the old rules may request to complete an early renewal and transition to MAGI rules prior to the end of their current certification period. Once transitioned to MAGI rules, the FPOS individual's 12-month certification period set for the old rules will end.

EBD/BC+ CHOICE:

When determining eligibility for individuals who meet non-financial criteria for health care as both an EBD individual and as a parent, caretaker, child, childless adult or pregnant woman under MAGI, CWW will explore eligibility for both EBD MA and BC+ simultaneously.

If the individual meets all non-financial and financial criteria for EBD MA and BC+, CWW will continue to choose the "best" benefit for the individual. In most cases, this will be EBD MA. However, is a pregnant woman is eligible for both, she will be put into BC+. CWW will continue to allow IM workers the ability to make a choice between the programs, if there is a reason the applicant chooses to enroll in one or the other.

If the individual fails to meet either the non-financial or financial criteria for EBD MA, CWW will explore eligibility under MAGI, and as long as all non-financial and financial criteria are met, CWW will make the individual eligible as appropriate in the AG under BC+. This includes situations in which an individual is waiting for a disability determination or has an unmet deductible. It also includes situations in which an individual does not meet the asset test for EBD MA, or fails to verify assets.

If an individual does not meet non-financial and/or financial criteria for either EBD MA or BC+, their application will be denied and transferred to the Marketplace.

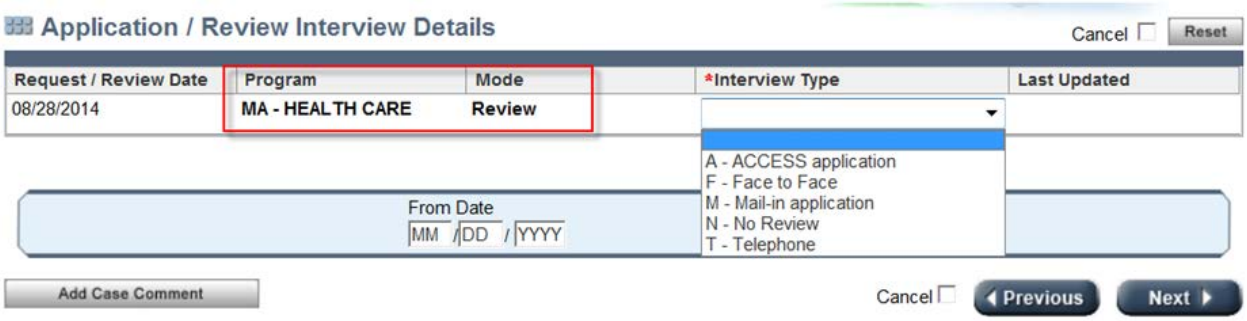
Childless adults can be eligible under BC+ until they turn 65 or become entitled to receive Medicare. These adults can be eligible under BC+ if they have had a disability determined but are not yet eligible for Medicare. A new alert, "503-Elig adult turning 65 Run Elig", will be generated whenever a BC+ member is turning 65. Workers must run eligibility and test the person for EBD MA. If the member is open for BC+ as a parent or caretaker, CARES will test eligibility for both BC+ and EBD MA as described above.

The case will also be triggered to go through the Adverse Action batch run in the month the childless adult will turn 65.

Because all BC+ members will be covered under the Standard Plan, anyone eligible for BC+ who is also requesting a Home and Community Based Waiver Program, including Partnership and Pace, will be eligible as a Group A Waiver participant based on his/her eligibility for BC+ Standard Plan. This includes a childless adult eligible for BC+.

RENEWALS:

Per federal regulations, renewals for BC+, under MAGI rules, must be completed once every 12 months, but not more than once every 12 months. For this reason, we will no longer be able to automatically consider a renewal for FoodShare, CTS or Childcare as a renewal for Health Care. Review dates between BC+ and other programs will no longer be automatically aligned. A household can request to complete an early renewal for BC+, either separately from or in coordination with a renewal for another program. The request must be documented in Case Comments. The CWW "Application/Review Interview Details" page will be updated to add "Health Care Renewal" to the drop down box. Workers will have to indicate on this page that the renewal is counted for Health Care.



The 12-month certification period for BC+ will be set at the case level. so BC+ renewals for the AGs within a case will be aligned as often as possible. If a new AG opens, the renewal date for that AG will be aligned with the current case level renewal date.

When a case includes AGs with a 12-month certification period, as well an AG with a time limited benefit (CEN, pregnant woman, deductible or extension) and the case level renewal date for the 12-month certification is greater than the renewal date for the limited time benefit AG, CARES will hold the case level renewal date set for the AG with the 12-month certification period. When the worker re-determines eligibility for the individual in the time limited benefit, the new AG renewal date will align with the current case level renewal date. A full renewal is no longer required for someone who no longer has a time-limited benefit, such as a woman at the end of her post-partum period or a CEN turning 13 months as long as there is a case level renewal date that is greater than the renewal date for the limited time benefit.

Example: Mary is eligible as a parent (MAGA) with a renewal date of 9/30. Her daughter Lizzy is eligible as a CEN with a renewal date of 5/31. When the worker runs eligibility in May to re-determine Lizzy's eligibility, a new MAGC AG is built. The renewal date for the MAGC AG will align with the case level renewal date of 9/30.

When the case level renewal date is based on an AG's 12-month certification and a time limited benefit AG on the same case has a later renewal date, the time limited benefit would remain open even if the household failed to complete a renewal for the AG with the 12-month certification period. If the renewal for the AG with the 12-month certification period is completed, the renewal date for the time limited benefit would remain the same and the process in the example above would follow.

In addition, BC+ members, whose eligibility has been determined under MAGI rules, and who subsequently lose eligibility for failure to complete a review or to verify information for a review, will have 90 days to complete their annual review or provide verification, and reinstate their eligibility without having to file a new application. In order to process a late renewal for benefits back to the 1st day of the month of closure, all financial information will have to be provided for each month of past eligibility.

Example: Joanne's renewal was due June 30th. She did not complete the renewal and her case closed for July. On September 20th, Joanne submitted her renewal. In order to determine her eligibility starting July 1st, Joanne must report income, expenses and household composition for July, August and September, as well as submit any necessary verification.

CWW will be updated to allow a worker to reactivate BC+ up to 3 months after the closure date.

FPOS members will continue to be certified for 12-months of continuous eligibility.

Because MAGI information must be collected at the next renewal in 2014, Administrative Renewals will be suspended for 2014 BC+ renewals.

HOUSEHOLD COMPOSITION:

MEMBERS WHO CAN FILE TOGETHER:

The rules concerning who may be included in a BC+ application and be determined eligible on the same case are not changing under MAGI rules. Only the following individuals, living in the same household, may be eligible on the same case:

- Primary Person
- Primary Person's Spouse
- Natural and adopted minor children under age 19 of Primary Person and/or Primary Person's Spouse
- NLRR minor children under age 19, in a qualifying relationship with the PP or PP's spouse, and who are under the care of the Primary Person or Primary Person's spouse
- Natural/acknowledged parents of included minors
- Minor siblings (full, half, step) under age 19 of included children
- Spouse, son and daughter of included minors

Individuals living outside of the household and adults age 19 or older who do not meet the criteria listed above may be included as a counted individual in a MAGI BC+ Assistance Group (AG) with other members of this household, but must apply for benefits on a separate application.

Example: A 22-year-old college student living with his/her parents must apply separately, even if he/she is a tax dependent of his/her parents.

TAX INFORMATION:

Tax filing status and tax dependency information are used to form BC+ AGs, under MAGI rules. This information is based on what the household expects to do with regard to filing taxes for

income received in the current year. The tax filing status and tax dependency information is based on the expectation of the household and is not required to be verified unless it is questionable, because there is other information that contradicts the applicant's statement.

In order to build the BC+ AGs under MAGI rules, the following information is required for each household member:

- Does the person expect to file taxes for the income s/he has this year?
  - If so, what is his/her tax filing status?
    - Single (or Head of Household)
    - Married Filing Jointly
    - Married Filing Separately
  - Whom do they expect to claim as tax dependents?
    - Tax dependents can be living in the same home as the tax filer or outside of the tax filer's home.
    - Tax dependents may be deceased. A deceased tax dependent can be claimed for the tax year they passed away. The individual will be included as "counted" in any BC+ AG he or she is pulled into but s/he cannot be eligible after the date of death.
  - Is anyone outside the household planning to claim the tax filer as a tax dependent?
- How are the individuals in the home related to one another?

Tax dependents who are living outside of the home or who are deceased must be added to CARES to be included in the BC+ AG as a counted member. Tax co-filers living outside the home must also be added to CARES. However, a deceased tax co-filer should not be added. Limited information is required to add these tax dependents and co-filers to the household:

- Name
- Gender
- Birthdate

If these criteria are not provided, the person will not be included in the tax filer's assistance group.

It is critical that workers adding a tax dependent or co-filer who lives outside the home consider any partial matches displayed when taking that person through clearance to avoid creating a duplicate PIN for an individual already known to CARES. ACCESS will ask for the SSN for these individuals, but because they cannot be made eligible on this case, they are not required to provide their SSN.

Married couples who are living apart and not temporarily absent, and who are filing taxes as "Married Filing Jointly", must be included in each other's cases. The income of the spouse living outside of the home must be collected. His/her countable income will be budgeted and s/he will be included in the spouse and children's AGs, even though s/he will not be eligible for benefits on this case.

Example: Janet applied for BC+ for herself and her child, Michael. Janet is separated from her husband, Ben, but they are still planning to file taxes as "Married Filing Jointly" for the current year. They are expecting to claim Michael as a tax dependent. Because Janet and Ben expect to file jointly, Ben must be added to Janet's case, along with his taxable income. He will be included in Janet and Michael's AGs but Ben would not be eligible on this case since he does not live in the household. The same rules would apply to Ben, if he applied on a separate application. He would have to include Janet and Michael, along with Janet's taxable income on his case.

➢**Note:** In situations where a spouse is unable to obtain income information for a separated spouse and the parent or caretaker has filed a good cause claim with the Child Support agency and that claim has not been denied, workers should proceed to determine eligibility without information from the absent parent. In those situations, treat the case as though the parents are married filing separately and ignore the absent parent's income.

With the exception of spouses who are living outside of the home but are planning to file jointly, tax and income information for individuals living outside of the home who are claiming any household members as tax dependents, will not need to be collected. This includes an absent parent who is claiming a child in the household as a tax dependent.

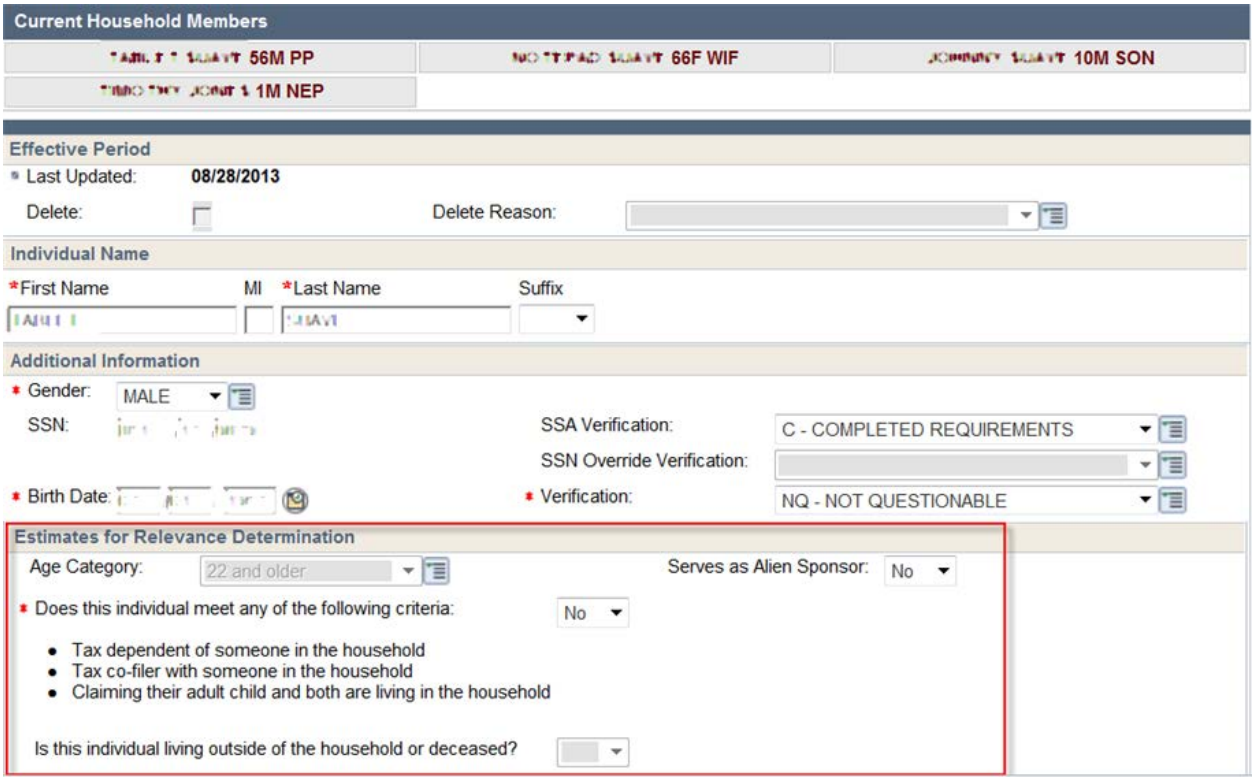
Tax dependents and co-filers who are outside of the home will be added as household members in CWW.

These individuals should be coded as "01-living in the household" on the "Current Demographics" page. A new question will be added to the "Current Demographics" page, to indicate the person is a tax dependent or co-filer living outside the household.

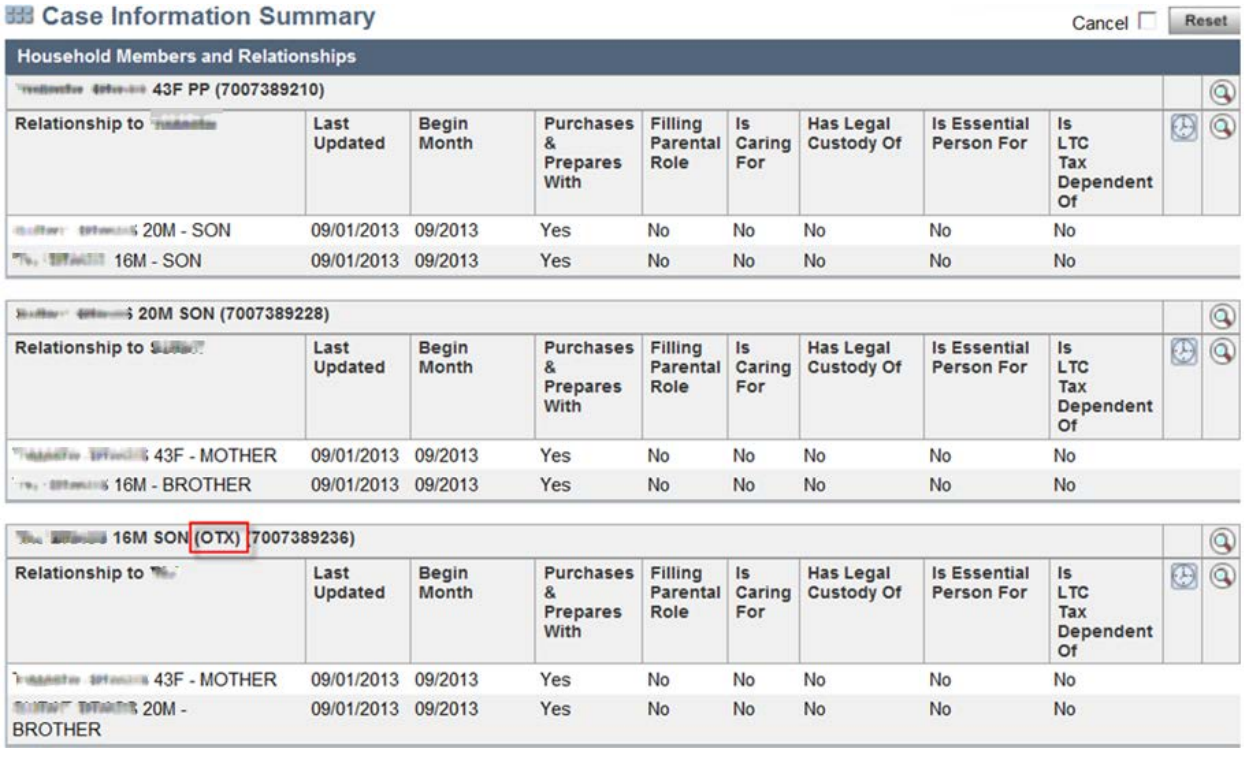
There will be new indicators in CWW to identify tax dependents or tax co-filers listed on the case who are living outside the home or who are deceased. Eligibility logic for other programs will be updated so these members are not counted or made eligible for other programs.

- OTX – Tax Dependent or Tax Co-Filer living OUTSIDE the home
- DTX – Deceased Tax Dependent
- DEC-Deceased Individual

New Question on the Current Demographics Page



New Indicators



BUILDING ASSISTANCE GROUPS USING MAGI RULES

Under MAGI rules, BC+ Assistance Groups (AG) are generally built based on tax filing status and tax dependency. This subset of MAGI rules is referred to as "Tax Rules". In some situations, the AG is built based on family relationships. This subset of MAGI rules is referred to as "Relationship Rules". An AG will be built for each individual (the target) in the household requesting health care benefits who meets the criteria to be eligible on the case.

Please refer to Attachment 1: *Forming a BC+ MAGI Assistance Group*, for the step-by-step process for forming a BC+ AG.

CHILD WELFARE PARENTS

Child Welfare Parents will continue to be tested as a parent or caretaker, but whether or not the child will be counted in the parent's AG will follow the new MAGI rules for building the AG.

TAX FILING RULES

If the target is a tax filer and NOT also a tax dependent, the target's group will include:

- The target,
- His/her spouse (if living in the household and/or filing jointly), and
- All expected tax dependents of the target, including those who are deceased or living outside the home.

If the target is a tax dependent of someone in the home, his/her AG will include the same individuals as that of his/her tax filer, unless one of the following exceptions is met. If one of these exceptions is met, the AG will be built using relationship rules.

1. The target is neither a tax filer nor a tax dependent, or

2. The target is a tax dependent who meets one of the following exceptions:
   - He/she will be claimed as a tax dependent by someone other than his/her parent or spouse, OR
   - He/she is living with both parents (this includes a parent and step-parent), but his/her parents are not filing taxes jointly; OR
   - He/she will be claimed as a tax dependent by his/her parent who lives outside of the household.

Under tax rules, if a minor child is a tax filer and is not claimed as a tax dependent by anyone in the home or by a parent outside of the home, that minor child's eligibility will not be affected by his/her parent's income, but instead be based solely on his/her own income, unless the child is married or has tax dependents.

Example: John is a single father filing taxes and claiming his two children who live with him as tax dependents. He is also claiming his nephew, Joseph, as a tax dependent. Joseph does not reside with John. John does not provide Joseph's date of birth, so Joseph cannot be included in John's AG. John's AG would include John and his two children.

Expected tax filing status and expected tax dependents do not need to be verified unless questionable. In situations where divorced parents indicate that they both expect to claim a given child as their tax dependent, verification should be requested. If the verification indicates definitively which parent can claim the child, then only that parent will have the child included in his/her AG. However, if a child's dependent status is found questionable and verification is requested and not provided, use relationship rules to determine if the parent(s) of that child will still be able to have the child included in his or her AG. This special rule only applies to children and their parents; for any tax dependent who is not the child of the tax filer, the dependent will not be included in the group, if verification is requested but not provided.

RELATIONSHIP RULES:

There are some exceptions when relationship rules will be used to form the AG. Note that these relationship rules are different from the rules that went into effect with the implementation of BC+ in 2008. Relationship Rules will be used when:

1. The target is neither a tax filer nor a tax dependent, or

2. The target is a tax dependent who meets one of the following exceptions:
   - S/he will be claimed as a tax dependent by someone other than his/her parent or spouse, OR
   - S/he is living with both parents (this includes a parent and step-parent), but his/her parents are not filing taxes jointly; OR
   - S/he will be claimed as a tax dependent by his/her parent who lives outside of the household.

Relationship rules are based on qualifying relationships and legal responsibility. MAGI groups formed using relationship rules **DO NOT** include people who are deceased or living outside the home.

If the target is age 19 or older and relationship rules are used, the AG includes the target, the target's spouse and the target's children under age 19.

If the target is under age 19 and relationship rules are used, the AG includes the target, the target's spouse, the target's children under age 19, the target's parents and the target's siblings (including half- and step-siblings) under age 19.

➢**Note:** Unmarried parents are not included in each other's group under relationship rules, even if they have a child in common.

SPECIAL RULES:

There are two "special rules" related to MAGI methodology:

1. If a married couple lives together, they will always be pulled into each other's AG, regardless of filing status.
2. As described above, if a worker deems a tax dependent's status to be questionable, use the relationship rules to determine whether the individual should be included in the tax filer's group. Tax dependents who are the child of a tax filer and living in the home will

be pulled into the tax filer's assistance group, if their dependent status is questionable and not verified.

Example: A mother states that she is claiming her 12 year old son in 2014. The child lives with both parents more than 40% of the time. The worker is told by the father who is open on a separate case that the child will be claimed by him for in 2014. The worker requests verification but verification is not received. When the worker enters the "QV" in the verification field, CARES will use relationship rules and pull the child into both the mother and father's AGs.

JOINT PLACEMENT:

Current BC+ policy regarding joint placement of children will remain the same (see BC+ Handbook 2.2.1.2: Joint Placement). This means that both parents can be considered a caretaker of the child, as long as the child resides with each of them at least 40% of the time. Their eligibility will be determined as a parent/caretaker, instead of as a childless adult. Both parents will be tested as parents. The AGs will then be formed based on the tax filing and tax dependency status in each case.

When parents are divorced, only one parent can claim the child as their tax dependent in a given year. If both parents are filing taxes, this means that only one parent should include the child in his/her MAGI AG. If only one parent is filing taxes or if no parent is filing taxes, it is possible that both parents will have the child in their MAGI group. When neither parent is filing taxes, and the child lives with both parents at least 40% of the time, the child may be put into both parents' MAGI AGs due to relationship rules. In addition, if a married couple who have both applied for health care on separate cases, do not live together, but will be filing "Married Filing Jointly", the child can be pulled in as a tax dependent into both parents' AGs.

MILITARY MEMBERS:

According to tax rules, deployed military members may still be considered part of the household if they are:

- Claiming a dependent,
- Being claimed as a dependent, or
- Filing jointly with a spouse in the home.

Under MAGI rules, if the absent military member is claiming a dependent in the home or filing jointly with a spouse in the home, that member's taxable income will count in the household and s/he will also be included in the household's group size, as appropriate. This military member will be included as part of the AG, but they will not be eligible for assistance on this case. If a household member is absent due to Military activity, their living arrangement should be coded using the code "13 – Military". If the military member is filing separately and not claiming any dependents in the home, or if the married couple is living apart and not planning to file taxes, do not add the military parent to the case. Certain types of military pay, including combat pay are still considered disregarded as income.

Example: The household consists of married parents, and two children. Dad is absent from the home solely due to military deployment. Mom and dad plan to file taxes as "Married Filing Jointly" and will claim both children as tax dependents. All four members of the household should be listed in CWW. On the Current Demographics page, dad's living arrangement should

be coded as “13 – Military”. Dad will not be eligible for any program of assistance on this case, but he will be included in other household member’s BC+ AGs assistance groups based on MAGI household composition rules and his taxable income will be budgeted in the AGs as appropriate.

FAMILY PLANNING ONLY SERVICES (FPOS):

Eligibility for individuals requesting FPOS will be determined using MAGI income budgeting rules. However, all FPOS assistance groups will be considered a household size of one, even if the member is pregnant. Income of a spouse or parent would never be counted when determining FPOS eligibility for an individual.

ASSISTANCE GROUPS AND SEQUENCES:

The following tables shows the new BC+ AGs that will be built once the target is tested, using MAGI rules instead of the old BC+ rules. These apply whether the group is tested under tax filing rules or relationship rules. The existing BC+ AGs will continue to display as long as the AG is tested using the old BC+ rules. Throughout 2014, workers may see both old AGs and new MAGI AG’s on one case. This can happen prior to the case’s MAGI-based renewal, when a new or existing case member is found ineligible under old BC+ rules and is subsequently tested and found eligible using MAGI rules.

Assistance Group	Description
MAGA	People age 19 or older who are parents, or stepparents of a child in the home.
MAGC	Children under age 19, living alone or with a parent or parents.
MAGB	Continuously Eligible Newborns
MAGP	Pregnant women, including those who become eligible by meeting a deductible or who are eligible for the BC+ Prenatal Program
MAGY	Former Foster Care Youth (formerly known as YEOHCs)
MAGN	People who are caretaker relatives, or the spouses of caretaker relatives in the home.
MAGL	Child living with a Non-legally responsible relative.
MAGS	Childless Adults (non-pregnant, adults ages 19 to 64 who are not living with/caring for children under 19)
MAGM	Individuals in an extension who have to pay a premium.
MAGD	Children who are eligible through a deductible.
MAGE	Adults and children in an Extension who are not required to pay a premium.
FPS	People enrolled in Family Planning Only Services

PARTICIPATION STATUS CODES:

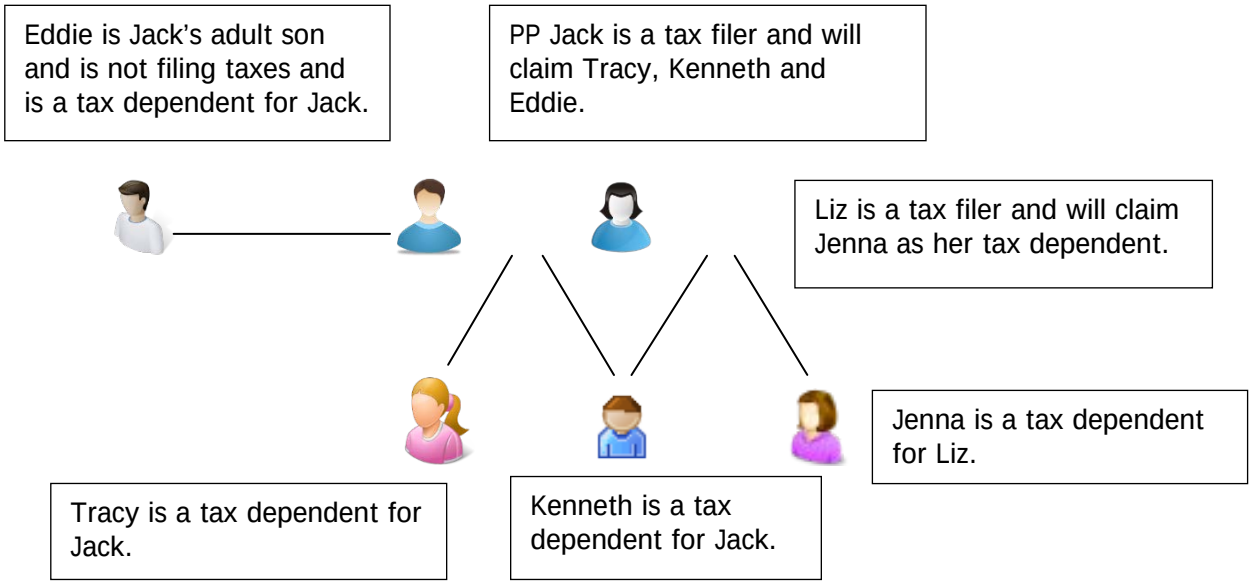
Participation status codes will not change under MAGI, but "Test Adult" and "Test Child" participation status codes will no longer be used. All individuals in a MAGI AG will be listed under one of the following participation statuses.

EA	Eligible Adult	Non-financially eligible in this BC+ AG
CA	Counted Adult	Ineligible for BC+ in this AG
XA	Excluded Adult	Ineligible for BC+ in this AG
EC	Eligible Child	Non-financially eligible in this BC+ AG
CC	Counted Child	Ineligible for BC+ in this AG
XC	Excluded Child	Ineligible for BC+ in this AG

A separate AG and sequence will be built for each target in the household. Multiple sequences of an AG can be built within the same case.

Example: A household with two non-marital co-parents, each with their own child and one child in common could have five AGs within their case:

Jack and Liz are non-marital co-parents, each is a tax filer. They have a child in common, Kenneth. Jack has a child of his own, Tracy. Liz has a child of her own, Jenna. Liz will be claiming Jenna as a tax dependent. Jack's adult son Eddie also lives in the home. Jack will be claiming Eddie, Tracy and Kenneth as tax dependents.



The following chart shows how the AGs are built for each family member.

Medicaid Eligibility For	Tax or Relationship Rules	Assistance Group and Sequence	Jack	Liz	Eddie	Tracy	Kenneth	Jenna	Group Size
Jack	Tax Filing Rules (Tax Filer)	MAGA 01	EA	XA	CA	CC	CC	XC	4
Liz	Tax Filing Rules (Tax Filer)	MAGA 02	XA	EA	XA	XC	XC	CC	2
Tracy	Tax Filing Rules (Tax Dependent)	MAGC 01	CA	XA	CA	EC	CC	XC	4
Kenneth	Relationship rules	MAGC 02	CA	CA	XA	CC	EC	CC	5
Jenna	Tax Filing Rules (Tax Dependent)	MAGC 03	XA	CA	XA	XC	XC	EC	2

- Jack is a tax filer. His assistance group will include himself, and his tax dependents Tracy, Kenneth and Eddie, using tax filing rules.

- Liz is filing taxes and will claim daughter Jenna as a tax dependent. Liz's group will include herself and her daughter using tax filing rules.

- Tracy is being claimed as a tax dependent of Jack (and does not meet any of the exceptions), so using tax filing rules will have the same individuals in his assistance group as father Jack (Jack, Tracy, Kenneth and Eddie).

- Kenneth is being claimed by his father as a tax dependent, but his mother is also in the home. Because he meets the exception rules, his AG will be formed using relationship rules. The group includes him, his father and mother, and his half-sisters Tracy and Jenna. Even though Eddie is Kenneth's half-brother, he is not included in Kenneth's group because he is over age 19.

- Jenna is being claimed as a tax dependent of her mother (and does not meet any of the exceptions). Using tax filing rules Jenna's group has the same individuals as her tax filer's group, so her group includes herself and her mother.

- Eddie is a tax dependent of his father and lives in the home. Because he is over age 19, he must apply for assistance on his own case (the new childless adult category), however he has a group size of four because he meets the rules for his group having the same individuals as his tax filer's group.

AGs with the exact same household composition under MAGI rules will be "rolled up" and included in one sequence.

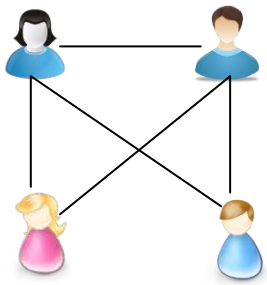
For children, MAGC sequences will be rolled up using the sequence for the oldest child in the group. In the situation with twins, the sequences will rolled up based on the lowest PIN.

For adults, MAGA sequences will be rolled up using the sequence for the primary person, as long as the primary person is requesting health care. If the primary person is not requesting health care, the MAGA sequence will rolled up based on the sequence of the oldest adult in the group.

Example: A married couple filing taxes jointly with two children would have the same group compositions for the two adults and two children, so the MAGA and MAGC AGs would be rolled up.

Peg and Al are married filing jointly and claiming both of their children. Al is the primary person and Beth is 1 year older than Kip.

Peg is filing taxes jointly with Al. They are claiming both children as tax dependents.



Al is filing taxes jointly with Peg.

Beth is not filing taxes and is being claimed as a tax dependent.

Kip is not filing taxes and is being claimed as a tax dependent.

Medicaid Eligibility For	**Tax or Relationship Rules**	**AG and Sequence number**	**Al**	**Peg**	**Beth**	**Kip**	**Group Size**
Al	Tax	MAGA 01	EA	CA	CC	CC	4
Peg	Tax	MAGA 01	CA	EA	CC	CC	4
Beth	Tax	MAGC 01	CA	CA	EC	CC	4
Kip	Tax	MAGC 01	CA	CA	CC	EC	4

- Al's assistance group includes himself, spouse Peg, daughter Beth and son Kip.
- Peg's assistance group includes herself, her spouse Al, daughter Beth and son Kip. Since her AG is the same composition as Al's AG, they will be "rolled" up into one MAGA AG, sequence 01.
- Beth's assistance group includes herself, her parents and her brother.
- Kip's assistance group includes himself, his parents and his sister. Since his AG is the same composition as Beth's, they will be "rolled" up into one MAGC AG, sequence 01.

INCOME CALCULATIONS:

Once a case or individual has transitioned to MAGI rules, his/her income calculations will be based on taxable income. This is true whether tax filing rules or relationship rules are used to build the BC+ AGs. There are four steps to determining what income to count for each individual.

- What is the timeframe for counting income?
- Whose income is counted?
- What income types are counted or disregarded?
- What deductions are allowed?

TIMEFRAME FOR COUNTING INCOME

The existing BC+ rules for determining eligibility based on current monthly income will continue when MAGI rules are applied. The same policies for prorating income in the following situations will also continue:

- People employed only during the school year
- Migrant workers
- Self-employed people
- People with periodic income

WHOSE INCOME IS COUNTED?

The countable income of all eligible or counted members within a BC+ AG is used in the eligibility determination for that AG with one exception:

If a group member is a child or tax dependent of another counted or eligible member of the same group, his/her income is only counted in that group if s/he is expected to be required to file a tax return for the current year, regardless of whether or not the child or tax dependent actually files or plans to file a tax return. If that child or tax dependent is not expected to be required to file a tax return, his/her income is not counted for that AG. When a child or tax dependent is expected to be required to file a tax return, his/her countable income will be included when determining eligibility for the AG.

Currently, children and tax dependents are only required to file a tax return if they have more than:

- $950 per year in taxable unearned income or
- $5,950 per year in taxable earned income.

These amounts are subject to change yearly. CWW and ACCESS will be updated with the new amounts. If the child or tax dependent of another member in the same AG expects to have less annual taxable income than the amounts above, we will not include his/her income in the eligibility determination for the AG. This is true even if the child or tax dependent chooses to file taxes for other reasons such as getting a tax refund.

➢**Note**: Taxable unearned income does not include child support, Supplemental Security Income (SSI), Worker's Compensation, Social Security or Veterans Benefits. For purposes of determining whether a child or tax dependent is above the $950 threshold, Social Security Income should also be excluded, even though this is not disregarded income.

CWW, ACCESS and the paper application will be updated to ask if the child or tax dependent is expected to have income in excess of each of the thresholds. If the answer to any of the questions is "'yes", CARES will count the income of that child or tax dependent. If the question is not answered on the application, the worker should enter a "?" and pend eligibility. If the applicant does not submit an answer to these questions, an "F" should be entered and BC+ eligibility denied. If one question is answered "yes", CARES will not pend or fail if a "?" or "F" is entered for the other income type.

The exception for counting a child's or tax dependent's income is only allowed when the person is a child or tax dependent of another counted or eligible member of the AG. When a child or tax dependent is being tested in an AG that does not include their parent or tax filer, the child's or tax dependent's income is always counted for their group. This includes children under age 19 enrolled in FPOS.

An NLRR child AG will not include his/her parent or tax filer so NLRR children's income will always be counted for the NLRR child's AG.

Example 4: Howie is 16 and lives with his grandmother Alice. Alice expects to file taxes for the current year and intends to claim Howie as a dependent. Alice works for the school and makes $1,200 per month. Howie works part time and earns around $150 per month.

Because Howie's income is less than the $5,950 filing threshold, Howie is not expected to be required to file taxes.

In Alice's AG, Howie will be a counted child, but his income will not count because he is a tax dependent of someone in his group and he is not expected to be required to file taxes.

In Howie's AG, he is the only counted or eligible person, so his monthly income will count for his eligibility determination.

WHAT INCOME TYPES ARE COUNTED?

The policy for most countable income for BC+ is not changing. Refer to the BC+ Handbook (chapter 16.1), for disregarding or counting specific income type rules. When testing eligibility under MAGI rules, the following income types will no longer be counted:

- Child Support Income
- Worker's Compensation
- Veterans benefits

These types of income are not taxable so are not counted when determining BC+ eligibility.

➢**NOTE:** Social Security income is not usually taxable income, however it will continue to be counted for BC+ because of a special provision in federal law. As noted above, Social Security income should be excluded when determining if someone is expected to be required to file taxes. Supplemental Security Income (SSI) will continue to be disregarded for BC+ eligibility determinations.

The following income types will now be countable for BC+

- Income from jobs funded by Americorps (Americorps educational awards will not be counted)
- Grants and scholarships, if not used for educational expenses (tuition, mandatory school fees, and books)
- All tribal per capita payments from gaming revenues: no longer disregard the first $500 per month
- Interest & dividends, irrespective of the amount
- Lump sum income in the month it is was received

Only the taxable amount of retirement, pension and annuity payments will be counted as unearned income for BC+. CARES will be updated with an additional field for the taxable amount on the "Unearned Income" page for these income types. The gross amount of these types of income will continue to be counted for other programs of assistance, including EBD and LTC MA.

Taxable income does not include active duty pay in combat zone and certain military allowances.

DEDUCTIONS:

Under MAGI rules "taxable income" is counted instead of gross income when determining an AG's household income. Taxable income takes into account both pre-tax deductions taken out of someone's paycheck, as well as certain deductions claimed on IRS Form 1040.

Pre-tax Deductions

Pre-tax deductions are expenses taken out of a paycheck before taxes are applied. Taxable earnings are determined by subtracting pre-tax deductions from gross earned income.

Example: Andy is paid monthly. He earns $9.73 per hour and works about 40 hours per week. His monthly gross income is $1,581.13. Andy has three pre-tax deductions:

1. Retirement
2. Dental
3. MC HCP health insurance

Andy's employer deducts $116.30 total, per month, pre-tax, from Andy's gross income. Therefore, Andy's taxable income is $1,464.83. ($1,581.13 - $116.30 = $1,464.83).

Allowable Pre-Tax Deductions include:

- Health insurance premiums
- Health care savings accounts (including flexible health spending accounts)
- Parking and transit costs
- Group life insurance premiums
- Retirement contributions
- Flexible savings accounts for child care or other dependent care

Ongoing and Calendar Year Tax Deductions

The pre-tax deductions described are amounts that the employer deducts from the employee's paycheck. In addition to these, BC+ will allow certain tax deductions that are listed on page one (1) of the 1040 Tax Form. These deductions are allowed even if that member has the related expense (for example, student loan interest) but is not planning to file taxes.

Itemized deductions like mortgage interest are not allowed under MAGI rules.

➢**Note:** Child support obligation is no longer an allowable deduction for BC+ because is it not an allowable tax deduction.

BC+ has grouped tax deductions into two types: "Ongoing" and "Calendar Year" deductions.

Ongoing Tax Deductions

Ongoing tax deductions will be prorated on a monthly basis and carried over until the next renewal or a reported change in the deduction is reported. Some examples of the most common ongoing tax deductions include:

- Student loan interest paid
- Higher education expenses
- Self-employment tax
- Certain retirement contributions
- Alimony payments

In most cases, if there is a cap imposed on the deduction under IRS rules, CWW will cap the amount of the expense used as a BC+ deduction based on the IRS rules.

Calendar Year Tax Deductions

Calendar Year tax deductions may be allowed as an expense for BC+. Currently there are only two allowable calendar year deductions:

- Out-of-pocket moving expenses for a job related move
- Penalties forfeited due to premature withdrawal of funds from time savings accounts or deposits

These deductions will be prorated on a monthly basis, beginning with the date the expense was incurred or first month of eligibility, whichever is later, through the end of the calendar year the expense was incurred. If the expense was incurred before the application date, it will not be counted.

SELF- EMPLOYMENT INCOME:

Self-employment income will continue to be based on the previous year's tax return. In situations where taxes were not filed in the previous year or where there has been a change in circumstances, applicants and members will continue to complete Self-Employment Income Report Forms (SEIRFs).

Under MAGI rules, countable self-employment income is equal to a person's taxable self-employment earnings.

To calculate taxable self-employment income, use the net income from the tax forms, allowing depreciation, depletion, and any other expenses allowed by the IRS. Other business expenses also allowed by the IRS will continue to be allowable expenses under MAGI rules.

Self-employment losses can offset other types of income for a self-employed person and his/her spouse, if they are filing jointly.

A new self-employment business type, “Royalties” will be added to the self-employment page to capture income from royalties. This income will be counted as “unearned income” in the budget, but will be collected under self-employment, because it is counted as earned income for EBD MA.

To avoid sending accounts back and forth between the State and the Marketplace, depreciation and depletion will be allowable deductions for BC+, starting January 1, 2014, for all BC+ cases including those currently eligible under old BC+ rules. These cases will be run through the November 23rd batch run and tested for the new income limits without adding depreciation back to the countable income.

INCOME LIMITS UNDER MAGI

Under MAGI rules, BC+ members will be allowed an income disregard equal to 5% of the FPL. For adults and parents/caretakers, this disregard is factored into the income limit of 100% FPL for these groups. For children, pregnant women, and individuals eligible under Family Planning Services, the disregard is added to the 300% FPL income limit, for an effective income limit of 305%. In addition, federal MAGI rules resulted in income limits for children, pregnant women and Family Planning Services being adjusted by an additional conversion factor equal to 1% of the FPL, for a total limit of 306% for these three groups. CWW will test these groups against the income level of 306% of the FPL, and this limit will be displayed on the BC+ MAGI budget screens. The dollar amounts for income limits and reporting requirements in the notices of decision will equal 306% FPL.

Certain other income limits for children under MAGI rules, such as those affecting whether or not to apply health insurance access or who is eligible for backdating, will also reflect the addition of 6% of the FPL. One exception is that the income thresholds for children’s premiums will only increase by the 1% conversion factor.

Certain other income limits for children under MAGI rules, such as those affecting whether or not to apply health insurance access or who is eligible for backdating, will also receive an additional disregard of 6% of the FPL. One difference is that the income thresholds for children’s premiums will only increase by the 1% conversion factor.

REPORTING RULES UNDER MAGI:

The reporting thresholds for BC+ households will be based on the income of the AG with the highest income amount. That amount will be used as the basis for the reporting threshold indicated on the Notice of Decision. Members in households eligible for BC+ under MAGI rules will also be required to report:

- Changes in expected tax filing status
- Changes in expected tax dependents
- If they no longer have a tax deduction they reported at application or renewal

Changes in the thresholds used to determine if someone is expected to be required to file taxes are not required to be reported. However, if the worker becomes aware that the child or tax dependent has gone over the thresholds, the answer to the question on the Tax Details Page should be updated.

PREMIUMS UNDER MAGI:

Under MAGI rules, there will be occasions where different children within the same household will be in separate AG's with different income levels.

Each child's premium will be based on his/her own AG's size and income, which may result in different premium amounts for different children in the same household.

A 5% cap will continue to apply to children's premiums. To determine a household-level premium, add all children's premiums together and compare the total premium amount to 5% of the premium-paying AG in the household with the highest countable income amount (not FPL %). The combined total of all children's premiums will be either the total of all premiums or 5% of that AG's income, whichever amount is less. The household level premium amount must be paid in order for all children in the household to remain eligible.

EXTENSIONS UNDER MAGI:

All BC+ Extensions that start in 2014, will be for 4 months. Parents, caretakers and pregnant women will be eligible for a 4-month Extension, if the countable income for their BC+ AG increases above 100% FPL due to an increase in earned income or an increase in spousal support. The individual must have been eligible as a parent, caretaker, or pregnant woman for 3 of the last 6 months immediately preceding the month in which the income increased and the eligibility was lost solely due to the increase in income.

Children, including NLRR children, will be granted an Extension if the child was eligible for BC+ under a MA category during the month that their own parent (including step-parent) or caretaker's income increased, and the parent/caretaker lost eligibility solely due to the income increase.

By MA category, we mean:

- Non-CEN children under age 1 with AG income at or below 300% FPL
- Children age 1 through 5 with AG income at or below 185% FPL
- Children age 6 through 18 with AG income at or below 150% FPL

Children who are already in an Extension are not eligible for a new Extension.

A child's Extension is based solely on their parent/caretaker being granted an Extension. Children do not have to have been eligible for MA for 3 out of the last 6 months or have had income for their AG below 100% FPL.

The child will only be eligible for an Extension once the Extension has been confirmed open for the parent/caretaker. If the adult going into the Extension does not pay a premium or provide requested verification and does not open in the Extension, the child would also not open for an Extension.

Adults in Extensions are subject to premium requirements starting at 100% FPL and are required to report changes in income as it may affect the premium amount. The adult will close if the premium is not paid. Children will remain in the Extension even if the parent/caretaker closes for not paying a premium or verifying a change in income.

If a member's income drops to 100% FPL or lower s/he will go out of the Extension and back into regular BC+. Children, who are in an Extension, will remain in the Extension even if the parent/caretaker's income decreases and the parent/caretaker moves back to regular BC+. Members will also remain in an Extension, even if the only child in the home turns 19 while in the Extension.

Members eligible under the Childless Adult category (MAGS/BCLA) are not eligible for an Extension.

ACCESS:

ACCESS "Apply For Benefits" and "Renew My Benefits" will be updated effective November 16, 2013, to include questions needed to determine eligibility under MAGI. "Report My Changes" will also be updated, but new reporting rules for a given household will not be displayed until January 1, 2014. "Check My Benefits", "Am I Eligible" and "ACCESS for Partners and Providers (Express Enrollment)" will be updated effective December 28, 2014, with new eligibility statuses, new income limits, and new eligibility criteria, as applicable.

IMPLEMENTATION OF POLICY CHANGES:

TRANSITION TO NEW POLICIES:

CARES updates to accommodate these and other changes will be implemented in phases on both September 28, 2013, and November 16, 2013. A batch run will be done on November 23rd, to apply the new income limits to existing BC+ households for benefits effective January 1, 2014.

Because the CWW changes to collect MAGI related information will not be implemented until November 16th, all applications referred from the Marketplace between October 1st and November 16th, will be held outside of the agency inboxes until November 16th. These applications will be ready to process from the agency inboxes on Monday, November 18th. See Ops Memo 13-25, for more information on processing timelines, dashboard and inbox search changes. A future Ops Memo will be released with information on processing an application referred from the Marketplace.

DEPENDENT 18 YEAR OLD:

Alerts 094 and 095 will be generated to inform workers when an 18 year old will graduate after age 19 or that an 18 year old has graduated. The text for these alerts will be updated as follows:

- 094: Turning 18 Graduation after 19, run elig.
- 095: 18 year old graduating. Run elig.

PREMIUMS:

A new alert, "502-Non CEN turning 1 inc >200%" will be generated for non-CEN infants over 200% of the FPL who are turning age 1 to notify the worker that the child will now be required to start paying premiums. The worker will have to run eligibility to update the premium status of the infant once s/he turns 1.

CARES WORKER WEB CHANGES:

CARES Worker Web (CWW) will be updated over the weekend of November 16th, to include new pages and new questions and fields on existing pages to collect the additional information necessary to determine BC+ eligibility based on MAGI rules.

NEW PAGES IN CWW:

Tax Filing Details Page

The "Tax Filing Details Page" will collect information on who is filing taxes along with the individual's filing status and the tax dependents for each tax filer. This page and the "Tax Information Summary" page can be found on the Navigation Menu, under the new "Tax Filing Information" heading.

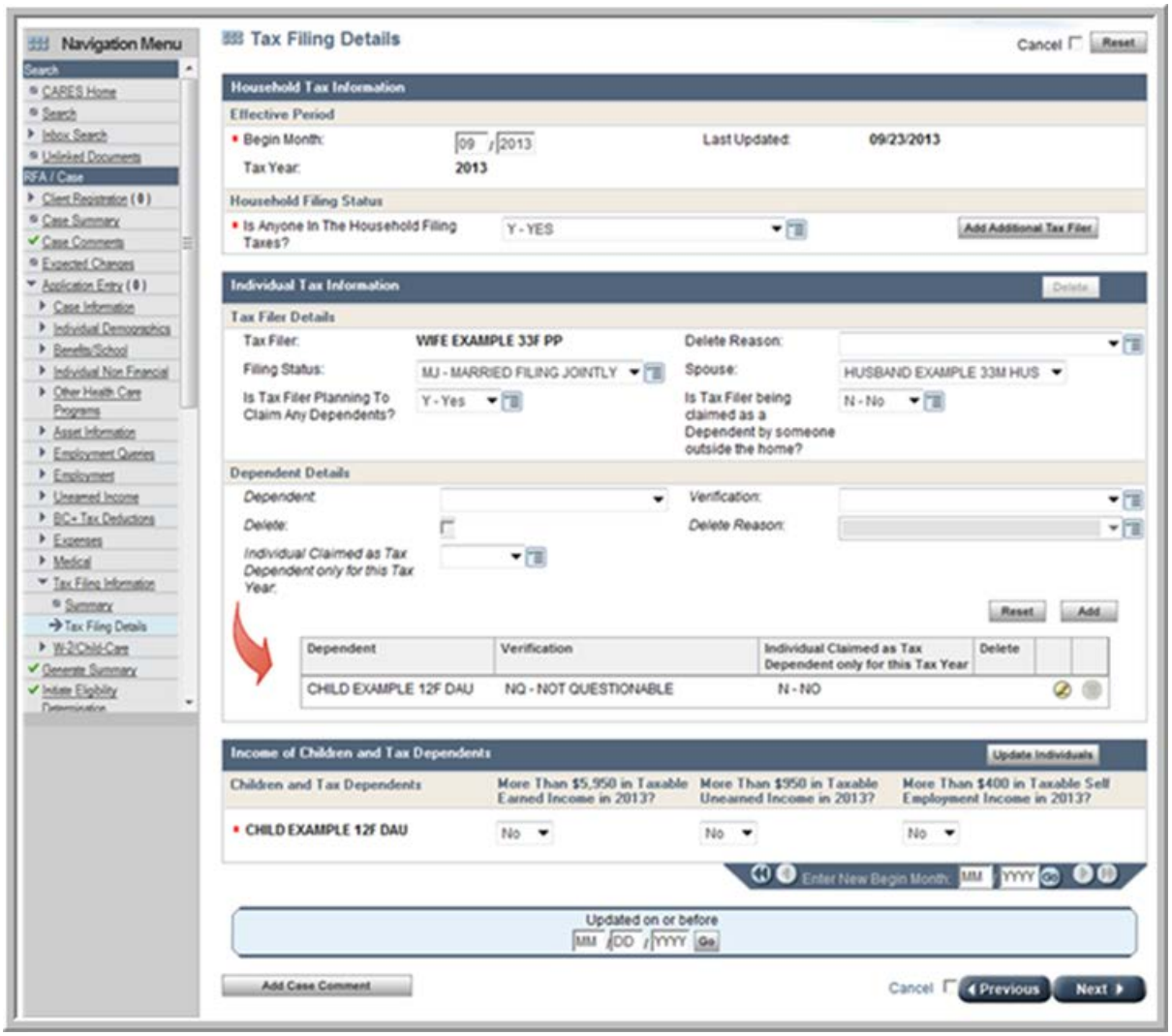
The page is divided into three sections:

Household Tax Information: This section collects the Begin Month, which determines the tax year and whether or not anyone in the household is filing taxes.

Individual Tax Information: This section collects the individual tax filers, their filing status and whether or not the filer has any tax dependents or is being claimed by anyone outside the household. If the filing status is "married filing jointly", the section will also collects the name of the spouse. This section also collects the name of the tax dependents for each filer and whether or not the dependent is claimed for the current tax year only.

If the tax dependent is deceased or claimed only for the current tax year, an alert will be generated at Adverse Action in November of that tax year to inform the worker to run eligibility for January, to remove that tax dependent for the following year. More information on these alerts will be announced in a future Operations Memo. The first alerts will not be set until November 2014 adverse action so the CARES update will be done with a future implementation. The case will also be triggered to go through Adverse Action in December, if the case is not updated by the worker prior to that date.

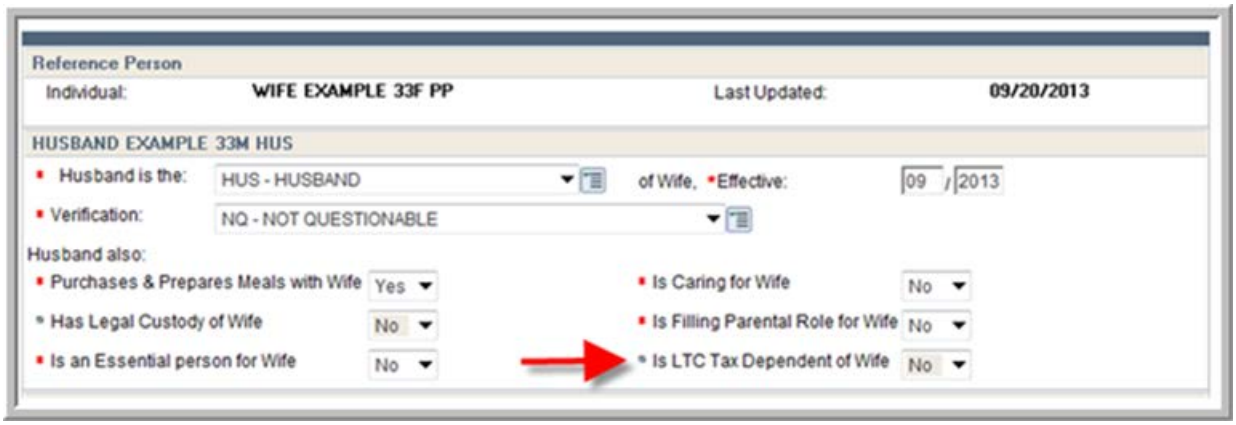
Income of Children and Tax Dependents: The section contains the questions to determine if the child or tax dependent will be expected to be required to file taxes. Answering "Yes" to either the earned or unearned income question, regarding the child or tax dependent's income, will indicate the child or tax dependent will be expected to be required to file taxes and his/her income will be counted. While the threshold for self-employment earnings is considered in the IRS requirement to file taxes, we have received clarification that self-employment earnings should not be used to determine if the individual's income is counted for BC+. Entries on the "More Than $400 in Taxable Self Employment Income" field will not be used in the "expected to be required to file taxes" determination. Workers should enter a "No" on this field.



At conversion, the fields on this page will be populated with a "?". The first time CARES tests any individual in this household using MAGI rules, CARES will pend BC+ eligibility for this information. If eligibility is pending for answers to the "Income of Children and Tax Dependents" questions, the Verification Checklist will ask if any children or tax dependents have income above the thresholds and ask for the name of any child or tax dependent with income exceeding the threshold. If one of the threshold questions is answered "yes", CARES will not pend for a "?" entered on the other questions for that individual since his or her income is going to be counted.

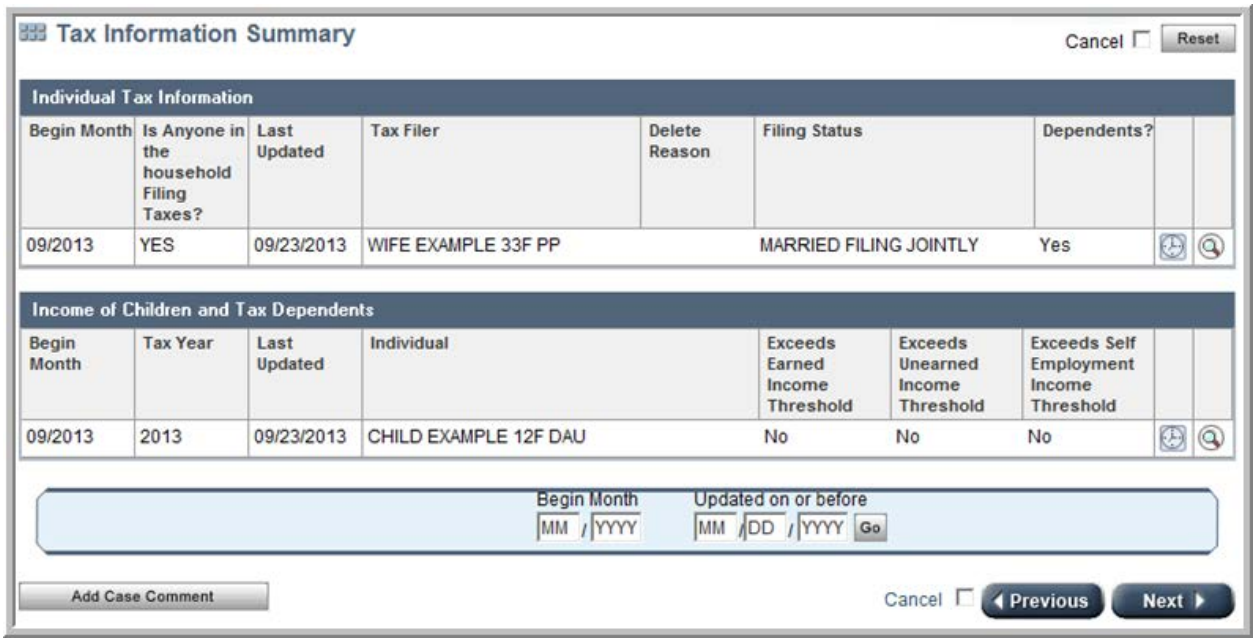
Household Relationships Page:

To avoid confusion, the question “Is Tax Dependent of XXXX” on the Household Relationships page will be changed to “Is LTC Tax Dependent of XXXX’. This question on the “Household Relationships” page is only relevant for Long Term Care MA eligibility. See Medicaid Eligibility Handbook, Chapter 18.6.1 #2, for more details on this policy.



TAX INFORMATION SUMMARY PAGE:

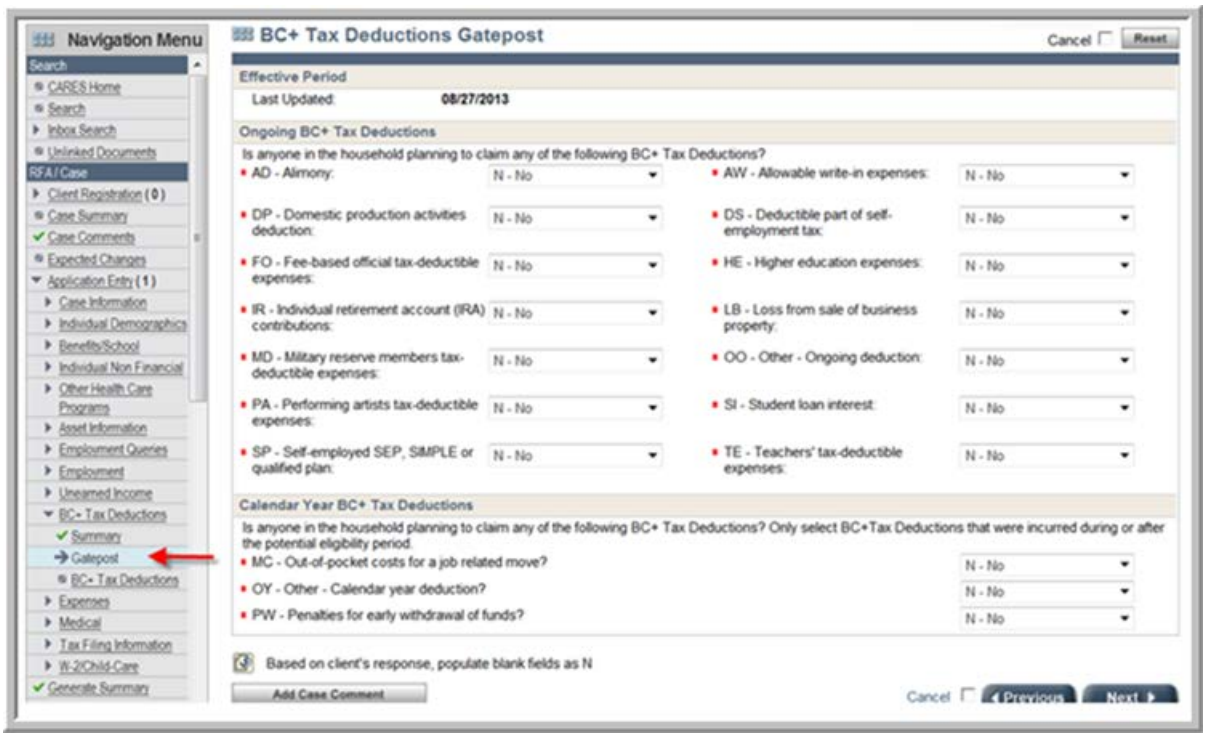
This page provides a summary of the information entered on the “Tax Filing Details” page.



➢**Note:** If a tax dependent has been deleted, the history for that tax dependent on the “Tax Information Summary” page will only display the PIN number for that tax dependent.

BC+ TAX DEDUCTIONS GATEPOST:

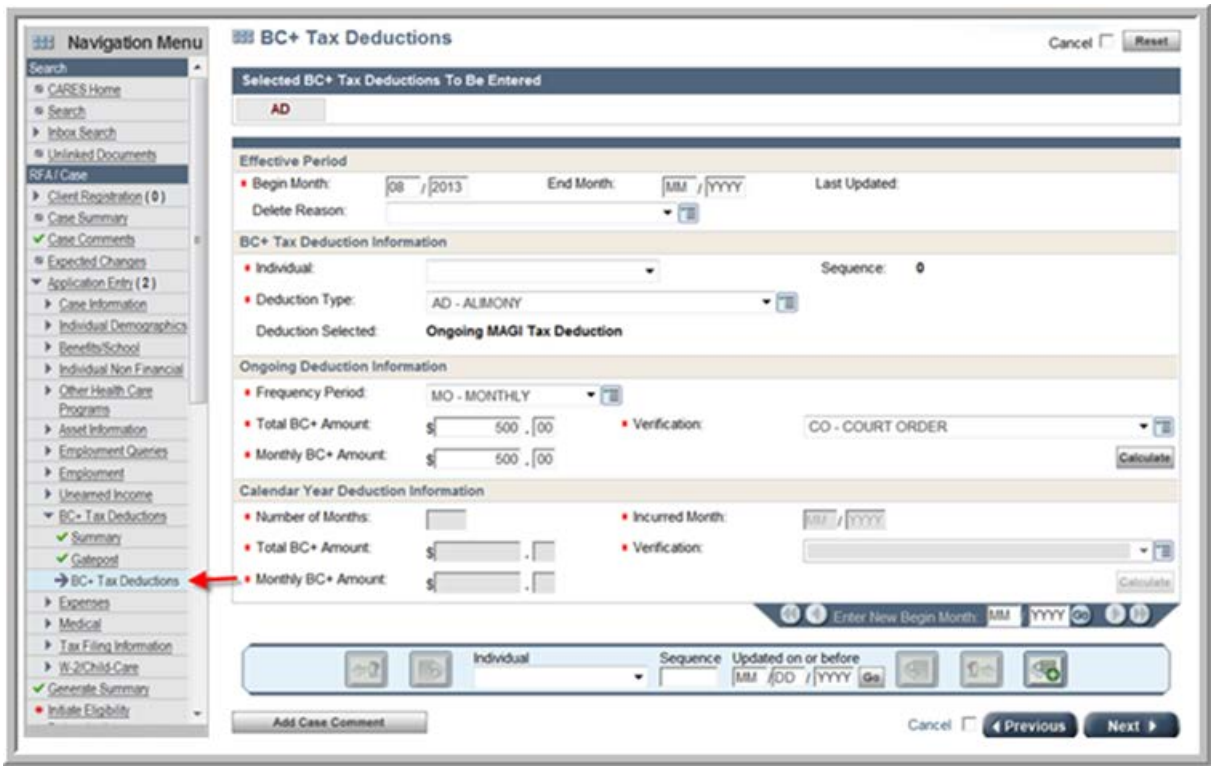
This new gatepost page will collect the information on which Ongoing and/or Calendar Year tax deductions the household is claiming. If the worker answers "Y – Yes" to any of the deduction types, the "BC+ Tax Deductions" detail page will be automatically scheduled. The gatepost page, the details page and the summary page can all be accessed from the Navigation Menu under the BC+ Tax Deductions heading.



At conversion the answers will be populated to an "N-No" for all questions. When an individual or household is being tested for BC+ using MAGI rules for the first time, workers should gather this information prior to confirming the BC+ eligibility.

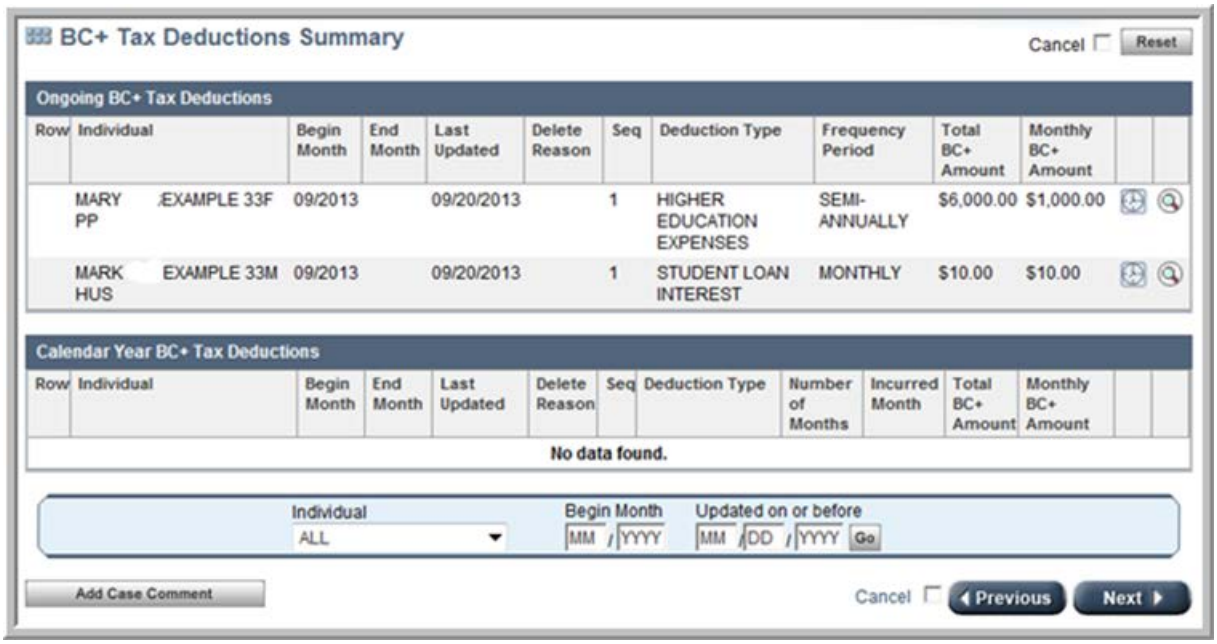
BC+ TAX DEDUCTIONS DETAILS PAGE:

This page collects the detailed information about each tax deduction claimed by the household. CARES will populate the "Deduction Selected" field, based on the type of the deduction. If the deduction is an "Ongoing MAGI Tax Deduction" the "Ongoing Deduction Information" section must be filled out. If the deduction is a "Calendar Year MAGI Tax Deduction" the "Calendar Year Deduction Information" section must be filled out. If a case includes a "Calendar Year Deduction", the case will be triggered to go through a batch run at December Adverse Action in the year listed in the "Begin Month" field for that Calendar Year Deduction.



BC+ TAX DEDUCTIONS SUMMARY:

The new “BC+ Tax Deductions Summary” page displays the information entered on the “BC+ Tax Deductions Details” page.

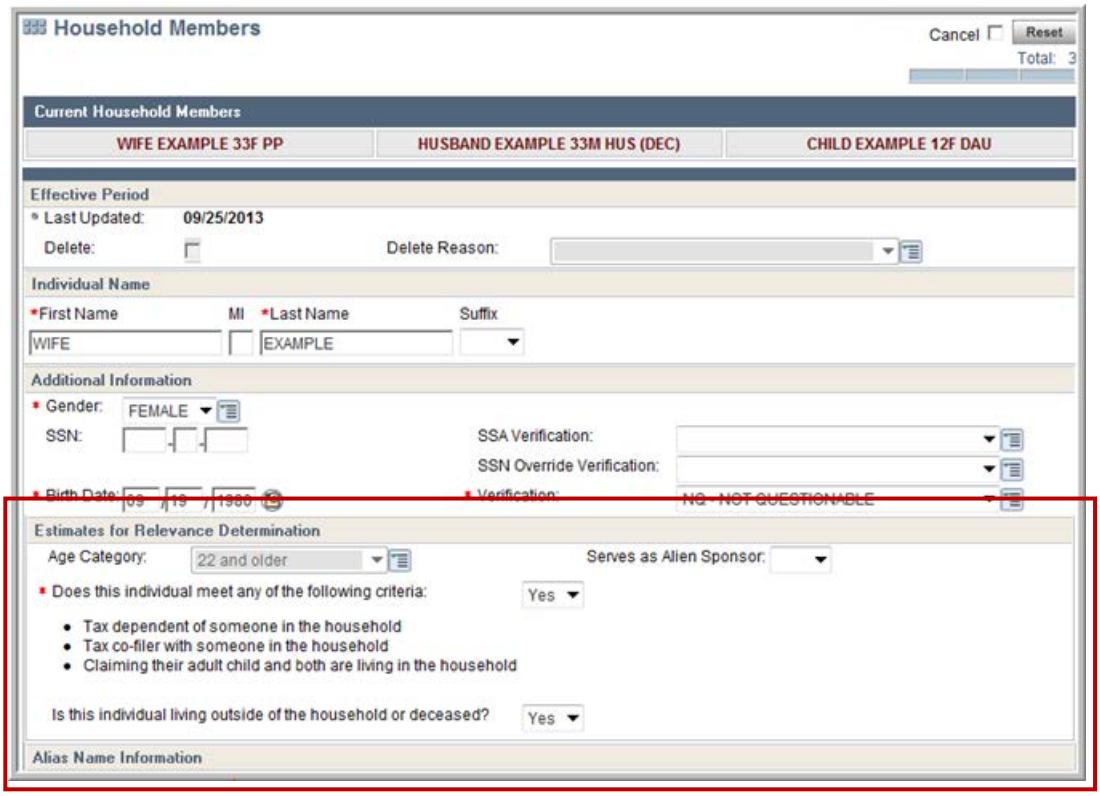


NEW FIELDS ADDED TO EXISTING CWW PAGES:

Household Members Page

Tax dependents and co-filers, who are living outside the household or are deceased, may now be included in a BC+ AG with others living in the household. Two new questions have been added to the "Estimates for Relevance Determination" section on the "Household Members" page. The new questions in this section will indicate if an individual living outside the household, an adult child of someone in the household, or a deceased tax dependent should be considered relevant to the case for BC+.

The last question in this section: "Is this individual living outside of the household or deceased?" will also determine the response to the new questions on the "Current Demographics" page.

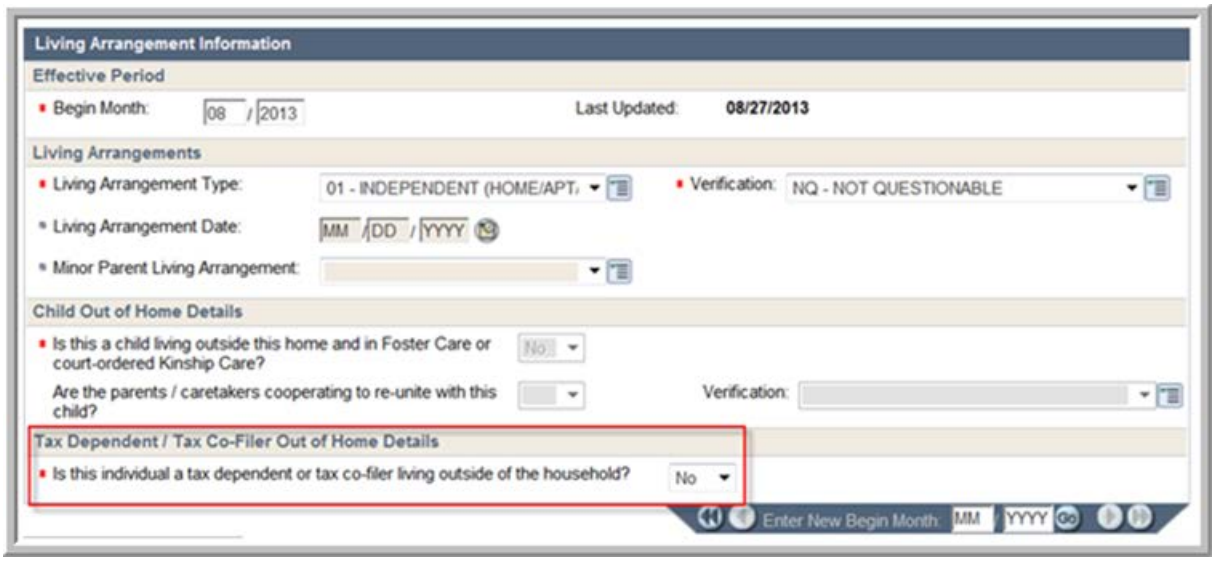


At conversion, the answers to the new questions will be populated with a "No"

Current Demographics Page

A new question has been added to the Current Demographics page to identify tax dependents and co-filers who live outside of the household. This enables CWW to appropriately include the individual in the BC+ AGs without including that individual in any other program of assistance.

The question will be pre-populated based on the response to the question on the Household Members Page: “Is this individual a tax dependent or a tax co-filer living outside the household?”.



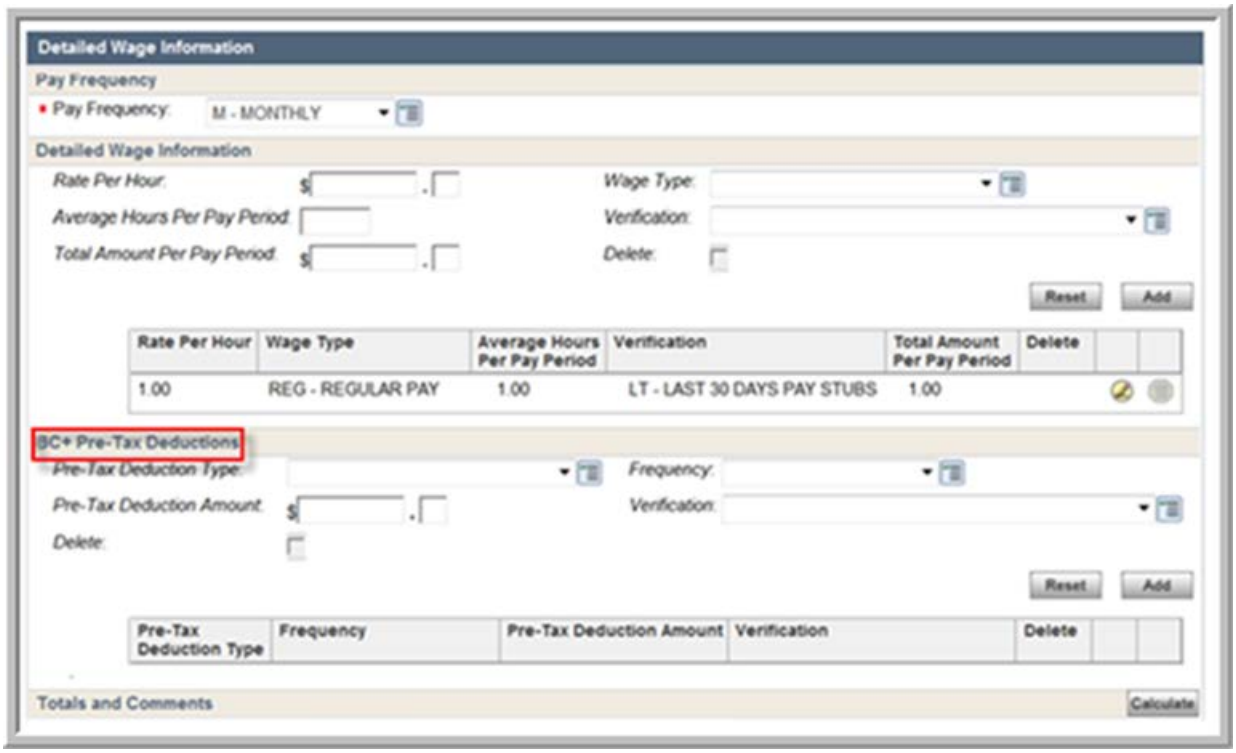
At conversion, the answer to the new question will be populated with a “No”.

Employment Page

A new section “BC+ Pre-Tax Deductions” will be added to the “Detailed Wage Information” section of the Employment page. This section will collect the pre-tax deduction type, amount, verification and frequency. Types of pre-tax deductions include:

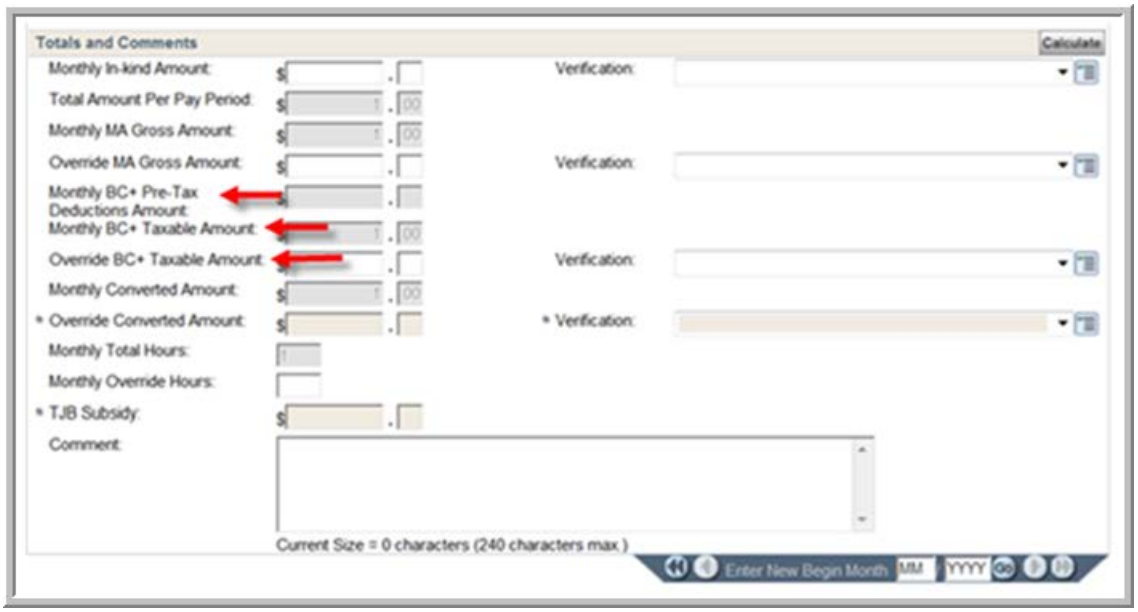
- Health Insurance Premiums
- Health Care Savings Accounts
- Parking and Transit Costs
- Group Life Insurance Premiums
- Retirement Contributions
- Flexible Savings Accounts (Child Care/Other Dependent Care)
- Other

➢**Note:** When an individual or household is being tested for BC+ eligibility using MAGI rules for the first time, workers should check the income verification for any pre-tax deductions and update this section appropriately. These deductions could make a difference in eligibility or premium amounts due on the case.



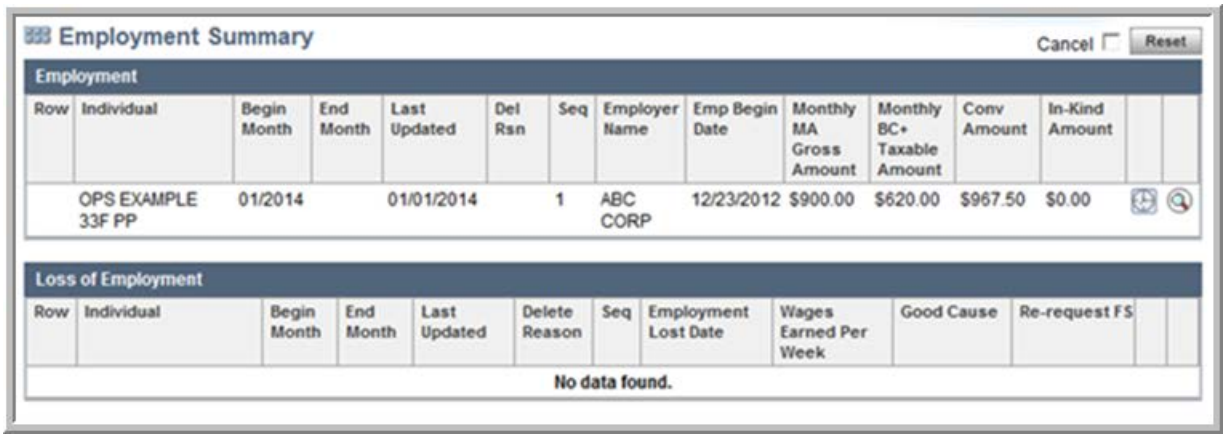
The “Totals and Comments” section will be updated as follows:

- The “Monthly MA Amount” and “Override Monthly MA Amount” fields will be renamed “Monthly MA Gross Amount” and “Override MA Gross Amount”.
- New fields “Monthly BC+ Pre-Tax Deductions Amount”, “Monthly BC+ Taxable Amount” and “Override Montly BC+ Taxable Amount” will be added to this section.



Employment Summary Page

The Employment Summary page will be updated to display the Monthly MA Gross Amount, Monthly BC+ Taxable Amount and the Converted Amount of income entered on the Employment Page.



Employment Summary

Cancel Reset

Employment

Row	Individual	Begin Month	End Month	Last Updated	Del Rsn	Seq	Employer Name	Emp Begin Date	Monthly MA Gross Amount	Monthly BC+ Taxable Amount	Conv Amount	In-Kind Amount		
	OPS EXAMPLE 33F PP	01/2014		01/01/2014		1	ABC CORP	12/23/2012	$900.00	$620.00	$967.50	$0.00		

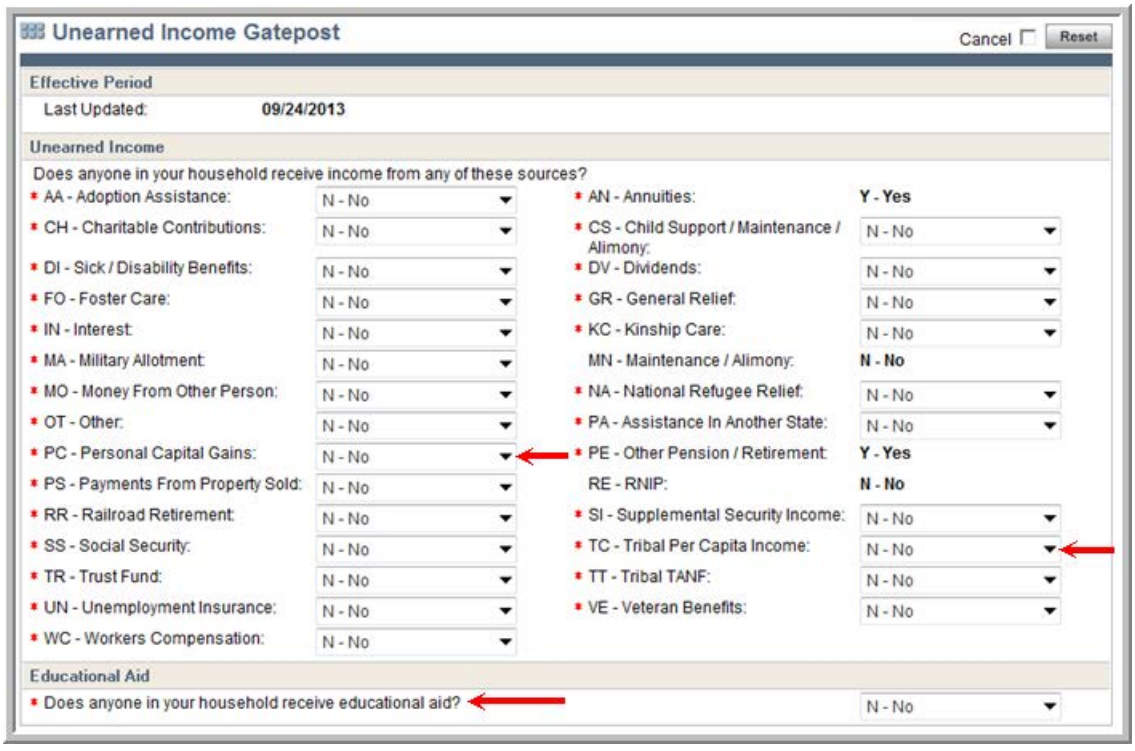
Loss of Employment

Row	Individual	Begin Month	End Month	Last Updated	Delete Reason	Seq	Employment Lost Date	Wages Earned Per Week	Good Cause	Re-request FS		
No data found.												

At conversion, the BC+ taxable amount will be populated with the Monthly Gross Amount.

Unearned Income Gatepost

The “Unearned Income Gatepost” page will be updated to include two new unearned income types: “TC – Tribal Per Capita Income” and “PC – Personal Capital Gains”. The question, “Does anyone in your household receive educational aid?” will now be required to be answered for BC+.



Unearned Income Gatepost

Cancel Reset

Effective Period

Last Updated: 09/24/2013

Unearned Income

Does anyone in your household receive income from any of these sources?

* AA - Adoption Assistance:	N - No	* AN - Annuities:	Y - Yes
* CH - Charitable Contributions:	N - No	* CS - Child Support / Maintenance / Alimony:	N - No
* DI - Sick / Disability Benefits:	N - No	* DV - Dividends:	N - No
* FO - Foster Care:	N - No	* GR - General Relief:	N - No
* IN - Interest:	N - No	* KC - Kinship Care:	N - No
* MA - Military Allotment:	N - No	MN - Maintenance / Alimony:	N - No
* MO - Money From Other Person:	N - No	* NA - National Refugee Relief:	N - No
* OT - Other:	N - No	* PA - Assistance In Another State:	N - No
* PC - Personal Capital Gains:	N - No	* PE - Other Pension / Retirement:	Y - Yes
* PS - Payments From Property Sold:	N - No	RE - RNIP:	N - No
* RR - Railroad Retirement:	N - No	* SI - Supplemental Security Income:	N - No
* SS - Social Security:	N - No	* TC - Tribal Per Capita Income:	N - No
* TR - Trust Fund:	N - No	* TT - Tribal TANF:	N - No
* UN - Unemployment Insurance:	N - No	* VE - Veteran Benefits:	N - No
* WC - Workers Compensation:	N - No		

Educational Aid

* Does anyone in your household receive educational aid? N - No

Unearned Income Page

Since only the taxable amount of retirement, pension and annuity payments will count as unearned income for BC+, the "Unearned Income" page will be updated with an additional field to allow workers to record the monthly "BC+ Taxable Amount" in the income information section. This new field will only be required when an Income Type of "PE - Other/Retirement Benefits" or "AN –Annuities" is selected on a case with a health care request. Functionality will continue to work the same as it currently does for all other unearned income types.

When an income type of "PE - Other/Retirement Benefits" or "AN –Annuities" is selected, a new, "BC+ Taxable Amount" field will be enabled in the "Details" section of the page. Once a worker enters an amount and verification code in the "Gross Income Amount" and corresponding verification field, these same values will be auto populated into the "BC+ Taxable Amount" and verification fields. If the taxable reported amount is the same as the gross amount, the worker can click "Add" and "Calculate" which will cause the same amounts to display in both the "Monthly MA Amount" and the new "Monthly BC+ Taxable Amount" field.

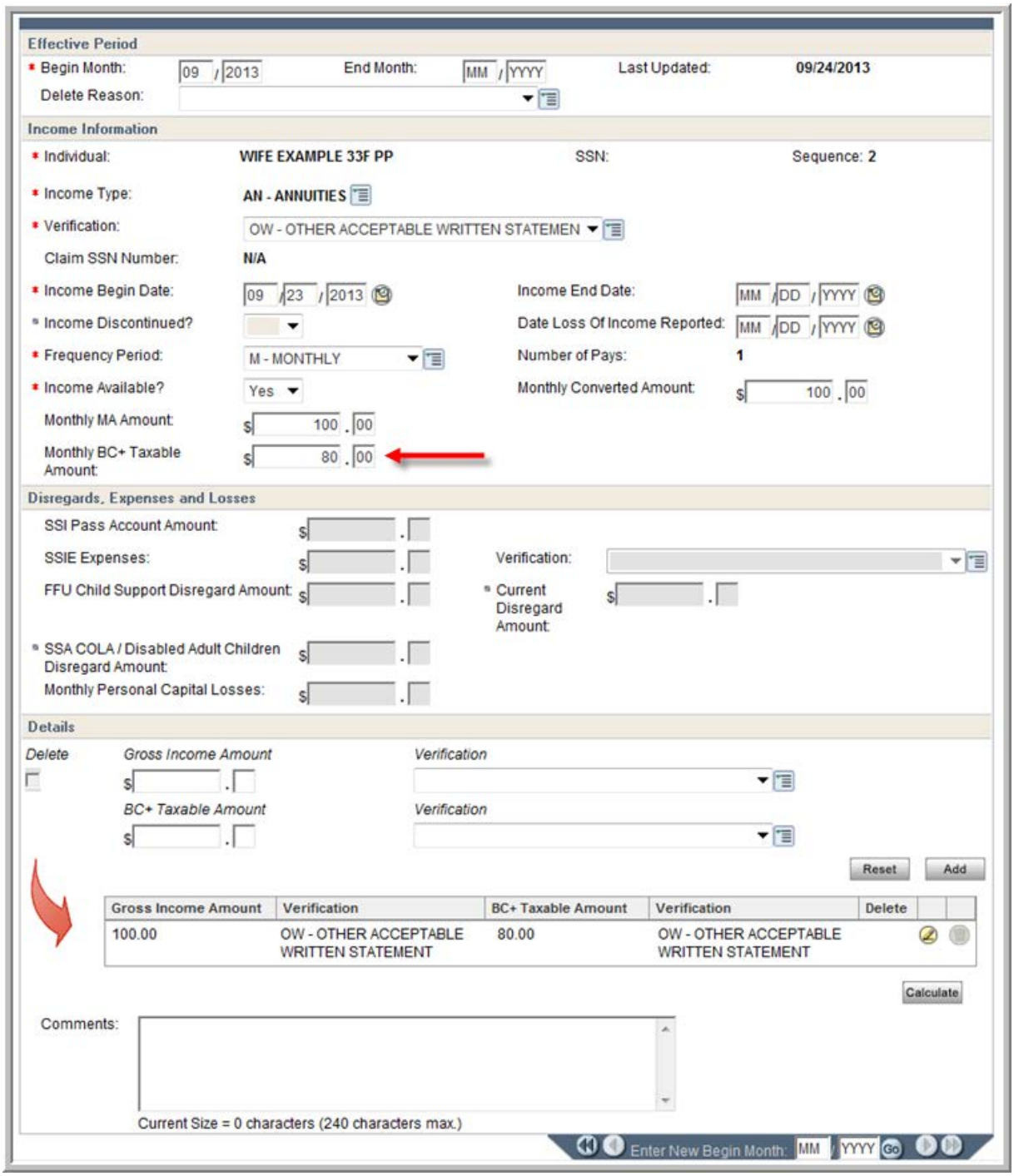
If the taxable amount of pension, retirement or annuity income differs from the gross, workers will have to enter the lower taxable amount in the "BC+ Taxable Amount" field and request verification of this amount, if necessary, so that the appropriate amount can be used in the BC+ determination. In this instance, the gross amount will display in the "Monthly MA Amount" field and the lower taxable amount will display in the "Monthly BC+ Taxable Amount" field after the "Calculate" button is clicked.

Verification of the Gross Income Amount or the MAGI Taxable Amount is mandatory for any countable income relevant to a BC+ MAGI determination.

➢**Note:** If the gross amount is verified and the lower "BC+ Taxable Amount" is not verified, the gross amount should be used in the BC+ eligibility determination. Workers should enter the gross amount as the "BC+ Taxable Amount", when the gross amount has been verified but the taxable amount has not.

To accommodate the policy for Personal Capital Gains/Losses, the "Disregards and Expenses" section of the page will be renamed to "Disregards, Expenses and Losses". A new field, "Monthly Personal Capital Losses" will be enabled only when the Unearned Income Type of "PC – Personal Capital Gains" is selected. This field will be disabled for all other income types. This field will be used to record both personal capital gains and losses for an individual. There will be more information about capital gains/losses in the BC+ Handbook and Process Help.

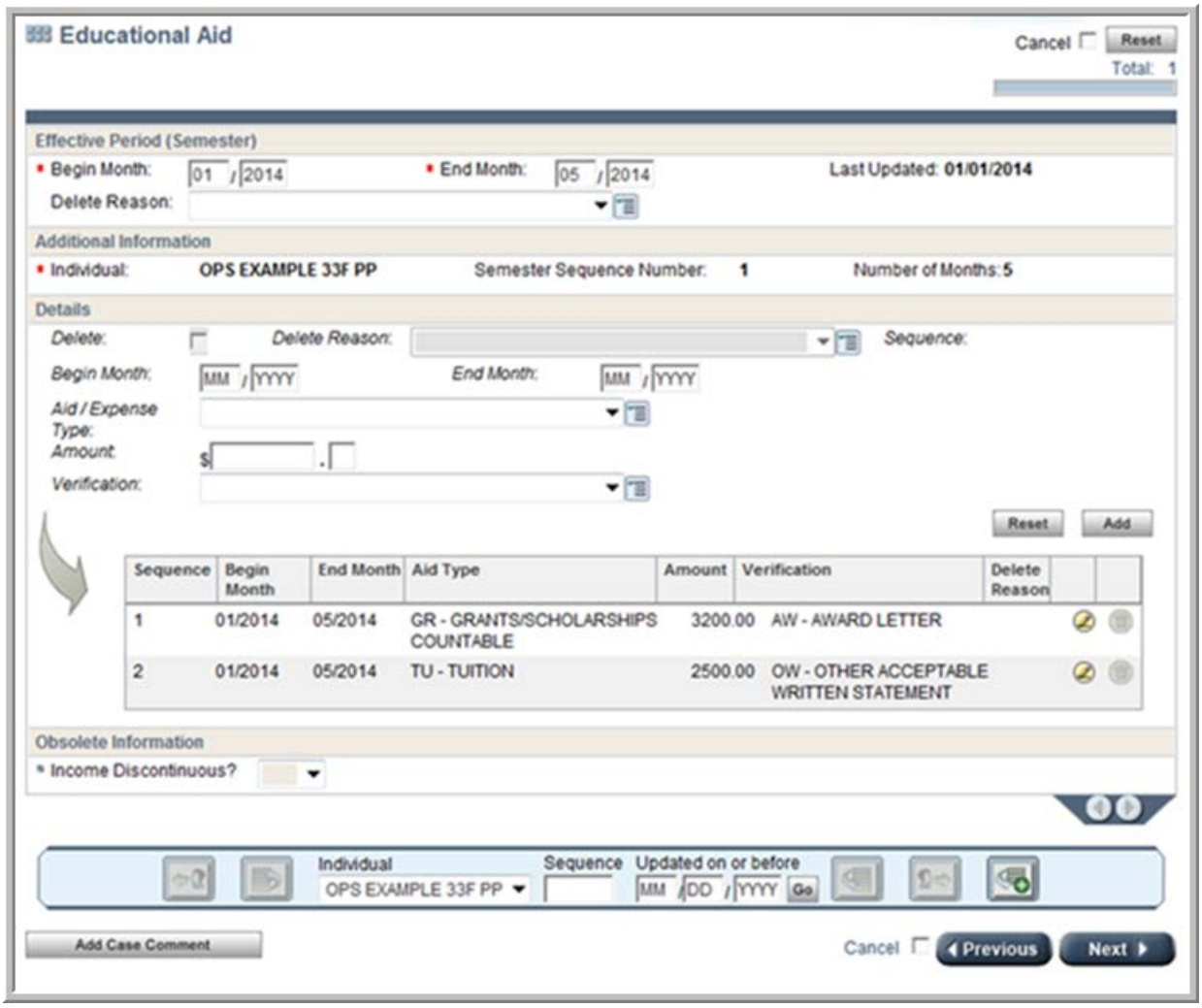
Additionally, there will be a new type of other income, "OTMG – Other MAGI". This income type will be used to record countable income that should be used only for BC+ MAGI eligibility determinations. This is similar to how we use OTFS and OTMA.



At conversion, the BC+ Taxable Amount will populate with the amount entered in the Monthly MA amount field.

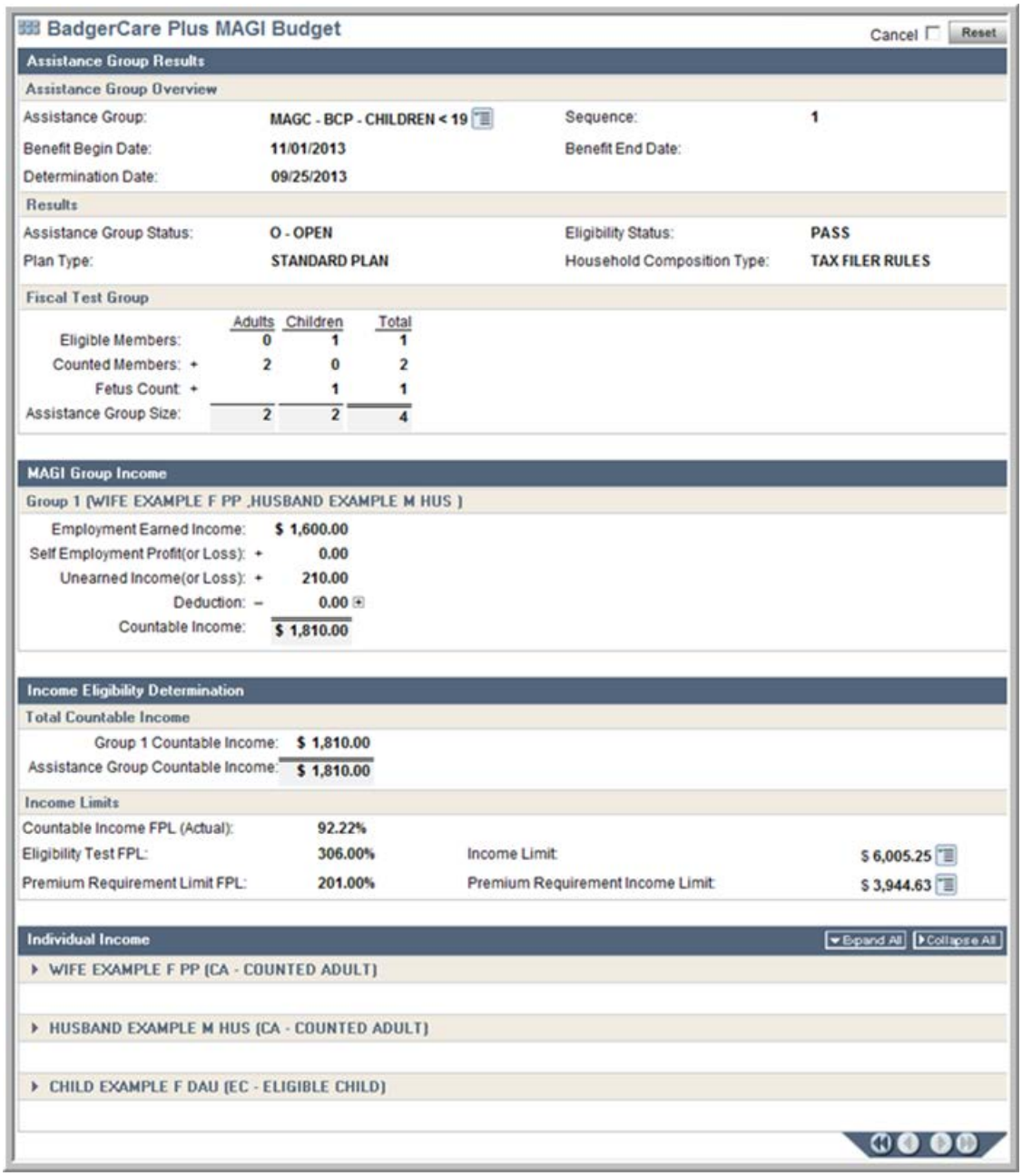
Educational Aid

The Educational Aid page in CWW will be used to record grants and scholarships, as well as the educational expense paid to determine the countable amount of educational assistance the individual receives. Alert “113-Educational Aid Expires” will be generated when the semester or term entered on the page is ending. The case will also be triggered to go through the Adverse Action batch run in the month the semester is ending. Refer to the BC+ Handbook for more information on the types of educational aid that are not counted.



BadgerCare Plus Budget Page

A new BC+ MAGI Budget page has been developed for displaying the budget for MAGI based BC+ eligibility determinations. The new budget page will include an indicator for the Household Composition Type (Tax Filer Rules or Relationship Rules). The MAGI fiscal test group will appear right after the “Results” Section. The income displayed will include only the income that is counted for that AG.



MEDICAL STATUS CODES:

Due to changes affecting benefit plans, program funding sources and eligibility income limits, effective January 1, 2014, the following changes to Medical Status Codes will take place.

➢**Note:** Codes are still valid and available for backdated eligibility, for months prior to 2014.

MED STAT CODES ENDING EFFECTIVE DECEMBER 31, 2013

Codes	Description
1B	Parents 100 - 130% FPL
7B	Parents >150 - 200%
7L	Caretakers >150 - 200% FPL
8A	Parents >133 - 150% FPL
8B	Caretakers >133 - 150% FPL
8G	Disabled parents >133% FPL
8H	Disabled caretakers >133% FPL
8J	Earnings extension - 12 mo, disabled p/c >133% FPL
8K	Child support extension - 4 mo, disabled p/c >133% FPL
B8	Parent/caretaker, Community waiver >150 - 200% FPL
BM	Caretakers >100 - 130% FPL
8C	Childless Adult Waiver >100 - 133% FPL
8D	Childless Adult Waiver > 133% FPL
8L	Disabled Childless Adult > 133% FPL
7C	Parents (Self Employed/Farmers) >200% FPL
7M	Caretakers (Self Employed/Farmers) >200% FPL
XA	Basic Plan
7Y	Child >300% FPL
PM	Pregnant minor, < 19 >300% FPL

MED STAT CODES CHANGING JANUARY 1, 2014:

8E	Earnings extension - 12 mo, p/c >133% FPL	Replaced by	9R
8F	Child support extension - 4 mo, p/c >133% FPL	Replaced by	9S
7G	Child, ages 1-18, >250 - 300% FPL,	Replaced by	9L
7H	Child, age < 1, >250 - 300% FPL,	Replaced by	9G
7P	Child, Age < 1, >200 - 250% FPL,	Replaced by	9F
BH	Child, 1-18 >200 - 250% FPL,	Replaced by	9K
7U	CEN >200% FPL,	Replaced by	9H
7T	EE for child, age < 1, >200 - 300% FPL,	Replaced by	9J
TC	Child, 1-18, tribal member >200 - 250% FPL,	Replaced by	T8
7Z	Child, ages 1-18, tribal member >250 - 300% FPL,	Replaced by	T9
7K	Child, <19, ded, >150% FPL BC+ SP,	Replaced by	9N
BZ	Pregnant inmate >200 - 300% FPL,	Replaced by	9B
PS	Pregnant woman - deductible >300% FPL,	Replaced by	9M
TP	Pregnant minor, tribal member >200 - 300% FPL,	Replaced by	9D

BB Pregnant woman >200 - 250% FPL, and
7E Pregnant Woman >250 - 300% FPL, Replaced by

9C Pregnant Woman >200 - 300% FPL

BT Pregnant immigrant >200 - 250% FPL, and
7X Pregnant immigrant >250 - 300% FPL, Replaced by

9A Pregnant immigrant >200 - 300% FPL

BW EE for pregnant woman >200 - 250% FPL, and
7R EE for pregnant woman >250 - 300% FPL, Replaced by

9E EE for pregnant woman >200 - 300% FPL

BF Child, 6 - 18, >100-150% FPL, Replaced by

9U Child, 6 - 18, >100-133% FPL, and
99 Child, 6 - 18, >133-150% FPL

CU Childless Adult Core Plan, 0-100% FPL, Replaced by

9W Childless Adult Core Plan, 0% FPL, and
9P Childless Adult (CLA), >0-100% FPL,

GT Transitional Childless Adult, 0-100% FPL, Replaced by

9X Transitional Childless Adult, 0% FPL, and
9V Transitional Childless Adult, >0-100% FPL

NEW DOCUMENT CODES FOR ECF:

Three new document codes will be added to the Electronic Case File (ECF), to track MAGI tax related verifications. These codes will also be updated on the Document Tracking Sheet. The code will be added under the Expenses Sub Folder.

TD-Tax Deductions: this code should be used to index documents that are submitted as verification of Ongoing and Calendar Year Tax Deductions. This code will be added under the Non-Financial Information Sub Folder.

TFI-Tax Filing Information: This code should be used to index documents submitted as verification of tax filing and/or tax dependency information.

DTS-Document Tracking Sheet: This code should be used to index the Document Tracking Sheet that is generated and mailed out as part of the verification checklist or by the member though ACCESS.

CORRESPONDENCE IMPACT:

Along with requests for verification of new expenses, deductions and income types, the "Verification Checklist" will be updated to include requests for information on tax filing status and tax dependency as well as asking if any child or tax dependent in the household is expected to have income over the threshold for being required to file taxes.

The "Application Summary" will be updated to include all new information gathered for a MAGI determination.

The "Employer Verification Earnings" form (EVF-E) will be updated to include fields for pre-tax deductions subtracted from the gross earnings.

CROSS PROGRAM IMPACT:

CARES/CWW determines eligibility for multiple programs of assistance, using many shared pages and fields. The following information describes how the new pages and fields will affect other IM programs of assistance, as well as Child Care and W-2.

TAX FILING DETAILS AND BC+ TAX DEDUCTIONS GATEPOST AND DETAILS PAGES:

Information entered on the new Tax Filing Details page and the BC+ Tax Deductions Gatepost and Details pages will only be used in the eligibility determination for BC+. No other program of assistance such as FoodShare (FS), Caretaker Supplement (CTS), Child Care, W-2 or EBD and LTC MA will be affected.

These pages will not be scheduled when a W-2 worker creates a new W-2 case, adds W-2 to an existing BC+ case or completes a W-2 renewal.

HOUSEHOLD MEMBERS PAGE:

The new tax related questions on the Household Members page will only be required for cases with a health care request. The questions will not be enabled for a W-2 worker. The information on these fields will not affect eligibility for any programs other than BC+.

When a W-2 worker adds W-2 to an existing BC+ case, the tax related questions on this page will be populated. The tax related questions will default to a "No" and will not be enterable when a W-2 worker adds an individual to an existing BC+ case.

CURRENT DEMOGRAPHICS PAGE:

When the new question on the Current Demographics page, "Is this individual a tax dependent or tax co-filer living outside the household", is answered "Yes" CWW will only consider the individual for BC+ eligibility determinations. The individual will not be included as a household member for any other program of assistance.

When a W-2 worker creates a new W-2 case this question will not be required to be answered. If a W-2 worker adds W-2 to an existing BC+ case this field will be populated by the IM worker's entry and should not be modified by the W-2 worker.

PERSON ADD:

The Tax Filing Details page will be scheduled in the Person Add driver flow when a W-2 worker adds an individual to an existing BC+ case. The tax filer and tax dependent information should not be updated by the W-2 worker. However, the Begin Month field will be blank. The W-2 worker will be expected to enter the current begin month in the field before clicking on "Next" and moving to the next scheduled page.

The income threshold questions in the "Income of Children and Tax Dependents" section will remain blank for any newly added children, until the IM worker accesses the page and enters the information. The W-2 worker is not expected to fill out these fields.

Whenever a W-2 worker adds a person to a BC+ case from the "Household Members" page, the primary worker on the case will receive an alert: "500-Person moved into Household", informing him/her that an individual has been added. The same alert will be generated to the W-2 worker, when an IM worker adds an individual to a case with W-2. When adding an individual to a BC+ case, the W-2 worker should add case comments indicating that a new individual has been added to the case. This will allow the IM worker to identify that tax information for that individual must be obtained and updated in CWW.

If a W-2 worker changes the response to the question on the Current Demographics Page "Is this individual a tax dependent or tax co-filer living outside the household" from a "Yes" to a "No", alert: "500-Person moved into Household" will be generated to the IM worker. The same alert will be generated to the W-2 worker, if the IM worker takes that same action.

PERSON DELETE:

When a W-2 worker deletes and individual who is a tax dependent or tax co-filer from a BC+ case, from either the "Household Members" page or by updating the living arrangement code on the "Current Demographics" page to a "15", the W-2 worker will receive the following edit to prevent the worker from deleting the individual:

"Cannot change to "15-OUT OF HOME" for an individual who has been listed as a tax co-filer or tax dependent on the Tax Filing Details page."

To delete the individual from the case, the W-2 worker should update the question on the "Current Demographics" page "Is this individual a tax dependent or tax co-filer living outside the household" from a "No" to a "Yes". This will remove the person from any other programs of assistance, including W-2. Alert: "501-Tax Dep/Co-Filer Moved Out" will be generated to the IM worker, when a W-2 worker takes this action. The alert will also be generated to the W-2 worker, if the IM worker takes the same action.

A W-2 worker can follow the current process for deleting an individual using either the "Household Members" page or by changing the living arrangement code on the "Current Demographics" page to a "15", when the person is neither a tax dependent nor a tax co-filer on the case.

DECEASED INDIVIDUALS:

When the death of a household member is reported to the W-2 worker, the W-2 worker should update the date of death on the "Permanent Demographics" page and add case comments indicating the death of the individual was reported. If the individual is a tax dependent, the IM worker will receive an alert at the end of that tax year to delete that individual from the case.

If the individual is not a tax dependent or tax co-filer on the case, the W-2 worker can complete the person delete process for that individual.

PREGNANCY VERIFICATION:

Pregnancy verification will continue to be required for W-2. The pregnancy verification field will default to an "NQ". The W-2 worker should use the PN and/or FN verification codes to either pend or fail the pregnancy for W-2, when determining eligibility for a CMP placement. These codes will not affect other programs of assistance. BC+ and CTS will pass when these codes are used, even though W-2 and/or Child Care will pend or fail. If the pregnancy is also questionable for BC+ and MA, a "Q?" will pend W-2 and a "QV" will fail W-2. When the IM worker has entered a Q? on the Pregnancy Page, the W-2 worker should not update the verification code to PN or FN. W-2 will pend or fail based on the Q? or QV entered by the IM worker.

CTS will follow the rules for BC+ and MA and will not require verification of pregnancy. If the worker determined the pregnancy is questionable, a "Q?" will pend CTS as well as BC+ and MA and a "QV" will fail those programs.

If a "QV" is entered for the fetus number, CARES will use a fetus count of one (1) in the BC+, MA and CTS eligibility determinations. No other program of assistance uses the fetus count when determining eligibility or benefit amounts.

SCHOOL ENROLLMENT PAGE:

The questions regarding school enrollment are currently scheduled for Child Care cases for any individual age 4 through age 19. This functionality will not change. The entries on the "Expected Date of High School Graduation" will not affect eligibility for any programs of assistance other than BC+, CTS and W-2. W-2 workers will be required to verify the expected date of graduation when the only child in the home is a dependent 18 year old.

AMERICORPS INCOME:

A new income Earned Income Type: "M-AMERICORPS" will be added to the drop down list on the "Employment" page. CWW will count the income for BC+ and compare the hourly rate to the income to determine if the income is countable for W-2. When a case is open for EBD MA or FoodShare with different rules for counting income from AmeriCorps, the income should be entered on the Employment page for those programs using the "Override Converted Amount" field for FoodShare (FS), and the Monthly MA Gross Amount override field for EBD and LTC MA.

ROYALTY INCOME:

The new self-employment income type "Royalties" will be counted as unearned income for BC+, FS, W-2 and Child Care. EBD and LTC programs will count this income type as earned income. The income will be entered on the "Self-Employment" page and CWW logic will be enhanced to correctly budget the income for the different programs of assistance. The number of hours worked should be entered as zero.

TRIBAL PER CAPITA PAYMENTS:

A new income type will be added to the list of unearned income types. The first $500 of Tribal Per Capita will no longer be disregarded for BC+; the entire amount will be counted. CWW will count this income type for all programs of assistance.

PERSONAL CAPITAL GAINS:

This income type will be added to the list of unearned income types. CWW will count the gains entered under this income type as unearned income for BC+, W-2 and Child Care. BC+ will allow personal losses as a deduction from personal capital gains. W-2 and Child Care will not allow the losses as an offset to the gains. This income is not counted for EBD or LTC MA or for FS.

EDUCATIONAL AID PAGE:

This page will be used to determine countable Educational Aid for BC+ and EBD MA. W-2 workers should use this page to capture counted unearned income for the amount used for living expenses for the first month (W-2 Manual 3.2.9.1). W-2 workers will have to convert the income into assets for the second, third and following months when available (W-2 Manual 3.3.2)

CONTACTS:

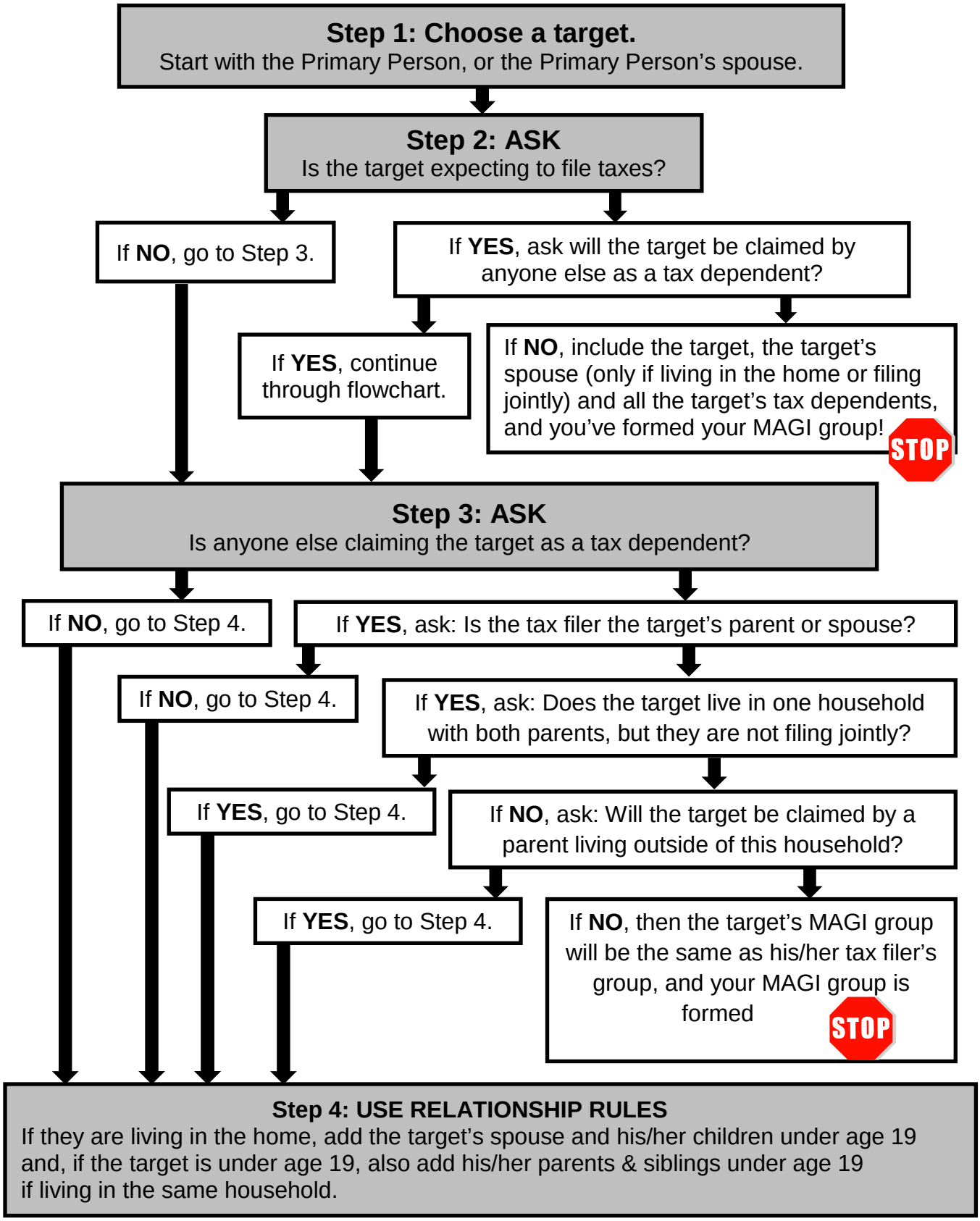
BEPS CARES Information & Problem Resolution Center

Attachment: Four Steps to Forming a BC+ MAGI Group

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/LA, AA, JL

Four Steps to Forming a BC+ MAGI Group



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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: 13-43

DATE: 12/20/2013

FS ☐	**MA** ☒	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: BadgerCare Plus Policy Updates

CROSS REFERENCE: Operations Memo 13-32; BadgerCare Plus Handbook

EFFECTIVE DATE: January 1, 2014

PURPOSE:

The purpose of this memo is to identify policy changes to BadgerCare Plus that will take effect on January 1, 2014.

BACKGROUND:

As described in Operations Memo 13-32, provisions in the federal Patient Protection and Affordable Care Act (PPACA or ACA) and in 2013 Wisconsin Act 20 (the State Biennial Budget) require changes in the policies used to determine eligibility for the BadgerCare Plus (BC+) program. The effective date for these changes was planned for January 1, 2014. However, due to difficulties with the federal Health Insurance Marketplace, Wisconsin has delayed the implementation of most of these policies.

Current BadgerCare Plus coverage groups, income limits, benefit plans and eligibility policies remain in effect until April 1, 2014. Systems changes to support future changes will be implemented February 1, 2014 and available on February 3, 2014. Additional information about changes that take effect after January 31, 2014 will be published in a future Operations Memo.

However, there are six policies that will take effect on January 1, 2014. Please note, three of these are new policies and were not included in operations memo 13-32. The policies that will take effect on January 1, 2014 are detailed below.

The policy changes in this memo are not related to FoodShare, Wisconsin Works (W-2) and Wisconsin Shares Child Care (CC) programs. DCF will issue an Operations Memo to the W-2 agencies related to the ACA changes in the first quarter of 2014.

POLICY CHANGES:

PREGNANCY VERIFICATION:

Beginning January 1, 2014, verification of pregnancy, the due date, and the number of fetuses for BC+ or MA is no longer required. These items should not be questioned, unless there is other information that contradicts the applicant's statement deeming it questionable.

This new policy also applies to the BC+ Pre-natal Program (BC+PP). Eligibility for pregnant women under BC+PP will no longer be tied to the date pregnancy was verified. Instead, the eligibility effective date will be the first day of the month of application. Backdating of eligibility for BC+PP is still not allowed.

CARES will not be updated until February 1, 2014 to reflect this policy change. In the meantime, workers should enter the "NQ" verification code in the Pregnancy, Pregnancy Due Date and Fetus Number verification fields. A "Q?" should only be entered if any of these items are considered questionable. The first day of the month of eligibility should be entered in the Pregnancy Verification Date field.

FORMER FOSTER CARE YOUTH:

Formerly known as YEOHCs (Youth's Exiting Out-of-Home Care), youths who were in foster care, subsidized guardianships or court-ordered kinship care when they turned 18 will be eligible for BC+ up to age 26, starting January 1, 2014. It does not matter what state the youth was residing in when the youth turned 18. Any former YEOHC whose case closed prior to January 1, 2014, due to turning 21 will have to reapply for eligibility beginning January 1, 2014. CARES will not automatically re-establish eligibility for these individuals. The "out-of-home" status at the time the youth turned 18 does not have to be re-verified, if the youth re-requests benefits under this program starting January 1, 2014.

Unlike YEOHC's who were required to have been born on or after January 1, 1990, Former Foster Care Youths born before that date are eligible, as long as they are under age 26. All other eligibility criteria for YEOHC's will continue to apply to Former Foster Care Youths. There will continue to be no income or asset test for this group as long as they are eligible under this status.

CARES will not be updated until February 1, 2014 to reflect this policy change. In the meantime, workers must manually certify any Former Foster Care Youth who meets the

eligibility criteria using Med Stat Code "9Q". Workers should maintain a list of individuals who are manually certified and rerun their eligibility through CARES on or after February 3, 2104.

RESTRICTIVE RE-ENROLLMENT:

Beginning January 1, 2014, Restrictive Re-enrollment Periods (RRPs) for children who fail to pay a premium will now be for 3 months. After the 3 month RRP is served, the arrears will be forgiven. Children will also have the option to re-enroll within the 3 month period as long as they pay all premiums due and request to re-enroll prior to the end of the RRP. For more details on this new policy, see Operations Memo 13-32.

CARES will not be updated until February 1, 2014 to reflect this policy change. In the meantime, workers should set RRPs according to the current policy starting in January. Late payments of premiums are allowed up to 3 months after the start of the RRP. If a premium is made within those 3 months, delete the RRP using the "LP-Late payment" code. Eligibility will have to be run to re-determine eligibility for the months the child was in the RRP. (See Process Help Chapter 23.4 for instructions on processing a late premium). The system will be updated in early 2014 to delete any RRPs that were set in January or February that have been in effect for longer than 3 months.

RESIDENCY:

Effective January 1, 2014, an individual can be considered a resident of Wisconsin if they are physically present in the State and have entered Wisconsin with a job commitment or seeking employment, whether or not they are employed at the time of application.

VERIFICATION OF CITIZENSHIP / IMMIGRATION STATUS:

Effective January 1, 2014, applicants will have 95 days to provide verification of citizenship and/or identify after this verification is requested. If the requested verification is not provided by the end of the 95 days, the eligibility will be terminated with Adverse Action notice, unless the eligibility worker believes a good-faith effort is being made by the applicant/member and the worker chooses to extend the good-faith period. This 95 day period applies to applications, reviews and person adds. An individual can only receive one 95 day good-faith effort period in his or her lifetime.

DEFINITION OF LAWFUL PRESENCE

The Centers for Medicare and Medicaid Services (CMS) has clarified and expanded the meaning of lawful presence in the United States with regard to Medicaid and BadgerCare Plus eligibility. Effective January 1, 2014, children under the age of 19, young adults under age 21 residing in an Institute for Mental Disease (IMD), and pregnant women described below will be considered to be lawfully present in the United States and may be eligible for full benefit BadgerCare Plus or Medicaid. These groups are in addition to those described in section 4.3 of the BadgerCare Plus Eligibility Handbook.

"Lawfully present" means an individual who is a non-citizen and who:

- Is in any valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws,
- Has been granted employment authorization under 8 CFR 274a.12(c),
- Is a beneficiary of an approved visa petition who has a pending application for adjustment of status;
- Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who:
    - Has been granted employment authorization, or
    - Is under the age of 14 and has had an application pending for at least 180 days.
- Has been granted withholding of removal under the Convention Against Torture
- Is a child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)), or
- Has been granted an administrative stay of removal under 8 CFR 241.

➢**Note:** One clarification concerns certain non-citizens who have been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year. They are considered lawfully present unless they are paroled for prosecution, for deferred inspection or pending removal proceedings.

CARES:

CARES and CWW will be updated February 1, 2014 to reflect these policies as described in detail above.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/AA

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: DHS 14-01

DATE: 1/15/2014

FS ☐	**MA** ☐	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐	**BC+ CORE** ☐	
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other**
☐*		
		EP

SUBJECT: 2014 Implementation Dates for BadgerCare Plus Policy Changes

CROSS REFERENCE: Operations Memos 13-32, 13-43 and 14-02
BC+ Handbook

EFFECTIVE DATE: February 1, 2014

PURPOSE:

The purpose of this memo is to communicate the timing of key policy and system changes to BadgerCare Plus in 2014, as well as describe the batch run used to implement new income limits effective April 1, 2014.

BACKGROUND:

As described in Operations Memo 13-32, provisions in the federal Patient Protection and Affordable Care Act (PPACA or ACA) and in 2013 Wisconsin Act 20 (the State

Biennial Budget) require changes in the policies used to determine eligibility for the BC+ program. The effective date for these changes was planned for January 1, 2014. However, due to difficulties with the federal Health Insurance Marketplace, the Legislature passed 2013 Wisconsin Act 116, which delayed the implementation of most of these policies to April 1, 2014.

Since the passage of 2013 Wisconsin Act 116, the Department of Health Services has completed final negotiations with the federal Centers for Medicare and Medicaid Services (CMS) regarding the necessary federal approvals to implement these policies. Based on the outcomes of these negotiations:

1) Wisconsin must apply Modified Adjusted Gross Income (MAGI) budgeting rules for eligibility determinations for all new BadgerCare Plus applicants beginning February 1, 2014;
2) Wisconsin will establish an income limit of 100% Federal Poverty Level (FPL) for all new parent and caretaker applicants beginning February 1, 2014. The new income limit of 300% FPL for children will not take effect until April 1, 2014.
3) Individuals found eligible for BC+ beginning February 1, 2014 or later will be enrolled in the Standard plan.
4) BC+ eligibility for new childless adult applicants will begin April 1, 2014.

For existing members, defined as individuals with a BC+ filing date of January 31, 2014 or earlier including childless adults open under the BC+ Core Plan, eligibility under their current benefit plan will continue through March 31, 2014, as long as they continue to meet program rules.

Prior to March 31, 2014, if an existing member loses eligibility under current BC+ income limits and budgeting rules, the member will be tested using MAGI rules and, if he or she is a parent or caretaker, under new income limits. Parents and caretakers will not lose coverage if eligible under MAGI rules and the new income limits. BC+ Core Plan members who lose eligibility for that program cannot be eligible under MAGI rules and the new income limits until April 1, 2014. Pregnant women will maintain continuous eligibility and children will not be subject to the new income limits prior to April 1, 2014.

The table on the next page summarizes when different members of the BC+ population will be subject to new income limits, MAGI rules, and changes in benefit plan:

Population	MAGI rules effective date	New income limit effective date	Standard Plan effective date
Parents and caretakers with a filing date before 2/1/14	4/1/14 or their 2014 renewal, whichever is later	4/1/14	4/1/14
Parents and caretakers with a filing date before 2/1/14 who report a change effective February or March	If the reported change results in a loss of eligibility under current rules and income limits, MAGI rules are used prior to termination	4/1/14, but if eligibility is tested under MAGI rules prior to 4/1/14, new income limits will be applied at this time, as well.	4/1/14, but if eligibility is confirmed under MAGI rules prior to 4/1/14, enrollment will be under Standard Plan
Parents and caretakers with a filing date on or after 2/1/14	2/1/14	2/1/14	2/1/14
Pregnant women with a filing date before 2/1/14	4/1/14 or their 2014 renewal, whichever is later	N/A	4/1/14
Pregnant women with a filing date on or after 2/1/14	2/1/14	N/A	2/1/14
Children, with a filing date before 2/1/14	4/1/14 or their 2014 renewal, whichever is later	4/1/14	4/1/14
Children, with a filing date on or after 2/1/14	2/1/14	4/1/14	2/1/14
Childless adults currently enrolled in the Core Plan	4/1/14 or their 2014 renewal, whichever is later	4/1/14	4/1/14
New childless adult applicants	4/1/14	4/1/14	4/1/14
Family Planning Only members with a file date prior to 2/1/14	4/1/14 or their 2014 renewal, whichever is later	N/A	N/A
Family Planning Only members with a file date on or after 2/1/14	2/1/14	N/A	N/A

CARES:

CARES will be updated over the weekend of February 1, 2014 to reflect the policies described above, with the exception of delaying the 300% FPL income limit for all children (new applicants and existing members) until April 1, 2014. Children with a filing date in February or March 2014 whom CARES determines to meet all other program rules and are above 300% FPL should be manually certified for February and/or March 2014.

In order to test eligibility using MAGI rules, the tax filing and tax dependency information must be entered on the Tax Filing Details Page in CARES Worker Web (CWW). Workers will be able to access and update this page effective February 3, 2014.

Childless Adults

CARES will begin to test childless adults under the new MAGS assistance group (AG) starting with March eligibility. The program for this population is not available until April 1st so the MAGS AG built for March will fail due to no available program. If the childless adult is over the 100% FPL income limit using MAGI rules, the worker will be able to confirm the MAGS AG as failing and the account will be transferred to the FFM. If the childless adult is at or below the new income limit, the worker will not be able to confirm the MAGS assistance group until after February Adverse Action (AA). CARES will use the information from the benefit calculation to determine whether or not to include the case in the conversion batch run (see information below). If the income is at or below 100% FPL, the case will not be included in the conversion batch run. These cases must have eligibility for April run and confirmed after February AA. As noted below, a report listing these cases will be generated after the conversion batch run.

TRANSITION TO NEW POLICIES

As part of the transition to MAGI rules, new income limits and new benefit plans, a conversion batch run will be completed on February 15, 2014 to:

- Apply the new income limits to existing BC+ households for benefits effective April 1, 2014.
- Establish Standard Plan benefits for any existing Benchmark or Core Plan member who remains eligible under the new income limits.
- Apply new med stat codes as needed – for example, to introduce a med stat code to eliminate cost sharing requirements for people with no income.

During this batch run, CARES will apply new income limits to members who are confirmed open for BC+ for the month of April. The batch run will exclude the following populations:

1. BC+ members who are confirmed open for April 2014 using MAGI rules.

2. Childless adults whose eligibility was last run prior to February AA, who met the eligibility requirements for BC+, but who could not yet be confirmed open for April 1, 2014 under MAGI rules.
    - Consortia will receive a report with these members and should re-run eligibility to establish benefits for April.
    - An additional report will include cases with both family BC+ and childless adult members that could not be confirmed prior to February AA because the childless adult benefit could not be confirmed.

3. BC+ members who have a disability determination, a Medicaid Purchase Plan (MAPP) disability determination or a presumptive disability. Because the batch run cannot evaluate these members for eligibility under Elderly, Blind or Disabled (EBD) Medicaid categories, workers must run these members online between February 17 and March AA to apply new income limits and explore eligibility under all categories of Medicaid.
    - Consortia will receive a report with these members and detailed instructions for processing.

4. BC+ members who provided complete MAGI information, for whom eligibility was run and a MAGI assistance group was built, and who meet the new income limits based on MAGI rules.
    - Consortia will receive a report with these members and detailed instructions for processing.
    - Note that cases will not be excluded from conversion if they provide incomplete information in their tax filing information (TFI) form and the case is pended for MAGI information. In addition, cases will not be excluded if the agency has received a TFI form but not yet processed it.

5. Cases for whom the Federally Facilitated Marketplace (FFM) has sent Wisconsin an application, unless the application has been processed and based on the outcome of that processing, the member is over the new income limits for BC+ and is not a childless adult who is categorically eligible under the determination state model. For a detailed explanation of the determination state model, see Operations Memo 14-02.
    - Consortia will receive a report with these members and detailed instructions for processing.

An additional report will be provided to consortia listing members who were included in the conversion and for whom a MAGI assistance group was subsequently built and confirmed open during conversion. Due to technical limitations in the batch run, these must be run online after February AA to establish benefits for April 1st. Given that most people who remain eligible because of the application of MAGI rules will be excluded from the batch run, the number of people for whom this will happen is expected to be very low.

- **NOTE:** To avoid sending accounts back and forth between the State and the FFM, self-employed members will be tested for the new income limits during the batch run without adding depreciation back to the countable income.

Upon completion of the batch run, notices of decision will be sent to members to communicate their eligibility results as of April 1, 2014. If a member's eligibility is ending April 1st or if they will have a change in BC+ benefit plan, they will receive a notice of decision. If their enrollment is continuing with no change, they will not receive a notice.

The FFM can only accept account transfers for members who have had a MAGI-based determination. For members who are determined ineligible for BC+ for April in the batch run:

- If the member provided a Tax Filer Information (TFI) form, the agency processed it and the member's eligibility was tested under MAGI rules during the batch run as a result, the member's account will be transferred automatically to the FFM as part of the batch run.
- If the member has not provided a TFI form (or if the TFI form has not yet been processed), the member's account will not be transferred and the notice of decision will direct the member to apply directly via the FFM.

As a reminder, for members who continue to be eligible for BC+ under new income limits, MAGI rules will be applied to the case at their next regularly scheduled renewal. For members who completed a renewal effective February or March 2014, MAGI rules will be applied the next time eligibility is run on the case.

ACCESS:

ACCESS Apply for Benefits, Renew My Benefits, Report My Changes, and Am I Eligible? will be updated as of February 3 to reflect the new policies for new applicants. ACCESS for Partners and Providers, which is used to establish presumptive eligibility for children and pregnant women, will also be updated as of February 3.

CONTACTS:

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: DHS 14-02 Amended

DATE: 01/16/2014

FS ☐	**MA** ☐	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: BadgerCare Plus Applications Received From and Sent to the Federally Facilitated Marketplace

CROSS REFERENCE: Operations Memos 13-28, 13-32, 13-43

EFFECTIVE DATE: February 3, 2014.

PURPOSE:
The purpose of this Operations Memo is to provide information to Income Maintenance (IM) workers on how to process a BadgerCare Plus (BC+) application that has been received from the Federally Facilitated Marketplace (FFM).

BACKGROUND:

The federal Patient Protection and Affordable Care Act (PPACA) established the Federally Facilitated Marketplace (FFM). The FFM allows individuals to shop for affordable private health insurance and apply for Advanced Premium Tax Credits (APTC) and reduced cost sharing.

Under federal regulations that mandate a no wrong door application approach, when an individual or family requests assistance with health care coverage through the FFM, that application is also considered an application for BC+ and will be assessed for BC+ eligibility.

FFM applicants who appear to be eligible for BC+ will be submitted to the IM agency inbox for processing. Although they are submitted via the FFM, they are transformed and submitted to the inbox via the same mechanism used for ACCESS applications. IM agencies will then be

responsible for processing these applications for BadgerCare Plus and/or EBD Medicaid through CARES Worker Web (CWW).

In general, applications from the FFM are subject to the same rules for processing and eligibility policies as applications that are submitted directly to IM consortia. This is referred to as the "assessment state model." Under this model, the FFM will only assess an individual's potential eligibility for state programs. However, FFM applications with a filing date from October 1 through December 31, 2013 will be processed under a "determination state model." Due to delays in Wisconsin's implementation of FFM transfers and MAGI rules, CMS has required Wisconsin to accept the FFM "determination" of BC+ eligibility for these FFM applications. The difference between the assessment state model and the determination state model is discussed in detail below.

Just like an application submitted directly to the FFM is considered an application for BC+, an application for health care benefits submitted to IM consortia is considered an application for private health insurance and APTCs. Effective February 1, 2014, when an individual is determined in CARES to be ineligible for BadgerCare Plus based on MAGI rules, the application, in some cases, will be transferred to the Marketplace. After the application is transferred, the Marketplace will contact the member to complete the application process.

CARES/CWW

Identifying an Application Received from the FFM

Applications received from the FFM will be transformed into an ACCESS application and submitted to the agency's inbox for processing. These applications will be identified in the Inbox Listing page with an 'Item Type' of 'FFM' and on the Application Summary page with a 'Data Collection Method' of 'Federally Facilitated Marketplace.' (Please refer to Operations Memo 13-28 for more detailed information) The application will be stored in the ECF but will not be viewable by the applicant through their ACCESS account.

The FFM tracks the processing status of all applications that are transferred. In order to send an accurate response to the FFM, all FFM applications must be processed in CARES Worker Web (CWW) through confirmation. These applications should not be withdrawn even if the household is already open for BC+ benefits. The application must be linked to the open case and processed.

Based on the outcome of the eligibility determination, the following reason codes will be used to determine which outcome (eligible or ineligible) is sent to the FFM. These reason codes will not generate any language that is included in the notice of decision but will be used to inform the FFM of the results of the eligibility determination.

- Reason Code 711: Indicates to the FFM that the FFM referred individual was found eligible in CARES.
  Reason Code 712: Indicates to the FFM that the FFM referred individual was found ineligible in CARES

The filing date for the health care request will be the date the application was received by the FFM. Agencies will have 30 days from the day the application is submitted to the inbox to process the application timely. The applications referred from the FFM will display in the Workload Dashboard and will be identified as an FFM application. See Operations Memo 13-28 for more detailed information on the changes to the Dashboard, the Inbox Search and Listing pages and the Application Summary pages related to the FFM applications.

When a household or member open for BC+ or Medicaid reports a change to the FFM, the FFM will encourage the member to report the change to their IM agency. However, the member has the right to report the change to the FFM. If the member prefers to report the change to the FFM, the change report will be transferred to Wisconsin as an application and must be processed as an application.

Because the Wisconsin BC+ specific "Rights and Responsibilities" information is not provided when a person applies for health care through the FFM, a summary must be sent to the applicant once the application is processed. No additional signature is required.

➢**NOTE**: Referrals from the FFM may include households with individuals whose eligibility may not be able to be determined on one case. For example, one referral may include an application for a man, his wife, their minor child and their 24 year old child who is also their tax dependent. Although the 24 year old is included in the request, his eligibility cannot be determined on his parent's case. A separate case should be set up for the 24 year old. No additional signature is required for that request. Tax dependents living outside the home will not be included in the health care request for their tax filer's household. A separate application would be required to determine eligibility for the tax dependent living outside the home.

Individuals and families cannot apply for other programs of assistance such as FoodShare, Wisconsin Works (W-2), and Child Care (CC) through the FFM. This includes Family Planning Only Services (FPOS). If a case already includes an FPOS request or FPOS is open for an individual the FPOS request should be retained on the case.

Information Not Provided by the FFM

Because the FFM does not base its determinations and assessments on all of the policies used to determine BC+ eligibility, not all information required in CWW will be available on the FFM application. The following items have been identified as information that will not be included in the FFM applications.

Month(s) of Backdate Request: The FFM application will gather whether or not the applicant is requesting backdated coverage, but it does not gather information on the number of months for a backdate request. If a backdate request is indicated, workers should always assume the backdate request is for 3 months.

Immigration Status: Information on immigration status reported to the FFM will not update on the ACCESS application. As a result, if someone reports on their FFM application that they are not a citizen, the ACCESS application will only include the "no" response for citizenship. Workers will have to follow up with the applicant to obtain and verify the immigration status and entry date. When processing an application for an individual determined eligible by the FFM under the Determination State model, the FFM has determined the individual meets the criteria of a qualifying immigrant, even though the specific immigration status and entry date will not be transferred on the FFM application. For these applications (FFM applications with filing dates from October 1 through December 31, 2013) workers should enter the "01" status code and an entry date earlier than 5 years from the filing date. This will allow BC+ to pass for the month(s) the individual is categorically eligible. The correct immigration status and entry date must be updated at the time the individual is tested under regular rules. Case comments must be entered at the time the FFM application is processed to indicate the actual immigration status and entry date is unknown and the information must be gathered prior to determining eligibility under the regular rules.

Marital Status: The FFM will only send "Married" or "Not Married". The application will not indicate if the individual is divorced, widowed or separated. Workers should use the best information available to determine the actual marital status of someone who indicates he or she is "Not Married". This information may be included in a past application or in history in CWW. If the FFM application indicates an individual is "Not Married" and no past information is available, workers should enter a marital status of 'SI – Single-Never Married' with a verification code of 'NQ'.

Disability: The FFM application will collect an individual's disability status but will not collect verification of the disability. Workers should access the SOLQ information to verify disability status. If disability information is not available through SOLQ a "?" should be entered on the disability page and a request for verification generated. BadgerCare Plus will not pend for the disability determination but if the individual is denied or terminated from BadgerCare Plus the eligibility determination for EBD Medicaid will pend.

Authorized Representative: The name of the representative will be available on the application but the FFM collects a more limited number of representative types than the ones available in CWW. The worker may have to follow up with the representative to gather the additional information. The address for the representative will not be available through the FFM application. To continue processing the application, workers should enter the applicant's address for the authorized representative with a "?" in the verification field to generate a verification request for the information.

Tax Filing Details Page: If there is an existing health care request on the page, this information will not update to CWW from the ACCESS application. A message will display on the page to let the worker know there is information on the PDF. Workers will have to enter the information from the PDF on the page. If there is no existing health care request on the case the tax filing status and information on tax dependents will pre-populate from the ACCESS Application. However, even in this situation, the information from the "Income of Children and Tax Dependents" section will not pre-populate. Workers will have to refer to the PDF for this information.

Household Relationships: The household relationships in CWW do not correlate with the questions asked on the FFM application. The FFM application does not distinguish between siblings and half siblings or step siblings or between a parent and a step parent. Workers should access resources such as KIDS, historical entries in CWW and the ECF, etc. to determine the relationship code to enter in CWW.

Current Demographics: Workers can assume "Yes" for SSN Cooperation. The SSN verification will continue to be completed through the SOLQI process. Workers should also assume "No" for the Migrant Worker question unless the individual has been open in CARES in the past as a migrant worker or the worker has other information that deems this questionable.

Gatepost Pages: If a question on a gatepost page is unanswered, workers can assume a "No" for those questions.

Absent Parent Information: Information related to absent parents is not collected by the FFM. Workers should access other resources such as KIDS, historical entries in CWW, the ECF and Birth Queries to find information on the absent parent.

Pregnancy Due Date: An FFM application that includes a pregnant woman will not include a 'Due Date'. Workers should enter a due date that is nine months from the filing date.

Employment Begin Date: An FFM application that includes employment will not include the 'Begin Date' of employment. Workers should use the Employment Query to try to obtain the hire date, when available. When the hire date is not available, workers should enter a 'Begin Date' that is the same as the filing date of the application and 'NQ' in the verification field.

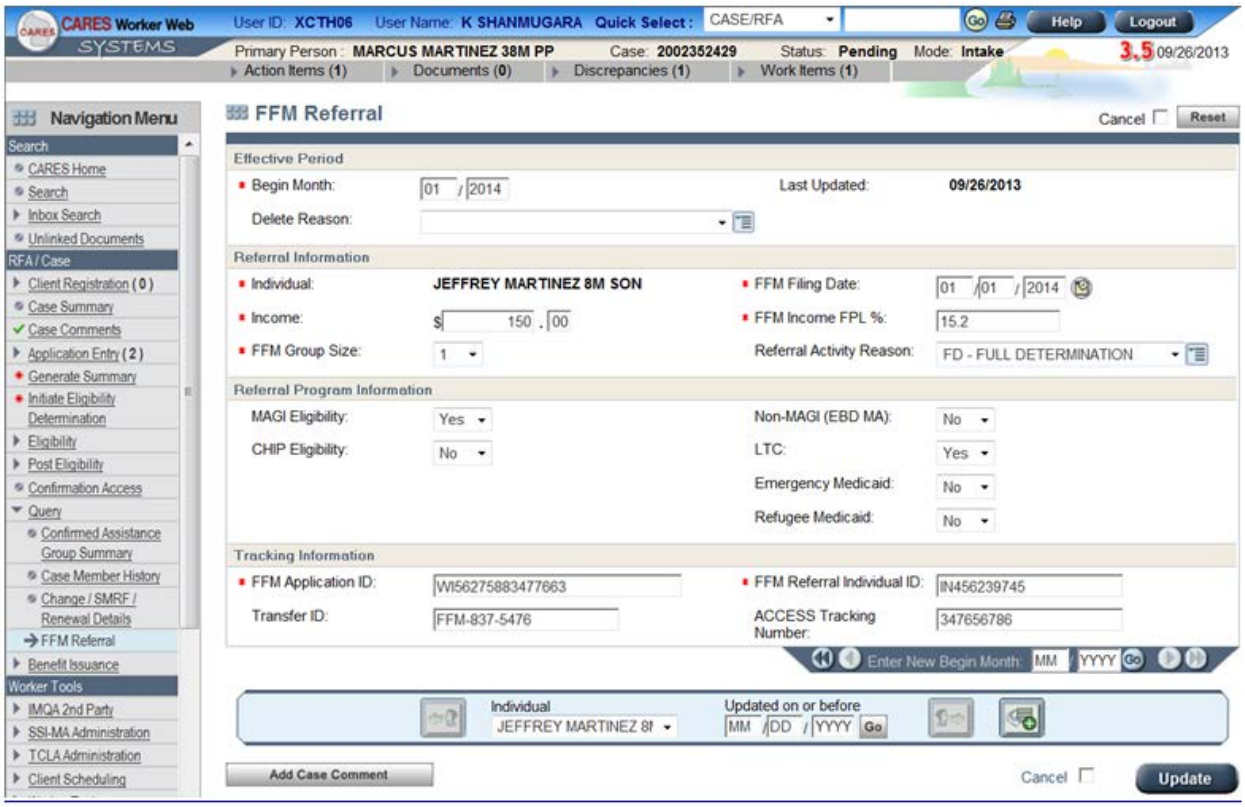
Workload Dashboard, Inbox Search and Income Maintenance Management Reports

Operations Memo 13-28 outlines in detail the changes made to the Workload Dashboard, the Inbox Search criteria and display as well as changes to the IMMR.

FFM Referral Page

A new CWW page has been created to display referral information about each individual who has been referred from the FFM. The page will be added to the navigation menu under the "Query" section but will not be included in any driver flows. The information on the page will be automatically populated when the application is processed. The referral pages for each individual will be updated after each referred individual passes clearance or is matched to an existing CARES individual during the clearance process. The page will contain the historical information for all referrals from the FFM for each individual on the case.

IM workers will not have access to update the information on the page. The DHS CARES Call Center staff will have update access to the page to adjust incorrect information.



Effective Period

Begin Month: Month and year of the referral filing date. CARES will use this information to determine if the application should be processed under the Determination or Assessment State model.

Last Updated: The date the referral information was updated.

Delete Reason: The reason the individual referral information was deleted from the page.

Referral Information

Individual: Person who was referred from the FFM because they were assessed or determined eligible or requested a full health care determination.

FFM Filing Date: This is the date the application was received by the FFM. This date is also the filing date for the Health Care Request.

Income: Combined monthly income for the Medicaid Group as defined by the FFM. This is the income that will be used for establishing BC+ eligibility under the Determination State model.

FFM Income FPL%: The FPL amount based on the group size and monthly income amount reported to the FFM. This FPL amount will be used for establishing BC+ eligibility and calculating premiums under the Determination State model.

FFM Group Size: The Medicaid Group Size as determined by the FFM. This group size will be used for establishing BC+ eligibility under the Determination State model.

Referral Activity Reason: The reason the individual was referred by the FFM. The reasons codes are:

- FD-Full Determination – Populated for individuals that did not appear to be MAGI or CHIP eligible but requested a full determination of health care benefits.
- GF-Gap Filling – Created for future use
- PD-Procedural Denial – Created for future use
- WP-Waiting Period Exception – Created for future use

Referral Program Information

MAGI Eligibility: Indicates whether or not the individual may be eligible under MAGI rules. This indicator refers only to BC+ populations.

Non-MAGI (EBD MA): Indicates whether or not the individual may be eligible under non-MAGI rules. This indicator refers to individuals who may be eligible for EBD, LTC, Refugee or Emergency MA.

CHIP Eligibility: Indicates eligibility for BC+ under CHIP funding.

LTC: Indicates potential eligibility for Long Term Care Services.

Emergency Medicaid: Indicates potential eligibility for coverage under Emergency Medicaid.

Refugee Medicaid: Indicates potential eligibility under the Refugee Medicaid program.

Tracking Information

FFM Application ID: The ID for the FFM application generated by the FFM. Individuals referred in the same application will have the same FFM application ID.

FFM Referral Individual ID: The referral ID for the specific individual generated by the FFM.

Transfer ID: The ID used for the transmission of data from the FFM generated by the FFM.

ACCESS Tracking Number: The ACCESS tracking number assigned to the FFM referral when the application is transformed to an ACCESS application.

Applications Processed under the Determination State Model

Individuals determined eligible by the FFM on applications received from the FFM with a filing date between October 1 and December 31, 2013 will be made categorically eligible for at least one month in 2014. By "categorically eligible" we mean those individuals determined as having Medicaid or CHIP eligibility by the FFM will be made eligible for BC+, regardless of income or other eligibility criteria. CARES will use the "MAGI Eligibility" and "CHIP Eligibility" indicators from the FFM Referral page to identify which applications have been determined eligible through the FFM.

- For parents/caretakers, children and pregnant women determined eligible through the FFM with a filing date between October 1 and December 31, 2013, CARES will establish February as the month of categorical eligibility under MAGI rules.

- For childless adults determined eligible through the FFM with a filing date between October 1 and December 31, 2013, CARES will establish April as the month of categorical eligibility under MAGI rules.

Because families who applied through the FFM may be eligible for BC+ as early as October 1, 2013, these applications will be processed under old BC+ rules for the months of October, November, December and January, as applicable.

➢ **NOTE:** The financial and non-financial information provided by the FFM must also be used in the eligibility determinations for October through January without requesting additional verification even though eligibility is determined using the old BC+ rules for counting income and forming assistance groups and the old income limits.

When processing a new case or adding new income provided through the FFM to an existing case, workers should use the "NQ" code for verification from October through January and update the verification code with a February effective date to either "FP" or "FF," whichever is appropriate.

Families who applied through the FFM starting in October may also have requested back dated eligibility. If eligible for backdated benefits, eligibility for July, August and/or September would have to be determined and certified manually.

Individuals eligible in January under the old rules would be considered an ongoing beneficiary if still eligible in February under the new income limits.

When processing an application with an October filing date after adverse action in February, workers may get the '9 month live' edit. To get around this, eligibility should be determined for the current and ongoing months and then re-run for the backdated months.

In the rare circumstance that a family who applied under the determination state model is not also found eligible under current BC+ rules for the month of January 2014, they must be manually certified as categorically eligible for January 2014 using the old BC+ medical status codes that are appropriate for their eligibility group and income.

Example: Hannah applied through the Marketplace on December 14, 2013, for herself and her two sons, Jack and Caleb. Hannah has earnings of $1500/month, while Jack receives $900/month in Child Support and Caleb receives $900/month in child support. CARES will test the family for December and January under current BC+ rules and current BC+ income limits. Jack and Caleb will be found eligible, but at $3300/month for a group size of 3, Hannah is over the 200% income limit and will be found ineligible for these months. In February, Hannah will be eligible because the child support income is no longer counted and her income will be under 100% FPL. Because this is an FFM application received between October 1, 2013 and December 31, 2013, and Hannah was found eligible for BC+ by the FFM effective January 1, 2014, Hannah should be manually certified for the month of January.

Under the Determination Model, Wisconsin will accept the information provided by the FFM as valid information for BC+ eligibility for any individuals determined eligible by the FFM. The only exceptions to this categorical eligibility are:

- Death
- Moving out of State
- Failure to pay a premium. BC+ members required to pay a premium must continue to do so to become or remain eligible. See BC+ Eligibility Handbook Chapter 19.5 for the rules regarding the initial premium payment. If January certification is completed through a manual process, CARES will look at February as the free month. We will accept that determination and the first premium owed in that situation will be for March.

For childless adult applicants, CARES will establish April as the month of categorical eligibility.

Like all BC+ members, when an FFM-referred applicant becomes eligible, it will be for a 12 month certification period. However, if a person is already part of a case with an existing review date, the new person's review date would be aligned with the existing BC+ review.

After the initial month of categorical eligibility (February for families and April for childless adults), the FFM-referred member's BadgerCare Plus eligibility would be re-determined using regular, non-determination state rules whenever:

- The member reports a change or completes a review.
- New information becomes known to the agency via a data exchange.
- New information becomes known to the agency via another program (For example, through a six-month report for FoodShare or a review for Child Care).

Depending on the new information, the worker may request additional information or verification. However, the member would not be required to re-verify for BC+ purposes any information reported to Wisconsin via the FFM unless a change has been reported or discovered for that information.

- **NOTE:** A re-determination of eligibility will also take place during the 2014 FPL changes scheduled for March. If an income change was reported and verified but not acted upon because of the categorical eligibility granted in February, for example, it would be applied to BC+ eligibility during the FPL mass change

Example: John, his wife Jane, and their 2 children applied through the FFM on December 15, 2013 and were determined eligible for BC+ by the FFM. On his FFM application John reported earnings of $1000 per month from his job at ACME Fireworks. The worker processed the application on February 5th. The family is eligible for December and January under old BC+ rules. Starting February 1st, the family is categorically eligible under the Determination State model. In April, the worker received a discrepancy indicating Jane was working at ABC Corporation making an average of $2000 per month. The worker should request verification of Jane's earnings and eligibility should be re-determined using the new income information along with the income reported for John on the FFM referral. Because there was no change reported or discrepancy created for John's income, the income information reported for John on the FFM referral would continue to be considered valid and no further verification would be required.

If eligibility is terminated based on the new eligibility determination, a notice would be generated at least 10 days prior to the closure. The account will be transferred to the Marketplace on the same day the closure is confirmed.

Applications may include both individuals who were determined eligible by the FFM and individuals who were determined ineligible. On these cases, the BC+ AG's may pend for information for the individuals not determined eligible through the FFM. Once information and verification requested is submitted, the eligibility for all individuals on the case may be confirmed. If the verification or information requested is not returned timely, the individuals found ineligible by the FFM will be denied and the individuals found eligible by the FFM can be confirmed open.

New Verification Codes for Applications Processed under the Determination State Model

Because the income information gathered through the FFM must be verified for other programs of assistance, two new verification codes have been created that indicate the information is verified for BC+ but not for the other programs of assistance. These codes should only be entered on an application that was referred by the FFM with a filing date from October 1 through December 31, 2013. The new codes are:

- **FP**: This code is a valid verification code for BC+ but not for any other programs of assistance. Use of this code will cause all other programs of assistance, including Family Planning Only Services (FPOS) and EBD Medicaid, to **pend** if that program requires verification of the information. The FP code will also be considered valid verification for Tribal Status for all Health Care programs. The code should be entered to generate a verification request for the other program(s) of assistance.

- **FF**: This code is a valid verification code for BC+ but not for any other programs of assistance. Use of this code will cause all other programs of assistance, including EBD Medicaid and FPOS, to **fail** if that program requires verification of the information. The code should be entered when verification has been requested for the other program(s) of assistance and that verification has not been submitted.

When earned or unearned income is reported for an individual on an FFM application that is being merged to an existing, open case:

- If employment is already recorded in CWW and the reported wage information matches what was reported on the FFM application, workers should use the existing verification on file.
- If employment is already recorded in CWW and the reported wage information is different, workers should enter the BC+ income from the FFM application in the Override BC+ Taxable Amount field on the Employment page, using "FP" in the associated verification field. The existing amounts in the Detailed Wage Information section and verification fields should not be changed.
- If the unearned income type is already recorded in CWW for the individual and the amount is the same as the amount reported on the FFM application, workers should use the existing verification on file. No updates to the Unearned Income page are needed.
- If the unearned income type is already recorded in CWW for the individual with a different amount, workers should enter the amount reported on the FFM application in the Monthly MA Amount field, leave the original amount in the Gross Income Field and enter a verification code of "FP".

A "Q?","?","QV" or "NV" entered for information necessary to determine BC+ eligibility will cause BC+ to pend or fail even when the application is being processed under the Determination State model. Workers should use the "FP" and "FF" codes for income verification when processing these applications.

Other Processing Guidelines for the Determination State Applications

The BadgerCare Plus MAGI Budget Page will be enhanced to include a new field "Determination" to indicate if the eligibility determination was done under the Assessment State Model (I-IM) or the Determination State Model (FFM).

Dependent 18 Year Old: The FFM application will not include the expected date of graduation. Workers should assume the 18 year old is in school and enter an expected date of graduation prior to the 18 year olds 19th birthday.

Tax Filing Details Page: If no information is provided to determine if a child or tax dependent is expected to be above the earned or unearned income thresholds to be required to file taxes, workers should assume the answers to those questions are "No". The information should be updated at the next renewal.

Employment Page: Workers should click the verify button on the Family Major Medical insurance Access for BadgerCare Plus section, enter off the page and then go back and enter the "PO" code in the verification field in both the Current Access and Past Access sections. Workers should answer 'No' to the question, 'Does this employee have access to the state employee health plan?' This will pass the BC+ but continue the request for verification of insurance access appropriately.

<u>Cross Program Impacts of the Determination Model</u>

The following chart outlines the process and policy for using information provided on the FFM application for other programs of assistance that may be open on the case when the FFM application is processed. When a new program of assistance is added to a case open for BC+ under the determination model, any information reported for the new program of assistance should be verified using the rules for that program of assistance. If changes are reported to information that was verified for BC+ using the FP/FF code, verification should also be requested for that information for BC+ and eligibility for BC+ re-determined based on the new information.

Type of Information from the FFM application	**Considered a Reported Change for FS?**	**Considered a Reported Change for W-2?**	**Considered a Reported Change for Child Care?**	**Worker Process**
New non-financial information (for example, changes in household composition, pregnancy status or household relationships)	Yes	Yes	Yes	Non-financial information will be updated when the worker processes the FFM application. The worker should follow up with the applicant and request verification if needed. Changes made to the case will impact FS/W-2 and CC, as appropriate, when eligibility is run.
A new source of earned or unearned income	Yes	Yes	Yes	Use the "FP" code and run eligibility; if verification is needed for that income source, the appropriate program will pend. If verification is not returned, enter "FF" to fail for lack of verification for other programs.
A change in frequency or amount for unearned income.	Yes	Yes	Yes	If the FFM-reported information is the same as the verified information in CARES, no action is needed. If there is a data exchange available for the unearned income type for which the change was reported, the worker should use the data exchange to verify the frequency or amount. If no data exchange is available, and the FFM-reported information is different from the verified information in CARES, the worker should use the "FP" code and run eligibility; if verification is needed for that income source, the case will pend. If verification is not returned, use "FF" to fail for lack of verification.

Type of Information from the FFM application	Considered a Reported Change for FS?	Considered a Reported Change for W-2?	Considered a Reported Change for Child Care?	Worker Process
Taxable earnings amount	No	No	No	The FFM is collecting taxable earnings, which are often lower than the gross earnings amount used to determine FS, W-2 or CC eligibility. Given this discrepancy, do not use FFM-reported taxable earning amounts to override the already verified gross earnings amount on an existing FS, W-2 or CC case.
Self-employment information	No	Yes	Yes	For FoodShare: The FFM self-employment amount includes disregards for depreciation and other business expenses that are not allowed for FoodShare. The amount from the FFM does not correspond directly to the FS self-employment amount. The difference between the countable income for FS and the amount counted on the FFM application should be entered as a BC+ tax deduction. For W-2 and Child Care: Changes in the frequency or amount of self-employment income should be treated as a reported change. Use the “FP” code and run eligibility; if verification is needed for that income source, the case will pend. If verification is not returned, use “FF” to fail for lack of verification. If verification is returned and the amounts used for W-2 and CC differ from the amount counted on the FFM application follow the process outlined above.
Employment details (hours worked, pay period, etc.)	Yes	Yes	Yes	Use the “FP” code and run eligibility; if verification is needed for that income source, the case will pend. If verification is not returned, use “FF” to fail for lack of verification.

Running eligibility for Childless Adults for Months Prior to April 2014

As described above, childless adults with filing dates from October 1, 2013 through December 31, 2013 are categorically eligible starting April 1, 2014 and must have their applications processed for eligibility starting in April under the Determination State model. Because Eligibility for this population does not start until April 1, 2014, these individuals will not be eligible in the backdated month(s) prior to April.

If such an application is processed and eligibility is being determined prior to adverse action in February 2014, eligibility for the childless adult for February and/or March will fail for reason code "698/699 – BC+ Program Not Available for Childless Adult". If, under the determination model, the individual's eligibility in MAGS assistance group (AG) should pass for April 2014, March eligibility will appear to pass with reason codes "708" and "698" to indicate categorical eligibility, but confirmation of MAGS AG for March will be prevented. These cases will appear on a report of cases that must have eligibility run after February adverse action to establish and confirm categorical eligibility for April.

If eligibility is run on these applications after February adverse action, February and March will fail due to no program being available. April will pass based on the applicant's categorical eligibility under the determination state model.

Duplicate Applications

Individuals and families may submit an ACCESS application or paper application even though they have already applied through the FFM and were told they are eligible for BC+. If the filing date of an ACCESS or paper application is later than that of the FFM application, the information on these applications should be treated as change reports, even if the ACCESS or paper application is processed before the FFM application is processed.

If an ACCESS or paper application with a filing date later than the filing date on the FFM application is processed first and an individual has an FFM filing date between October 1, 2013 and December 31, 2013:

- The FFM application must still be processed and the individual(s) determined BC+ eligible through the FFM must be made categorically eligible for January and February 2014 (for families) or April 2014 (for childless adults) based on the information provided on the FFM application.
- The worker should then re-run eligibility for the month after the categorically eligible month(s) to re-determine eligibility based on the information from the ACCESS or paper application. Be sure the effective dates entered on the CWW pages correspond to the filing date on the applications.

If the FFM application is processed first, but the ACCESS or paper application has a later filing date, the information in the ACCESS application should be used to re-run eligibility for months after the categorical eligibility month(s), and workers should pend for appropriate verification.

Note that while eligibility for families can be re-run immediately, eligibility for Childless Adults must be run after March adverse action in order to terminate eligibility effective May 1. Workers may choose to re-run eligibility online, but the mass FPL update on March 22, 2014 will also pick up these cases.

Example: Joe, a childless adult, applied through the FFM on October 20th and was determined BC+ eligible by the FFM. He also submitted a paper application on November 30th.

Scenario 1: The paper application is processed February 3, 2014. The income reported on the paper application is over 100% of the FPL and he is not eligible for BC+. The FFM application is processed February 25th. Since the FFM determined him eligible, Joe must be made categorically eligible for April. The CWW effective dates for the FFM application information would be 10/2013. The CWW effective dates for the information included on the paper application would be 11/2013. After confirming April open, the worker can rerun eligibility after March adverse action for May, using the information from the paper application. Since Joe was over the income limit when that application was processed his eligibility will terminate April 30th, 2014 and he will be able to sign up for health insurance through the Marketplace.

Scenario 2: The FFM application is processed on February 5, 2014 and Joe is determined categorically eligible for April. When the paper application is processed on February 20th, the worker determines Joe is not eligible for BC+ based on the income reported on the paper application. In the FPL mass change on March 22, 2014, the eligibility run will use the information entered from the paper application, and Joe's BC+ will close effective April 30, 3014.

Applications Processed under the Assessment State Model

Applications from the FFM with a filing date on or after January 1, 2014 should be processed using all the same rules for requesting verification and additional information as the rules used for processing any other BC+ application. Workers should not use the "FP" or "FF" codes when processing an application received from the FFM with a filing date on or after January 1, 2014. These codes will be valid only for BC+ applications from the FFM with filing dates from October 1 through December 31st, 2013. Please see the section above "Information not provided by the FFM" for instructions on the actions to take for missing information. All other information must be gathered and verified if appropriate.

Account Transfers to the FFM

In some cases, when a BadgerCare Plus applicant is denied eligibility or a recipient's eligibility is terminated, CARES will transfer the application to the FFM so the individual can be considered for Advanced Premium Tax Credit (APTC) eligibility and sign up for a private insurance plan.

If a case closes or an application is denied due to procedural reasons such as failure to verify information, non-payment of premium, failure to cooperate with SSN requirements, etc., the account will not be automatically transferred to the FFM. This is because the reason for the termination or denial can be resolved and the individual may be made eligible for BC+. In this situation, the following language will appear on the notice of decision:

"You may be able to buy private health insurance through the federal Health Insurance Marketplace (Exchange). You also may be able to get help paying for it. To apply, go to HealthCare.gov, call 1-800-318-2596 (TTY 1-855-889-4325) or contact your agency for help."

Similar language will be included on notices of decision during the batch conversion on February 15th when BC+ is failing for a non-procedural reason and MAGI information was either not provided or eligibility was not run for March.

When BC+ is denied or terminated for a procedural reason the language below will appear on the notice of decision OR when a case closes for a non-procedural reason such as excess income, access to other insurance, etc., the account will be automatically transferred to the FFM. The Notice of Decision will inform the individual or household that their account has been sent to the FFM. (Please see below for a full list of "non-procedural" reasons.) Reason codes 713 (for an FFM referred individual) or 714 (for a CARES initiated individual) will be set and the Notice of Decision language will read:

"You may be able to buy and get help paying for private health insurance through the federal Health Insurance Marketplace (Exchange). Your application has been sent to the Marketplace. If you have questions, call the Marketplace at 1-800-318-2596 (TTY 1-855-889-4325)."

Non-Procedural Reason Codes

CARES Reason Code #	Description
014	Income exceeds the net income limit.
016	Income exceeds the gross income limit.
024	Countable assets are over program limits.
039	Is neither a citizen nor a qualifying alien
122	MA Extension requires employment of one group member.
123	Assets exceed Spousal Impoverishment limit
128	Is 21 years old or over, but not 65, and resides in an IMD.
280	Is covered by an insurance plan.
281	Had health plan coverage in the last 3 months.
309	Cost share exceeds Family Care cost of care plan.
318	No capacity in the Family Care Care Management organization
319	Is not functionally eligible
327	You are not in a valid Family Care county
329	There is no valid CMO enrollment period for Family Care
334	You must be at least 18 years of age to receive Family Care
336	Comm. Waiver program slots are not available at this time
342	Program recipient must be aged, blind, or disabled
343	You are not in a valid PACE/Partnership county.
347	Invalid SMCP code for this program of assistance
441	MAPP indiv not blind or disabled or MAPP disabled per DDB
473	Not enrolled in MAPP for 6 mos prior to exemption request
475	Two Work Exemptions have already been approved
476	No hospitalization or serious illness exists
482	Not expected to return to work within 6 months
566	The pregnancy is past due.
589	You were in an invalid placement when you left home care.
592	Child not in home (in Foster or court ordered kinship care)
593	Individual has access to 80% insurance now.
594	Individual had access to 80% insurance in the past 12 month.
595	Individual has access to state insurance.
615	Individual disenrolled from Pace/Partnership Program

CARES Reason Code #	Description
674	Individual has access to affordable employer's insurance plan
675	Individual has affordable employer's health coverage.
680	Individual had affordable health coverage in last 3 months.
682	This benefit is only for individuals 18 years old and older
683	This benefit is only for individuals less than 22 years old

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

DHS OPERATIONS MEMO

No: DHS 14-03

DATE: 03/13/2014

FS ☐	**MA** ☐	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: **BadgerCare Plus Extensions Policy Changes**

CROSS REFERENCE: Operations Memo 13-32, 13-43, 14-01, 14-02
BadgerCare Plus Eligibility Handbook, Chapters 18 & 19

EFFECTIVE DATES: February 1, 2014 and April 1, 2014

PURPOSE:

The purpose of this memo is to announce policy changes to BadgerCare Plus (BC+) Extensions (also known as Transitional Medical Assistance) for 2014 resulting from recent federal legislation and new waiver requirements.

BACKGROUND:

As described in Operations Memos 13-32 and 14-01, provisions in the federal Patient Protection and Affordable Care Act (PPACA or ACA), 2013 Wisconsin Act 20 (the State Biennial Budget), 2013 Wisconsin Act 116, and 2013 Wisconsin Act 117, require changes in the policies used to determine eligibility for the BC+ program. These changes included a change in the length of BC+ Extensions so that all Extensions started in 2014 would be for 4 months.

Recent federal legislation has extended the current policy of setting 12-month earned income and 4-month child support extensions through March 31, 2014. Ongoing budget negotiations at the federal level may extend this 12-month earned income extension policy even further.

In addition, as part of BC+ changes for 2014, Wisconsin requested a federal waiver to collect premiums from adults in Extensions. This Operations Memo also describes the specific premium-related policies for adults in Extensions that will take effect April 1, 2014.

POLICY CHANGES:

12-MONTH EXTENSIONS:

Recent federal legislation has extended through March 31, 2014, the current policy of setting 12-month Extensions for people who lose eligibility due to an increase in earned income. Additional budget negotiations at the federal level may extend these policies even further.

As described in Operations Memo 13-32, CARES was updated to set all Extensions that start in 2014 as 4-month Extensions. These changes were implemented in CARES, effective February 1, 2014. All earned income Extensions set in February and March 2014 will be set as 4-month Extensions. To accommodate the change in policy these extensions will be updated systematically to 12 months prior to the end of the 4-month Extension. Workers will not be required to take action to update the extension from 4 to 12 months. CARES will be updated to reflect the extension of the 12-month earned income Extension policy, if and when Congress extends this authority beyond March 31, 2014.

Ongoing BC+ members who are in a 12-month earned income or a 4-month child support Extension will remain in that Extension, until the end of the Extension certification period, as long as they continue to meet all other eligibility criteria.

Members eligible as a childless adult are not eligible for an Extension.

OTHER CHANGES IN EXTENSIONS POLICY FOR 2014:

As described in Operations Memo 13-32, the basic policies for becoming eligible for an Extension are generally not changing in 2014, with the exceptions discussed below.

Starting Extensions

Because of MAGI-related changes in household composition and income counting rules, there are some differences in how extensions will be set for households whose eligibility is determined under old BC+ budgeting rules vs. households whose eligibility is determined under MAGI rules:

- Households whose eligibility is determined under old BC+ rules must have been eligible for BC+ with household income at or below 100% of the FPL for 3 out of the last 6 months and had their income increase to over 100% FPL due to earnings and/or child support.

- Parents, caretaker relatives and pregnant women whose eligibility is determined under MAGI rules must have been eligible with income at or below 100% of the FPL for 3 out of the last 6 months and had their income increase to over 100% FPL due to earnings and/or alimony. When a parent, caretaker relative or pregnant woman enters an Extension, all dependent children, stepchildren and NLRR children of that person will be eligible for the same Extension, provided that they are eligible for BC+ under MAGI rules with incomes at or below the income limits described here in the month prior to the start of the extension:

Group	Extension eligibility under MAGI Rules
Children under age 1	Income at or below 306% FPL
Children ages 1 through 5	Income at or below 191% FPL
Children ages 6 through 18	Income at or below 156% FPL

Effective February 1, 2014, CARES was updated to implement these rules.

Losing Extensions

There are three policy changes related to losing extensions:

Effective February 1, 2014, the household (under old BC+ rules) or the individual (under MAGI rules) does not need to maintain employment in order to continue their earned income extension. Effective February 1, 2014, CARES was updated to implement this policy for MAGI-based extensions only. If a household whose Extension was built under old BC+ rules reports a loss of employment, and the members are not otherwise eligible for BC+ due to that loss of income, contact the CARES Call Center for assistance in continuing the Extension.

Based on the planned implementation of 4-month earned income Extensions, CARES was updated so that parents / caretaker relatives in a MAGI-based extension may continue their extension even if there are no more children under age 19 in the home. Similarly, CARES was updated so that children in a MAGI-based extension could continue their Extension if they turned 19. However, under the implementation of 12-month earned income Extensions, the existing policies will stay in effect:

- Parents / caretaker relatives only continue to be eligible for an earned income extension if there is still a child under age 19 in the home. If all children leave the home or turn 19, the extension should end.
- Children only continue to be eligible for an earned income extension until they turn 19.

CARES will be updated to reflect this change, but in the meantime, contact the CARES Call Center for assistance with ending any MAGI-based earned income extension for the reasons described above.

➢**Note:** these policies for losing extensions based on no longer qualifying as a parent / caretaker or child are for earned income extensions only. They do not apply to extensions based on increases in child support or alimony.

Extensions policies based on old BC+ vs. MAGI rules

There are some additional differences in extension policy based on whether the household or individual was eligible under old BC+ rules or MAGI rules when the extension started. They include:

Requirement for households entering an extension under old BC+ rules (Existing extensions policy)	**Requirement for households entering an extension under MAGI rules**
Pregnant women can only enter an earned income or child support extension once the pregnancy reaches the 8th month.	All pregnant women can enter an earned income or alimony extension if they qualify.
Youth Exiting Out-of-Home Care (also known as Former Foster Care Youth) with children may qualify for an extension.	Former Foster Care Youth (also known as YEOHCs) never qualify for extensions.
If an extension ends because the parent's income decreases below 100% FPL, the child's extension also ends. If the parent qualifies for a new extension, the child will be put into the new extension.	If an extension ends because the parent's income decreases below 100% FPL, the child's extension will continue to stay in the original extension eligibility category until it expires.
If a child in an unexpired extension has the other parent qualifying for an extension, the child could be put into the new extension. (Note that this is possible but not likely to happen under current BC+ rules.)	If a child is in an unexpired extension and a parent qualifies for a new extension, the child's extension will continue to stay in the original extension eligibility category until it expires. The child is not eligible for the other parent's extension.

Effective February 1, 2014, CARES was updated to reflect the new policies for MAGI-based extensions described above.

Premiums for Adults in Extensions:

In addition, as part of BC+ changes for 2014, Wisconsin requested a federal waiver to collect premiums from adults in Extensions. As outlined in Operations Memo 13-32, Wisconsin planned to require premium payment from all non-exempt adults in Extensions, including those with incomes between 100% and 133% of the FPL.

Based on recent waiver approval from CMS, adults with incomes at or below 133% of the FPL will **not** be subject to premiums for the first six calendar months of their Extension. Non-exempt adults with incomes above 133% of the FPL in an Extension will continue to be subject to premium requirements in 2014.

The six months of premium exemption will start with the begin date of the Extension for someone in an Extension whose income is at or below 133% FPL. If the member has an increase in income that puts their income above 133% FPL, they will be subject to premiums, even if they are still in the first six months of the Extension. If the member's income subsequently decreases to below 133% FPL, they will be exempt from premiums as long as they are in the first six months of their Extension. If the member's income drops below 100%, then later increases and the member qualifies for a new Extension, the six-month premium

exemption will begin with the new Extension. If the member's income drops below 100% and then later increases but the member does not qualify for a new Extension, the member will be re-enrolled in the previous Extension and the original 6-month timeframe for exempting premiums will apply.

Note that the requirement to pay premiums after the first six months only applies to Extensions that began on or after April 1, 2014:

- Members with income at or below 133% FPL who are in an Extension *that began prior to April 1, 2014* will not be subject to premiums during that Extension period.

- Members with income at or below 133% FPL who are in an Extension *that began on or after April 1, 2014* will be subject to premiums starting with the seventh calendar month of the extension.

Example 1: Jane starts a 12-month Extension in June, when her income increases from 90% FPL to 110% FPL. On August 5th, she reports she received a raise, and her income goes up to 155% FPL. If her income stays at 155% for the rest of the Extension, she will owe a premium each month from September through May.

Example 2: Joe starts a 12-month Extension in May, when his income increases from 90% FPL to 110% FPL. On June 3rd, he reports he received a raise, and his income goes up to 155% FPL. In July, he will owe a premium. In August, he reports a reduction in hours, bringing his income down to 120% FPL. He will not owe a premium in August, September or October, but starting with the month of November, his 6-month exemption is over, so he will start paying premiums again.

Example 3: Jim starts a 12-month Extension in August, when his income increases from 90% FPL to 140% FPL. He owes a premium. He reports a reduction in hours effective December, which brings his income down to 120% FPL. He will not owe a premium in December or January, but starting in February, his 6-month exemption is over, so he will start paying premiums again.

RESTRICTIVE RE-ENROLLMENT FOR ADULTS IN EXTENSIONS:

Under the waiver approved by CMS, adults in extensions who are subject to premiums will be subject to the same restrictive re-enrollment policies as children who are subject to premiums (see Operations Memo 13-32), effective April 1, 2014.

Starting April 1, 2014, Restrictive Re-enrollment Periods (RRPs) for adults who fail to pay a premium will now be for 3 months. After the 3 month RRP is served, the arrears will be forgiven. Adults will also have the option to re-enroll within the 3-month period as long as they pay all premiums due and request to re-enroll prior to the end of the RRP. Adults must request to re-enroll and should not be automatically re-opened at the end of the RRP.

> ➢**Note:** these policies apply to all adults in extensions who are subject to RRPs, including those for whom an RRP started prior to April 1, 2014. If the member has served at least three months in an RRP as of April 1, 2014, the RRP may be ended and the member may reenroll at their request. If a 12 month RRP has been set by CARES workers must override the end date of the RRP to the last day of the 3rd month of the RRP, but only if the member has made a request to re-enroll.

Example: Tina did not pay the June premium while in an Extension. Tina will be in a 3-month RRP for July, August & September. Tina contacted the IM agency in August and requested to have her BC+ re-instated. Tina will have to pay the June, July and August premiums in order to re-instate her BC+ in August. If Tina had not contacted the IM agency until after September 30th, Tina would not have been able to re-enroll for July, August or September. In that situation, the June premium would have been forgiven and she could re-enroll, as long as there are still months left in the Extension.

As with current policy, members whose income decreases to an amount that would not require a premium will be removed from the RRP and re-enrolled in BC+.

To align all RRP policies effective April 1, 2014, this same RRP policy will be implemented for children who entered an RRP prior to January 1, 2014. Any such RRPs will be updated in CARES in March to ensure they have an RRP end date no later than 3 months after the RRP started. If eligibility is subsequently re-run for an open case, these children's eligibility will re-open. However, if the case has been closed for more than 30 days, the household would have to reapply in order to regain benefits for the child.

CARES will be updated in late June 2014 to reflect these RRP policies for adults. In the meantime workers will have to adjust the RRP following the process outlined below. Note that reason code language will be adjusted prior to March Adverse Action to reflect this 3-month RRP policy for adults on the notice of decision. CARES will continue to set a 12-month RRP until the update planned for June, but the notice of decision will indicate the RRP is for 3 months.

Beginning April 1, 2014 for adults, late payments of all premiums that are due are allowed up to 3 months after the start of the RRP. If a premium is made within those 3 months, delete the RRP using the "LP-Late payment" code. Eligibility will have to be run to re-determine eligibility for the months the adult was in the RRP. (See Process Help Chapter 23.4 for instructions on processing a late premium). If no premium is paid and no request to restore eligibility is made within the 3 month RRP period and the individual later requests BC+, the RRP should be end dated using the last day of the third month of the RRP as the override end date. The Premium Tracking page must also be updated to show the past due premium as paid.

CARES:

CARES and CWW will be updated to reflect these policies as described in detail above. Note that changes have not yet been made to implement the premium policies and restrictive re-enrollment periods for extensions starting on or after April 1, 2014.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/AA

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

BEPS/DFS OPERATIONS MEMO

No: DHS 14-08

DATE: 01/28/2014

FS ☐	**MA** ☐	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: **MAGI Policy Clarifications for 2014**

CROSS REFERENCE: Operations Memo 13-32, 13-43, 14-01, 14-02
BadgerCare Plus Handbook

EFFECTIVE DATES: February 1, 2014

PURPOSE:

The purpose of this memo is to announce BadgerCare Plus policy clarifications resulting from recent federal guidance on deceased tax co-filers, tax filing thresholds, and calculation of deductibles.

BACKGROUND:

As described in Operations Memos 13-32 and 14-01, provisions in the federal Patient Protection and Affordable Care Act (PPACA or ACA), 2013 Wisconsin Act 20 (the State Biennial Budget), 2013 Wisconsin Act 116, and 2013 Wisconsin Act 117, require changes in the policies used to determine eligibility for the BadgerCare Plus (BC+) program.

The federal Centers for Medicare and Medicaid Services (CMS) has provided additional guidance on implementation of budgeting rules based on Modified Adjusted Gross Income (MAGI). This guidance, along with questions raised during in-person training for Income Maintenance consortia, resulted in minor changes and clarifications to BadgerCare Plus policies, effective with the implementation of MAGI rules on February 1, 2014.

POLICY CHANGES:

"EXPECTED TO BE REQUIRED TO FILE" THRESHOLD:

As described in detail in Operations Memo 13-32, the income of certain children and tax dependents is only counted if that child or tax dependent is expected to be required to file taxes, based on the amount of income they expect to have that year.

As noted in Operations Memo 13-32, Social Security Income is excluded when determining if the child or tax dependent exceeds the $950 threshold for unearned income, even though that income is a countable income type for BC+.

The following income types are also excluded when determining if the child or tax dependent exceeds the annual threshold:

Self-Employment Income

CARES and ACCESS currently include a question about whether children or tax dependents expect to have more than $400 in self-employment for the current tax year. This threshold will not be used by CARES when determining whether a child or tax dependent is expected to be required to file taxes. Only the questions about earned income and unearned income thresholds will be used for this purpose. Until this self-employment question can be removed from CARES, workers should enter a "No" for this question.

Educational Aid

CARES and ACCESS currently include questions about whether children or tax dependents expect to have more than $950 in unearned income or $5,950 in earnings for the current tax year. Educational aid does not count toward either of these thresholds and should not be considered when determining if a child or tax dependent is expected to be required to file.

Reminder: These income types are not counted when determining if the child or tax dependent is over the earned or unearned income threshold. However, if the child or tax dependent has other income sources that put him or her over the threshold, Social Security income, self-employment income, and any grants or scholarships other than those used for tuition, books and mandatory fees, will be included as countable income for that child or tax dependent.

INCLUSION OF DECEASED CO-FILERS IN MAGI ASSISTANCE GROUPS:

Effective February 1, 2014, deceased tax co-filers will be included in the tax filer's MAGI assistance group if the tax filer plans to file jointly with that spouse. The deceased co-filer will be added to assistance groups according to MAGI rules for adding the jointly filing spouse of a tax filer, and will increase the group size by one. The income of a deceased individual should not be counted in any month after the date of death. The worker must end date the Employment/Self-Employment or Unearned Income page for the deceased individual.

Note that someone can only file jointly with their deceased spouse for the tax year in which the spouse passed away.

Like deceased tax dependents, deceased co-filers should be added as household members in CARES. Co-filers will be marked as "DEC" in CARES and only limited information will be required to be collected for them.

CARES will be updated effective February 1, 2014 to reflect this policy.

CALCULATING DEDUCTIBLES:

As described in detail in Operations Memo 13-32, children under age 19 and pregnant women can qualify for BadgerCare Plus in 2014 by meeting a deductible. The deductible amount is calculated over a six-month period using the amount of income that exceeds 150% FPL for children and 300% FPL for pregnant women.

When determining the deductible amount, only the income of the member, the member's spouse, and if the member is under age 19, the member's parents should be considered. If a sibling's or tax dependent's income has been counted as part of the applicant's regular MAGI assistance group, it should be excluded for purposes of calculating the deductible.

CARES has not yet been updated to reflect this change. Workers should adjust deductible calculations manually by entering the correct monthly amount in the 'Amount' column using CARES screen AGMD to reflect these exclusions.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/AA

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TO: **Income Maintenance Supervisors**
Income Maintenance Lead Workers
Income Maintenance Staff
W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Shawn Smith, Bureau Director
Bureau of Enrollment Policy & Systems
Division of Health Care Access and Accountability

DHS OPERATIONS MEMO

No: DHS 14-09

DATE: 2/3/2014

FS ☐	**MA** ☒	**BC+** ☒
SC ☐	**CTS** ☐	**FSET** ☐
BC+ Basic ☐		**BC+ CORE** ☐
CC ☐	**W-2** ☐	**EA** ☐
CF ☐	**JAL** ☐	**JC** ☐
RAP ☐	**WIA** ☐	**Other** ☐* **EP**

SUBJECT: Presumptive Eligibility Policy Changes and Addition of Qualified Hospitals

CROSS REFERENCE: BadgerCare Plus Handbook Chapters 3.6, 4.3.4, 32 and 40.2
Medicaid Eligibility Handbook Chapters 6.9 and 36.2.2.1

EFFECTIVE DATE: February 1, 2014

PURPOSE:

The purpose of this memo is to announce the changes to the BadgerCare Plus and Medicaid policies on presumptive eligibility (PE) resulting from changes in Federal laws and regulations governing Medicaid.

BACKGROUND:

The federal Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, requires changes in the policies used to determine certain BadgerCare Plus and Medicaid populations as presumptively eligible for services. The required changes include adjustments to non-financial eligibility criteria for existing populations eligible for PE determinations, the addition of new populations eligible for PE determinations, and the expansion of the populations

for which qualified hospitals can make PE determinations. In addition, required changes to income disregards will result in an increase in the income limits for PE. Children, pregnant women and individuals applying for Family Planning Only Services will be allowed an income disregard equal to 5% of the FPL in addition to a conversion factor adjustment equal to 1% of the FPL. Parents, caretakers and childless adults already have the income disregard included in the income limit of 100% of the FPL.

In addition to these federal changes, Benchmark Plan coverage of services will be ending March 31, 2014. All services for PE eligible persons applying on or after February 1, 2014, will be under the BC+ Standard Plan. PE services for pregnant women are still limited to outpatient services. Family Planning PE is still limited to Family Planning and related services.

Note: Wisconsin's PE programs are known by multiple terms: express enrollment, temporary enrollment and presumptive eligibility. In this Operations Memo, all such policy will be collectively referred to as presumptive eligibility (PE).

CHANGES TO EXISTING POPULATIONS ELIGIBLE FOR PRESUMPTIVE ELIGIBLITY:

CHILDREN

Effective February 1, 2014, children who are lawfully present in the United States may be eligible for PE.

The non-financial criteria that children must meet to be determined presumptively eligible for the BC+ Standard Plan are as follows:

1. Under age 19 (Minors under age 18 must apply with a parent/guardian),
2. A Wisconsin resident, **and**
3. A U.S. citizen or lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).

Children will continue to be allowed one PE period in a 12-month period.

The following table displays the income limits for PE for children, including the income disregard and the conversion factor:

Age	**Income Limit**
Child younger than age 1	At or below 306% FPL
Child age 1 through 5	At or below 191% FPL
Child age 6 through 18	At or below 156% FPL

PREGNANT WOMEN

Effective February 1, 2014, pregnant women who are lawfully present in the United States may be eligible for PE. In addition, verification of the pregnancy will no longer be required and women will be allowed only one PE period per pregnancy.

The non-financial criteria that pregnant women must meet to be determined presumptively eligible for pregnancy related outpatient care, including pharmacy services, are as follows:

1. Currently pregnant (verification of pregnancy not required),
2. A Wisconsin resident, **and**
3. A U.S. Citizen or is lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).

Pregnant women will only be allowed one PE period per pregnancy. If a pregnant woman already had one PE period for her current pregnancy prior to February 1, 2014, she will not be eligible for another PE period for that same pregnancy.

Effective February 1, 2014, the income limit for PE for pregnant women, including the income disregard and the conversion factor, will be 306% FPL. All pregnant women determined presumptively eligible for prenatal services on or after February 1, 2014, will be eligible under the BC+ Standard Plan for outpatient services.

Note: Pregnant women who are not lawfully present in the United States may be eligible for the BC+ Prenatal Program. See the BadgerCare Plus Handbook Chapter 41 for information about the BC+ Prenatal Program.

FAMILY PLANNING ONLY SERVICES

Effective February 1, 2014, individuals who are lawfully residing in the United States may be eligible for PE for Family Planning Only Services (FPOS). How we determine whether someone is lawfully residing in the United States in order to be eligible for PE for FPOS depends on the age of the individual.

The non-financial criteria that individuals must meet to be determined presumptively eligible for FPOS are as follows:

1. Of childbearing age,
2. Not enrolled in BC+ or receiving other full benefit Medicaid,
3. A Wisconsin resident, **and**
4. One of the following:

   For individuals under age 19:
   - Lawfully present in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).

   For individuals age 19 and older:
   - U.S. Citizen;
   - Lawfully residing in the United States for at least 5 years;
   - Lawfully residing in the United States and a refugee or is seeking asylum;
   - From Cuba or Haiti and is lawfully residing in the United States; **or**
   - Lawfully residing in the United Status under one of the eligible immigration statuses listed in the BadgerCare Plus Eligibility Handbook Chapter 4.3.4.

Individuals will continue to be allowed one PE period for FPOS services in a 12-month period.

Effective February 1, 2014, the income limit for PE for FPOS, including the income disregard and the conversion factor, will be 306% FPL.

NEW POPULATIONS ELIGIBLE FOR PRESUMPTIVE ELIGIBILITY:

PARENTS, CARETAKERS AND CHILDLESS ADULTS

Effective April 1, 2014, childless adults under age 65, parents and caretakers may be presumptively eligible for the BC+ Standard Plan, *if their PE is determined by a qualified hospital* and they:

1. Are a Wisconsin resident,
2. Have assistance group income at or below 100% of the FPL, **and**
3. Are one of the following:
    - A U.S. Citizen;
    - Lawfully residing in the United States for at least 5 years;
    - Lawfully residing in the United States and a refugee or is seeking asylum;
    - Is from Cuba or Haiti and lawfully residing in the United States; **or**
    - Lawfully residing in the United Status under one of the eligible immigration statuses listed in the BadgerCare Plus Eligibility Handbook Chapter 4.3.4.

Parents, caretakers and childless adults will be allowed one PE period in a 12-month period.

Once a parent, caretaker or childless adult is determined presumptively eligible for the BC+ Standard Plan, the individual will remain enrolled until the last day of the calendar month after the month in which the presumptive eligibility is granted.

If an application is made for BC+ at the local IM agency by the end of the month following the month in which the individual was determined presumptively eligible, the enrollment period ends the day on which the agency completes processing the BC+ application, regardless of the result of the eligibility determination.

If a BC+ application is not submitted by the end of the month following the month in which the individual was temporarily enrolled, the PE period ends the last day of the month following the month in which the individual was enrolled.

QUALIFIED HOSPITALS:

Only qualified hospitals will be able to determine presumptive eligibility for parents, caretakers and childless adults.

Hospitals are currently eligible to make PE determinations for children, pregnant women, and for individuals applying for FPOS. Due to provisions in PPACA, qualified hospitals will be allowed to make PE determinations for the additional BadgerCare Plus and Medicaid populations described above, effective April 1, 2014. Any Medicaid-enrolled hospital that agrees to the PE determination process and meets standards set forth by DHS will be considered a qualified hospital. Qualified hospitals will be expected to assist PE applicants with the completion of the full Medicaid and BadgerCare Plus application at the time that they are applying for PE. The completion of the full Medicaid and BadgerCare Plus application does not influence the determination of the applicant's eligibility for PE. Starting in calendar year 2015,

hospitals that fall short of an established submission rate for a completed Medicaid and BadgerCare Plus application may be subject to corrective action and ultimate disqualification for up to two years. The performance expectation for this measure will be established in 2015, based on the ratio of PE applications to full Medicaid and BadgerCare Plus submissions.

Effective April 1, 2014, qualified hospitals will be allowed to make PE determinations for the following populations:

- Pregnant women.
- Children under age 19.
- Individuals applying for the FPOS benefit plan.
- Childless adults under age 65.
- Parents and other caretakers.
- Women under age 65 with breast or cervical cancer.

PE for women under age 65 with breast or cervical cancer is part of Wisconsin Well Woman Medicaid. EM CAPO will continue to process all enrollments for full Wisconsin Well Woman Medicaid.

Qualified hospitals will be allowed to make PE determinations for patients who are inmates of certain public correctional institutions.

Inmates of Non-State Public Correctional Institutions
Qualified hospitals will be allowed to make PE determinations for patients who are inmates of public correctional institutions that are not state correctional facilities (e.g., county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The PE determination process for these patients will be the same as for other patients.

Inmates of State Correctional Institutions
Qualified hospitals will not be allowed to make PE determinations for patients who are inmates of state correctional institutions. A list of state correctional facilities can be found in the Medicaid Eligibility Handbook Chapter 6.9.4. Information on full Medicaid or BadgerCare Plus eligibility for inmates of state correctional institutions can be found in the Medicaid Eligibility Handbook Chapter 6.9 and the BadgerCare Plus Handbook Chapter 3.6.

Qualified hospitals will be able to complete PE determinations for all eligible populations through the ForwardHealth portal until ACCESS for Partners and Providers (APP) is modified to handle PE determinations for the new populations. Qualified hospitals, along with other providers enrolled to make PE determinations, have the option to continue to complete PE determinations through APP for children and pregnant women following the existing process or using the paper forms for pregnant women and individuals requesting FPOS. Enrolled partners will continue to complete PE determinations for children through APP following the existing process.

CHANGES TO MEDICAL STATUS CODES FOR EXTENDING PE:

If a presumptively eligible individual submits a full Medicaid and BadgerCare Plus application and the IM agency is unable to finish processing the application by the end of the individual's PE period, the IM worker must extend the PE period for an additional calendar month. Prior to the last date of the presumptive eligibility period, the worker must complete a paper

Medicaid/BadgerCare Plus Certification form (F-10110, former DES 3070) and send to the fiscal agent or extend the PE eligibility through the manual certification process in the ForwardHealth portal (www.forwardhealth.wi.gov).

There are new medical status codes effective February 1, 2014. When extending a PE certification for a month after January 2014, use the following medical status codes:

Med Stat	Population
9J	Children under age 1 with assistance group income above 200% FPL and at or below 306% FPL
7Q	Children under age 1 with assistance group income above 133% FPL and at or below 200% FPL
EC	Children under age 1 with assistance group income at or below 133% FPL
7S	Children age 1 through 5 with assistance group income above 156% FPL and at or below 191% FPL
BU	Children age 1 through 18 with assistance group income at or below 156% FPL
9E	Pregnant women with assistance group income above 200% FPL and at or below 306% FPL
BV	Pregnant women with assistance group income at or below 200% FPL
PP	Parents and caretakers*
PN	Childless adults*

***Note**: The medical status codes PP and PN are not effective until April 1, 2014.

CARES:

The presumptive eligibility application process remains outside of CARES so there are no changes to CARES.

APP was updated February 3, 2014, to reflect the changes for PE for children and pregnant women.

CONTACTS:

BEPS CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, BC+ Core – BadgerCare Plus Core, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHS/DHCAA/BEPS/RW

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

July 12, 2013
2:30-3:15PM CST/3:30-4:15PM EST
877-267-1577 Meeting ID: 0710

I. CMS/Wisconsin Health Reform Check-in

II. Eligibility Systems Progress
   a. Eligibility Systems Progress
   b. Status
   c. Hub/FFE Releases
   d. Status on critical factors for success

III. SOTA Update/Information Sharing
   a. Release of Healthcare.gov
   b. Targeted Enrollment Strategies and early MAGI options
   c. SPA Process (see attached for Wisconsin questions)
   d. Verification Plan Next Steps
      5/10: Initial Verification Plan Review held
      5/31: Revisions sent to Wisconsin
   e. MAGI Conversion Update:
      6/28: MAGI Conversion rerun data sent to Wisconsin
   f. Application Check-in:
      Wisconsin has not had an application discussion

IV. Wisconsin additions?
   a. Account transfer for non-MAGI based determinations
   b. Technical Assistance Questions (see attached)
   c. FFM Account Creation and Linking to Account Transfers
   d. As we evaluate options for how to assist members transition to the FFM one of the means of assisting them would be providing assistance over the phone. If State Merit Rule Employees assist clients with completing the FFM application over the phone what if any certification will state employees need and how

could they meet the signature requirements over the phone? Will a verbal authorization be sufficient or will telephonic signatures be allowed/required?

Will an applicant signature be required as part of QHP selection?

Has there been any estimate given on how long the online application will take when done with assistance, including the QHP selection?

V. Next Steps

a. Upcoming call: August 9, 2013

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

August 9, 2013
2:30-3:15 PM CT/3:30-4:15 PM ET
877-267-1577 Meeting ID: 3872

I. CMS/Wisconsin Health Reform Check-in – if Brett is in the room/on the call I would suggest hitting the following to open the meeting from a Wisconsin perspective:
   a. Update on submission of Waiver
   b. Mitigation Plan Follow-Up – hopefully we are able to send Autumn's paper in advance of the meeting, otherwise she will provide a verbal walk through of our short-term determination model. Please ask for an update on rollout-training for states using the Leveraged FFM Option.
   c. Verification Plan – looking to schedule a meeting for next Tuesday. Craig ask Jess Kahn if she could participate to help tie the mitigation planning and verification together.

II. Benefits
   a. Existing ABP Discussion (Rebecca, Rachel will not be in attendance. From my correspondence with Renee they wanted to have a conversation on the existing Benchmark Plan. I think it would suffice to provide an update that we will be redacting the applicable SPA pages. Al will also be in the meeting. If they do bring up the Foster Care Medical Home ABP simply tell them that we do not have the necessary staff on the call to address and will need to follow-up.

III. Eligibility Systems Progress
   a. Day 1 Readiness – Autumn, Caitlin, and Deloitte staff should be able to cover anything that was not discussed in the opening.
   b. Hub/FFM Updates – We completed the Wave 4 testing last week. Preparing for the Account Transfer – Receive Testing scheduled to start next week.
   c. Critical success factors/mitigation plans – should have covered under the first agenda item.

IV. SOTA Update/Information Sharing

a. Targeted Enrollment Strategies and early MAGI options – this should pretty much be a dead topic, I do not expect anything to be discussed.
b. Tribal Consultation on SPAs – Al should give a simple update on the rough timing of the consultation.
c. MAGI Conversion Update – I don't believe there is any update, but Autumn can address any questions.
d. Application Discussion – We (Autumn, Caitlin, myself and Deloitte) met with CMS on Tuesday. The SPA specific to the conditional approval of Wisconsin's alternative single streamlined application will be submitted after the other identified SPAs. We understand that Wisconsin is required to submit a timeline that documents when the required changes will be completed.
e. SPA Process – I believe CMS is going to provide an update on the process. Al will be able to address any questions.
f. Continuation of Badger Care Plus Transition Discussion – if Autumn did not already address the proposed short-term Determination model support, it should be discussed at this time.

V. Wisconsin additions?

a. Brett sent CMCS drafts of the one-time and system generated notices. We need to schedule a follow-up meeting with the applicable CMCS staff. Please just ask them to identify a few days/times for next week and work with Amy to schedule. From our side it will need to be Autumn, Adam, and Angie.

VI. Next Steps

a. Upcoming call: To be determined

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

September 4, 2013
1:30-2:00 PM CT/2:30-3:00 PM ET
1-877-267-1577 x992 946 727

I. CMS/Wisconsin Health Reform Check-in

II. Benefits
   a. Benchmark Discussion

III. Eligibility Systems Progress
   a. Status
   b. Hub/FFM Releases
   c. Critical success factors/mitigation plans

IV. SOTA Update/Information Sharing
   a. Targeted Enrollment Strategies and early MAGI options
   b. Tribal Consultation on SPAs
   c. MAGI Conversion Update
   d. Application Discussion
   e. Continuation of Badger Care Plus Transition Discussion

V. Wisconsin additions?
   a. FFM Account Transfer Contingency – given the current status of testing the account transfer process has CMS developed a contingency? Given Wisconsin's mitigation strategy to use the Leveraged FFM Option and have the FFM temporarily conduct full determinations Wisconsin is concerned that the account transfer process will not be functional for October 1.

   b. FDDR Account Transfer Follow-Up – one of the follow-up from Wisconsin's FDDR was to conduct a comprehensive review of the account transfer data elements with Erica Tibbals and Jason McNamara to determine if there were any other issues/concerns with the account transfer sends that Wisconsin will be sending

to the FFM starting on January 1, 2014. We have provided the comprehensive mapping documents to CMS and are waiting for confirmation on a meeting.

c. CMS recently published some new ACA Q & A at: http://www.medicaid.gov/federal-policy-guidance/downloads/faq-08-09-2013.pdf.

   One answer they provided reads as follows:

   Q14: Will states continue to receive the CHIP enhanced FMAP for children currently enrolled in a separate CHIP up to 133 percent of the FPL after the transition to coverage of these children under the Medicaid mandatory group for poverty-level related children?

   A14: Yes. The CHIP enhanced FMAP will continue to be available for children whose income is greater than the Medicaid applicable income level (defined in § 457.301 and based on the 1997 Medicaid income standard for children) after these children transition to Medicaid. This includes children who previously qualified for CHIP in a separate program and uninsured children whose family incomes are up to 133 percent of the Federal poverty level, and therefore will be eligible for Medicaid in 2014. Regular Medicaid matching rates will apply for all other children covered under the mandatory group for children aged 6-18—children with income no more than 100 percent FPL and insured children with income above 100 percent to 133 percent FPL.

   So this topic relates to a new med stat code group, 9U, which are the children 6 – 18 with incomes > 100% and up to 133% FPL. They are currently eligible for the Medicaid-expansion CHIP or MCHIP program, but will be eligible for Title 19 Medicaid starting 2014. I believe this group should be eligible for CHIPRA enhanced funding match. However, this CMS Q&A only mentions children with incomes in this range currently being covered under the separate CHIP program being eligible for the enhanced funding. Can you please ask CMS if our former MCHIP population will also qualify for enhanced funding for this group?

d. What happens to denied applications at the FFM under the determination model? Will the FFM send Notices of Decision denying Medicaid/CHIP or will the FFM refer the cases to us and expect the state to send a negative notice? What about mixed cases where the children are eligible for BC+ (and the FFM sends us a referral for them) but the parents are ineligible. Will the FFM send the negative notice to the parents?

e. Wisconsin is planning to delegate appeals authority to the Marketplace for the determinations completed by the Marketplace. However, individuals who request a fair hearing will be given the option to request that their fair hearing

be conducted by the Medicaid agency instead of the Marketplace. How will the State be notified of these appeal requests? Will the FFM transfer an electronic file (or some type of paper documents) to the State so that we can see what the FFM determination was based on?

VI. Next Steps

a. Upcoming call: September 18

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

October 2, 2013
1:30-2:00 PM CT/2:30-3:00 PM ET
877-267-1577 Meeting ID: 992 946 727

A G E N D A

I. Update on Implementation

II. SOTA Update/Information Sharing
   a. Day 2 Operations
   b. Other

III. Wisconsin additions?
   a. MEC Verifications
      i. Does the FFM perform the MEC check before determining eligibility for Medicaid / CHIP?
      ii. If the FFM finds the applicant is already eligible for Medicaid / CHIP, does an eligibility determination still get made and account transfer still get sent to the state?
      iii. If parents are found eligible for APTC and children eligible for Medicaid / CHIP, will the children still get referred even though the MEC check indicates they are receiving Medicaid / CHIP? Does this depend on the individual level program request?
      iv. What happens in instances when 2 sisters who are living together in the same household apply for help in FFM? Does the application information for both the sisters come in the same account transfer or as separate account transfers?

IV. Next Steps
   a. Upcoming call-October 16th

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October 2, 2013
1:30-2:00 PM CT/2:30-3:00 PM ET
877-267-1577 Meeting ID: 992 946 727

A G E N D A

I. Update on Implementation

II. SOTA Update/Information Sharing
   a. Day 2 Operations
   b. Other

III. Wisconsin additions?
   a. Policy
      i. Earned Income Verification Waiver discussion – Letter sent to HHS on October 3.
      ii. FFM MAGI Determinations for existing BadgerCare Plus members

      We would like to get clarification on the requirement when an existing BadgerCare Plus member applies via the FFM and is transferred to Wisconsin. Specifically, the direction to process the application and enroll them under MAGI rules seems to contradict the regulation that we are not to apply MAGI rules to existing beneficiaries until March 31, 2014 or their next regularly scheduled renewal, whichever is later. If we receive an account transfer from existing member whose next renewal is in 2014, which of these takes priority? And how will or will this change once Wisconsin becomes an assessment state starting on January 1, 2014?

      For example: a family with two parents and one child is at 125% FPL, with their next renewal scheduled for July 2014. We sent a letter to the family last month encouraging them to apply via the Marketplace. Let's say

DRAFT

they apply through the Marketplace in mid-November, and include all three family members on their application. The child is determined to be eligible for Medicaid/CHIP , while the parents are eligible for APTCs and enrolled in a QHP. The FFM will refer the child to us, and we understand CMS' direction to be that we should, as a determination state, make the child eligible effective January 1 under MAGI rules. However, that child is an ongoing beneficiary, so we are not allowed to apply MAGI rules to the child until July 2014. The child should continue to be tested under old BC+ budgeting rules through July.

iii. Alternative Single Streamlined Application – in alignment with Wisconsin's mitigation plan for Day 1 readiness, we would like to confirm how the real-time processing requirements (verification/determination) will be addressed.

b. Operations
    i. Anticipated Processing Timeliness for Applications Submitted to the federal Marketplace – should we hold off on asking people to submit paper applications if they are not able to submit an application online?
    ii. Over the Phone/Paper Applications – are there any instances where a person is not permitted to submit an application using one of these two methods? E.g. What if they started an application at healthcare.gov?
    iii. Find Local Help – appears as though FFM call center is using tool along with other Wisconsin specific customer service information. Instance of people in UP of Michigan being referred to Wisconsin, and people in Wisconsin counties being directed to county offices in another county.
    iv. Medicaid Assistor Line for FFM States – attempts to call are received with a message to submit an application online.
c. Technical
    i. Weekly Flat File Update (if available).
    ii. Account Transfer Update (if available); Testing (10/21), Production (11/1).
    iii. Split family potential issue (application ID# is 109200458) – Dena is aware of details.
    iv. Non-ESI MEC Issues
        1. Potential concern regarding people who may have or are being enrolled and receiving an APTC
        2. Receiving duplicate requests – reported to help desk
    v. Account Transfer Income Frequency and Amount – does a calculation need to be applied to determine the actual income amount (email sent to SOTA distribution on 10/9)

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IV. Next Steps

a. Upcoming call-October 16th

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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

November 6, 2013
1:30-2:00 PM CT/2:30-3:00 PM ET
877-267-1577 Meeting ID: 993 623 197
A G E N D A

I. State Status of Implementation
   a. Outstanding Waiver TMA Premium Issue (Brett/Craig)
   b. November Release Update (Shawn/Vinoth)
   c. December Release Update (Shawn/Vinoth)

II. Desk Officer Check In
   a. Report Log (Craig)

III. SOTA Updates & Information Sharing

IV. Account Transfer Discussion
   a. Testing Update (Andre)
   b. Initial "Throttling" Capability (Andre)
   c. Readiness to begin Processing (Shawn/Vinoth)

V. Wisconsin additions
   a. Single Streamlined Application Follow-Up (Autumn)

VI. Next Call: November 20th

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

December 4, 2013

1:30-2:00 PM CT/2:30-3:00 PM ET

877-267-1577 Meeting ID: 993 623 197

A G E N D A

I. Wisconsin 3-Month Delay Follow-Up
   a. Federal authority (waivers and SPAs)
   b. MAGI
   c. APTC impacts for BadgerCare Plus members that have already enrolled in a QHP and paid their initial premium

II. Determination vs. Assessment – Wisconsin request to switch to an assessment state

III. Account Transfers
   a. New target date for receiving account transfers from FFM
   b. Timing for FFM to receive and process account transfers from Wisconsin

IV. Next SOTA Call: December 18, 2013

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

December 18, 2013

1:30-2:00 PM ET / 2:30-3:00 PM ET

877-267-1577 Meeting ID: 992 946 727

A G E N D A

I. Status of Implementation and Desk Officer Check-in

II. Enhanced Flat File/Account Transfer Discussion

a. Nearly half the file's records do not contain a MAGI/Non-MAGI indicator, should we assume that those records that do not contain either are non-applicants? Or is there some other logic that needs to be applied to identify those applicants that received an FFM determination, and those that are being provided as non-MAGI referrals.

b. It does not appear that the records were processed through address validation software, there is a mixture of upper and lower case used in the actual address fields. Please confirm.

c. Some of the records either do not contain a DOB and/or SSN, or invalid SNN (e.g. 8 digits JKahn: If the SSN is less than 9 digits, it had leading zeros). Should we assume these are for non-applicants?

d. The ELIGIBILITY_TYPE_ADULTGROUP field is not populated on any of the records. We were expecting a large portion of the records to fall within this eligibility type.

e. How long will states continue to receive the enhanced flat files? Will they be terminated once the state starts receiving the account transfers? JKahn: we will work it out with each individual state until they are ready for us to discontinue them.

III. SOTA Updates & Information Sharing

IV. Wisconsin additions

a. Messaging on Remove Functionality as it relates to possible FFM determination issues for BadgerCare Plus. Wisconsin would like to provide partners clarification on the Remove Functionality limitation for FFM determinations for BadgerCare Plus. If people believe that the FFM determination is incorrect they should be instructed to file an appeal with the Marketplace. The State must accept FFM determinations with a application filing date between October 1, 2013 and January 31, 2014 and enroll people in BadgerCare Plus based on the coverage effective dates for the program (e.g. childless adults for April 1, 2014 parents/families as early as October 1, 2013).

i. Question for CMS: If states believe that the information provided in the account transfer records are inconsistent with a determination for BadgerCare Plus can states re-run eligibility for those applicants prior to enrolling those people into the program?

V. Next SOTA Call: January 15, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

January 15, 2014

1:30-2:00 PM ET / 2:30-3:00 PM ET

877-267-1577 Meeting ID: 992 946 727

A G E N D A

I. Status of Implementation and Desk Officer Check-in

II. Account Transfer Discussion

III. SOTA Updates & Information Sharing

IV. Wisconsin additions

a. Wisconsin updates to the FFM – confirm status of notice changes and switch to assessment state.

b. FFM call center scripts – confirm scripts have been updated to reflect Wisconsin's 3-month delay.

c. Limitations/Restrictions on Premium Assistance – are there any limitations or restrictions for organizations that may wish to provide premium assistance for people purchasing coverage through the federal Marketplace?

d. QA File – in the CMCS bulletin from January 3 regarding the enhanced flat file enrollment options the following is noted:

"We have also started sending states a weekly quality assurance (QA) list to identify those cases where because information is missing, or for other reasons, our quality assurance review suggests that enrollment based on the information in the flat file would not be appropriate."

Are these applications included in the Account Transfer File?

V. Next Steps

a. Upcoming call: February 5, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

February 5, 2014
1:30-2:00PM CST/2:30-3:00 PM EST
877-267-1577 Meeting ID: 993 623 197

A G E N D A

I. State Update on Implementation & Desk Officer Check In

II. SOTA Updates/Information sharing

III. Wisconsin additions
   a. Status on processing FFM account transfers/sending ATs to FFM
   b. FFM notices for Wisconsin not reflecting phone number data collection tool update from December 2013
   c. Follow-up on possible mitigation strategies for people that received an erroneous FFM determination
   d. Follow-up on discussion regarding completing a "data match" and doing outreach for BadgerCare Plus members that will be losing eligibility effective April 1, 2014
   e. Ongoing process to report case specific FFM issues reported by county Consortia and Regional Enrollment Networks (RENs)

IV. Next Steps
   a. Upcoming call: February 19, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

February 19, 2014
1:30-2:00 PM CST/2:30-3:00 PM EST
877-267-1577 Meeting ID: 992 946 727

A G E N D A

I. State Update on Implementation & Desk Officer Check In

II. ABD Conversions

III. SOTA Updates/Information sharing

IV. Wisconsin additions

a. Just wanted to make sure that everyone was on the same page in regards to our plans to identify these cases in March. We also wanted to confirm that if these individuals lose BadgerCare Plus eligibility after open enrollment closes that they would be eligible for a SEP in the federal Marketplace. These would obviously come across through the account transfer process, but it would be very helpful for us to understand what it is that people will need to do once the FFM has received the account from Wisconsin. As I indicated in my original email we could consider doing direct outreach to these individuals once they are identified, but we really need to make sure that our messaging is clear. So at this point I think we have two options in regards to messaging:

1. Have them re-apply at the Marketplace and check the box indicating that they were denied Medicaid/CHIP coverage so they bypass the assessment for Medicaid/CHIP.

2. Assuming that the FFM is processing account transfers by April 1, we could provide them specific directions on how to identify their applications at the FFM and/or what if anything they need to do to complete the process at the FFM.

b. Status on processing FFM account transfers/sending ATs to FFM

c. FFM notices for Wisconsin not reflecting phone number data collection tool update from December 2013
d. Follow-up on discussion regarding completing a “data match” and doing outreach for BadgerCare Plus members that will be losing eligibility effective April 1, 2014
e. FFM Appeals – will CMS be releasing information to FFM determination states on the process when an individual requests a state to hear their appeal and what documentation states can expect to receive from the FFM on the determination?

V. Next Steps
a. Upcoming call: March 5, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and CHIP Services

Wisconsin/CMS State Operations and Technical Assistance (SOTA) Call

March 5, 2014
1:30-2:00 PM CST/2:30-2:00 PM EST
877-267-1577 Meeting ID: 993 623 197

A G E N D A

I. State Update on Implementation & Desk Officer Check In

II. Eligibility Determinations and Enrollments – Processing Timeframes

III. SOTA Updates/Information sharing

IV. Wisconsin additions
   a. FFM Account Transfer Issues (application dates 10/1/13 – 12/31/13)
      ii. Household income of zero
      iii. No MAGI/CHIP/Non-MAGI/LTC/Emergency Medicaid/Refugee Medicaid indicators
      iv. Out of state applications
      v. AT referrals for people identifying disability or special needs
   b. Status on processing FFM account transfers/sending ATs to FFM
   c. FFM notices for Wisconsin not reflecting phone number data collection tool update from December 2013
   d. Follow-up on discussion regarding completing a "data match" and doing outreach for BadgerCare Plus members that will be losing eligibility effective April 1, 2014
   e. FFM Appeals – what date is used to start the 90-day clock for filing an appeal?
   f. PE Follow-Up
   g. Are there any plans for the IRS to update the amounts of income a tax dependent has to have before they are required to file a tax return? Their numbers are from 2012 and they have gone up slightly for 2014.

V. Next Steps
   a. Upcoming call: March 19, 2014

Wisconsin Transition Plan

Coverage in 2014:

Eligibility Category - Current Authority	Eligibility Category - 1/1/2014 Authroity	Benefits	Delivery System
Optional State Plan - Parent and Caretaker Relatives 133% to 200%	FFM	EHB	QHP
Mandatory State Plan - Parent and Caretaker Relatives in TMA >133%	New 1115 Waiver Demonstration - Parent and Caretaker Relatives in TMA >100%	Standard Medicaid	Managed Care/FFS
Expansion Childless Adults 101%-200%	FFM - 101% to 200%	EHB	QHP
Expansion Childless Adults 0% - 100%	New 1115 Waiver Demonstration - 0% to 100%	Standard Medicaid	Managed Care/FFS

Process for transition:

The transition process for current BadgerCare Plus non-pregnant adult members anticipated to be over 100% of the federal poverty level (FPL) will begin in September 2013.

On September 20, 2013, the Wisconsin Department of Health Services (DHS) will run a one-time process to identify members (parent/caretaker relatives and childless adults) with incomes that exceed 100% FPL using current income rules. The intent of the one-time informational notice is to provide current members additional time to report any changes prior to re-determining eligibility on November 23, 2013, as well as apply for coverage in the Marketplace either directly through HealthCare.gov or with the assistance from a qualified/certified individual including, as needed, a state/county income maintenance worker using the Leveraged Federally Facilitated Marketplace Option.

From October 1, 2013 through December 31, 2013 Wisconsin will delegate temporary eligibility determination authority to the Marketplace. Starting on October 1, 2013 individuals transferred from the Marketplace will be mailed a confirmation letter from Wisconsin within 7 business days to notify them that they will be enrolled in BadgerCare Plus with a January 1, 2014 effective date.

Also, starting in October 2013, DHS will launch a direct call outreach campaign to those members that received the one-time informational notices mentioned previously. The objective of the call outreach campaign is to ensure that members received the notice and are aware of potential changes in their eligibility. Members will be advised to report any changes that may impact their eligibility to their local income maintenance worker and how to apply for coverage in the Marketplace including how to access additional assistance as needed to do so.

Starting on November 18, 2013 Wisconsin will begin processing Marketplace account transfers. To ensure a streamlined transition for current BadgerCare Plus members and in accordance with Wisconsin's mitigation plan, Wisconsin will accept all Medicaid/CHIP eligible Marketplace transfers as determinations from October 1, 2013 to December 31, 2013. Also starting on November 18, 2013, Wisconsin will begin making MAGI-based eligibility determinations. For those individuals applying to Wisconsin that are determined ineligible for BadgerCare Plus, Wisconsin will generate an account transfer and begin sending to the FFM starting on January 1, 2014.

On November 23, 2013 Wisconsin will conduct a full redetermination of eligibility for all BadgerCare Plus members. This full redetermination of eligibility will be based on 2013 income rules using 2014 income eligibility levels, and follow all standard protocol for eligibility determinations. We will also test the member for other eligibility categories. To be clear this redetermination will be made using existing case information, including any updates reported by the member or obtained through existing data exchanges. As a reminder, our intent with the one-time informational notice in September and the enrollment outreach calls starting in October is to provide members additional time to report any changes prior to the redetermination on November 23, and as much time as possible to applying in time to not have a gap in coverage. The redetermination process in November will not include asking the member to complete a renewal form or consider any additional information related to MAGI. And again, the mitigation strategy for not collecting the MAGI information prior to running the redetermination is to use the Leveraged FFM Option and have transitioning members receive a MAGI-based determination from the Marketplace, along with accepting full determinations from the FFM from October 1, 2013 through December 31, 2013.

Furthermore, those individuals that are determined eligible by the FFM during the temporary determination period will be excluded from the redeterminations conducted by Wisconsin on November 23. After November 23, members will still have the opportunity to report changes that may retain their BadgerCare Plus eligibility into 2014.

Notification:

Official notices for transitioning members include the mailing address and phone number for the members' local income maintenance agency, as well as the link to healthcare.gov and the toll-free Marketplace telephone number.

CMS has reviewed and provided comments on the one-time informational letters referred to in the transition plan above.

Wisconsin is also sharing member communications with other community partners and stakeholders including contracted managed care agencies, advocates, veterans affairs, provider associations, and community health centers.

Community outreach (including education and training):

Starting in July 2013, DHS, in partnership with the Wisconsin Primary Healthcare Association, Wisconsin's Covering Kids and Families, the University of Wisconsin's Population Health Institute, and the Milwaukee Health Care Partnership launched a statewide outreach effort to create 11 regional enrollment networks that will be made up of a diverse group of community partners.

From August 20, 2013 to September 4, 2013 11 regional enrollment network kickoff meetings were held across the state, with more than 1,500 participants in attendance. Partners attending the meetings included:

- Wisconsin Tribes
- Community Health Centers
- AmeriCorps Members
- Public Health Departments
- County Correctional Agencies
- Sheriff Departments
- Libraries
- Churches
- Qualified Health Plans
- Insurance Agents/Brokers
- Volunteers
- Community Health Advocates
- Media
- Economic Support Agencies
- Disability Benefit Specialists
- Aging and Disability Resource Centers
- Foodbanks

The objective for the regional enrollment networks is to create a broad and diverse group of partners that will act as mobilizers and in-person assistors for both those transitioning from BadgerCare Plus to private insurance as well as those seeking either BadgerCare Plus or private insurance for the first time. Each regional enrollment network will have a steering committee that will help facilitate communication and monitor capacity within the network to provide the assistance necessary to all applicants.

DHS and its partners also formed a strategic planning committee that provides support to the regional enrollment networks. A new website will also be used as a clearinghouse to support communication among the networks and to provide a one-stop shop for information and training related to BadgerCare Plus and the Marketplace.

DHS also partnered with the Office of the Commissioner of Insurance (OCI) to conduct 11 Town Hall meetings during the week of September 2, along with editorial board meetings to discuss the specific BadgerCare Plus changes and promote the federal Marketplace.

In addition to the partnership activities noted above, DHS is also conducting BadgerCare Plus specific outreach, education, and training to its existing partners including tribes, managed care organizations, hospitals, member advocates, and the county income maintenance agencies.

DHS has scheduled (and is recording for webcast) the following partner webinars:

- **August 12, 2013, 10am - noon:** Overview of Eligibility and Policy Changes
- **September 17, 2013, 10am - noon:** General MAGI Training and Overview of Upcoming Notices that will be sent to members regarding those that will be transitioning to the Marketplace.
- **October 14, 2013, 10am - noon:** Information for those current members that will be transitioning off BadgerCare Plus. Timeline of transition, review of letters that will be received, and information on resources to assist with the transition will be provided including basic information of the FFM application.
- **November 11, 2013, 10am - noon:** Policy Overview- More in depth discussion of MAGI and a demo of the updated ACCESS application/WI Streamlined Application.

For those income maintenance agencies that will work directly with transitioning members, DHS is providing training as follows:

- Phase I: High Level Overview (May – June 2013)
- Phase II: Details of BC+ 2014 Policy Changes (Aug – Sept 2013)
- Phase III: CARES changes (Oct – Nov 2013)

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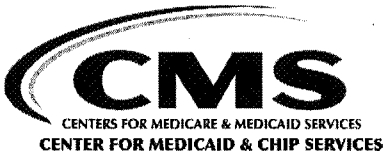

December 20, 2013

Mr. Brett Davis
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street, Room 350
PO Box 309
Madison, WI 53701-0309

Dear Brett:

I am writing to confirm our agreement regarding Wisconsin's plans for effectuating the transition of the BadgerCare and BadgerCare Plus Core Plan section 1115 demonstrations in light of the changes to the Medicaid program resulting from the Affordable Care Act. This agreement reflects a series of discussions over the past several months, including the exchange of written documents outlining the state's proposed mitigation strategies for transitioning the source of health coverage for 77,500 Wisconsin residents from Medicaid to the new health insurance Marketplace.

Eligibility and Waiver Authority

The state has proposed to delay the expiration date for two Wisconsin section 1115 demonstrations – BadgerCare and BadgerCare Plus – from December 31, 2013 until March 31, 2014 for parents and caretaker relatives and adults without dependent children.

The temporary extension of these demonstrations allows Wisconsin to continue to cover childless adults currently enrolled in the program up to 200% FPL through March 31, 2014; and to continue to cover parents and caretaker adults consistent with authorities currently provided under the waivers.

The state has indicated that it will not scale back eligibility levels as proposed, from 200 percent of the federal poverty level (FPL) to 100 percent of the FPL for adults without children as well as parents and caretaker relatives on December 31st, instead putting into place a temporary extension of coverage through the demonstrations and current state plan authority. Based on our agreement, the coverage levels and effective dates for the following populations will be as follows:

- **Parents and Caretaker Relatives.** Existing beneficiaries will remain eligible up to 200% of the FPL through March 31, 2014, at which point the Medicaid eligibility level will reduce to

100% of the FPL. New applicants will be enrolled based on 2013 (non-MAGI) rules until February 1st, at which point MAGI-based rules will be applied, along with the reduction in eligibility. Individuals who apply on or after February 1st will receive a MAGI-based eligibility determination and either be enrolled in Medicaid or be sent to the Marketplace via an account transfer for consideration for an advance premium tax credit (APTC). CMS will work with Wisconsin to provide the necessary 1115 waiver extensions and Medicaid state plan authorities.

The accounts for the parents/caretaker relatives who have applied at the FFM since October 1st, but have incomes up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard), will be transferred to the state in the very near future. Wisconsin will promptly contact these individuals upon receipt of the accounts to inform them that their coverage will begin on January 1, 2014.

Currently enrolled parents/caretakers will receive a form by mail from the state within the next few weeks asking them to provide information needed to complete a MAGI-based redetermination of eligibility before having their accounts either retained in Medicaid or transferred to the FFM. Beginning on February 17th the state will conduct redeterminations under the new eligibility levels and initiate account transfers to the Marketplace for consideration for APTC eligibility for individuals determined to have income above 100% of the FPL.

- **Adults without dependent children.** Pursuant to Wisconsin's direction to the FFM, individuals who are newly applying for coverage through the Marketplace are being screened and determined eligible for Medicaid if their income is up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard). If they have income above 100% of the FPL, these individuals have the opportunity to enroll in coverage in the Marketplace and receive an APTC to subsidize their premium costs. The accounts for the individuals who have applied at the FFM since October 1, but have incomes below 100% of the FPL, will be transferred to the state in the very near future. Wisconsin will promptly contact these individuals upon receipt of the accounts to inform them that their coverage will begin on April 1, 2014.

  Adults without dependent children who apply for coverage in Wisconsin will receive a MAGI-based eligibility determination once the MAGI-based rules are in place in February 2014. New applicants whose income is up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard) will be informed that their eligibility for BadgerCare coverage will take effect on April 1, 2014. Individuals whose income is over 100% of the FPL will have their accounts promptly transferred to the Marketplace for consideration for APTC eligibility.

  Adults without dependent children with incomes up to 200% of the FPL who are currently enrolled in the BadgerCare Plus Core Plan will continue to be eligible to receive these benefits through March 31, 2014.

Wisconsin residents with incomes above 100% of the FPL who have applied at the FFM during the fall of 2013 for coverage effective January 1st, 2014 will remain in Marketplace coverage.

Transitioning Populations and Implementation of MAGI-based Eligibility Rules

The state has adjusted its mitigation planning in order to implement MAGI-based eligibility rules on February 3, 2014 for new parent/family applicants; with full implementation of MAGI rules on February 17th to conduct redeterminations and account transfers for transitioning populations and for processing of all new applicants.

In order to minimize the impact of the delay in implementing MAGI rules, Wisconsin will send a letter and questionnaire to existing enrollees asking them to fill in information about their tax filing status and other information needed to complete a MAGI-based redetermination before the state transfers the accounts to the FFM. This document will be referred to as the Verification Check List (VCL). The individuals who return the information and whose incomes are above the reduced eligibility levels that Wisconsin is adopting will have their MAGI-based eligibility information transferred to the FFM beginning on February 17th.

CMS will continue to work with the state to establish acceptable mechanisms for tracking the individuals who do and do not successfully make the transition to coverage through the Marketplace, including the strategies discussed below.

Communication to Applicants

Because the FFM, at Wisconsin's instruction, is currently determining Medicaid eligibility for those Wisconsin applicants with incomes below up to 95% of the FPL (effectively 100% of the FPL including the 5% disregard), messaging is needed to explain the delay in coverage until April 1, 2014 for adults without dependent children. It is our understanding (as noted above) that the state will enroll eligible parents/caretaker relatives promptly upon receipt of the account transfers from the FFM to effectuate January 1, 2014 coverage. The state can also conduct post-eligibility checks and, with proper notice and appeal rights, disenroll beneficiaries based on those results and transfer their cases back to the FFM for action. It is important to note that individuals applying at the FFM have already received a notice indicating that they are Medicaid eligible and that their coverage will take effect on January 1st.

The state will use the information provided in the enhanced weekly account transfer "flat files" and the formal Account Transfer files to develop telephone and written messages to families informing them of their eligibility determination and coverage start date. As part of the calls, beneficiaries will be asked whether they have completed an application at the FFM, enrolled in a QHP, and paid the initial premium, and these outcomes will be recorded and reported. These messages need to go out as soon as possible.

FFM Programming for Wisconsin

As noted above, as part of its mitigation strategy, Wisconsin agreed to delegate the authority for the FFM to make Medicaid eligibility determinations for individuals who apply through the Marketplace.

The FFM has been making those determinations for applicants with incomes below 100% of the FPL and will be transferring those accounts to the state shortly. As described above, Wisconsin will act on those determinations and enroll individuals for the appropriate coverage effective date depending on the eligibility group.

Wisconsin has indicated interest in changing the delegation of authority to permit the FFM to make assessments, rather than determinations, of eligibility beginning on January 1, 2014. CMS will approve that request provided the other elements of this agreement, in particular the execution of MAGI rules in February 2014, are in place. In addition, the enhanced maintenance and operations funding will become available in February, when all of the critical success factors have been met.

I hope this information is helpful in confirming our mutual understanding of how Wisconsin will proceed with implementation of the Medicaid eligibility changes included in the Affordable Care Act. Please do not hesitate to contact me with any questions or concerns and we look forward to your written confirmation of this agreement.

Sincerely,

Eliot Fishman
Director
Children and Adults Health Programs Group

Cc: Cindy Mann, Director, CMCS
Jennifer Ryan, Director, Intergovernmental and External Affairs Group, CMCS
Verlon Johnson, ARA for Medicaid, Chicago Regional Office

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

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December 30, 2013

Eliot Fishman
Director
Children and Adults Health Programs Group
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Mr. Fishman:

Thank you for your December 20, 2013, letter regarding Wisconsin's plans for effectuating the transition of the BadgerCare and BadgerCare Plus Core Plan section 1115 demonstrations in light of changes to the Medicaid program resulting from the Affordable Care Act. I am writing to confirm our agreement as outlined in your letter.

Governor Walker's entitlement reforms mean that for the first time in state history all Wisconsin citizens will have access to affordable health care coverage. As noted in a recent report by the Kaiser Family Foundation, Wisconsin will have no gaps in coverage for our citizens. In addition, Governor Walker is investing in an enhanced set of benefits for people who need it.

Since these changes were signed into law in July we have implemented a very proactive and aggressive outreach plan, not only for current BadgerCare Plus members but also to those adults living in poverty who do not currently have access to coverage.

Beginning in July the Department of Health Services (DHS) partnered with the Wisconsin Primary Health Care Association (WPHCA), Covering Kids and Families (CKF), the University of Wisconsin's Population Health Institute, and the Milwaukee Health Care Partnership to create 11 regional enrollment networks (RENs) throughout the state. In September and October DHS co-sponsored kickoff meetings for over 1,500 individuals throughout the state and held trainings for almost 600 individuals. We currently have almost 800 individuals who have taken the state training, and nearly 400 individuals who have received state certification. We will continue to work with our partners throughout the state during the 3-month delay to continue to assist BadgerCare Plus members with their transition and provide in-person assistance to those applying and enrolling for health insurance.

From September through November DHS issued more than 250,000 letters and made 156,000 calls to current BadgerCare Plus families and individuals on the BadgerCare Plus Core Plan wait list to make them aware of the changes that were originally scheduled to take effect in January. DHS also provided the county Income Maintenance Consortia, BadgerCare Plus managed care

organizations and Medicaid providers lists of the current BadgerCare Plus members to coordinate outreach and provide consistent messaging regarding health coverage options in the federal Marketplace.

Following Governor Walker's announcement and request for a 3-month delay on November 14 DHS has developed a revised outreach plan. Last week DHS mailed over 200,000 letters to BadgerCare Plus members who will be able to maintain their coverage for the next three months as well as individuals on the Core Plan wait list. Additionally, last week DHS sent over 32,000 letters to those people who have already applied at the federal Marketplace and been determined eligible for BadgerCare Plus.

In addition to sending letters, we will proactively make phone calls to households that will likely transition to private insurance and to childless adults on the former Core Plan wait list starting in the New Year. We are putting special emphasis on assisting current members with higher risk conditions to make sure they are aware of all their coverage options.

In order to implement Wisconsin's agreement with the Centers for Medicare and Medicaid Services, it is our understanding that we will need to adjust the effective dates of several already approved MAGI state plan amendments (SPAs). Wisconsin will submit these SPAs early next quarter to effectuate these additional changes.

Thank you for working collaboratively to ensure our goal of ensuring every Wisconsin citizen has access to affordable health care becomes a reality. Please contact me if you have any questions at 608-266-8922 or Brett.Davis@wisconsin.gov.

Sincerely,

Brett Davis
Medicaid Director
State of Wisconsin

Wisconsin and CMS Communication re: Transition Planning with WI Tribes

Email from CMS to WI: January 14, 2014

I know the attached transition plan you previously submitted to us is now out of date, but I was wondering whether the state is following through with its plans to do special outreach on BadgerCare Reform to tribal groups. I'm asking for informational purposes only, a colleague in our division has been tasked with internally tracking data related to Indian-specific activities in states.

Email from WI to CMS: January 14, 2014

Below is our team's response:

Yes, we continue to conduct consultation with the Wisconsin Tribes through our regularly scheduled income maintenance workgroup meetings, as well as targeted training webinars and in person meetings. Additionally, we continue to consult with the tribal health directors on any modifications to the state plan and waivers through the scheduled quarterly meetings.

We also meet quarterly with the Tribal Health Directors to address specific concerns related to Medicaid and healthcare provision more generally – ACA implementation is a regular focus of these meetings.

Let me know if you need additional information.

Email from CMS to WI: January 14, 2014

Thanks for the info and speedy response! In addition to meeting to address tribal health-specific concerns, how does the state plan to implement the demonstration in Indian territories in terms of notice and enrollment, etc., or will implementation pretty much be the same across the board? Any additional detail would be appreciated. Thanks!

Email from CMS to WI: January 23, 2014

Do you have anything else in response to this request for information below? We would like to have a complete picture of how WI plans to implement the waiver in Indian country. For example, are there any special options for tribal populations or reimbursement agreements that were not part of our formal discussions? Is it possible to get back to us by COB today?

In addition to meeting to address tribal health-specific concerns, how does the state plan to implement the demonstration in Indian territories in terms of notice and enrollment, etc., or will implementation pretty much be the same across the board?

Email from WI to CMS: January 23, 2014

sorry for my delayed response:

There aren’t any special reimbursement agreements, etc that we are working through with the tribes that would be specific to anything included in the waiver or other eligibility changes – the work we do with the tribes is based on the needs described by the tribes and we have been meeting with them regularly to discuss issues/concerns and potential partnerships, but that is a normal and standard process for us.

Attached is a document outlining the work that we have done with the tribes over the past year prepping for ACA related changes. Please let me know if you have any questions related to this document.

ACA PREPARATION TIMELINE
TRIBAL IM AGENCIES
JANUARY 2014

March 2013	Brett Davis and Craig Steele attend joint meeting of tribal health directors and tribal IM directors to present overview on WI entitlement reforms and PPACA overview. OCI representatives also present overview.
April 2013	Tribal IM directors meet. Debbie Waite presents timeline for implementation of ACA – also shares planning for tribal IM worker and supervisor trainings on ACA policy and systems changes. Encourages tribal IM directors to attend ACA Phase I training at Area Administration Regional meetings.
July 2013	Linda Auchue attends the July Tribal IM Directors meeting to present a detailed implementation overview and answer related questions (a version of Phase I training customized to tribes) Each tribal IM director is given their tribe's ACA case projection print-out to use for workload planning purposes
August 2013	Enhanced Tribal IM allocation amounts for ACA implementation are shared with tribal leaders
Aug-Sept 2013	Phase II trainings for IM workers and supervisors are held at numerous locations throughout the state. Trainings held on September 17 at Lac du Flambeau and August 21 at Shawano were targeted to the tribal IM agencies. The Phase II training included detailed information on the BC+ policy changes plus exercises on determining household composition and income calculation scenarios.
Sept 2013	Tribal IM directors meet. Debbie Waite provides progress update on ACA implementation and takes feedback on Phase II training. Directors share information from their internal discussion on how they plan to use ACA enhanced funding to meet increased workload expectations

Oct 2013	Tribal IM directors are sent password protected CD with information on their agency's BC+ transitioning members to use for outreach purposes.
Oct-Nov 2013	Phase III trainings for IM workers statewide are conducted via Adobe Connect. IM workers had the option of signing up for the Adobe Connect trainings or viewing the pre-recorded training. Records indicate that 11 tribal IM workers completed the live training, although registration was not required to view the recorded training. The Phase III training focused on the updates to the CWW pages and walked IM workers through what they will see in CWW when processing a case using MAGI rules.
Nov 2013	Tribal IM directors meet. Debbie Waite shares information on changes to implementation schedule as a result of Governor Walker's plan to delay to April 1 for BC+ transitioning members. IM directors provide feedback on how they used CD information – several used data to do proactive outreach.
Jan 2014	Tribal IM directors are sent password protected updated information on their agency's BC+ transitioning members to use for outreach purposes.

NOTE: Tribal IM agencies also received numerous forwarded messages from CMS and communications updates from DHS throughout the year as part of broader communication efforts to consortia and partners.

BadgerCare Plus 2014 Policy Changes: An Overview

Sarah Fraley, Connor Sperry and Adam VanSpankeren

Partner Training Webcast

August 12, 2013

Goals for Today's Discussion

- Provide framework and background
- Describe at a high-level the BadgerCare Plus (BC+) policy changes
  - New Income Limits
  - Basic Modified Adjusted Gross Income (MAGI) Introduction
  - Other Policy Changes
- **Please Note:** There will be no changes for Elderly, Blind or Disabled (EBD) Medicaid members

Background

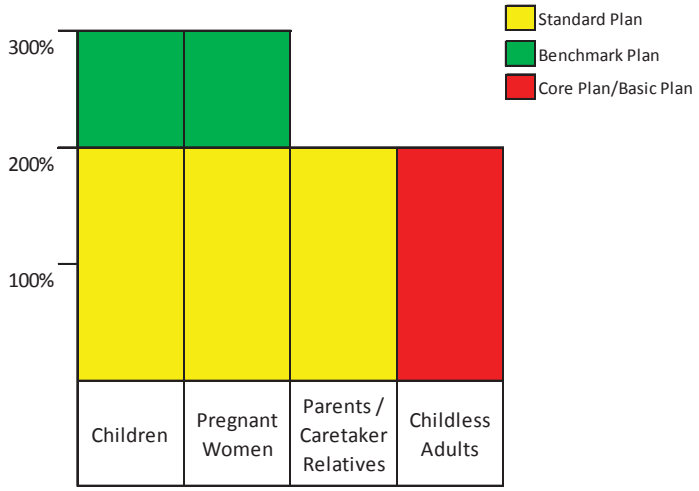
- Act 20, the 2013-15 state budget includes:
  - Changes in income limits for some BadgerCare Plus (BC+) groups
  - BadgerCare Plus Standard Plan coverage for all eligible parents and caretakers, children, and childless adults
- The Patient Protection and Affordable Care Act (PPACA) implements:
  - Marketplace/Federally Facilitated Marketplace (FFM)
  - Advance Premium Tax Credits
  - New “MAGI” rules to align eligibility between Medicaid and the Marketplace

2013 Federal Poverty Levels

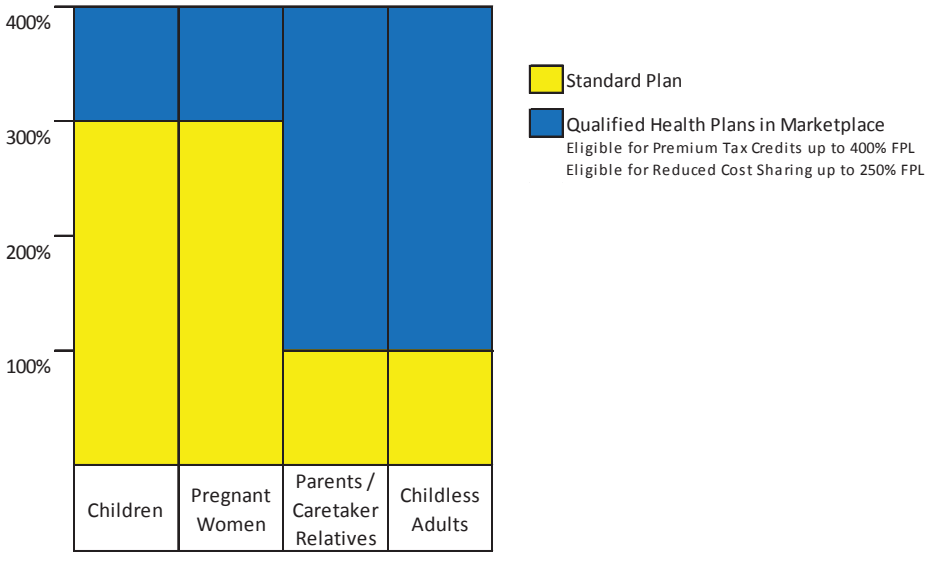
Monthly Income Levels by Family Size

Family size	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1	$957.50	$1,149.00	$1,273.48	$1,292.63	$1,436.25	$1,915.00	$2,393.75	$2,872.50
2	$1,292.50	$1,551.00	$1,719.03	$1,744.88	$1,938.75	$2,585.00	$3,231.25	$3,877.50
3	$1,627.50	$1,953.00	$2,164.58	$2,197.13	$2,441.25	$3,255.00	$4,068.75	$4,882.50
4	$1,962.50	$2,355.00	$2,610.13	$2,649.38	$2,943.75	$3,925.00	$4,906.25	$5,887.50

Current BadgerCare Plus Enrollment and Benefit Plan



Future BadgerCare Plus & Marketplace Enrollment and Benefit Plan



Key Policy Changes

- Income limit changes:
  - Income limit changes for parents/caretakers, childless adults and children
  - No income limit changes for pregnant women, Family Planning Only or EBD Medicaid
- MAGI budgeting rules implemented

BC+ Policy Changes: Parents and Caretakers

- Eligible at or below 100%FPL
  - Access to full Standard Plan Benefits
  - No premiums
  - Nominal cost sharing for certain services will apply ranging from $.50 to $3.00
  - No insurance access and coverage test
- Over 100% FPL→ will have access through the Marketplace

BC+ Policy Changes: Childless Adults

- Eligible at or below 100% FPL
  - Access to full Standard Plan Benefits
  - No monthly premiums or annual enrollment fee
  - No mandatory HNA (Health Needs Assessment) for eligibility
  - No Waitlist, coverage on or after 1/1/14
  - No Processing fee
  - No insurance access and coverage test
  - Nominal cost sharing for certain services will apply ranging from $.50 to $3.00
- Over 100% FPL→Access through Marketplace

BC+ Policy Changes: Children

- Continue to be eligible at or below 300% FPL
  - Premiums over 200% FPL
- Over 300% FPL→Marketplace

What is “MAGI”?

- MAGI = Modified Adjusted Gross Income
- Refers to new rules on household composition and income calculation
- Members and applicants will be asked some different questions about their tax status, tax dependents, and tax deductions
- Introduced by PPACA to align BC+ eligibility rules with tax rule-based policy in the Marketplace

Who is Subject to MAGI Rules?

- BadgerCare Plus Members :
  - Children
  - Parents / caretakers
  - Pregnant women
  - Childless adults

Who is Not Subject to MAGI Rules?

- MAGI rules do ***not*** apply to:
  - Elderly, blind and disabled groups
    - EBD MA
    - LTC
    - SeniorCare
    - QMB, SLMB, SLMB+
  - Categorically eligible populations
    - Former Foster Care Youth

MAGI Rules

- Household Composition
- Income
- Deductions
- **Please Note:** DHS will be providing more detailed information about MAGI rules at an upcoming training.

Other Policy Changes

- All BC+ members will be enrolled in the BC+ Standard Plan
- Changes in extensions policies
- Restrictive Re-enrollment Policy (RRP)
- 12-month certification periods
- Former Foster Care Youth age limit to 26

Implementation

- ACCESS and CARES Worker Web changes
  - Updated mid-November 2013
  - Check My Benefits, Am I Eligible and ACCESS for Partners and Providers will not be updated until late December 2013
- Income Limits
  - Mass change late November 2013
  - Effective January 1, 2014
- MAGI budgeting rules
  - New Applicants→ MAGI rules as of January 1, 2014
  - Existing Members→ MAGI rules beginning April 1, 2014 or at next renewal, whichever is later

Training and Outreach

- DHS IM Training Unit is offering training on the policy and system changes for IM Consortia
  - 3 Phases
    - Phase I: High Level Overview (May – June 2013)
    - Phase II: Details of BC+ 2014 Policy Changes (Aug – Sept 2013)
    - Phase III: CARES changes (Oct – Nov 2013)
- Partners and providers will receive outreach and training similar to Phase I and Phase II

Additional Information

- http://www.dhs.wisconsin.gov/health-care

DHS Initial Outreach

- DHS is focused on outreach to current members that may transition to the Marketplace and uninsured individuals that will be eligible for BadgerCare Plus
  - DHS will notify current members that may be impacted by coverage changes starting late September 2013
    - 87,000 parents and caretaker relatives.
    - 5,000 childless adults.
  - DHS will notify individuals on Core Plan waitlist and Basic Plan members starting late September 2013

Things to Keep in Mind

- Things are subject to change
  - Aggressive implementation timeline
  - Federal guidance not final
- We will do our best to keep partners and stakeholders informed through IM Consortia and Regional Enrollment Network

Questions?

- Questions during the live webcast can be submitted via the questions feature
- Questions after the live webcast can be emailed to dhshealthcare@dhs.wisconsin.gov

BadgerCare Plus 2014 Modified Adjusted Gross Income (MAGI) Basics & Upcoming Letters

September 17, 2013

Goals for Today's Discussion

- Provide descriptions of letters being mailed to members impacted by upcoming changes to BadgerCare Plus
- Provide basic information regarding the new Modified Adjusted Gross Income (MAGI) eligibility rules

BadgerCare Plus Policy Changes: Parents & Caretaker Relatives

- Eligible at or below 100% FPL
  - No monthly premiums
  - No insurance access and coverage test
  - Receive Standard Plan Benefits
- Over 100% FPL→ will have access through the Marketplace

BadgerCare Plus Policy Changes: Adults without Dependent Children

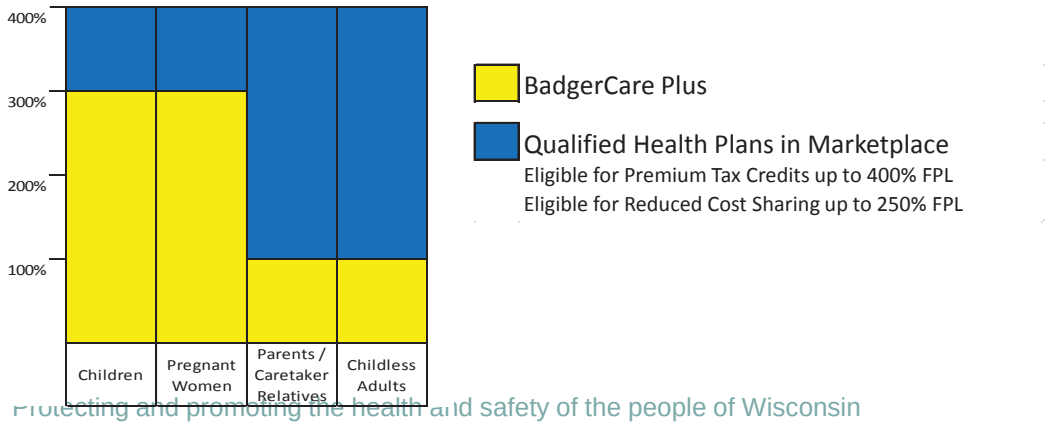
- Eligible at or below 100% FPL
  - Receive Standard Plan Benefits – a full benefits plan
  - No monthly premiums or annual enrollment fee
  - No Processing fee
  - No mandatory HNA (Health Needs Assessment)
  - No insurance access and coverage test
- Over 100% FPL→ Access through Marketplace

BadgerCare Plus Policy Changes: Children

- Eligible at or below 300% FPL
  - Monthly premiums for those above 200% FPL
- Over 300% FPL→Marketplace

BadgerCare Plus Financial Eligibility Summary Chart

The following chart displays the income limits for potential BadgerCare Plus members. It also displays the income levels to qualify for assistance with Qualified Health Plans in the Marketplace for coverage beginning on or after January 1, 2014:



2013 Federal Poverty Levels

Monthly Income Levels by Family Size

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4	$1,962.50	$2,355.00	$2,610.13	$2,649.38	$2,943.75	$3,925.00	$4,906.25	$5,887.50

Letters to Members – an Overview

- Mailings target those who may be affected by the changes to BadgerCare Plus programs
- Populations include the following:
  - Adults on BadgerCare Plus (Benchmark & Standard) and BadgerCare Plus Core Plan over 100% of the Federal Poverty Level (FPL) and Children over 300%
  - BadgerCare Plus members enrolled in extensions between 100 and 133% FPL
  - Individuals on the Core Plan Wait List
  - Adults enrolled in BadgerCare Plus Basic Plan

Goals of the Letters

- Inform members ahead of time that it appears that they will no longer be eligible for Badger Care Plus as of January 1, 2014 due to new income limit rules
- Provide new thresholds for BadgerCare Plus eligibility in 2014
- Provide information about the federal Health Insurance Marketplace, also known as the Exchange, and encourage them to apply for benefits to avoid a gap in coverage
- Let members know where to call if they have questions

Identifying Each Letter

Each letter is numbered in the lower left-hand corner, so members will have an easy time identifying it for workers or stakeholders if they have any questions about the letter they received.

Example: The letter going out to individuals on the Core Plan Waiting List is “Letter 3.”

Letter 1: BadgerCare Plus Members

- Audience: Adults on BadgerCare Plus and Core Plan above 100% of the Federal Poverty Level (FPL) and Children above 300% FPL
- Lets members know it looks like they no longer meet the new BadgerCare Plus eligibility rules beginning January 1, 2014
- Provides information about the federal Marketplace
- Reminds members to report changes, as changes may allow them to remain eligible for BadgerCare Plus

Letter 2: BadgerCare Plus Members in Extensions

- Audience: BadgerCare Plus members between 100 and 133% FPL currently in extensions (sometimes called “Transitional Medicaid or TMA”)
- Lets members know that they will now have to pay a premium to stay enrolled in BadgerCare Plus
- Tells members they will receive another notice in December telling them the premium amount and how to pay the premium
- Tells members when their first premium payment is due (January 10, 2014)
- Reminds members to report changes, as they could be eligible for BadgerCare Plus without a premium

Letter 3: Individuals on Core Plan Wait List

- Audience: Individuals on the Core Plan Wait List
- Informs recipient that the Core Plan Wait List is ending
- Explains the FPL changes and new thresholds for BadgerCare Plus eligibility in 2014, which will now include adults without dependent minor children
- Explains how to apply for coverage through the Marketplace or for BadgerCare Plus, depending on their income

Letter 4: Members on BadgerCare Plus Basic Plan

- Audience: Individuals on the BadgerCare Plus Basic Plan
- Informs individual that the Basic Plan will end, as of Dec. 31, 2013
- Explains the FPL changes and new thresholds for BadgerCare Plus eligibility in 2014, which will now include adults without dependent minor children
- Explains how to apply for coverage through the Marketplace or for BadgerCare Plus, depending on their income

Letter 5: Members on BadgerCare Plus Basic Plan in December

- Audience: Individuals enrolled in the BadgerCare Plus Basic Plan as of Dec. 15, 2013
- Lets individual know that the Basic Plan officially ends at the end of the month (Dec. 31, 2013)
- Provides information about the federal Health Insurance Marketplace

Outreach Timeline

Date	Milestone
07/16/2013	Begin establishing Regional Enrollment Networks
08/15/2013	Regional Enrollment Network Identification
09/16/2013	Regional Enrollment Network Operations Plan Complete
09/23/2013	Current BadgerCare Plus Members Notified of Potential Changes
09/28/2013	Core Plan Waitlist / Basic Plan Members Notified of Potential Changes
10/01/2013	DHS Targeted Call Outreach Begins for Transitioning Members
10/01/2013	Marketplace Open Enrollment Begins
11/18/2013	DHS Begins Processing Applications Transferred from Marketplace
11/23/2013	DHS begins notifying Members of Coverage Changes Effective January 1, 2014
12/15/2013	Marketplace Enrollment Deadline for Coverage Effective January 1, 2014
01/01/2014	New BadgerCare Plus Coverage Changes Effective
03/31/2014	Marketplace Open Enrollment Ends

Letters for Members - Online

These letters can be found online at dhs.wisconsin.gov/health-care/training/index.htm

For current information on all DHS outreach and other initiatives:

http://www.dhs.wisconsin.gov/health-care/

What is “MAGI”?

- MAGI = Modified Adjusted Gross Income
- Refers to new household composition and budgeting rules
- Members and applicants will be asked some different questions about their tax status, tax dependents, and tax deductions
- Introduced by PPACA to align BadgerCare Plus eligibility rules with tax rule-based policy in the Marketplace

Who is Subject to MAGI Rules?

- BadgerCare Plus Members:
  - Children
  - Parents / caretakers
  - Pregnant women
  - Childless adults
- Family Planning Only Services (FPOS) members are subject to MAGI income rules, but always with a group size of one

Who is Not Subject to MAGI Rules?

- MAGI rules do ***not*** apply to:
  - Elderly, blind and disabled groups
    - Elderly, Blind and Disabled (EBD) Medicaid
    - Long-Term Care (LTC) Waiver Enrollees
    - SeniorCare
    - QMB, SLMB, SLMB+
    - MAPP
    - Well Woman Medicaid
  - Categorically eligible populations
    - Former Foster Care Youth

When will members subject to MAGI Rules?

- ACCESS changes
  - Updated November 16, 2013
- Income Limits
  - Mass change November 23, 2013
  - Effective January 1, 2014
- MAGI budgeting rules
  - New Applicants→ MAGI rules as of January 1, 2014
  - Existing Members→ MAGI rules beginning April 1, 2014 or at next renewal, whichever is later

Something to Keep in Mind

While it is important for everyone to know these new rules and how they differ from the current rules for determining eligibility, please remember that IM workers determine eligibility.

This information will allow you to help applicants to submit complete and accurate applications.

MAGI Rules

- Income
- Deductions
- Household Composition
- **Please Note:** DHS will be providing an even more in-depth training on MAGI rules later this fall, including examples of how households will be formed

BadgerCare Plus Income

Under MAGI, countable income = taxable income. This includes (but is not limited to):

- Taxable Earned Income
- Taxable Net Self-Employment Income
- Unemployment Compensation
- Alimony/Spousal Maintenance
- Social Security Income

BadgerCare Plus Income

Some common income types that will **NOT** be counted for BadgerCare Plus eligibility include:

- Child Support
- Supplemental Security Income (SSI)
- Workers' Compensation
- Veterans Benefits

New Types of Countable Income

- Financial aid, if used for living expenses
- All Tribal per capita payments
- AmeriCorps income
- Taxable retirement, pension and annuities
- Interest & dividends
- Lump sum income counted in month received

Whose income is counted?

- In general, everyone in an assistance group will have their income counted
- In some cases, children and tax dependents' income will not be counted, if their income is so low that they are not required to file taxes

Tax Deductions

- Pre-tax deductions are allowed as deductions
  - For example, contributions to health savings accounts
- Tax deductions listed on page 1 of Tax Form 1040 are also allowed. Examples include:
  - Student loan interest paid
  - Higher education expenses
  - Self-employment tax
- Itemized deductions are not allowed

Questions?

Don’t forget, you can submit questions online to dhshealthcare@wisconsin.gov*

*__Note__: Do not send personal health information or personally identifiable information to the inbox

BadgerCare Plus
Modified Adjusted Gross Income (MAGI)
Partner Training

October 14, 2013

Agenda

- Goals for today's training
- Additional Resources
- MAGI Implementation timeline
- Important reminders
- MAGI Questions and helpful documents
  - Tax Filing
  - Tax Dependents
  - Pre-Tax Deductions
  - Unearned Income
  - Educational/Financial Aid
  - Tax Deductions
- Outreach Timeline
- Questions and Resources

Goals for Today

- Understand the Modified Adjusted Gross Income (MAGI) questions that will be asked of individuals and families applying for BadgerCare Plus.
- Helpful tips for partners when they are assisting applicants with applying for BadgerCare Plus.

Additional Resources – Marketplace/Exchange

- Marketplace Checklist and Employer Coverage Tool https://www.healthcare.gov/downloads/MarketplaceApp_Checklist_Generic.pdf
- Kaiser Family Foundation – FAQs About ACA http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
- Kaiser Family Foundation – Fact Sheets http://kff.org/health-reform/fact-sheet/obamacare-and-you/

When will members subject to MAGI Rules?

- ACCESS changes
  - Updated November 18, 2013
- MAGI budgeting rules
  - New Applicants→ MAGI rules as of January 1, 2014
  - Existing Members→ MAGI rules beginning April 1, 2014 or at next renewal, whichever is later

Reminder – Eligibility Determinations

While it is important for everyone to know what questions will be asked of applicants, please remember that IM workers determine eligibility.

The information in this training will allow you to help applicants to submit complete and accurate applications.

Reminder – "Expect to…"

- For MAGI questions, ACCESS will ask about what individuals are planning to do for the current tax year in which they are applying, not the previous year.
- Example: If applying for benefits in March 2014, ACCESS will ask about the taxes that the individual ***expects to*** file for income.

Reminder – Documents

- Except for self-employed individuals, applicants will not be required to submit tax documents from previous years.
- However, some previously filed tax documents, such as a Form 1040, may be helpful in figuring out how individuals plan to file for the current year. They could help figure out:
  - Whether spouses file jointly or are married filing separately, and
  - Who and when they have claimed tax dependents in the past.
- Current pay stubs can also help someone find out what pre-tax deductions they have.
  - Note that pay stubs are generally required to verify income
  - It will be helpful for the applicant to have their pay stubs available, if applicable, when they complete their application

Reminder – Important Information

- It is important, but not required, that applicants have the name(s), date(s) of birth, and, where applicable, Social Security Number(s) for all individuals in the household.
- Having this information allows Income Maintenance Agencies to utilize data exchanges to verify some information provided on the application and reduce the amount of information or proof that the individuals is asked for on the verification checklist.

Training Note

- Throughout this training we will use the ACCESS online application tool for its simplicity and demonstration purposes.
- If an applicant chooses to apply via another route, *i.e.* in-person, over the phone, or paper application, all MAGI-related questions will still be asked.
- ACCESS will be updated to reflect MAGI policy changes on November 18, 2013.
  - BadgerCare Plus paper applications will also be available.

Training Note (cont'd)

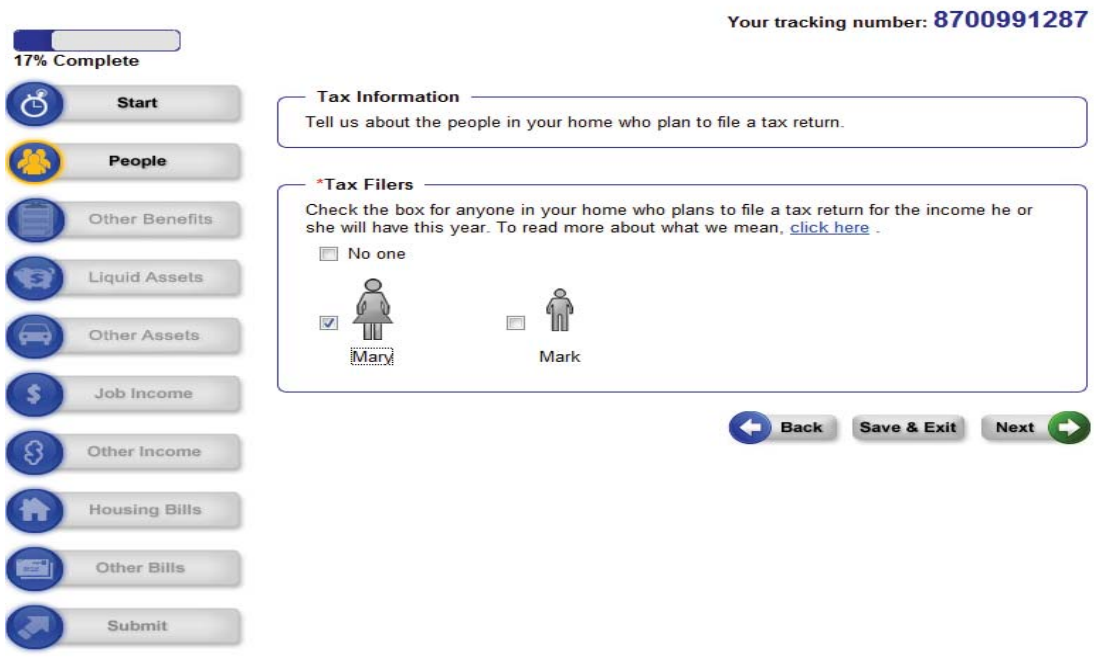
- This training will address basic MAGI-related questions and introduce the tax concepts used in MAGI.
- This training is focused on BadgerCare Plus.

INTRODUCTION TO MAGI TAX FILING QUESTIONS

MAGI – Tax Filer Question

- ACCESS will ask which individual(s) in the household plan to file a tax return for income they will have in the current tax year.
- Note that an individual can file a tax return even if they do not have any income or owe any taxes.
- **Important Reminder :** If two people in the household are married and filing taxes, they will either file jointly or as married filing separately.

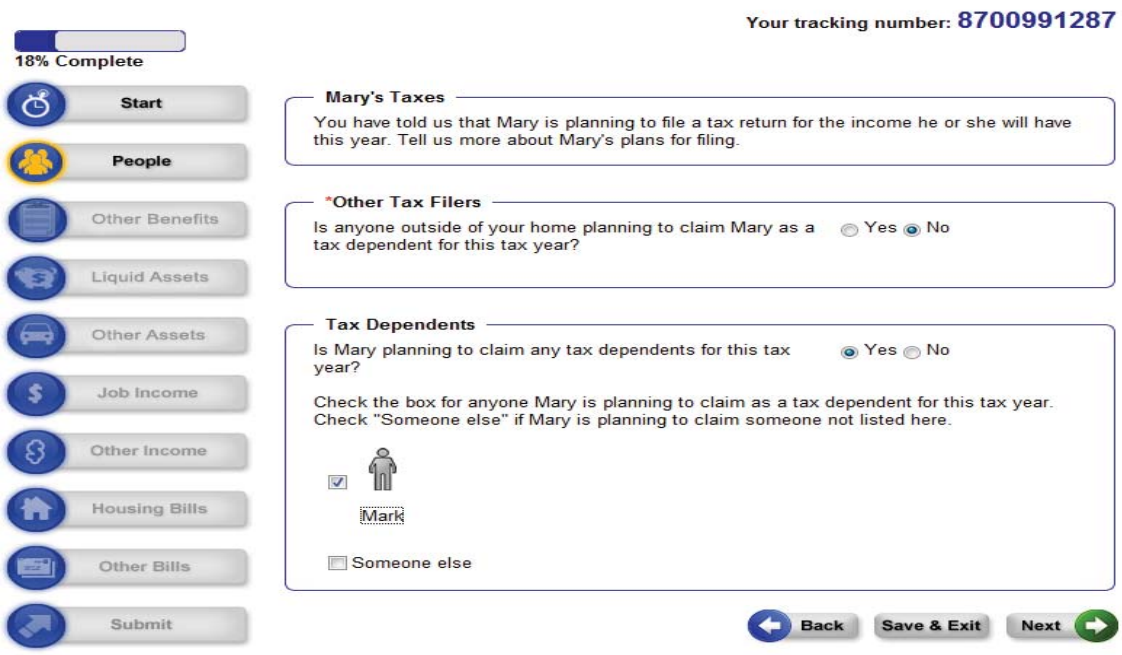
Screenshot – Tax Filer Question



MAGI – Tax Dependents

- Next, ACCESS will ask about tax dependents in the household.
  - In most cases, a tax dependent will be a tax filer's child(ren) or a relative for whom the tax filer provides support.
- ACCESS will also ask if someone outside the applicant's household will be claiming any tax filers included on the application as a tax dependent.
  - For example, a parent outside the home who is claiming a teenager who is working and is planning to file taxes

Screenshot – Tax Dependents



MAGI – Tax Dependents (cont'd)

- If the individual is planning on claiming a tax dependent that is not included on the ACCESS application, the applicant can select "Someone Else" and tell ACCESS about the person.
  - Examples include:
    - Someone claiming a tax dependent outside the home, or
    - Someone claiming a tax dependent that is deceased.

MAGI – Tax Dependents (cont'd)

- ACCESS is an intuitive application tool, and some basic tax rules will be incorporated into the questions that are asked.
  - For example:
    - A spouse cannot claim their spouse as a tax dependent, and
    - Unless spouses are married filing jointly, only one adult can claim a given child as a tax dependent.
    - A tax dependent cannot claim their own dependents

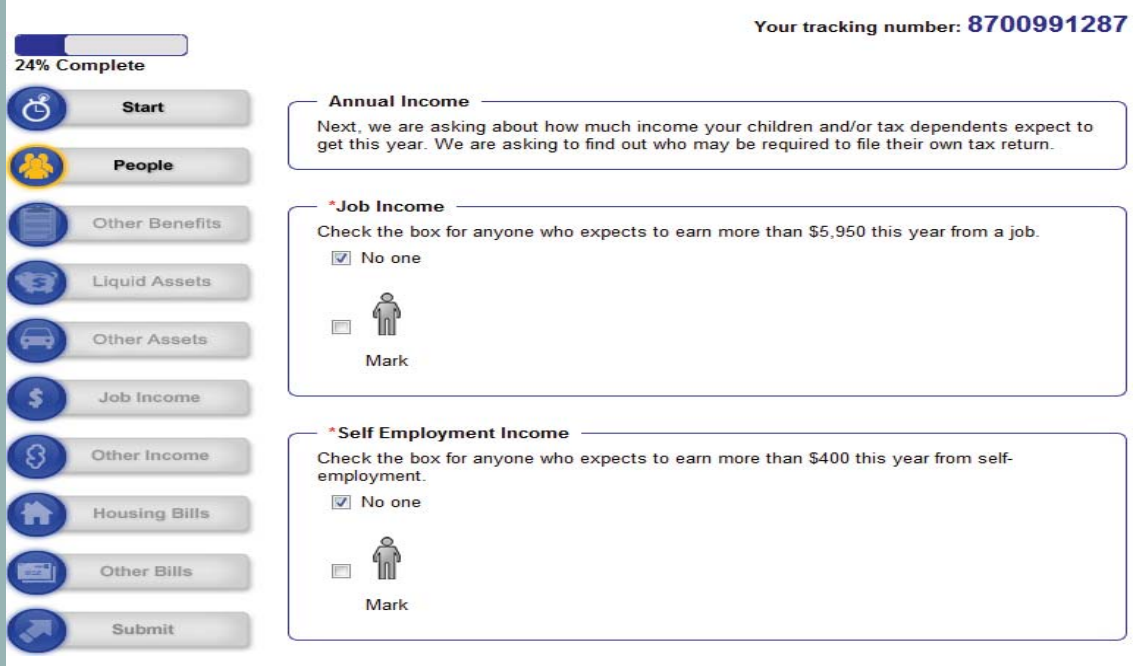
MAGI – Tax Dependents (cont'd)

- Remember that a previous year's tax return may help an individual remember how they have claimed tax dependents in the past, but ACCESS will only ask about how the individual plans to file a tax return for the **current tax year**.
- Keep in mind that two people who are not married cannot claim the same child as a tax dependent in the same year.
  - Some separated or divorced parents claim a child as a tax dependent alternating every other year.
  - Even if a parent is not claiming a child as a tax dependent in the current year, they can still apply for heath care benefits.

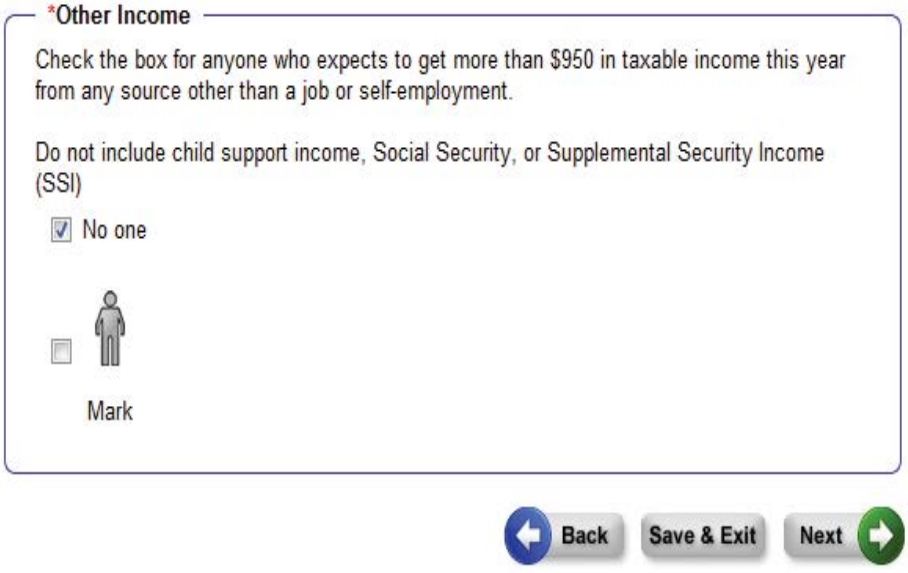
MAGI – "Required to File"

- Next, ACCESS will ask about the income that children and tax dependents are expected to have in the current tax year.
- The applicant will be asked if the child(ren) or dependent(s) on the applicant expect to have income above a certain threshold for the current tax year.
- If the income is above the threshold the child(ren) or dependent(s) are required to file a tax return, and the income will be included in the household income calculation.

Screenshot – "Required to File"



Screenshot – "Required to File" (cont'd)



MAGI – "Required to File" (cont'd)

- **Note:** For the purposes of the ACCESS "Other Income" question here, include taxable unearned income, including but not limited to:
  - Unemployment compensation
  - Retirement benefits
  - Tribal per capita payments
- **Do not** include:
  - Child support
  - Supplemental Security Income (SSI)
  - Social Security (not taxable in most cases)
  - Veterans benefits
  - Workers Compensation

INTRODUCTION TO MAGI INCOME QUESTIONS

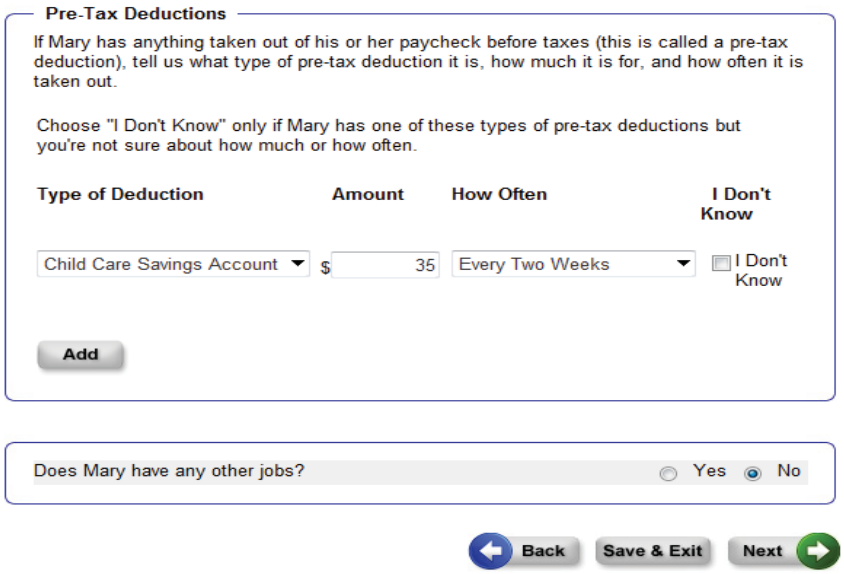
MAGI Income Changes

- Pre-tax deductions will be added to the ACCESS Earned Income pages
- There are some changes to the Unearned Income questions
- An Educational Aid & Expenses page in ACCESS will be added
- A Tax Deductions page will be added to ACCESS

MAGI – Pre-tax Deductions

- ACCESS will now ask about any pre-tax deductions that an individual may have taken out of their pay check before taxes.
  - Select the type of pre-tax deduction from the drop down list, noting the amount of the deduction and how often it is deducted.
- In most cases, these pre-tax deductions are listed on the individual's pay stub.
  - Examples of allowable pre-tax deductions:
    - Health Insurance Premiums
    - Health Savings Account
    - Retirement Contributions
    - Parking & Transit Costs
    - Child Care Savings Account
    - Group Life Insurance

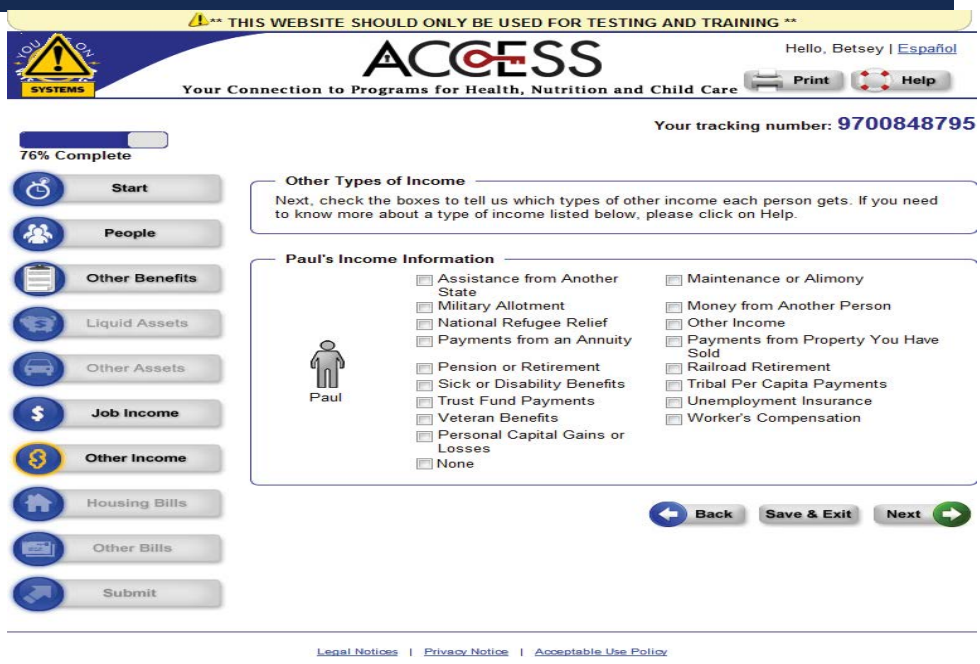
Screenshot – Pre-tax deductions



MAGI – Unearned Income Types

- ACCESS will continue to ask about unearned income, or what is referred to as “Other Income” in ACCESS.
- Note that for now, ACCESS will ask about all unearned income.
- **The Income Maintenance agency will determine which income is counted for MAGI purposes.**
  - Some unearned income, such as worker’s compensation, veterans benefits, and child support will no longer be counted

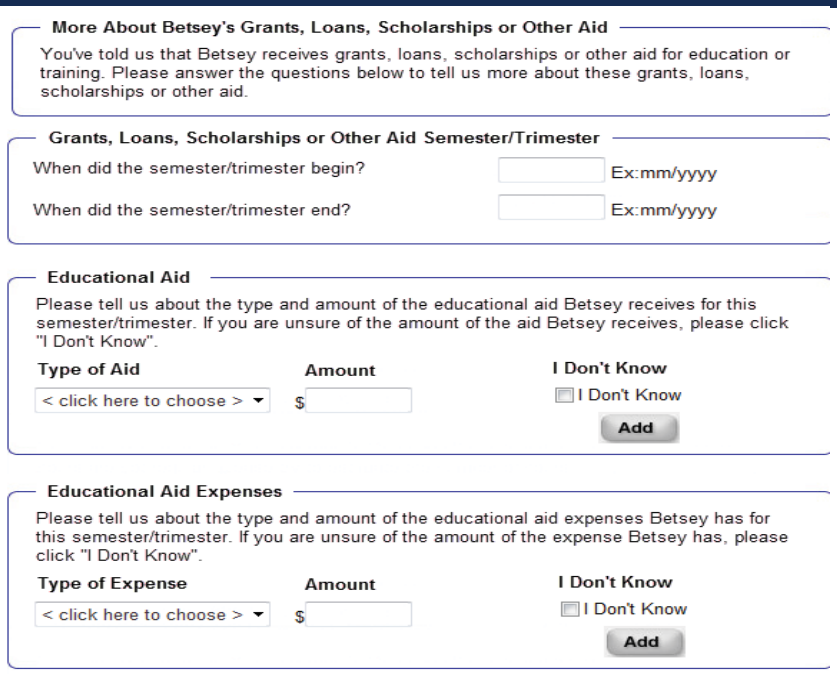
Screenshot – “Other Income”



MAGI – Educational Aid

- ACCESS will ask about an individual’s Educational Aid, commonly referred to as “Financial Aid.”
- Grants and loans will be counted as income if they are used for living expenses (i.e. anything other than tuition, books or fees)
- ACCESS asks if any person on the application gets grants, scholarships, or other financial aid in the current school term.
  - ACCESS will not ask about school loans, but any other kind of aid.
  - Select the type of aid and amount from a drop-down list of applicable aids.
- ACCESS will also ask about Educational Expenses.
  - Select the type of expense and amount from a drop-down list of applicable expenses.
- Be sure to note the start and end date for the current term in which the individual gets grants, scholarships, or other aids.

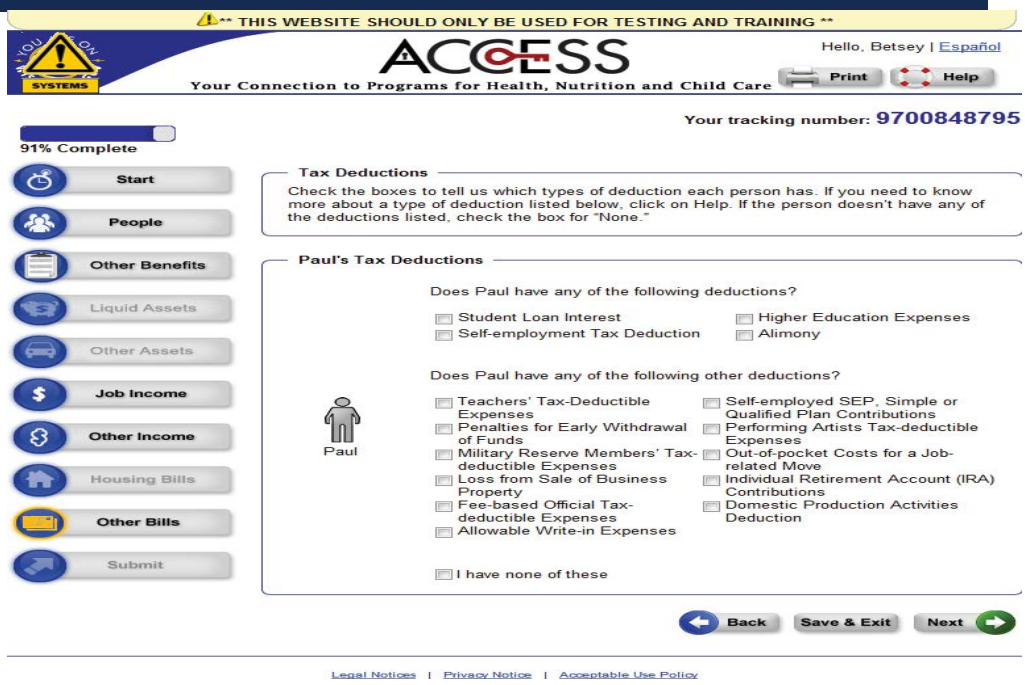
Screenshot – Educational Aid



MAGI – Tax Deductions

- ACCESS will also ask if individuals are planning on taking certain tax deductions for the current year.
  - Note that these tax deductions are listed on IRS Form 1040, but remember that ACCESS is asking about planned tax deductions for the current year.
- Verification of current monthly expenses will be required
  - For example, someone's alimony or monthly student loan interest payment

Screenshot – Tax Deductions



Outreach Timeline

Date	Milestone
07/16/2013	Begin establishing Regional Enrollment Networks
08/15/2013	Regional Enrollment Network Identification
09/16/2013	Regional Enrollment Network Operations Plan Complete
09/23/2013	Current BadgerCare Plus Members Notified of Potential Changes
09/28/2013	Core Plan Waitlist / Basic Plan Members Notified of Potential Changes
10/01/2013	DHS Targeted Call Outreach Begins for Transitioning Members
10/01/2013	Marketplace Open Enrollment Begins
11/18/2013	ACCESS Updated to Reflect MAGI-related changes
11/23/2013	DHS begins notifying Members of Coverage Changes Effective January 1, 2014
12/15/2013	Marketplace Enrollment Deadline for Coverage Effective January 1, 2014
01/01/2014	New BadgerCare Plus Coverage Changes Effective
03/31/2014	Marketplace Open Enrollment Ends

In-Person BadgerCare Plus and MAGI Trainings

Questions & Resources

- For questions that were not answered today, or that come up after this presentation, please send them to:
  - DHSHealthCare@dhs.wisconsin.gov
  - **Note**: Do not send personal health information or personally identifiable information to the inbox
- For current, up to date information on BadgerCare Plus in 2014, please visit http://www.dhs.wisconsin.gov/health-care/

Health Care Options 2014
BadgerCare Plus & The Marketplace
Partner Training

Location
October and November 2013

Agenda

- Outreach and Enrollment Timeline
- BadgerCare Plus Policy Changes
- MAGI (Modified Adjusted Gross Income)
- Important Reminders
- Partner Discussion
- Additional Resources

Outreach and Enrollment Timeline

Date	Milestone
07/16/2013	Begin establishing Regional Enrollment Networks
08/15/2013	Regional Enrollment Network Identification
09/16/2013	Regional Enrollment Network Operations Plan Complete
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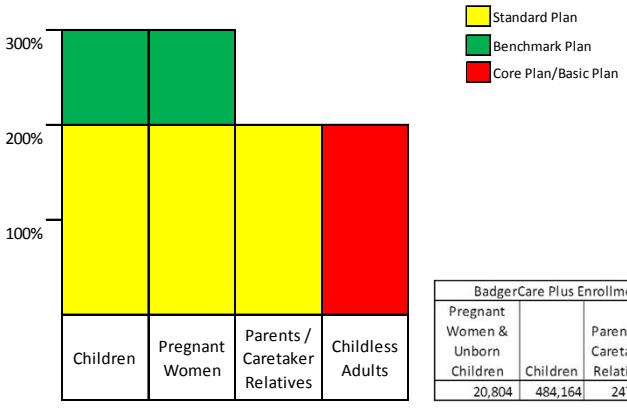
11/18/2013	ACCESS Updated to Reflect MAGI-related changes
11/23/2013	DHS notifies Members of Coverage Changes, effective January 1, 2014 for new applicants
12/15/2013	Marketplace Enrollment Deadline for Coverage Effective January 1, 2014
01/01/2014	New BadgerCare Plus Coverage Changes Effective
03/31/2014	Marketplace Open Enrollment Ends

3

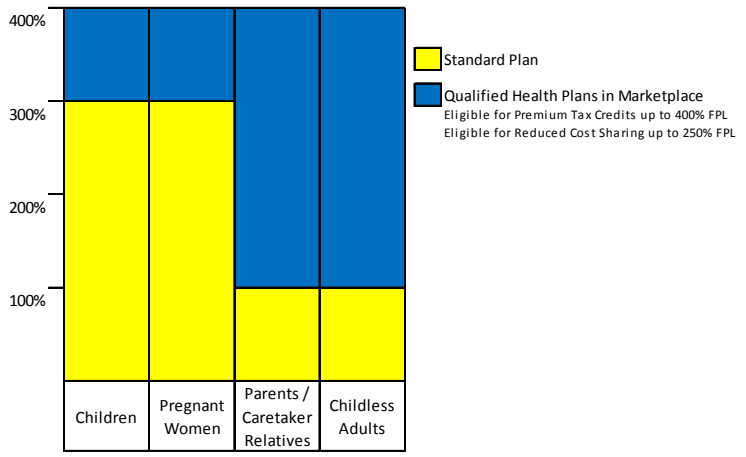
Current BadgerCare Plus Enrollment and Benefits



BadgerCare Plus Enrollment - By December 2013				
Pregnant Women & Unborn Children	Children	Parents & Caretaker Relatives	Childless Adults	Total
20,804	484,164	247,712	16,450	769,130

4

New 2014 Healthcare Options



5

BadgerCare Plus Key Policy Changes

- Income limit changes:
  - Income limit changes for parents/caretakers, childless adults and children
  - No income limit changes for pregnant women, Family Planning Only Services, or Elderly, Blind and Disabled (EBD) Medicaid
- MAGI budgeting rules implemented

6

BadgerCare Plus Policy Changes: Adults

Parents and Caretakers:

- Eligible at or below 100%FPL
  - Access to Standard Plan Benefits
  - No premiums
  - Nominal cost sharing for certain services

  Over 100% FPL→ will have access through the Marketplace

BadgerCare Plus Policy Changes: Adults (continued)

Childless Adults:

- Eligible at or below 100% FPL
  - Standard Plan Benefits
  - No monthly premiums or annual enrollment fee
  - No mandatory Health Needs Assessment for eligibility
  - No Waitlist
  - Nominal cost sharing for certain services
  - No insurance access or coverage test
- Over 100% FPL→Access through Marketplace

BadgerCare Plus Policy Changes: Children

- Eligible at or below 300% FPL
  - Premiums over 200% FPL
- Over 300% FPL→Marketplace

Other Policy Changes

- All BadgerCare Plus members will be enrolled in the BadgerCare Plus Standard Plan
  - Nominal Cost Sharing
- 12-month certification periods
- Former Foster Care Youth age limit to 26

What is “MAGI”?

- MAGI = Modified Adjusted Gross Income
- Refers to new household composition and budgeting rules that will be applied for BadgerCare Plus and the Marketplace.
- Members and applicants will be asked some different questions about their tax status, tax dependents, and tax deductions
- Introduced by Patient Protection & Affordable Care Act to align BadgerCare Plus eligibility rules with tax rule-based policy in the Marketplace

Who is Subject to MAGI Rules?

BadgerCare Plus Members :

- Children
- Parents / caretakers
- Pregnant women
- Childless adults

MAGI rules do ***not*** apply to:

- Elderly, blind and disabled groups
  - EBD MA, LTC, SeniorCare
  - QMB, SLMB, SLMB+
- Categorically eligible populations
  - Former Foster Care Youth

When will members be subject to MAGI Rules?

- ACCESS changes
  - Updated November 18, 2013, and will be applied for those seeking coverage on for after January 1, 2014
- MAGI budgeting rules
  - New Applicants→ MAGI rules applied for coverage beginning on or after January 1, 2014
  - Existing Members→ MAGI rules begin to be applied April 1, 2014 or at next renewal, whichever is later

Reminder – Eligibility Determinations

While it is important for everyone to know what questions will be asked of applicants, please remember that **income maintenance (IM) workers determine eligibility.**

The information in this training will allow you to help applicants submit complete and accurate applications.

Reminder – "Expect to…"

- For MAGI questions, ACCESS will ask about what individuals are planning to do for the current tax year in which they are applying, not the previous year.
- Example: If applying for benefits in March 2014, ACCESS will ask about the taxes that the individual ***expects to*** file for income received in 2014.

Reminder – Documents

- Except for self-employed individuals, applicants will not be required to submit tax documents from previous years.
- However, some previously filed tax documents, such as a Form 1040, may be helpful in figuring out how individuals plan to file for the current year. They could help figure out:
  - Whether spouses file jointly or are married filing separately, and
  - Who and when they have claimed tax dependents in the past.
- Current pay stubs can also help someone find out what pre-tax deductions they have.
  - Note that pay stubs are generally required to verify income
  - It will be helpful for the applicant to have their pay stubs available, if applicable, when they complete their application

Reminder – Important Information

- It is important, but not required, that applicants have the name(s), date(s) of birth, and, where applicable, Social Security Number(s) for all individuals in the household.
- Having this information allows Income Maintenance Agencies to utilize data exchanges to verify some information provided on the application and reduce the amount of information or proof that the individual is asked for on the verification checklist.

Updates from the Field: Discussion with Partners, RENs

- Marketplace Best Practices w/ Covering Kids & Families
- REN & Community Updates

Questions & Resources

- To view archived trainings that go more in-depth into topics discussed today please go to http://www.dhs.wisconsin.gov/health-care
- For questions that were not answered today, or that come up after this presentation, please send them to:
  - DHSHealthCare@dhs.wisconsin.gov
  - **Note**: Do not send personal health information or personally identifiable information to the inbox
- For current, up to date information on BadgerCare Plus in 2014, please visit http://www.dhs.wisconsin.gov/health-care/

Additional Resources – Marketplace/Exchange

- Marketplace Checklist and Employer Coverage Tool https://www.healthcare.gov/downloads/MarketplaceApp_Checklist_Generic.pdf
- Kaiser Family Foundation – FAQs About ACA http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
- Kaiser Family Foundation – Fact Sheets http://kff.org/health-reform/fact-sheet/obamacare-and-you/

BadgerCare Plus Tax Filer Information Form Overview

January 8, 2014

Agenda

- Training Purpose
- Entitlement Reform Status Update
- Important Dates
- Upcoming Communications and Trainings
- Updated Informational Mailings
  - Letter 1A & BC+ Tax Filer Information (TFI) Form
  - Letter 3A
- Additional Information About the TFI Form
- Questions
  - Please note that this presentation, including these slides, will be available at dhs.wisconsin.gov/health-care/

Training Purpose

- Provide additional information about the letters and materials that members and applicants are getting in the mail.
- Give you information to help answer the member or applicant's questions or help direct them to the best place to get help.
- **Please note:** ONLY Income Maintenance workers can determine a member or applicant's eligibility for BadgerCare Plus. If in doubt, refer the member or applicant to their local agency to get further assistance.

Entitlement Reform Update

- Governor Walker signed Special Session Assembly Bill 1 into law, delaying BC+ program changes until April 1, 2014.
- CMS approved the delay, with one change:
  - Beginning February 1, 2014, MAGI rules will be applied to all new applicants. As part of this, the new income limit (100% FPL) will be applied to parents and caretaker relatives who are newly applying for BadgerCare Plus.

Entitlement Reform Update - Continued

- As a result of CMS's requirement to apply MAGI rules to all new applicants beginning February 1, 2014, a technical modification is needed to align Wisconsin statutes with CMS requirements.
- DHS is working with the legislature to make this technical modification by the end of January 2014.

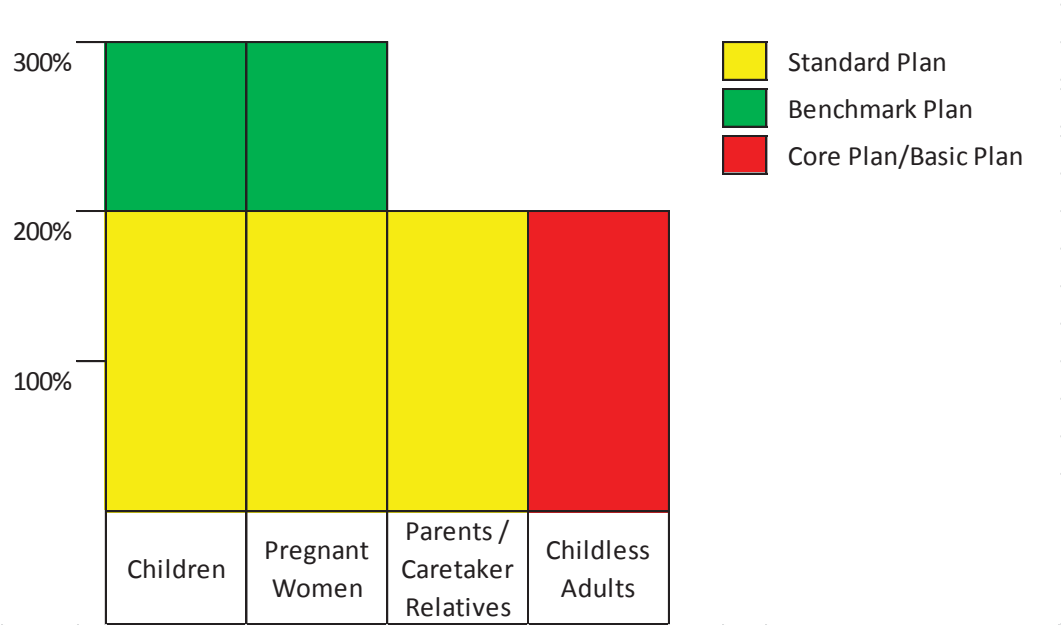
Important Dates

- January 17, 2014: Due date for submitting completed BadgerCare Plus TFI forms.
- February 1, 2014: Implementation of MAGI rules and 100% FPL income limit for BadgerCare Plus parents and caretakers applying for new coverage. (Note that parents and caretakers with incomes from 100% to 200% FPL who are enrolled in BadgerCare Plus as of January 31, 2014 will remain eligible through March 31, 2014, as long as they continue to meet program rules).

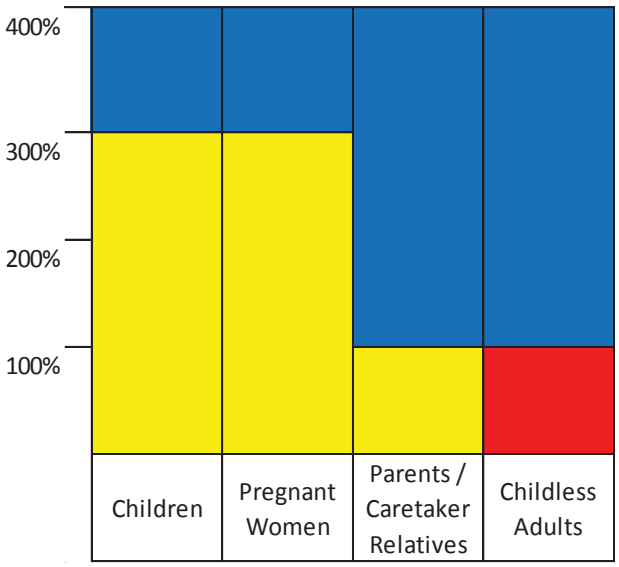
Important Dates– Continued

- February 3, 2014:
  - ACCESS.wi.gov will be updated with the new program rules.
  - Adults without dependent children can begin submitting new applications via ACCESS, over the phone, or in person at their local agency. Please note that newly eligible adults without dependent children will begin coverage no earlier than April 1, 2014.
- April 1, 2014: Newly eligible populations begin coverage.

Current BadgerCare Plus Enrollment and Benefits



February 1, 2014 BadgerCare Plus & Marketplace Enrollment and Benefits (*New Applicants)



Standard Plan

Core Plan/Basic Plan (Enrollment Cap)

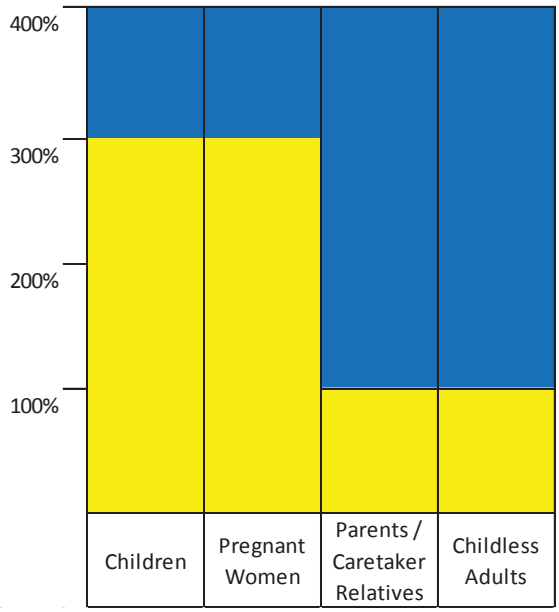
Qualified Health Plans in Marketplace

Eligible for Premium Tax Credits up to 400% FPL

Eligible for Reduced Cost Sharing up to 250% FPL

*This chart refers to new applicants only. Current BadgerCare Plus members will maintain eligibility in their current programs (Standard, Core, Basic) through March 31, 2014, as long as they continue to meet current program rules.

April 1, 2014 BadgerCare Plus & Marketplace Enrollment and Benefits



Standard Plan

Qualified Health Plans in Marketplace

Eligible for Premium Tax Credits up to 400% FPL

Eligible for Reduced Cost Sharing up to 250% FPL

New BadgerCare Plus income limits and benefits apply to new applicants and existing members

Upcoming Communications and Trainings

- A series of statewide in-person partner trainings will be held in late January/early February. Details will be announced soon.
- Continued partner emails when new information or updates become available, including the upcoming trainings.
- Updated FAQ documents.
- Updated member materials.

More Information on BadgerCare Plus Policy Changes

- For more information about the 2014 BadgerCare Plus policy changes, please visit http://www.dhs.wisconsin.gov/health-care/
  - Previous web-based trainings, frequently asked question (FAQ) documents and other resources are available at this site.
- The BadgerCare Plus Eligibility Handbook has been updated with the 2014 policy changes; however, many changes will not take effect until April 1, 2014.
  - The BadgerCare Plus Eligibility Handbook is available at http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm

Updated Informational Mailings

- Letter 1A – this letter informs some current BadgerCare Plus members about the delay in BadgerCare Plus policies. The recipients are:
  - Non-pregnant BadgerCare Plus parents and caretakers with household income over 100% of the Federal Poverty Level (FPL),
  - BadgerCare Plus children with household income over 300% FPL, and
  - BadgerCare Plus Core Plan members with income over 100% FPL.
- **Letter 1A:** includes the Tax Filer Information form for the household to complete.
  - Child support will no longer be counted as income so individual receiving child support are encouraged to fill out this form.
- **Letter 3A:** informs individuals on the BadgerCare Plus Core Plan Waitlist about the delay in new BadgerCare Plus policies.
- Letters 1A and 3A were mailed the week of December 23, 2013.
- Copies of DHS Informational Mailings are available at http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm

Letter 1A and the "Tax Filer Information" Form

- Letter 1A informs current BadgerCare Plus members affected by the 2014 policy changes that they will continue to receive BadgerCare Plus benefits through March 31, 2014 as long as they continue to meet the current program rules.
- Letter 1A also reminds these BadgerCare Plus members that they need to apply for private health insurance coverage and provides information about the federal Health Insurance Marketplace (also called the Exchange).
- Letter 1A includes an attachment titled "BadgerCare Plus Tax Filer Information"
  - This form is optional and should be completed and returned by **Friday, January 17, 2014**.

Submitting the TFI Form

- If the member lives in Milwaukee County, submit the TFI Form to:

  MDPU
  PO Box 05676
  Milwaukee, WI 53205
  Fax: 1-888-409-1979

- If the member DOES NOT live in Milwaukee County, submit the TFI Form to:

  CDPU
  PO Box 5234
  Janesville, WI 53547-5234
  Fax: 1-855-293-1822

The Importance of Submitting a Completed TFI Form

- CMS has required the Department to send the TFI form to all BadgerCare Plus members who will be transitioning from BadgerCare Plus to the Marketplace.
- Filling out the TFI Form is optional; however, it allows DHS to test members under new MAGI rules to see if application of MAGI rules results in continued eligibility for BadgerCare Plus after new income limits are applied for April 1, 2014.
- Members who received Letter 1A and a TFI form and choose to fill it out need to return the TFI form by January 17, 2014.

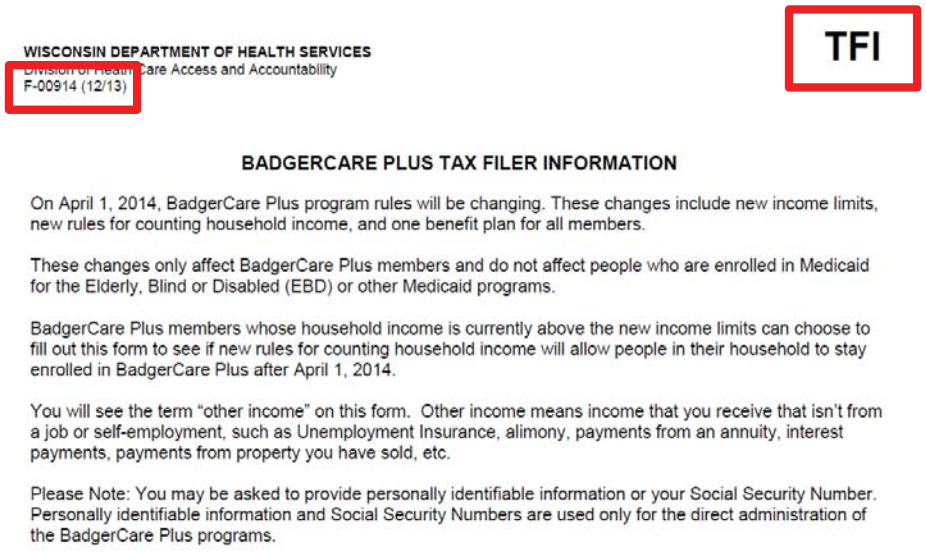
The Importance of Submitting a Completed TFI Form - Continued

- If a member completes the TFI Form and is not able to stay enrolled in BadgerCare Plus under the new program rules, the Department will send the member's information to the Marketplace so their Marketplace application can be completed more easily.
- If a member completes the form and is able to remain enrolled in BadgerCare Plus, they will remain enrolled as long as they continue to meet program rules.

BadgerCare Plus TFI Form – Important Reminders

- ****Please Note**:** Only BadgerCare Plus members that receive Letter 1A should complete and submit the TFI.
  - This form is **NOT** an application or renewal for BadgerCare Plus benefits.
- DHS has created an instruction document that provides community partners, providers, and other stakeholders more information about the TFI Form. This document is available at http://www.dhs.wisconsin.gov/forms/f0/f00914A.pdf
  - This document provides section-by-section instructions for completing the form.

BadgerCare Plus TFI Form – Sample



WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00914 (12/13)

TFI

BADGERCARE PLUS TAX FILER INFORMATION

On April 1, 2014, BadgerCare Plus program rules will be changing. These changes include new income limits, new rules for counting household income, and one benefit plan for all members.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus members whose household income is currently above the new income limits can choose to fill out this form to see if new rules for counting household income will allow people in their household to stay enrolled in BadgerCare Plus after April 1, 2014.

You will see the term "other income" on this form. Other income means income that you receive that isn't from a job or self-employment, such as Unemployment Insurance, alimony, payments from an annuity, interest payments, payments from property you have sold, etc.

Please Note: You may be asked to provide personally identifiable information or your Social Security Number. Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

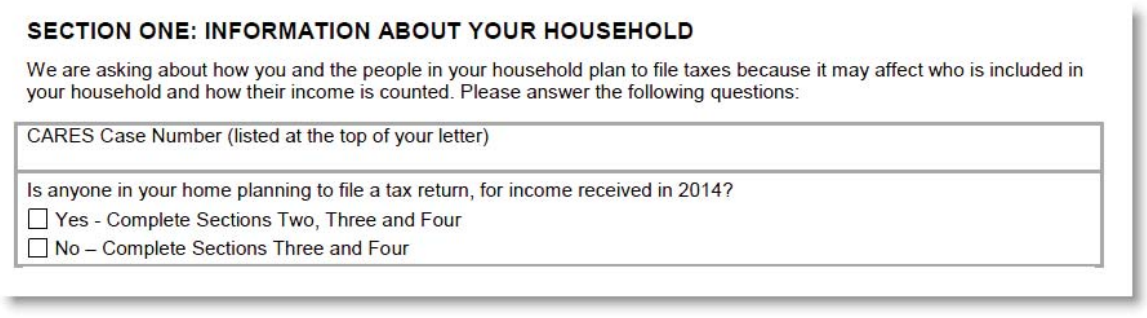
BadgerCare Plus TFI Form - Features

- The BadgerCare Plus Tax Filer Information (TFI) Form is Form "F-00914 (12/13)," and can be identified by the large "TFI" lettering on the top right corner of each page.
- The TFI Form is four (4) pages long.
- There are four (4) sections included in the TFI Form:
  1. Information About Your Household
  2. Tax Information For Your Household
  3. Information about Children Living In Your Home
  4. Signature
- The TFI Form should be completed and submitted to the CDPU or MDPU by **Friday, January 17, 2014**.

BadgerCare Plus TFI Form – General Instructions

- The TFI form will ask for Social Security Numbers and other personally identifiable information. This information will **ONLY** be used for the administration of the BadgerCare Plus program.
  - Please encourage the member to provide the most complete information as possible.
- When the TFI form refers to "Other Income" please **DO NOT** include:
  - Child Support
  - Supplemental Security Income (SSI)
  - Social Security
  - Veterans Benefits
  - Workers Compensation
- If more space is required for answering the questions in Sections Two and Three, please include additional paper and write the member's case number on the additional pages (This will be listed on the top of the member's letter).

TFI Form – Section One



SECTION ONE: INFORMATION ABOUT YOUR HOUSEHOLD

We are asking about how you and the people in your household plan to file taxes because it may affect who is included in your household and how their income is counted. Please answer the following questions:

CARES Case Number (listed at the top of your letter)
Is anyone in your home planning to file a tax return, for income received in 2014? ☐ Yes - Complete Sections Two, Three and Four ☐ No – Complete Sections Three and Four

TFI Form – Section One

- Section 1 asks the member to provide their case number (available at the top right hand corner of Letter 1A).
- This section also asks if anyone in the household plans on filing a tax return for income received in 2014.
  - Note that this question is asking about income received during the 2014 tax year, **NOT** in 2013.
  - The question is referring to tax returns that will be filed in 2015, **NOT** in 2014.
- If no one in the household is planning on filing taxes in 2015 for income they get in 2014, they can skip Section Two.

TFI Form – Section Two

SECTION TWO: TAX INFORMATION FOR YOUR HOUSEHOLD

Each tax filer in your household must fill out Section Two A or B. Please note: if anyone is married and filing a joint tax return, only one spouse needs to fill out Section Two A or B. Use additional paper if there are more than two tax filers in the household.

A. TAX FILER 1	
Name of Tax Filer 1	Name of Spouse (if married and filing jointly)
Tax Filing Status ☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household	
Will this tax filer be claimed as a dependent by someone outside of the home ☐ Yes ☐ No	

Tax Dependents: Answer the questions below for the dependents this tax filer will be claiming on his or her taxes. Include any tax dependents not living with the tax filer. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			
Is this tax dependent living outside of the home? ☐ Yes ☐ No		Is this tax dependent deceased ☐ Yes ☐ No	

TFI Form – Section Two

- Section Two asks about the people in the home who plan on filing a tax return in 2015 for income they get in 2014.
- This section asks about tax filers in the home and their tax filing status.
  - Note that married couples may either “file jointly” or “file separately.” Most married couples file jointly. If the married couple files jointly, be sure to include BOTH married couples’ names in A and they do not have to list the spouse in B.
  - If a tax filer is going to be claimed by someone outside of the home (for example a teenager that plans to file taxes but is claimed by a parent outside the home), note that in this section.
- This section also asks some questions about any tax dependents that the tax filers may have (either living in the home or outside of the home).

TFI Form – Section Three

SECTION THREE: INFORMATION ABOUT CHILDREN LIVING IN YOUR HOUSEHOLD

Answer the questions below for any children under age 19 who are living in the home and who are NOT listed as a tax dependent above. Provide this information even if no one in your home is filing taxes. Use an additional sheet of paper if more room is needed.

Are any children under age 19 living with you?
☐ Yes – Complete the rest of Section Three and Section Four
☐ No – Complete Section Four

Name of Child 1	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female
Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No			
Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No			

TFI Form – Section Three

- Section Three asks about any children in the home that were NOT included as tax dependents in Section Two.
  - For example, if a tax filer has a child living in the home but is not planning to claim that child as a tax dependent for 2014, or
  - For example, if the parents are divorced a parent only claims the child as a tax dependent every other year.

TFI Form – Section Four

- Section Four collects the member's signature.
- It is very important that only the member, their Authorized Representative, or someone with durable power of attorney signs the TFI form.
- Community partners and other stakeholders can assist the member with completing and submitting the TFI form, but the member must provide the information and physically sign the TFI form.

TFI Form Help and Questions

- If a member has questions or needs more help with filling out the TFI form, they should contact their agency.
- To get the contact information for the member's agency, please visit the agency directory at: dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Questions?

Don't forget, you can submit questions online at dhshealthcare@wisconsin.gov.*

*__Note__: Do not send personal health information or personally identifiable information to this email.

BadgerCare Plus Update

January and February 2014
In-Person Partner and Stakeholder Trainings

Wisconsin DHS

Agenda

- Entitlement Reform Update
  - BadgerCare Plus 2014 Policy Changes
  - Federal approval of BadgerCare Plus Waiver
- Overview 2014 BadgerCare Plus Policy and System Changes
  - System Changes
  - New Income Limits
- New Implementation Timeline
- Assisting BadgerCare Plus Members and Applicants
- Modified Adjusted Gross Income (MAGI)
- Questions
  - Please note that this presentation, including these slides, will be available at dhs.wisconsin.gov/health-care/.

Background

- Act 20, the 2013-15 state budget includes:
  - Changes in income limits for some BadgerCare Plus (BC+) groups, and
  - BadgerCare Plus Standard Plan coverage for all eligible pregnant women, parents and caretakers, children, and adults age 19-64 without dependent children living in the household (commonly referred to as “childless adults”).
- The Affordable Care Act (ACA) implements:
  - New “MAGI” rules to align eligibility between BC+ and the Marketplace.

Entitlement Reform Update

- Governor Walker signed Special Session Assembly Bill 1 into law, delaying most BC+ program changes until April 1, 2014.
- The Centers for Medicare and Medicaid Services (CMS) approved the delay, with one change:
  - Beginning February 1, 2014, all new applicants will be subject to MAGI rules. As part of this, the new income limit (100% FPL) will be applied to parents and caretaker relatives who are newly applying for BadgerCare Plus.

Entitlement Reform Update – State Legislation

- As a result of CMS's change, a technical modification was needed to align Wisconsin statutes with CMS requirements.
- Governor Walker signed AB 610/SB 475 into law on January 16, 2014, aligning Wisconsin statutes with the CMS requirements.

BadgerCare Plus Waiver Approval

- On January 9, 2014, Wisconsin and CMS formally agreed to a new Medicaid waiver to serve adults without dependent children living in poverty.
- More detailed information about the waiver is available at: dhs.wi.gov/badgercareplus/waivers.htm.

BadgerCare Plus 2014 Policy and System Changes

BadgerCare Plus Income Limits

2013 Federal Poverty Level (FPL) Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children and Pregnant Women (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

- For complete and updated FPL charts, see: http://badgercareplus.org/fpl.htm.

Entitlement Reform Update

- ACCESS will be updated February 3rd. All applications submitted in February, including those of adults with no dependent children, will be processed for possible BadgerCare Plus enrollment and will have MAGI applied.
  - The new BadgerCare Plus income limit (100% FPL) will be applied to parents and caretaker relatives who apply on or after February 1, 2014 for coverage starting the month they applied.
  - Newly eligible adults age 19-64 without dependent children living in the household (childless adults) cannot begin coverage until April 1, 2014.

BadgerCare Plus Policy Changes: Parents & Caretaker Relatives

- Effective February 1, 2014 for new applicants and April 1, 2014 for current members.
- Parents and caretaker relatives are eligible at or below 100% FPL:
  - No monthly premiums,
  - No insurance access and coverage test, and
  - Receive Standard Plan Benefits.
- Over 100% FPL→ will have access through the Marketplace.

BadgerCare Plus Policy Changes: Adults with no Dependent Children

- Adults with no dependent children are eligible at or below 100% FPL:
  - Receive Standard Plan Benefits – a full benefits plan,
  - No monthly premiums or annual enrollment fee,
  - HNA (Health Needs Assessment) is no longer tied to enrollment, and
  - No insurance access and coverage test.
- Over 100% FPL→ Access through Marketplace.

BadgerCare Plus Policy Changes: Adults with no Dependent Children

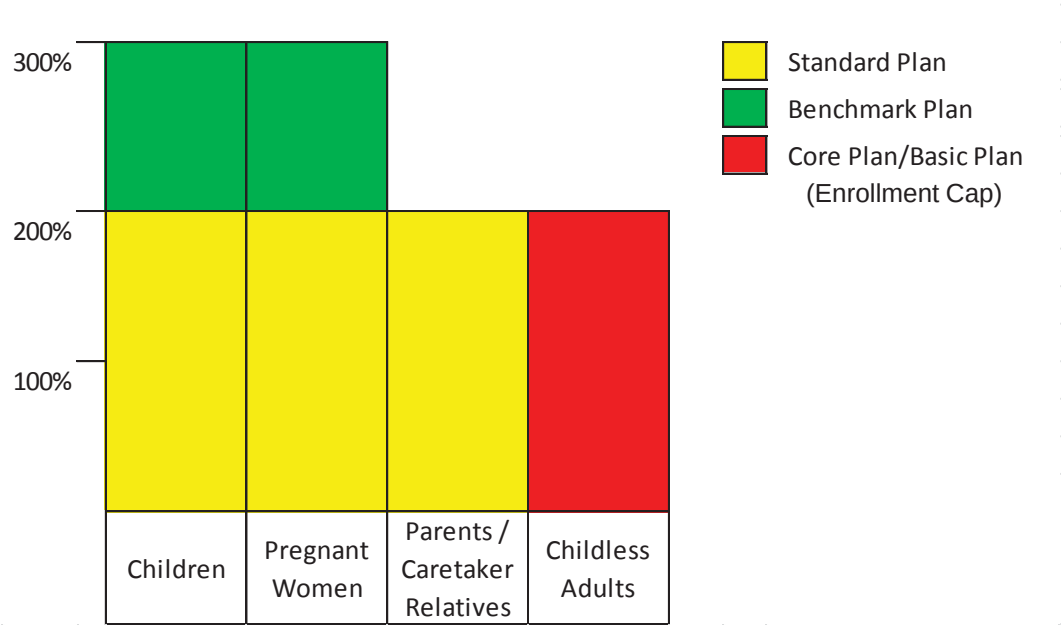
- BadgerCare Plus Emergency Services is a limited BadgerCare Plus benefit for applications that do not meet the BadgerCare Plus citizenship eligibility requirements.
- ****Important note****: BadgerCare Plus Emergency Services will **not** be available for BadgerCare Plus “childless adults”.

BadgerCare Plus Policy Changes: Children and Pregnant Women

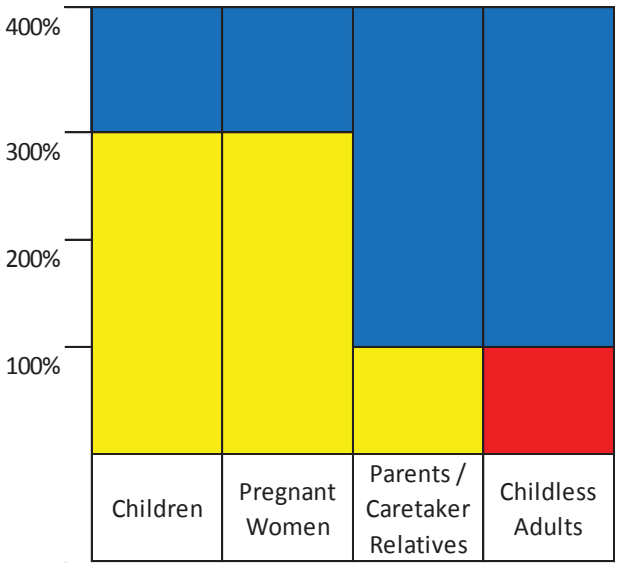
- Children and pregnant women are eligible at or below 300% FPL:
  - Monthly premiums for children with a household income above 200% FPL and
  - Note: Those over 300% FPL may be able to enroll in BC+ if they meet a deductible

- Over 300% FPL→Access through Marketplace.

BadgerCare Plus Enrollment and Benefits Prior to February 1, 2014



February 1, 2014 BadgerCare Plus & Marketplace Enrollment and Benefits (*New Applicants)



Standard Plan

Core Plan/Basic Plan (Enrollment Cap)

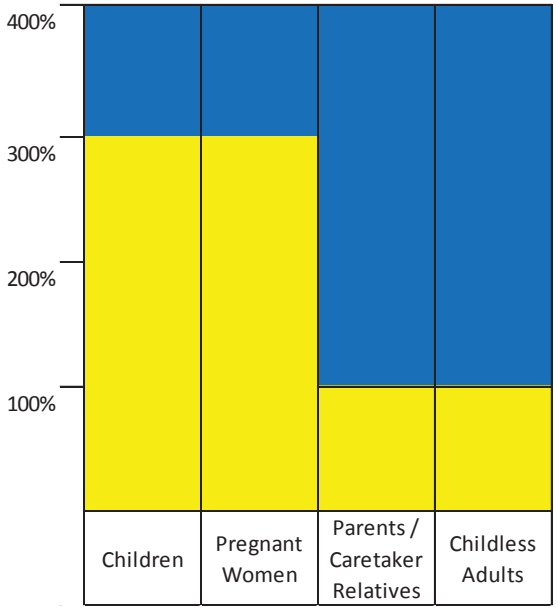
Qualified Health Plans in Marketplace

Eligible for Premium Tax Credits up to 400% FPL

Eligible for Reduced Cost Sharing up to 250% FPL

*This chart refers to new applicants only. Current BadgerCare Plus members will maintain eligibility in their current programs (Standard, Benchmark Core, Basic) through March 31, 2014, as long as they continue to meet current program rules.

April 1, 2014 BadgerCare Plus & Marketplace Enrollment and Benefits



Standard Plan

Qualified Health Plans in Marketplace

Eligible for Premium Tax Credits up to 400% FPL

Eligible for Reduced Cost Sharing up to 250% FPL

New BadgerCare Plus income limits and benefit apply to new applicants and existing members.

UPDATED IMPLEMENTATION DATES

Important Dates

- Week of December 23, 2013: Updated informational mailings regarding the delay of BadgerCare Plus policy changes were sent to the following populations:
  - **Letter 1A**: Sent to current BadgerCare Plus members that may need to purchase private health insurance through the Marketplace for coverage after March 31, 2014.
    - Non-Pregnant adults above 100% FPL
    - Children above 300% FPL
  - **Letter 3A**: Sent to individuals on the BadgerCare Plus Core Plan waitlist.
- Visit the following page for information on these letters: dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm.

Important Dates – Continued

- February 1, 2014
  - MAGI rules will be implemented for all new applicants.
  - New income limits will be implemented for new parents and caretaker relative applicants.
  - **Please Note:** Parents and caretakers with incomes from 100% to 200% FPL who are enrolled in BadgerCare Plus as of January 31, 2014 will remain eligible through March 31, 2014, as long as they continue to meet program rules.

Important Dates – Continued

- February 3, 2014:
  - Adults without dependent children can begin submitting new applications via ACCESS, over the phone, or in person at their local agency. **Please note that newly eligible adults without dependent children will begin coverage no earlier than April 1, 2014**.
  - Am I Eligible will be updated with MAGI rules.
    - Another tool you can use to determine if someone should apply through ACCESS or the Marketplace.
- February 17, 2014: Notices will begin to be mailed to members who have a change in eligibility or plan effective April 1 because of income limit and benefit plan changes.
- April 1, 2014: Newly eligible adults begin coverage.

ASSISTING BADGERCARE PLUS MEMBERS & APPLICANTS

Marketplace Applications: Assessment vs. Determination

- Wisconsin is a Determination State
  - Applications submitted to the Marketplace between October 1, 2013 and December 31, 2013.
  - Marketplace processes applications that WI residents submit and determine them eligible to be enrolled in BC+.
- Wisconsin is an Assessment State
  - Applications submitted to the Marketplace beginning January 1, 2014.
  - Marketplace transfers applications of WI residents who appear to be eligible for BC+ and Wisconsin IM workers process the application and determine BC+ eligibility.

See Handout for additional information

Account Transfers

- Account Transfers = method the Marketplace and Wisconsin will use to transfer cases back and forth.
- Currently, Wisconsin is working with CMS to validate small batches of test account transfer files to ensure the transfer process is working properly.
- Once account transfer process is up and running DHS will:
  - Enroll individuals who were determined eligible by the Marketplace December 31, 2013 and earlier, and
  - Process the applications received by the Marketplace beginning January 1, 2014.
  - Transfer BadgerCare Plus applications/cases processed using MAGI rules to the Marketplace when someone in the household is not able to enroll in BadgerCare Plus.

Incorrect Marketplace Determination

- Members can remove an application from their Marketplace account and submit a new one. If members have any questions, call the Marketplace at 1-800-318-2596.

Partners Assisting Clients - Reminders

- Community partners, health care providers, and other stakeholders are a vital component of Wisconsin's Medicaid enrollment strategy.
- It is important to remember that only Income Maintenance agencies can make eligibility determinations, which include calculating the correct household size and income.
- Community partners should encourage and assist all interested applicants in applying for health care coverage.

Assisting Current BadgerCare Plus Members

- If a current BadgerCare Plus household has not received Letter 1A and continues to meet BadgerCare Plus program rules including the new income limits, they will continue to be enrolled in BadgerCare Plus and do not need to re-apply.
- If a household has received Letter 1A, and/or is above the new BadgerCare Plus income limits, they should apply for and purchase private health insurance through the Marketplace.
  - The household can stay enrolled in BadgerCare Plus until March 31, 2014, as long as they continue to meet program rules and pay any premiums that may be due.
  - The household will receive a letter about its enrollment status in March.

Assisting Current BadgerCare Plus Members

- If a current BadgerCare Plus household who received Letter 1A wants to see if they can stay enrolled in BadgerCare Plus under the new MAGI rules they can fill out and return the Tax Filer Information Form (F-00914) which was included with Letter 1A .
  - As some types of income, like child support, will not be counted under the MAGI rules, members may want to fill out this form.

Assisting Current BadgerCare Plus Members

- Filling out the TFI Form is optional; however, it allows DHS to test members under new MAGI rules to see if application of MAGI rules results in continued eligibility for BadgerCare Plus after new income limits are applied for April 1, 2014.
- Members who received Letter 1A and a TFI form and choose to fill it out needed to return the TFI form by January 17, 2014.
- If a member did not fill out the form but wants to see if they may still be eligible under the new MAGI rules, they should contact their agency.

Protecting and promoting the health and safety of the people of Wisconsin

Assisting Newly Eligible BadgerCare Plus Applicants

- If someone has received Letter 3A or is currently uninsured AND is **at or below 100% FPL**, they should apply for BadgerCare Plus coverage either through the federal Marketplace or ACCESS.
  - Note that the ACCESS online application tool will begin accepting these applications on February 3, 2014.

Assisting Newly Eligible BadgerCare Plus Applicants

- If someone has received Letter 3A or is currently uninsured AND **is above 100% FPL**, they should purchase private health insurance through the federal Marketplace at healthcare.gov/.
  - Note that if applicants apply through ACCESS after February 3, 2014, and are determined to be above 100% FPL, DHS will transfer their information to the Marketplace.

Assisting Households with Children

- Households with uninsured children should apply immediately for BadgerCare Plus coverage.
- For BadgerCare Plus coverage prior to March 31, 2014:
  - Children under age 19 with household income at or below 200% FPL can enroll without a premium.
  - For households with income above 200% FPL, children under age 19 will have a monthly premium.

Assisting Households with Children

- For BadgerCare Plus April 1, 2014 and later:
  - Children under age 19 with household income at or below 200% FPL can enroll without a premium.
  - For households with income between 200% and 300% FPL, children under age 19 will have a monthly premium.
  - For households with income above 300% FPL, children under age 19 can enroll in BadgerCare Plus after meeting a deductible.
- Children in households with income above 300% FPL can also purchase health insurance through the Marketplace or the private market.

Application – Providing Complete Information

- It is important, but not required, that applicants have the name(s), date(s) of birth, and, where applicable, Social Security Number(s) for all individuals in the household.
- Having this information allows Income Maintenance Agencies to utilize data exchanges to verify some information provided on the application and reduce the amount of information or proof that the individuals is asked for on the verification checklist, if necessary.

IMPORTANT REMINDER!

- **Please note:** ONLY Income Maintenance workers can determine a member or applicant's eligibility for BadgerCare Plus. If in doubt, refer the member or applicant to their local agency to get further assistance.

MODIFIED ADJUSTED GROSS INCOME (MAGI)

What is “MAGI”?

- MAGI = Modified Adjusted Gross Income.
- Refers to new household composition and budgeting rules.
- Members and applicants will be asked some different questions about their tax status, tax dependents, and tax deductions.
- Introduced by ACA to align BadgerCare Plus eligibility rules with tax rule-based policy in the Marketplace.

BadgerCare Plus Income

Under MAGI, countable income = taxable income. This includes (but is not limited to):

- Taxable Earned Income,
- Taxable Net Self-Employment Income,
- Unemployment Compensation,
- Alimony/Spousal Maintenance, and
- Social Security Income.

BadgerCare Plus Income

Some common income types that will **NOT** be counted for BadgerCare Plus eligibility include:

- Child Support,
- Supplemental Security Income (SSI),
- Workers' Compensation, and
- Veterans Benefits.

New Types of Countable Income

- Financial aid, if used for living expenses.
- All Tribal per capita payments from gaming revenue.
- AmeriCorps income.
- Taxable retirement, pension and annuities.
- Interest & dividends.
- Lump sum income counted in month received.

Whose income is counted?

- In general, everyone in an assistance group will have their income counted.
- In some cases, children and tax dependents' income will not be counted, if their income is so low that they are not required to file taxes.

Tax Deductions

- Pre-tax deductions are allowed as deductions.
  - For example, contributions to health savings accounts.
- Tax deductions listed on page 1 of Tax Form 1040 are also allowed. Examples include:
  - Student loan interest paid,
  - Higher education expenses, and
  - Self-employment tax.
- Itemized deductions are not allowed.

Who is Subject to MAGI Rules?

- BadgerCare Plus Members:
  - Children,
  - Parents and caretaker relatives,
  - Pregnant women, and
  - Adults with no dependent children.
- Family Planning Only Services (FPOS) members will be subject to MAGI income rules, but always with a group size of one.

Who is Not Subject to MAGI Rules?

- MAGI rules do ***not*** apply to:
  - Elderly, blind and disabled groups
    - Elderly, Blind and Disabled (EBD) Medicaid
    - Long-Term Care (LTC) Waiver Enrollees
    - SeniorCare
    - QMB, SLMB, SLMB+
    - MAPP
    - Well Woman Medicaid
  - Categorically eligible populations
    - Former Foster Care Youth

Reminder – "Expect to…"

- For MAGI questions, ACCESS will ask about what individuals are planning to do for the current tax year in which they are applying, not the previous year.
- Example: If applying for benefits in March 2014, ACCESS will ask about the taxes that the individual ***expects to*** file in 2015 for income that he or she has in 2014.

Reminder – Documents

- Except for self-employed individuals, applicants will not be required to submit tax documents from previous years.
- However, some previously filed tax documents, such as a Form 1040, may be helpful in figuring out how individuals plan to file for the current year. They could help figure out:
  - Whether spouses file jointly or are married filing separately, and
  - Who and when they have claimed tax dependents in the past.
- Current pay stubs can also help someone find out what pre-tax deductions they have.
  - It will be helpful for the applicant to have their pay stubs available, if applicable, when they complete their application.

IMPORTANT REMINDER!

- **Please note:** ONLY Income Maintenance workers can determine a member or applicant's eligibility for BadgerCare Plus. If in doubt, refer the member or applicant to their local agency to get further assistance.

More Information on BadgerCare Plus Policy Changes

- For more information about the 2014 BadgerCare Plus policy changes, please visit http://www.dhs.wisconsin.gov/health-care/.
  - Previous web-based trainings, frequently asked question (FAQ) documents and other resources are available at this site.
- The BadgerCare Plus Eligibility Handbook has been updated with the 2014 policy changes, however, many changes will not take effect until April 1, 2014.
  - The BadgerCare Plus Eligibility Handbook is available at http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm.

Questions?

Don't forget, you can submit questions online at dhshealthcare@wisconsin.gov.*

*__Note__: Do not send personal health information or personally identifiable information to this email.

ForwardHealth
Wisconsin serving you

Update
August 2013

No. 2013-40

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Family Planning Only Services
To: All Providers, HMOs and Other Managed Care Programs

Policy Clarification for Services That Are Prescribed, Referred, or Ordered

Prior authorization requests received on and after July 15, 2013, and claims with dates of service on and after July 15, 2013, for services that are prescribed, referred, or ordered will be returned or denied, respectively, if they do not include the National Provider Identifier of the Medicaid-enrolled provider who prescribed, referred or ordered the service.

Prior authorization (PA) requests received on and after July 15, 2013, and claims with dates of service (DOS) on and after July 15, 2013, for services that are prescribed, referred, or ordered will be returned or denied, respectively, if they do not include the National Provider Identifier (NPI) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service.

This new requirement was first announced in the June 2013 *ForwardHealth Update* (2013-34), titled "New Requirements for Prescribing/Referring/Ordering Providers Due to the Affordable Care Act."

Previous ForwardHealth policy already required that most PA requests and claims for services prescribed, referred, or ordered include the name and NPI of the provider who prescribed, referred, or ordered the service; however, ForwardHealth is now taking the following additional steps to ensure compliance with the Affordable Care Act (ACA):

- Expanding the requirement to **all** PA requests and claims for services that are prescribed, referred, or ordered.
- Enhancing enforcement of the requirement in its claims processing.
- Ensuring that all prescribing/referring/ordering providers are Medicaid-enrolled.

Note: Providers should **not** include the NPI of a prescribing/referring/ordering provider on claims for services that are not prescribed, referred, or ordered, as those claims may be denied if the provider is not Medicaid-enrolled.

Impacted Programs

The following programs are impacted by information in this *Update*:

- BadgerCare Plus Standard Plan.
- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.
- Wisconsin Medicaid.
- SeniorCare.
- Family Planning Only Services.

Note: The Wisconsin Chronic Disease Program, the Wisconsin Well Woman Program, and the Wisconsin AIDS/HIV Drug Assistance Program are **not** impacted by information in this *Update*. Managed care organizations are **not** affected by information included in this *Update*.

When a Prescribing/Referring/Ordering Provider Is Required

Attachment 1 of this *Update* lists services for which the name and NPI of the prescribing/referring/ordering provider is required on the claim. For the following services, this represents a change in claim requirements:

- Child/Adolescent Day Treatment, HealthCheck "Other Services."
- Community Support Program services.
- Comprehensive Community Services.
- Personal Care services.

Providers may refer to the applicable service area of the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for updated claim instructions for these services.

Where to Indicate Prescribing/Referring/Ordering Provider Information on Claims

Where providers should indicate the name and NPI of a prescribing/referring/ordering provider on claims is dependent upon the claim type being submitted and the submission method (paper or electronic). Attachment 2 provides a table detailing the fields or elements to complete with this information for each claim type and submission method.

Who Can Be a Prescribing/Referring/Ordering Provider

Not all providers may be prescribing/referring/ordering providers. Providers may only prescribe, refer, or order services within their legal scope of practice. Prior authorization requests and claims for services that are prescribed, referred, or ordered will be reviewed to ensure that it is within the indicated provider's legal scope of practice to prescribe, refer, or order the service.

In addition, only individual providers may be prescribing/referring/ordering providers. Prior authorization requests or claims that have an organization or provider group indicated as the prescribing/referring/ordering provider may be returned or denied. For services prescribed, referred, or ordered by an intern or resident without his or her own NPI, the supervising physician should be indicated as the prescribing/referring/ordering provider on the PA request or claim.

Providers may refer to the applicable service area in the Online Handbook for provider types that are allowed to prescribe, refer, or order services.

Claims Denials

Claims Responses for Missing or Invalid Prescribing/Referring/Provider Information

Attachment 3 lists some of the possible explanation of benefits codes, Health Insurance Portability and Accountability Act codes, and National Council for Prescription Drug Programs Telecommunication Standard Format Version D.0 codes providers may see for missing or invalid prescribing/referring/ordering provider information on claims.

Contacting Non-Medicaid-Enrolled Prescribing/Referring/Ordering Provider After a Claims Denial

If a claim for services prescribed, referred, or ordered is denied because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and do the following:

- Communicate that the prescribing/referring/ordering provider is required to be Medicaid-enrolled.
- Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers.
- Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid.

Providers May Not Bill Members for Services

Providers are reminded that if a claim is denied because it does not include the name and NPI of the prescribing/referring/ordering provider, or the prescribing/referring/ordering provider is not Medicaid-enrolled, they may not bill the member for the service. (The prescribing/referring/ordering provider not being Medicaid-enrolled is *not* a condition that would qualify the service as a noncovered service.)

Medicaid Enrollment for Prescribing/Referring/Ordering Providers

As a reminder, all physicians and other professionals who prescribe, refer, or order services for ForwardHealth members on and after July 15, 2013, are required to be Medicaid-enrolled, either as a prescribing/referring/ordering provider or as a full Medicaid provider.

Medicaid enrollment specifically for prescribing/referring/ordering providers is available for physicians and other professionals who do not wish to be reimbursed for services provided to ForwardHealth members. The process for enrolling as a prescribing/referring/ordering provider is an abbreviated one, which offers the following benefits:

- Providers do not need to sign a provider agreement.
- There are fewer panels to complete during the enrollment process, as compared to a full enrollment.
- Providers only need to complete basic address information along with additional personal data information for persons with an ownership or controlling interest, managing employees, and agents.

Providers may apply for Medicaid enrollment as a prescribing/referring/ordering provider by completing the Medicaid Prescribing/Referring/Ordering Enrollment Application on the Portal.

Providers who wish to be reimbursed for services as a Medicaid provider are required to apply for full Medicaid enrollment by completing the Medicaid Provider Enrollment Application on the Portal.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS/HIV Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
When a Prescribing/Referring/Ordering Provider Must Be Indicated on a Claim

The table below lists services for which a prescribing/referring/ordering provider is required and must be indicated on the claim.

Services for Which a Prescribing/Referring/Ordering Provider Is Required and Must Be Indicated on the Claim
Ambulance*
Ambulatory Surgery Center
Child/Adolescent Day Treatment, HealthCheck "Other Services"**
Community Support Program**
Comprehensive Community Services**
Durable Medical Equipment
Disposable Medical Supplies
End-Stage Renal Disease
Enteral Nutrition Products
Family Planning Clinic
Hearing*
Home Health
Hospice
In-Home Mental Health, Substance Abuse Treatment Services for Children, HealthCheck "Other Services"
Laboratory/Pathology
Nurses in Independent Practice
Personal Care**
Pharmacy
Radiology
Specialized Medical Vehicle*
Therapies: Physical, Occupational, and Speech and Language Pathology*

* Some services in this category are *not* required to be prescribed, referred, or ordered in order to be reimbursed. Refer to the claim instructions for this service area of the Online Handbook for more information.

** The claim instructions for this service have been revised to reflect this change.

ATTACHMENT 2
Where to Indicate Prescribing/Referring/ Ordering Provider Information on Claims

The table below lists the elements or fields where providers should indicate prescribing/referring/ordering provider information on claims.

Claim Type	Fields or Elements Used to Indicate Prescribing/ Referring/Ordering Provider Name and/or National Provider Identifier	Description
Professional Claim		
Submitted on 1500 Health Insurance Claim Form	Element 17	Name of Referring Provider or Other Source
	Element 17b	NPI
Submitted via ASC X12 837 Health Care Claim: Professional	Loop 2310A NM1 segment Loop 2420F NM1 segment	Referring Provider Name
Submitted via Provider Electronic Solutions (PES) software — Professional Claim	Referring Provider Provider ID	
Submitted via Direct Data Entry (DDE) on the Portal	Referring Provider	
Institutional Claim		
Submitted on UB-04 (CMS 1450) Claim Form	Form Locators 78 and 79	Other Provider Names and Identifiers
Submitted via ASC X12 837 Health Care Claim: Institutional	Loop 2310F NM1 segment Loop 2420D NM1 segment	Referring Provider
Submitted via PES software — Institutional Outpatient Claim	Referring Provider Provider ID	
Submitted via DDE on the Portal	Referring Provider	
Compound Drug Claim		
Submitted on the Compound Drug Claim form, F-13073	Element 9	Prescriber Number
Submitted via National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Format Version D.0	Field #411-DB	Prescriber ID
Submitted via PES software — Pharmacy Claim	Prescriber Number	NPI of the prescriber
Submitted via DDE on the Portal	Prescriber ID	

Claim Type	Fields or Elements Used to Indicate Prescribing/ Referring/Ordering Provider Name and/or National Provider Identifier	Description
Noncompound Drug Claim		
Submitted on Noncompound Drug Claim form, F-13072	Element 9	Prescriber Number
Submitted via NCPDP Telecommunication Standard Format Version D.0	Field #411-DB	Prescriber ID
Submitted via PES software — Pharmacy Claim	Prescriber Number	NPI of the prescriber
Submitted via DDE on the Portal	Prescriber ID	

ATTACHMENT 3
Claims Responses for Missing or Invalid Prescribing/Referring/Ordering Provider Information

The table below lists some of the possible explanation of benefits (EOB) codes, Health Insurance Portability and Accountability Act (HIPAA) codes, and National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Format Version D.0 codes providers may see for missing or invalid prescribing/referring/ordering provider information on claims.

EOB Code	HIPAA Claim Status Code	HIPAA Claim Adjustment Reason Code	HIPAA Remittance Advice Remark Code	NCPDP D.0 Reject Reason Code
0030 — Prescribing/ referring/ ordering provider is not currently enrolled.	109 — Entity not eligible.	183 — The referring provider is not eligible to refer the service billed.	N286 — Missing/ incomplete/invalid referring provider primary identifier.	71 — Prescriber Is Not Covered.
0091 — A valid Referring/ Ordering/ Prescribing Provider NPI is required.	48 — Referral/ authorization.	207 — National Provider Identifier — Invalid format	N265 — Missing/ incomplete/invalid ordering provider primary identifier.	71 — Prescriber Is Not Covered.
1202 — Prescribing ID is required.	21 — Missing or invalid information.	16 — Claim/service lacks information which is needed for adjudication.	N31 — Missing/ incomplete/invalid prescribing provider identifier.	71 — Prescriber Is Not Covered.
1285 — The Prescribing ID is invalid.	91 — Entity not eligible/not approved for dates of service.	B7 — This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N31 — Missing/ incomplete/invalid prescribing provider identifier.	71 — Prescriber Is Not Covered.

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Update
September 2013

No. 2013-43

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: In-State Emergency Providers, Out-of-State Providers, HMOs and Other Managed Care Programs

New Requirements for In-State Emergency Providers and Out-of-State Providers Due to the Affordable Care Act

This *ForwardHealth Update* provides information about new requirements for in-state emergency providers and out-of-state providers due to the Affordable Care Act.

This *ForwardHealth Update* provides information about new requirements for in-state emergency providers and out-of-state providers due to the Affordable Care Act (ACA), which was signed into law in 2010. The ACA, also known as federal health care reform, is extensive legislation that affects several aspects of Wisconsin health care. ForwardHealth has been working toward ACA compliance by implementing new provider requirements and provider screening processes.

As a reminder, out-of-state providers are only reimbursed for services that are provided in an emergency or for which they have obtained prior authorization (PA) from ForwardHealth.

Information in this *Update* applies to the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, the BadgerCare Plus Basic Plan, Wisconsin Medicaid, and SeniorCare. Managed care organizations are **not** affected by information included in this *Update*.

ForwardHealth has published an *Update* that specifically addresses requirements for dentists who provide only urgent or emergency services to BadgerCare Plus or Medicaid members. For more information, refer to the June 2013 *Update* (2013-36), titled "New Requirements for Dentists Who Provide Only Urgent or Emergency Services to BadgerCare Plus or Medicaid Members."

In-State Emergency Providers and Out-of-State Providers Will Be Required to Be Medicaid-Enrolled

ForwardHealth will require all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members on and after August 9, 2013, to be enrolled in Wisconsin Medicaid.

In-State Emergency Provider Data Sheet and Out-of-State Provider Data Sheet Will Be Obsolete

Effective for dates of service (DOS) on and after August 9, 2013, in-state emergency providers and out-of-state providers will no longer need to submit the In-State Emergency Provider Date Sheet, F-11002 (07/12), or the Out-of-State Provider Data Sheet, F-11001 (07/12),with claims for services provided to BadgerCare Plus, Medicaid, or SeniorCare members. The forms will become obsolete effective August 9, 2013, and will be removed from the Forms page of the ForwardHealth Portal.

Providers Who Only Prescribe, Refer, or Order Services

In-state emergency providers or out-of-state providers who only prescribe, refer, or order services must enroll as prescribing/referring/ordering providers using the new abbreviated enrollment process for prescribing/referring/ordering providers on the ForwardHealth Portal at *www.forwardhealth.wi.gov*/. For more information about the new requirements for prescribing/referring/ordering providers, refer to the June 2013 *Update* (2013-34), titled "New Requirements for Prescribing/Referring/Ordering Providers Due to the Affordable Care Act."

Medicaid Enrollment Process for In-State Emergency Providers and Out-of-State Providers

Providers may apply for Medicaid enrollment as an in-state emergency provider or an out-of-state provider on the Portal.

To access the in-state emergency provider enrollment application or the out-of-state provider enrollment application on the Portal, providers should follow these steps:

1. Access the Portal at *www.forwardhealth.wi.gov*/.
2. Select the Become a Provider link on the left side of the Portal home page. The Provider Enrollment Information home page will be displayed.
3. Select the Start or Continue Your Enrollment Application link at the top of the Provider Enrollment Information home page.
4. Select the Medicaid In-State Emergency/Out-of-State Provider Enrollment Application link.

Completing and Submitting Enrollment Application

After providers have accessed the appropriate enrollment application on the Portal, they will be guided through a series of screens on which they will be asked to complete or verify specific information based on their provider type. Providers may call Provider Services at (800) 947-9627 if they have questions or need assistance while completing the enrollment application.

At the end of the enrollment application, providers will be required to do the following:

1. Upload any additional supporting documents (e.g., licenses or certifications).
2. Select the Submit link to submit the enrollment application.
3. Print the enrollment documents for their records.

Tracking Enrollment Through the Portal

Upon submission of their enrollment application, providers will receive an application tracking number (ATN), which will allow them to track their enrollment application through the Portal. To check on the status of their enrollment application, providers should follow these steps:

1. Access the Portal home page.
2. Select the Enrollment Tracking Search quick link.
3. Enter the ATN.

Providers will receive current information on their application, such as whether it is being processed or has been returned for more information.

Effective Date of Enrollment

The effective date of enrollment as an in-state emergency provider or an out-of-state provider will be the date the provider rendered the service to the BadgerCare Plus, Medicaid, or SeniorCare member. In-state emergency providers will only be Medicaid-enrolled for that DOS. Each time a provider renders emergency services to a BadgerCare Plus, Medicaid, or SeniorCare member, the provider will be required to re-enroll as an in-state emergency provider for that date in order to be reimbursed. Out-of-state providers will continue to be Medicaid-enrolled until it is time to revalidate their enrollment.

Out-of-State Providers Required to Revalidate Their Enrollment

Out-of-state providers will be required to revalidate their Medicaid enrollment every three years. Out-of-state

providers will receive a Provider Revalidation Notice in the mail from ForwardHealth when it is time to undergo revalidation. For more information on the revalidation process, providers may access the Medicaid Provider Revalidation page on the Portal by selecting the Provider Revalidation link on the left side of the Portal home page.

Medicaid-Enrolled Providers May Not Charge Members as Private-Pay Patients

Providers are reminded that while they are enrolled in Wisconsin Medicaid, they may not charge any BadgerCare Plus, Medicaid, or SeniorCare members directly for services that are covered by the Medicaid program.

Additional Enrollment Requirements Due to the Affordable Care Act

During the enrollment process, providers will be subject to additional enrollment requirements due to the ACA including the following:

- Reporting of personal data information for persons with an ownership or controlling interest, managing employees, and agents.
- Screening activities based on their risk level assignment.
- Application fees, if applicable.

For more information on additional enrollment requirements due to the ACA, refer to the Provider Enrollment Information home page by selecting the Become a Provider link from the Portal home page.

National Provider Identifier of Medicaid-Enrolled Provider Required on Prior Authorization Requests and Claims

Prior Authorization Requests for Non-Emergency Services Rendered by Out-of-State Providers

Prior authorization requests received on and after August 9, 2013, for non-emergency services rendered by out-of-state providers to BadgerCare Plus, Medicaid, or SeniorCare members must include the National Provider Identifier (NPI) of the Medicaid-enrolled out-of-state provider who rendered the service. Prior authorization requests that do not include the NPI of a Medicaid-enrolled provider will be returned.

Note: Emergency services do not require PA.

Claims for Services Rendered by In-State Emergency Providers or Out-of-State Providers

Claims with DOS on and after August 9, 2013, for services rendered by in-state emergency providers or out-of-state providers to BadgerCare Plus, Medicaid, or SeniorCare members must include the NPI of the Medicaid-enrolled provider who rendered the service. Claims that do not include the NPI of a Medicaid-enrolled provider will be denied.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS/HIV Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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Update
September 2013

No. 2013-44

Affected Programs: BadgerCare Plus, Medicaid
To: Nurse Midwives, Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

Policy Clarifications for the Affordable Care Act Primary Care Rate Increase Provider Attestation

This *ForwardHealth Update* clarifies current policy for the Affordable Care Act primary care rate increase provider attestation.

This *ForwardHealth Update* clarifies policy for the Affordable Care Act (ACA) primary care rate increase provider attestation originally published in the April 2013 *Update* (2013-25), titled "Affordable Care Act Primary Care Rate Increase Portal Attestation," and is intended to encourage providers to submit attestations prior to December 31, 2013, to receive the rate increase for 2013 services.

Providers are reminded that if they do not submit this attestation by December 31, 2013, they will not receive the rate increase for 2013 services.

Clarifications to Physician Eligibility for Primary Care Rate Increase

Physicians eligible for the rate increase are those who primarily practice as primary care providers and are either:

- Certified with an eligible specialty or subspecialty by one of the certifying boards named in the Centers for Medicare and Medicaid Services (CMS) Final Rule (CMS-2370-F) listed in the Attachment of this *Update*, or
- A physician who submits claims with at least 60 percent of procedure codes coming from the code group identified by the rule.

Clarifications to Eligibility for Advanced Practice Providers (Physician Assistants, Nurse Practitioners, Nurse Midwives)

Advanced practice providers (APPs) who are physician assistants, nurse practitioners, or nurse midwives are also eligible for the primary care rate increase if they are supervised by an eligible physician.

In implementing the ACA primary care rate increase rule, ForwardHealth expects that all APPs attesting for this increase follow the guidelines for supervisory protocol outlined by the Department of Safety and Professional Services (DSPS). The DSPS explanation of supervisory protocol for nurses may be found in the Board of Nursing section, s. N 6.03(2), Wis. Admin. Code. Protocol for physician assistant supervision is contained in the Medical Examining Board section, s. Med 8, Wis. Admin. Code.

Additionally, for purposes of APP eligibility for the primary care rate increase, the final federal rule requires that each APP is supervised by a physician who accepts professional responsibility for the services that the APP provides. APPs fulfilling each of these requirements and who function as primary care providers, as described in *Update* 2013-25, will be eligible for the rate increase.

Reimbursement Schedules

Providers who attest by October 31, 2013, can expect to have claim adjustments and reimbursements initiated by December 31, 2013.

Providers who attest on and after October 31, 2013, and before December 31, 2013, are still able to attest as eligible backdated to January 1, 2013. These providers can expect to have claim adjustments and reimbursements initiated on and after December 31, 2013.

Providers who attest on and after December 31, 2013, are only eligible for the rate increase beginning on the date of attestation forward. These providers should expect to have claims initiated in real time; each claim will be processed upon receipt by ForwardHealth.

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For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ATTACHMENT
Specialties and Subspecialties Eligible for the Affordable Care Act Primary Care Rate Increase as Defined by the Three Certifying Boards

American Board of Medical Specialties (ABMS)	
Specialties	**Subspecialties**
Family Medicine	Adolescent Medicine Geriatric Medicine Hospice and Palliative Medicine Sleep Medicine Sports Medicine
Internal Medicine	Adolescent Medicine Adult Congenital Heart Disease Advanced Heart Failure and Transplant Cardiology Cardiovascular Disease Clinical Cardiac Electrophysiology Critical Care Medicine Endocrinology, Diabetes, and Metabolism Gastroenterology Geriatric Medicine Hematology Hospice and Palliative Medicine Infectious Disease Interventional Cardiology Medical Oncology Nephrology Pulmonary Disease Rheumatology Sleep Medicine Sports Medicine Transplant Hepatology
Pediatrics	Adolescent Medicine Child Abuse Pediatrics Developmental-Behavioral Pediatrics Hospice and Palliative Medicine Medical Toxicology Neonatal-Perinatal Medicine

Pediatrics (Continued)	Neurodevelopmental Disabilities Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Emergency Medicine Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Pulmonology Pediatric Rheumatology Pediatric Transplant Hepatology Sleep Medicine Sports Medicine
American Board of Physician Specialties (ABPS)	
Specialties	**Subspecialties**
Family Medicine Obstetrics	N/A
Internal Medicine	N/A
Family Practice	N/A
American Osteopathic Academy (AOA)	
Specialties	**Subspecialties**
Family Physicians	Addiction Medicine Adolescent and Young Adult Medicine Geriatric Medicine Sports Medicine Undersea and Hyperbaric Medicine Hospice and Palliative Medicine Sleep Medicine
Internal Medicine	Allergy/Immunology Cardiology Endocrinology Gastroenterology Hematology Hematology/Oncology Infectious Disease Pulmonary Diseases Nephrology Oncology Rheumatology Addiction Medicine Critical Care Medicine

Internal Medicine (Continued)	Clinical Cardiac Electrophysiology Interventional Cardiology Geriatric Medicine Sports Medicine Undersea and Hyperbaric Medicine Hospice and Palliative Medicine Sleep Medicine
Pediatrics	Adolescent and Young Adult Medicine Neonatology Pediatric Allergy/Immunology Pediatric Endocrinology Pediatric Pulmonology Sports Medicine

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Update
October 2013

No. 2013-54

Affected Programs: BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, Medicaid
To: Nurse Midwives, Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

Reimbursement for Services Provided Under the Affordable Care Act Primary Care Rate Increase

This *ForwardHealth Update* outlines when and how eligible providers will receive reimbursement for the primary care rate increase for eligible services provided to eligible members under the Affordable Care Act.

As announced in the April 2013 *ForwardHealth Update* (2013-25), titled "Affordable Care Act Primary Care Rate Increase Portal Attestation," effective for dates of service (DOS) from January 1, 2013, through December 31, 2014, certain providers who are identified as primary care practitioners may be eligible to receive a temporary rate increase for specified evaluation and management (E&M) services and vaccine administration services. This increase is provided for in 42 CFR 447.400(a), as instituted by the Affordable Care Act (ACA), and applies to services provided to members enrolled in fee-for-service and members enrolled in a state-contracted HMO.

This *Update* outlines when and how eligible providers will receive reimbursement for the primary care rate increase for eligible services provided to eligible members under the ACA.

Eligibility Reminders

As a reminder, services that are eligible for the ACA Primary Care Rate Increase are those that meet **all** of the following criteria:

- Are E&M services (procedure codes 99201-99499) or vaccine services. (Refer to the Billing for Vaccine Administration Services section of this *Update* for clarification on rate increase eligibility for vaccines and appropriate billing.)
- Are provided to a BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or Medicaid member.
- Are rendered by an attested physician or advanced practice provider. (For information on provider eligibility and attestation, refer to the Affordable Care Act Primary Care Rate Increase topic [topic #15337] in the Amounts chapter of the Reimbursement section of the Physician service area of the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.)
- Have a DOS from January 1, 2013, through December 31, 2014.

Providers are reminded that in order to be eligible for reimbursement at the increased rate for services dating back to January 1, 2013, they are required to complete the Portal attestation by December 31, 2013. Providers who attest on or after January 1, 2014, will only be eligible for the rate increase beginning on the date of attestation going forward.

Providers who have received a letter confirming their attestation status do *not* need to take any further steps to receive the rate increase.

Note: Services eligible for the rate increase are submitted on a professional claim. Standard timely filing rules apply (refer

to the Exceptions to the Submission Deadline topic [topic #548] in the Requirements chapter and the Requirements topic [topic #549] in the Timely Filing Appeals Requests chapter of the Claims section of the applicable service area of the Online Handbook). The ACA Primary Care Rate Increase will also be applied to eligible services submitted on crossover claims. For all claims, providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure, which includes the ACA Primary Care Rate Increase for eligible claims.

Billing for Vaccine Administration Services

The vaccine administration procedure codes identified in 42 CFR 447.400(a) continue to be noncovered by Wisconsin Medicaid because reimbursement for both the vaccine (when appropriate) and the administration are included in the reimbursement for the vaccine procedure code. However, eligible providers will receive the increased reimbursement for vaccine administration services. Providers should continue to follow current Medicaid billing rules for vaccines and indicate the procedure code of the actual vaccine administered, not the administration code, on claims. Providers are required to indicate their usual and customary charge for the service with the procedure code.

New Explanation of Benefits Codes

Providers may receive one of the following new explanation of benefits (EOB) codes related to the ACA Primary Care Rate Increase on their Remittance Advices (RAs).

Explanation of Benefits	
Code	**Description**
3024	Service met requirements for the ACA Primary Care Rate Increase.
3025	Service met requirements for the ACA Primary Care Rate Increase. However, this service qualifies for an enhanced Medicaid reimbursement rate, which is higher than the ACA Primary Care Rate Increase, so the enhanced Medicaid rate was applied.

Rate Increase Applied to Fee-for-Service Claims

Reimbursement for Claims Received On and After October 13, 2013

Effective for claims received on and after October 13, 2013, ForwardHealth will begin applying the ACA Primary Care Rate Increase to fee-for-service claims.

Adjustments to Eligible Claims Received Prior to October 13, 2013

In mid-November, ForwardHealth will begin automatically adjusting fee-for-service claims and applying the increased rate for eligible services with DOS on and after January 1, 2013 (and submitted on claims received prior to October 13, 2013). Adjustments will be reflected as such on provider RAs.

Note: Due to the volume of adjustments necessitated by the rate increase, providers may not receive all reimbursements in one lump sum. ForwardHealth will be processing adjustments in batches, so providers may receive their reimbursements on more than one check date.

Rate Increase Applied to Claims for Services Provided to Members Enrolled in State-Contracted HMOs

For eligible services provided to members enrolled in a state-contracted HMO, providers should continue to submit claims for the services to the member's HMO. The HMO will first reimburse at the normal rate for the service, per existing reimbursement policy. The HMO will then send claim information to ForwardHealth for ForwardHealth to determine the appropriate additional payment due to the rate increase. Beginning in November 2013, ForwardHealth will provide monthly reports to HMOs listing attested providers and the additional amounts to be paid to those providers for the preceding month due to the rate increase. Beginning in December 2013, the HMO will send this additional payment monthly to eligible providers.

Claims previously submitted to HMOs with DOS on and after January 1, 2013, will be adjusted in batches at the same time as fee-for-service claims. Reimbursements for the adjusted amounts will also be given to the HMOs in the same monthly reimbursement report and passed through the HMOs for return to providers.

If providers who are contracted with an HMO have questions or concerns regarding their reimbursements, they should contact the HMO directly and/or follow the HMO's standard grievance procedures.

Rates Will Be Updated in 2014

Rates for the ACA Primary Care Rate Increase will be updated in 2014 when Medicare adjusts its annual fee schedule.

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Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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Update
October 2013

No. 2013-55

Affected Programs: BadgerCare Plus, Medicaid
To: Hospice Providers, HMOs and Other Managed Care Programs

Hospice Reimbursement Rate Changes

Effective for dates of service on and after October 1, 2013, Wisconsin Medicaid and BadgerCare Plus hospice service reimbursement rates have changed.

Beginning in federal fiscal year 2014, hospice providers are required to report required quality data to the Centers for Medicare and Medicaid Services (CMS) per sections 3004 and 3132(a) of the Patient Protection and Affordable Care Act. Since Wisconsin Medicaid and BadgerCare Plus hospice reimbursement rates are based on hourly and per diem rates established by CMS for all covered hospice services, the amount hospice providers are reimbursed for covered hospice services is directly affected by their compliance with the new reporting requirements.

Attachment 1 of this *ForwardHealth Update* includes the new hospice rates that are effective for dates of service (DOS) on and after October 1, 2013, for hospice providers who have reported required quality data to CMS. Attachment 2 includes the new hospice rates that are effective for DOS on and after October 1, 2013, for hospice providers who have *not* reported required quality data to CMS.

The CMS has communicated to ForwardHealth which hospice providers reported required quality data, and ForwardHealth will use that information to determine which Wisconsin Medicaid and BadgerCare Plus hospice reimbursement rates to apply.

Nursing home room and board rates are not impacted by these hospice reimbursement rate changes.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

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ATTACHMENT 1
Wisconsin Medicaid and BadgerCare Plus Hospice Reimbursement Rates for Hospice Providers Who Have Submitted the Required Quality Data

Effective for dates of service on and after October 1, 2013.

County	Revenue Code			
	0651 (Daily) Routine Home	0652 (Hourly) Continuous Home	0655 (Daily) Inpatient Respite	0656 (Daily) General Inpatient
Brown	$155.98	$37.90	$169.68	$693.03
Calumet	$150.24	$36.50	$164.76	$669.26
Chippewa	$155.01	$37.66	$168.85	$689.04
Columbia	$172.06	$41.80	$183.46	$759.60
Dane	$172.06	$41.80	$183.46	$759.60
Douglas	$166.34	$40.41	$178.56	$735.91
Eau Claire	$155.01	$37.66	$168.85	$689.04
Fond du Lac	$149.03	$36.21	$163.73	$664.29
Iowa	$172.06	$41.80	$183.46	$759.60
Kenosha	$164.34	$39.93	$176.85	$727.65
Kewaunee	$155.98	$37.90	$169.68	$693.03
La Crosse	$159.01	$38.63	$172.27	$705.57
Marathon	$146.45	$35.58	$161.51	$653.58
Milwaukee	$157.48	$38.26	$170.97	$699.26
Oconto	$155.98	$37.90	$169.68	$693.03
Outagamie	$150.24	$36.50	$164.76	$669.26
Ozaukee	$157.48	$38.26	$170.97	$699.26
Pierce	$172.85	$41.99	$184.13	$762.84
Racine	$149.03	$36.21	$163.73	$664.29
Rock	$152.32	$37.01	$166.54	$677.88
Sheboygan	$152.94	$37.16	$167.08	$680.46
St. Croix	$172.85	$41.99	$184.13	$762.84
Washington	$157.48	$38.26	$170.97	$699.26
Waukesha	$157.48	$38.26	$170.97	$699.26
Winnebago	$152.04	$36.94	$166.31	$676.73
Rural WI*	$148.86	$36.17	$163.58	$663.57

* All counties in Wisconsin not otherwise listed.

ATTACHMENT 2
Wisconsin Medicaid and BadgerCare Plus Hospice Reimbursement Rates for Hospice Providers Who Have *Not* Submitted the Required Quality Data

Effective for dates of service on and after October 1, 2013.

County	Revenue Code			
	0651 (Daily) Routine Home	0652 (Hourly) Continuous Home	0655 (Daily) Inpatient Respite	0656 (Daily) General Inpatient
Brown	$152.92	$37.15	$166.34	$679.41
Calumet	$147.28	$35.78	$161.51	$656.10
Chippewa	$151.97	$36.92	$165.52	$675.49
Columbia	$168.68	$40.98	$179.84	$744.66
Dane	$168.68	$40.98	$179.84	$744.66
Douglas	$163.07	$39.62	$175.04	$721.44
Eau Claire	$151.97	$36.92	$165.52	$675.49
Fond du Lac	$146.11	$35.50	$160.50	$651.22
Iowa	$168.68	$40.98	$179.84	$744.66
Kenosha	$161.12	$39.14	$173.36	$713.34
Kewaunee	$152.92	$37.15	$166.34	$679.41
La Crosse	$155.88	$37.87	$168.88	$691.69
Marathon	$143.57	$34.88	$158.33	$640.73
Milwaukee	$154.39	$37.51	$167.60	$685.51
Oconto	$152.92	$37.15	$166.34	$679.41
Outagamie	$147.28	$35.78	$161.51	$656.10
Ozaukee	$154.39	$37.51	$167.60	$685.51
Pierce	$169.45	$41.17	$180.50	$747.84
Racine	$146.11	$35.50	$160.50	$651.22
Rock	$149.33	$36.28	$163.26	$664.55
Sheboygan	$149.94	$36.43	$163.78	$667.08
St. Croix	$169.45	$41.17	$180.50	$747.84
Washington	$154.39	$37.51	$167.60	$685.51
Waukesha	$154.39	$37.51	$167.60	$685.51
Winnebago	$149.05	$36.21	$163.03	$663.42
Rural WI*	$145.94	$35.46	$160.36	$650.53

* All counties in Wisconsin not otherwise listed.

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Update
December 2013

No. 2013-66

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin AIDS Drug Assistance Program, Wisconsin Chronic Disease Program, Wisconsin Well Woman Program
To: All Providers, HMOs and Other Managed Care Programs

Medicaid-Enrolled Providers Are Required to Change Demographic Information Through the ForwardHealth Portal

On November 11, 2013, ForwardHealth updated the demographic maintenance tool on the ForwardHealth Portal to include new fields and panels that capture all of the information from the Provider Change of Address or Status form, F-01181 (10/12). On and after December 6, 2013, Medicaid-enrolled providers are required to change their demographic information using the demographic maintenance tool. The Provider Change of Address or Status form is being discontinued effective December 6, 2013. Provider Change of Address or Status forms received on and after December 6, 2013, will be returned to providers.

Demographic Information Must Be Changed Through the Demographic Maintenance Tool

ForwardHealth has enhanced the process by which providers notify ForwardHealth of changes to their demographic information as a result of the Patient Protection and Affordable Care Act and in an effort to streamline the process. On November 11, 2013, ForwardHealth updated the demographic maintenance tool on the ForwardHealth Portal to include new fields and panels that capture all of the information from the Provider Change of Address or Status form, F-01181 (10/12), in order to make the process paperless. Providers can now change all of their demographic information using the demographic maintenance tool.

On and after December 6, 2013, Medicaid-enrolled providers are required to change their demographic information using the demographic maintenance tool. The Provider Change of Address or Status form is being discontinued effective December 6, 2013, and will no longer be available on the Forms page of the Portal. Provider Change of Address or Status forms received on and after December 6, 2013, will be returned to providers.

The demographic maintenance tool allows providers to securely, efficiently, and conveniently update their information. In most cases, once information is submitted through the demographic maintenance tool, providers' files will be immediately updated. If providers' files are immediately updated, providers will receive a confirmation message above the panel from which they submitted their information indicating that their information was updated successfully. In some cases ForwardHealth may need to manually verify information, which may take additional processing time and will result in a Change Notification letter being sent to providers.

Providers may access the demographic maintenance tool by clicking the Demographic Maintenance link located in the Home Page box on the right side of their secure Provider home page. The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role.

For information about assigning roles, providers should refer to the Account User Guide, which is located on the Portal User Guides page of the Portal at *www.forwardhealth.wi.gov/WIPortal/content/Provider/userguides/userguides.htm.spage*.

Providers should refer to the Demographic Maintenance Tool User Guide for detailed information about using the demographic maintenance tool.

Changes That Require ForwardHealth to Be Notified

Providers are reminded that they are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, prior authorization (PA), and/or financial.
  Note: Changes to the practice location address on file with ForwardHealth may alter providers' ZIP+4 code information that is required on transactions.
- Business name.
- Contact name.
- Federal Tax ID number (Internal Revenue Service number).
- Group affiliation.
- Licensure.
- National Provider Identifier.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.
- Taxonomy code.
- Telephone number, including area code.

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address.

Entering new information on a claim form or PA request is *not* adequate notification.

Manual Verification

In some cases, ForwardHealth may need to manually verify changes before providers' files can be updated. If ForwardHealth needs to manually verify changes, providers will receive a confirmation message upon submission indicating that their information was uploaded successfully. An Application Submitted panel will display recommending that providers print a copy of the changes for their records and indicate that ForwardHealth may contact them if additional information is required. Once ForwardHealth verifies the changes and updates providers' files, ForwardHealth will mail providers a Change Notification letter. Providers should review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers may correct the information using the demographic maintenance tool. Providers may contact Provider Services at (800) 947-9627 if they have questions regarding the letter.

Providers Enrolled in Other Programs

ForwardHealth strongly encourages providers enrolled in the Wisconsin AIDS Drug Assistance Program (ADAP), Wisconsin Chronic Disease Program (WCDP), or the Wisconsin Well Woman Program (WWWP) to update their demographic information using the demographic maintenance tool since providers' files are immediately updated in most cases. If providers enrolled in ADAP, WCDP, or WWWP are unable to update their information online, they can complete and mail the Provider File Update Request form, F-00916 (12/13), which is available on the Forms page of the Portal, to ForwardHealth. Alternate versions of this form will not be accepted and will be returned to providers.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (e.g., Wisconsin Medicaid and WCDP) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program may change their information for each program using the demographic maintenance tool. For information about switching organizations, providers should refer to the Account User Guide.

Reminder for Providers Licensed or Certified by the Division of Quality Assurance

As a reminder, providers licensed or certified by the Division of Quality Assurance (DQA) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481. Since the DQA will inform ForwardHealth of the changes, providers do not need to also notify ForwardHealth.

Information Regarding Managed Care Organizations

This *ForwardHealth Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

Members enrolled only in WCDP are not enrolled in MCOs.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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The information from this *Update* has been incorporated into the Online Handbook.

ForwardHealth
Wisconsin serving you

Update
December 2013

No. 2013-70

Affected Programs: BadgerCare Plus, Medicaid
To: All Providers, HMOs and Other Managed Care Programs

Copayment No Longer Required for Specified Preventive Services and Adult Vaccines

Effective for dates of service on and after January 1, 2014, Wisconsin Medicaid and BadgerCare Plus will no longer require copayments for certain preventive services and adult vaccines for members who are now required to make such payments. These new copayment requirements are part of ForwardHealth's ongoing implementation of the Affordable Care Act.

No Copayment for Certain Preventive Services and Adult Vaccines

To align its copayment requirements with those of the Affordable Care Act, ForwardHealth will no longer require copayments for certain preventive services and adult vaccines for members who are required to make copayments. This policy applies to members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and Wisconsin Medicaid.

Effective for dates of service (DOS) on and after January 1, 2014, providers should no longer request copayment for the following:

- Preventive services that have a rating of A or B from the U.S. Preventive Services Task Force (USPSTF).
- Approved vaccines recommended for adults by the Advisory Committee on Immunization Practices (ACIP).

The USPSTF recommendations include screening tests, counseling, immunizations, and preventive medications for targeted populations. These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice. The list of USPSTF recommendations includes, but is not limited to, the following:

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked.
- Aspirin use to prevent cardiovascular disease for men and women of certain ages.
- Folic acid supplementation for pregnant women.
- Bone density screening for osteoporosis in women with certain risk factors.
- Cervical cancer screening.
- Colorectal cancer screening for adults over 50.
- Diabetes screening in certain asymptomatic adults.
- Depression screening.
- High blood pressure screening for adults.
- Iron supplementation for certain children.
- Screening mammography for women.
- Cholesterol screening for adults of certain ages or who are at higher risk.
- Sexually transmitted disease screening and counseling.

BadgerCare Plus and Wisconsin Medicaid are not publishing the specific preventive services since the services change periodically. To view the current listing of USPSTF and ACIP recommendations, refer to the USPSTF Web site at *www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm* and the ACIP Web site at *www.cdc.gov/vaccines/acip/index.html* .

Modifier Required for Certain Preventive Services

Effective for DOS on and after January 1, 2014, Wisconsin Medicaid and BadgerCare Plus will stop deducting copayment for services that are identified as USPSTF and ACIP requirements. Since many of the USPSTF recommendations are provided as part of the regular preventive medicine visit, ForwardHealth will no longer deduct a copayment for these services (CPT procedure codes 99385-99387 and 99395-99397). ForwardHealth will also not deduct copayment for the ACIP recommended vaccines. Preventive medicine services for children under 18 years old are already exempt from copayment. For USPSTF services that are not specifically identified as preventive, providers will need to add *Current Procedural Terminology* (CPT) modifier 33 on claims. In many cases, modifier 33 will be needed to indicate that the service provided was preventive in nature. The definition for modifier 33 reads as follows:

> When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Copayment for Other Services Unchanged

Copayment for other services requiring copayment will remain unchanged. Providers shall collect the allowable copayment, unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected. Providers may not deny services to a Standard Plan or Medicaid member who fails to make a copayment.

Copayment Exemptions for Medicaid and BadgerCare Plus Standard Plan

As a reminder, following current policy, providers are prohibited from collecting any copayments from the following Standard Plan and Medicaid members:

- Children in a mandatory coverage category. In Wisconsin, this includes:
  - ✓ Children in foster care, regardless of age.
  - ✓ Children in adoption assistance, regardless of age.
  - ✓ Children under age 1 year with household income up to 150 percent of the Federal Poverty Level (FPL).
  - ✓ Children ages 1 through 5 years with household income up to 185 percent of the FPL.
  - ✓ Children ages 6 through 18 years with household incomes at or below 133 percent of the FPL.
- Children in the Katie Beckett program, regardless of age.
- Children who are American Indian or Alaskan Natives who are enrolled in the state's Child Health Insurance Programs (CHIP).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.
- Members enrolled in Wisconsin Well Woman Medicaid.
- Children under age 19 eligible through Express Enrollment.

As a reminder, the following services do not require copayments from any member enrolled in BadgerCare Plus or Wisconsin Medicaid:

- Care coordination services (prenatal and child care coordination).
- Community recovery services.
- Community support program services.
- Comprehensive community services.
- Crisis intervention services.
- Emergency services.

- Family planning services and supplies, including sterilizations.
- HealthCheck.
- Home care services (home health, personal care, and private duty nursing services).
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- Pregnancy-related services.
- Preventive services with an A or B rating from the USPSTF.
- School-Based Services.
- Substance abuse day treatment services.
- Surgical assistance.
- Targeted case management services.

Further Information

Refer to service-specific areas of the ForwardHealth Online Handbook on the Portal at *www.forwardhealth.wi.gov/* for information on copayment amounts, limitations, and other requirements.

Information Regarding Managed Care Organizations

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Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ForwardHealth
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Update
February 2014

No. 2014-10

Affected Programs: BadgerCare Plus Standard Plan, Medicaid
To: Hospital Providers, HMOs and Other Managed Care Programs

Effective April 1, 2014, Qualified Hospitals Allowed to Make Presumptive Eligibility Determinations

This *ForwardHealth Update* announces that, effective April 1, 2014, qualified hospitals will be able to make presumptive eligibility determinations for BadgerCare Plus eligibility for specific populations due to the Affordable Care Act.

Introduction

To expedite enrollment of eligible members and provider reimbursement, ForwardHealth is implementing the Affordable Care Act (ACA) requirement that allows qualified hospitals to make presumptive eligibility (PE) determinations for certain Medicaid and BadgerCare Plus populations. Any Medicaid-enrolled hospital that agrees to the PE determination process set forth by ForwardHealth will be considered a qualified hospital.

In Wisconsin, PE is also known as express enrollment or temporary enrollment. Presumptive eligibility refers to temporary BadgerCare Plus eligibility determinations that are based solely on preliminary household and financial information provided by the applicant. This process allows the applicant to receive immediate health care coverage while his or her application for Medicaid or BadgerCare Plus is processed.

Becoming a Qualified Hospital

Becoming a qualified hospital is a straightforward process and there is no cost for this designation. Hospitals will be required to notify ForwardHealth of their interest via the ForwardHealth Portal. To be designated as a qualified hospital for making PE determinations, hospitals must meet both of the following requirements:

- The hospital must be enrolled in Wisconsin Medicaid and BadgerCare Plus.
- The hospital must agree, via a one-time attestation, to do the following:
  - ✓ Conduct PE determinations internally and only for patients of the hospital (inpatient or outpatient). Hospitals may not delegate their PE determination authority to an outside entity.
  - ✓ Only allow hospital staff who have received training on PE policies and procedures to conduct PE determinations.
  - ✓ Assist PE applicants with the completion of a full Medicaid and BadgerCare Plus application.
  - ✓ Retain a copy of all "Am I Eligible" (AIE) results pages for three years (AIE is a feature of ACCESS).

While hospitals may not delegate their PE determination authority to a third-party contractor, hospitals may rely on such contractors to assist patients with the PE process. Hospital staff must review and approve the AIE screening results and the information provided in the ForwardHealth Portal prior to submission.

ForwardHealth will establish performance standards and will hold hospitals accountable based on these attestations. Refer to the Performance Reviews and Reasons for Disqualification section of this *ForwardHealth Update* for specific performance criteria and corrective action requirements related to these attestations.

Hospitals will provide their attestation via the ForwardHealth Portal at *www.forwardhealth.wi.gov/*. To access the Attestation page, the Portal account administrator of the hospital will need to log in to the hospital's secure home page and click the new Hospital Presumptive Eligibility Attestation link in the Quick Links box on the right side of the page. Access to the Attestation page will be available February 17, 2014; however, hospitals will not be able to submit PE determination information until April 1, 2014.

Refer to Attachment 1 of this *Update* for a flowchart that illustrates the process for becoming a qualified hospital to make PE determinations.

Eligible Populations

To meet the ACA requirement, effective April 1, 2014, ForwardHealth will allow qualified hospitals to make PE determinations for the following Wisconsin residents:

- Pregnant women.
- Children under age 19.
- Individuals applying for Family Planning Only Services benefit plan.
- Childless adults under age 65.
- Parents and other caretakers.
- Women under age 65 with breast or cervical cancer.

Additional eligibility information (e.g., specific poverty levels) will be included in the ForwardHealth training materials. Hospitals are currently eligible to make PE determinations for children, pregnant women, and for individuals applying for the Family Planning Only Services plan. Hospitals must meet the requirements outlined in this *Update* to make PE determinations for the new PE categories of childless adults, parents and other caretakers, and women under age 65 with breast or cervical cancer.

Eligible Populations Who Are Inmates of Public Correctional Facilities

Hospitals will be allowed to make PE determinations for patients who are inmates of certain public correctional institutions (e.g., county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The PE determination process for these patients will be the same as for other patients. Patients who are inmates of a state correctional facility are not eligible for Medicaid or BadgerCare Plus through the hospital PE process.

Presumptive Eligibility Determination Process

The PE determination process will be Web-based and will be based on the results of a few questions. If the applicant is found presumptively eligible, the hospital will be required to assist him or her with completion of the full Medicaid and BadgerCare Plus application.

Process for Presumptive Eligibility Determinations

The Department of Health Services (DHS) will implement a temporary application process that hospitals will use until a permanent process can be implemented. Hospitals will use a combination of the AIE feature of ACCESS at *access.wisconsin.gov/* and the ForwardHealth Portal to determine PE.

Note: Qualified hospitals that are currently using ACCESS for Providers and Partners (APP) are encouraged to continue to use that tool to make determinations for children and pregnant women.

The hospital worker will first lead the applicant through the AIE process on ACCESS to determine if he or she is eligible. The AIE screen takes about 15 minutes to complete and includes questions about the following as they pertain to the applicant:

- Household size.
- Household income.
- Access to health insurance.
- Monthly bills (housing, child care, child support).

If the applicant does not qualify for PE after completing the AIE process on ACCESS, the PE process stops there.

If the applicant is determined to be presumptively eligible after completing the AIE process, the hospital worker will then go to the Hospital Presumptive Eligibility Attestation link on the hospital's secure Portal page on the ForwardHealth Portal and complete the following information related to the applicant:

- Social security number.
- Full legal name (first, middle initial, last).
- Date of birth.
- Gender.
- Complete mailing address.
- Date of application.
- Indication of state residency.
- Indication that the applicant is a United States citizen or lawful immigrant.

Note: ForwardHealth will require hospitals to ask applicants about state residency and citizenship.

ForwardHealth will use this information to enroll the member in BadgerCare Plus.

In addition to providing the member's demographic information, ForwardHealth will ask the hospital staff to provide their attestations to the following actions:

- The hospital staff assisted the patient with the AIE screening.
- The hospital staff provided the patient with a copy of the AIE screening results.
- The hospital staff obtained the patient's signature in acknowledgement of the information provided.

For this purpose, hospital staff includes third-party contractors working within the hospital (inpatient or outpatient) setting.

Hospitals will receive confirmation of the PE status and the ForwardHealth Enrollment Verification System will immediately reflect the PE eligibility dates. Hospitals will not have the option of printing a temporary card for the member. ForwardHealth will mail a ForwardHealth identification card to the member within two business days if the member has not already been issued a ForwardHealth card.

Refer to Attachment 2 for a flowchart that illustrates the PE determination process.

Future Permanent Process for Presumptive Eligibility Determinations

At a future date, ForwardHealth will modify the PE process to have all PE determinations conducted through ACCESS APP, which is the current process for children and pregnant women. The use of APP will streamline the PE process and will allow hospitals to print a temporary identification card for eligible members. Hospitals will be notified when ForwardHealth is ready to make the transition to the APP eligibility tool.

Presumptive Eligibility Period

The PE period begins on the date of application. For all eligibility categories, the PE period ends on the earlier of the following:

- The last day of the month following the month in which the PE determination was made if no application for Medicaid or BadgerCare Plus is filed by that date.
- The date an eligibility determination for full Medicaid or BadgerCare Plus is made, regardless of the outcome of the determination.

For example, if a child is found presumptively eligible for BadgerCare Plus on July 3, he is certified until August 31. However, if on July 5, his mother completes a full BadgerCare Plus application for him, and on August 6, he is found ineligible for BadgerCare Plus for some reason such as excess income, the child's PE would end on August 6. Hospitals will not be required to amend the end date of the PE period.

Limits on Number of Presumptive Eligibility Periods

There are limits on the number of PE periods for all eligibility groups. Pregnant women will be eligible for one PE period per pregnancy. All other populations will be limited to one PE period within a rolling 12-month period, starting with the effective date of the initial PE period. Since multiple PE periods will not be allowed, hospitals are required to assist applicants with the completion of the full Medicaid and BadgerCare Plus application.

Covered Services

Effective with the date of determination,(i.e., the date an application that meets the PE criteria is submitted) individuals will be eligible to receive coverage under Wisconsin Medicaid and BadgerCare Plus as indicated below.

Pregnant Women

As currently allowed, pregnant women will be eligible for *ambulatory* pregnancy-related care as outlined in the Express Enrollment for Children and Pregnant Women service area of the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov/*. The member is required to be fully enrolled for coverage of inpatient services, including the delivery.

Family Planning Only Services

Individuals who are determined eligible for the Family Planning Only Services benefit will be eligible for family planning and family planning-related services only. Refer to the Online Handbook for the specific listing of services.

All Other Populations

All other populations indicated below will be eligible for Medicaid and BadgerCare Plus Standard Plan coverage, as outlined in the Online Handbook:

- Children.
- Parents and caretakers.
- Childless adults.
- Women with breast and cervical cancer.

Performance Reviews and Reasons for Disqualification

ForwardHealth will monitor PE submissions and will conduct periodic, random reviews of the hospital PE process. Reviews could include on-site visits. ForwardHealth will provide technical assistance to hospitals if a need is indicated. However, ForwardHealth will make immediate referrals to the state's Office of the Inspector General (OIG), if internal monitoring or random reviews lead to a suspicion of inappropriate PE submissions. ForwardHealth may immediately suspend the hospital's ability to submit applications pending the outcome of OIG's investigation. If an allegation of fraud is substantiated, ForwardHealth will pursue recovery of payments made to the hospital during the PE period, if submissions do not meet ForwardHealth requirements.

ForwardHealth will also monitor, on a hospital-by-hospital basis, the number of presumptively eligible members who are subsequently found eligible for Medicaid or BadgerCare Plus. ForwardHealth may require additional training for hospitals with resulting Medicaid or BadgerCare Plus enrollment levels that fall below 90 percent of the number of PE determinations made in a 12-month period.

On an annual basis, ForwardHealth will monitor each hospital to ensure that the hospital is following the stated policies and procedures. ForwardHealth will use the criteria outlined below to disqualify hospitals:

- Hospitals delegating their PE determination authority to an outside entity will immediately have PE submissions suspended by ForwardHealth. Hospitals will be disqualified for two years if this practice is not corrected as requested by ForwardHealth.
- Hospitals committing fraudulent violations of the PE policies will be disqualified for five years by ForwardHealth, if such violations are verified.
- Starting in calendar year 2015, hospitals that fall short of an established submission rate for a completed Medicaid and BadgerCare Plus application may be subject to corrective action and ultimate disqualification for up to two years. The performance expectation for this

measure will be established in 2015, based on the ratio of PE applications to full Medicaid and BadgerCare Plus submissions.

ForwardHealth will send a written notification to hospitals stating the reason for the disqualification. ForwardHealth will not accept PE determinations from hospitals during the period of disqualification.

Training

ForwardHealth will provide qualified hospitals with a step-by-step user guide and training on the hospital PE process. Training sessions will be conducted in mid-March 2014. ForwardHealth will notify qualified hospitals of the initial training dates. The initial and subsequent training dates will also be posted on the ForwardHealth Portal. Hospitals will be responsible for ensuring that their staff receives training and understand the PE process, prior to conducting determinations. Hospitals must retain documentation that shows the names of trained individuals and the dates they received their training.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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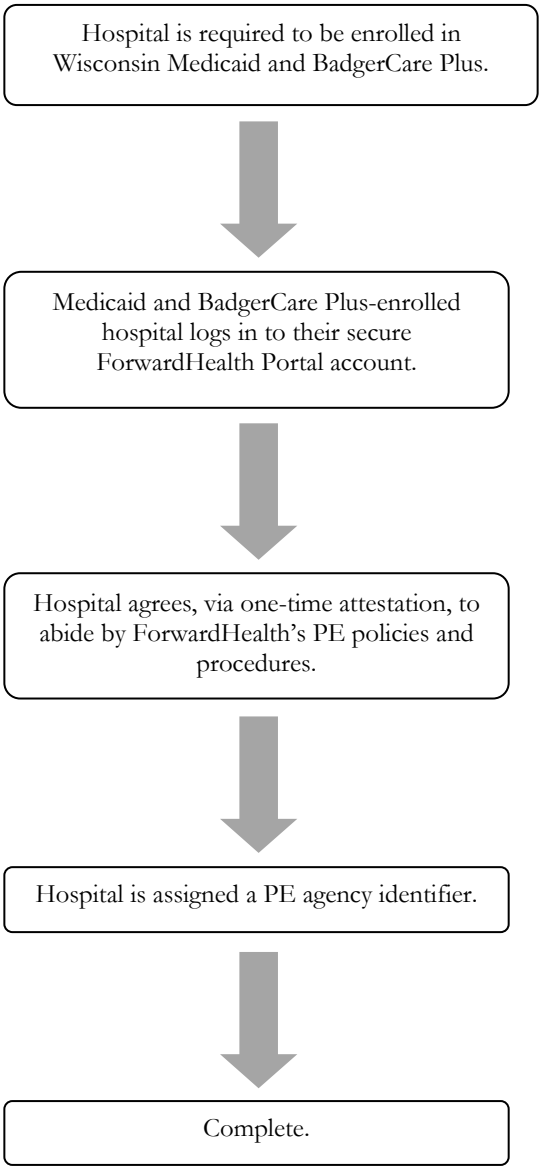
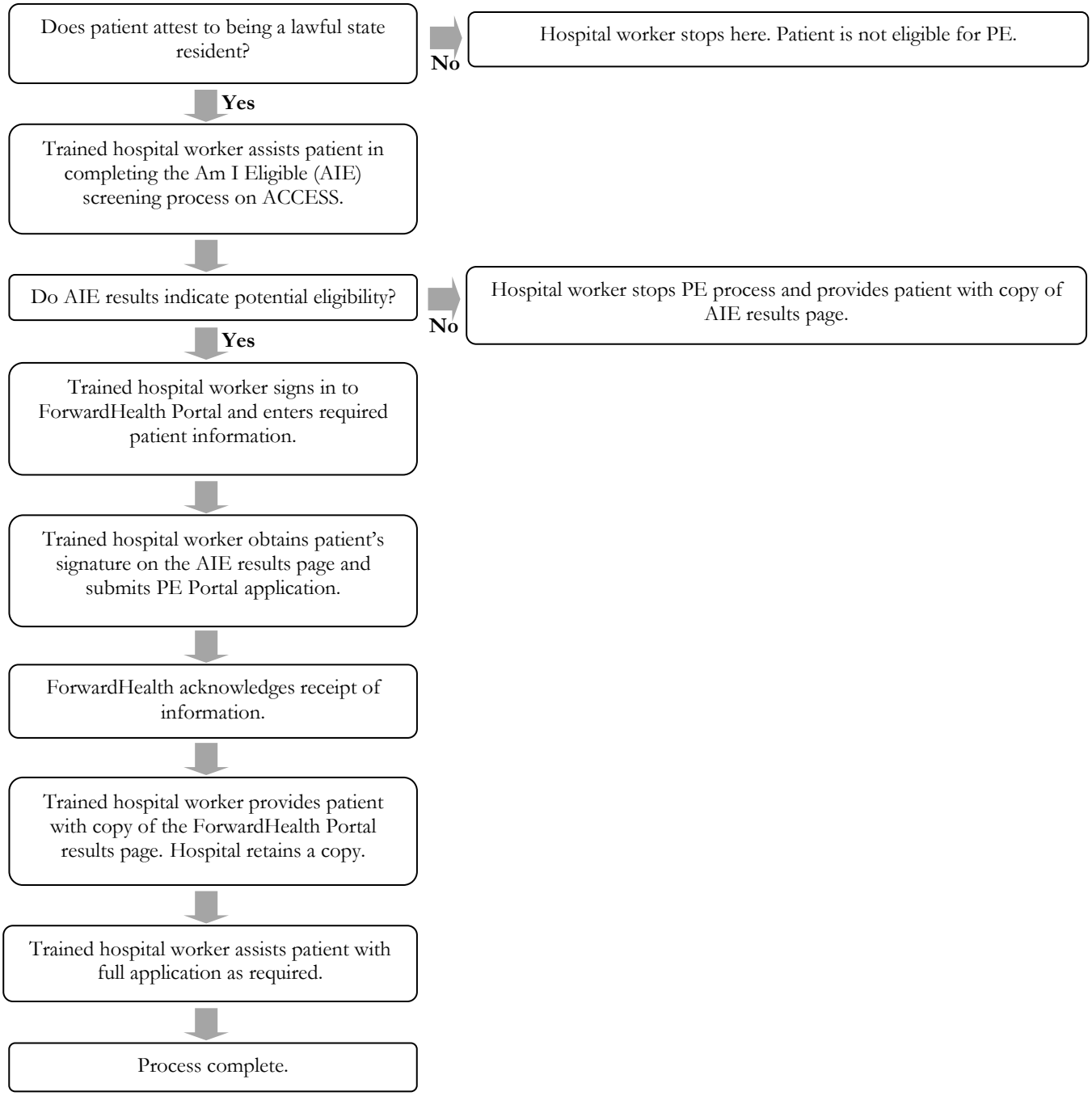
ATTACHMENT 1
Process for Becoming a Qualified Hospital

The following flowchart details the process a hospital needs to follow when seeking to be designated as a qualified hospital for making presumptive eligibility (PE) determinations.



ATTACHMENT 2
Presumptive Eligibility Determination Process

The following flowchart details the steps needed to complete the presumptive eligibility (PE) determination process.



ForwardHealth
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Update
February 2014

No. 2014-12

Affected Programs: BadgerCare Plus, Medicaid
To: All Providers, HMOs and Other Managed Care Programs

Changes to BadgerCare Plus Due to the Affordable Care Act and 2013-15 Wisconsin Act 20

This *ForwardHealth Update* provides information about changes that have been made to the BadgerCare Plus program due to the Affordable Care Act and 2013-15 Wisconsin Act 20. Information in this *Update* highlights the populations that are impacted by the changes and provides details about benefit plan changes.

Changes to BadgerCare Plus

This *ForwardHealth Update* provides information about changes that have been made to the BadgerCare Plus program due to the Affordable Care Act and 2013-15 Wisconsin Act 20. Information in this *Update* highlights the populations that are impacted by the changes and provides details about the benefit plan changes.

A *Member Update*, titled "Important Information About Your BadgerCare Plus Enrollment," will be mailed to affected members that details the enrollment changes. Refer to Attachment 1 of this *Update* for a copy of the *Member Update*.

Populations Eligible for BadgerCare Plus

Newly enrolling parents and caretaker relatives are subject to new income levels beginning February 1, 2014. All new BadgerCare Plus applicants will be subject to the new Modified Adjusted Gross Income (MAGI) rules beginning February 1, 2014. Modified Adjusted Gross Income is a calculation of income based on household composition that aligns BadgerCare Plus rules with tax rule-based policy used in the federal Health Insurance Marketplace (also known as the Exchange or *HealthCare.gov*). Parents and caretaker relatives currently enrolled in BadgerCare Plus with household incomes between 100 and 200 percent will remain enrolled in their current plan until March 31, 2014, as long as they continue to meet program rules.

Effective April 1, 2014, the following populations will be eligible for BadgerCare Plus, regardless of when they applied:

- Parents and caretaker relatives with incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with incomes at or below 300 percent of the FPL.
- Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.
- Childless adults (adults ages 19-64 without dependent children living in the household) with incomes at or below 100 percent of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

2014 Federal Poverty Level Guidelines*		
Family Size	**Monthly Income Limit for Adults (100% FPL)**	**Monthly Income Limit for Children and Pregnant Women (300% FPL)**
1	$972.50	$2,917.50
2	$1,310.83	$3,932.50
3	$1,649.17	$4,947.50
4	$1,987.50	$5,962.50
5	$2,325.83	$6,977.50

* Federal Poverty Level limits are subject to change.

Refer to Attachment 2 for information regarding eligibility for BadgerCare Plus and the federal Health Insurance Marketplace.

Premiums

Effective April 1, 2014, the following members will be required to pay premiums to be enrolled in BadgerCare Plus:

- Transitional medical assistance individuals with incomes over 133 percent of the FPL. Transitional medical assistance individuals with incomes between 100 and 133 percent FPL are exempt from premiums for the first six months of their eligibility period.
- Children (ages 18 and younger) with household incomes greater than 200 percent with the following exceptions:
  - ✓ Children under age 1 year.
  - ✓ Children who are tribal members or otherwise eligible to receive Indian Health Services.

Populations Not Eligible for BadgerCare Plus

Effective April 1, 2014, the following populations will transition from the BadgerCare Plus program and may apply for and purchase private health insurance coverage through the federal Health Insurance Marketplace (also known as the Health Insurance Exchange and *HealthCare.gov*):

- Parents and caretaker relatives with incomes over 100 percent of the FPL.
- Children (ages 18 and younger) with household incomes over 300 percent of the FPL.
- Childless adults with incomes over 100 percent of the FPL.

The Department of Health Services (DHS) sent letters and notices to transitioning members informing them of these changes. Members may obtain private health insurance coverage through the federal Health Insurance Marketplace. Refer to the Health Insurance Marketplace section of this *Update* for additional information.

Programs Not Affected

The changes to the BadgerCare Plus program do not affect members who are enrolled in the following ForwardHealth programs:

- Wisconsin Medicaid.
  - ✓ Adoption Assistance.
  - ✓ Elderly, Blind, and Disabled.
  - ✓ Foster Care.
  - ✓ Katie Beckett.
  - ✓ Medicaid Waivers.
  - ✓ Supplemental Security Income.
  - ✓ Well Woman Medicaid.
- SeniorCare.
- Wisconsin AIDS Drug Assistance Program (ADAP).
- Wisconsin Chronic Disease Program.
- Wisconsin Well Woman Program.
- Tuberculosis-only services.

BadgerCare Plus Benefit Plan

Effective April 1, 2014, all members eligible for BadgerCare Plus will be enrolled in the BadgerCare Plus Standard Plan.

As a result of this change, the following benefit plans will be discontinued effective April 1, 2014:

- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.

Members who were enrolled in the Benchmark Plan or the Core Plan who meet the new income limits for BadgerCare Plus eligibility will be automatically transitioned into the Standard Plan effective April 1, 2014.

Refer to Attachment 3 for a chart that lists the covered services under the Standard Plan for eligible populations, effective April 1, 2014.

Members who were enrolled in the Benchmark Plan or the Core Plan who do not meet the new income limits for BadgerCare Plus eligibility have the opportunity to apply for and purchase private insurance through the Health Insurance Marketplace. Members who were enrolled in the Basic Plan will need to apply for BadgerCare Plus or enroll in the Health Insurance Marketplace, based on income levels.

As a reminder, all claims and adjustments for services rendered to Benchmark Plan and Core Plan members must be submitted within 365 days of the date of service (DOS).

As a result of the Benchmark Plan, the Core Plan, and the Basic Plan ending, BadgerRx Gold (the reduced-cost prescription drug program) will also end. The last day of BadgerRx Gold program coverage for all existing members is March 31, 2014.

Covered Services

Covered services, service limitations, prior authorization (PA) requirements, and other policies and procedures under the Standard Plan will remain the same. Enrollment year limits that had previously applied to the Benchmark Plan, the Core Plan, or the Basic Plan will not carry over or apply to members transitioning to the Standard Plan.

Refer to the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information regarding covered services, policies, and procedures.

Reimbursement

Medicaid and BadgerCare Plus reimbursement rates will remain the same. The following Terms of Reimbursement will be revised to reflect the discontinuation of the Benchmark Plan, the Core Plan, and the Basic Plan:

- Dental/Dental Hygienists Terms of Reimbursement, F-01092.
- Medical Supply and Equipment Vendor Terms of Reimbursement, F-01506.

Refer to the Provider Enrollment Information page of the Portal for all current Terms of Reimbursement.

Services Requiring Prior Authorization

Existing Prior Authorizations

For Benchmark Plan or Core Plan members transitioning to the Standard Plan, approved or modified PA requests for continuing services with dates that span from 2013 to 2014 will be transferred by ForwardHealth to the Standard Plan if PA is still required for the services. No action will be required by the provider. This will be a one-time PA transfer process and providers will be required to follow normal procedures when submitting future PA requests. Providers will receive a decision notice to confirm transferred PAs.

New Prior Authorization Requests

For members transitioning to the Standard Plan, providers will be required to submit a new PA request for any new service that requires PA under the Standard Plan for DOS on and after April 1, 2014.

As a reminder, once member enrollment is updated, providers will be allowed to request PA for new or transitioning Standard Plan members prior to April 1, 2014, effective for DOS on and after April 1, 2014. Providers are encouraged to verify enrollment every time before rendering services.

Pharmacy Prior Authorizations

Pharmacy PAs will be addressed based on the type of PA (e.g., non-preferred, Drug Authorization and Policy Override Center [DAPO]) and providers will be notified if action taken requires a new PA to be requested.

HMO Enrollment

BadgerCare Plus members will continue to be enrolled in HMOs.

Identification Cards

ForwardHealth identification cards will be issued for members transitioning from the Core Plan to the Standard Plan. There are no ID card changes for members transitioning from the Benchmark Plan to the Standard Plan.

Changes to Express Enrollment for Pregnant Women

Effective February 1, 2014, only one temporary enrollment period will be allowed per pregnancy. Since multiple express enrollment periods will not be allowed, providers are encouraged to counsel members on completing the entire BadgerCare Plus application process.

In Wisconsin, presumptive eligibility is also known as express enrollment or temporary enrollment. More detailed information regarding presumptive eligibility is available in the February 2014 *Update* (2014-10), titled "Effective April 1, 2014, Qualified Hospitals Allowed to Make Presumptive Eligibility Determinations." For information regarding the current presumptive eligibility process, refer to the Online Handbook.

Transition Plan for Certain Services

Inpatient Hospital Services

Inpatient hospital stays will be reimbursed based on which benefit plan the member is in on the date of discharge. If the member is shown as not eligible on the date of discharge, providers are required to follow the policies, procedures, and cost sharing of the plan the member was enrolled in on the first day of the hospitalization admittance. Providers are reminded to verify eligibility for services provided after April 1, 2014.

As a reminder there is no deductible for hospital stays under the Standard Plan.

Enrollment Verification Reminder

Providers should always verify a member's enrollment on each DOS *before* providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers can access Wisconsin's Enrollment Verification System to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's Automated Voice Response system.
- Commercial enrollment verification vendors.
- 270/271 Health Care Eligibility/Benefit Inquiry and Information Request transactions.
- Provider Services.

Portal and Online Handbook Changes

References to the three discontinued benefit plans will be updated as needed on the ForwardHealth Portal and in the Online Handbook.

Health Insurance Marketplace

The federal Health Insurance Marketplace (also known as the Health Insurance Exchange) will be available to help individuals and families find a Qualified Health Plan (QHP). Open enrollment for 2014 ends March 31, 2014. Individuals must enroll in a QHP and pay the applicable premium by March 15, 2014, for coverage on April 1, 2014. Individuals who enroll between March 16, 2014, and March 31, 2014, and pay their premium will have coverage beginning May 1, 2014.

Individuals with incomes up to 400 percent of the FPL are eligible for Premium Tax Credits. Additionally, individuals with incomes up to 250 percent of the FPL are eligible for reduced cost sharing.

Plans in the new Marketplace will be run by private companies, and every health insurance plan will cover a core set of benefits called essential health benefits.

Refer to *www.healthcare.gov/* or call (toll free) (800) 318-2596 for more information.

Further Information

Providers and/or members are encouraged to get further information regarding BadgerCare Plus benefit plan changes via the following:

- BadgerCare Plus letters — Providers and members can access BadgerCare Plus letters regarding enrollment changes at *www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm*.
- The Health Insurance Marketplace — Providers and members can access the Health Insurance Marketplace Web site at *www.healthcare.gov/* or call (toll free) (800) 318-2596 for more information regarding options for health care coverage.
- ForwardHealth Portal — Providers can access the ForwardHealth Online Handbook on the Portal at *www.forwardhealth.wi.gov/* for the most up-to-date policy and program information.
- Centers for Medicare and Medicaid Services (CMS) — Providers can access the CMS Web site at *www.cms.gov/* for more information regarding its policies.
- The Wisconsin DHS — Providers can access the DHS Web site at *www.dhs.wisconsin.gov/* for information regarding its programs and services.
- ACCESS — Individuals can apply, check eligibility, check on the status of their benefits and report changes online via *access.wisconsin.gov/*.
- Regional Enrollment Networks — Regional Enrollment Networks throughout the state consisting of regional partners and tribes are also available to provide application and enrollment assistance to people newly eligible for the Standard Plan. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin Web site at *e4healthwi.org/* or *211wisconsin.org/*.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
ForwardHealth Member Update

(A copy of the March 2014 *ForwardHealth Member Update*, titled "Important Information About Your BadgerCare Plus Enrollment," is located on the following pages.)

ForwardHealth
Wisconsin serving you

Member Update
March 2014

Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະຣຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Affected Programs: BadgerCare Plus, Medicaid
To: Members

Important Information About Your BadgerCare Plus Enrollment

Changes to Your BadgerCare Plus Benefits

On April 1, 2014, all BadgerCare Plus members will be covered under the Standard Plan. If you were covered under the Benchmark or Core Plan, you will receive benefits under the Standard Plan, starting April 1.

This is an informational Member *Update*. No action is required on your part.

Covered Services

More services are covered under the Standard Plan than the Benchmark Plan or the Core Plan. Some of those services include:

- Generic and brand name prescription drugs and some over-the-counter (OTC) drugs.
- Additional outpatient mental health and substance abuse treatment services.
- Dental services.
- Medical transportation to and from a covered service.

Note: BadgerCare Plus Benchmark Plan and Core Plan members were also enrolled in BadgerRx Gold, a reduced-cost prescription drug program. The BadgerRx Gold program is ending March 31, 2014, so your enrollment in BadgerRx Gold is also ending. However, on April 1, 2014, when you begin getting health care coverage through the BadgerCare Plus Standard Plan, more prescription drug coverage will be available to you at a lower cost.

For more information about BadgerCare Plus Standard Plan covered services, see the covered services attachment on page 3.

Copayment

Copayments for services will be between $0.50 and $3 per service. There are no copayments for preventive services.

Your providers are required to make a reasonable effort to collect the copayment but cannot refuse to provide you with health care services if you do not pay your copayment.

HMO Enrollment

Most BadgerCare Plus members are enrolled in an HMO. If you are enrolled in an HMO, no action is required on your part at this time. If you need to choose a new HMO, you will be notified by mail.

Identification Cards

If you were a Core Plan member, your ForwardHealth ID card is changing, so you will be mailed a new ForwardHealth ID card. Your member ID number will not change. If you were in the Standard Plan or Benchmark Plan, your ForwardHealth ID card will not change.

New BadgerCare Plus Rules

As of April 1, 2014, the following people can enroll in the BadgerCare Plus Standard Plan:

- Adults with household incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with household incomes at or below 300 percent of the FPL.
- Children (under 19 years old) with household incomes at or below 300 percent of the FPL.

2014 FPL Guidelines*		
Family Size	**Monthly Income Limit for Adults (100% FPL)**	**Monthly Income Limit for Children and Pregnant Women (300% FPL)**
1	$972.50	$2,917.50
2	$1,310.83	$3,932.50
3	$1,649.17	$4,947.50
4	$1,987.50	$5,962.50
5	$2,325.83	$6,977.50

*Federal Poverty Level (FPL) limits are subject to change. Current FPL guidelines can be found at *badgercareplus.org/fpl.htm*.

For More Information

- ForwardHealth Enrollment and Benefits handbook — Available on the DHS Web site at *dhs.wi.gov/em/CustomerHelp/* or the BadgerCare Plus Web site at *badgercareplus.org/*.
- *ACCESS.wi.gov* — To apply, check the status of your benefits, do your renewal, and report changes.
- ForwardHealth Member Services — 1-800-362-3002.

ATTACHMENT
Covered Services for BadgerCare Plus Standard Plan Members

The chart below lists the health care services covered by the BadgerCare Plus Standard Plan as of April 1, 2014, and what the copayment will be for these services. Some members are exempt from copayments. The following members do not need to pay copayments:

- Children in foster care, regardless of age.
- Children in adoption assistance, regardless of age.
- Children under age 1 year with household income up to 150 percent of the Federal Poverty Level (FPL).
- Children ages 1 through 5 years with household income up to 185 percent of the FPL.
- Children ages 6 through 18 years with household incomes at or below 133 percent of the FPL.
- Children in the Katie Beckett program, regardless of age.
- Children who are American Indian or Alaskan Natives who are enrolled in the state's Child Health Insurance Program (CHIP).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.
- Members enrolled in Wisconsin Well Woman Medicaid.
- Children under age 19 eligible through Express Enrollment.

Please note: Because services and copayments change, you should ask your provider what services are covered and what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

Service	Coverage Under the BadgerCare Plus Standard Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3 copayment per service.
Chiropractic	Full coverage. $0.50 to $3 copayment per service.
Dental	Full coverage. $0.50 to $3 copayment per service.
Disposable Medical Supplies (DMS)	Full coverage. $0.50 to $3 copayment per service and $0.50 per prescription for diabetic supplies.

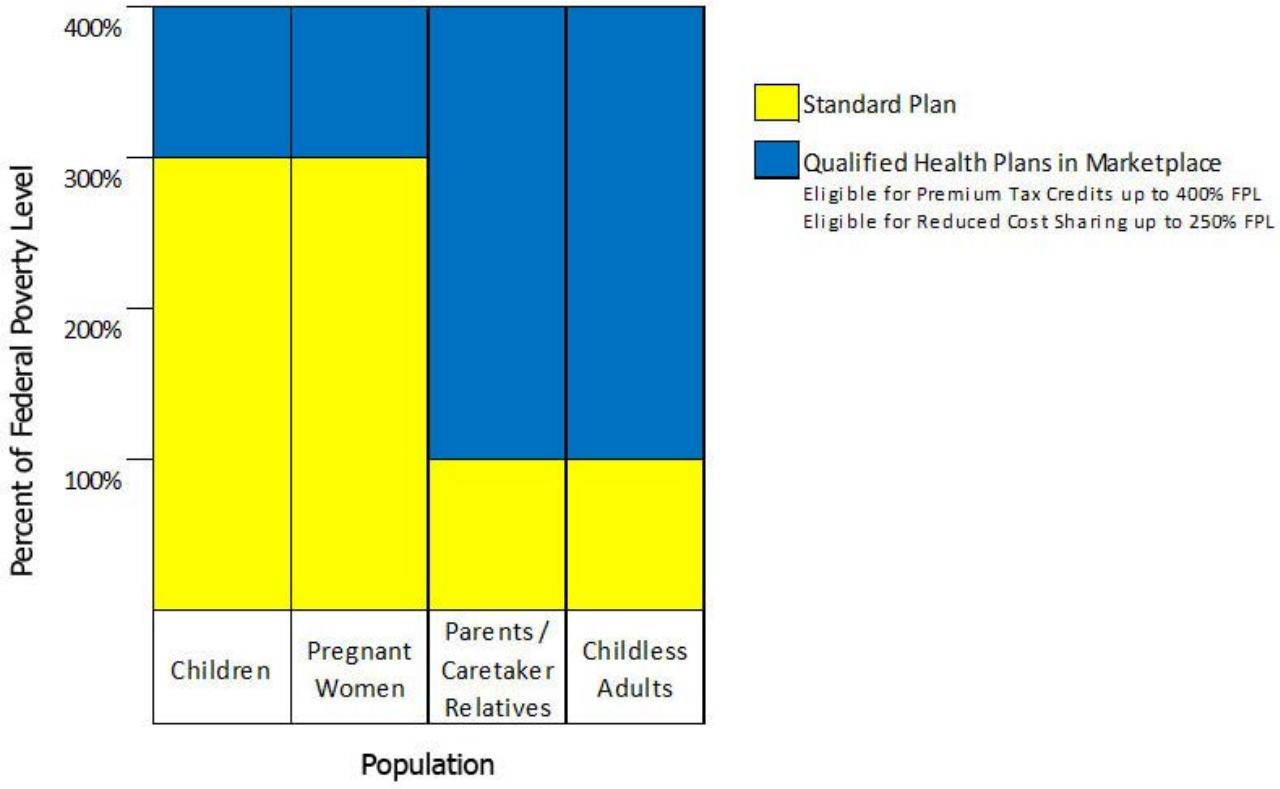
Service	Coverage Under the BadgerCare Plus Standard Plan
Drugs (Prescription)	Coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Copayment: • $0.50 for OTC drugs. • $1 for generic drugs. • $3 for brand name drugs. Copayments are limited to $12 per member, per provider, per month. Over-the-counter drugs do not count towards the $12 maximum. Limit of five opioid prescription fills per month.
Durable Medical Equipment (DME)	Full coverage. $0.50 to $3 copayment per item. Rental items are not subject to copayment.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals 20 years and under. No copayment.
Hearing Services	Full coverage. $0.50 to $3 copayment per procedure. No copayment for hearing aid batteries.
Home Care Services — Home Health, Private Duty Nursing (PDN), and Personal Care	Full coverage of home health services, PDN, and personal care. No copayment.
Hospice	Full coverage. No copayment.
Hospital — Inpatient	Full coverage. $3 copayment per day with a $75 cap per stay.

Service	Coverage Under the BadgerCare Plus Standard Plan
Hospital — Outpatient	Full coverage. $3 copayment per visit.
Hospital — Outpatient Emergency Room	Full coverage. No copayment.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3 copayment per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. Copayments are not required when services are provided in a hospital setting.
Nursing Home Services	Full coverage. No copayment.
Physician	Full coverage, including laboratory and radiology. $0.50 to $3 copayment per service, limited to $30 per provider per calendar year. No copayment for emergency services, preventive services, anesthesia, or clozapine management.
Podiatry	Full coverage. $0.50 to $3 copayment per service, limited to $30 per provider per calendar year.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service — Family Planning Services	Full coverage with the exceptions listed below. No copayment for services provided by a family planning clinic or contraceptive management. Does not cover: • Reversal of voluntary sterilization. • Infertility treatments. • Surrogate parenting and related services, including but not limited to: ✓ Artificial insemination. ✓ Obstetrical care. ✓ Labor or delivery. ✓ Prescription and OTC drugs.

Service	Coverage Under the BadgerCare Plus Standard Plan
Routine Vision	Full coverage including eyeglasses. $0.50 to $3 copayment per service.
Therapy — Physical Therapy, Occupational Therapy, and Speech and Language Pathology	Full coverage. $0.50 to $3 copayment per service. Copayment limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency medical transportation to and from a covered service. Copayment: • $2 for non-emergency ambulance trips. • $1 per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.

ATTACHMENT 2
BadgerCare Plus and Marketplace Eligibility, Effective April 1, 2014

The following graph shows which populations will be eligible for BadgerCare Plus and the Marketplace based on Federal Poverty Level income limits, effective April 1, 2014.



ATTACHMENT 3
Covered Services Under the BadgerCare Plus Standard Plan for Eligible Populations

Effective April 1, 2014, the following populations will be eligible for BadgerCare Plus:

- Parents and caretaker relatives with incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with incomes at or below 300 percent of the FPL.
- Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.
- Childless adults with incomes at or below 100 percent of the FPL.
- Transitional medical assistance individuals with incomes over 100 percent of the FPL.

The following table includes a list of covered services and limitations under the BadgerCare Plus Standard Plan that eligible members will receive.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.
Chiropractic	Full coverage. $0.50 to $3.00 copayment per service.
Dental	Full coverage. $0.50 to $3.00 copayment per service.
Disposable Medical Supplies	Full coverage. $0.50 to $3.00 copayment per service and $0.50 per prescription for diabetic supplies.
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to five prescriptions per month for opioid drugs. Copayments are as follows: • $0.50 for OTC drugs. • $1.00 for generic drugs. • $3.00 for brand name drugs. Copayments are limited to $12.00 per member, per provider, per month. Over-the-counter drugs are excluded from this $12.00 maximum.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid
Durable Medical Equipment	Full coverage. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment.
End-Stage Renal Disease	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. No copayment.
Hearing Services	Full coverage. $0.50 to $3.00 copayment per procedure. No copayment for hearing aid batteries.
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of PDN, home health, and personal care services. No copayment.
Hospice	Full coverage. No copayment.
Inpatient Hospital	Full coverage. $3.00 copayment per day with a $75.00 cap per stay.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3.00 copayment per service, limited to the first 15 hours or $825.00 of services, whichever comes first, provided per calendar year. Copayment not required when services are provided in a hospital setting.
Nursing Home Services	Full coverage. No copayment.
Outpatient Hospital — Emergency Room	Full coverage. No copayment.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid
Outpatient Hospital	Full coverage. $3.00 copayment per visit.
Physical Therapy, Occupational Therapy, and Speech and Language Pathology	Full coverage. $0.50 to $3.00 copayment per service. Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).
Physician	Full coverage, including laboratory and radiology. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year. No copayment for preventive services, emergency services, anesthesia, or clozapine management.
Podiatry	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service	Full coverage, excluding infertility treatments, surrogate parenting and related services, including, but not limited to, artificial insemination and subsequent obstetrical care as a noncovered service, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	Full coverage including coverage of eyeglasses. $0.50 to $3.00 copayment per service.
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency medical transportation to and from a certified provider for a covered service. Copayments are as follows: • $2.00 copayment for non-emergency ambulance trips. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.

Note: For additional information on copayments, providers may refer to the Copayment chapter of the Reimbursement section of their specific-service area of the Online Handbook at *www.forwardhealth.wi.gov/*.

Operations Memos

BadgerCare Plus Handbook

Medicaid Eligibility Handbook

FoodShare Wisconsin Handbook

Income Maintenance Manual

Income Maintenance Forms

BadgerCare Plus Publicatons

FoodShare Publications

Medicaid Publications

Training

BadgerCare Plus Letters Regarding Enrollment Changes

The following letters will be mailed to BadgerCare Plus members and individuals regarding changes due to the Affordable Care Act (ACA) and state law changes.

Letter 1 — BadgerCare Plus Members to Apply through the Marketplace (Mail Date Week of 9/23/13) (PDF, 175 KB)

This letter is to let current BadgerCare Plus members know that their income on file is above the 2014 income thresholds and they may not be eligible for BadgerCare Plus after December 31, 2013. Information about the Marketplace (Exchange) is included as well as information about how to report any changes in circumstance.

Letter 1A — BadgerCare Plus Members to Apply through the Marketplace (Mail Date Week of 12/23/13) (PDF, 181 KB)

This letter is to let current BadgerCare Plus members know that due to difficulties with HealthCare.gov, the new BadgerCare Plus income limits will now be effective April 1, 2014. As long the member continues to meet program rules, their coverage will continue through March 31, 2014.

Letter 1A Attachment F-00914 Tax Filer Information (Mail Date Week of 12/23/13) (PDF, 238 KB)

This form is also included with Letter 1A. It informs the member that if they want to see if they are able to stay enrolled in BadgerCare Plus after April 1, 2014, under the new rules to complete and return the form by January 17, 2014. If they are not eligible for BadgerCare Plus, the information will be sent to the Marketplace to see if they member is eligible for tax credits.

Please Note: Only BadgerCare Plus members receiving Letter 1A should complete and return the Tax Filer Information form at this time.

More About Form F-00914, for Consortia, Partners and Stakeholders

These instructions will provide the Department of Health Services' partners to assist members in completing the the form, F-00914 BadgerCare Plus Tax Filer Information.

Letter 2 — BadgerCare Plus Member Enrolled in an Extension (Mail Date Week of 9/23/13) (PDF, 172 KB)

This letter will inform current members enrolled in a BadgerCare Plus Extension if they will now be required to pay a monthly premium for coverage on or after January 1, 2014.

Letter 3 — BadgerCare Plus Core Plan Waitlist Ending (Mail Date Week of

9/28/13) (PDF, 184 KB)

This letter will inform individuals on the Core Plan Waitlist that the Core Plan and Waitlist are ending. Information is included directing them to the Marketplace if their income is above 100% of the Federal Poverty Level (FPL) or to BadgerCare Plus if their income is at or below 100% of the FPL.

Letter 3A — BadgerCare Plus Core Plan Waitlist Ending (Mail Date Week of 12/23/13) (PDF, 184 KB)

This letter will inform individuals on the Core Plan Waitlist that the Core Plan that due to difficulties at HealthCare.gov and a change in state law, BadgerCare Plus will not be available until April 1, 2014.

Information is included directing them to the Marketplace if their income is above 100% of the Federal Poverty Level (FPL) or to BadgerCare Plus if their income is at or below 100% of the FPL.

Letter 4 — BadgerCare Plus Basic Plan is Ending (Mail Date Week of 9/28/13) (PDF, 181 KB)

This letter is to inform BadgerCare Plus Basic Plan members that effective December 31, 2013, the Basic Plan is ending. Information is included directing them to the Marketplace if their income is above 100% of the Federal Poverty Level (FPL) or to BadgerCare Plus if their income is at or below 100% of the FPL.

Letter 4A — BadgerCare Plus Basic Plan is Ending (Mail Date Week of 12/9/13) (PDF, 164 KB)

This letter will inform individuals on the BadgerCare Plus Basic Plan that due to difficulties at HealthCare.gov and a change in state law, the BadgerCare Plus Basic will continue until March 31, 2013.

Information is included directing them to the Marketplace if their income is above 100% of the Federal Poverty Level (FPL) or to BadgerCare Plus if their income is at or below 100% of the FPL.

Please Note: Letters 5, 6, 7 and 8 are situational.

Letter 9 — Important Information about Applying for Health Insurance for January 1, 2014 (Mail Date Week of 11/11/13) (PDF, 169 KB)

This letter is a follow up to the letter sent to in early October to remind members of the new options for health care coverage through the federal Health Insurance Marketplace, also known as the Exchange. The letter also includes a copy of the paper Marketplace Family Application (Exit DHS). Instructions for the Marketplace Family Application (Exit DHS).

Letter 10 — Important Information About Your Application to the Federal Health Insurance Marketplace for BadgerCare Plus (Mail Date Week of 12/23/13) (PDF, 180KB)

This letter is being sent to individuals who applied for health care through the federal Health Insurance Marketplace and received a notice stating they were eligible for BadgerCare Plus/Medicaid.

It informs the individual that due to a delay in program changes, BadgerCare Plus will continue to be closed to new enrollment until April 1, 2014 for adults age 19 to

64 who are not living with and caring for a child under age 19. As a result, you will not be enrolled in the BadgerCare Plus Standard Plan until April 1, 2014.

It also informs the individual that if they are a parent or caretaker relative living with and caring for a child under age 19 or if you are a child under age 19, the Marketplace has not yet sent us their complete application. After the Marketplace sends the complete application for BadgerCare Plus, it will be processed and they will have BadgerCare Plus coverage that will be effective back to January 1, 2014. Depending on when they filed their application with the Marketplace, their coverage could be effective even earlier than January 1, 2014.

PDF: The free *Adobe Reader*® software is needed to view and print portable document format (PDF) files. Learn more.

Last Revised: January 02, 2014

Protecting and promoting the health and safety of the people of Wisconsin
The Official Internet site of the Wisconsin Department of Health Services

[CONSORTIA]
[P O BOX XXXX]
[XXXXX WI XXXXX-XXXX]

MEMBER SHOULD APPLY AT MARKETPLACE

DATE

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State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະຣຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Important Information about Your BadgerCare Plus Enrollment

This letter is to let you know about new income limits for BadgerCare Plus and new options for health care coverage through the federal Health Insurance Marketplace, also known as the Exchange.

Due to changes in state law**,** adult members with household income above 100% of the Federal Poverty Level (FPL) and children with household income above 300% FPL will no longer be eligible for BadgerCare Plus. These changes will take effect January 1, 2014.

You have received this letter because you or someone in your household may be above these limits. If anyone in your household is affected by the change in income limits and you are still enrolled in BadgerCare Plus, you will get another letter in December letting you know exactly who is affected and how their eligibility will change.

Please Note: These new limits do not affect pregnant women or people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD). If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away, as it may affect your enrollment.

What Can I Do?

Members who are above the new income limits for BadgerCare Plus in 2014 may apply for private health insurance through the federal Health Insurance Marketplace.

You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

Please Note: For any coverage that you get through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

The Marketplace offers help with paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

If you have questions about this letter or about your BadgerCare Plus enrollment, call the agency number listed at the top of page 1.

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

[CDPU]
[P O BOX XXXX]
[XXXXX WI XXXXX-XXXX]

MEMBER FYI PLUS TAX INFO FORM

DATE

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State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະຣຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

New Information about Your BadgerCare Plus Enrollment

You recently received a letter stating that you or someone in your household would no longer be enrolled in BadgerCare Plus as of December 31, 2013, because of new income limits. Due to difficulties with HealthCare.gov, **the new BadgerCare Plus income limits will now be effective April 1, 2014.** As long as you continue to meet program rules, your coverage will continue through March 31, 2014. For more information about the new BadgerCare Plus rules, see the section in this letter called "What Are the New BadgerCare Plus Rules Effective April 1, 2014?"

What Do I Need to Do?

- If you or someone in your household is enrolled in BadgerCare Plus with a premium, you must keep paying your monthly premiums to remain enrolled.
- You should apply and pay for private health insurance through the federal Health Insurance Marketplace, also called the Exchange, before March 31, 2014. See the section in this letter called "How Do I Apply Through the Marketplace?"
- If you want to see if you may be able to stay enrolled in BadgerCare Plus after March 31, 2014 under new program rules, you should fill out the form in this letter and answer questions about how you plan to file your taxes. You may want to complete the form if you receive child support because child support is no longer counted as income. **Fill out the form in this letter and return it by January 17, 2014.** We will also use this information to tell the Marketplace that you may be eligible for tax credits so your application at the Marketplace can be completed more easily.

Please Note: Completing the form is optional, but is strongly encouraged to help make sure you do not have a gap in health insurance coverage. As long as you continue to meet current program rules, you will stay enrolled in BadgerCare Plus through March 31, 2014. You will receive a letter about your enrollment status in early March.

What Happens Next?

- If you complete and return the form, we will send you a letter about your enrollment status in early March.
- If you do not complete and return the form, we will not be able to use new program rules when checking if the people in your home are over the new income limits. If you or someone in your home is over the new income limits, we will send you a letter in early March telling you that your BadgerCare Plus enrollment is ending and you need to purchase private health insurance through the Marketplace. Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014.**

What Are the New BadgerCare Plus Rules Effective April 1, 2014?

Due to changes in state law, as of April 1, 2014 non-pregnant adult members with household income up to 100% of the Federal Poverty Level (FPL) will be able to enroll in BadgerCare Plus. Children with a household income up to 300% of the FPL will be able to enroll in BadgerCare Plus. Some children above 300% FPL may be able to enroll in BadgerCare Plus by meeting a deductible. All BadgerCare Plus members will get the same benefit plan – the Standard Plan.

BadgerCare Plus will also be changing how it determines your household size and income. In addition to child support no longer being counted as income, you will be asked new questions about things like how you plan to file your taxes.

Please Note: The new program rules do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

How Do I Apply Through the Marketplace?

If you have not already done so, you should complete an application through the federal Health Insurance Marketplace.

Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014. Do not wait to apply or you risk having a gap in health insurance coverage.**

You can apply through the federal Health Insurance Marketplace:

- Online at HealthCare.gov,
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov,
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org or 211wisconsin.org.

Keep In Mind: If you want to see if you may be able to stay enrolled in BadgerCare Plus under new program rules, you will need to answer questions about how you plan to file taxes. Fill out the form in this letter and return it by January 17, 2014. We will use the information provided to see if you or someone in your household is eligible for BadgerCare Plus, under the new program rules. For example, child support is no longer counted as income. You may want to complete the form if you receive child support. We will also use this information to tell the Marketplace that you may be eligible for tax credits so your application at the Marketplace can be completed more easily.

Please Note: Completing the form is optional, but strongly encouraged to help make sure you do not have a gap in health insurance coverage. As long as you continue to meet current program rules, you will stay enrolled in BadgerCare Plus through March 31, 2014. You will receive a letter about your enrollment status in early March.

If you have questions about this letter, please call the agency listed at the top of page 1.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Heath Care Access and Accountability
F-00914 (12/13)

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BADGERCARE PLUS TAX FILER INFORMATION

On April 1, 2014, BadgerCare Plus program rules will be changing. These changes include new income limits, new rules for counting household income, and one benefit plan for all members.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus members whose household income is currently above the new income limits can choose to fill out this form to see if new rules for counting household income will allow people in their household to stay enrolled in BadgerCare Plus after April 1, 2014.

You will see the term “other income” on this form. Other income means income that you receive that isn’t from a job or self-employment, such as Unemployment Insurance, alimony, payments from an annuity, interest payments, payments from property you have sold, etc.

Please Note: You may be asked to provide personally identifiable information or your Social Security Number. Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

Complete, sign and return this form by January 17, 2014. Mail or fax it to:

If you live in Milwaukee County:

MDPU
PO Box 05676
Milwaukee WI 53205
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County

CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 1-855-293-1822

If you need help filling out this form or want to answer the questions in person or by telephone, contact your agency. To get the address or phone number of your agency, call **1-800-362-3002** or go to **dhs.wi.gov/em/customerhelp**.

TFI

SECTION ONE: INFORMATION ABOUT YOUR HOUSEHOLD

We are asking about how you and the people in your household plan to file taxes because it may affect who is included in your household and how their income is counted. Please answer the following questions:

CARES Case Number (listed at the top of your letter)

Is anyone in your home planning to file a tax return, for income received in 2014?

☐ Yes - Complete Sections Two, Three and Four

☐ No – Complete Sections Three and Four

SECTION TWO: TAX INFORMATION FOR YOUR HOUSEHOLD

Each tax filer in your household must fill out Section Two A or B. Please note: if anyone is married and filing a joint tax return, only one spouse needs to fill out Section Two A or B. Use additional paper if there are more than two tax filers in the household.

A. TAX FILER 1

Name of Tax Filer 1	Name of Spouse (if married and filing jointly)

Tax Filing Status ☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

Will this tax filer be claimed as a dependent by someone outside of the home ☐ Yes ☐ No

Tax Dependents: Answer the questions below for the dependents this tax filer will be claiming on his or her taxes. Include any tax dependents not living with the tax filer. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

B. TAX FILER 2

Name of Tax Filer 2	Name of Spouse (if married and filing jointly)

Tax Filing Status ☐ Single ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Head of Household

Will this tax filer be claimed as a dependent by someone outside of the home ☐ Yes ☐ No

Tax Dependents: Answer the questions below for the dependents this tax filer will be claiming on his or her taxes. Include any tax dependents not living with the tax filer. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this dependent expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No | Is this tax dependent deceased ☐ Yes ☐ No

SECTION THREE: INFORMATION ABOUT CHILDREN LIVING IN YOUR HOUSEHOLD

Answer the questions below for any children under age 19 who are living in the home and who are NOT listed as a tax dependent above. Provide this information even if no one in your home is filing taxes. Use an additional sheet of paper if more room is needed.

Are any children under age 19 living with you?

☐ Yes – Complete the rest of Section Three and Section Four

☐ No – Complete Section Four

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Name of Child 1	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Name of Child 2	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

Name of Child 3	Date of Birth	Social Security Number	Sex ☐ Male ☐ Female

Is this child expected to have more than $5,950 in income in 2014 from a job? ☐ Yes ☐ No

Is this child expected to have more than $950 in other income in 2014? (Include any income they get that is NOT from a Job, Self-Employment, Child Support, Social Security, Supplemental Security Income, Workers Compensation or Veterans Benefits.) ☐ Yes ☐ No

SECTION FOUR: SIGNATURE

Signature of Member	Date Signed	Case Number

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00914A (12/13)

BADGERCARE PLUS TAX FILER INFORMATION
MORE ABOUT FORM F-00914 FOR CONSORTIA, PARTNERS AND STAKEHOLDERS

On April 1, 2014, BadgerCare Plus program rules for counting household income will be changing.

These changes only affect BadgerCare Plus members and do not affect people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD) or other Medicaid programs.

BadgerCare Plus members whose household income is currently above the new income limits can choose to fill out a form to see if new rules for counting household income will allow people in their household to stay enrolled in BadgerCare Plus after April 1, 2014.

- If someone fills out and returns the form by January 17, 2014, we will use the new rules for counting household income.
- If someone does not fill out and return the form, we will not be able to use the new rules when applying new income limits for BadgerCare Plus.

Providing the information in the form will also allow us to forward a member's application automatically to the federal Health Insurance Marketplace (also known as the Exchange) if they are above the new income.

The main differences between current rules and new rules for counting household income are:

- Child support income is no longer counted.
- Household sizes may be larger or smaller depending on how someone plans to file taxes.
- For self-employed households, depreciation is an allowable expense.
- In most cases, the income of children under 19 and tax dependents is only counted if they are expected to be required to file taxes.

The answers to the questions in this form should be based on whether someone *expects* to file their taxes for the 2014 tax year. If they don't know for sure, they should give their best estimate of what their tax filing plans will be.

Section One: Information about people in your household
In this section, we're asking if anyone plans to file a tax return for income they will get during the 2014 tax year. Since we need information about the current tax year, we are referring to the taxes they would file in 2015 for income they get in 2014.

By tax return, we mean the tax form or forms used to file federal taxes, either on paper or electronically. Someone can file a tax return even if they do not have any income or owe any tax.

Section Two: Tax information for your household
In this section, we're asking about the people in the home who plan to file a tax return in 2015 for income they will get during the 2014 tax year.

First, provide the name of the first tax filer. If a married couple is filing taxes jointly, they should list both filers in this section and they do not have to list the spouse again later.

Next, tell us the person's filing status.

- For someone who is married, choose "married filing jointly" or "married filing separately." By "filing jointly", we mean that they are filing one tax return for the income they both have. Almost all married couples file jointly, but if the couple plans to file separately, they should choose "married filing separately."
- For someone who is not married, choose either "single" or "head of household". (If the person is not sure, choose single; this will not affect their eligibility results.)

Then tell us whether anyone who lives outside of the home is planning to claim the tax filer as a tax dependent.

For example, there may be a teenager in the home who has a part-time job and is planning to file taxes. If she or he is listed on this page as the tax filer, answer yes if she or he is going to be claimed as a dependent by a parent who does not live in the home.

Tax Dependents
Next, list all of the people whom this person plans to claim as tax dependents for the 2014 tax year. In most cases, this will be the person's children who live in the home, but it could include other people for whom the person provides support, even if they live outside of the home. For example, non-custodial children or adult children who are in college can be claimed as tax dependents.

If someone only claims a child as a tax dependent every other year, the child should be listed only if the person plans to claim them for the 2014 tax year. **Please Note**: Even if someone is not claiming a child as a tax dependent for the current tax year, they can still apply for health care benefits for that child.

Keep in mind that there are tax rules around who can be claimed as a tax dependent. For example, two people who are not married cannot claim the same tax dependent, and a married person cannot claim his or her spouse as a tax dependent. If someone is planning to claim a tax dependent who is deceased, they can only claim the deceased in the same year they passed away.

For each tax dependent, answer the questions about the income they **expect** to have in 2014:

Job Income
Answer yes if the tax dependent expects to earn more than $5,950 in income from a job in 2014. If you aren't sure, you should estimate based on the person's current monthly earnings, and whether they plan to work all of the months in the year.

Other Income
Answer yes if the tax dependent expects to get more than $950 from any taxable source other than a job or self-employment in the current tax year.

Include:
- Unemployment compensation
- Tribal per capita payments
- Alimony
- Taxable annuity or retirement income

Do *not* include:
- Child Support
- Supplemental Security Income (SSI)
- Social Security
- Veterans Benefits
- Workers Compensation

Section 3: Information about children living in your household
If there are any children under 19 living in the home, list them in this section only if they have NOT been listed as tax dependents above. For example, if the tax filer has a child living in the home but is not planning to claim them as a tax dependent for 2014, list the child in this section.

Job Income
Answer yes if the child expects to earn more than $5,950 in income from a job in 2014. If you aren't sure, you should estimate based on the child's current monthly earnings, and whether they plan to work all of the months in the year.

Other Income
Answer yes if the child expects to get more than $950 from any taxable source other than a job or self-employment in the current tax year.

Include:
- Unemployment compensation
- Tribal per capita payments
- Alimony
- Taxable annuity or retirement income

Do *not* include:
- Child Support
- Supplemental Security Income (SSI)
- Social Security
- Veterans Benefits
- Workers Compensation

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

BC+ Extension Premium Letter

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State of Wisconsin

Case #: XXXXXXXXXX

[CONSORTIA]
Phone: xxx-xxx-xxxx

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
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Important Information about Your BadgerCare Plus Enrollment

This letter is to let you know that you or someone in your household will now be required to pay a monthly premium for your BadgerCare Plus coverage in 2014.

Adults enrolled in BadgerCare Plus who are in an extension will now have premiums if they are above 100% of the Federal Poverty Level (FPL). You or someone in your household is enrolled in a BadgerCare Plus extension because of an increase in income from a job or child support.

If you are still enrolled in BadgerCare Plus in December, you will receive a letter letting you know the amount of your premiums and how to pay them.

It is very important that you pay your premiums on time. Your first payment will be due on **January 10, 2014**, for coverage in January 2014. If you do not pay your premiums, your BadgerCare Plus will end.

If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away, as it may affect your enrollment or your premium amount.

If you have questions about this letter or your BadgerCare Plus enrollment, contact the agency listed at the top of this page.

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

MEMBER SERVICES -- ACA
P O BOX 6678
MADISON WI 53716-0678

CORE WAITLIST HEADS-UP LETTER

DATE

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State of Wisconsin

Case #: XXXXXXXXXX

[MEMBER SERVICES]
Phone: 1-800-362-3002

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Important Information about the BadgerCare Plus Core Plan Waitlist

Our records show that you are on the BadgerCare Plus Core Plan Waitlist. This letter is to let you know that the BadgerCare Plus Core Plan is ending as of December 31, 2013. The Waitlist for the Core Plan has also ended.

There are new health care options available to you. You may be able to enroll in BadgerCare Plus, or apply for private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

- If your household income is above 100% of the Federal Poverty Level (FPL), you should contact the new federal Marketplace to apply for private health insurance. For a single person in 2013, 100% FPL means you have monthly household income of $958. For a family of two, it means you have monthly household income of $1,293 (please see the chart on the following page).

- The Marketplace offers a variety of health insurance plan options and allows you to choose the one that is best for you and your family. You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

  Please Note: For any coverage through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

(OVER)

- The Marketplace offers help paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

- To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

- If your income is at or below 100% FPL, you may be eligible for BadgerCare Plus as of January 1, 2014. You may apply for these benefits on or after November 18, 2013**.** If you apply before this date, we will not be able to process your application. You can apply for BadgerCare Plus online at access.wi.gov, or through your local agency. To find your local agency, go to: dhs.wi.gov/forwardhealth/imagency/index.htm

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
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5	$2,298	$6,893

*Note: FPL limits are subject to change

If you have questions about this letter, please call Member Services at 1-800-362-3002.

MEMBER SERVICES -- ACA
P O BOX 6678
MADISON WI 53716-0678

CORE WAITLIST TRANSITION LETTER

DATE

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State of Wisconsin

Account #: XXXXXXXXXX

[MEMBER SERVICES]
Phone: 1-800-362-3002

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New Information about BadgerCare Plus Core Plan Waitlist and the Health Insurance Marketplace

Our records show that you were on the BadgerCare Plus Core Plan Waitlist. You received a letter in early October letting you know that the BadgerCare Plus Core Plan was ending as of December 31, 2013. The letter said that that beginning January 1, 2014, you would be able to enroll in BadgerCare Plus if your household income was below the income limits for the program. **Due to difficulties at HealthCare.gov and a change in state law, BadgerCare Plus will not be available to you until April 1, 2014.**

However, you may be able to purchase private health insurance through the federal Health Insurance Marketplace, also known as the Exchange, with coverage beginning as soon as January 1, 2014. For more information about how to apply through the Marketplace, see the section in this letter called "How Do I Apply Through The Marketplace?"

What Do I Need to Do?

- If your household income is above 100% of the Federal Poverty Level (FPL), you should apply for private health insurance through the Marketplace before March 31, 2014. For more information about this income limit, see the chart below.
- If you have already applied for private health insurance at the Marketplace and received a response that you may be eligible for BadgerCare Plus, you will receive a letter in March letting you know about your BadgerCare Plus enrollment starting April 1, 2014.

- If your household income is below 100% FPL, you should wait until February 3, 2014 to apply directly through BadgerCare Plus for benefits that start April 1, 2014. Beginning February 3, 2014, you can apply for BadgerCare Plus online at access.wi.gov or through your agency. To find your agency, go to: dhs.wi.gov/em/customerhelp or call 1-800-362-3002. If you apply directly to BadgerCare Plus before February 3, 2014, we will not be able to process your application.

How Do I Apply Through The Marketplace?

- Online at HealthCare.gov,
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov, or
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org or 211wisconsin.org.

Keep in mind that **March 15, 2014 is the deadline to purchase Marketplace coverage that begins April 1, 2014.**

BadgerCare Plus 2013 Federal Poverty Level (FPL) Income Limits*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

What Should I Do If I Need To Go To The Doctor Before My Health Care Coverage Starts?

If you need to go to the doctor before your BadgerCare Plus coverage or private health insurance starts, there are health care facilities in Wisconsin that provide services for people with little or no health insurance. These facilities provide primary care and preventive care, including health, oral, and mental health/substance abuse services to people of all ages, regardless of their ability to pay. They charge for services on a sliding-fee scale that is based on your family income and size.

You can get additional information about free and low cost health clinics in Wisconsin at dhs.wi.gov/forwardhealth/clinics.htm.

If you have questions about this letter, please call Member Services at 1-800-362-3002.

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

BASIC PLAN HEADS-UP LETTER

DATE

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XXXXXXXXXXXXXXX WI 99999 9999

State of Wisconsin

Case #: XXXXXXXXXX

[BASIC PROCESSING UNIT]
Phone: XXX-XXX-XXXX

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Important Information About Your BadgerCare Plus Basic Plan Enrollment

This letter is to let you know that the BadgerCare Plus Basic Plan is ending on December 31, 2013. If you continue to pay your premiums through November, there will be no change in your enrollment through December 31, 2013. As of January 1, 2014, you will no longer have BadgerCare Plus Basic coverage.

There are new health care options available to you. You may be able to enroll in BadgerCare Plus, or apply for private health insurance through the federal Health Insurance Marketplace, also known as the Exchange.

- If your household income is above 100% of the Federal Poverty Level (FPL), you should contact the new federal Marketplace to apply for private health insurance. For a single person in 2013, 100% FPL means you have monthly household income of $958. For a family of two, it means you have monthly household income of $1,293 (please see the chart on the following page).

- The Marketplace offers a variety of health insurance plan options and allows you to choose the one that is best for you and your family. You can apply for private health insurance in the Marketplace starting October 1, 2013. For coverage starting on January 1, 2014, you must apply for health insurance through the Marketplace before **December 15, 2013.**

  Please Note: For any coverage through the Marketplace, it is very important that you pay your first premium on time. If you do not, you will not be covered in January 2014.

- The Marketplace offers help with paying for health insurance in the form of advance premium tax credits and cost sharing reductions. You will find out if you are eligible for this help when you apply.

- To apply for private health insurance through the Marketplace, go to HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325).

- If your income is at or below 100% FPL, you may be eligible for BadgerCare Plus as of January 1, 2014. You may apply for these benefits on or after November 18, 2013**.** If you apply before this date, we will not be able to process your application. You can apply for BadgerCare Plus online at access.wi.gov, or through your local agency. To find your local agency, go to: dhs.wi.gov/forwardhealth/imagency/index.htm

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

If you have questions about this letter, please call the agency listed number listed at the top of page 1.

CENTRAL DOCUMENT PROCESSING UNIT
P O BOX 5234
JANESVILLE WI 53547-5234

4A BASIC PLAN 3 MONTH LETTER

DATE

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XXXXXXXXXXXXXXX WI 99999 9999

State of Wisconsin

Case #: XXXXXXXXXX

[BASIC PROCESSING UNIT]
Phone: XXX-XXX-XXXX

English — For help to translate or understand this, please call 1-800-362-3002 (TTY).
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Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

New Information About Your BadgerCare Plus Basic Plan Enrollment

You recently received a letter that said the BadgerCare Plus Basic Plan would end December 31, 2013. **This letter is to let you know that due to early enrollment challenges for healthcare.gov, Governor Walker extended your coverage for BadgerCare Plus Basic.** Your BadgerCare Plus Basic Plan will now continue through March 31, 2014. Your January premium slip is included with this letter. If you want to stay enrolled in the BadgerCare Plus Basic Plan, you need to pay your premium by December 12, 2013.You should **continue to pay your premiums** and stay enrolled in the BadgerCare Plus Basic Plan through March 31, 2014 if any of these apply to you:

- You applied through the Marketplace (also known as the Exchange) and they said you would be enrolled in the BadgerCare Plus Standard Plan starting January 1, 2014. Because these benefits will not start until April 1, 2014, you should stay enrolled in Basic through March 31, 2014.
- You applied through the Marketplace but you have not yet paid your first premium to enroll in a private health plan (unless your premiums for private health insurance are less than your Basic premiums and you want to switch to private health insurance before March 31, 2014).
- You have not yet applied for private health insurance through the Marketplace. You can read more about how to apply through the Marketplace on the next page.

You should **stop paying your Basic Plan premiums** only if you have already signed up for private health insurance through the Marketplace AND you have paid your first premium for coverage starting January 1, 2014.

If you have questions about this letter, please call the agency listed at the top of this page.

Applying for Health Insurance through the Marketplace:

If you have not done so already, you will need to complete a health care application through the federal Health Insurance Marketplace (also called the Exchange) in order to have health insurance coverage after the Basic Plan ends. Keep in mind that March 15, 2014 is the deadline to apply for and purchase Marketplace coverage that begins on April 1, 2014.

You can apply health care coverage through the federal Health Insurance Marketplace:

- Online at HealthCare.gov
- Over the phone by calling 1-800-318-2596 or TTY 1-855-889-4325,
- By mail, using a paper application. You can get the application and instructions online at HealthCare.gov by clicking on the orange button with the paper icon, or
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin website at e4healthwi.org.

On the Marketplace application: It is important to answer "No" to Question 1 in Step 4 (on page 6 of the paper application), "Is anyone enrolled in health care coverage now from the following?" if BadgerCare Plus Basic is the only health insurance you currently have. This will tell the Marketplace that your BadgerCare Plus Basic Plan coverage will be ending and allow the Marketplace to process your application.

If you have questions about this letter, please call the agency listed at the top of page 1.

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[<<Return Address City>><<Return Address State>> <<Return Address Zip>>]

Mailing Date: MM/DD/YYYY

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<<Recipient Name>>
<<Address Line1>>
<<Address Line2>>
<<city>> <<State>><<Zip>>

State of Wisconsin

Case #: <<CASE Num>>

<<Agency Contact Line1>>
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<<Agency Contact Line3>>
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Important Information about Applying for Health Insurance for January 1, 2014

This letter is a follow up to the letter we sent to you in early October. We wanted to remind you there are new options for health care coverage through the federal Health Insurance Marketplace, also known as the Exchange.

Due to changes in state law**,** adult members with household income above 100% of the Federal Poverty Level (FPL) and children with income above 300% FPL will no longer be eligible for BadgerCare Plus. These changes will take effect January 1, 2014. For more information on the new income limits, see the next page.

You have received this letter because you or someone in your household may be above these limits and will need to take action.

What Do I Need to Do?

Members who are above the new income limits for BadgerCare Plus in 2014 may apply for private health insurance through the federal Health Insurance Marketplace.

You must apply for health insurance through the Marketplace before December 15, 2013, and pay your premium on time, for coverage starting on January 1, 2014.

How to Apply

(OVER)

To apply for private health insurance through the Marketplace, you can:

- go to HealthCare.gov and apply online
- call 1-800-318-2596 (TTY: 1-855-889-4325) to apply over the phone
- apply by mail. We have enclosed a paper application for you to fill out and send to:

  Health Insurance Marketplace
  Dept. of Health and Human Services
  465 Industrial Blvd.
  London, KY 40750-0001

  There are instructions for filling out the application included with this letter as well. However, if you need help with your application, you may call 1-800-318-2596 (TTY: 1-855-889-4325).

  Note: It is important to answer "No" to Question 1 in Step 4 (on page 6 of the paper application), "Is anyone enrolled in health care coverage now from the following?" if BadgerCare Plus is the only health insurance you currently have. This will tell the Marketplace that your BadgerCare Plus coverage may be ending on December 31, 2013, and will allow the Marketplace to process your application.

PLEASE NOTE: If you have already submitted an application online, over the phone, or by mail, you do not need to do anything else.

To find in-person help in your area, go to e4healthwi.org. You should be able to find people in your area that can help you apply.

BadgerCare Plus Income Limits

2013 FPL Guidelines*

Family Size	Monthly Income Limit for Adults (100% FPL)	Monthly Income Limit for Children (300% FPL)
1	$958	$2,873
2	$1,293	$3,878
3	$1,628	$4,883
4	$1,963	$5,888
5	$2,298	$6,893

*Note: FPL limits are subject to change

Please Note: These new limits do not affect pregnant women or people who are enrolled in Medicaid for the Elderly, Blind or Disabled (EBD). If you had a recent loss in income, or if you or someone in your household becomes pregnant, report the change right away to your local agency, as it may affect your enrollment.

If you have questions about this letter or about your BadgerCare Plus enrollment, call the agency number listed at the top of page 1.

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<<Return Address line4>>
[<<Return Address City>><<Return Address State>> <<Return Address Zip>>]

Mailing Date: MM/DD/YYYY

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<<Recipient Name>>
<<Address Line1>>
<<Address Line2>>
<<city>> <<State>><<Zip>>

State of Wisconsin

Ref #: <<CASE Num>>

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Important Information About Your Application to the Federal Health Insurance Marketplace for BadgerCare Plus

You recently submitted an application through the federal health Insurance Marketplace (also called the Exchange) and you may have received a notice stating you may be eligible for Medicaid or BadgerCare Plus coverage beginning no earlier than January 1, 2014.

- If there are no children under age 19 living in your home, please read the information below.
- If you are a parent or caretaker relative living with and caring for a child under age 19 or if you are a child under age 19, please read the information on page two.
- If the Marketplace told you that you may be eligible for services because you have special health care needs like needing help with daily living or having a disability, we will contact you after the Marketplace sends us your complete information. There is no other action required on your part.

If there are no children under age 19 in your home

Due to a delay in program changes, BadgerCare Plus will continue to be closed to new enrollment until April 1, 2014 for adults age 19 to 64 who are not living with and caring for a child under age 19. **As a result, you will not be enrolled in the BadgerCare Plus Standard Plan until April 1, 2014**.

The Marketplace has not yet sent us your complete application. After the Marketplace sends your complete application for BadgerCare Plus, it will be processed and you will have BadgerCare Plus coverage beginning April 1, 2014.

You do not need to reapply or take any other action at this time. You will get a letter in March with more information about your enrollment in BadgerCare Plus.

What Should I Do If I Need To Go To The Doctor Before My Health Care Coverage Starts?

If you need to go to the doctor before your BadgerCare Plus coverage or private health insurance starts, there are health care facilities in Wisconsin that provide services for people with little or no health insurance. These facilities provide primary care and preventive care, including health, oral, and mental health/substance abuse services to people of all ages, regardless of their ability to pay. They charge for services on a sliding-fee scale that is based on your family income and size.

You can get additional information about free and low cost health clinics in Wisconsin at dhs.wi.gov/forwardhealth/clinics.htm.

Please Note: If you are already enrolled in the BadgerCare Plus Core Plan, your current Core Plan benefits will continue through March 31, 2014, as long as you continue to meet program rules. Your BadgerCare Plus Standard Plan benefits will begin April 1, 2014.

If there are children under age 19 in your home

If you are a parent or caretaker relative living with and caring for a child under age 19 or if you are a child under age 19, **t**he Marketplace has not yet sent us your complete application. After the Marketplace sends your complete application for BadgerCare Plus, it will be processed and you will have BadgerCare Plus coverage that will be effective back to January 1, 2014. Depending on when you filed your application with the Marketplace, your coverage could be effective even earlier than January 1, 2014.

You do not need to reapply or take any other action at this time. You will get a letter with more information about your enrollment in BadgerCare Plus once we receive and process your application from the Marketplace.

Please Note: If you are already enrolled in BadgerCare Plus, your current enrollment will continue as long as you continue to meet program rules.

If you have questions or would like more information

If you have questions about this letter or would like more information about BadgerCare Plus:

- Go to dhs.wi.gov/em/customerhelp.
- Call Member Services at 1-800-362-3002.

Please Note: If you submitted more than one application through the Marketplace, you may receive more than one copy of this letter. There is no other action required on your part.

CDPU
CENTRALIZED DOCUMENT PROCESSING UNIT
PO BOX 9999
JANESVILLE WI 54677 9999

Mailing Date: 02/21/2014

000001
IAM NOTICE
433 W WASHINGTON AV
MADISON WI 53717 8540

State of Wisconsin

Case #: 1111111111

The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-800-362-3002, press option #7 and state your language. Or, e-mail us at: memberservices@wisconsin.gov. These services are free.

About Your Benefits

This letter tells you about your benefits. If you have a question, please call the agency above. If you need help because of a disability or need translation help, please see the Key Contacts at the end of this letter.

Which benefit?	Status of your benefits?
Health Care	Your benefits will be ending on Apr. 01, 2014. Please see Your Health Care Benefits page to learn more about why.
FoodShare	There have been no changes to this benefit.

If you don't agree with this decision, you have the right to a Fair Hearing. Please see the last page of this letter to learn more. You may also talk with the agency above.

Your Health Care Benefits

Who is not enrolled?

When?	Which plan?	Who and why?
As of Apr. 01, 2014	BadgerCare Plus	IAM: The income we counted for your household is over the program limit. To learn more, please see the part of your letter that shows how we counted your income. IAM: You may be able to buy private health insurance through the federal Health Insurance Marketplace (Exchange). You also may be able to get help paying for it. To apply, go to HealthCare.gov, call 1-800-318-2596 (TTY 1-855-889-4325) or contact your agency for help. IAM: The BadgerCare Plus income limit was reduced by state law. The income we counted for your household is now over the new limit. You may not ask for a Fair Hearing if the only reason you want a hearing is because you disagree with this change in the law.

Supporting Laws: S.49.45 (23), 42 CFR 435.1200, S.49.45(5)

Your Household's Reported Income and Bills

Here is a list of the income and bills that we have on file for your household.

Income

Who has income?	When and how much? As of Apr. 2014		
IAM Social Security	$1,139.00 each month		

Bills

Type of bill	When and how much? As of Apr. 2014		
Medical Bills	$16.00 each month		
Utilities	Yes*		
Rent Or Lot Rent	$300.00 each month		

* We have on file that you had utility bills for these months.

How We Counted Your Income

Here are the amounts and limits that were used to decide whether you could get benefits. To learn more, please see your Enrollment & Benefits handbook.

BadgerCare Plus (new rules as of 2014)

This was used for: IAM

	Apr. 2014		
Your Counted Income	$1,139.00		
Counted Income Limit	$972.50		

BadgerCare Plus Standard Plan

This was used for: IAM

	Apr. 2014		
Your Gross Income	$1,139.00		

Your Counted Income	$1,139.00		
Counted Income Limit	$972.50		

Key Contacts

Disability Services: If you have a disability and need this information in an alternate format, or if you need it translated to another language, call 1-800-362-3002. Translation and TTY services are available and are free of charge.

Online Help: ACCESS is an internet tool that lets you apply for other benefits, check your benefits or report changes. Visit access.wisconsin.gov.

General Questions about FoodShare or Health Care Benefits or your ForwardHealth Card: See your Enrollment & Benefits handbook or go to dhs.wisconsin.gov/em/customerhelp. Or, call 1-800-362-3002 (TTY and translation services are available).

Any Other Questions: See the contact information on page 1.

YOU HAVE THE RIGHT TO A FAIR HEARING ABOUT YOUR BENEFITS

What is a Fair Hearing and why should I ask for one?	A Fair Hearing gives you the chance to tell why you think there has been a wrong decision about your application or benefits. At the hearing, a hearing officer will hear from you and the agency to find out if the decision was right or wrong. You may bring a friend or family member with you to the hearing. You may also be able to get free legal help. To learn more about free legal help, call 1-800-472-1638.
How long do I have to ask for a hearing?	The Division of Hearings & Appeals must get your request for a hearing about the decision in this letter by the date below: Health Care → May. 23, 2014
Can I keep my benefits while I wait for my hearing?	Yes, if you are already getting benefits and if you ask for a hearing before your benefits change, you can keep getting the same benefits until the hearing officer makes a decision. If the hearing officer decides that the agency was right, you may need to return the extra benefits that you got after your benefits were supposed to change.
How do I ask for a hearing?	You can ask for a fair hearing and/or a hearing request form at the agency shown on the first page of this notice. Or, you can get a request form at dhs.wisconsin.gov/em/customerhelp. You can send the form or a letter asking for a hearing to the Division of Hearings & Appeals, PO Box 7875, Madison, WI 53707-7875, or fax it to 608-807-3533.

CDPU
CENTRALIZED DOCUMENT PROCESSING UNIT
PO BOX 5234
JANESVILLE WI 53547 5234

Mailing Date: 03/21/2014

000010
COLLINS CRAIG
W3236 WOLF RIVER DRIVE
PO BOX 411
KESHENA WI 54135 0411

State of Wisconsin

Case #: 1111111111

The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-800-362-3002, press option #7 and state your language. Or, e-mail us at: memberservices@wisconsin.gov. These services are free.

About Your Benefits

This letter tells you about your benefits. If you have a question, please call the agency above. If you need help because of a disability or need translation help, please see the Key Contacts at the end of this letter.

Which benefit?	Status of your benefits?
Health Care	Your benefits will be ending on May. 01, 2014. Please see Your Health Care Benefits page to learn more about why.

If you don't agree with this decision, you have the right to a Fair Hearing. Please see the last page of this letter to learn more. You may also talk with the agency above.

Your Health Care Benefits

Who is not enrolled?

When?	Which plan?	Who and why?
As of May. 01, 2014	BadgerCare Plus	BABY, COLLINS: You do not live in Wisconsin. COLLINS: The income we counted for your household is over the program limit. To learn more, please see the part of your letter that shows how we counted your income. COLLINS: You may be able to buy and get help paying for private health insurance through the federal Health Insurance Marketplace (Exchange). Your application has been sent to the Marketplace. If you have questions, call the Marketplace at 1-800-318-2596 (TTY 1-855-889-4325) or go to HealthCare.gov.

Supporting Laws: S.49.471, 42 CFR 435.1200

Your Household's Reported Income

Here is a list of the income that we have on file for your household.

Income			
Who has income?	**When and how much? As of May. 2014**		
COLLINS Job: DOC	$3,000.00 each month		

How We Counted Your Income

Here are the amounts and limits that were used to decide whether you could get benefits. To learn more, please see your Enrollment & Benefits handbook.

BadgerCare Plus (new rules as of 2014)			
This was used for: COLLINS			
	May. 2014		
Your Counted Income	$3,000.00		
Counted Income Limit	$1,292.50		

Key Contacts

Disability Services: If you have a disability and need this information in an alternate format, or if you need it translated to another language, call 1-800-362-3002. Translation and TTY services are available and are free of charge.

ACCESS www.access.wisconsin.gov

Online Help: ACCESS is an internet tool that lets you apply for other benefits, check your benefits or report changes. Visit access.wisconsin.gov.

General Questions about FoodShare or Health Care Benefits or your ForwardHealth Card: See your Enrollment & Benefits handbook or go to dhs.wisconsin.gov/em/customerhelp. Or, call 1-800-362-3002 (TTY and translation services are available). If you have been approved to get other public assistance benefits or SSI, you may be able to enroll in FoodShare. You can apply for FoodShare online at ACCESS.wi.gov or contact your agency on page 1.

Any Other Questions: See the contact information on page 1.

YOU HAVE THE RIGHT TO A FAIR HEARING ABOUT YOUR BENEFITS

What is a Fair Hearing and why should I ask for one?	A Fair Hearing gives you the chance to tell why you think there has been a wrong decision about your application or benefits. At the hearing, a hearing officer will hear from you and the agency to find out if the decision was right or wrong. You may bring a friend or family member with you to the hearing. You may also be able to get free legal help. To learn more about free legal help, call 1-888-278-0633.
How long do I have to ask for a hearing?	The Division of Hearings & Appeals must get your request for a hearing about the decision in this letter by the date below: Health Care → Jun. 16, 2014
Can I keep my benefits while I wait for my hearing?	Yes, if you are already getting benefits and if you ask for a hearing before your benefits change, you can keep getting the same benefits until the hearing officer makes a decision. If the hearing officer decides that the agency was right, you may need to return the extra benefits that you got after your benefits were supposed to change.
How do I ask for a hearing?	You can ask for a fair hearing and/or a hearing request form at the agency shown on the first page of this notice. Or, you can get a request form at dhs.wisconsin.gov/em/customerhelp. You can send the form or a letter asking for a hearing to the Division of Hearings & Appeals, PO Box 7875, Madison, WI 53707-7875, or fax it to 608-264-9885.

ForwardHealth
Wisconsin serving you

Member Update
March 2014

Spanish — Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-362-3002 (V/TTY).
Russian — Если вам не всё понятно в этом документе, позвоните по телефону 1-800-362-3002 (V/TTY).
Hmong — Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-362-3002 (V/TTY).
Laotian — ເພື່ອຊ່ວຍໃນການແປ ຫລື ເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະຣຸນາໂທຣະສັບຫາ 1-800-362-3002 (V/TTY).

Affected Programs: BadgerCare Plus, Medicaid
To: Members

Important Information About Your BadgerCare Plus Enrollment

Changes to Your BadgerCare Plus Benefits

On April 1, 2014, all BadgerCare Plus members will be covered under the Standard Plan. If you were covered under the Benchmark or Core Plan, you will receive benefits under the Standard Plan, starting April 1.

This is an informational Member *Update*. No action is required on your part.

Covered Services

More services are covered under the Standard Plan than the Benchmark Plan or the Core Plan. Some of those services include:

- Generic and brand name prescription drugs and some over-the-counter (OTC) drugs.
- Additional outpatient mental health and substance abuse treatment services.
- Dental services.
- Medical transportation to and from a covered service.

Note: BadgerCare Plus Benchmark Plan and Core Plan members were also enrolled in BadgerRx Gold, a reduced-cost prescription drug program. The BadgerRx Gold program is ending March 31, 2014, so your enrollment in BadgerRx Gold is also ending. However, on April 1, 2014, when you begin getting health care coverage through the BadgerCare Plus Standard Plan, more prescription drug coverage will be available to you at a lower cost.

For more information about BadgerCare Plus Standard Plan covered services, see the covered services attachment on page 3.

Copayment

Copayments for services will be between $0.50 and $3 per service. There are no copayments for preventive services.

Your providers are required to make a reasonable effort to collect the copayment but cannot refuse to provide you with health care services if you do not pay your copayment.

HMO Enrollment

Most BadgerCare Plus members are enrolled in an HMO. If you are enrolled in an HMO, no action is required on your part at this time. If you need to choose a new HMO, you will be notified by mail.

Identification Cards

If you were a Core Plan member, your ForwardHealth ID card is changing, so you will be mailed a new ForwardHealth ID card. Your member ID number will not change. If you were in the Standard Plan or Benchmark Plan, your ForwardHealth ID card will not change.

New BadgerCare Plus Rules

As of April 1, 2014, the following people can enroll in the BadgerCare Plus Standard Plan:

- Adults with household incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with household incomes at or below 300 percent of the FPL.
- Children (under 19 years old) with household incomes at or below 300 percent of the FPL.

2014 FPL Guidelines*		
Family Size	**Monthly Income Limit for Adults (100% FPL)**	**Monthly Income Limit for Children and Pregnant Women (300% FPL)**
1	$972.50	$2,917.50
2	$1,310.83	$3,932.50
3	$1,649.17	$4,947.50
4	$1,987.50	$5,962.50
5	$2,325.83	$6,977.50

*Federal Poverty Level (FPL) limits are subject to change. Current FPL guidelines can be found at *badgercareplus.org/fpl.htm*.

For More Information

- ForwardHealth Enrollment and Benefits handbook — Available on the DHS Web site at *dhs.wi.gov/em/CustomerHelp/* or the BadgerCare Plus Web site at *badgercareplus.org/*.
- *ACCESS.wi.gov* — To apply, check the status of your benefits, do your renewal, and report changes.
- ForwardHealth Member Services — 1-800-362-3002.

ATTACHMENT
Covered Services for BadgerCare Plus Standard Plan Members

The chart below lists the health care services covered by the BadgerCare Plus Standard Plan as of April 1, 2014, and what the copayment will be for these services. Some members are exempt from copayments. The following members do not need to pay copayments:

- Children in foster care, regardless of age.
- Children in adoption assistance, regardless of age.
- Children under age 1 year with household income up to 150 percent of the Federal Poverty Level (FPL).
- Children ages 1 through 5 years with household income up to 185 percent of the FPL.
- Children ages 6 through 18 years with household incomes at or below 133 percent of the FPL.
- Children in the Katie Beckett program, regardless of age.
- Children who are American Indian or Alaskan Natives who are enrolled in the state's Child Health Insurance Program (CHIP).
- American Indians or Alaskan Natives, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Terminally ill individuals receiving hospice care.
- Nursing home residents.
- Members enrolled in Wisconsin Well Woman Medicaid.
- Children under age 19 eligible through Express Enrollment.

Please note: Because services and copayments change, you should ask your provider what services are covered and what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

Service	Coverage Under the BadgerCare Plus Standard Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3 copayment per service.
Chiropractic	Full coverage. $0.50 to $3 copayment per service.
Dental	Full coverage. $0.50 to $3 copayment per service.
Disposable Medical Supplies (DMS)	Full coverage. $0.50 to $3 copayment per service and $0.50 per prescription for diabetic supplies.

Service	Coverage Under the BadgerCare Plus Standard Plan
Drugs (Prescription)	Coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Copayment: • $0.50 for OTC drugs. • $1 for generic drugs. • $3 for brand name drugs. Copayments are limited to $12 per member, per provider, per month. Over-the-counter drugs do not count towards the $12 maximum. Limit of five opioid prescription fills per month.
Durable Medical Equipment (DME)	Full coverage. $0.50 to $3 copayment per item. Rental items are not subject to copayment.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals 20 years and under. No copayment.
Hearing Services	Full coverage. $0.50 to $3 copayment per procedure. No copayment for hearing aid batteries.
Home Care Services — Home Health, Private Duty Nursing (PDN), and Personal Care	Full coverage of home health services, PDN, and personal care. No copayment.
Hospice	Full coverage. No copayment.
Hospital — Inpatient	Full coverage. $3 copayment per day with a $75 cap per stay.

Service	Coverage Under the BadgerCare Plus Standard Plan
Hospital — Outpatient	Full coverage. $3 copayment per visit.
Hospital — Outpatient Emergency Room	Full coverage. No copayment.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3 copayment per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. Copayments are not required when services are provided in a hospital setting.
Nursing Home Services	Full coverage. No copayment.
Physician	Full coverage, including laboratory and radiology. $0.50 to $3 copayment per service, limited to $30 per provider per calendar year. No copayment for emergency services, preventive services, anesthesia, or clozapine management.
Podiatry	Full coverage. $0.50 to $3 copayment per service, limited to $30 per provider per calendar year.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service — Family Planning Services	Full coverage with the exceptions listed below. No copayment for services provided by a family planning clinic or contraceptive management. Does not cover: • Reversal of voluntary sterilization. • Infertility treatments. • Surrogate parenting and related services, including but not limited to: ✓ Artificial insemination. ✓ Obstetrical care. ✓ Labor or delivery. ✓ Prescription and OTC drugs.

Service	Coverage Under the BadgerCare Plus Standard Plan
Routine Vision	Full coverage including eyeglasses. $0.50 to $3 copayment per service.
Therapy — Physical Therapy, Occupational Therapy, and Speech and Language Pathology	Full coverage. $0.50 to $3 copayment per service. Copayment limited to the first 30 hours or $1,500, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency medical transportation to and from a covered service. Copayment: • $2 for non-emergency ambulance trips. • $1 per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.

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Member Update
March 2014

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Affected Programs: BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, BadgerCare Plus Basic Plan
To: Members

BadgerRx Gold Program Will End March 31, 2014

Because of changes in state law and implementation of the Affordable Care Act, BadgerRx Gold, the reduced-cost prescription drug program, is ending. The last day you will be able to purchase prescriptions through the BadgerRx Gold Program is March 31, 2014.

Health Care Options

You have the option of applying for and purchasing private health insurance through the federal Health Insurance Marketplace, also known as the Exchange. The Marketplace offers a variety of health insurance plans and allows you to choose what is best for you and your family. Prescription drug coverage is required to be part of an insurance plan purchased through the Marketplace. You can apply now for coverage. Keep in mind that the last day to apply for coverage through the Marketplace is March 31, 2014.

You can apply through the federal Health Insurance Marketplace:

- Online at *www.healthcare.gov/*.
- Over the telephone by calling 1-800-318-2596 or TTY 1-855-889-4325.
- By mail, using a paper application. You can get the application and instructions online at *www.healthcare.gov/*.
- In-person with the help of a certified navigator, certified application counselor (CAC), agent, broker, or other public benefits assisters. A list of individuals who can provide in-person help can be found on the Enrollment for Health Wisconsin Web site at *e4healthwi.org/* or *211wisconsin.org/*.

For More Information

BadgerRx Gold Program information is available on the BadgerRx Gold Web site at *www.badgerrxgold.com/* or by calling a BadgerRx Gold Customer Care Specialist at 1-866-809-9382.

SCOTT WALKER
GOVERNOR
STATE OF WISCONSIN

November 15, 2013

The Honorable Jacob Lew
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Lew and Secretary Sebelius,

Given the ongoing issues Wisconsinites are facing in accessing the federal exchange, I am asking you to allow Wisconsin citizens to use their premium tax credits to purchase any qualified plan and not just plans on the exchange. According to the enrollment data released by the Department of Health and Human Services (HHS), only 877 Wisconsinites were able to enroll in health plans through the exchange. Meanwhile, the proposed fix is not expected to be complete until late November at the earliest. These timeframes place undue burden on Wisconsinites interested in enrolling by the December 15th deadline for January 1st effective dates.

We have repeatedly sent letters asking for flexibility, all of which have been denied. We warned you about the problems with your opaque and cumbersome regulatory approach, and now, Wisconsinites are paying the price through high premiums, limited choice, and a federal exchange website that does not work effectively. It is far past time to start fixing these problems. However, allowing Wisconsinites to use the subsidies for which they qualify with an insurer of their choice provides a very reasonable alternative to the federal exchange.

Wisconsin has one of the most competitive insurance markets in country. In our state, over 20 insurers are offering coverage in the individual market. Indeed, in looking at the Wisconsin map (http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf), you can clearly see nearly every county provides individuals four or more insurers off-exchange from which they can choose qualified health plans. In addition, our off-exchange market allows consumers to choose from different kinds of insurers, including for-profit and non-profit, HMO and PPO, local and national, and other choices. I am asking you to allow all consumers access to that market.

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983 •
WWW.WISGOV.STATE.WI.US

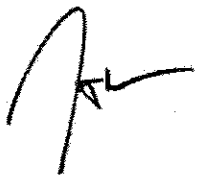
Due to the bottlenecks and the ongoing technology problems, the current process is unworkable. Wisconsinites need actual solutions and access to available health plans. I am asking for the IRS to issue regulations allowing consumers to access a premium tax credit for any qualified health plan they choose to purchase – on or off the exchange. These tax credits are based on the second least costly silver plan in each county, and there is no reason the tax credit cannot be applied uniformly. This solution would ensure that Wisconsinites will not be forced to attempt to purchase coverage through a website, which is currently not functioning and hosts a limited selection of insurers.

It is important to note the same market rules apply both on- and off-exchange. Consumers purchasing plans off the exchange will be purchasing essentially the same policies, but be allowed to choose from a wider variety of insurers.

The Affordable Care Act is the law, and it is my responsibility to protect consumers within my state in compliance with the law. It is our mutual responsibility to ensure consumers are not harmed. In that spirit, I am asking you to provide Wisconsinites with this commonsense solution and flexibility.

I look forward to your response.

Sincerely,



Scott Walker
Governor

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983 •
WWW.WISGOV.STATE.WI.US

FEB 27 2014

The Honorable Scott Walker
Governor of Wisconsin
Post Office Box 7863
Madison, WI 53707-7863

Dear Governor Walker:

Thank you for your letter regarding the use of premium tax credits by Wisconsinites seeking to purchase qualified health insurance plans. Because this issue involves a matter of tax policy as it relates to the Marketplaces, your letter was referred to us.

Treasury and the Internal Revenue Service take seriously the responsibility to implement the Tax Code. The statutory language of the Affordable Care Act indicates that premium tax credits are available only to taxpayers who enroll in coverage through a Marketplace. On February 12, 2014, HHS reported that nearly 3.3 million Americans have selected a plan through state and federal Marketplaces, reflecting the dramatic improvements in the federal website. We continue to work diligently to add new functionality to HealthCare.gov. It is also worth noting that consumers have several options when enrolling through a Marketplace. They can work with Navigators, in-person Assisters or brokers, and they can apply at the Marketplace's website, through an issuer's website, via telephone, or by paper application. In all cases, these individuals will enroll through a Marketplace, so they will be eligible to receive a premium tax credit on the same terms as others.

We share your commitment to making sure that Americans have access to affordable coverage and look forward to working with you further as we continue to implement the Affordable Care Act.

If you have additional questions on this topic, you may contact either of us, or your staff may contact Ahmed (A.J.) Bhadelia, Treasury's Office of Legislative Affairs, at (202) 622-1900.

Sincerely,

Mark J. Mazur
Assistant Secretary for Tax Policy
U.S. Department of the Treasury

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

December 2, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On November 19, 2013, Governor Walker submitted a written request asking you to allow Wisconsin citizens to use their premium tax credits to purchase any health plan and not just plans on the federal facilitated exchange (FFE).

While we have yet to receive a response to Governor Walker's request, we have been made aware that you have offered a direct enrollment pilot program to a number of states including Florida, Ohio, and Texas. Given Governor Walker's prior request, we are requesting that Wisconsin be added to the new pilot program.

Consumers and their representatives are currently limited to utilizing healthcare.gov, contacting the call center or submitting a paper application, which only determines eligibility to purchase coverage through the FFE and federal subsidies. Consumers need a more streamlined option where they are able to contact an insurer of their choice and enroll in a plan.

In light of the implementation issues that have plagued the FFE, the direct enrollment process is vital. With only a scant three weeks remaining for individuals and families to enroll in a plan with an effective date of January 1, alternative options are needed to ensure consumers who need coverage are able to purchase it.

As Governor Walker noted in his prior request to you, Wisconsin has one of the most competitive insurance markets in the country. In our state, over 20 insurers are offering coverage in the individual market. Indeed, in looking at the Wisconsin map (http://oci.wi.gov/healthcare_ref/find_health_insurer.pdf), you can clearly see nearly every county provides individuals four or more insurers off-exchange from which they can choose any health plans. In addition, our off-exchange market allows consumers to choose from different kinds of insurers, including for-profit and non-profit, HMO and PPO, local and

national, and other choices. It makes sense to allow all consumers access to that market and to use their subsidy with the insurer of their choice.

Therefore, we again reiterate the Governor's request to expand consumer choice by allowing subsidy-eligible consumers to choose from any health plan not just those offered through the FFE. The ability for consumers to access federal subsidies when purchasing any health plan, in concert with the ability to directly enroll with an insurer, will allow greater access to health insurance coverage and ease consumer frustration.

I look forward to hearing from you on how we can move forward with the direct enrollment pilot program in this state and look forward to your response on Governor Walker's request.

Sincerely,

Theodore K. Nickel
Commissioner

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR 11 2014

RECEIVED
MAR 13 PM 8:20
OFFICE OF THE COMMISSIONER
WISCONSIN OFFICE OF INSURANCE

The Honorable Theodore K. Nickel
Commissioner of Insurance
Office of the Commissioner of Insurance
State of Wisconsin
Madison, WI 53707-7873

Dear Commissioner Nickel:

Thank you for your letter to the Department of Health and Human Services (HHS) regarding the use of premium tax credits by Wisconsinites seeking to purchase qualified health insurance plans. She asked me to respond to you directly.

The statutory language of the Affordable Care Act indicates that premium tax credits are available only to taxpayers who enroll in coverage through a Marketplace. On February 12, 2014, HHS reported that nearly 3.3 million Americans have selected a plan through state and federal Marketplaces, reflecting the dramatic improvements in the federal website. We continue to work diligently to add new functionality to http://www.HealthCare.gov. It is also worth noting that consumers have several options when enrolling through a Marketplace. They can work with Navigators, in-person assisters, or brokers, and they can apply at the Marketplace's website, through an issuer's website, via telephone, or by paper application. In all cases, these individuals will enroll through a Marketplace, so they will be eligible to receive a premium tax credit on the same terms as others.

We share your commitment to making sure that Americans have access to affordable coverage and look forward to working with you further as we continue to implement the Affordable Care Act. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: ociinformation@wisconsin.gov
Web Address: oci.wi.gov

March 26, 2014

The Honorable Mark J. Mazur
Assistant Secretary (Tax Policy)
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Assistant Secretary Mazur and Administrator Tavenner:

On November 15, 2013, Governor Scott Walker sent a letter to Secretary Jacob Lew and Secretary Kathleen Sebelius asking for the federal government to provide increased flexibility and additional health insurance options to Wisconsin citizens. The letter requested Wisconsinites be allowed to use available tax credits to purchase any qualified health plan, whether on the exchange or not, and not to limit their choices to those plans available through the federal exchange Web site. As was highlighted, Wisconsinites in every county would have expanded health insurance choices if the federal government would provide this flexibility.

We received your response on behalf of your individual Departments on February 27, 2014. Unfortunately, it does not address the concerns of Wisconsin consumers. It also conflicts with guidance received simultaneously from the Department of Health and Human Services.

Due to the failed federal rollout of the Affordable Care Act (ACA), in recent months, Wisconsin took action to protect its citizens transitioning into ACA-qualified health insurance plans while the federal government worked to fix the problems with its exchange Web site. While the people of our state continue to cope with the troubled rollout of the ACA, it is important to give as many options and choices to them as possible.

It was indicated in your letter that your Departments do not have the statutory authority to accommodate our request to allow our citizens to use their subsidies to purchase qualified plans outside of the federal exchange Web site.

However, there are multiple instances where both the Department of Treasury and the Department of Health and Human Services have utilized broad regulatory authority to substantially alter the implementation of the law.

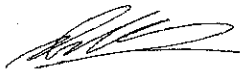
In addition, the same week we received the response letter, the Department of Health and Human Services issued a bulletin titled "CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances." In the bulletin the Department of Health and Human Services allowed consumers unable to access plans through the federal exchange Web site, due to its previous and ongoing issues, to use their tax credits to purchase qualified plans outside of the exchange.

These conflicting responses create unnecessary confusion. Clearly, based on this change issued by the Department of Health and Human Services, the federal government has the statutory authority to allow consumers to use their tax credits to purchase qualified health plans off the exchange.

Therefore, we again request that the federal government provide the same flexibility and increased options to all Wisconsin consumers, regardless of whether or not they have yet attempted to purchase plans through the federal exchange Web site. This is a practical tool to help our consumers cope with the ongoing issues in the federal exchange.

I look forward to your quick response.

Sincerely,



Theodore K. Nickel
Commissioner

Tom Barrett
Mayor, City of Milwaukee

October 31, 2013

Governor Scott Walker
Office of the Governor
115 East State Capitol
Madison, WI 53702

Dear Governor Walker:

In light of the problems at the national level with www.healthcare.gov and enrollment in the Health Insurance Marketplace, I urge you to delay the implementation of the BadgerCare changes, which are scheduled to go into effect January 1, 2014.

Approximately 92,000 people will lose BadgerCare coverage on January 1, 2014. The rationale supporting the decision to end coverage for these individuals was that they would be able to purchase insurance coverage through the federal market place exchanges, prior to the termination of their BadgerCare coverage.

Due to the problems associated with the launch of the federal program, it is clear that it will be very difficult, if not impossible, for these 92,000 people to obtain insurance coverage through the federal marketplace prior to December 15, 2013 which would provide coverage for them beginning January 1, 2014.

Even if the problems with the federal system are resolved by the end of November, individuals would only have two weeks to obtain coverage, which would be very difficult.

The simple solution to this problem is to postpone implementation of all BadgerCare changes until March 31, 2014, when the Marketplace enrollment period ends. This action would be consistent with the intent of the action taken by the Joint Finance Committee when it amended the Budget Bill. The Joint Finance amendment would delay the changes to the Badger Care program for 90 days "if, by October 15, 2013 DHS has not received a certification of an American health benefit exchange…if such certification is required under federal law."

Office of the Mayor • City Hall • 200 East Wells Street • Milwaukee, Wisconsin 53202
(414) 286-2200 • fax (414) 286-3191 • mayor@milwaukee.gov

I am unaware of the state receiving any such certification or of the federal government issuing one. Nevertheless, the intent of the amendment is clear: if the federal exchange is not working properly, BadgerCare recipients should not lose their coverage.

The purpose of this letter is not to argue the merits of the Affordable Care Act, or your proposed changes to BadgerCare. I am simply asking you to delay the changes to BadgerCare to ensure that the health and well-being of some of the most vulnerable people in our state are protected in this time of uncertainty.

Thank you for your attention to this important issue.

Sincerely,

Tom Barrett
Mayor

November 7, 2013

Dear Governor Walker:

As advocates for expanded access to health insurance coverage and health care, we are writing with shared concerns regarding transitions in health care coverage as directed by the Biennial Budget and implementation of the Affordable Care Act.

On February 13, 2013, you shared your plan to limit adult BadgerCare eligibility to those with incomes no greater than 100% of the federal poverty level (FPL), but also to help 224,600 Wisconsinites secure health insurance coverage. We applaud your commitment to that goal, and we are pleased to hear state officials reiterate your intent to significantly reduce the number of uninsured Wisconsinites. We want to work with your Administration to help achieve that important goal.

The projection that Wisconsin could nearly cut in half the number of uninsured Wisconsinites assumed that 90% of the 77,000 custodial parents who are losing eligibility for BadgerCare on January 1, 2014, would transition to a qualified health plan offered via the federal insurance Marketplace. We have serious concerns that these individuals will not make the transition and will instead be uninsured. This will hinder progress towards our shared goal of reducing the uninsured rate in Wisconsin, but also further strain the resources of Community Health Centers, Emergency Departments and other health providers, and the millions of health care consumers in Wisconsin shouldering the health care costs of the uninsured.

The Department of Health Services has indicated it will make eligibility determinations on November 18, 2013, and will then begin officially notifying BadgerCare enrollees who will lose their coverage. In order to avoid a gap in coverage, those individuals and families will have to use the Marketplace to enroll in a qualified health plan and make their first premium payment by December 15, 2013. We are concerned that this short window does not allow enough time for all 77,000 custodial parents who are losing BadgerCare eligibility to complete the process of enrolling in qualified health plans via the Marketplace. These concerns are magnified by the healthcare.gov technical glitches that have hindered enrollment thus far.

In order to continue our shared work of reducing the number of uninsured in Wisconsin, we ask that you provide us with any information for our feedback related to any contingency plans that the state may implement in the event that:

- Enrollment in qualified health plans via the federal insurance Marketplace continues to face challenges;
- The federal government delays or rejects Wisconsin's state plan amendment for dropping coverage of custodial parents; or
- The federal government delays the end of the maintenance of effort (MOE) provision of the Affordable Care Act that requires Wisconsin to keep its adult BadgerCare eligibility until an exchange is operational in the state.

We look forward to partnering with you and your Administration to achieve our common goal of greatly reducing the number of uninsured Wisconsinites.

Sincerely,

Community Advocates Public Policy Institute
Wisconsin Council on Children and Families
Mental Health America of Wisconsin
Wisconsin Primary Health Care Association
Wisconsin Alliance for Women's Health
ABC for Health

Cc: Secretary Kitty Rhoades, Director Brett Davis, Senator Scott Fitzgerald, Speaker Robin Vos, Senator Chris Larson, Representative Peter Barca

United States Senate
WASHINGTON, DC 20510

November 12, 2013

The Honorable Scott Walker
Governor of Wisconsin
115 East Capitol
Madison, WI 53702

Dear Governor Walker:

I am writing in regards to the 77,000 low-income, working Wisconsin residents whose health coverage expires on January 1, 2014. As a result of your decision to move these individuals off of BadgerCare, these citizens must be enrolled in the federal Health Insurance Marketplace created by the Affordable Care Act (ACA) by December 15 in order to prevent a lapse in coverage at the start of the new year. Your current outreach plan calls for residents who will lose their BadgerCare coverage to receive final notice at the end of November, leaving them just two weeks to enroll or they will lose coverage on January 1. Given the state's current timeline for direct outreach to these individuals, the major issues with the federal government's ACA website, and the fast-approaching deadline, thousands of people are at risk of losing their coverage. Therefore, I am writing to raise this concern and to offer potential options in the hope that we can work together to ensure our constituents maintain the health coverage they need.

Over the past year, I have written to you on a number of occasions regarding the ACA and I have had an opportunity to meet with representatives from the Department of Health Services and the Office of the Commissioner of Insurance. First, I urged you to build a Wisconsin-made, state-based Health Insurance Marketplace for individuals and small businesses. Instead, you chose to rely on the federal government's website. Second, I urged you to seize the opportunity to accept a federal partnership and investment to strengthen our BadgerCare program by expanding Medicaid under the ACA. Our Midwestern neighbors have widely accepted these opportunities. Governors from both parties in Michigan, Iowa, Illinois and Minnesota are supporting the ACA's Medicaid expansion. Instead, you chose to make Wisconsin one of just two states in the nation that are set to kick a large number of individuals off their current Medicaid coverage in 2014. While you have not taken our state down the strongest path, I am committed to working with you to ensure these 77,000 BadgerCare recipients do not lose health coverage on January 1.

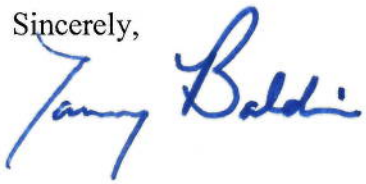
My most recent letter to you outlined problems with the state's outreach to individuals losing their BadgerCare. Since then, the state has made positive improvements, including making phone calls to affected families. I commend you for taking this positive step, yet reaching all of these individuals in a timely manner remains a significant challenge. Furthermore, these residents must enroll through the federal ACA enrollment program and website—www.healthcare.gov—which has been plagued with problems. I am deeply disappointed and extremely frustrated with the website. While the Obama Administration has vowed to fix it as soon as possible, I have called on the Administration to redouble its efforts to ensure that all Wisconsin residents, including the 77,000 BadgerCare recipients facing the December 15 enrollment deadline, have access to coverage through the federal Health Insurance Marketplace.

Because of the transition issues and the fast-approaching December 15 deadline, I am offering a few solutions that you could pursue to help solve this problem. First, I would urge you to alter your current request to the Centers for Medicare & Medicaid Services so that BadgerCare enrollees maintain their current coverage through the end of March. Such a change would extend the deadline that BadgerCare enrollees face today to ensure uninterrupted health security from December 15, 2013 and align it with the deadline for open enrollment on the federal Health Insurance Marketplace—March 31, 2014. To me, this is a commonsense solution that will ensure that individuals receiving BadgerCare today will not lose coverage on January 1, 2014. This solution would give the people we work for more time to enroll, gain access to ACA premium tax credits and cost-sharing subsidies, and eliminate the risk of lost coverage on January 1.

In addition, you could choose to fully expand BadgerCare under the Affordable Care Act—at no cost to the State of Wisconsin—temporarily until March 31, 2014. Such changes would provide the state with a 100 percent federal match for all newly-eligible BadgerCare enrollees. These cost savings would allow you to offset any additional costs of continuing BadgerCare coverage for current enrollees through the end of open enrollment.

I remain committed to working with you and the Obama Administration to ensure that the ACA works for Wisconsin and fixing what does not. I ask that you strongly consider these solutions and I look forward to working together on this shared responsibility.

Sincerely,



Tammy Baldwin
United States Senator

Cc: The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

COMMUNITY ADVOCATES
Where Meeting Basic Needs Inspires Hope
Public Policy Institute

For Immediate Release
Media Contact: Mike Bare (920.242.1639; mbare@communityadvocates.net)
Date: November 25, 2013

Health Advocates Call on Governor Walker to Keep His BadgerCare Promise to Non-Custodial Adults

WISCONSIN— Today, a group of advocates for access to health coverage and care sent the attached letter to Governor Walker thanking him for his decision to delay changes to BadgerCare eligibility that would shift 77,000 parents to private coverage offered via the marketplace, and asked that he keep his BadgerCare promise to non-custodial adults below the poverty level.

The 2013-2015 biennial budget passed by the Legislature and signed into law by Governor Walker establishes a BadgerCare Plus Core program for adults without dependent children that would include a full benefits package. The Governor is proposing to delay eligibility for those benefits by three months. Currently, there is no affordable health coverage with full benefits available to those Wisconsinites.

“A promise was made to all Wisconsinites below the poverty level that BadgerCare would be available to them on January 1. The Governor’s proposal to delay that coverage for non-custodial adults will cause many to remain uninsured, which will continue to strain the resources of providers and health consumers’ pocketbooks. That promise should be kept,” said Mike Bare, Research and Program Coordinator at the Community Advocates Public Policy Institute (Bio: http://communityadvocates.net/ppi/who_we_are/#Mike).

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November 25, 2013

Dear Governor Walker:

As advocates for expanded access to health insurance coverage and health care, we are writing to thank you for your proposal to delay the transition in health care coverage directed by the Biennial Budget for parents who are eligible for BadgerCare and above 100% of the federal poverty level (FPL) and those in the Health Insurance Risk Sharing Pool (HIRSP). The additional 90 days will give those approximately 100,000 Wisconsinites more time to successfully make the transition to a qualified health plan offered via the health insurance marketplace and potentially obtain premium and cost-sharing subsidies. It will also help all of us achieve our common goal of greatly reducing the number of uninsured Wisconsinites.

We also request that you keep the promise you made to non-custodial adults below the poverty level.

Your proposal to delay the partial expansion of the BadgerCare Plus Core program with a full benefits package for 98,600[1] non-custodial adults below 100% of the FPL will leave those Wisconsinites without an affordable health insurance option. We have begun to hear distressing stories from individuals who have preexisting conditions and an imminent need for critical care, which they are unlikely to be able to postpone much longer. It is of urgent importance for those individuals and their families that lawmakers keep their promise not to create a coverage gap for people below the poverty level.

Keeping your promise to these poor Wisconsinites will also help reach our shared goal of reducing the uninsured rate in Wisconsin, and will put less strain on the resources of Community Health Centers, Emergency Departments and other health providers, and will reduce the uncompensated health care costs that are shouldered by millions of covered consumers in Wisconsin.

We continue to look forward to partnering with you and your Administration to achieve our common goal of greatly reducing the number of uninsured Wisconsinites.

Sincerely,

Community Advocates Public Policy Institute
Wisconsin Council on Children and Families
ABC for Health
Wisconsin Alliance for Women's Health
AARP of Wisconsin

Cc: Secretary Kitty Rhoades, Director Brett Davis, Senator Scott Fitzgerald, Speaker Robin Vos, Senator Chris Larson, Representative Peter Barca

[1] Estimate of projected monthly average enrollment in 2014-2015. Wisconsin Legislative Fiscal Bureau. Paper #321. May 30, 2013. http://legis.wisconsin.gov/lfb/publications/budget/2013-15%20Budget/Documents/Budget%20Papers/321.pdf

WISCONSIN COUNCIL ON
children &families
Raising Voices to Make Every Kid Count

555 West Washington Ave, Suite 200
Madison, WI 53703

www.wccf.org
☎ 608-284-0580
608-284-0583

For immediate release **Contact:** Bob Jacobson, 608-284-0580, ext. 303

WCCF Applauds Governor's Proposal to Delay Changes to BadgerCare and HIRSP

Statement from WCCF Research Director Jon Peacock:

The Wisconsin Council on Children and Families commends the Governor for proposing a 90-day delay in the negative changes to BadgerCare and the state's high risk insurance pool (HIRSP) scheduled to take effect in January. Moving about 100,000 people off of BadgerCare and HIRSP beginning January 1st would have resulted in tens of thousands of uninsured Wisconsin families. Giving current BadgerCare and HIRSP participants additional time to transition into the new Health Insurance Marketplace is a common sense adjustment to the state's plans, and is consistent with the intent of a budget amendment approved by the Joint Finance Committee.

We are disappointed that the Governor's proposals will also delay the state's plans to cover childless adults below the poverty level. The Governor's desire to keep that expansion of coverage from boosting spending could be accomplished more effectively by at least temporarily increasing eligibility of childless adults to 133% of the poverty level, and accepting the federal funding that would pay all the cost for that improvement.

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(more)

Independent Insurance Agents of Wisconsin

November 14, 2013 **FOR IMMEDIATE RELEASE**
Contact: Matt Banaszynski - (608) 256-4429

IIAW STATEMENT ON GOVERNOR WALKER'S HEALTH CARE ANNOUNCEMENT

MADISON - The Independent Insurance Agents of Wisconsin's executive vice president, Matt Banaszynski, issued the following statement regarding Governor Walker's announcement on health care:

"The IIAW commends Governor Walker in taking immediate action by calling for a special legislative session on health care to address the federal government's inability to implement a federal health exchange. We believe Gov. Walker is making the right decision to step in now and protect Wisconsin's most vulnerable citizens.

Independent insurance agents all throughout Wisconsin have been ready and waiting to assist Wisconsin consumers with their health insurance needs as a result of the mandated federal Affordable Care Act. Unfortunately, the Obama Administration's short sightedness has given the American public a system that is inoperable with no timeline as to when it may become operational creating mass disruption and confusion for average citizens.

The IIAW strongly supports Gov. Walker's call on the Obama Administration to re-open Wisconsin's competitive private market to all consumers and include those who qualify for subsidies and allow them to use those subsidies to purchase a qualified health plan either inside or outside the exchange. This would give Wisconsin consumers more health insurance choices. In fact, many consumers are likely to find that more choices exist in the traditional private market outside the exchange than inside it leading to greater control over their personal health insurance needs."

The IIAW is the 8th largest trade association in the state with over 5,000 independent insurance agents selling property, casualty, life and health insurance.

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725 John Nolen Drive, Madison, WI 53713
(608) 256-4429 * FAX (608) 256-0170 * www.iiaw.com

Wisconsin Hospital Association, Inc.

Hospitals Support Governors Decision to Delay Medicaid Program Changes

MADISON (November 14, 2013) --- The Wisconsin Hospital Association called Governor Walker's announcement to delay implementing changes in the Medicaid program until April 1, 2014, "a good decision in the face of the Exchange's ongoing problems."

The delay will allow more time for adults who were set to be disenrolled from the Medicaid program January 1, 2014 to find coverage on the health insurance exchange.

"The Governor has made a good decision in the face of the Exchange's ongoing problems. The delay keeps the Medicaid program we have today in place and unchanged through the first three months of 2014, allowing more time for the Exchange to improve," Brenton said. "We'll continue to work closely with our members, the Department of Health Services, the Walker Administration, the State Legislature and the federal government to reach the goal of reducing the number of uninsured in Wisconsin."

Brenton said hospitals and health systems have committed considerable resources to help people in their communities connect to coverage. The delay gives hospitals and community-based organizations more time to implement effective and appropriate outreach strategies to the thousands of people affected by the new Medicaid policies.

End

Contact: Mary Kay Grasmick 608-274-1820, 575-7516

SCOTT WALKER

OFFICE OF THE GOVERNOR

FOR IMMEDIATE RELEASE
November 14, 2013
Contact: Tom Evenson, (608) 267-7303

After Federal Government's Failed ACA Rollout, Governor Scott Walker to Call Special Session to Protect Wisconsin Citizens

Calls on President Barack Obama's Administration to Allow Wisconsinites to Use Subsidies in the Private Market to Work around Failed Federal Exchange

Madison—Due to the failed federal rollout of the Affordable Care Act (ACA), Governor Scott Walker announced he will be calling a special session of the Legislature to take up legislation to move forward with a three-month delay through March 31, 2014, in the implementation for people in Wisconsin moving into health care plans in the federal exchange. Governor Walker also announced a three-month extension for the state's high-risk insurance plan, known as the Health Insurance Risk-Sharing Plan (HIRSP), to provide a safety net during the transition for some of the state's most vulnerable.

"In Wisconsin, we are taking action to protect our citizens from the federal government's failure," said Governor Walker. "We will take care of the people of our state and not let them slip through the cracks. This delay will give Wisconsinites additional time, but the federal government must fix the issues with its health care exchange, so our people can make a logical transition."

After the difficulties many have experienced in using the federal exchange and seeing the dismal enrollment numbers from the federal government, it is necessary to protect Wisconsinites from the failure of the federal government's rollout of the Affordable Care Act.

In addition, Governor Walker called on President Barack Obama's Administration to open up Wisconsin's competitive market to all consumers and allow those who qualify for subsidies to use them to purchase any qualified health plan, not just those listed in the exchange. Currently, those who qualify for subsidies can only use those subsidies on health plans listed on the federal exchange. By allowing people to use their subsidies in the private market and not just on the exchange, they will have more insurance provider options all offering ACA-qualified plans. Wisconsinites can access a full list of insurers offering health insurance plans in their counties at the following link.

"Since the federal exchange is not working, it only makes sense to allow Wisconsinites, who are eligible for subsidies, to use those subsidies to access qualified health care plans in the private market," said Governor Walker. "In many counties, people will have more insurer options off the exchange than they do on it. Let people use their subsidies with the insurers of their choice."

-more-

The Wisconsin plan reforms the Medicaid entitlement to preserve it for the neediest, while protecting our taxpayers from uncertainty related to the federal government's funding. For the first time in our state, Wisconsin will provide health coverage for everyone living in poverty through Medicaid and allow those above that level to access health insurance through the exchanges or the private market. Governor Walker's reforms will not be changing, but will be delayed by three months to help ensure a smooth transition for the 77,000 Wisconsinites who will now be moving into health insurance plans through the exchanges.

Wisconsin was ready to move forward, but the federal government clearly was not. In Wisconsin, the Department of Health Services (DHS) and the Office of the Commissioner of Insurance (OCI) have implemented extensive outreach efforts to help those transitioning into health plans on the exchanges. DHS contacted those transitioning onto the exchange several times by mail and by phone to make sure they were aware of the changes in their eligibility and to provide them with information about how to enroll in health insurance in the exchanges. Just this week, DHS sent out letters to the approximately 77,000 individuals transitioning into the federal exchange with paper applications and directions about how to fill out the applications and turn them in.

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SCOTT WALKER

OFFICE OF THE GOVERNOR

FOR IMMEDIATE RELEASE
November 22, 2013
Contact: Tom Evenson, (608) 267-7303

Governor Scott Walker Calls Special Session to Address Failed Federal Rollout of the Affordable Care Act

Special Session Bill Extends Deadline to March 31, 2014, for Participants in the Federal Exchange

Madison – Governor Scott Walker today issued Executive Order #123 calling a special session of the Legislature to address the implications of the failed federal launch of the Affordable Care Act. The special session will begin on December 2.

"The federal government failed to get its website fully operational, and it is irresponsible to force some Wisconsinites to pay the price for the federal government's failure," Governor Walker said. "I'm calling a special session of the Legislature to approve our plan extending the deadline for individuals moving to the federal exchange. We need to give people more time."

Last week, Governor Walker laid out a plan for a three-month delay in the implementation of people moving into health care plans in the federal exchange. A three-month extension of the Health Insurance Risk-Sharing Plan (HIRSP) was also announced in order to provide a safety net during the transition for some of the state's most vulnerable residents.

At the same time, Governor Walker called on President Barack Obama's Administration to allow Wisconsinites, who qualify for subsidies, to use their subsidies to purchase any qualified health plan. This will provide more insurance provider options because in many counties people will have more options outside of the exchange than they do on it.

A copy of the Governor's Executive Order is attached.

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The State of Wisconsin

OFFICE OF THE GOVERNOR

EXECUTIVE ORDER #123

Relating to a Special Session of the Legislature

WHEREAS, the State of Wisconsin is committed to protecting and caring for its citizens, especially its poorest and most vulnerable; and

WHEREAS, after the difficulties many have experienced in using the federal exchange and seeing the dismal enrollment numbers from the federal government, it is necessary to take action to protect Wisconsinites from the failure of the federal government's rollout of the Affordable Care Act;

NOW, THEREFORE, I, Scott Walker, Governor of the State of Wisconsin, pursuant to Article IV, Section 11, and Article V, Section 4 of the Wisconsin Constitution, do hereby require the convening of a special session of the Legislature at the Capitol in Madison, to commence at 11 a.m. on December 2, 2013, solely to consider and act upon the following legislation:

1. LRB-3678;
2. LRB-3687, both relating to a three-month delay through March 31, 2014, of BadgerCare and the Health Insurance Risk Sharing Plan.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this twenty-second day of November, in the year two thousand thirteen.

SCOTT WALKER
Governor

By the Governor:

DOUGLAS LA FOLLETTE
Secretary of State

Entitlement Reform Delay
November 27, 2013

The Governor's 2013-15 budget made a number of changes to Wisconsin's Medicaid program. These entitlement reforms focused on reducing dependency on government programs, cutting the uninsured rate in half and restoring the Medicaid program to be a true safety net for all people living in poverty. However, these changes were contingent on people having access to affordable health care through the federal Health Insurance Exchange. Fewer than 900 Wisconsin residents were able to sign-up for private health insurance through the exchange through October. These issues have left the approximately 77,000 people who are anticipated to transition from Medicaid to the exchange with not enough time to sign-up for health insurance. In order to allow these individuals the opportunity to enroll and purchase health insurance through the exchange, the Governor has called for a special session to delay the implementation of his entitlement reforms by three months.

The problems at the federal level make it clear; Wisconsin must delay its reforms in order to ensure that these impacted populations do not fall through the cracks, but have an opportunity to successfully transition into private health insurance through the Marketplace.

The Governor's entitlement reforms will allow Wisconsin to maintain control of its Medicaid program. These changes will give people a path to independence while preserving a true safety net for individuals and families in poverty. These reforms protect Wisconsin taxpayers by not relying so heavily on the unpredictability of federal funding.

This delay will have the following impact on these populations:

- *Parents and Caretakers between 100%-200% FPL*
    - These individuals will continue to have Medicaid coverage through March 31, 2013
- *Childless Adults in Core Plan*
    - These individuals will continue to have Core Plan coverage through March 31, 2013
- *Members of the Basic Plan*
    - These individuals will continue to have the option to pay for the Basic Plan through March 31, 2013
- *Childless Adults under 100% FPL and Uninsured or Underinsured*
    - These individuals will now have access to Medicaid on April 1, 2014

After April 1, 2014, all individuals who are eligible for Medicaid will be on the Standard Plan and will receive the same level of benefits. The Standard Plan is a comprehensive plan that includes services previously not covered for some members:

- *Outpatient mental health and substance abuse services*
- *Dental services*
- *Generic and brand name prescription drugs*
- *Emergency and non-emergency medical transportation*

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Key Questions and Talking Points on Entitlement Reform Delay

1. How does the delay impact Wisconsin's Medicaid program?

The Governor's 2013-15 state budget made a number of changes to Wisconsin's Medicaid program. These entitlement reforms were aimed at reducing dependency on government programs, cutting the state's non-elderly uninsured rate by 50% and preserving Medicaid to be a true safety net for all people living in poverty.

The budget, as approved by the legislature and signed by the Governor, would make these changes to Wisconsin's Medicaid program on January 1, 2014. However, many of these changes were contingent on people having the opportunity to access and purchase affordable private health insurance through the federal health insurance exchange. Because of significant technical and governance issues related to the federal exchange, in October less than 900 Wisconsin residents were able to sign up for coverage through healthcare.gov, the toll-free number, with the paper application, or with the help of assisters.

While the federal government has announced that the issues with the exchange would be resolved by the November 30, 2013, this is not enough time for the approximately 77,000 current BadgerCare Plus members (the transition population) to navigate, select and purchase private health insurance through the exchange.

Through this one-time, 90 day delay, the federal government will have additional time to attempt to address the systemic issues in the exchange and will provide members of the transition population additional time to find coverage in the exchange.

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2. **What is the fiscal impact to the state because of this delay?**

The Governor's budget proposal was built on the assumption that the federal health insurance exchanges would be up and operational on October 1, 2013, that people in the transition populations would move from Medicaid into private coverage offered in the exchanges, and that new childless adults living in poverty would have access to Medicaid.

The state's Medicaid program currently has the funding to maintain the existing income eligibility levels for the next three months. According to the Department and the non-partisan Legislative Fiscal Bureau, Medicaid spending will be lowered by $23.1 million GPR in the next three months. This should not be considered "savings" to Medicaid, as the Department must identify additional spending reductions to offset a $52 million reduction in federal Medicaid funding as highlighted by the Legislative Fiscal Bureau on October 7th, 2013.

A decision to delay the transition population's move from Medicaid to the exchange for three months AND to still allow childless adults with incomes below 100% FPL to receive BadgerCare Plus benefits on January 1, 2014 would eliminate the estimated spending reduction and would require an additional $21.6 million in GPR to pay for the newly eligible childless adults.

There are some who continue to bring up policy debates and rehash decisions that were made in the 2013-15 budget and are urging the state to accept the Medicaid expansion in the Affordable Care Act by covering childless adults with incomes up to 133% FPL for three months. This option is problematic for a number of reasons.

First, the goal of the Governor's entitlement reforms was to reduce the dependency on government programs. Expanding Medicaid to people living above poverty creates new barriers for people to move away from government dependency. Second, the Department created its transition plan and supporting system changes based on the effective date of January 1, 2014. While the delay will cause some system changes, the majority of the operational issues will remain the same. Moving to expand Medicaid to 133% FPL on January 1, 2014 has not been part of the Department's operational plan and would require additional planning and resources in a limited timeframe. Even with increased financial and human resources, it is not possible to implement, test, communicate to members and provide training on the

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system changes needed for this option in within the next three months without severe disruptions to systems and operations.

It is also important to note this concept to "expand" Medicaid would still require the Department to transition people with incomes above 133% FPL from the current Medicaid program to the exchanges. In addition, under this model, people with incomes between 100% and 133% FPL would be covered under Medicaid even though the Affordable Care Act provides premium and cost sharing subsidies for this same population to purchase private insurance.

In April 2012, the Department of Health Services received approval from the Obama Administration's federal Centers for Medicare and Medicaid Services (CMS) to pilot a program within Medicaid to charge premiums to specific groups in July 2012. These premiums were modeled exactly off of the premium models in the Affordable Care Act and saw 77% of individuals pay the new premiums for their health coverage. This pilot showed that people are willing to pay the premiums outlined in the Affordable Care Act for their coverage.

The Governor's entitlement reforms will encourage people to move from dependency on the government's Medicaid program to private health insurance that allows for individuals and families to climb the economic ladder without worrying about losing their benefit due to an extra shift or a possible promotion.

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3. Who will be impacted by the delay?

Neither the delay, the entitlement reform provisions, nor the Affordable Care Act will affect the individuals who are enrolled in Medicaid for the Elderly, Blind or Disabled.

The delay will impact the following populations:

- **Parents, Caretakers, and Childless Adults between 100-200% FPL** – Known as the transition population, these 77,000 individuals will continue to be eligible for their existing BadgerCare Plus benefits until March 31, 2014. The state will also allow for parents and caretakers with incomes up to 200% of the federal poverty level and who meet current program rules to enroll in Medicaid through March 31, 2014.

  The Governor's decision to delay will give the transition population more time to find and purchase health insurance on the federal exchange. The Department intends to continue outreach and education to members of the transition population through the first three months of 2014. Effective April 1, 2014, the new eligibility standards will go into effect, and only parents and caretakers living in poverty (with incomes between 0-100% FPL) will have access to Medicaid coverage. Those with household incomes above 100% FPL will have access to affordable health insurance through the federal health insurance exchange.

- **Childless Adults in the BadgerCare Plus Core Plan** – The nearly 17,000 individuals who are currently in the BadgerCare Plus Core Plan will continue to receive coverage through the Core Plan until March 31, 2014. The Department will continue to keep the enrollment cap, originally placed on the program in 2009, in place for the next three months.

  Some of these adults, those with incomes above 100% FPL, are included in the transition population. For those individuals in the Core Plan who have incomes above 100% FPL, the Department intends to continue outreach and education to these members through the first three months of 2014 to encourage them to apply for private health insurance through the exchange.

  For those people who are living in poverty (under 100% FPL), the Department will transition them into the BadgerCare Plus Standard Plan for benefits beginning April 1, 2014. This will be a more comprehensive benefit than they have been receiving and it includes preventive dental care and comprehensive mental health and substance abuse treatment services.

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- **Members of the BadgerCare Basic Program** – The 1,200 people who are currently paying $325 for the limited Basic Plan benefit will continue to have the option to pay for the Basic benefit through March 31, 2014. The Basic Plan is not a Medicaid program and was created to provide a minimal level of services for people who were waiting for services through the Core Plan.

  For members of the Basic Plan who have income above 100% FPL, the Department intends to continue outreach and education about the federal health insurance exchange to these members through the first three months of 2014. However, Basic Plan members may find that the monthly premiums are cheaper in the private market than what they pay through the Basic Plan. They have the option to stop receiving health care through the Basic Plan and can begin purchasing private health insurance through the exchange as early as January 1, 2014.

  For members of the Basic Plan with incomes below 100% FPL who choose to remain enrolled in the Basic Plan through March 31, 2014, the Department will continue to process Basic payments. In order to have health care beginning April 1, 2014, all Basic Plan members will need to apply for health care benefits. The easiest way for Basic members to complete an application is through the exchange. If the exchange determines that the individual is eligible for BadgerCare Plus, then the exchange will send the application to Wisconsin and the member will be enrolled in BadgerCare Plus.

- **Childless Adults and Currently Uninsured or Underinsured with incomes under 100% FPL–** The 82,000 individuals who are living in poverty (under 100% FPL) and were anticipated to access Medicaid on January 1, 2014 will now have the effective date for their Medicaid coverage moved to April 1, 2014. To receive this new coverage, the individuals who are uninsured or underinsured will need to apply for Medicaid.

  The new benefit will cover new individuals who are not currently enrolled in the program, members who are in the current Core and Basic programs with incomes below 100% FPL, as well as individuals who are on the Core waiting list who are also under 100% FPL.

- **Children and Pregnant Women on Medicaid** – The 2013-15 state budget made no change to the Medicaid eligibility standards for children and pregnant women. The current income eligibility, which will not change in 2014, is 0-300% FPL for both groups.

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- **Children Above 300% FPL** – Under current law, children with incomes above 300% FPL can purchase health insurance through BadgerCare Plus. This option is not a Medicaid benefit because no state or federal dollars are used to pay for benefits for these children because either a parent or a caretaker must pay 100% of the premiums and out-of-pocket costs. The 2013-15 state budget eliminated the option for children with incomes above 300% FPL to purchase BadgerCare Plus coverage because of the new private health insurance options available in the insurance exchanges. However, because of the delay in implementing the Governor's reforms, children with incomes above 300% FPL will continue to have the option to purchase into BadgerCare Plus and pay 100% of all costs through March 31, 2014.

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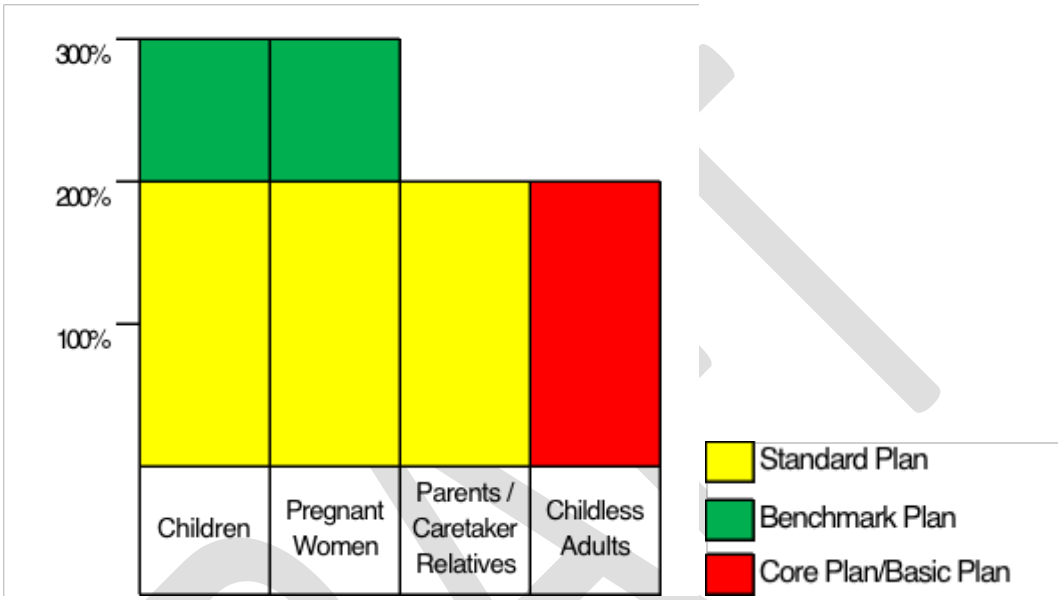
4. What are the <u>current</u> income eligibility limits under Medicaid?

The following are the current eligibility levels and corresponding benefits for children, pregnant women, parents and caretakers and childless adults that will remain in effect through March 31, 2014:



As of September 2013, the enrollment figures for these programs are as follows:

- Children – 428,277
- Pregnant Women – 18,512
- Parents and Caretaker Relatives – 222,060
- Childless Adults in the BadgerCare Plus Core Plan – 16,774
- **TOTAL: 685,623**

These eligibility limits and benefit plans will remain in place until March 31, 2014.

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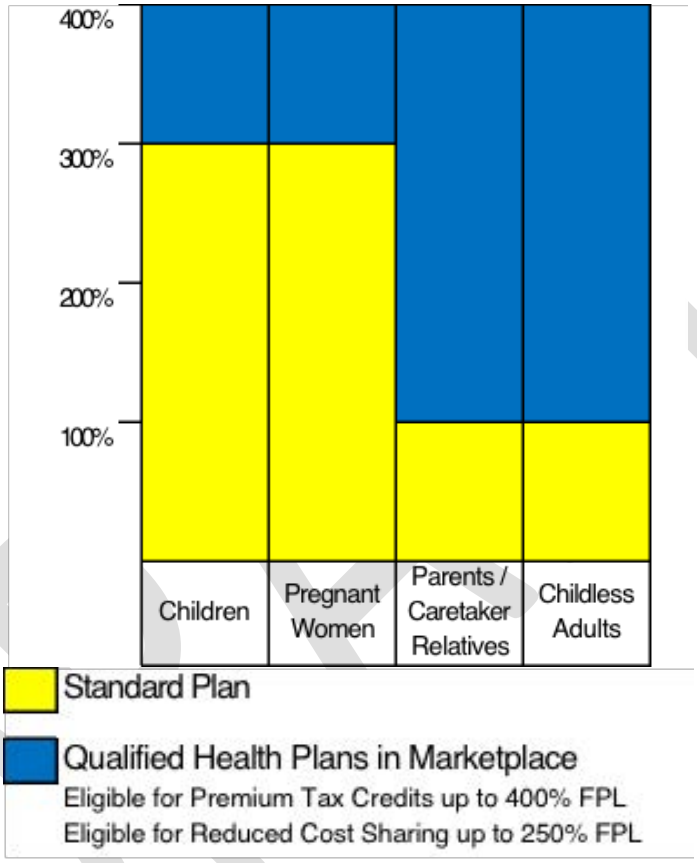
5. What are the <u>new</u> income eligibility limits under Medicaid effective April 1, 2014?

The following are the eligibility levels and corresponding benefits for children, pregnant women, parents and caretakers and childless adults that will be effective on April 1, 2014:



Based on the changes in eligibility and benefit plans that will be effective on April 1, 2014, the Department estimates the following enrollment figures for the 2013-15 biennium:

- Children – 466,808
- Pregnant Women – 20,804
- Parents and Caretaker Relatives – 142,009
- Childless Adults– 98,641
- **TOTAL: 728,262**

These eligibility limits and benefit plans will take effect on April 1, 2014.

Effective April 1st, Wisconsin will be the only state of the 26 that did not expand Medicaid to have no coverage gap. View the report.

6. **Why is the state delaying the new eligibility standards for childless adults below 100% FPL until April 1, 2014?**

   In building the 2013-15 state budget, the Governor highlighted that his entitlement reforms would cut the number of uninsured in Wisconsin by half while providing Medicaid coverage to all Wisconsin resident living in poverty. These reforms were dependent on the successful implementation of the federal health insurance exchange, which enrolled fewer than 900 Wisconsin residents in October.

   In addition, a key element in the Governor's entitlement reform plan was that it did not require any of the enhanced federal Medicaid dollars provided by the Affordable Care Act. Instead, the Governor's reforms allow Wisconsin to remain in control of its own Medicaid program.

   The decision to allow members above 100% FPL or the transition population, to remain on Medicaid means the state must continue to fund Medicaid benefits for these people for the next three months and keep the program operating as it is today through March 31, 2014. Under the state budget, the state savings from transitioning this population from Medicaid to private health insurance through the health insurance exchange was invested into new Medicaid benefits for the uninsured and underinsured childless adults who are living in poverty.

   If the state were to keep both the transition population on Medicaid AND bring on the new childless adult population, the Wisconsin Medicaid program would need an additional $21.6 million GPR to support both populations for the three month delay.

   Finally, as was discussed in a memo from Legislative Fiscal Bureau Director Bob Lang to the Co-Chairs of the Joint Committee on Finance, the Wisconsin Medicaid program is expected to lose $52 million in federal Medicaid matching funds in the current biennium. This loss of federal aid, compounded with ongoing health cost pressures, makes it fiscally irresponsible to bring on the new childless adult population until the transition population begins purchasing private health insurance through the exchange.

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Therefore, because of the problems at the federal level, Wisconsin needs the three month delay to allow for a successful transition and to not allow Wisconsin residents to fall through the cracks caused by the problems with the exchange rollout.

7. **Why does the state not accept the 100% federal funding for the childless adults for the next three months? Why not expand Medicaid immediately?**

The decision to delay the Governor's entitlement reforms was done due to the failure of the federal government to create a website that was able to help people access affordable health insurance. Throughout 2013, the Department, along with other state Medicaid agencies, asked the federal government for assurances that the exchanges would be operational on October 1, 2013. Because of the assurances from the federal government, the Department and the Office of the Commissioner of Insurance held outreach and training efforts throughout September.

With the failure of the exchange website to work, Wisconsin must modify its operational plan so Wisconsin families do not fall through the cracks created by Washington. The three month delay will give members of the transition population more time to purchase private health insurance and will provide the federal government with more time to address their operational failures.

As we move forward, Wisconsin's reasons for not expanding Medicaid remain the same. Wisconsin's reforms are about giving people a path to independence while establishing Medicaid as the true safety net for those people who are living in poverty.

Wisconsin built its budget to be sustainable by not relying on the promise of enhanced federal funding. Given the fiscal uncertainty highlighted by the federal shutdown, reliance on enhanced federal dollars to expand programs would be fiscally reckless and would move Wisconsin backward.

Wisconsin has seen firsthand the budget dangers when states accept enhanced federal funding for Medicaid. In October 2008 through June 2011, the federal government used the American Recovery and Reinvestment Act (ARRA) to provide states with enhanced federal matching funds. Normally Wisconsin's Federal Medical Assistance Percentage (FMAP) is approximately 60% and under ARRA the FMAP was increased to 70%, at its highest point. As a result, the 2009-11 biennial budget reduced GPR in the Medicaid base budget to reflect the temporary increase in federal funding.

In Wisconsin, the loss of enhanced federal funding contributed to a $1.8 billion hole in the Medicaid program in the 2011-13 state budget. With one-time federal dollars gone and federal law prohibiting states from making any changes to Medicaid eligibility

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rules, the Governor and the Legislature invested $1.3 billion in state GPR to fill the Medicaid hole created by the loss of federal funds. In addition, the Department was tasked with creating more than $500 million in efficiencies to cover the remainder of the funding loss.

The 2013-15 state budget was built with the expectation that federal funding for Medicaid would be cut $258.2 million GPR. Additional reductions to the state's federal match rate will increase state spending on Medicaid by an additional $52 million in the 2013-15 biennium. As a result, Wisconsin has had to fund the loss of federal dollars with GPR and will continue to work to meet the federal funding loss throughout the biennium.

Instead of being able to use these GPR resources to support and reform programs across state government, this money needed to be used to sustain Wisconsin's Medicaid program. Based on our experience of federal reductions, the Governor believes that Wisconsin should not rely on federal dollars to expand coverage.

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8. **Other than the changes to income eligibility, are there other changes occurring in the Medicaid program on April 1, 2014?**

In addition to ensuring that all Wisconsin residents who live in poverty have access to Medicaid, the Medicaid benefit plans will be changing on April 1, 2014.

The current BadgerCare Plus program consists of three separate benefit plans depending on the income of the child or adult. Children and pregnant women between 200% and 300% FPL have access to the Benchmark Plan, and not the standard Medicaid benefit, the Standard Plan. Childless adults in the Core Plan have coverage that has even fewer benefits than the Benchmark Plan. Adults in the Basic Plan have benefits that are severely limited and have a $7,500 deductible per year per individual.

Under the Governor's reforms, the current Medicaid program will move from four different benefit plans to the Standard Plan. This change will increase administrative efficiency for the state, and for insurers and for providers, while offering an improved benefit to those individuals and families on BadgerCare Plus.

For many of the members in Medicaid, there will be no change to their existing benefit plan. However, for children and pregnant women between 200-300% FPL and childless adults living in poverty, the new standard benefit will provide a broader array of services to address the health needs of these populations.

One reason for the decision to offer the Standard benefit plan is due to the underlying medical and general health issues facing individuals living in poverty. The Standard Plan will provide a more robust set of mental health, substance abuse treatment and dental services than the current Benchmark, Core or Basic plans. Through the mental health and substance abuse treatment benefits, many Wisconsin residents will have access to treatment services for the first time. The improved dental benefit will help thousands of people living in poverty improve their oral health.

Combined with other benefits offered in the Standard Plan, these changes will help improve the overall health of tens of thousands of Wisconsin citizens who are living in poverty and creates a Medicaid program that is truly fair for all people living in poverty.

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FAQ

Why did we end HIRSP in the first place?

HIRSP was created in Wisconsin in 1981 to ensure every citizen had guaranteed access to health insurance, since we allowed insurance carriers to underwrite based on health status and to reject applications if the risk was too high. After 1996, federal law required that every state had to either have a high risk pool like Wisconsin or require insurance carriers to guarantee issue and accept all risk. The new market rules under the ACA remove the option for states and now require every insurer – on or off the exchange – to provide guaranteed access coverage regardless of health status so there is no need for the high risk pools any longer.

Why did some states like Minnesota keep their high risk pool?

States can certainly keep their high risk pools if they like, but consumers with high risk pool coverage can now choose coverage from any insurer in the market and not just high risk pool coverage. With the available subsidies from the federal government, it is likely many consumers will pay less in the exchange – with the federal subsidy – than they will for their high risk pool coverage..

Would there be any benefit to Wisconsin consumers who are in HIRSP if we kept it place?

It is important to note that more than 70% of HIRSP members will have access to subsidized coverage or other government coverage under the ACA. This means that many HIRSP members would absolutely leave HIRSP for cheaper coverage in the exchange or other government programs. Therefore, even if someone who didn't qualify for a subsidy wanted to remain on HIRSP (and again, it is highly unlikely as they have more options in the open market) this would lead to far fewer HIRSP members and much higher administrative costs.

What is the risk if a state keeps a high risk pool?

First, for states that use taxpayer dollars to support the high risk pool, taxpayers will continue to subsidize the pool even though more affordable and federally subsidized coverage may be available outside the high risk pool. Again, it is important to remember that Wisconsin does not use taxpayer dollars to fund our high risk pool.

For Wisconsin consumers, they run the risk of higher premiums from keeping the pool open. This is because insurers in Wisconsin would be required to pay for HIRSP (including the administration of it) and pay into the ACA reinsurance pool to cover high risk individuals. The insurer will get a double hit and will simply pass those costs on to the consumer.

Why should HIRSP be extended past 12/31?

In short, the Governor was concerned about the slow pace of enrollments through the federal exchange. Only 877 Wisconsinites enrolled in coverage and that means there simply may not be enough time to process all the necessary applications in time. Since the report of only 877 consumers getting into the exchange, the numbers have more than doubled in the last week, so more folks are getting through the website or through the call center. In addition, we anticipate the federal government will continue to work on direct enrollment that allows consumers to sign up for subsidies directly from the insurers who are on the exchange. Just recently HHS approved a pilot direct enrollment for Florida, Ohio and Texas.

The 90-day extension will also allow individuals more time to shop and make decisions about their health care.

With federal government now allowing individuals to enroll until December 23rd for a January 1st effective date (it was Dec. 15th) will consumers have enough time to enroll in new coverage?

Maybe, but given the vulnerabilities in both of these populations, it makes sense to assure that they have enough time make the right decision for them. Given the anemic enrollment so far, there is no question more time will be better for these consumers, including the extra time needed for paper applications if that is how they try to obtain coverage.

Should HIRSP be extended longer than the 90 days?

No. First and foremost, there won't be a need for an extension longer than the 90 days since everyone in HIRSP who wants coverage is guaranteed to get coverage in the open market since the ACA requires guarantee issue now. If they want access to subsidies, as we stated before, they can and have been able to get through the website or call center. Because it has been so slow, HIRSP will now be sending any remaining HIRSP members after 1/1/14 a paper application to get into the exchange and obtain the subsidy. This 90 days is ample time for the paper applications if the website remains slow after 1/1/14.

Secondly, logistically, there is no way to keep HIRSP operating past March 31st. The authority and its board have been winding down for the past several months. Their lease expires at the end of February and the space is already leased. And, more importantly, the administrator for HIRSP has no ability to process claims or process premiums or any accounting function past October 1st, as their entire company went through a system conversation and did not include HIRSP in that conversation. The old system physically goes away on 10/1 and for them to convert the HIRSP data to the new system would cost millions.

Is the HIRSP delay revenue neutral?

Yes. For more than a decade HIRSP has not used taxpayer dollars. It is completely funded by the policyholders, insurers and providers. Any shortfall from reserves will be charged to insurers and providers, not policyholders.

Are childless adults left out in this delay?

No. Childless adults with medical conditions were not only eligible for subsidized coverage on HIRSP, but will continue to have both the coverage and the HIRSP subsidy during the 90 day extension. They will then be eligible for the expanded Medicaid after March 31st.

The bill requires that all surpluses be used before insurers are charged. Is that fair to policyholders?

The delay in HIRSP is intended to benefit policyholders by giving them more time. No matter how many claims occur during the 90 days, policyholders are protected from paying anything more than their current premium. However, insurers are at risk for covering unexpected high claims during this transition and run out. Because the policyholders are protected, and since insurers are subject to a number of ACA fees for high risk individuals in a national reinsurance pool, it is both fair and logical that we would spend down reserves first, before assessing insurers twice for the same high risk individuals.

SCOTT WALKER

OFFICE OF THE GOVERNOR

FOR IMMEDIATE RELEASE
December 19, 2013
Contact: Tom Evenson, (608) 267-7303

Governor Scott Walker Releases Statement on Legislature's Passage of Special Session Bill Addressing the Failed Federal Rollout of the Affordable Care Act

Madison – Governor Scott Walker today released the following statement after the Senate's concurrence of Special Session Assembly Bill 1, which addresses the failed federal rollout of the Affordable Care Act:

It is irresponsible to force some Wisconsinites to pay the price for the federal government's failure. I am pleased the Senate and Assembly passed this legislation, which will give our fellow Wisconsinites additional time to make a logical transition. In 2014, everyone living in poverty will be covered—for the first time—under Medicaid in Wisconsin. No more waiting lists, and no more enrollment caps. Wisconsin's unique solution to health care will ensure everyone in our state has access to health care. I look forward to signing this bill into law tomorrow.

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SCOTT WALKER

OFFICE OF THE GOVERNOR

FOR IMMEDIATE RELEASE
December 20, 2013
Contact: Tom Evenson, (608) 267-7303

Governor Scott Walker Signs Bill Extending BadgerCare and HIRSP Coverage to Address the Failed Federal Rollout of the Affordable Care Act

Madison – Governor Scott Walker today signed Special Session Assembly Bill 1 into law at the Wisconsin State Capitol. In response to the failed federal rollout of the Affordable Care Act, the bill extends current coverage for Wisconsin citizens under several medical assistance programs and the Health Insurance Risk-Sharing Plan (HIRSP) through March 31, 2014.

"This bill gives the federal government more time to fix major issues with the Affordable Care Act and it gives Wisconsinites more time to make a logical health care transition," Governor Walker said. "In 2014, everyone living in poverty will be covered – for the first time – under Medicaid in Wisconsin. The waiting lists and enrollment caps that once denied coverage to our most vulnerable citizens will be gone. I thank members of the Legislature for their bipartisan support."

According to a recent study by the Kaiser Family Foundation, Wisconsin is the only state of the 26 states choosing not to expand Medicaid programs as a part of the Affordable Care Act that will not have a gap in health care coverage.

For those transitioning from Medicaid to the federal health care exchange, please visit http://www.dhs.wisconsin.gov/health-care/member/index.htm for fact sheets and additional information.

December Special Session Assembly Bill 1 is 2013 Wisconsin Act 116.

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State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

Technical Bill Summary
LRB 3908 and LRB 3896
January 9, 2014

The Centers for Medicare and Medicaid Services (CMS) recently approved Wisconsin's request to extend two existing federal waivers until March 31, 2014. This approval allows the Department of Health Services to move forward with Governor Walker's request to delay the entitlement reforms scheduled for January 1, 2014 to April 1, 2014 for transition population who are shopping for health insurance coverage on the Federal Exchange.

As part of negotiations, CMS is requiring Wisconsin to begin using the new Modified Adjusted Gross Income (MAGI) rules effective February 1, 2014 for all new parent and caretaker applicants as opposed to April 1, 2014, which was Wisconsin's original request. Starting February 1, 2014, Wisconsin is also required to complete a MAGI-based determination for any existing BadgerCare Plus members who lose eligibility.

What this means for new applicants:

- Parent and caretaker relatives who apply for BadgerCare Plus **before** February 1, 2014 will be enrolled using current BadgerCare Plus budgeting rules, program income limits (up to 200% FPL), and benefits (Benchmark and Standard).
- Parent and caretaker relatives who apply for BadgerCare Plus **on or after** February 1, 2014 will be enrolled using the new MAGI rules, program income limits (up to 100% FPL), and benefits (Standard).
- If a parent or caretaker relative applies for BadgerCare Plus **before** February 1, 2014 but reports a change during the transition period of February 1, 2014 to April 1, 2014:
    - They will be tested first as an existing member, with current BadgerCare Plus budgeting rules and program income limits (up to 200% FPL).
    - If they are above the current income limits, they will then be tested as a new applicant, using new MAGI rules and new program income limits (up to 100% FPL).
    - If they are found ineligible under new MAGI rules, they will be referred to the Marketplace.
- New income limits will be applied to all BadgerCare Plus members effective April 1, 2014, as required by ACT 116.

What this means for existing members:

- The Department of Health Services has sent a letter to members identified to be in the population transitioning to the Federal Exchange. The letter allows individuals the opportunity to see if they can stay enrolled in BadgerCare Plus after March 31, 2014, by filling out a new tax filer form which will allow their eligibility to be checked under the MAGI-based eligibility rules. A copy of Letter 1A and form can be found here: http://www.dhs.wisconsin.gov/em/CustomerHelp/bcpletters.htm

This technical modification will allow Wisconsin to begin implementing Governor Walker's entitlement reforms earlier than under current law. It will also align Wisconsin statutes with CMS requirements.

Finally, the technical bill would allow new applicants who are children and pregnant women with incomes between 200% and 300% FPL to receive the standard Medicaid benefit rather than the Benchmark Plan effective February 1, 2014. This change was originally scheduled to occur on April 1, 2014, however because of the system changes outlined above, the Benchmark Plan will not be offered for newly eligible individuals. This change brings Wisconsin's Medicaid in-line with state statutes and will accelerate the Governor's reforms for newly eligible children and pregnant women with incomes between 200-300% FPL.

SCOTT WALKER

OFFICE OF THE GOVERNOR

FOR IMMEDIATE RELEASE
January 16, 2014
Contact: Tom Evenson, (608) 267-7303

Governor Scott Walker Signs Senate Bill 475

Madison – Governor Scott Walker signed Senate Bill 475 today affecting the timing of eligibility changes to BadgerCare Plus and released the following statement:

Faced with the limited choices presented to us under the Affordable Care Act, we developed a uniquely Wisconsin plan eliminating waiting lists and enrollment caps for our state's most vulnerable to access health care through Medicaid. In addition, in 2014, Wisconsin will have no coverage gap. This bill will allow us to continue to implement our plan to ensure that no Wisconsin citizens fall through the cracks and can make a logical transition.

The changes to BadgerCare Plus eligibility will now go into effect on February 1, 2014 for all new parent and caretaker applicants. Also beginning February 1, Wisconsin is now required to complete a Modified Adjusted Gross Income-based determination for any existing BadgerCare Plus members who lose eligibility. Parent or caretaker relatives, who apply prior to February 1, will be enrolled using current income limits and benefits.

The Department of Health Services has sent a letter to individuals identified to be among those transitioning to the federal exchange, allowing people the opportunity to see if they can remain enrolled in BadgerCare Plus after March 31, 2014, by filling out a new tax filer form. Additionally, new applicants, who are children or pregnant with incomes between 200 percent and 300 percent of the federal poverty level, will receive the standard Medicaid benefits rather than the Benchmark Level, as was scheduled to occur on April 1, 2014.

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Office of Governor Scott Walker
115 East Capitol • Madison, WI 53702
Press Office: (608) 267-7303
Email: govpress@wisconsin.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 30 2013

Brett Davis
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53703

Dear Mr. Davis:

This letter is to inform you that Wisconsin's request for a new section 1115 demonstration, entitled "BadgerCare Reform" (Project No. 11-W-00293/5), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). In alignment with our correspondence sent to the state on December 20, 2013, the accompanying special terms and conditions (STCs), waivers, and expenditure authorities are effective January 1, 2014 through December 31, 2018. The demonstration will receive federal financial participation at the state's regular federal medical assistance percentage (FMAP).

This demonstration provides authority for the state to provide full state plan benefits to non-pregnant, non-disabled childless adults with effective incomes of up to 100 percent of the Federal Poverty Level (FPL) and the demonstration allows the state to require premiums to parent and caretaker adults who qualify for Medicaid through Transitional Medical Assistance (TMA) only and with incomes above 100 percent of the FPL. The sliding scale premiums under the demonstration will align with Marketplace premium levels. The demonstration permits the state to charge premiums to TMA Adults with incomes above 133 percent of the FPL from the date of TMA enrollment, and to TMA Adults with incomes from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage. TMA adults who fail to pay premiums after a 30-day grace period may lose eligibility and ability to re-enroll in TMA for a period of 3 months, after which time they may re-enroll for TMA coverage, whether or not they have repaid the premiums. Individuals above 100 percent of the FPL who have completed their time-limited TMA will be reviewed first for Medicaid eligibility under other eligibility categories and, if not eligible, will be assessed for Marketplace eligibility. If appropriate, their account will be transferred to the Marketplace consistent with applicable regulations. We look forward to continuing to work with the state on its transition plan to facilitate a seamless transfer of coverage for those who will be eligible for Marketplace coverage.

The CMS' approval of the BadgerCare Reform demonstration is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the projects. The award is subject to

our receiving your written acknowledgement of the award and acceptance of both sets of STCs within 30 days of the date of this letter.

A copy of the BadgerCare Plus STCs, and waiver and expenditure authorities is enclosed. Your project officer is Leila Ashkeboussi. Leila is available to answer any questions concerning your section 1115 demonstration, and may be reached by phone at (202) 205-4730 or by email at Leila.Ashkeboussi@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted at the following address:

Division of State Demonstrations & Waivers
Center for Medicaid & CHIP Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

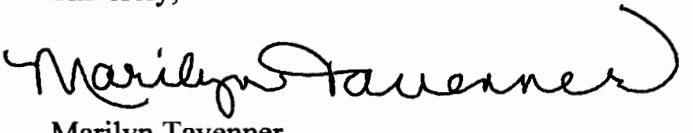
Official communications regarding program matters should be submitted simultaneously to Ms. Ashkeboussi and to Ms. Verlon Johnson, Associate Regional Administrator for the Division of Medicaid & Children's Health in the Chicago Regional Office. Ms. Johnson's contact information is as follows:

Ms. Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children Health Operations
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

If you have additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at 410-786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,



Marilyn Tavenner

Enclosures

cc: Verlon Johnson, Associate Regional Administrator, Region V

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform**

AWARDEE: **Wisconsin Department of Health Services**

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the affected populations, as described for the Demonstration project from January 1, 2014 through December 31, 2018.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Wisconsin to implement the Wisconsin BadgerCare Reform Medicaid section 1115 Demonstration.

1. Provision of Medical Assistance Eligibility — **Section 1902 (a)(8)** **Section 1902(a)(10)**

To the extent needed to enable the state to enforce premium payment requirements under the Demonstration by not providing medical assistance for a period of 3 months for adults that qualify for Medicaid only under section 1925, or sections 1902(e)(1) and 1931(c)(1), of the Act whose eligibility has been terminated as a result of not paying the required monthly premium.

2. Premiums — **Section 1902(a)(14) insofar as it incorporates section 1916** **Section 1902(a)(52)**

To the extent needed to permit the state to impose monthly premiums based on household income on individuals that qualify for Medicaid under TMA only. This waiver allows the state to apply premiums to TMA Adults with income above 133 percent of the FPL starting from the date of enrollment, and to TMA Adults with income from 100-133 percent of the FPL starting after the first 6 calendar months of TMA coverage.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00293/5**

TITLE: **Wisconsin BadgerCare Reform Section 1115 Demonstration**

AWARDEE: **Wisconsin Department of Health Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable the State to operate its BadgerCare Reform section 1115 Medicaid demonstration beginning January 1, 2014 through December 31, 2018.

1. **Childless Adults Demonstration Population.** Expenditures for health care-related costs for childless, non-pregnant, uninsured adults ages 19 through 64 years who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL including the 5 percent disregard), who are not otherwise eligible under the Medicaid State plan, other than for family planning services or for the treatment of Tuberculosis, and who are not otherwise eligible for Medicare, Medical Assistance, or the State Children's Health Insurance Program (CHIP).

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Childless Adults Demonstration Population beginning April 1, 2014, through December 31, 2018.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. **Freedom of Choice** **Section 1902(a)(23)(A)**
   To the extent necessary to enable the State to require enrollment of eligible individuals in managed care organizations.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00293/5

TITLE: Wisconsin BadgerCare Reform Demonstration Project

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) to enable Wisconsin (state) to operate the Badger Care Reform section 1115(a) demonstration (demonstration). The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective January 1, 2014, and the demonstration is approved through December 31, 2018.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. General Financial Requirements
X. Monitoring Budget Neutrality for the Demonstration
XI. Evaluation of the Demonstration; and
XII. Schedule of State Deliverables During the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A. Quarterly Report Content and Format
Attachment B. Summary of Cost Sharing
Attachment C. Demonstration Evaluation Plan (once approved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

With the implementation of the Affordable Care Act provisions that will provide federally-funded subsidies to help individuals and families purchase private health insurance, Wisconsin sees the BadgerCare Reform demonstration as an opportunity to reduce the uninsured rate and encourage beneficiaries to access coverage in the private market.

The Wisconsin BadgerCare Reform demonstration provides state plan benefits other than family planning services and tuberculosis-related services to childless adults who have family incomes up to 95 percent of the Federal Poverty Level (FPL) (effectively 100 percent of the FPL considering a disregard of 5 percent of income), and permits the state to charge premiums to adults who are only eligible for Medicaid through the Transitional Medical Assistance eligibility group (hereinafter referred to as "TMA Adults") with incomes above 133 percent of the FPL starting from the first day of enrollment and to TMA Adults from 100-133 percent of the FPL after the first 6 calendar months of TMA coverage.

The demonstration will allow the state to provide health care coverage for the childless adult population at or below an effective income of 100 percent of the FPL with a focus on improving health outcomes, reducing unnecessary services, and improving the cost-effectiveness of Medicaid services. Additionally, the demonstration will enable the state to test the impact of providing TMA to individuals who are paying a premium that aligns with the insurance affordability program in the Marketplace based upon their household income when compared to the FPL.

The state's goals for the program are to demonstrate whether the program will:

- Ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate.
- Provide a standard set of comprehensive benefits for low income individuals that will lead to improved healthcare outcomes.
- Create a program that is sustainable so Wisconsin's healthcare safety net is available to those who need it most.

Wisconsin had previously submitted a waiver (the BadgerCare demonstration) first implemented in April 1999 to provide coverage to uninsured children and families up to 200 percent of the FPL The demonstration was later amended to focus on providing coverage to parents and caretaker relatives with income from 150 to 200 percent of the FPL. This demonstration was last amended on July 1, 2012 to enable the state to test the effect of increased premiums on enrollment, utilization, and health outcomes on the non-pregnant, non-disabled parent/caretaker relative population. Under this existing demonstration, the state is permitted to charge premiums for TMA Adults with incomes above 133 percent of the FPL. The amendment permitted a 12-month restrictive re-enrollment policy as a penalty for non-payment of premiums, sliding scale premiums in excess of 5 percent of household income, and the application of the 9.5 percent affordability test.

Wisconsin also has prior experience providing medical assistance to childless adults up to 200 percent of the FPL under its BadgerCare Plus Health Insurance for Childless Adults

demonstration, which was approved in January 2009. This demonstration provided a limited set of benefits through the "Core Plan" for childless adults up to 200 percent FPL. Both demonstrations (BadgerCare and BadgerCare Plus Health Insurance for Childless Adults) are set to expire on March 31, 2014. The BadgerCare Reform demonstration will begin providing coverage on April 1, 2014. In addition to phasing out the BadgerCare Plus and BadgerCare demonstrations prior to the implementation of the BadgerCare Reform demonstration, the state also intends to make corresponding changes to Wisconsin's Medicaid state plan, effective April 1, 2014, which will limit Medicaid coverage for parents and caretaker relatives to those with MAGI at or below an effective income level 100 percent of the FPL.

Ultimately, the state estimates that nearly 99,000 childless adults will enroll in BadgerCare Reform in the first demonstration year. The state also estimates that nearly 5,000 childless adults will transition to the federal Marketplace and may be eligible to receive a federal tax subsidy to help them purchase private individual health insurance.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes shall be considered in force once the state accepts the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

4. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.

5. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC **6** below.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in STC 7,reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

   b. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming title XIX state plan amendment, if necessary.

   c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

d. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.**

a. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, pursuant to 42 CFR 431.412, no later than 12 months prior to the expiration date of the demonstration when requesting an extension under section 1115(e), or no later than six months prior to the expiration date of the demonstration when requesting an extension under section 1115(f). The chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.

b. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

c. Upon application from the state, CMS may temporarily extend the demonstration and make any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

8. **Demonstration Transiton and Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.:

   a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plans for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved Tribal Consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

   The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

   b. Transition and Phase-out Plan Requirements The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible individuals, as well as any community outreach activities including community resources that are available. The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

   c. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR section 435.916.

   d. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX would be served or under circumstances described in 42 CFR section 431.416(g).

   e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers

suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. **Expiring Demonstration Authority and Transition.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

    a. Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    b. Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.

    c. Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

    d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may amend, suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms amendment, reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure

authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.**

    The state must comply with the public notice requirements set forth in 42 CFR § 431.416. The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)). In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR.§431.408(b)(3)).

    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or a later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

IV. ELIGIBILITY

16. **State Plan Eligibility Groups Affected By the Demonstration.**

    a. General requirements. Mandatory and optional state plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and

regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Eligibility standards and methodologies for all state plan groups are as reflected in the state plan, unless expressly modified through the waivers, expenditure authorities, and STCs for this demonstration. Should the state amend the state plan to make any changes to eligibility for Medicaid state plan populations, upon submission of the state plan amendment, the state must notify the project officer in writing of the pending state plan amendment that has a material impact on the populations covered in this demonstration. The Medicaid Eligibility Groups (MEGs) listed in the Reporting and the Budget Neutrality sections of the STCs will be updated upon approval of changes to state plan eligibility and will be considered a technical change to the STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard will apply to this demonstration.

b. State plan populations affected by this demonstration. The state plan populations affected by the Wisconsin BadgerCare Reform demonstration are outlined in Table 1, which which summarizes each specific group of individuals; under what authority they are eligible for coverage, and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed. For the purposes of eligibility, "disabled" is defined as meeting the disability standard for eligibility for federal supplemental security income under 42 USC 1382c(a)(3).

17. **Demonstration Expansion Eligibility Group.**

a. General. Table 1 summarizes the specific groups of individuals, under what authority they are eligible for coverage, and the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed. Population 1 is eligible under the state plan. Population 2 in Table 1 is made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration, and is subject to Medicaid laws or regulations (including all enrollment requirements described in paragraph b. below) unless otherwise specified in the not applicable expenditure authorities for this demonstration.

b. Seamless Coverage. Individuals whose incomes are determined by the Marketplace to be too low for advanced payments of the premium tax credit through the Marketplace will be considered income eligible for demonstration Population 2.

c. Application of Medicaid eligibility and enrollment policies. All Medicaid eligibility and enrollment requirements that apply to state plan groups shall apply to demonstration Population 2, including the following:

i. *Application of Modified Adjusted Gross Income (MAGI).* The state must use MAGI income rules for demonstration populations in the same manner that they are applied to the state plan.

ii. *Presumptive Eligibility*. The state will allow presumptive eligibility for demonstration population 2, to be determined and certified by qualified hospitals, in the same manner as for parents and caretaker relatives who could be eligible under the Medicaid state plan.

iii. *Redeterminations*. Redetermination of eligibility for demonstration population 2 must occur at least once every 12 months. An enrollee may request a redetermination of eligibility for the demonstration due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the state must perform such redeterminations upon request. Each redetermination must include a reassessment of the individual's eligibility for Medicaid to ensure that enrollees are not eligible for coverage under the Medicaid state plan prior to re-enrollment into the demonstration.

iv. *Disenrollment.* Demonstration Population 1 may be disenrolled for failure to pay premiums after a 30 day grace period. Once they are disenrolled, they may be restricted from re-enrollment for up to 3 months. They may enroll for other Medicaid if they become eligible during the 3-month restrictive re-enrollment period. At any point during this 3-month period, they may pay the owed premiums to re-enroll in TMA for the remainder of the 12-month TMA extension period. After the 3-month period, they may re-enroll for TMA for the remainder of the 12-month TMA extension period if requested even if they have an outstanding unpaid premiums. Demonstration Population 2 beneficiaries may be disenrolled with the requisite notice (consistent with 42 CFR §431.206, §431.210, and §431.213) if they:

1. Become entitled to Medicare;
2. Become eligible for a full-benefit Medicaid state plan group;
3. Become eligible for CHIP coverage;
4. No longer reside in the state of Wisconsin;
5. Become incarcerated or are institutionalized in an institution for mental disease;
6. Have effective income greater than 100 percent of the FPL;
7. Attain age 65;
8. Are no longer living; or
9. Fail to meet other requirements that apply to state plan MAGI populations.
10. If section 1925 sunsets or is otherwise inapplicable and TMA is then available only for a four-month extension, Demonstration Population 1 individuals may not re-enroll in TMA.

Table 1: Eligibility Groups Groups Affected by the Demonstration

Medicaid State Plan Mandatory Groups	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Population 1. Parents and caretaker relatives who are non-pregnant, non-disabled, and whose effective family income is above 100 percent FPL and who qualify for TMA under section 1925 of the Act	Parents and caretaker relatives eligible for Medicaid under Wisconsin's Medicaid State plan under section 1925 of the Act or if section 1925 sunsets or is otherwise inapplicable, under sections 1902(e)(1) and 1931(c)(1) of the Act.	Title XIX	TMA Adults
Demonstration Expansion Groups	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Population 2. Non-pregnant childless individuals Age 19 through 65 with an effective income that does not exceed 100 percent FPL	• Between the ages of 19 and 64 years • Effective income at or below 100 percent of the FPL • Not pregnant • Do not qualify for any other full-benefit Medicaid or CHIP eligibility group. • Are not entitled to receive Medicare • Childless adults may have children, but do not qualify as a parent or caretaker relative (e.g. either the minor children are not currently living with them or those children living with them are 19 years of age or older). • The state will implement coverage for Population 2 effective April 1, 2014.	Title XIX	BC Reform Adults

19. **Transition to Marketplace Coverage.** Individuals in Population 1 above 100 percent of the FPL who have completed their time-limited TMA will be reviewed first for Medicaid eligibility under other eligibility categories and, if not eligible, will be assessed for Marketplace eligibility. If appropriate, their account will be transferred to the Marketplace consistent with applicable regulations. Beneficiaries in Populations 2 who become ineligible because of an increase in income will be transitioned to coverage through the Marketplace, as appropriate, according to the process described below:

    a. Ongoing Administrative Reviews to Determine Alternative Medicaid Eligibility Category. Before beginning the transition to the Marketplace, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different Medicaid eligibility category as discussed in the October 1, 2010 State Health Official Letter #10-008.

    b. Notice and Hearings and Appeals. The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

    c. Transfer of Enrollees Eligibility Information to the Marketplace. The state must transfer all of an individual's eligibility information to the Marketplace.

V. BENEFITS

20. **Wisconsin BadgerCare Reform.** All enrollees in this demonstration (as described in Section IV) will receive benefits as specified in the Medicaid state plan, to the extent that such benefits apply those individuals. Beneficiaries in the demonstration childless adult demonstration population will not receive family planning services or tuberculosis-related services. In addition, beneficiaries in the demonstration adult population will not receive pregnancy related services, but instead must be administratively transferred to the pregnant women group in the state plan if they are pregnant. Refer to the state plan for additional information on benefits.

VI. COST SHARING

21. **Cost sharing.** For all enrollees in this demonstration, except for premiums for TMA Adults, cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan. Cost sharing for BC Reform Adults will be the same as indicated in the Medicaid state plan as applicable to non-pregnant, individuals who are 19 to 64 years of age. The premium requirements described in this section for TMA Adults will be implemented by the state on April 1, 2014.

    a. Premiums for TMA Adults-- TMA Adults with income above 133 percent of the FPL are subject to monthly premiums based on the sliding scale as outlined in Attachment B from the date of enrollment. The 5 percent MAGI disregard does not apply for the

income thresholds for calculating premiums. TMA Adults with effective income between 100 percent and 133 percent of the FPL are subject to monthly premiums based on a sliding scale starting 6 calendar months after the date of enrollment. There will be a 30 day grace period for non-payment of the monthly premium before being disenrolled. Eligibility and enrollment for TMA will be terminated for a maximum period of 3 months for demonstration participants who fail to make a premium payment. However, a participant may re-enroll at any point during this 3-month period by paying owed premiums. After the 3-month disenrollment period, TMA Adults must be reenrolled in TMA on request, even if they have an outstanding unpaid premiums, provided their respective 12-month TMA period has not yet expired. If section 1925 sunsets or is otherwise inapplicable and TMA is then available only for a 4-month extension, Demonstration Population 1 individuals may not re-enroll in TMA. No premium may be charged during the 3-month exclusion period, and premiums that remain unpaid from a prior TMA enrollment period may not be used as a basis for termination of the reenrollment period.

b. Premiums for TMA Adults whose income changes after time of application, i.e., decreases or increases (including an increase in which the individual's income exceeds 200 percent of the FPL), but before his/her annual redetermination, will be recalculated after the individual has reported the change. Once the state has calculated an individual's new monthly premium amount based on the sliding scale outlined above, the state will provide the individual with at least a 10-day notice prior to effectuating the new monthly premium amount. If income increases to above 133 percent FPL for TMA demonstration enrollees who had income under 133 percent FPL when their TMA began, premiums will be due immediately after the 10-day notice.

c. American Indians are exempt from the premium amounts outlined above

d. The state will mail letters to the demonstration participants, who will be disenrolled for failure to pay premiums with notice of the disenrollment and right to an appeal.

e. The state will monitor and include in the quarterly report information related to disenrollments from the demonstration including nonpayment of premiums broken down by the income levels specified in the table in Appendix B.

VII. DELIVERY SYSTEM

22. **General.** BadgerCare Reform beneficiaries will be enrolled in the current managed care organization (MCO) provider network that provides health care services to the existing Medicaid and BadgerCare Reform programs in most of the state to serve persons eligible under this demonstration. Demonstration enrollees will be required to join an MCO as a condition of eligibility, as long as there is at least one MCO available in their county of residence, and the county has been granted a rural exception under Medicaid State plan authority. The state may mandate enrollment into the single MCO in the counties that have been granted the rural exception by CMS. If the county has not been granted a rural exception, the state must offer the option of either MCO enrollment or Medicaid fee-for-

service. All demonstration eligible enrolled in an MCO or not must be provided a Medicaid card. MCOs may elect to provide an MCO specific card to MCO enrollees as well. The state must comply with the manage care regulations published at 42 CFR §438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR §438.6. No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR §438 requirements prior to CMS approval of this demonstration authority as well as such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

VIII. GENERAL REPORTING REQUIREMENTS

23. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section IX of these STCs.

24. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section IX of these STCs.

25. **Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including early planning for potential future renewal activities. Areas to be addressed include, but are not limited to: transition and implementation activities, stakeholder concerns, including those raised at the Native American Advisory Board and the Native American Technical Advisory Subcommittee, MCO operations and performance, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

26. **Post Award Forum Transparency Requirement:** The state must comply with the Post Award Forum transparency requirements set forth in 42 CFR § 431.420. Within 6 months after the implementation date of the demonstration and annually thereafter the state must hold a public forum to solicit comments on the progress of a demonstration project. The state shall include a summary of the forum in the quarterly report associated with the quarter in which the forum was held, as well as in its annual report to CMS. The public forum to solicit feedback on the progress of a demonstration project must occur using one of the following:

    a. A Medical Care Advisory Committee that operates in accordance with 42 CFR § 431.412

    b. A commission or other similar process, where meetings are open to members of the public, and would afford an interested party the opportunity to learn about the demonstration's progress.

    The State must publish the date, time, and location of the public forum in a prominent location on the State's public Web site, at least 30 days prior to the date of the planned public forum.

27. **Quarterly Progress Reports.** The state must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. A summary of any issues identified or recommendations made during the semi-annual consultation meeting between the Department and the federally recognizes tribes in Wisconsin, as well as tribal consultations with the Wisconsin Tribal Health Directors Association and other ad hoc meetings with tribal representation;

    d. Action plans for addressing any policy, administrative, or budget issues identified;

    e. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;

    f. Complaints, grievances and appeals filed during the quarter by type.

g. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.

h. Identify any quality assurance/monitoring activity in current quarter.

28. **Demonstration Annual Report.** The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the Demonstration Year (DY) to CMS.

    a. All items included in the quarterly report pursuant to STC 27 must be summarized to reflect the operation/activities throughout the DY;

    b. A budget neutrality workbook that contains total annual expenditures for the demonstration population for each DY including a comparison analysis of the projected without waiver and with waiver cost analysis to the actual expenditures, with administrative costs reported separately;

    c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement.

    d. The number of TMA Adults who are disenrolled per month starting from April 1, 2014, due to non-premium payment.

29. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

IX. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX services rendered during the demonstration period. This section describes the general financial requirements for these expenditures:

30. **Quarterly Financial Reports.** The state must provide quarterly title XIX expenditure reports using Form CMS-64, to separately report total title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in Section **X** of the STCs.

31. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures: In order to track expenditures under this demonstration, he state will report demonstration expenditures through the Medicaid and state Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the state Medicaid Manual. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on the appropriate prior period adjustment schedules (Forms CMS-64.9 Waiver) for the Summary Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below.

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c. Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Using specific medical status codes, the state has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures for BC Reform Adults. The State will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The state will report the portion of rebate revenue assigned to BC Reform Adults on the appropriate Forms CMS-64.9 WAIVER. This revenue will be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid. Budget neutrality will reflect the net cost of prescriptions.

e. Federally Qualified Health Center Settlement Expenses. Using specific medical status codes, the State will assign FQHC settlement expenses to claims covered under the demonstration for BC Reform Adults and will report these costs on the appropriate Forms CMS-64.9 WAIVER. The state will be able to generate reports using MMIS data to show the assignment of these settlement payments to demonstration expenditures.

f. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent. These amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

g. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration (Section X of these STCs). The state must complete separate waiver forms for the following Medicaid eligibility groups/waiver names:

    i. **"BC Reform Adults"**

    ii. **"TMA Adults"**

h. Demonstration Year Definition. The Demonstration Years (DYs) will be defined as follows:

January 1, 2014 through December 31, 2014	Demonstration Year 1 (DY1)
January 1through December 31, 2015	Demonstration Year 2 (DY2)
January through December 31, 2016	Demonstration Year 3 (DY3)
January 1 through December 31, 2017	Demonstration Year 4 (DY4)
January 1 through December 31, 2018	Demonstration Year 5 (DY5)

32. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".

33. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

34. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

    a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 27, the actual number of eligible member months for BCReform Demo Adults. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

       To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

35. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will makefFederal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

36. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in Section X of these STCs:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

    c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

37. **Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding, including up to date responses to the CMS standard funding questions

    c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

38. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.

    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs

eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

39. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

40. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in Section IV, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state

at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

41. **Calculation of the Budget Neutrality Limit:** For the purpose of calculating the overall budget neutrality limit for the demonstration, an annual budget limits will be calculated for each DY on a total computable basis. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 43 below. The demonstration expenditures subject to the budget neutrality limit related to demo population 2 as described in STC 17(c) are those reported under the following Waiver Name: BC Reform Adults.

    For each DY, separate annual budget limits of demonstration service expenditures will be calculated based on projected PMPM expenditures for BC Reform Adults. The PMPM amounts for BC Reform Adults are shown on the table below.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
BCReform Adults	5.1% (with 5.0% for Year 1 of waiver)	582.68	612.40	643.63	676.46	710.95

42. **Hypothetical Eligibility Group.** BC Reform Adults (as related to population 2 defined under pagragraph 17(c) of the STCs) is considered to be a hypothetical population for budget neutrality. BC Reform Adults consists of individuals who could have been added to the Medicaid program through the state plan, but instead are covered through demonstration authority. The budget neutrality expenditure limit for BC Reform Adults reflects the expected costs for this population, and there is no requirement that the state produce savings from elsewhere in its Medicaid program to offset hypothetical population costs. States may not accrue budget neutrality "savings" from hypothetical populations that could be used to offset the cost of other, non-hypothetical expenditures.

43. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual expenditures for BC Reform Adults during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

44. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

45. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap on a PMPM basis by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition on a PMPM basis	Percentage
DY 1	Cumulative budget neutrality limit plus:	1 percent
DY 2	Cumulative budget neutrality limit plus:	0.75 percent
DY 3	Cumulative budget neutrality limit plus:	0.5 percent
DY 4	Cumulative budget neutrality limit plus:	0.25 percent
DY 5	Cumulative budget neutrality limit plus:	0 percent

46. **Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

47. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval within 120 days of the approval date of the new demonstration a draft evaluation design. At minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in STC 48. The design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroguly documents.

    The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal per review, as appropriate for each aspect of the evaluation including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.
    The design must describe the state's process to contract with an independent evaluator, enrusing no conflict of interest.

    The design, including the contracting budget and adequacy of approach to assure the evaluation meets the requirements of STC 48, is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above.

48. **Evaluation Design.**

    a. Domains of Focus – The state must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs.

    b. Core Elements of Demonstration Evaluation. As outlined below, the evaluation describes whether the state met the demonstration goal and objectives with recommendations for future efforts. The state must submit to CMS for approval a revised evaluation design no later than September 1, 2014. At a minimum, the revised draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration. Specifically, the evaluation must test the following specific hypotheses related to sliding scale premiums required for those demonstration participants whose income exceeds the 100 percent FPL (TMA adults) and the effectiveness of the demonstration's expanded eligibility of Medicaid for BC Reform at or below an effective income of 100 percent FPL:

        i. For the TMA demonstration participants, will the premium requirement reduce the incidence of unnecessary services, slow the growth in healthcare spending, and increase the cost effectiveness of Medicaid services?

ii. Is there any impact on utilization and/or costs associated with individuals who were disenrolled, but re-enrolled after the 3-month restrictive re-enrollment period?
iii. Are costs and/or utilization of services different for those that are continuously enrolled compared to costs/utilization for individuals that have disenrolled and then re-enrolled?
iv. What impact does the 3-month restrictive re-enrollment period for failure to make a premium payment have on the payment of premiums and on enrollment? Does this impact vary by income level (if so, include a break out by income level)?
v. What is the impact of premiums on enrollment broken down by income level and the corresponding monthly premium amount?
vi. How is enrollment or access to care affected by the application of new, or increased, premium amounts?
vii. Will the provision of a benefit plan that is the same as the one provided to all other BadgerCare adult beneficiaries result in improved health outcomes, a reduction in the incidence of unnecessary services, an increase in the cost effectiveness of Medicaid services and an increase in the continuity of health coverage?

Methods by which the state can evaluate these hypotheses include enrollment data, premium statistics, utilization and cost data associated with this population compared to childless adults and TMA adults outside of the demonstration, as well as similar populations covered under previous demonstrations prior to April 1, 2014.

The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from the other initiatives occurring in the state. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

c. Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:
   i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
   ii. The baseline data that will be used and baseline value for each measure;
   iii. Any sampling methodology that may be used for assessing these outcomes; and
   iv. The methods and timing of data collection.

d. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set

of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

49**. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. Once approved by CMS, the evaluation plan will become Attachment C of these STCs. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation final report by June 1, 2019 The state must submit the final evaluation report within 60 days after receipt of CMS' comments. The final report must include the following:

a. An executive summary;
b. A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
c. A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
d. A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
e. Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
f. Successes, challenges, and lessons learned.

50. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. The state shall submit the required data to HHS or its contractor.

51. Completion of Expiring Demonstrations' Evaluations. By September 30, 2014, the state must submit a draft final evaluation report (or reports) for the BadgerCare and BadgerCare Plus Health Insurance for Childless Adults demonstrations to CMS. This requirement supersedes any corresponding requirement included in the special terms and conditions for those demonstrations. The draft final report(s) will include reports on all evaluations conducted under the CMS-approved evaluation plans for those demonstrations. CMS will provide comments within 60 days after receipt of the report, and the State must submit the final evaluation report within 60 days after receipt of CMS's comments.

XII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverables	STC Reference
Submission of notification letter and draft phase-out plan due 6 months before the effective date of demonstration's suspension or termination	Demonstration Transition and Phase Out Plan	STC 9
Within 6 months after the implementation date of the demonstration and annually thereafter	Post Award Public Forum pursuant to 42 CFR §431.420	STC 26
Submission due no later than 60 days following the end of each quarter	Quarterly Progress Reports	STC 27
Submission due 90 days after the end of each DY	Draft Annual Reports	STC 28
Submission due within 30 days of receipt of comments from CMS each DY	Final Annual Reports	STC 28
Submission due by June 30, 2019 (i.e. 120 days following the end of the demonstration) for CMS comments. The final report is due to CMS no later than 120 days after receipt of CMS' comments.	Final Report	STC 29
With quarterly reports	Quartery Financial Reports	STC 30
Submission of draft evaluation design within 120 days of the approval date. CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of	Evaluation Design	STC 47

receipt of CMS' comments (September 1, 2014).		
Submission of draft final report due to CMS by June 1, 2019. The state must submit the final evaluation report within 60 days after receipt of CMS' comments	Final Evaluation	STC 49
September 30, 2014	Final evaluation report for expiring BadgerCare and BadgerCare Plus Evaluation	STC 51

ATTACHMENT A. QUARTERLY REPORT CONTENT AND FORMAT

Pursuant to STC 27 *(Quarterly Progress Report)* of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –Wisconsin BadgerCare Reform 1115 Waiver Demonstration
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
[Example: Demonstration Year: 1 (4/1/2014– 12/31/2014)
Federal Fiscal Quarter:
Footer: Date on the approval letter through December 31, 2018]

Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

Enrollment and Benefits Information

Discuss the following:
Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Information about the beneficiary rewards program, including the number of people participating, credits earned, and credits redeemed.

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Enrollment Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations	Total Number of Demonstration participants Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter	TMA Adults disenrolled due to non-payment of premiums
BC Reform Adults				
TMA Adults				

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

X. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations[1]

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
BC Reform Adults				

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of MCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 28.

XIV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVI. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

Attachment B. Summary of Cost-sharing for TMA Adults Only

Individuals affected by, or eligible under, the demonstration will with the co-payments below.

TMA Adults (Demonstration Population 1)

Monthly Premium Amount based on FPL Percentage	Monthly Premium Amount as a Percentage of Income
100.01 – 132.99%	2.0%
133 – 139.99%	3.0%
140 – 149.99%	3.5%
150 – 159.99%	4.0%
160 – 169.99%	4.5%
170 – 179.99%	4.9%
180 – 189.99%	5.4%
190 – 199.99%	5.8%
200 – 209.99%	6.3%
210 – 219.99%	6.7%
220 – 229.99%	7.0%
230 – 239.99%	7.4%
240 – 249.99%	7.7%
250 – 259.99%	8.05%
260 – 269.99%	8.3%
270 – 279.99%	8.6%
280 – 289.99%	8.9%
290 – 299.99%	9.2%
300% and above	9.5%

Attachment C. Demonstration Evaluation Plan

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

January 9, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner:

Thank you for your December 30, 2013 letter informing Medicaid Director Brett Davis of the Centers for Medicare & Medicaid Services' approval of Wisconsin's request for a new section 1115 demonstration, entitled "BadgerCare Reform"(Project No. 11-W-00293/5), in accordance with section 1115(a) of the Social Security Act. I am writing to officially acknowledge the award and accept both sets of Standards, Terms and Conditions (STCs) referenced in the letter.

The agreement we have reached is historic. Governor Scott Walker's entitlement reforms make certain that all residents of our state have access to affordable health insurance options for the first time in Wisconsin history. In addition, the comprehensive benefits being offered ensure that all Wisconsin adults living in poverty can receive the health care services they need to improve their overall well-being.

I appreciate the hard work that you and your team put into helping us achieve this important accomplishment. Working together, we are improving the lives of thousands of Wisconsin residents.

Sincerely,

Kitty Rhoades
Secretary

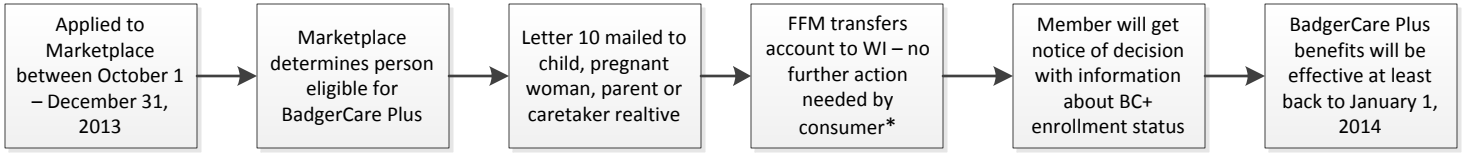
What happens after a Wisconsin resident submits an application at the federal Health Insurance Marketplace (also known as the Exchange or Healthcare.gov) and at least one applicant is eligible for BadgerCare Plus?

APPLICATION COMPLETED THROUGH MARKETPLACE ON OCTOBER 1 THROUGH DECEMBER 31, 2013

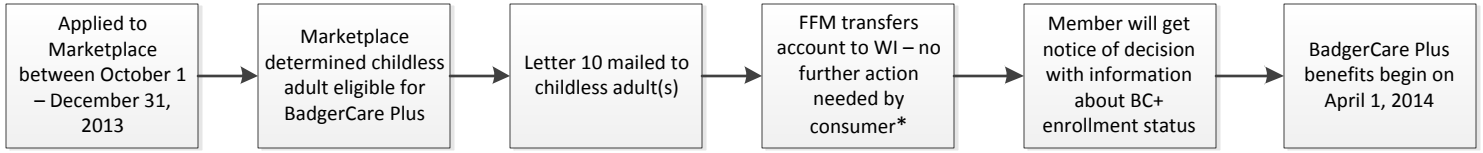
Wisconsin is a Determination State

Marketplace is able to process applications that Wisconsin residents submit to the Marketplace and determine them eligible to be enrolled in BadgerCare Plus. After the member is enrolled, once they report a change or a renewal is completed, an Income Maintenance worker will re-determine their BadgerCare Plus eligibility.

CHILDREN, PREGNANT WOMEN, PARENTS AND CARETAKER RELATIVES



CHILDLESS ADULTS

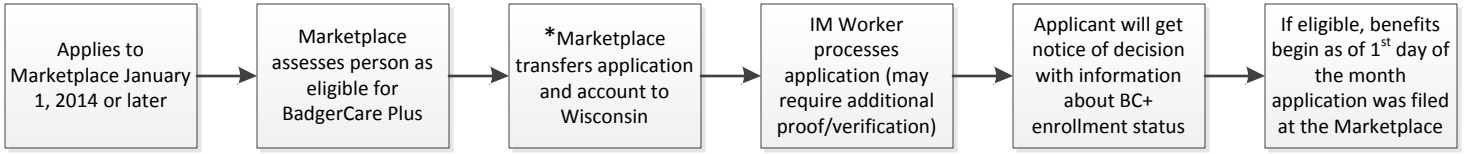


APPLICATION COMPLETED THROUGH MARKETPLACE ON OR AFTER JANUARY 1, 2014

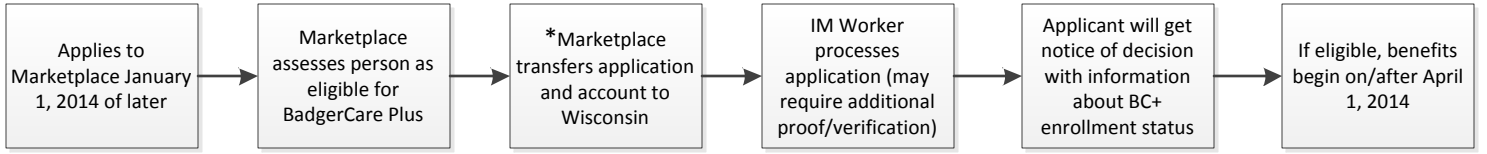
Wisconsin is an Assessment State

Marketplace transfers applications of Wisconsin residents who apply for health care at the Marketplace and appear to be eligible for BadgerCare Plus and Wisconsin Income Maintenance workers process the applications and determine BadgerCare Plus eligibility.

CHILDREN, PREGNANT WOMEN, PARENTS AND CARETAKER RELATIVES



CHILDLESS ADULTS



*Note that February 3, 2014, is the earliest an account transfer could be processed. Processing timeframes will depend on when a given account transfer is received from the Marketplace.

State of Wisconsin
Department of Health Services
Division of Health Care Access and Accountability

P-00594 (01/14)

Medicaid and CHIP MAC Learning Collaboratives

Federally Facilitated Marketplace Eligibility & Enrollment Learning Collaborative

FFM Eligibility Determination Issues and Resolution

January 14, 2014

4:00 – 5:00 pm ET

URL: https://manatt.webex.com/manatt/onstage/g.php?t=a&d=571853613
Event Password: Eligibility1
Dial: 1.866.922.3257
Passcode: 514849#

Agenda

- Background on Eligibility Determination Issues
- Issue Identification and Resolution
  - Issue Identification & Resolution Process
  - Quality Assurance Process
- Fixed Eligibility Defects That May Be Seen in Account Transfers
- Next Steps

Background on Eligibility Issues

Background – FFM to State Account Transfers

- Substantial progress is being made in supporting outgoing account transfers from the Federally Facilitated Marketplace (FFM) to states
- As CMS makes those transfers, technical issues may arise (handled through XOC processes) as well as issues or questions relating to FFM processing
- The FFM is making accurate eligibility decisions for the vast majority of users.
- Three types of issues:
  - Resolved:
    - Existed in the FFM system for short periods of time
    - Existed in the FFM system in October and November during the early period of FFM performance
  - Limited issues still await resolution
- Purpose of today's meeting is to discuss these issues

CMS has resolved many issues already and will work with states to resolve issues as they arise

Overview of Identification and Resolution Process

Issue Identification and Resolution Process

CMS Testing
CMS conducts regular testing to proactively identify and investigate system and account errors.

Ongoing Communication with States and Stakeholders
CMS continues to meet with states and stakeholders to discuss issues they may have identified, as well as how they can report further problems.

State Reporting Process
CMS will release procedures to the states to report issues identified in Account Transfers.

Issue Identification and Resolution Process

Issue Resolution

CMS proactively researches problems; where necessary, a CMS team develops solutions and works with the programmers to fix the code, test the result, and deploy the solution for applications filed going forward. Many issues have been resolved.

Ongoing CMS Testing

Ongoing testing at the FFM continues, which consists of additional and more complex scenarios being run through the environment to identify potential issues. CMS expects to continue to improve reliability and performance through the open enrollment period and beyond.

Quality Assurance Process

CMS Quality Assurance (QA) Procedure

The QA procedure consists of a set of extra checks by CMS on accounts after decisions are made that someone is Medicaid eligible.

- Example: CMS looks for evidence of anomalous results (higher than expected income levels for the number of household members) and for internal issues (such as null fields).

Communication to States

As accounts are transferred to states, states will be notified if the QA process flagged a concern, if the account passed QA checks, or the QA checks were not applicable to that case, to assist the states in taking the appropriate next steps.

State Post-Eligibility Determination/Assessment Checks

States can conduct post-eligibility checks to validate questioned information and, with proper notice and appeal rights, dis-enroll beneficiaries based on those results and transfer their cases back to the FFM for action.

Fixed Eligibility Defects

Fixed Eligibility Defects

1. Erroneous CHIP Denials Based on Incarceration Status
2. Erroneous Household Income Calculation
3. Erroneous Ineligibility Determination for Child of Parents Filing Separately
4. Erroneous Assessment/Determination of Eligibility for Medicaid Adult Group (Expansion)
5. Erroneous Categorization of Spouse as Dependent, Impacting Income Calculation
6. Erroneous Medicaid Eligibility Assessments/Determinations for Applications with FPL Incorrectly Recorded
7. Flag for Non-MAGI Referrals Applied to Applications Lacking Certain Indicators
8. Non-Applicants Erroneously Permitted to Request Full Medicaid Determinations
9. Applications Erroneously Sent to Determination States
10. Erroneous Income Calculations for Married Applicants Who File Taxes Separately

Fixed Eligibility Defects

Erroneous CHIP Denials Based on Incarceration Status

Description: FFM applicants with multiple CHIP-eligible children receive denials for some of their children as a result of a defect impacting applicant incarceration status. As a result, states will not receive CHIP eligibility referrals for every eligible applicant, and consumers may receive erroneous CHIP denials for all but the last child applicant. (Began in November, resolved in December)

State Identification Strategy: Using Account Transfer (AT): If applicant's "CHIP Incarceration Status" indicator does not match attestation and child is otherwise eligible, then child should be CHIP eligible.

- Confirm "Insurance Application- Attested Not Incarcerated Indicator" = Y. If it is:
- If "CHIP Incarceration Basis- CHIP Incarceration Status Code" = N and "CHIP Incarceration Ineligibility Reason Code" = 443 (applicant attested incarcerated) and there is no other legitimate basis for CHIP ineligibility, child is CHIP eligible

Recommended State Action: Process enrollment for CHIP-eligible children using Account Transfer payload data. Follow up with family if additional information is needed.

Erroneous Household Income Calculation

Description: In certain cases, the FFM calculated some applications' household income incorrectly, using only individual IRS data rather than tax household IRS data. As a result, states may receive erroneous Medicaid Gap Filling referrals for individuals above income limits. This would have occurred when applicants were processed using the expedited income path. (Resolved in December)

State Identification Strategy: Check for applications with non-applicant spouses; states should ensure all Medicaid Household members' income is counted. Using AT: Use AT header values (Referral Activity Reason Code = GapFilling) to identify applicants referred for MAGI Medicaid under Gap Filling Rules. If authorized to receive FTI, use Tax Return data elements to compare attested annual income with attested annual tax household income. All states can use Member of Applicant Tax Household to establish which individuals belong to applicant's tax household.

Recommended State Action: If income attestation information is available, make appropriate determination; if not, request income attestation from applicants.

Fixed Eligibility Defects

Erroneous Ineligibility Determination for Child of Parents Filing Separately

Description: When married/domestic partners filing separately listed a child as the second applicant and the second parent as third, the FFM may have incorrectly determined the child as Medicaid ineligible. (Eligible parents were still correctly referred for transfer to state in these cases). States will not receive Medicaid referral for every eligible applicant. (Resolved in December)

State Identification Strategy: Using AT: Parents who file separately and have a child found Medicaid/CHIP ineligible despite income eligibility. Use "Relationship to Tax Filer Code Type" and "Attested Child of Caretaker Code" to identify child applicants – if these codes are null for child but other household members were determined eligible based on income. Apply to transfers with Tax Return Data Element: "Married Filing Jointly Code" = 3 or 6

Recommended State Action: Use name, birthdate and relationships information contained within AT payload to determine child eligible; follow up with family for more information when needed.

Erroneous Assessment/Determination of Eligibility for Medicaid Adult Group (Expansion)

Description: FFM applicants otherwise eligible for Medicaid Adult Group but who do not provide health care for dependent children were incorrectly assessed/determined Medicaid eligible; FFM should have found them ineligible and considered for QHP/APTC. Medicaid Expansion states may receive erroneous MAGI Medicaid referrals for Adult Group applicants who are above income levels who have dependent children for whom they do not provide health care (Resolved in December)

State Identification Strategy: Check for applicants eligible for adult group with income above Parent/Caretaker Relative category with non-applicant dependent child

- Using AT: Use Income Basis, Parent Caretaker Basis, Adult Group Basis, Dependent Child Basis to identify applicant's eligibility basis. Then use Household Member to identify presence of non-applicant child (Relationship to Application Filer Code (e.g. 19-child) + Member of Applicant's Medicaid Household (Y/N). Account may also contain CHIP ID or Medicaid ID for other non-applicant Household Members currently enrolled in Medicaid/CHIP
- Using Flat File: Check "ELIGIBILITY_TYPE_ADULTGROUP" and "ELIGIBILITY_TYPE_PARENTCARETAKER" for what category adult applicant's Medicaid eligibility was assessed/determined under

Recommended State Action: Check if non-applicant child is already covered on a state program; if not, follow up with family to ask if child has coverage.

Fixed Eligibility Defects

Erroneous Categorization of Spouse as Dependent, Impacting Income Calculation

Description: Tax-filers were not prevented from listing spouses as tax dependents, which caused the FFM to enlarge the applicant's household size and undercount income in these cases. States may receive erroneous Medicaid/CHIP referrals for married applicants with both spouses as tax filers who are above income limits. (Resolved in November and December)

State Identification Strategy: Identify spouses claimed as tax dependents. Using AT: Verify household composition using Applicant-Relationship to Tax Filer and Household Member-Relationship to Application Filer Code (01 = spouse). Verify who is listed as a claimed dependent using the Tax Return data element, Dependent Indicator. If Medicaid Household Size indicator is inconsistent with number of household members listed, manually recalculate. Income and information for each individual on the application should be contained in the Applicant and Household Member data elements.

Recommended State Action: Subtract 1 person from household size; add spouse's income to household income; calculate FPL %. If needed, reach out to families with spouse claimed as dependent if spouses' income information is unavailable in transfer payload.

Erroneous Medicaid Eligibility Assessments/Determinations for Applications with FPL Incorrectly Recorded

Description: Attested current income FPL percentage for some applicants was incorrectly recorded as null, resulting in some applicants being incorrectly assessed/determined eligible for Medicaid. States may receive erroneous MAGI Medicaid referrals for individuals who are actually over the income limit. (Resolved in November)

State Identification Strategy: Check for applicants with current income attestations over the Medicaid income limit, who are not being referred on the basis of non-MAGI, full determination requests, gap-filling, or reasonably predictable changes.

- Using AT: Compare the eligibility data elements in the account transfer payload to confirm the Medicaid MAGI Eligibility Basis for the referral (Applicant Income Medicaid Eligibility Status) to the values in Medicaid Household Income data elements (Monthly Income Greater than FPL, Income Amount, Attested Monthly Medicaid Household Current Income).
- Using Flat File: Use the FPL% field "INCOME_PERCENT_QUANTITY" to identify applicants whose income is being reported as 0%, and the Medicaid income field "INCOME_MONTHLY" to cross-check whether the applicant has a non-zero income amount.

Recommended State Action: Request more information from the family, if needed, and potentially deny Medicaid based on the income attestation. States should transfer the account back to the FFM for an APTC determination.

Fixed Eligibility Defects

Flag for Non-MAGI Referrals Applied to Applications Lacking Certain Indicators

Description: FFM flagged some applicants for non-MAGI referrals although their application did not have indicators specifically identifying them as disabled, over age 65, or needing long-term care or SSDI. States may receive non-MAGI Medicaid referrals with a referral reason absent from AT payload; some of these applicants may still be eligible for ABD Medicaid benefits. (Resolved in November)

State Identification Strategy:

- Using AT: Identify non-MAGI referrals (Referral Activity Eligibility Reason = MedicaidNonMAGIEligibility). Check for the presence of a long-term care attestation, blind/disabled attestation, Medicare entitlement, age over 65 or SSDI indicator in the AT payload to validate the reason for a non-MAGI referral; however such indicators may be missing in the account transfer payload even if an applicant indicated one of the above reasons.
- Using Flat File: Use the non-MAGI indicator in the Flat File (ELIGIBILITY_TYPE_NONMAGI = Y) to identify non-MAGI referrals.

Recommended State Action: Continue to send information to all applicants with non-MAGI referrals to request additional information needed for a non-MAGI determination. The state may want the notice to clarify that applicants need not return the additional information if they do not fit into one of the non-MAGI categories.

Non-Applicants Erroneously Permitted to Request Full Medicaid Determinations

Description: FFM did not prevent non-applicants from requesting a full determination of Medicaid eligibility by the state. States may receive erroneous Medicaid/CHIP full determination requests for non-applicants. (Resolved in November)

State Identification Strategy: For applicants requesting a full Medicaid determination, check whether the individual is applying for coverage. Using AT: Use account transfer header values to identify full determination requests (Referral Activity Reason Code=FullDetermination), and the Referral Id to identify whether or not the individual is an applicant (non-applicants will not have Referral Id numbers). Use the full determination indicator (FULLDETERMINATION_INDICATOR = True) to identify full determination requests.

Recommended State Action: States do not need to follow-up on a non-applicant's eligibility if they request a full Medicaid determination.

Fixed Eligibility Defects

Applications Erroneously Sent to Determination States

Description: FFM prematurely flagged applications for "transfer to Medicaid" in determination states. Determination states may receive ATs for applications with open pends for income/residency; applicants with unresolved verification pends for income and/or residency will still be processed by FFM and ultimate verification outcome will be transmitted to the state via update AT. (Resolved in November)

State Identification Strategy: Check for the presence of an income or residency verification pend.

- Using AT: Use the account transfer header values (Referral Activity Overall Verification Status Code) to confirm an application's verification status (P= verification pended).
- Using Flat File: Use flat file verification fields to confirm verification status of an application. "OVERALL_VERIFICATION_STATUS_CODE_MAGIMEDICAID"/"OVERALL_VERIFICATION_STATUS_CODE_CHIP" = P indicates an application has been pended for income or residency verification.

Recommended State Action: Determination states should not enroll such applicants, but should wait for updated accounts from the FFM after the FFM has resolved the income and/or residency pend.

Erroneous Income Calculations for Married Applicants Who File Taxes Separately

Description: FFM may have incorrectly calculated household income and composition for applicants who are married and file taxes separately. States may receive erroneous Medicaid/CHIP referrals for individuals who are actually over the income limit. Such consumers received inaccurate assessments/determinations of their Medicaid/CHIP eligibility. (Resolved in October)

State Identification Strategy: Check for couples who have indicated a tax filing status of “Married Filing Separately” and have a non-applicant spouse.

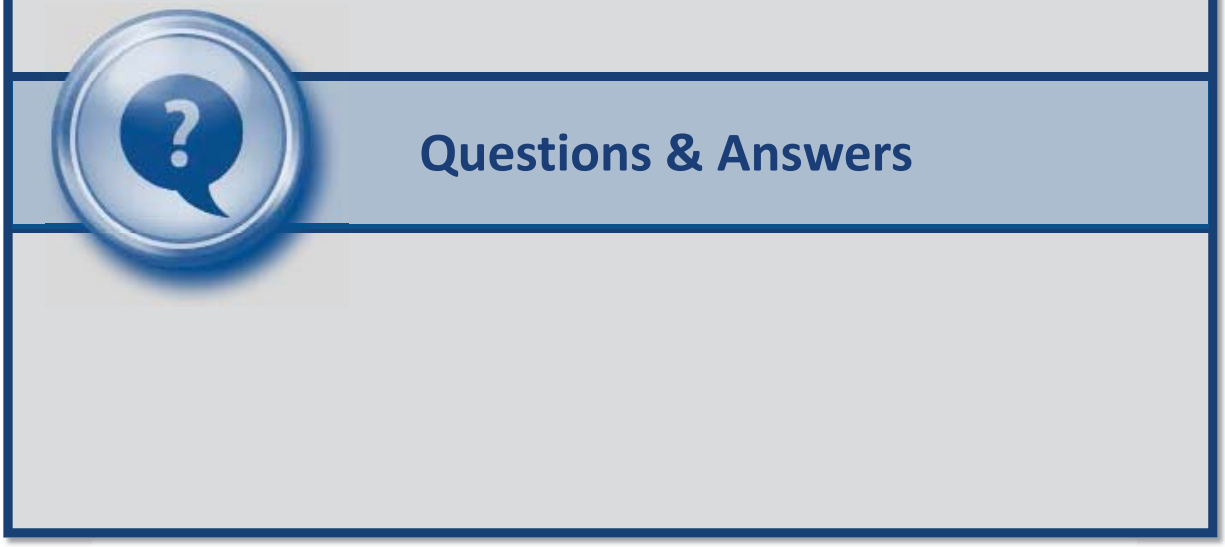
- Using AT: Confirm the household income and household composition values contained within the Medicaid household data elements in the account transfer payload.
- Using Flat File: Use the "HOUSEHOLD_SIZE" data field in the flat file to compare household composition information provided by applicant with the Medicaid household size determined by the FFM.

Recommended State Action: Add 1 person to the Medicaid household size of each spouse, and add the spouse's income to the Medicaid household income before calculating the FPL %.

Next Steps

Next Steps

- Discussion of how states can report additional eligibility errors to CMS
- Brief discussion of account transfer technical issues
- Discussion of notices, record-keeping, and traceability
- Strategy to ensure people are directed to appropriate program
- Next meetings:
  - Tuesday, January 21, 3-4pm ET
  - Thursday, January 30, 4-5pm ET
    - To receive Outlook calendar appointment with webinar access information, please email Chris Cantrell (ccantrell@manatt.com)



Medicaid and CHIP MAC Learning Collaboratives

Federally Facilitated Marketplace Eligibility & Enrollment Learning Collaborative

FFM Account Transfer – Inbound Processing Functionality

March 7, 2014

3:00 – 4:30pm ET

URL: https://manatt.webex.com/manatt/onstage/g.php?t=a&d=575893351
Event Password: Eligibility1
Dial: 1.866.922.3257
Passcode: 514849#

Agenda

- Status Update on Account Transfer
- Overview of Inbound Processing Functionality
- Preventing "Loopers"
- Notice Content and Help for Consumers
- Processing Transfers Received to Date
- Question and Answer Session

Account Transfer Status Update

Inbound Processing Functionality

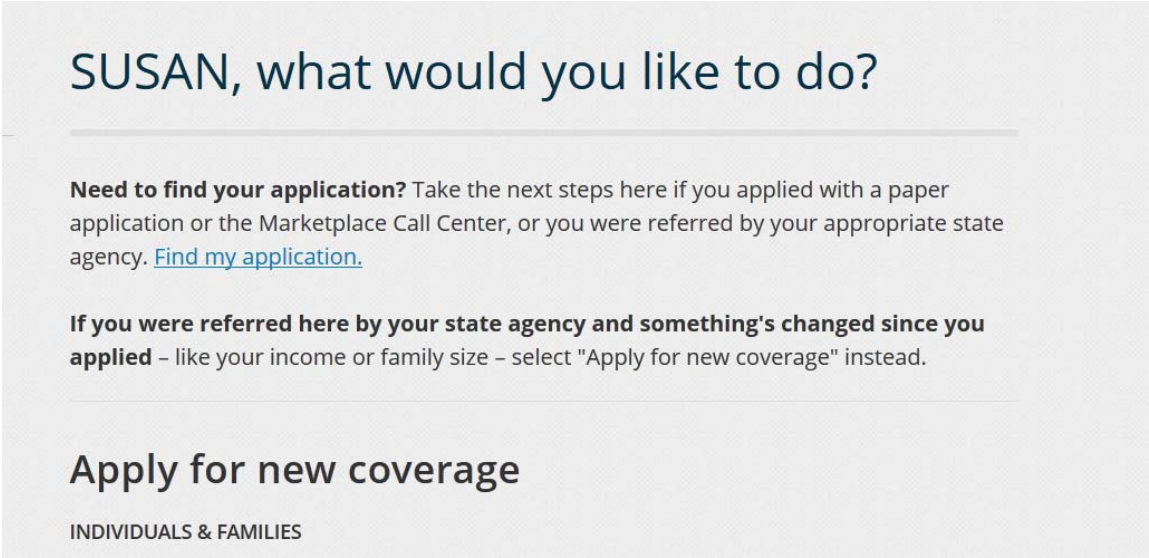
Account Transfer Inbound Processing

- State finds applicant(s) ineligible for MAGI Medicaid or CHIP and transfers an account to the FFM.
- FFM receives the account and uses the state payload to create a FFM application.
- A notice is generated with a unique Application ID – the notice invites the primary contact to log into the FFM, create an account (if they do not already have one), and retrieve their application.
- The primary contact then steps through the application and provides any additional information. Once the application is complete the applicant receives an eligibility determination from the FFM.

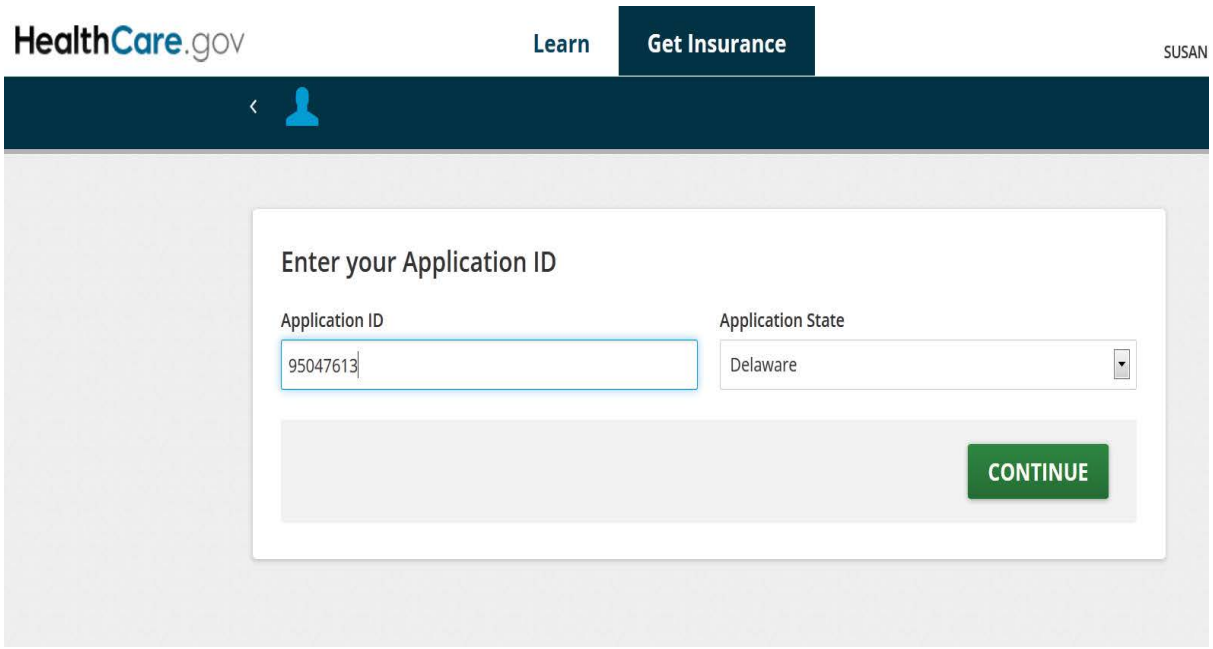
Account Transfer Inbound Processing

- If the user's MyAccount data does not match the information for the primary contact, the user can choose to continue an existing FFM application, report a change on a submitted FFM application, or start a new application.
- If the applicant attempts to pick up an inbound application but is already enrolled in a QHP, the user will not be allowed to retrieve the inbound application, and will need to use the "Report a Life Change" function to update the existing FFM application.
- If the application is successfully retrieved but the user has an FFM application (without enrollment), there are two options:
  - If the user selects the inbound application, the FFM application is marked as inactive.
  - If the user selects the existing FFM application, the inbound application will not be linked to the user's account.

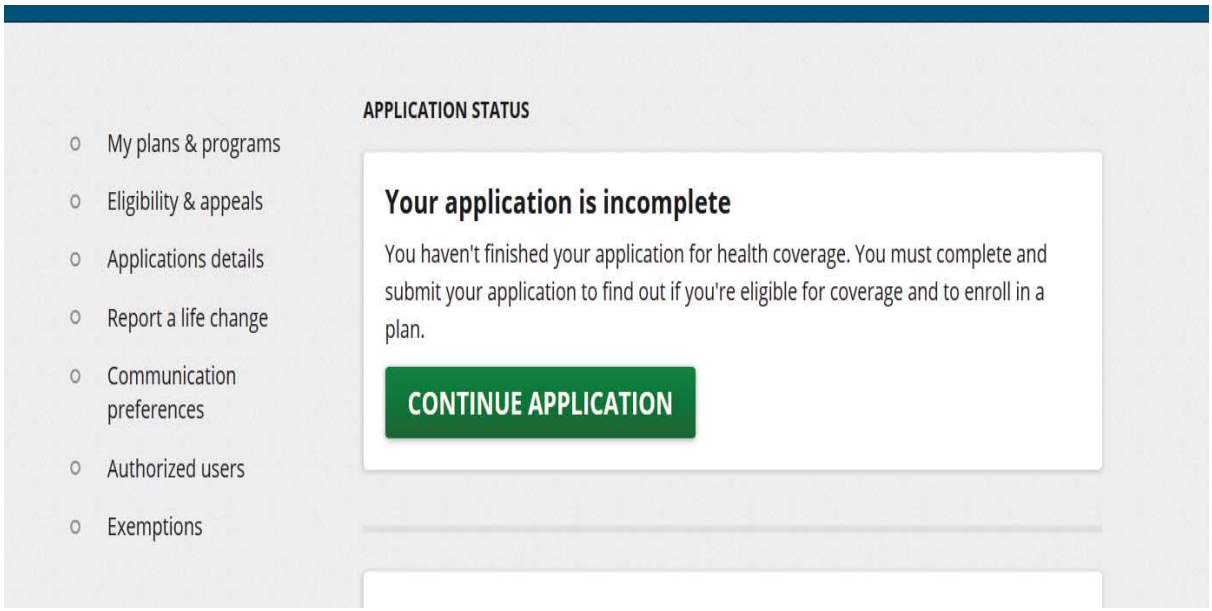
Find My Application



Enter Your Application ID



Continue Application



Preventing “Loopers”

Preventing “Loopers”

- Applications marked as inbound account transfers will set a Medicaid denied indicator for applicants referred to the FFM. This indicator automatically blocks these applicants from going back to Medicaid/CHIP and forces a QHP eligibility decision.
- If the user chooses to continue with an existing FFM application, report a change in circumstance on a submitted FFM application, or start a new application, the question-based Medicaid blocker will be in place to prevent applicants from going back to Medicaid/CHIP.
- Note that when user has experienced a decrease in income or increase in household size the notice encourages them not to indicate a recent Medicaid/CHIP denial so that the FFM can reevaluate Medicaid/CHIP eligibility. The user will also be instructed not to retrieve their inbound state application.

Notice Content and Help for Consumers

Notice Content and Help for Consumers

- The notice for inbound account transfers will instruct the primary contact to retrieve their state application using a unique application ID.
- The notice instructs the primary contact to either log into an existing account, create an account at healthcare.gov, or contact the call center.
- The notice also directs the consumer to: **www.healthcare.gov/help/statetransfer** to read "What if my state application was transferred to the Marketplace?" for additional help completing the application.
- If a consumer already has an eligibility determination from the FFM or is enrolled at the FFM, the notice instructs the consumer not to retrieve the inbound application.
- The notice instructs the consumer to start a new FFM application if they have experienced a decrease in income or increase in family size since applying at the state Medicaid/CHIP agency.

Outbound Response Status

Questions & Answers

Partner Information from Feds

January 3, 2014

Just wanted to share the following update:

On December 20, 2013, the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) posted the applications consumers will use to apply for exemptions from the shared responsibility payment (also known as the "individual mandate penalty") that will be used by the Marketplaces, as described in previous final rulemaking published in the Federal Register on July 1, 2013, also known as the "Exemptions Final Rule." The applications cover seven different categories of exemptions, and include:

- Hardship.
- Affordability, State-based Marketplace (SBM).
- Affordability, Federally-facilitated Marketplace (FFM).
- Tribal.
- Health Care Sharing Ministry.
- Religious Sects.
- Incarceration.

February 13, 2014

Good afternoon,

Below are three updates that the Department recently received from the Centers for Medicare and Medicaid Services (CMS).

Update #1

A new question has been added to the Marketplace application that allows applicants to attest that their local agency has found them to be ineligible for BadgerCare Plus since October 1, 2013. When an individual answers yes to this question, it will prevent the Marketplace from assessing them as Medicaid eligible. This question allows those individuals who have already been determined by Wisconsin to not be eligible for BadgerCare Plus to bypass being assessed for Medicaid by the Marketplace. By answering yes to the question, they will only be assessed for an Advanced Premium Tax Credit (APTC), Cost Sharing Reduction (CSR) and Qualified Health Plan (QHP) coverage, and can then continue progressing through the private health insurance enrollment process so they can select and purchase their private health insurance plan. More information about this question and how consumers should answer it is available at https://www.healthcare.gov/help/found-not-eligible-for-medicaid/.

The following members/applicants should use this option when they apply or reapply at HealthCare.Gov:

- Parents, Caretaker Relatives, Children and Childless Adults who are transitioning from BC+ to private health insurance because of new income limits. These members will receive a notice of decision that will be mailed the week of Feb. 17, 2014.
- Parents, Caretaker Relatives, Children and Childless Adults who applied for coverage through HealthCare.Gov, were determined/assessed eligible for BadgerCare Plus, but later received a notice of

decision that they were not eligible for BadgerCare Plus. This population in particular should be sure to answer "yes" to the new question in order to avoid being transferred back to BadgerCare Plus.

Please note that childless adults should only use this process if they have gotten a notice of decision that they do not meet program rules as of April 1, 2014.

Update #2

In response to questions from partners nationally, the Centers for Medicare and Medicaid Services (CMS) has informed states that HealthCare.gov was recently updated to include new functionality that allows individuals and families that completed and submitted an application to the Marketplace to make changes to the application that they submitted. For example, applicants can report increases or decreases in income; add or remove household members; or report a change in address, a new pregnancy, or a gain or loss in health coverage. CMS will be providing additional information regarding these new functionalities and how individuals can navigate them in the near future.

Until we get more information from regarding specifically how individuals can report a change online at HealthCare.gov, we recommend that anyone wanting to report a change call the Marketplace at 1-800-318-2596.

Guidance for members/applicants re: reporting changes:

- If they applied through HealthCare.gov and have an application pending or were determined eligible for an Advanced Premium Tax Credit, they should report changes through HealthCare.gov.
- If they applied through HealthCare.gov and were determined eligible for BC+ or transferred to WI for processing, they should report changes to local agency.
- If they applied through Wisconsin, they should report changes to local agency.

Please note: If someone who applied at the Marketplace feels that they should have been found eligible for BadgerCare Plus, they should contact their agency or apply for BadgerCare Plus directly through ACCESS.wisconsin.gov, in person at their local agency, on paper, or over the phone. If members believe that they have received an incorrect determination by the Marketplace, they may be able to remove their application from their Marketplace account and submit a new application. They also have the ability to appeal the Marketplace determination. Additional information about this process is available at https://www.healthcare.gov/can-i-appeal-a-marketplace-decision.

Update #3

The Social Security Administration will be conducting regularly scheduled maintenance activities from Saturday February 15, 2014 at 3:00PM until Tuesday, February 18, 2014 at 5:00AM EST. During this period, verification of Social Security Numbers and other related data via the Data Services Hub will be unavailable. All other services of the Hub will be functioning as normal.

HealthCare.gov has provided direction for applicants and explained how these regularly scheduled maintenance activities could affect them at https://www.healthcare.gov/blog/want-coverage-starting-march-1-plan-ahead-for-best-results/.

February 26, 2014

Good afternoon,

Below are four updates issued last week by the Centers for Medicare and Medicaid Services (CMS).

Update #1 - CMS Issues New Guidance on Application Changes, Special Enrollment Periods in FFM

On February 6, 2014, CMS finalized a series of policies regarding enrollment and termination for consumers and issuers participating in the Federally-facilitated Marketplace (FFM) and State Partnership Marketplaces (SPMs). This set of guidance describes new functionality in the FFM that will allow consumers to make certain changes to their application and/or plan selections based on changes in life circumstances or as the result of being granted a special enrollment period (SEP) by the FFM. This guidance includes a series of bulletins and frequently asked questions (FAQs):

- Bulletin #2: Functionality for Consumer-Initiated Application and Enrollment Changes.
- Bulletin #3: Special Enrollment Periods: Effective Dates and Processes.
- Bulletin #4: Enrollee-Initiated Terminations.
- Bulletin #5: Flexibility During the Initial Open Enrollment Period to Change Plans Offered by the Same Issuer at the Same Metal Level.
- Bulletin #6: Clarifications of the Instructions Presented in the December 12, 2013, Interim Final Rule and Bulletin #001.

The guidance is posted on REGTAP and is intended to work in conjunction with previously issued guidance related to enrollment in the FFM, including the December 12, 2013, Interim Final Rule, the FFM Enrollment Operational Policy and Guidance issued in draft on October 3, 2013, and all previously released bulletins, except where otherwise indicated.

Update #2 - CMS Clarifies Third-Party Payments of Premiums for QHPs

On February 7, 2014, CMS issued two new FAQ documents addressing how a November 4, 2014, FAQ, released by CMS, applies to payors making premium payments on behalf of QHP enrollees by certain types of third-party payors such as Indian tribes, tribal organizations, urban Indian organizations, state and Federal government programs or grantees, and private not-for-profit foundations. The November 4, 2013, FAQ pertains to third-party payments of premiums for QHPs in the Marketplace.

Update #3 – CMS Issues Updated FFM Model Eligibility Notices

On February 12 CMS posted updated versions of the FFM model eligibility notices, which include:

- APTC-CSR and Medicaid Assessment Sample
- APTC-CSR Sample
- Medicaid Assessment Model
- APTC-CSR and Medicaid Assessment Sample

Update #4 – Update on Preventing “Looping” and Eligibility for a Special Enrollment Period (SEP)

On February 21, 2104 CMS released additional documentation that includes screen shots showing how consumers should answer specific questions related to Medicaid/CHIP (aka BadgerCare Plus) eligibility and

triggering a SEP. Please see the attached document for this information. Below is the original update DHS provided to partners on February 11, 2014.

A new question has been added to the Marketplace application that allows applicants to attest that their local agency has found them to be ineligible for BadgerCare Plus since October 1, 2013. When an individual answers yes to this question, it will prevent the Marketplace from assessing them as Medicaid eligible. This question allows those individuals who have already been determined by Wisconsin to not be eligible for BadgerCare Plus to bypass being assessed for Medicaid by the Marketplace. By answering yes to the question, they will only be assessed for an Advanced Premium Tax Credit (APTC), Cost Sharing Reduction (CSR) and Qualified Health Plan (QHP) coverage, and can then continue progressing through the private health insurance enrollment process so they can select and purchase their private health insurance plan. More information about this question and how consumers should answer it is available at https://www.healthcare.gov/help/found-not-eligible-for-medicaid/.

The following members/applicants should use this option when they apply or reapply at HealthCare.Gov:

- Parents, Caretaker Relatives, Children and Childless Adults who are transitioning from BC+ to private health insurance because of new income limits. These members will receive a notice of decision that will be mailed the week of Feb. 17, 2014.
- Parents, Caretaker Relatives, Children and Childless Adults who applied for coverage through HealthCare.Gov, were determined/assessed eligible for BadgerCare Plus, but later received a notice of decision that they were not eligible for BadgerCare Plus. This population in particular should be sure to answer "yes" to the new question in order to avoid being transferred back to BadgerCare Plus.

Please note that childless adults should only use this process if they have gotten a notice of decision that they do not meet program rules as of April 1, 2014.

(Attachments begin on page 7)

March 19, 2014

Good Afternoon,

Below are six updates issued by the Centers for Medicare and Medicaid Services (CMS) since early March 2014. Hyperlinks to the new guidance and FAQ documents are included in the updates.

Update #1 - CMS Issues New Guidance on Retroactive QHP Coverage Options for Marketplaces Due to Exceptional Circumstances During Open Enrollment

On February 27, 2014, the Centers for Medicare & Medicaid Services (CMS) issued new guidance for Marketplaces that have experienced technical difficulties that have hindered their efforts to provide timely eligibility determinations to consumers during open enrollment. This guidance discusses the flexibilities that are available to Marketplaces to establish retroactive coverage effective dates in qualified health plans (QHPs) through the Marketplace for consumers in these exceptional circumstances once the Marketplace has made an eligibility determination for those consumers. The guidance also addresses the availability of premium tax credits (PTCs) and cost-sharing reductions (CSRs) on a retroactive basis to consumers in these exception

circumstances once they have been determined by the Marketplace to be eligible for these subsidies. Accordingly, the guidance also describes the steps that CMS and Marketplaces need to take to ensure that payments of the PTCs and CSRs are appropriately applied based on the retroactive enrollment effective date established by the Marketplace in these exceptional circumstances. This guidance is posted on the **CCIIO Regulations and Guidance page**.

Update #2 - CMS Issues New FAQ Documents on Remote Identity Proofing and Resolution of Application Inconsistencies in the FFM

On February 24, 2014, CMS issued a new **FAQ document** addressing two aspects of verification of applicant information in the Federally-facilitated Marketplace (FFM). The first set of FAQs in the document describe the FFM's remote identity proofing process and describes the steps a consumer can take if he or she is not able to pass the FFM's remote identity proofing process when attempting to create an account on the FFM. The second set of FAQs describes the situation where inconsistencies occur when the information provided by a consumer on his or her application cannot be verified by the FFM, and how the consumer can provide and submit additional documentation to resolve any inconsistencies in his or her application for health coverage through the FFM.

Update #3 – Healthcare.gov's Find Local Help Feature Updated

In partnership with national and local agent-broker associations, CMS has updated **Healthcare.gov's Find Local Help** search feature to include local agent and broker associations from across the country. Now, individuals and small employers can use this feature to better locate agents and brokers in their areas. To find agent and broker associations near you, please visit **Healthcare.gov** and input your city and state or ZIP code.

In addition, national agent-broker associations can also help make connections to local assistance. Agents and brokers on the sites listed below are not endorsed by the Marketplace. To verify an agent or broker is registered with the Marketplace, licensed, and in good standing, please contact your state Department of Insurance (DOI).

- **National Association of Health Underwriters**
- **Independent Insurance Agents and Brokers of America**
- **National Association of Insurance and Financial Advisors**
- **Professional Insurance Agents**

Update #4 – IRS Releases Health Care Tax Tips

On February 25, 2014, the Internal Revenue Service (IRS) launched new **Health Care Tax Tips**, advice for consumers on how health insurance coverage can affect their taxes. The tips cover the following topics:

- **IRS Reminds Individuals of Health Care Choices for 2014** – Find out what you need to know about how health care choices you make for 2014 may affect your taxes.
- **The Health Insurance Marketplace: Learn About Your Health Insurance Coverage Options** – Find out about getting health care coverage through the Health Insurance Marketplace.
- **The Premium Tax Credit** – Learn the basics of the premium tax credit, including who might be eligible and how to get the credit.

- **The Individual Shared Responsibility Payment: An Overview** – Provides information about the types of qualifying coverage, exemptions from having coverage, and making a payment if you do not have qualifying coverage or an exemption.
- **Three Timely Tips about Taxes and the Health Care Law** – Provides tips that help with filing the 2013 tax return, including information about employment status, tax favored health plans, and itemized deductions.
- **Four Tax Facts about the Health Care Law for Individuals** – Offers basic tips to help people determine if the Affordable Care Act (ACA) affects them and their families, and where to find more information.
- **Changes in Circumstances Can Affect Your Premium Tax Credit** – Learn the importance of reporting any changes in circumstances that involve family size or income when advance payments of the premium tax credit are involved.

Update #5 - Interim Final Rule: Third Party Payment of Qualified Health Plan Premiums

This Interim Final Rule, with comment, that requires issuers to immediately begin accepting third party payments for enrollee premiums and cost sharing from Indian tribes, tribal organizations, urban Indian organizations, the Ryan White HIV/AIDS programs, and state and federal government programs for enrollees in the individual Marketplaces. This rule builds on previous guidance CMS issued that encouraged issuers and Marketplaces to accept these types of payments. The rule was effective March 14, 2014. This ensures that consumers who rely on the specific third party payors identified in the rule to pay their premiums or cost-sharing payments can continue to access the care they need without delay. The interim final rule has been attached to this email.

Update #6 - Market standards NPRM:

This proposed rule would update policy based on experience with initial open enrollment. Updates may include clarifying federally-managed services available for states in the second year of operations, expanding the use of data for efficient operations of the Exchange instead of minimum Exchange functions, developing privacy standards in the Exchange for the FFE and non-Exchange entities, implementing penalties related to false, fraudulent, or improper use of information, clarifying eligibility and appeals coordination responsibilities with state Medicaid agencies, and addressing treatment of retroactive eligibility from an appeal. This proposed rule would also establish requirements for Exchanges and QHPs to implement specific quality-related provisions of the Affordable Care Act. The NPRM has not yet been issued to the Federal Register.

Enrollment, Termination, and SEPs

Center for Consumer Information and Insurance Oversight
February 6, 2014

Overview

- CMS has finalized a series of processes and policies regarding enrollment and termination for issuers participating in Marketplaces using the CMS system, including Federally-facilitated Marketplaces (FFM) and State Partnership Marketplaces.
- The set of guidance covers a variety of topics related to consumers or issuers being able to make changes to information or plan selections based on changes in life circumstances or as the result of being granted a special enrollment period.
- New functionality in the FFM will allow consumers to make certain changes to their application. Interim processes are outlined for situations where functionality is not yet available, such as special enrollment periods (SEPs).

Overview

- **Bulletin #2:** Functionality for Consumer-Initiated Application and Enrollment Changes
- **Bulletin #3:** Special Enrollment Periods: Effective Dates and Processes
- **Bulletin #4:** Enrollee-Initiated Terminations
- **Bulletin #5:** Flexibility During the Initial Open Enrollment Period to Change Plans Offered by the Same Issuer at the Same Metal Level
- **Bulletin #6:** Clarifications of the Instructions Presented in the December 12, 2013, Interim Final Rule and Bulletin #001

Bulletin #2: Consumer-Initiated Application and Enrollment Changes

- New functionality on healthcare.gov allows consumers to report changes directly through the Federally-facilitated Marketplace (FFM).
- In some cases, consumers may receive an SEP eligibility determination as a result of these changes.
- This replaces previously issued guidance in which CMS allowed enrollees to add a dependent as a result of a birth, adoption, or placement for adoption or foster care through their qualified health plan (QHP).
- Current functionality does not allow for the granting of all SEPs.
  - For example, the granting of SEPs that arise due to changes in income that result in a person becoming newly eligible or ineligible for Advance Payments of the Premium Tax Credit or for cost-sharing reductions. Issuers will be notified when this functionality is available.

Bulletin #2: Consumer-Initiated Application and Enrollment Changes

1. The consumer logs in to their account and presses the "Report a Life Change" button (this button is only enabled for consumers who have already submitted an application).
2. The consumer will land on a page with information about the types of changes that must be reported to the Marketplace or both the Marketplace and the issuer.
   a. Changes which do not impact eligibility, such as an address change within the same zip code and county, must be reported to both the issuer and the Marketplace, as an 834 will not be generated.
3. If the consumer has changes to report that may affect eligibility, a new copy of their application is created, pre-populating some information and attestations from their earlier application.
4. The consumer completes the new application and answers questions which determine whether the applicants for whom new information is being provided are eligible for QHP enrollment through the FFM, and if so, whether the new information triggers a Special Enrollment Period (SEP).
5. If the consumer is eligible for an SEP, the consumer's eligibility determination notice will contain SEP eligibility language.

Bulletin #2: Consumer-Initiated Application and Enrollment Changes

5. If any applicants for whom new information is being provided are eligible to enroll in a QHP through a Marketplace (i.e., they are qualified individuals), the qualified individual will proceed to the enrollment to-do list page.
   a. If the applicant for whom new information is being provided is a qualified individual and his/her addition to coverage is based on an event that triggers an SEP, the qualified individual will have the ability to compare and select from all QHPs available to the applicants in the service area.
   b. If the new information being provided does not trigger an SEP, the qualified individual will be limited to updating his or her enrollment information in the QHP in which he or she is currently enrolled.
6. The qualified individual will select a new plan (or the existing plan, depending on the situation) and set the amount of APTC the tax household will use.
7. Once the qualified individual selects a plan, the system will generate an 834 termination transaction to the issuer with whom the individual was initially enrolled, and an 834 enrollment transactions will be sent to the gaining issuer (in cases where the qualified individual updates his or her existing enrollment, the enrollment transaction will go to the same issuer and should be treated as a modification, rather than a new enrollment).

Bulletin #2: Consumer-Initiated Application and Enrollment Changes

Type of SEP	Termination Date of Existing Enrollment, if Currently Enrolled	Plan Selection Date	Effective Date
Not eligible for an SEP or eligible for the following SEPs: 1. Move to a new exchange service area 2. Release from incarceration 3. Becoming lawfully present 4. Gain status as an Indian	Day before effective date	Between the 1st and 15th day of the month (Between 1/1/14 and 3/15/14)	First day of the following month
		Between the 16th and last day of the month (Between 1/16/13 and 03/31/14)	First day of the second following month
Loss of MEC and gaining a dependent through Marriage SEP	Day before effective date	Any day of the month	First day of the following month
Future loss of MEC (loss up to 60 days in the future)	Day before effective date	Any day of the month	First day of the month following the date of the loss of MEC
Birth, adoption, or placement for adoption or foster care SEP	Day before effective date	Any day of the month	Day the child was born, adopted, or placed for adoption or foster care

Bulletin #2: Consumer-Initiated Application and Enrollment Changes

- Select Q&A:
  - *Q3: What enrollment transaction will the issuer receive?*
  - A3: The issuer will receive an 834 termination transaction from the Marketplace followed by an 834 initial enrollment transaction. This is true for qualified individuals who are re-enrolling in the same plan either due to making a change that did not allow for an SEP and for qualified individuals who are eligible for an SEP but choosing the same plan. The issuer will be responsible for ensuring maximum out-of-pocket expenses and deductibles do not reset for the enrollment group.
  - *Q4: Can a consumer report a change in circumstance through the agent/broker or direct enrollment process?*
  - A4: At this time consumers should report changes directly to healthcare.gov.

Bulletin #3: Special Enrollment Periods

- Several categories of special enrollment periods (SEPs) exist that allow a consumer to enroll in a Qualified Health Plan (QHP) with accelerated effective dates or to change their QHP selection.
- These SEP types are handled through a special process outlined below and are not initiated through the Qualified Individual Initiated Application and Enrollment Changes Functionality recently added to the Federally-facilitated Marketplace. They include:
  - SEPs that have accelerated coverage effective dates with no prior QHP enrollment:
    - Enrollment error SEP
    - Exceptional circumstance SEP
    - Misrepresentation SEP
  - SEPs that permit a consumer to change from a prior QHP enrollment:
    - Marketplace benefit display errors
    - Issuer benefit display errors
    - Misrepresentation SEP

Bulletin #3: Special Enrollment Periods

- Consumers seeking an SEP when they have not yet completed an initial enrollment need to call the Marketplace call center.
- Call center representatives will help the consumer select a plan and forward cases that need additional review to CMS caseworkers.
- The consumer's situation will be evaluated by a caseworker, if appropriate, to determine whether to grant an SEP.
- If the SEP is granted, a record will be assigned to issuers through the Health Insurance Casework System (HICS) directing them to move the coverage effective date, if applicable.

Bulletin #3: Special Enrollment Periods

- Effective dates will generally be for the first of the next available month.
- Enrollments in the first half of a month will not require a change in effective date; enrollments that occur after the fifteenth are eligible for earlier coverage effective dates.

Plan Selection Date	Normal Effective Date	Accelerated SEP Effective Dates for 2014
January 1 – January 15	February 1	January 1
January 16 – January 31	March 1	February 1
February 1 – February 15	March 1	March 1
February 16 – February 28	April 1	March 1
March 1 – March 15	April 1	April 1
March 16 – March 31	May 1	April 1

Bulletin #3: Special Enrollment Periods

- CMS will implement an interim process for allowing someone **already enrolled** in a QHP to select a new QHP by calling the Marketplace call center.
- The call center will help the consumer create a new application, including a new eligibility determination, and select a QHP.
- The issuer of the QHP in which the consumer was previously enrolled will be directed to terminate the coverage on the day before the new coverage effective date.

Bulletin #3: Special Enrollment Periods

- Benefit display errors will be identified after CMS investigates potential display discrepancies raised by issuers or consumers, or noticed by CMS.
  - Marketplace benefit display errors include situations where coding on healthcare.gov displayed benefits incorrectly.
  - Issuer benefit display errors include situations where an issuer notices that they submitted incorrect data for a plan.
- When a benefit display error is identified, CMS will work with the issuer to ensure that the error is corrected as quickly as possible to ensure that enrollments moving forward are based on accurate information.
- In order to resolve the impact of the error on current enrollees when the change either reduces a benefit or increases costs to the consumer, CMS will work with the issuer and state department of insurance to arrive at a solution that has a minimal impact on impacted consumers and ensures, to the extent possible, that they are not negatively affected by a Marketplace or issuer error.

Bulletin #3: Special Enrollment Periods

- The option that is the most beneficial to the consumer and the most straightforward to implement for issuers, consumers, and CMS is for issuers to honor the benefit that was displayed incorrectly for current enrollees.
  - If the issuer honors the benefit as displayed for current enrollees, no further action would be needed.

- Depending on the significance of the benefit display error, there could be several options for mitigating impacts.
  - If a benefit display error would not have a substantial impact on the consumer, an issuer may be able to send out an “errata” notice that informs the consumer of the benefit difference. We anticipate releasing future guidance on this issue.

Bulletin #3: Special Enrollment Periods

- If the benefit display error is significant and it is reasonable to expect that it may have impacted a consumer's purchasing decision, then issuers will need to inform the enrollees of the error and present them with other options.
- CMS will work with the impacted issuers to provide consumers with options to enroll in other QHPs offered by the issuer within the same level of coverage.
- In these cases, issuers should follow the guidance in bulletin #5 on allowing consumers to switch QHPs within metal tiers.
- Remaining with the issuer will provide a benefit to consumers in that it requires minimal actions on their part and would allow any out-of-pocket costs already incurred to be transferred to their new QHP to count towards the new plan's deductible and the maximum out-of-pocket costs.

Bulletin #3: Special Enrollment Periods

- If a consumer is not able to find another QHP offered by the same issuer that meets their needs, then the consumer would be directed to the Marketplace call center to review and select QHPs available to them.
- Consumers would generally have 60 days to select a new plan.
- Depending on the type of benefit display error, the consumer may have the option to choose a retroactive coverage effective date back to the original enrollment or prospective to the first day of the next month.
  - CMS will determine whether a given benefit display error warrants the option for a retroactive coverage date; retroactive coverage would be appropriate if the consumer selects a new plan within ten business days of receiving notification of the data error.
- The coverage effective date for the new QHP will be communicated to the new issuer through HICS if it is different from what the system automatically assigns.
- The consumer will need to call the former issuer and request a termination to be effective on the day before the new coverage starts.

Bulletin #4: Enrollee-Initiated Terminations

- Enrollees have the right to terminate their coverage in a QHP.
- CMS has developed new functionality on healthcare.gov that allows enrollees to terminate enrollments through the FFM and allows enrollees to select an effective date of termination that can be 14 days from the present date or greater.
- Upon terminating, individuals will not be able to enroll in a new QHP unless they qualify for an SEP.
- Note: consumers who are notified that their enrollment has been canceled by the issuer for non-payment of premiums will need to create a new account, complete an application and make a new plan selection.
  - The effective date of coverage will be based on the date of the new plan selection under the regular effective date schedule.

Bulletin #4: Enrollee-Initiated Terminations

- Process for enrollee-initiated terminations:
  - The enrollee logs into their “MyAccount” on the FFM and navigates to the “My plans & programs” tab.
  - The qualified individual then selects the red button labeled “End (Terminate) All Coverage”.
  - This will terminate the entire enrollment group.
  - This process will apply when the enrollee is single (enrollment group of 1) or requests termination of the entire enrollment group.
  - If the enrollee would like to terminate less than a full enrollment group, the enrollment group must use the “report a life change” functionality.

- The issuer will receive an 834 termination transaction with the effective date of termination indicated.

Bulletin #4: Enrollee-Initiated Terminations

- **Example 1**: An individual enrolls himself and his family with a QHP for January 1, 2014. On February 25th, the individual and his family submit a request to terminate their enrollment and select a termination effective date of March 12, 2014. An 834 termination transaction is sent to the QHP to terminate all the individuals in the enrollment group from their coverage, containing a termination effective date of March 12, 2014.

- **Example 2**: An individual enrolls with a QHP issuer for January 1, 2014. On February 4, the individual terminates her enrollment through the FFM and selects a termination effective date of February 28, 2014. An 834 termination transaction is sent to the QHP to terminate the individual from their coverage, containing a termination effective date of February 28, 2014.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- Previously, CMS has indicated that, once the effective date of an individual's enrollment with an issuer had passed and the first month's premium was paid, that enrollee would not be able to switch Qualified Health Plans (QHPs) without a new enrollment period.
- CMS will now allow enrollees to change plans during the Initial Open Enrollment Period after the effective date of their enrollment under certain, discrete circumstances.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- This process can be used for individuals who have paid their first month's premium and whose coverage is already effective may change plans provided the change meets ALL of the following criteria:
  1. Change is to another plan offered by the same issuer,
  2. Change is to another plan offered at the same metal level and Cost Sharing Reduction (CSR) level, if applicable (i.e. bronze to bronze, silver to silver, 87% actuarial value (AV) silver plan variation to 87% AV silver plan variation, etc.),
  3. Change is made in order to move to a plan with a more inclusive provider network or for other isolated circumstances determined by CMS, and
  4. Change is being requested within the Initial Open Enrollment Period.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- The individual who makes a change that meets the criteria above must do so by going to the issuer and the issuer will initiate the plan change. QHP issuers can determine the effective date for the plan change.
- Issuers may allow retroactive changes. Issuers may also allow for accelerated effective dates. If the issuer does not apply a retroactive or accelerated effective date, then issuers must apply marketplace effective date rules.
- Issuers must not be discriminatory in implementing plan changes, meaning that they should be consistent in applying effective date rules and treat enrollees in similar circumstances in a consistent manner.
- The issuer will either cancel or terminate the existing coverage in their system, and activate the new coverage.
- When determining effective dates, issuers must ensure no break in coverage.
- The Marketplace will reconcile these plan changes during the formal monthly Reconciliation process.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- Issuers would process the change in plan within their own systems and should not send a termination transaction to FFM.
- Issuers should document all changes in plans and must be prepared to send the new plan enrollee data to CMS in the same format as the pre-audit file.
- All out-of-pocket costs incurred by the enrollee in the initial plan should be credited towards the deductible and annual maximum out-of-pocket cost limit in the new plan.
- Because eligibility is not being re-determined for enrollees, APTC amounts will not change. Advanced CSR amounts will change as CSR amounts are QHP-specific. CMS is currently collecting information from issuers to make APTC and advanced CSR payments.
- Issuers should include enrollees that change plans under this policy modification in the new plan in their request to CMS for payments.
- When payment system functionality is available, CMS will make payments based on updated information provided through the monthly reconciliation process.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- **Example 1**: An individual enrolls in an issuer's silver plan on November 28th for a January 1st effective date. On February 8th, the enrollee discovers that a specialist that he/she sees is not part of the network for that plan. Additionally, the enrollee discovers that the issuer offers another silver product with a more expansive network that includes the specialist he/she wants to see. The enrollee calls the issuer and asks to change plans. If completed before February 15th and the issuer chooses to apply Marketplace rules to all such changes, the change would be effective for March 1st. If completed after February 15th but on or before March 15th, the change would be effective April 1st.

- **Example 2**: Same as *Example 1*, except after contacting the issuer on February 8th, the enrollee completes changing plans with the issuer on February 11th. The change would be normally effective for March 1st under Marketplace rules for determining effective dates. However, the issuer allows enrollees making this type of change to choose a retroactive effective date. The enrollee chooses to change for January 1st. In addition to retroactively cancelling the first enrollment back to January 1st, the issuer makes coverage in the newly selected plan effective for January 1st. The issuer must transfer all claims made on the cancelled enrollment to the new enrollment and must apply the new cost sharing as appropriate. Additionally, the issuer will then recalculate any progress towards any out-of-pocket maximum that applies to the new enrollment.

Bulletin #5: Flexibility to Change Plans at the Same Metal Level

- **Example 3**: Same as *Example 1*, except the product with the provider network that includes the specialist in question is a gold metal level product. The individual could not make the change using this functionality because the metal level is different from that of the product in which he initially enrolled. He will have to wait for either the Annual Open Enrollment Period (OEP) or a valid Special Enrollment Period (SEP).

- **Example 4**: Same as *Example 1*, except the individual does not attempt to make the change until May 4th. Without a valid SEP, the individual could not make the change because the Initial Open Enrollment Period is over.

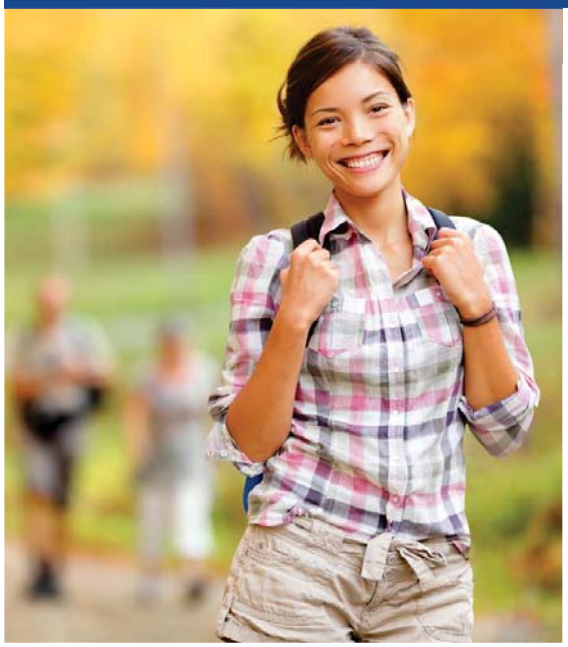
Bulletin #6: Clarifications of the Interim Final Rule and Bulletin #1

- Since the release of the IFR and Bulletin #001, issuers have requested additional clarification regarding the parameters for establishing the due date for the first month's premium when coverage is granted for a retroactive effective date.
- The IFR established that QHP issuers in the FFM must establish due dates for payment of the initial month's premium **no earlier than** the day before coverage becomes effective during the Initial Open Enrollment Period.
- In instances where issuers are processing retroactive enrollment, CMS expects issuers to provide a due date for the first month's premium that is reasonably achievable by the enrollee.
- CMS believes that a date that is at least seven (7) calendar days after the date that the issuer receives both the 834 enrollment transaction and the concurrent HICS record establishing the retroactive effective date granted on the basis of an approved Marketplace SEP would be reasonably achievable.

Bulletin #6: Clarifications of the Interim Final Rule and Bulletin #1

- **Example 1:** A consumer contacts the Marketplace's call center on January 13, 2014. He indicates that he attempted to enroll in November, 2013, for a January 1, 2014 effective date, but that the issuer with whom he attempted to enroll has no record of the enrollment. On the basis of an approved Marketplace Error SEP, the CMS call center representative enrolls the individual in the desired QHP. Then the Marketplace sends an 834 enrollment transaction to the issuer with a 2/1/2014 effective date (based on the January 13, 2014 selection). The call center representative then creates an entry in HICS establishing that the enrollment should have a 1/1/2014 effective date, and links the HICS entry to the issuer's queue. The issuer downloads the HICS data and receives the 834 enrollment transaction on 1/14/2014 and enrolls the individual for 1/1/2014 per the HICS entry. Then the issuer sends a bill to the enrollee for the first month's premium and indicates a due date of 1/21/2014. The consumer now has until 1/21/2014 to pay the first month's premium in order to keep the coverage that was started retroactively for 1/1/2014.
- **Example 2:** Same as *Example 1*, except the premium due date on the bill is 1/17/2014. In this case, the issuer has created a premium due date for the first month's premium that is less than seven (7) days after 1/14/2014 which is the date that the issuer received the 834 enrollment transaction. CMS does not believe that this would be a reasonably achievable date that would satisfy the requirements of the premium payment date regulation.
- **Example 3:** Same as *Example 1*, but the issuer assigns a premium due date of 1/31/2014. In this case, the issuer has created a premium due date for the first month's premium that CMS believes would be reasonably achievable, as 1/31/2014 is greater than seven (7) days after 1/14/2014 which is the date that the issuer received the 834 enrollment transaction.

Overview of the New Change in Circumstances Functionality

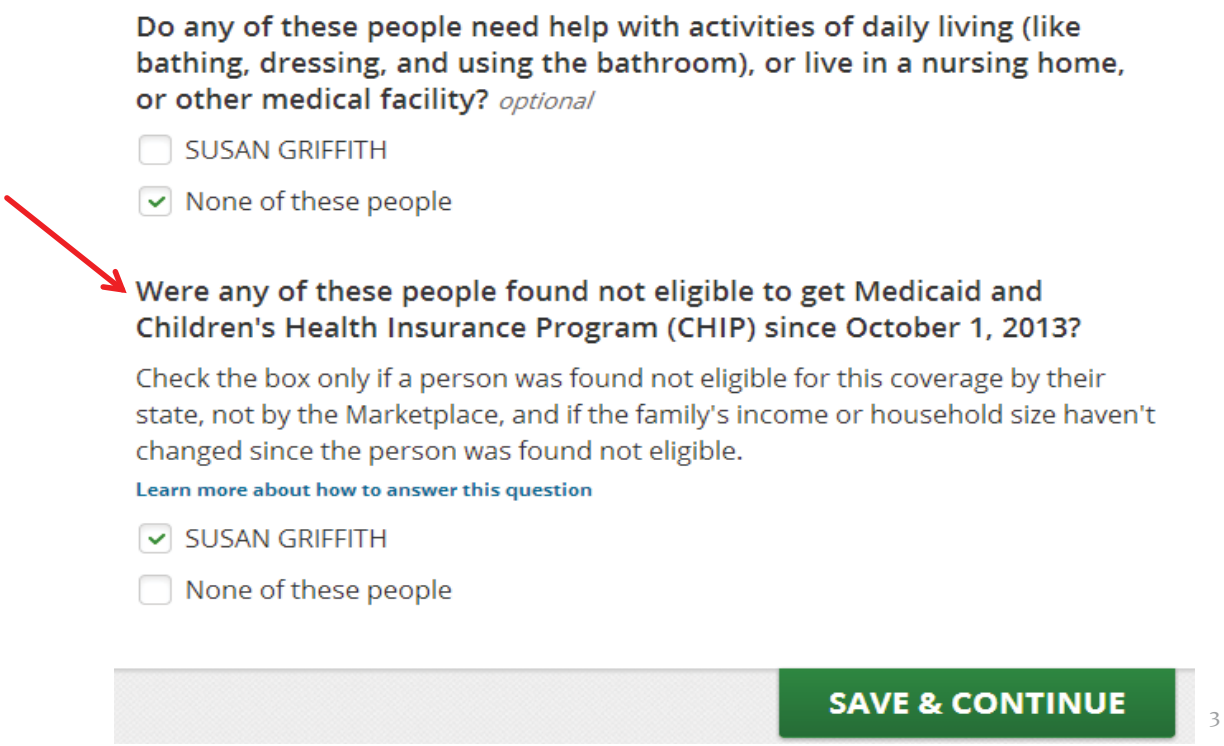


February 21, 2014

Agenda

- Medicaid/CHIP Block question to prevent looping on all applications
- Functionality to Report Changes
- Special Enrollment Periods
- Reported Changes and Account Transfers
- Next Steps
- Q&A

New question can block Medicaid/CHIP to prevent "loopers"



Help Text– available at:

https://www.healthcare.gov/help/found-not-eligible-for-medicaid

Select "None of these people" if no one on your application applied for Medicaid or CHIP since October 1, 2013.

Don't check the box if any of these apply to a person on your application:

- Hasn't applied for Medicaid or CHIP before
- Got a Medicaid or CHIP denial, but had recent changes in income or family size. See below for more information about income or family size changes.
- Was denied Medicaid or CHIP coverage before October 1, 2013
- Applied for Medicaid or CHIP but hasn't received a response yet
- Was denied Medicaid or CHIP because of the results of a disability determination or because of having too many assets
- Was denied Medicaid or CHIP coverage because the family didn't turn in paperwork that the state asked for.

Help Text- continued

Check the box if any of these apply to a person on your application:

- Had their Medicaid coverage end because of a change in state rules
- Was denied coverage by the state because their income is too high for Medicaid and CHIP
- Was denied coverage by the state because their immigration status doesn't qualify for Medicaid and CHIP
- Was denied Medicaid and CHIP because their state doesn't cover people with their household type
- Was told by the state that their current Medicaid or CHIP coverage will end within the next month
- Is a child denied by the state because he or she needs to wait for a month or more before starting CHIP coverage

Help Text- continued

- Recent income changes

When this list suggests that you don't check the box if there's been a change in income, it means that you should select "None of these people" if your household makes less money now than at the time the Medicaid agency sent the denial. For example, if anyone in your household lost their job, had their hours or wages at work cut, or stopped getting unemployment benefits or another taxable income source, select "None of these people."

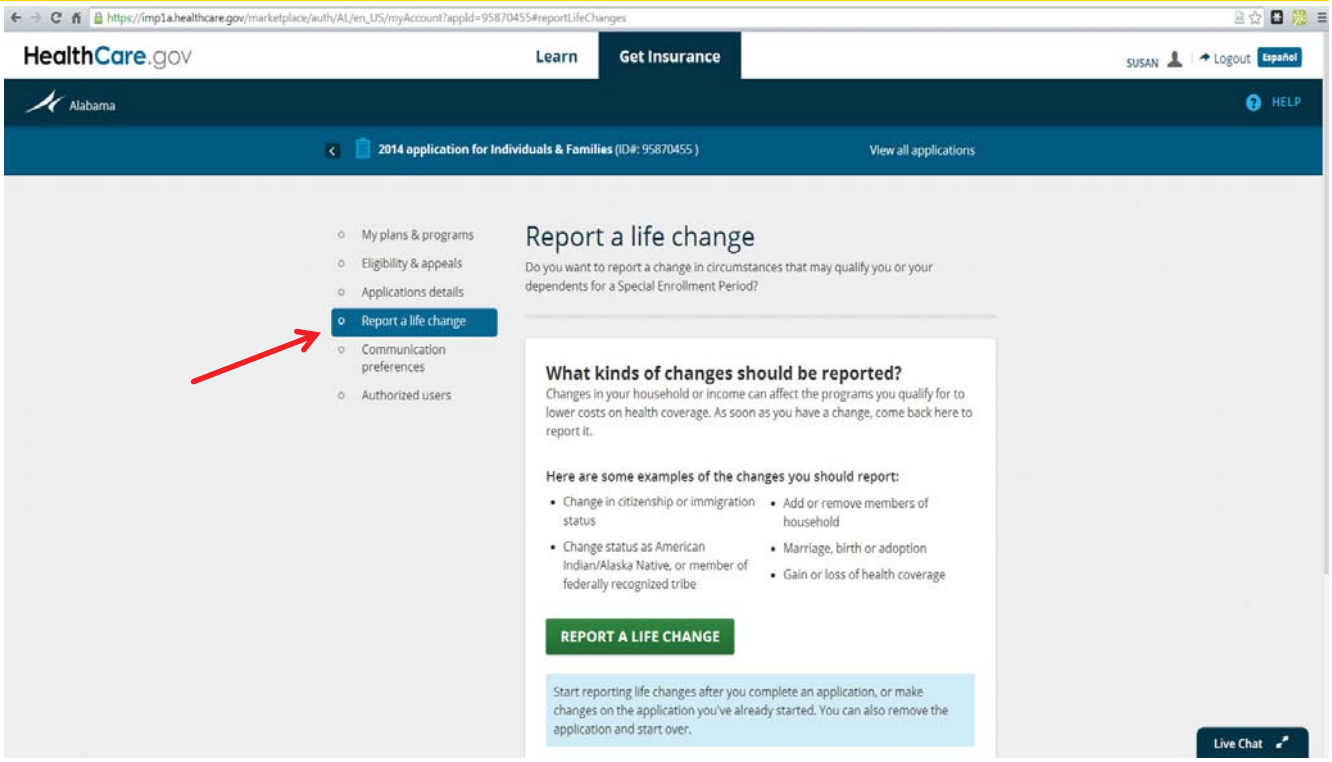
- Recent family size changes

When this list suggests that you don't check the box if there's been a change in household size, it means that you should select "None of these people" if, since the time that you were denied Medicaid by the state, you or another household member got married, had a baby, adopted a child, became pregnant, or started claiming someone new as a dependent on your tax return.

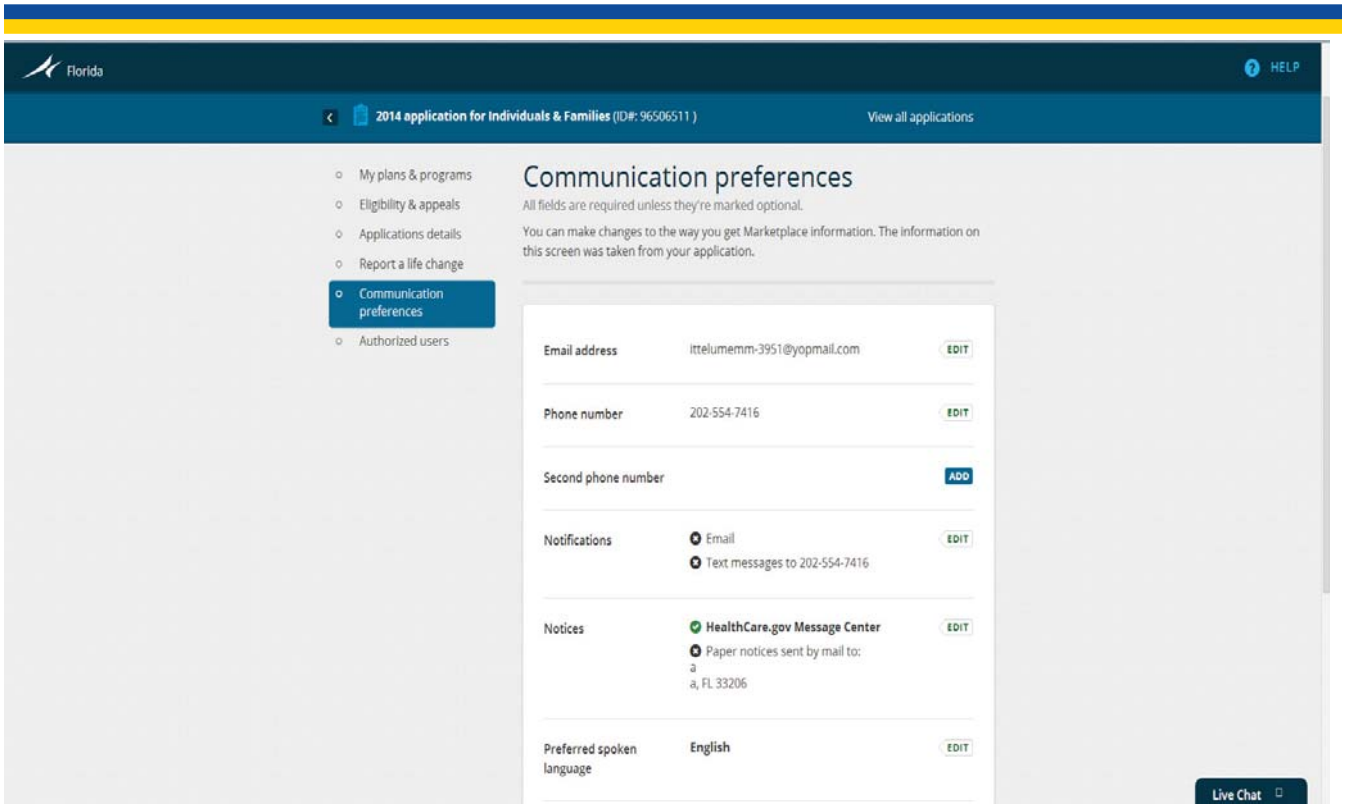
Reportable Changes

Type of Life Change/Change in Circumstance
New person on the application (e.g., birth, marriage)
Moves
Loss of access to other coverage (e.g., employer coverage)
Release from incarceration
Change in citizenship or immigration status
Removal of a person from the application (e.g., death, divorce)
Become incarcerated
New access to other coverage (e.g., employer coverage)
Pregnancy
Change in tax filing status/tax household composition
Change in status as an American Indian/Alaska Native or tribal status
Change in disability status
Correction to name, date of birth (DOB), or Social Security number (SSN)
Increase or decrease in income
Change in contact information, like: • Email address • Phone number • Add or remove phone text alert • Mailing of paper notices

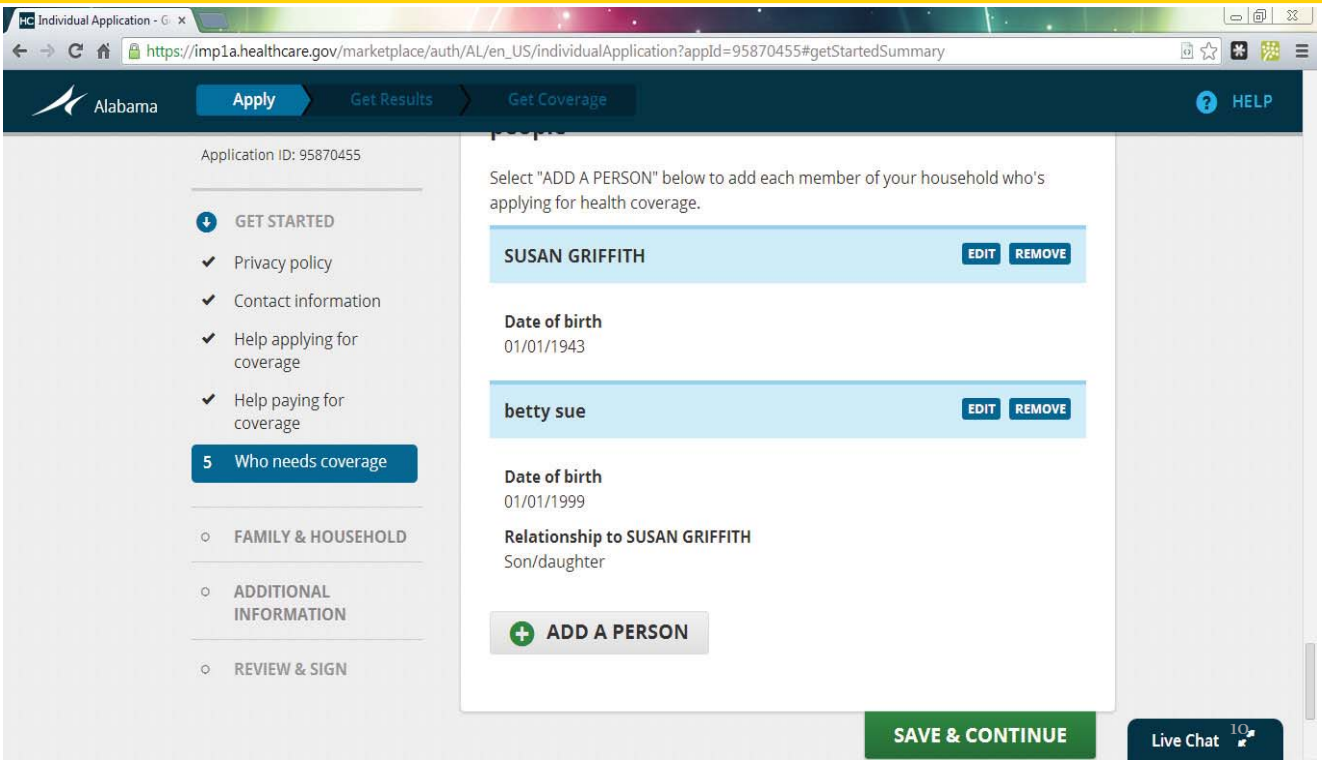
Consumers report changes from within their accounts



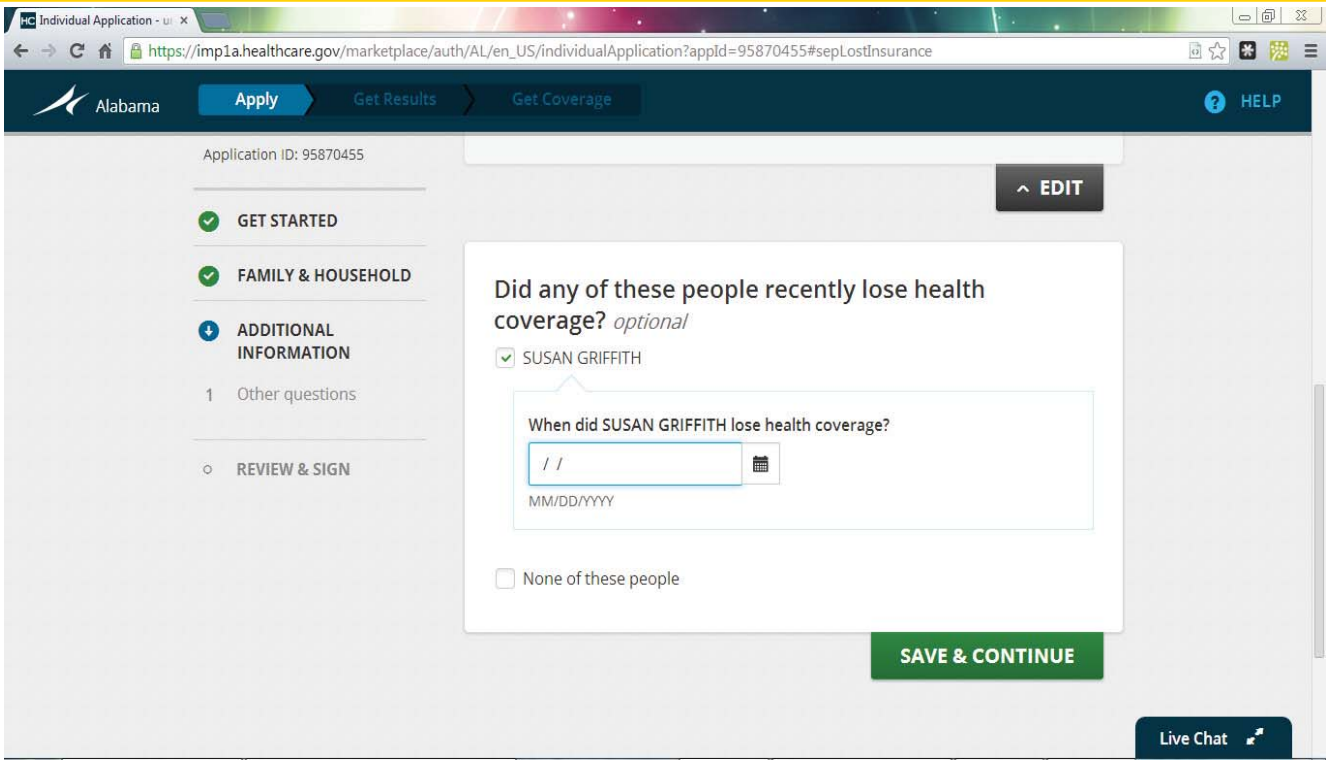
Changes to Communication Preferences are not sent to the State Agency



Consumers reporting changes that affect eligibility enter a pre-populated version of their application



Consumers answers questions that determine their eligibility for an SEP



If the consumer is eligible for QHP and an SEP, their determination notice will contain SEP eligibility language

Dear SUSAN:

Thank you for reporting a change in circumstance to the Marketplace.

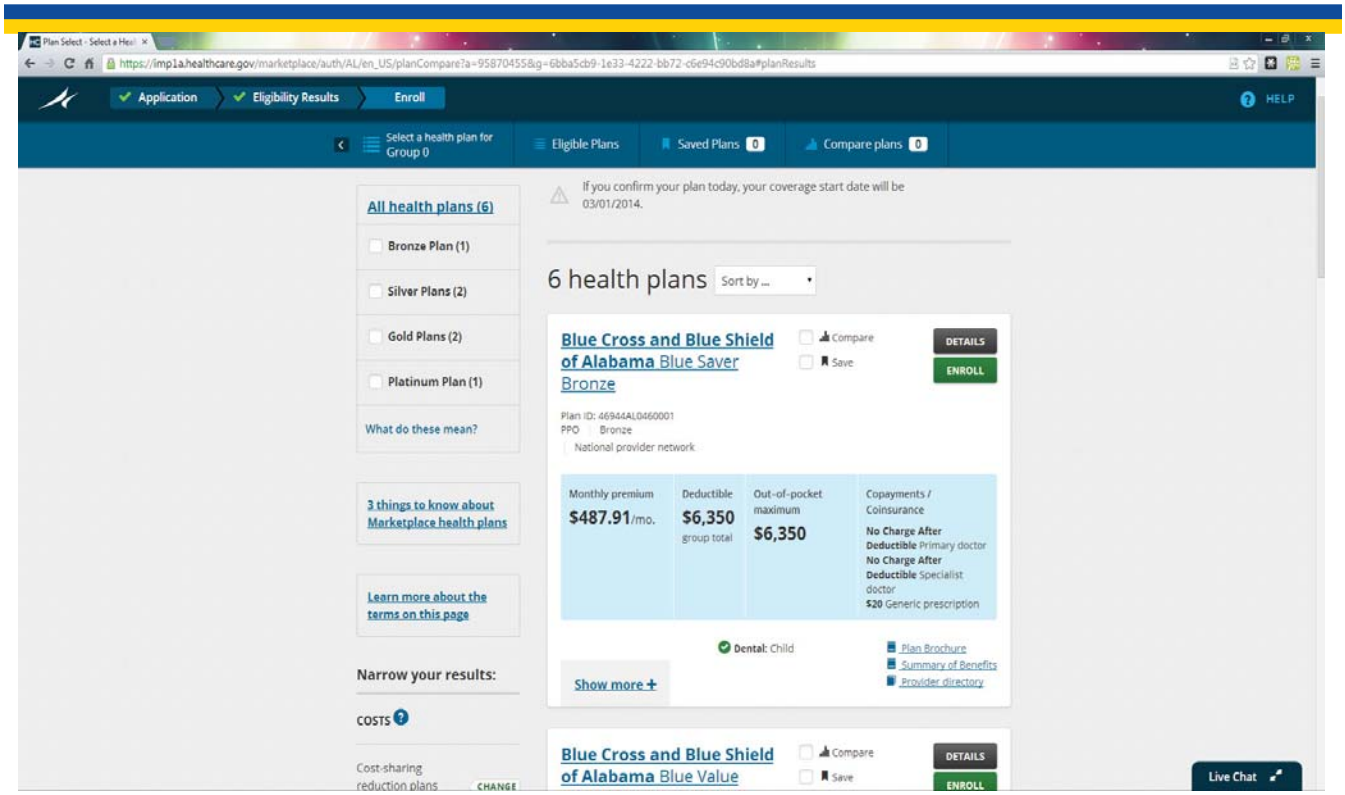
What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	
SUSAN GRIFFITH	• Eligible for a special enrollment period	
SUSAN GRIFFITH	• Eligible to purchase health coverage through the Marketplace, but more information is needed	•

- If the table above says you are eligible for a special enrollment period, April 7, 2014 is the last day to choose a health plan. To make a selection, visit HealthCare.gov/marketplace to compare health plans side by side, or call 1-800-318-2596 (TTY: 1-855-889-4325).
- If you miss the deadline, you may not be able to enroll in a health insurance plan through the Marketplace until the next open enrollment period, starting November 15, 2014, unless you qualify for another special enrollment period.

Consumers eligible for SEPs can select any available QHP in their service area.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

Date: February 7, 2014

Subject: Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces

On November 4, 2013, the Center for Medicare & Medicaid Service (CMS) issued a frequently asked question (FAQ) related to third party payments of premiums for qualified health plans (QHPs) in the Marketplace.[1] Since then, questions have arisen whether this FAQ applies to payments of premiums and cost sharing made on behalf of QHP enrollees by certain types of third party payors.

Q1. Does the November 4, 2013 FAQ apply to QHP premium and cost sharing payments on behalf of QHP enrollees from Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program)?

A1. No. The November 4, 2013 FAQ does not apply to payments for premiums and cost sharing made on behalf of QHP enrollees by Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs or grantees (such as the Ryan White HIV/AIDS Program). QHP issuers and Marketplaces are encouraged to accept such payments.

As CMS stated in its 2015 Draft Letter to Issuers on Federally-facilitated and State Partnership Exchanges,[2] pursuant to section 1312 of the Affordable Care Act, section 402 of the Indian Health Care Improvement Act, and 45 CFR 155.240(b), a Marketplace may permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums on behalf of members who are qualified individuals, subject to terms and conditions determined by the Marketplace. Indeed, Federal law specifically provides for this approach.

In addition, guidance from the Health Resources Services Administration (HRSA) on the Ryan White HIV/AIDS Program[3] specifically describes how grantees can use grant funds to pay premiums and cost sharing for eligible individuals enrolled in QHPs.

[1] Available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.
[2] Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf. The 2015 Draft Letter would continue the policy announced previously by CMS in the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.
[3] Available at: http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf.

Q2. Does the November 4, 2013 FAQ apply to QHP premium and cost sharing payments on behalf of QHP enrollees from private, not-for-profit foundations?

A2. No. The concerns addressed in the November 4, 2013 FAQ would not apply to payments from private, not-for-profit foundations if: (a) they are described in Question 1, or (b) if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. In situation (b), CMS would expect that premium and any cost sharing payments cover the entire policy year.

Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name]
[Address]

[Notice date]

Application date: [insert date]
Application ID: [insert ID number]

Dear [First name]:

You recently submitted an application to the Health Insurance Marketplace. We reviewed your application to see if you can get coverage through the Marketplace and help paying for health coverage through:

- A new tax credit that can be used right away to lower your monthly premium
- Health plans that lower your out-of-pocket costs
- [State Medicaid program name] (Medicaid) and [state CHIP name] (Children's Health Insurance Program (CHIP)), which are joint federal and state programs that help with medical costs for people with limited income or special health care needs

What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	Next Steps
[First name Last name]	• Eligible to purchase health coverage through the Marketplace • Eligible for a tax credit ($XX each month, which is $X for the year) • Can choose a health plan with lower copayments, coinsurance, and deductibles	• Choose a health plan and make first month's payment

If the table above says that you're eligible for a tax credit or cost sharing reductions, it means that we didn't find you eligible for Medicaid. This could be based on several things, like your income, household size, residency, or immigration status among other things. More information on how to appeal an eligibility decision is described in the section of the notice, "What should I do if I think my eligibility results are wrong?".

What should I do next?

- First name Last name – Compare health plans side by side, choose a health plan, and enroll in coverage. If you don't already have a Marketplace account, you'll need the Application ID that's printed on this notice. You can choose a plan 2 different ways:
    - If you applied through HealthCare.gov, log in again to compare plans and enroll.
    - If you applied a different way, like with a paper application or over the phone, you can:
        - Compare plans and enroll online at HealthCare.gov. You'll need to create a Marketplace account if you don't already have one. Go to HealthCare.gov, click the "Log In" button in the top right of your screen, and then click "Create Account" to create a Marketplace account before choosing your plan.
        - Compare plans and enroll over the phone. Call the Marketplace Call Center for assistance.
- Enroll by March 31, 2014
    - Open enrollment for the Marketplace ends on March 31, so you must enroll in a plan and pay the first month's bill (the "premium") by then.
    - If you miss the deadline, you may not be able to enroll in a health insurance plan through the Marketplace until the next open enrollment period, October 15 through December 7, 2014, unless you qualify for a special enrollment period.
    - For more information, go to https://www.healthcare.gov/enroll-after-applying/

- If the table above tells you that you or any of your family members are or may be eligible for [state Medicaid program name] or [state CHIP program name], the state agency will contact you with more information about your health benefits, services and how much you pay for them. If you don't hear from them, call them at the phone number listed in the in the section, "Where can I find more information?"

When will coverage begin?

If you are eligible to purchase health coverage through the Marketplace and you choose a health plan by December 23, 2013, your coverage will start on January 1, 2014. If you don't choose a plan by December 23, then your coverage start date will depend on when you select a health plan.

- Between December 24, 2013 and March 31, 2014, if you choose a health plan by the 15th of the month, your coverage will start on the first day of the following month. If you choose a health plan after the 15th, your coverage will start on the first of the next following month. For example,

if you choose a plan on January 16, coverage will not start until March 1.

- You have to pay the first month's premium before your coverage starts.

If you are eligible for [state Medicaid program name] or [state CHIP program name] and you applied between October and December 2013, health coverage will begin no earlier than January 1, 2014. If you applied after January 1, 2014 your coverage will begin in the month your application was received by the Marketplace. If you received health care services during the three months before these dates, contact Medicaid at the phone number including in this notice to see if you are eligible to have those services covered by Medicaid.

What if information from my application changes during the year?

Changes to the information you provided on your application can affect your eligibility for coverage through the Marketplace, including tax credits, plan with lower copayments, coinsurance, deductibles, and coverage through [state Medicaid program name] or [state CHIP program name].

If you're eligible for a tax credit and you don't report a change that may affect your eligibility, you may have to pay back some or all of your tax credit when you file your taxes. If information from your application changes during the year, you should report the change within 30 days. Contact the Marketplace at the phone number below to report changes that may affect your eligibility.

If you're eligible for [state Medicaid program name] or [state CHIP program name], contact the state agency at the phone number in the section, "Where can I find more information" to report changes.

What should I do if I think my eligibility results are wrong?

If you have received a final eligibility determination and you think we made a mistake, in many cases, you can appeal our decision about your eligibility for health coverage, including Medicaid, CHIP, purchasing health coverage through the Marketplace, a tax credit, cost-sharing reductions, and enrollment periods.

Below is important information to consider when requesting an appeal:

- You have 90 days to request an appeal from the date of this notice.

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.

- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.

- The outcome of an appeal could change the eligibility of other members of your household even if they don't ask for an appeal.

- If we did not find you eligible for Medicaid and you appeal our decision, you will have a choice about whether the Marketplace or your state's Medicaid agency hears your Medicaid appeal. More information about your options is included on the appeals request form. If you write your own letter to appeal a denial of Medicaid eligibility, please specific whether you would like to have your Medicaid appeal heard by the Medicaid agency or the Marketplace.

To request an appeal, you can do one of these things:

- Go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ to find and complete the appeal request form for your state and mail to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY, 40750-0061;

- Call [Marketplace phone number and TTY] and ask for an appeals request form; or

- Mail your own letter requesting an appeal to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0061. If you write your own letter please include your name, address, and the reason you are filing an appeal. If you are filing an appeal for someone else (like your child), also include the name of the person for whom you are filing the appeal.

Continuing your Medicaid or CHIP Application

If the table with your eligibility results above tells you that you "May be eligible for [Medicaid program name]" or you "May be eligible for [CHIP program name]" then this section, "Continuing your Medicaid or CHIP Application" DOESN'T APPLY to you, and you don't need to take any action.

This Marketplace application looks at whether you qualify for Medicaid based on many reasons, but if your eligibility results tell you that you're eligible for coverage through the Marketplace, we don't think you qualify for [state Medicaid program name]. Some people may still qualify for [state Medicaid program name] but only [state Medicaid agency name] can make the final decision.

You can ask the [state Medicaid agency name] to continue to review your [state Medicaid program name] application for other ways to qualify for [state Medicaid program name]. There is more information about this in the "Does Medicaid cover special health care needs?" section below. You should also ask [state Medicaid program name] to continue your application if you:

- Need a lot of medical services or have high medical bills, or
- Have a family income close to the [state Medicaid program name] income limit, or you don't agree with the income on your application.

You have 10 days to request that your application by reviewed by your state's Medicaid agency for other ways to qualify for [state Medicaid program name]. If the table above says "May be eligible for [state

Medicaid program name]," then the Marketplace has already sent your information to [state Medicaid agency name] and they are reviewing your application.

If you're not sure whether you should ask [state Medicaid agency name] to look at other ways you may qualify, then you should make this request. You can keep your coverage described in this notice while [state Medicaid agency name] reviews your application. If you don't want [state Medicaid agency name] to take another look at your application, then you don't need to take any action. If the table on the first page of this letter said you "May be eligible for [state Medicaid program name]," you will still receive a final decision from the state about this.

To ask the [state Medicaid agency name] to continue to review your application for other ways you may qualify, log into your Marketplace account at HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325) to let us know. If you don't ask for the [state Medicaid agency name] to continue to review your application, your application will no longer be considered, and you will not be able to appeal the fact that you aren't being enrolled in the [state Medicaid program name] program without also appealing your eligibility for tax credits and cost-sharing reductions.

Does Medicaid cover special health care needs?

A person may qualify to get coverage for more health services and pay less for care through [state Medicaid program name] if he or she has special health care needs. For example if a person:

- Has a medical, mental health or substance use condition that limits the ability to work or go to school
- Needs help with daily activities, such as bathing or dressing
- Regularly gets medical care, personal care, or health services at home, an adult day center, or another community setting
- Lives in a long term care facility, group home, or nursing home
- Is blind or
- Is terminally ill

If a person applying for coverage has special health care needs, and wants to see if he or she qualifies, call us at 1-800-318-2596 (TTY: 1-855-889-4325) or log into your Marketplace account at HealthCare.gov/marketplace. If the person already qualified for other health coverage, he or she can keep it while the Medicaid agency decides if he or she qualifies for more coverage through Medicaid.

Where can I find more information?

Visit us online at HealthCare.gov. Or, call the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325). For more information about [state Medicaid program name], contact the [state Medicaid agency name] at [insert state Medicaid agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*]. For more information about [state CHIP program name], contact the [state CHIP agency name] at [insert state CHIP agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*].

Sincerely,

Health Insurance Marketplace
Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

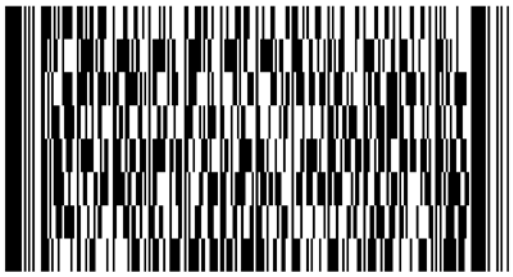
The determinations or assessments in this letter were made based upon 45 CFR 155.305, 155.410, 155.420-430 and 42 CFR 435.603, 435.403, 435.406 and 435.911.

Privacy Disclosure: The Health Insurance Marketplace protects the privacy and security of the personally identifiable information (PII) that you have provided (see https://www.healthcare.gov/privacy/). This notice was generated by the Marketplace based on 45 CFR 155.230. The PII used to create this notice was collected on the application you filled out and from other data sources through the electronic eligibility verification process used to get an eligibility determination for enrollment in a qualified health plan through the Marketplace and for insurance affordability programs. For more information about the privacy and security of your PII, visit HealthCare.gov.

The Marketplace may have used data from a consumer reporting agency to determine eligibility for the individuals on your application. If you have questions about this data, please contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1207. The time required for a health insurance Exchange as defined in CFR 155.20 to generate this information collection is estimated to be 100 hours, including the time to draft appropriate notice text, review the notice, conduct user testing, incorporate changes, ensure compliance with plain writing, language access, and readability standards. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Important: If you mail in your documentation, please include this page in the same envelope, which includes a barcode, along with any documents. This page helps the Marketplace make sure your documents can be easily associated with your application.



[State code], Application ID

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

More information about Tax Credits

What is a tax credit?
A tax credit lowers the monthly cost (called a "premium") you pay for health insurance. In some cases, you may pay no premium if your tax credit covers the entire premium amount. Tax credits help people with incomes too high to qualify for Medicaid or the Children's Health Insurance Program (CHIP), but who still may not be able to afford health coverage.

How do I qualify for a tax credit?
The Marketplace will check your information, such as your income and household size, to see if you qualify for a tax credit. The tax credit is only available if you enroll in coverage through the Marketplace. If you're eligible for Medicare or most other types of health insurance coverage, then you probably don't qualify for a tax credit. If you're eligible for coverage from a job, you can only qualify for a tax credit if your employer doesn't offer affordable health coverage or the coverage doesn't meet a minimum value standard. In addition, your income must be above the limit for Medicaid in your state, but within the limits for a tax credit, which are outlined in the chart below.

Income Limits for Tax Credits

Household size	Income limit	Household size	Income limit
1	$45,960 ($57,400 for Alaska)	4	$94,200 ($117,760 for Alaska)
2	$62,040 ($77,520 for Alaska)	5	$110,280 ($137,880 for Alaska)
3	$78,120 ($97,640 for Alaska)	6	$126,360 ($158,000 for Alaska)

How much of a tax credit can I get?
Your tax credit amount is based on:

- The number of people in your household. Your household includes the person who pays taxes and his or her spouse and dependents,
- The income amount that you expect to put on your on your federal income tax return for 2014, and
- The cost of a "silver level" health plan in your area. A silver level health plan is a plan that provides the set of essential health benefits required for the Marketplace and also covers 70% of health care costs for the average person. You can see the health plans available using our plan finder on healthcare.gov.

Do I have to wait until I file my federal tax return to get the tax credit?
You do not have to wait until you file your federal income tax return to get your tax credit. You can have some or all of your tax credit paid directly by the Federal government to your health plan to reduce the premium for the health plan that you select through the Marketplace. You will make this choice when you choose a plan.

You can decide to enroll in a plan without a tax credit or with less than the full amount, and get the full amount, based on your actual income at the end of the year, when you file your taxes. Even if you don't owe any taxes, you may still be eligible for a tax credit. You need to enroll in a plan

through the Marketplace in order for the IRS to see if you qualify for a tax credit when you file your taxes. If you don't enroll in a plan through the Marketplace, you won't be eligible for a tax credit when you file your federal tax return with IRS (and you may owe a penalty if you don't have qualifying coverage for three months or longer).

I'm not sure what my income for the year will be, so I just guessed on my application. What happens if I'm wrong?

When it's time to file your federal income tax return, the IRS will compare the income from your application with the income you report on your tax return.

- If your income is lower than what you told us on your application, you may receive a tax refund.
- If your income is higher than what you told us on your application, you may have to pay back some of all your tax credit.

If you're worried about owing back any tax credit, you can take a smaller amount of the tax credit to use each month. You can decide how much of the tax credit you want to take when you enroll in a plan through the Marketplace.

What kind of changes do I need to report?

If information from your application changes, you should report the change to us within 30 days of the change occurring. If you don't report changes, you may have to pay back some or all of your tax credit when you file your taxes. Examples of changes you should report include:

- A move
- Household income changes
- Household size changes. For example, someone in your household marries or divorces, becomes pregnant, or has a child
- Becoming qualified for other health coverage
- Changes in immigration status
- Becoming incarcerated, other than pending the disposition of charges
- A change in plan for filing your federal income tax return for 2014; for example, you plan to claim new dependents on your tax return

To report changes, log into your Marketplace account on HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325).

Will my employer know that I am getting a tax credit?

We're required to notify your employer if you're getting a tax credit or cost-sharing reductions because your employer may need to make a shared responsibility payment. Your employer is not allowed to treat you differently based on your eligibility for a tax credit or cost-sharing reductions. The law prohibits your employer from firing or discriminating against you because you or someone in your household has been determined eligible for a tax credit or cost-sharing reductions. If you believe that you were fired or otherwise discriminated against because you or someone in your household was determined eligible for a tax credit or cost-sharing reductions, you can file a complaint with the U.S. Occupational Safety and Health Administration (OSHA). Visit www.whistleblowers.gov for more information.

If you have questions:

Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Do I need to apply for a new tax credit every year?
You must renew your tax credit every year. Watch for a letter from us in August or September with information about next year.

More information about Lower Out-of-Pocket Costs

What are copayments, coinsurance, and deductibles?
Copayments, coinsurance, and deductibles are the money you pay toward your share of the cost of your health care. They are also called "cost sharing." Your insurance company pays the rest.

- A copayment is an amount you may be required to pay each time you receive a service, like going to the doctor or getting a prescription. It's usually a set dollar amount, like $20.
- Coinsurance is your share of the costs of a covered health service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.
- A deductible is the amount of money you must spend every year on health care before the plan starts paying. Even after you pay your deductible, you may still be required to pay copayments or coinsurance when you receive services.

How do I qualify for lower copayments, coinsurance, and deductibles?
Your income must be within certain limits in order to also qualify for a Marketplace plan with discounted copayments, coinsurance, and deductibles. Once you qualify, most people must enroll in a "silver level plan" to get lower copayments, copayments, and deductibles.

How does the Marketplace decide what my cost sharing is?
You qualify to enroll in a plan with lower copayments, coinsurance, and deductibles based on:

- Whether you are eligible for a tax credit
- The number of people in your household (the taxpayer and dependents listed on your federal income tax return)
- The income amount that you expect to put on your federal income tax return for 2014
- Whether you are American Indian or Alaska Native and a member of a federally-recognized tribe

More information about Medicaid

Medicaid is health coverage for people with limited income or special health care needs. Medicaid covers services such as doctor visits, laboratory tests and hospital care. Medicaid also covers additional services for children up to a certain age.

Do you have past medical bills?
Medicaid may pay medical bills from the past three months. If you want to see if Medicaid will pay recent medical bills, contact the Medicaid at the number included above in this notice. You may then need to send the Medicaid copies of your unpaid medical bills from the last three months.

How long can I keep my Medicaid health coverage?
You must renew your Medicaid health coverage every year. Watch for a letter in the mail telling you if you need to send Medicaid more information at renewal time.

What if information from my application changes during the year?
Over the next year, you must report any changes that might affect whether you qualify for Medicaid, like if you move, your income changes, or the size of your family changes (for example, if you marry, divorce, become pregnant, or have a child.) To report changes, call the Medicaid agency in your state.

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

Here's a listing of the available languages and the same message provided above in those languages:

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجانا. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace" zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

हिन्दी (Hindi)

आपके पास अपनी भाषा में सहायता व सूचना नि:शुल्क प्राप्त करने का अधिकार है। हेल्थ इंश्योरेंस मार्केटप्लेस (स्वास्थ्य बीमा बाजारस्थल) के बारे में हिन्दी में दुभाषिए से बात करने के लिए 1-800-318-2596 पर फ़ोन करें।

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku.
Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional.
Para falar com um intérprete de [Português] sobre o Mercado
de Seguros de Saúde, ligue para 1-800-318-2596.

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

اردو (Urdu)

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ہیلتھ انشورنس مارکیٹ پلیس کے بارے میں کسی مترجم سے اردو میں بات کرنے کے لئے 1-800-318-2596 پر رابطہ کریں۔

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.

June 2013

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name]
[Address]

[Notice date]

Application date: [October 2, 2013]
Application ID: [insert ID number]

Dear [First name]:

You recently submitted an application to the Health Insurance Marketplace. We reviewed your application to see if you can get coverage through the Marketplace and help paying for health coverage through:

- A new tax credit that can be used right away to lower your monthly premium
- Health plans that lower your out-of-pocket costs
- [State Medicaid program name] (Medicaid) and [state CHIP name] (Children's Health Insurance Program (CHIP)), which are joint federal and state programs that help with medical costs for people with limited income or special health care needs

What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	Next Steps
[First name Last name]	• Eligible to purchase health coverage through the Marketplace • Eligible for a tax credit ($XX each month, which is $X for the year) • Can choose a health plan with lower copayments, coinsurance, and	• Choose a health plan and make first month's payment

	deductibles	
[First name Last name]	• May be eligible for [Medicaid program name]	• You will receive a final decision from the [state Medicaid agency name]. If you qualify for [state Medicaid program name], you won't qualify for a tax credit and lower copayments, coinsurance, and deductibles for Health Insurance Marketplace coverage.

If the table above says that you're eligible for a tax credit or cost sharing reductions, it means that we didn't find you eligible for Medicaid. This could be based on several things, like your income, household size, residency, or immigration status among other things. More information on how to appeal an eligibility decision is described in the section of the notice, "What should I do if I think my eligibility results are wrong?".

What should I do next?

- First name Last name – Compare health plans side by side, choose a health plan, and enroll in coverage. If you don't already have a Marketplace account, you'll need the Application ID that's printed on this notice. You can choose a plan 2 different ways:
    - If you applied through HealthCare.gov, log in again to compare plans and enroll.
    - If you applied a different way, like with a paper application or over the phone, you can:
        - Compare plans and enroll online at HealthCare.gov. You'll need to create a Marketplace account if you don't already have one. Go to HealthCare.gov, click the "Log In" button in the top right of your screen, and then click "Create Account" to create a Marketplace account before choosing your plan.
        - Compare plans and enroll over the phone. Call the Marketplace Call Center for assistance.
- Enroll by March 31, 2014
    - Open enrollment for the Marketplace ends on March 31, so you must enroll in a plan and pay the first month's bill (the "premium") by then.
    - If you miss the deadline, you may not be able to enroll in a health insurance plan through the Marketplace until the next open enrollment period, October 15 through December 7, 2014, unless you qualify for a special enrollment period.
    - For more information, go to https://www.healthcare.gov/enroll-after-applying/

- If the table above tells you that you or any of your family members are or may be eligible for [state Medicaid program name] or [state CHIP program name], the state agency will contact you with more information about your health benefits, services and how much you pay for them. If you don't hear from them, call them at the phone number listed in the in the section, "Where can I find more information?"

When will coverage begin?

If you are eligible to purchase health coverage through the Marketplace and you choose a health plan by December 23, 2013, your coverage will start on January 1, 2014. If you don't choose a plan by December 23, then your coverage start date will depend on when you select a health plan.

- Between December 24, 2013 and March 31, 2014, if you choose a health plan by the 15th of the month, your coverage will start on the first day of the following month. If you choose a health plan after the 15th, your coverage will start on the first of the next following month. For example, if you choose a plan on January 16, coverage will not start until March 1.

- You have to pay the first month's premium before your coverage starts.

If you are eligible for [state Medicaid program name] or [state CHIP program name] and you applied between October and December 2013, health coverage will begin no earlier than January 1, 2014. If you applied after January 1, 2014 your coverage will begin in the month your application was received by the Marketplace. If you received health care services during the three months before these dates, contact Medicaid at the phone number including in this notice to see if you are eligible to have those services covered by Medicaid.

What if information from my application changes during the year?

Changes to the information you provided on your application can affect your eligibility for coverage through the Marketplace, including tax credits, plan with lower copayments, coinsurance, deductibles, and coverage through [state Medicaid program name] or [state CHIP program name].

If you're eligible for a tax credit and you don't report a change that may affect your eligibility, you may have to pay back some or all of your tax credit when you file your taxes. If information from your application changes during the year, you should report the change within 30 days. Contact the Marketplace at the phone number below to report changes that may affect your eligibility.

If you're eligible for [state Medicaid program name] or [state CHIP program name], contact the state agency at the phone number in the section, "Where can I find more information" to report changes.

What should I do if I think my eligibility results are wrong?

If you have received a final eligibility determination and you think we made a mistake, in many cases, you can appeal our decision about your eligibility for health coverage, including Medicaid, CHIP, purchasing health coverage through the Marketplace, a tax credit, cost-sharing reductions, and enrollment periods.

Below is important information to consider when requesting an appeal:

- You have 90 days to request an appeal from the date of this notice.

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.

- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.

- The outcome of an appeal could change the eligibility of other members of your household even if they don't ask for an appeal.

- If we did not find you eligible for Medicaid and you appeal our decision, you will have a choice about whether the Marketplace or your state's Medicaid agency hears your Medicaid appeal. More information about your options is included on the appeals request form. If you write your own letter to appeal a denial of Medicaid eligibility, please specific whether you would like to have your Medicaid appeal heard by the Medicaid agency or the Marketplace.

To request an appeal, you can do one of these things:

- Go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ to find and complete the appeal request form for your state and mail to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY, 40750-0061;

- Call [Marketplace phone number and TTY] and ask for an appeals request form; or

- Mail your own letter requesting an appeal to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0061. If you write your own letter please include your name, address, and the reason you are filing an appeal. If you are filing an appeal for someone else (like your child), also include the name of the person for whom you are filing the appeal.

Continuing your Medicaid or CHIP Application

If the table with your eligibility results above tells you that you "May be eligible for [Medicaid program name]" or you "May be eligible for [CHIP program name]" then this section, "Continuing your Medicaid or CHIP Application" DOESN'T APPLY to you, and you don't need to take any action.

This Marketplace application looks at whether you qualify for Medicaid based on many reasons, but if your eligibility results tell you that you're eligible for coverage through the Marketplace, we don't think you qualify for [state Medicaid program name]. Some people may still qualify for [state Medicaid program name] but only [state Medicaid agency name] can make the final decision.

You can ask the [state Medicaid agency name] to continue to review your [state Medicaid program name] application for other ways to qualify for [state Medicaid program name]. There is more

information about this in the "Does Medicaid cover special health care needs?" section below. You should also ask [state Medicaid program name] to continue your application if you:

- Need a lot of medical services or have high medical bills, or
- Have a family income close to the [state Medicaid program name] income limit, or you don't agree with the income on your application.

You have 10 days to request that your application by reviewed by your state's Medicaid agency for other ways to qualify for [state Medicaid program name]. If the table above says "May be eligible for [state Medicaid program name]," then the Marketplace has already sent your information to [state Medicaid agency name] and they are reviewing your application.

If you're not sure whether you should ask [state Medicaid agency name] to look at other ways you may qualify, then you should make this request. You can keep your coverage described in this notice while [state Medicaid agency name] reviews your application. If you don't want [state Medicaid agency name] to take another look at your application, then you don't need to take any action. If the table on the first page of this letter said you "May be eligible for [state Medicaid program name]," you will still receive a final decision from the state about this.

To ask the [state Medicaid agency name] to continue to review your application for other ways you may qualify, log into your Marketplace account at HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325) to let us know. If you don't ask for the [state Medicaid agency name] to continue to review your application, your application will no longer be considered, and you will not be able to appeal the fact that you aren't being enrolled in the [state Medicaid program name] program without also appealing your eligibility for tax credits and cost-sharing reductions.

Does Medicaid cover special health care needs?

A person may qualify to get coverage for more health services and pay less for care through [state Medicaid program name] if he or she has special health care needs. For example if a person:

- Has a medical, mental health or substance use condition that limits the ability to work or go to school
- Needs help with daily activities, such as bathing or dressing
- Regularly gets medical care, personal care, or health services at home, an adult day center, or another community setting
- Lives in a long term care facility, group home, or nursing home
- Is blind or
- Is terminally ill

If a person applying for coverage has special health care needs, and wants to see if he or she qualifies, call us at 1-800-318-2596 (TTY: 1-855-889-4325) or log into your Marketplace account at HealthCare.gov/marketplace. If the person already qualified for other health coverage, he or she can keep it while the Medicaid agency decides if he or she qualifies for more coverage through Medicaid.

Where can I find more information?

Visit us online at HealthCare.gov. Or, call the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325). For more information about [state Medicaid program name], contact the [state Medicaid agency name] at [insert state Medicaid agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*]. For more information about [state CHIP program name], contact the [state CHIP agency name] at [insert state CHIP agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*].

Sincerely,

Health Insurance Marketplace
Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

The determinations or assessments in this letter were made based upon 45 CFR 155.305, 155.410, 155.420-430 and 42 CFR 435.603, 435.403, 435.406 and 435.911.

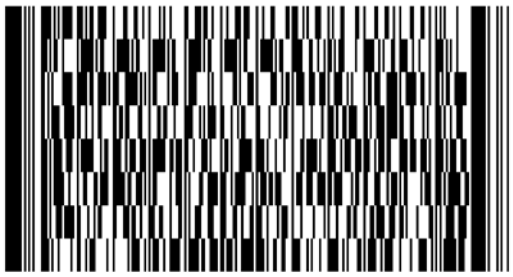
Privacy Disclosure: The Health Insurance Marketplace protects the privacy and security of the personally identifiable information (PII) that you have provided (see https://www.healthcare.gov/privacy/). This notice was generated by the Marketplace based on 45 CFR 155.230. The PII used to create this notice was collected on the application you filled out and from other data sources through the electronic eligibility verification process used to get an eligibility determination for enrollment in a qualified health plan through the Marketplace and for insurance affordability programs. For more information about the privacy and security of your PII, visit HealthCare.gov.

The Marketplace may have used data from a consumer reporting agency to determine eligibility for the individuals on your application. If you have questions about this data, please contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1207. The time required for a health insurance Exchange as defined in CFR 155.20 to generate this information collection is estimated to be 100 hours, including the time to draft appropriate notice text, review the notice, conduct user testing, incorporate changes, ensure compliance with plain writing, language access, and readability standards. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Important: If you mail in your documentation, please include this page in the same envelope, which includes a barcode, along with any documents. This page helps the Marketplace make sure your documents can be easily associated with your application.



[State code], Application ID

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

More information about Tax Credits

What is a tax credit?
A tax credit lowers the monthly cost (called a "premium") you pay for health insurance. In some cases, you may pay no premium if your tax credit covers the entire premium amount. Tax credits help people with incomes too high to qualify for Medicaid or the Children's Health Insurance Program (CHIP), but who still may not be able to afford health coverage.

How do I qualify for a tax credit?
The Marketplace will check your information, such as your income and household size, to see if you qualify for a tax credit. The tax credit is only available if you enroll in coverage through the Marketplace. If you're eligible for Medicare or most other types of health insurance coverage, then you probably don't qualify for a tax credit. If you're eligible for coverage from a job, you can only qualify for a tax credit if your employer doesn't offer affordable health coverage or the coverage doesn't meet a minimum value standard. In addition, your income must be above the limit for Medicaid in your state, but within the limits for a tax credit, which are outlined in the chart below.

Income Limits for Tax Credits

Household size	Income limit	Household size	Income limit
1	$45,960 ($57,400 for Alaska)	4	$94,200 ($117,760 for Alaska)
2	$62,040 ($77,520 for Alaska)	5	$110,280 ($137,880 for Alaska)
3	$78,120 ($97,640 for Alaska)	6	$126,360 ($158,000 for Alaska)

How much of a tax credit can I get?
Your tax credit amount is based on:

- The number of people in your household. Your household includes the person who pays taxes and his or her spouse and dependents,
- The income amount that you expect to put on your on your federal income tax return for 2014, and
- The cost of a "silver level" health plan in your area. A silver level health plan is a plan that provides the set of essential health benefits required for the Marketplace and also covers 70% of health care costs for the average person. You can see the health plans available using our plan finder on healthcare.gov.

Do I have to wait until I file my federal tax return to get the tax credit?
You do not have to wait until you file your federal income tax return to get your tax credit. You can have some or all of your tax credit paid directly by the Federal government to your health plan to reduce the premium for the health plan that you select through the Marketplace. You will make this choice when you choose a plan.

You can decide to enroll in a plan without a tax credit or with less than the full amount, and get the full amount, based on your actual income at the end of the year, when you file your taxes. Even if you don't owe any taxes, you may still be eligible for a tax credit. You need to enroll in a plan

through the Marketplace in order for the IRS to see if you qualify for a tax credit when you file your taxes. If you don't enroll in a plan through the Marketplace, you won't be eligible for a tax credit when you file your federal tax return with IRS (and you may owe a penalty if you don't have qualifying coverage for three months or longer).

I'm not sure what my income for the year will be, so I just guessed on my application. What happens if I'm wrong?

When it's time to file your federal income tax return, the IRS will compare the income from your application with the income you report on your tax return.

- If your income is lower than what you told us on your application, you may receive a tax refund.
- If your income is higher than what you told us on your application, you may have to pay back some of all your tax credit.

If you're worried about owing back any tax credit, you can take a smaller amount of the tax credit to use each month. You can decide how much of the tax credit you want to take when you enroll in a plan through the Marketplace.

What kind of changes do I need to report?

If information from your application changes, you should report the change to us within 30 days of the change occurring. If you don't report changes, you may have to pay back some or all of your tax credit when you file your taxes. Examples of changes you should report include:

- A move
- Household income changes
- Household size changes. For example, someone in your household marries or divorces, becomes pregnant, or has a child
- Becoming qualified for other health coverage
- Changes in immigration status
- Becoming incarcerated, other than pending the disposition of charges
- A change in plan for filing your federal income tax return for 2014; for example, you plan to claim new dependents on your tax return

To report changes, log into your Marketplace account on HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325).

Will my employer know that I am getting a tax credit?

We're required to notify your employer if you're getting a tax credit or cost-sharing reductions because your employer may need to make a shared responsibility payment. Your employer is not allowed to treat you differently based on your eligibility for a tax credit or cost-sharing reductions. The law prohibits your employer from firing or discriminating against you because you or someone in your household has been determined eligible for a tax credit or cost-sharing reductions. If you believe that you were fired or otherwise discriminated against because you or someone in your household was determined eligible for a tax credit or cost-sharing reductions, you can file a complaint with the U.S. Occupational Safety and Health Administration (OSHA). Visit www.whistleblowers.gov for more information.

If you have questions:

Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Do I need to apply for a new tax credit every year?
You must renew your tax credit every year. Watch for a letter from us in August or September with information about next year.

More information about Lower Out-of-Pocket Costs

What are copayments, coinsurance, and deductibles?
Copayments, coinsurance, and deductibles are the money you pay toward your share of the cost of your health care. They are also called "cost sharing." Your insurance company pays the rest.

- A copayment is an amount you may be required to pay each time you receive a service, like going to the doctor or getting a prescription. It's usually a set dollar amount, like $20.
- Coinsurance is your share of the costs of a covered health service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.
- A deductible is the amount of money you must spend every year on health care before the plan starts paying. Even after you pay your deductible, you may still be required to pay copayments or coinsurance when you receive services.

How do I qualify for lower copayments, coinsurance, and deductibles?
Your income must be within certain limits in order to also qualify for a Marketplace plan with discounted copayments, coinsurance, and deductibles. Once you qualify, most people must enroll in a "silver level plan" to get lower copayments, copayments, and deductibles.

How does the Marketplace decide what my cost sharing is?
You qualify to enroll in a plan with lower copayments, coinsurance, and deductibles based on:

- Whether you are eligible for a tax credit
- The number of people in your household (the taxpayer and dependents listed on your federal income tax return)
- The income amount that you expect to put on your federal income tax return for 2014
- Whether you are American Indian or Alaska Native and a member of a federally-recognized tribe

More information about Medicaid

Medicaid is health coverage for people with limited income or special health care needs. Medicaid covers services such as doctor visits, laboratory tests and hospital care. Medicaid also covers additional services for children up to a certain age.

Do you have past medical bills?
Medicaid may pay medical bills from the past three months. If you want to see if Medicaid will pay recent medical bills, contact the Medicaid at the number included above in this notice. You may then need to send the Medicaid copies of your unpaid medical bills from the last three months.

How long can I keep my Medicaid health coverage?
You must renew your Medicaid health coverage every year. Watch for a letter in the mail telling you if you need to send Medicaid more information at renewal time.

What if information from my application changes during the year?
Over the next year, you must report any changes that might affect whether you qualify for Medicaid, like if you move, your income changes, or the size of your family changes (for example, if you marry, divorce, become pregnant, or have a child.) To report changes, call the Medicaid agency in your state.

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

Here's a listing of the available languages and the same message provided above in those languages:

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجانا. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace" zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

हिन्दी (Hindi)

आपके पास अपनी भाषा में सहायता व सूचना नि:शुल्क प्राप्त करने का अधिकार है। हेल्थ इंश्योरेंस मार्केटप्लेस (स्वास्थ्य बीमा बाजारस्थल) के बारे में हिन्दी में दुभाषिए से बात करने के लिए 1-800-318-2596 पर फ़ोन करें।

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku.
Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional.
Para falar com um intérprete de [Português] sobre o Mercado
de Seguros de Saúde, ligue para 1-800-318-2596.

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

اردو (Urdu)

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ہیلتھ انشورنس مارکیٹ پلیس کے بارے میں کسی مترجم سے اردو میں بات کرنے کے لئے 1-800-318-2596 پر رابطہ کریں۔

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.

June 2013

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name]
[Address]

[Notice date]

Application date: [insert date]
Application ID: [insert ID number]

Dear [First name]:

You recently submitted an application to the Health Insurance Marketplace. We reviewed your application to see if you can get coverage through the Marketplace and help paying for health coverage through:

- A new tax credit that can be used right away to lower your monthly premium
- Health plans that lower your out-of-pocket costs
- [State Medicaid program name] (Medicaid) and [state CHIP name] (Children's Health Insurance Program (CHIP)), which are joint federal and state programs that help with medical costs for people with limited income or special health care needs

What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	Next Steps
[First name Last name]	• May be eligible for [state Medicaid program name]	• You will receive a final decision from the [state Medicaid agency name]. If you qualify for [state Medicaid program name], you won't qualify for a tax credit and lower copayments, coinsurance, and deductibles for Health Insurance Marketplace coverage.

If the table above says that you're eligible for a tax credit or cost sharing reductions, it means that we didn't find you eligible for Medicaid. This could be based on several things, like your income, household size, residency, or immigration status among other things. More information on how to appeal an eligibility decision is described in the section of the notice, "What should I do if I think my eligibility results are wrong?".

What should I do next?

- If the table above tells you that you or any of your family members are or may be eligible for [state Medicaid program name] or [state CHIP program name], the state agency will contact you with more information about your health benefits, services and how much you pay for them. If you don't hear from them, call them at the phone number listed in the in the section, "Where can I find more information?"

When will coverage begin?

If you are eligible to purchase health coverage through the Marketplace and you choose a health plan by December 23, 2013, your coverage will start on January 1, 2014. If you don't choose a plan by December 23, then your coverage start date will depend on when you select a health plan.

- Between December 24, 2013 and March 31, 2014, if you choose a health plan by the 15th of the month, your coverage will start on the first day of the following month. If you choose a health plan after the 15th, your coverage will start on the first of the next following month. For example, if you choose a plan on January 16, coverage will not start until March 1.

- You have to pay the first month's premium before your coverage starts.

If you are eligible for [state Medicaid program name] or [state CHIP program name] and you applied between October and December 2013, health coverage will begin no earlier than January 1, 2014. If you applied after January 1, 2014 your coverage will begin in the month your application was received by the Marketplace. If you received health care services during the three months before these dates, contact Medicaid at the phone number including in this notice to see if you are eligible to have those services covered by Medicaid.

What if information from my application changes during the year?

Changes to the information you provided on your application can affect your eligibility for coverage through the Marketplace, including tax credits, plan with lower copayments, coinsurance, deductibles, and coverage through [state Medicaid program name] or [state CHIP program name].

If you're eligible for a tax credit and you don't report a change that may affect your eligibility, you may have to pay back some or all of your tax credit when you file your taxes. If information from your

application changes during the year, you should report the change within 30 days. Contact the Marketplace at the phone number below to report changes that may affect your eligibility.

If you're eligible for [state Medicaid program name] or [state CHIP program name], contact the state agency at the phone number in the section, "Where can I find more information" to report changes.

What should I do if I think my eligibility results are wrong?

If you have received a final eligibility determination and you think we made a mistake, in many cases, you can appeal our decision about your eligibility for health coverage, including Medicaid, CHIP, purchasing health coverage through the Marketplace, a tax credit, cost-sharing reductions, and enrollment periods.

Below is important information to consider when requesting an appeal:

- You have 90 days to request an appeal from the date of this notice.

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.

- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.

- The outcome of an appeal could change the eligibility of other members of your household even if they don't ask for an appeal.

- If we did not find you eligible for Medicaid and you appeal our decision, you will have a choice about whether the Marketplace or your state's Medicaid agency hears your Medicaid appeal. More information about your options is included on the appeals request form. If you write your own letter to appeal a denial of Medicaid eligibility, please specific whether you would like to have your Medicaid appeal heard by the Medicaid agency or the Marketplace.

To request an appeal, you can do one of these things:

- Go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ to find and complete the appeal request form for your state and mail to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY, 40750-0061;

- Call [Marketplace phone number and TTY] and ask for an appeals request form; or

- Mail your own letter requesting an appeal to: Health Insurance Marketplace, 465 Industrial Blvd., London, KY 40750-0061. If you write your own letter please include your name, address, and the reason you are filing an appeal. If you are filing an appeal for someone else (like your child), also include the name of the person for whom you are filing the appeal.

Continuing your Medicaid or CHIP Application

If the table with your eligibility results above tells you that you "May be eligible for [Medicaid program name]" or you "May be eligible for [CHIP program name]" then this section, "Continuing your Medicaid or CHIP Application" DOESN'T APPLY to you, and you don't need to take any action.

This Marketplace application looks at whether you qualify for Medicaid based on many reasons, but if your eligibility results tell you that you're eligible for coverage through the Marketplace, we don't think you qualify for [state Medicaid program name]. Some people may still qualify for [state Medicaid program name] but only [state Medicaid agency name] can make the final decision.

You can ask the [state Medicaid agency name] to continue to review your [state Medicaid program name] application for other ways to qualify for [state Medicaid program name]. There is more information about this in the "Does Medicaid cover special health care needs?" section below. You should also ask [state Medicaid program name] to continue your application if you:

- Need a lot of medical services or have high medical bills, or
- Have a family income close to the [state Medicaid program name] income limit, or you don't agree with the income on your application.

You have 10 days to request that your application by reviewed by your state's Medicaid agency for other ways to qualify for [state Medicaid program name]. If the table above says "May be eligible for [state Medicaid program name]," then the Marketplace has already sent your information to [state Medicaid agency name] and they are reviewing your application.

If you're not sure whether you should ask [state Medicaid agency name] to look at other ways you may qualify, then you should make this request. You can keep your coverage described in this notice while [state Medicaid agency name] reviews your application. If you don't want [state Medicaid agency name] to take another look at your application, then you don't need to take any action. If the table on the first page of this letter said you "May be eligible for [state Medicaid program name]," you will still receive a final decision from the state about this.

To ask the [state Medicaid agency name] to continue to review your application for other ways you may qualify, log into your Marketplace account at HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325) to let us know. If you don't ask for the [state Medicaid agency name] to continue to review your application, your application will no longer be considered, and you will not be able to appeal the fact that you aren't being enrolled in the [state Medicaid program name] program without also appealing your eligibility for tax credits and cost-sharing reductions.

Does Medicaid cover special health care needs?

A person may qualify to get coverage for more health services and pay less for care through [state Medicaid program name] if he or she has special health care needs. For example if a person:

- Has a medical, mental health or substance use condition that limits the ability to work or go to school
- Needs help with daily activities, such as bathing or dressing
- Regularly gets medical care, personal care, or health services at home, an adult day center, or another community setting
- Lives in a long term care facility, group home, or nursing home
- Is blind or
- Is terminally ill

If a person applying for coverage has special health care needs, and wants to see if he or she qualifies, call us at 1-800-318-2596 (TTY: 1-855-889-4325) or log into your Marketplace account at HealthCare.gov/marketplace. If the person already qualified for other health coverage, he or she can keep it while the Medicaid agency decides if he or she qualifies for more coverage through Medicaid.

Where can I find more information?

Visit us online at HealthCare.gov. Or, call the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325). For more information about [state Medicaid program name], contact the [state Medicaid agency name] at [insert state Medicaid agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*]. For more information about [state CHIP program name], contact the [state CHIP agency name] at [insert state CHIP agency phone number (TTY xxx-xxx-xxxx); *if TTY is blank, don't list the TTY*].

Sincerely,

Health Insurance Marketplace
Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

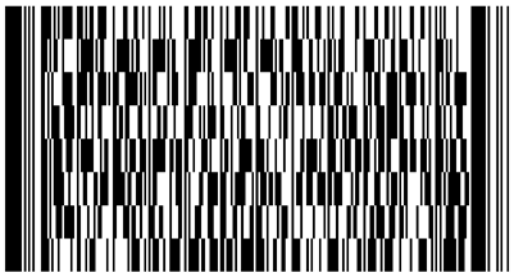
The determinations or assessments in this letter were made based upon 45 CFR 155.305, 155.410, 155.420-430 and 42 CFR 435.603, 435.403, 435.406 and 435.911.

Privacy Disclosure: The Health Insurance Marketplace protects the privacy and security of the personally identifiable information (PII) that you have provided (see https://www.healthcare.gov/privacy/). This notice was generated by the Marketplace based on 45 CFR 155.230. The PII used to create this notice was collected on the application you filled out and from other data sources through the electronic eligibility verification process used to get an eligibility determination for enrollment in a qualified health plan through the Marketplace and for insurance affordability programs. For more information about the privacy and security of your PII, visit HealthCare.gov. The Marketplace may have used data from a

consumer reporting agency to determine eligibility for the individuals on your application. If you have questions about this data, please contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1207. The time required for a health insurance Exchange as defined in CFR 155.20 to generate this information collection is estimated to be 100 hours, including the time to draft appropriate notice text, review the notice, conduct user testing, incorporate changes, ensure compliance with plain writing, language access, and readability standards. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Important: If you mail in your documentation, please include this page in the same envelope, which includes a barcode, along with any documents. This page helps the Marketplace make sure your documents can be easily associated with your application.



[State code], Application ID

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

More information about Tax Credits

What is a tax credit?
A tax credit lowers the monthly cost (called a "premium") you pay for health insurance. In some cases, you may pay no premium if your tax credit covers the entire premium amount. Tax credits help people with incomes too high to qualify for Medicaid or the Children's Health Insurance Program (CHIP), but who still may not be able to afford health coverage.

How do I qualify for a tax credit?
The Marketplace will check your information, such as your income and household size, to see if you qualify for a tax credit. The tax credit is only available if you enroll in coverage through the Marketplace. If you're eligible for Medicare or most other types of health insurance coverage, then you probably don't qualify for a tax credit. If you're eligible for coverage from a job, you can only qualify for a tax credit if your employer doesn't offer affordable health coverage or the coverage doesn't meet a minimum value standard. In addition, your income must be above the limit for Medicaid in your state, but within the limits for a tax credit, which are outlined in the chart below.

Income Limits for Tax Credits

Household size	Income limit	Household size	Income limit
1	$45,960 ($57,400 for Alaska)	4	$94,200 ($117,760 for Alaska)
2	$62,040 ($77,520 for Alaska)	5	$110,280 ($137,880 for Alaska)
3	$78,120 ($97,640 for Alaska)	6	$126,360 ($158,000 for Alaska)

How much of a tax credit can I get?
Your tax credit amount is based on:

- The number of people in your household. Your household includes the person who pays taxes and his or her spouse and dependents,
- The income amount that you expect to put on your on your federal income tax return for 2014, and
- The cost of a "silver level" health plan in your area. A silver level health plan is a plan that provides the set of essential health benefits required for the Marketplace and also covers 70% of health care costs for the average person. You can see the health plans available using our plan finder on healthcare.gov.

Do I have to wait until I file my federal tax return to get the tax credit?
You do not have to wait until you file your federal income tax return to get your tax credit. You can have some or all of your tax credit paid directly by the Federal government to your health plan to reduce the premium for the health plan that you select through the Marketplace. You will make this choice when you choose a plan.

You can decide to enroll in a plan without a tax credit or with less than the full amount, and get the full amount, based on your actual income at the end of the year, when you file your taxes. Even if you don't owe any taxes, you may still be eligible for a tax credit. You need to enroll in a plan

through the Marketplace in order for the IRS to see if you qualify for a tax credit when you file your taxes. If you don't enroll in a plan through the Marketplace, you won't be eligible for a tax credit when you file your federal tax return with IRS (and you may owe a penalty if you don't have qualifying coverage for three months or longer).

I'm not sure what my income for the year will be, so I just guessed on my application. What happens if I'm wrong?

When it's time to file your federal income tax return, the IRS will compare the income from your application with the income you report on your tax return.

- If your income is lower than what you told us on your application, you may receive a tax refund.
- If your income is higher than what you told us on your application, you may have to pay back some of all your tax credit.

If you're worried about owing back any tax credit, you can take a smaller amount of the tax credit to use each month. You can decide how much of the tax credit you want to take when you enroll in a plan through the Marketplace.

What kind of changes do I need to report?

If information from your application changes, you should report the change to us within 30 days of the change occurring. If you don't report changes, you may have to pay back some or all of your tax credit when you file your taxes. Examples of changes you should report include:

- A move
- Household income changes
- Household size changes. For example, someone in your household marries or divorces, becomes pregnant, or has a child
- Becoming qualified for other health coverage
- Changes in immigration status
- Becoming incarcerated, other than pending the disposition of charges
- A change in plan for filing your federal income tax return for 2014; for example, you plan to claim new dependents on your tax return

To report changes, log into your Marketplace account on HealthCare.gov/marketplace, or call 1-800-318-2596 (TTY: 1-855-889-4325).

Will my employer know that I am getting a tax credit?

We're required to notify your employer if you're getting a tax credit or cost-sharing reductions because your employer may need to make a shared responsibility payment. Your employer is not allowed to treat you differently based on your eligibility for a tax credit or cost-sharing reductions. The law prohibits your employer from firing or discriminating against you because you or someone in your household has been determined eligible for a tax credit or cost-sharing reductions. If you believe that you were fired or otherwise discriminated against because you or someone in your household was determined eligible for a tax credit or cost-sharing reductions, you can file a complaint with the U.S. Occupational Safety and Health Administration (OSHA). Visit www.whistleblowers.gov for more information.

If you have questions:

Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

Do I need to apply for a new tax credit every year?
You must renew your tax credit every year. Watch for a letter from us in August or September with information about next year.

More information about Lower Out-of-Pocket Costs

What are copayments, coinsurance, and deductibles?
Copayments, coinsurance, and deductibles are the money you pay toward your share of the cost of your health care. They are also called "cost sharing." Your insurance company pays the rest.

- A copayment is an amount you may be required to pay each time you receive a service, like going to the doctor or getting a prescription. It's usually a set dollar amount, like $20.
- Coinsurance is your share of the costs of a covered health service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.
- A deductible is the amount of money you must spend every year on health care before the plan starts paying. Even after you pay your deductible, you may still be required to pay copayments or coinsurance when you receive services.

How do I qualify for lower copayments, coinsurance, and deductibles?
Your income must be within certain limits in order to also qualify for a Marketplace plan with discounted copayments, coinsurance, and deductibles. Once you qualify, most people must enroll in a "silver level plan" to get lower copayments, copayments, and deductibles.

How does the Marketplace decide what my cost sharing is?
You qualify to enroll in a plan with lower copayments, coinsurance, and deductibles based on:

- Whether you are eligible for a tax credit
- The number of people in your household (the taxpayer and dependents listed on your federal income tax return)
- The income amount that you expect to put on your federal income tax return for 2014
- Whether you are American Indian or Alaska Native and a member of a federally-recognized tribe

More information about Medicaid

Medicaid is health coverage for people with limited income or special health care needs. Medicaid covers services such as doctor visits, laboratory tests and hospital care. Medicaid also covers additional services for children up to a certain age.

Do you have past medical bills?
Medicaid may pay medical bills from the past three months. If you want to see if Medicaid will pay recent medical bills, contact the Medicaid at the number included above in this notice. You may then need to send the Medicaid copies of your unpaid medical bills from the last three months.

How long can I keep my Medicaid health coverage?
You must renew your Medicaid health coverage every year. Watch for a letter in the mail telling you if you need to send Medicaid more information at renewal time.

What if information from my application changes during the year?
Over the next year, you must report any changes that might affect whether you qualify for Medicaid, like if you move, your income changes, or the size of your family changes (for example, if you marry, divorce, become pregnant, or have a child.) To report changes, call the Medicaid agency in your state.

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

Here's a listing of the available languages and the same message provided above in those languages:

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجانا. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace" zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

हिन्दी (Hindi)

आपके पास अपनी भाषा में सहायता व सूचना नि:शुल्क प्राप्त करने का अधिकार है। हेल्थ इंश्योरेंस मार्केटप्लेस (स्वास्थ्य बीमा बाजारस्थल) के बारे में हिन्दी में दुभाषिए से बात करने के लिए 1-800-318-2596 पर फ़ोन करें।

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku.
Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional.
Para falar com um intérprete de [Português] sobre o Mercado
de Seguros de Saúde, ligue para 1-800-318-2596.

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

اردو (Urdu)

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ہیلتھ انشورنس مارکیٹ پلیس کے بارے میں کسی مترجم سے اردو میں بات کرنے کے لئے 1-800-318-2596 پر رابطہ کریں۔

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.

June 2013

If you have questions:
Go to HealthCare.gov/marketplace. Or, call 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free. You can also find out how to talk to someone in person, online or through the help line.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: June 26, 2013

From: Gary Cohen, CMS Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight

Subject: Guidance on Hardship Exemption Criteria and Special Enrollment Periods

Purpose and Scope:
In the final regulation titled, "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions", and published on June 26, 2013, ("Exemptions/MEC final rule"), the Department of Health and Human Services (HHS) finalized provisions concerning how Marketplaces (also known as "Exchanges") will determine eligibility for and grant certificates of exemption from the individual shared responsibility payment described in section 5000A of the Internal Revenue Code.

We noted in the Exemptions/MEC final rule that we would provide further guidance regarding criteria that Federally-facilitated Marketplaces will use for the hardship exemption described at 45 CFR 155.605(g)(1). While State-based Marketplaces may use these criteria, they have the flexibility to develop their own as long as the criteria meet the requirements of the final regulation. We also specified that we would address an individual's ability to enroll in a qualified health plan (QHP) during a special enrollment period in situations in which he or she loses eligibility for an exemption within a coverage year. This guidance is intended to describe the circumstances that Marketplaces may use in determining what constitutes a hardship if they prevent an individual from obtaining coverage under a QHP. It also specifies situations for Marketplaces to consider in determining whether an individual experienced exceptional circumstances that provide eligibility for a special enrollment period.

Hardship
In the Exemptions/MEC final rule, HHS specified at 45 CFR 155.605(g)(1) that a Marketplace must grant a hardship exemption to an applicant if the Marketplace determines that:

1. He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan;

2. The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing, or other necessities;

3. He or she experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan.

We clarify that Marketplaces may consider the following circumstances in determining what constitutes a hardship under 45 CFR 155.605(g)(1) if they prevent an individual from obtaining coverage under a QHP, which include an individual who--

- becomes homeless;
- has been evicted in the past six months, or is facing eviction or foreclosure;
- has received a shut-off notice from a utility company;
- recently experienced domestic violence;
- recently experienced the death of a close family member;
- recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to the individual's property;
- filed for bankruptcy in the last 6 months;
- incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt;
- experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member;
- is a child who has been determined ineligible for Medicaid and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide medical support. We note that this exemption should only be provided for the months during which the medical support order is in effect; or
- as a result of an eligibility appeals decision, is determined eligible for enrollment in a QHP through the Marketplace, advance payments of the premium tax credit, or cost-sharing reductions for a period of time during which he or she was not enrolled in a QHP through the Marketplace, noting that this exemption should only be provided for the period of time affected by the appeals decision.

Special Enrollment Periods

In the proposed regulation titled, "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule" (78 FR 4647), and published on January 22, 2013, 45 CFR 155.420(d)(9) proposes a special enrollment period when:

> - The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

In accordance with this provision, HHS provides the following guidelines for Marketplaces to use in determining whether an individual meets such exceptional circumstances and is thus entitled to receive a special enrollment period:

1. If an individual receives a certificate of exemption from the Marketplace based on the eligibility standards described in 45 CFR 155.605(g)(1) for a month or months during the coverage year, and based on the circumstances of the hardship attested to, he or she is no longer eligible for a

hardship exemption within a coverage year but outside of an open enrollment period described in 45 CFR 155.410, the Marketplace will determine the individual and his or her dependents, as proposed in 45 CFR 155.420(a)(2), eligible for a special enrollment period if otherwise eligible for enrollment in a QHP; and

2. If an individual with a certificate of exemption reports a change with respect to the eligibility standards for an exemption as required under 45 CFR 155.620(b), and the Marketplace implements a change resulting from a redetermination, the certificate provided for the month in which the redetermination occurs, and for prior months, remains effective. If the Marketplace notifies the individual that he or she is no longer eligible for an exemption, the Marketplace will determine the individual and his or her dependents, as proposed in 45 CFR 155.420(a)(2), eligible for a special enrollment period if otherwise eligible for enrollment in a QHP.

We appreciate the ongoing partnership with State-based Marketplaces to ensure the effective implementation of the Affordable Care Act. We will update State-based Marketplaces with any additional guidance regarding the hardship exemption and special enrollment periods. Please feel free to contact your CCIIO State Officer with any questions regarding this guidance.

Processing applications: Multi-tax households

The Issue: Multiple Tax Households

- Families who are seeking help paying for coverage – advance payments of the premium tax credit, cost sharing reductions, Medicaid or CHIP
- For eligibility, the Marketplace will ask for each applicant's tax filing status and who will be on their 2014 tax return.
- Some households file more than one tax return (Examples: Domestic partners, Parents with children who file taxes)
- Current system limitations prevent people on separate tax returns from enrolling in a plan together

The Solution

- **Step 1**: Determine whether the application filer is applying for help paying for coverage. If yes, continue to 2.
- **Step 2**: Determine if they are filing more than one tax return. If yes, continue to 3.
- **Step 3**: Assist them by either calling the call center OR helping them complete separate applications

Determining a multi-tax household

- Identify the people in the household and their plans for filing taxes for 2014
  - Do you plan on filing a federal income tax return for 2014?
  - If married, do you plan to file jointly with your spouse?
  - Will you claim any dependents?
  - Does anyone file taxes separately?
- Figure out the people on the different tax returns and whether there's more than one
- If more than one, call the call center OR assist with submitting separate applications

Completing separate applications

- Submit one application per tax household
  - Need separate user accounts for each application
- List each tax household as applicants on only ONE application
  - List the other household members as non-applicants on the application
- Each application group will be on their own health plan policy, but can still select the same plan, if they choose to.

Scenario 1

- Two domestic partners (Jane and Joe) and their two children (Sue and Billy) are applying for help paying for health coverage.
- Jane claims Sue as a dependent on her tax return. Joe claims Billy as a dependent on his tax return.
- Application 1: Jane is the application filer
  - List Jane and Sue as applying for coverage
  - List Joe and Billy as non-applicants
- Application 2: Joe is the application filer
  - List Joe and Billy as applying for coverage
  - List Jane and Sue as non-applicants

Scenario 2

- Mary lives with her 18 year old child Julie.
- Mary and Julie file separate tax returns. Mary does not claim Julie as a dependent on her return.
- Application 1: Mary is the application filer
  - List Mary as applying for coverage
  - List Julie as a non-applicant
- Application 2: Julie is the application filer
  - List Julie as applying for coverage
  - List Mary as a non-applicant

Key points to remember

- Identify how a household plans to file taxes
- If the household plans to file more than one tax return, call the call center for help OR submit separate applications for each

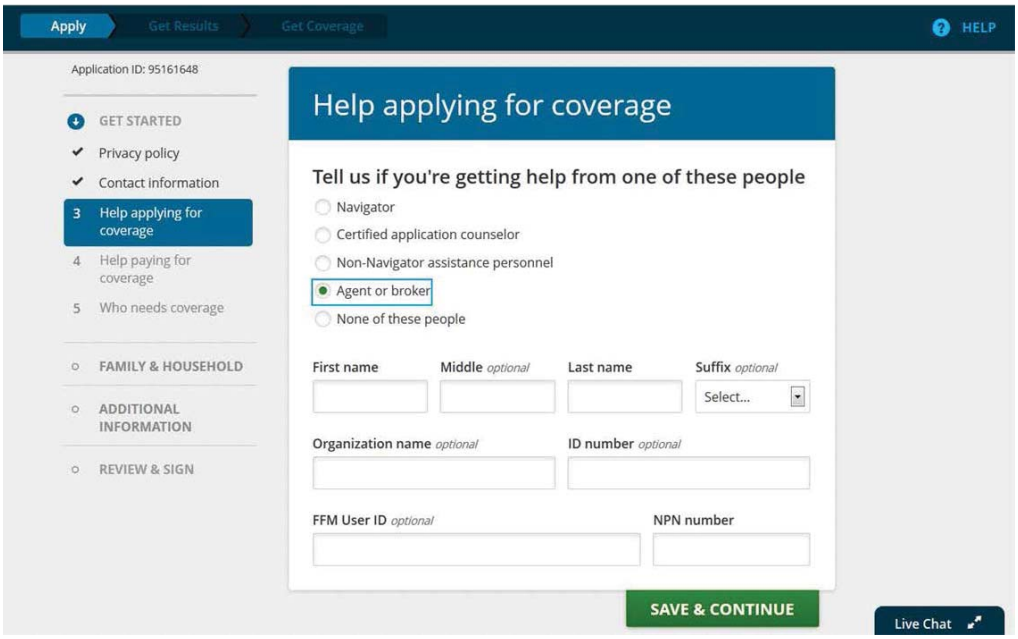
Tips for Assisting Consumers with Applications

Eligibility Application Tips

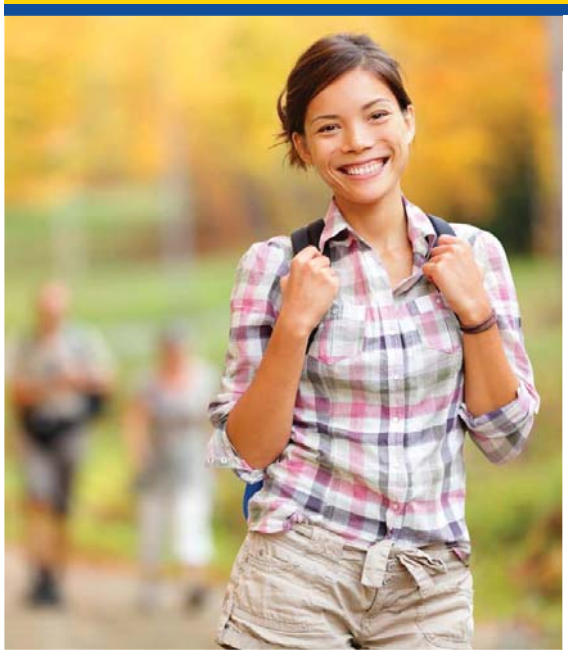
- For financial assistance, include people on the same tax return and family members who live together on the application
- Include everyone in the household, even if they don't need health coverage
- Most questions are required; labeled optional if not
- Best to check information is correct before moving to next page to avoid going backwards or editing information
- Do not click buttons multiple times; the system often pings data sources between pages and may take a few seconds depending on volume

Don’t Forget: Include Producer Information When Using Marketplace Pathway

When assisting a consumer with the eligibility application through HealthCare.gov, be sure the consumer accurately completes this page.



Overview of the New Change in Circumstances Functionality

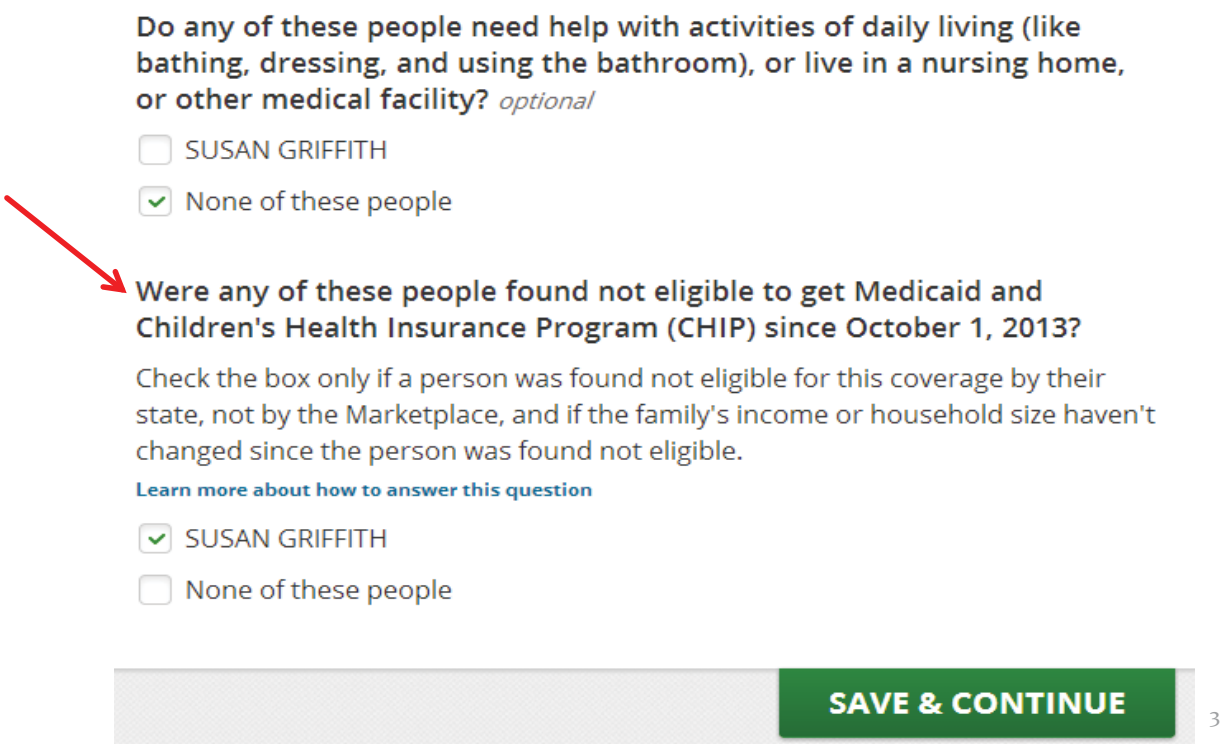


February 21, 2014

Agenda

- Medicaid/CHIP Block question to prevent looping on all applications
- Functionality to Report Changes
- Special Enrollment Periods
- Reported Changes and Account Transfers
- Next Steps
- Q&A

New question can block Medicaid/CHIP to prevent "loopers"



Help Text– available at:

https://www.healthcare.gov/help/found-not-eligible-for-medicaid

Select "None of these people" if no one on your application applied for Medicaid or CHIP since October 1, 2013.

Don't check the box if any of these apply to a person on your application:

- Hasn't applied for Medicaid or CHIP before
- Got a Medicaid or CHIP denial, but had recent changes in income or family size. See below for more information about income or family size changes.
- Was denied Medicaid or CHIP coverage before October 1, 2013
- Applied for Medicaid or CHIP but hasn't received a response yet
- Was denied Medicaid or CHIP because of the results of a disability determination or because of having too many assets
- Was denied Medicaid or CHIP coverage because the family didn't turn in paperwork that the state asked for.

Help Text- continued

Check the box if any of these apply to a person on your application:

- Had their Medicaid coverage end because of a change in state rules
- Was denied coverage by the state because their income is too high for Medicaid and CHIP
- Was denied coverage by the state because their immigration status doesn't qualify for Medicaid and CHIP
- Was denied Medicaid and CHIP because their state doesn't cover people with their household type
- Was told by the state that their current Medicaid or CHIP coverage will end within the next month
- Is a child denied by the state because he or she needs to wait for a month or more before starting CHIP coverage

Help Text- continued

- Recent income changes

When this list suggests that you don't check the box if there's been a change in income, it means that you should select "None of these people" if your household makes less money now than at the time the Medicaid agency sent the denial. For example, if anyone in your household lost their job, had their hours or wages at work cut, or stopped getting unemployment benefits or another taxable income source, select "None of these people."

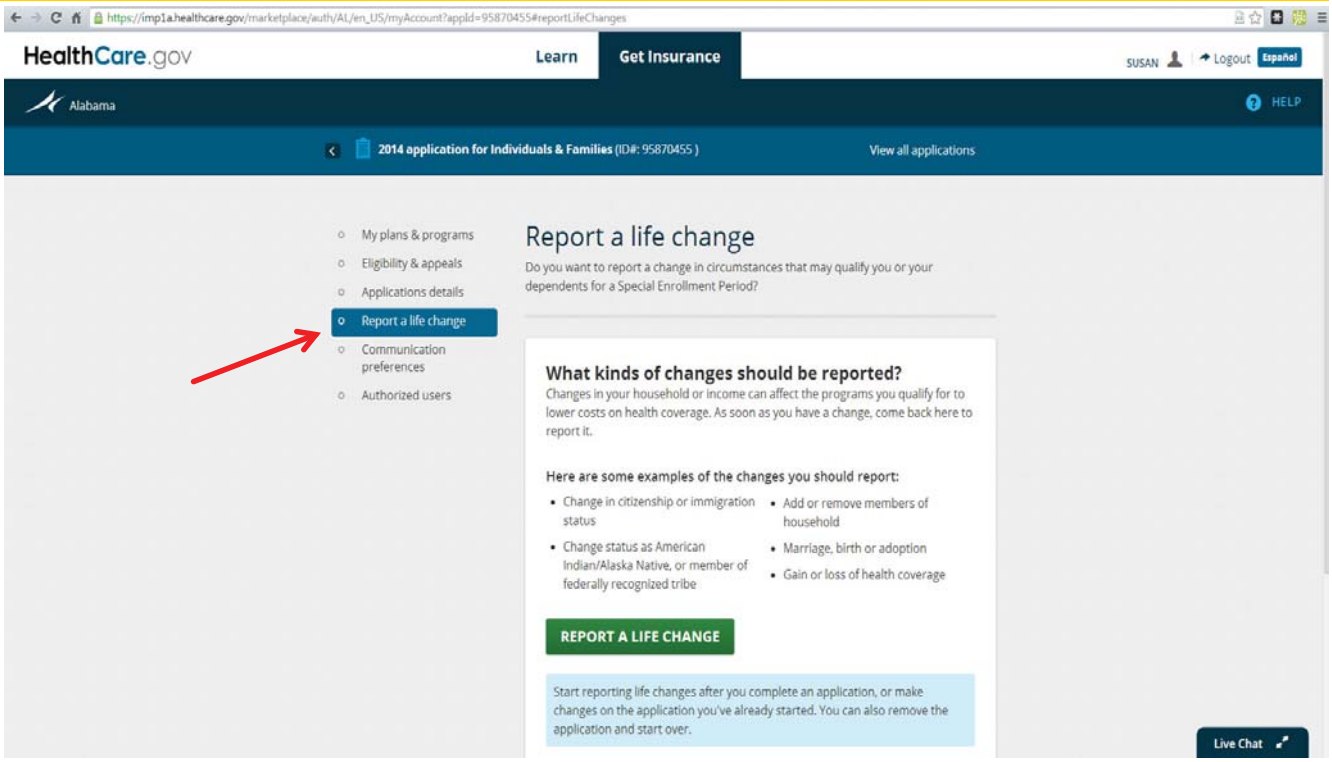
- Recent family size changes

When this list suggests that you don't check the box if there's been a change in household size, it means that you should select "None of these people" if, since the time that you were denied Medicaid by the state, you or another household member got married, had a baby, adopted a child, became pregnant, or started claiming someone new as a dependent on your tax return.

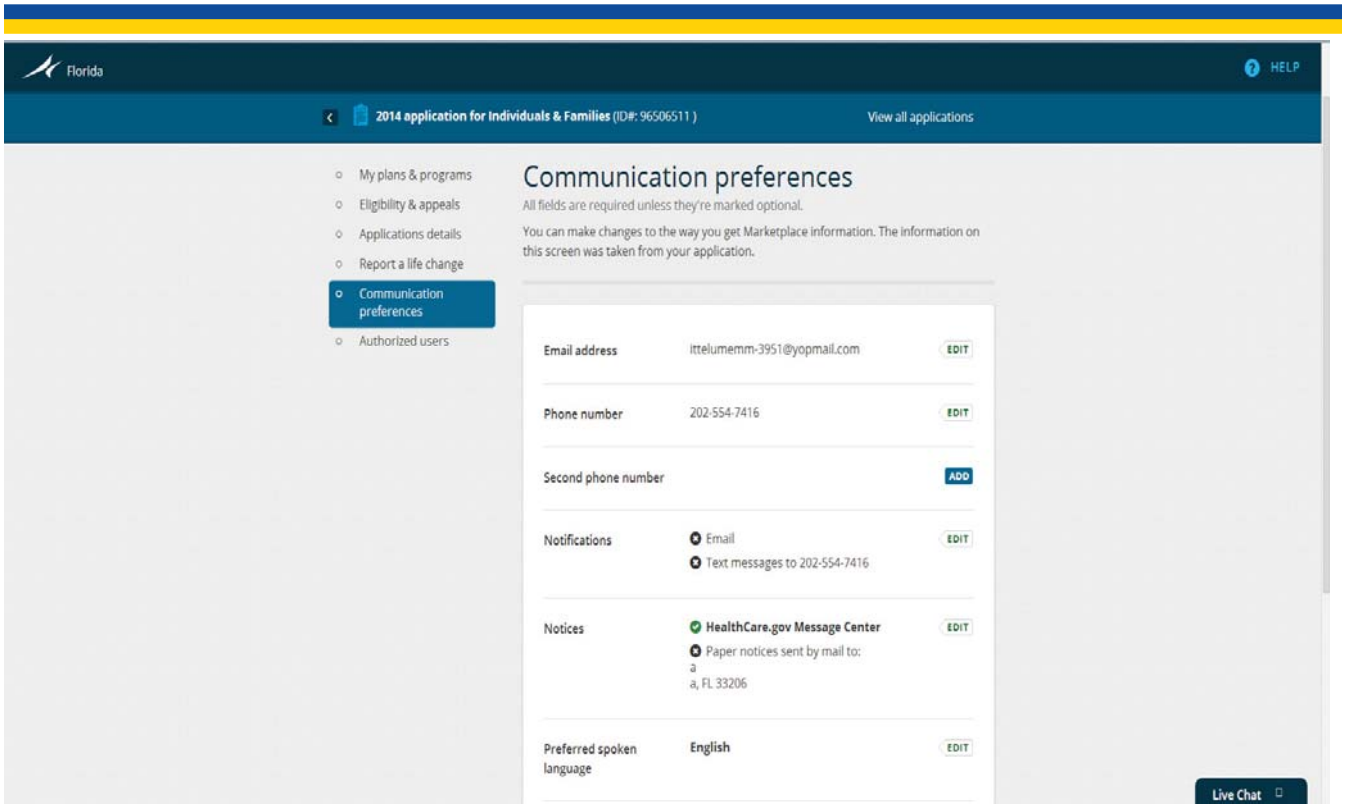
Reportable Changes

Type of Life Change/Change in Circumstance
New person on the application (e.g., birth, marriage)
Moves
Loss of access to other coverage (e.g., employer coverage)
Release from incarceration
Change in citizenship or immigration status
Removal of a person from the application (e.g., death, divorce)
Become incarcerated
New access to other coverage (e.g., employer coverage)
Pregnancy
Change in tax filing status/tax household composition
Change in status as an American Indian/Alaska Native or tribal status
Change in disability status
Correction to name, date of birth (DOB), or Social Security number (SSN)
Increase or decrease in income
Change in contact information, like: • Email address • Phone number • Add or remove phone text alert • Mailing of paper notices

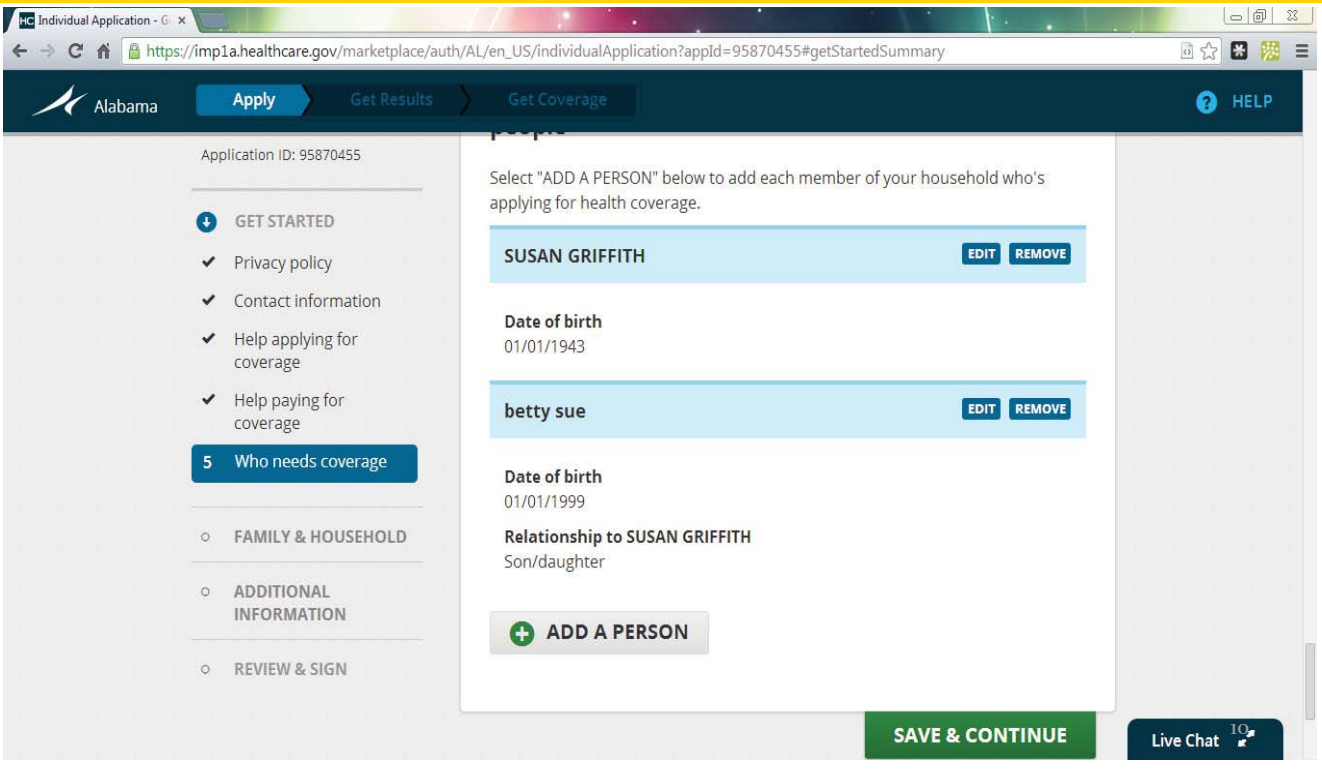
Consumers report changes from within their accounts



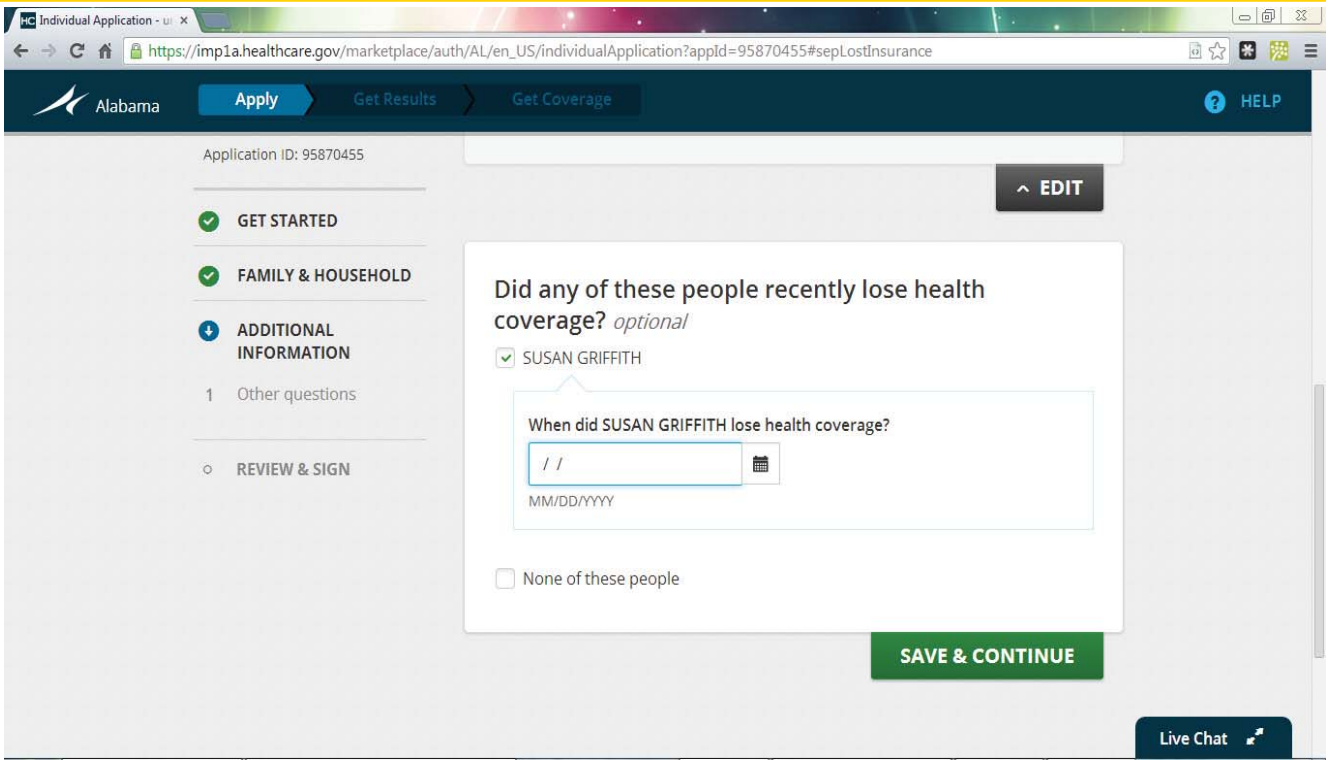
Changes to Communication Preferences are not sent to the State Agency



Consumers reporting changes that affect eligibility enter a pre-populated version of their application



Consumers answers questions that determine their eligibility for an SEP



If the consumer is eligible for QHP and an SEP, their determination notice will contain SEP eligibility language

Dear SUSAN:

Thank you for reporting a change in circumstance to the Marketplace.

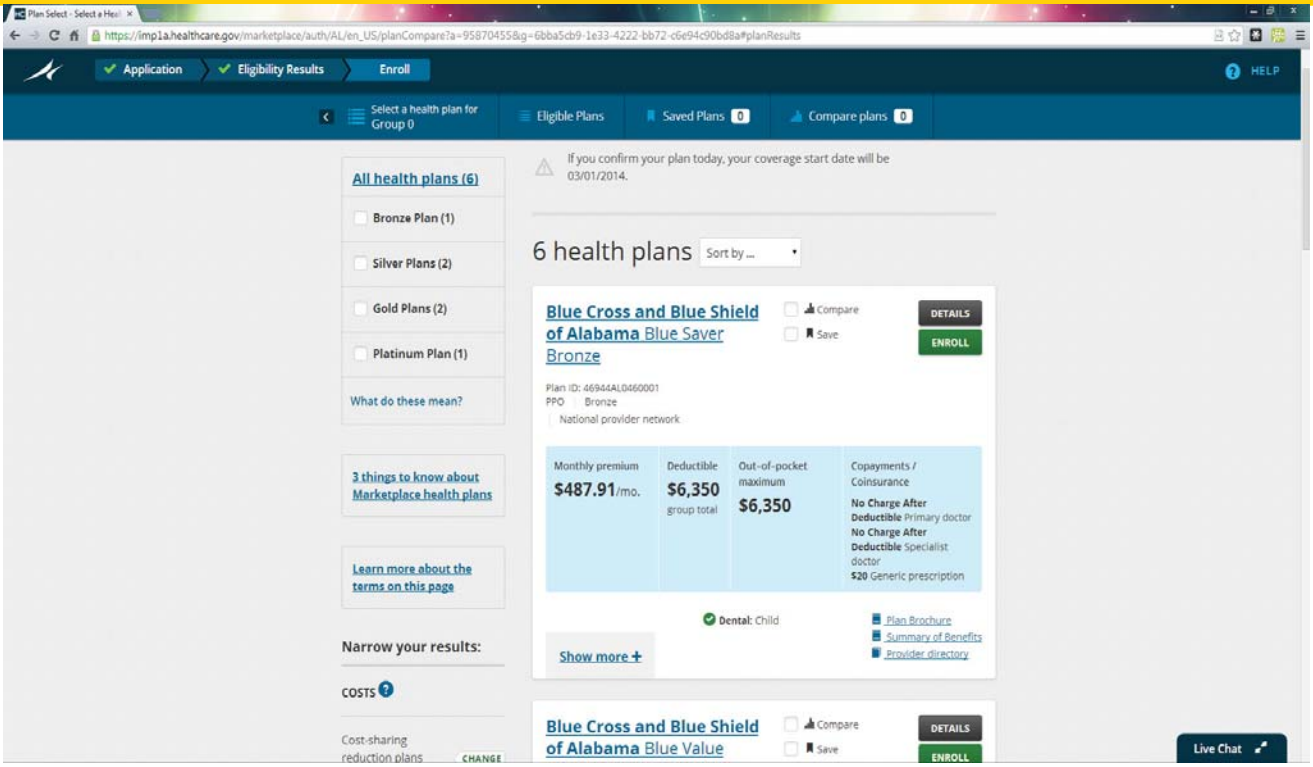
What are the results of my application?

Review the table below with your eligibility results.

Family Member(s)	Results	
SUSAN GRIFFITH	• Eligible for a special enrollment period	
SUSAN GRIFFITH	• Eligible to purchase health coverage through the Marketplace, but more information is needed	•

- If the table above says you are eligible for a special enrollment period, April 7, 2014 is the last day to choose a health plan. To make a selection, visit HealthCare.gov/marketplace to compare health plans side by side, or call 1-800-318-2596 (TTY: 1-855-889-4325).
- If you miss the deadline, you may not be able to enroll in a health insurance plan through the Marketplace until the next open enrollment period, starting November 15, 2014, unless you qualify for another special enrollment period.

Consumers eligible for SEPs can select any available QHP in their service area.



Reported Changes and Account Transfers to States: Scenario 1

Scenario 1: The FFM assesses or determines an applicant as ineligible for Medicaid/CHIP. The individual then reports a change to the FFM, and after re-running eligibility, the FFM assesses or determines the applicant to be eligible for Medicaid/CHIP.

Next Steps:

- The FFM transfers the account to the state reflecting the information submitted when the applicant reported the change.
- The state agency determines if the applicant already has a record and creates/updates the applicant's record.
- Assessment states apply additional eligibility rules and verification procedures, as applicable, and makes an eligibility determination.
- The state agency sends eligibility decision/enrollment information back to the FFM, through the Hub, if applicable.

Reported Changes and Account Transfers to States: Scenario 2

Scenario 2: The FFM assessed or determined an individual as eligible for Medicaid/CHIP, then later, the applicant reports a change to FFM. The FFM re-runs eligibility, and finds that applicant continues to be eligible for Medicaid/CHIP.

FFM Action:

- The FFM transfers two separate accounts to the state: the first to reflect the initial finding, and the second to reflect the full information after the change.
- If the state is already receiving outbound account transfers from the FFM, then these two transfers will occur sequentially as the FFM processes the applicant's eligibility.
- If a state is not yet ready to receive accounts from the FFM, both accounts will be queued. When States are ready to receive outbound account transfers from the hub, the FFM will send all queued account transfers.
- The state can link the two accounts by the application ID. CMS is working on a potential change to the outbound AT header.

Reported Changes and Account Transfers to States: Scenario 2

Next Steps for the state:

- States initiating account transfers for the first time may process the most recent accounts first to use the most updated information, but would need to check for any earlier account information for this individual to use the appropriate effective date to start coverage.
- Upon receiving an account transfer, states that have already been actively receiving accounts should determine if the transferred applicant already has a record and create or update the applicant's record.
- Assessment states apply additional eligibility rules and verification procedures, as applicable, and make an eligibility determination.
- The state agency sends eligibility decision/enrollment information back to the FFM, through the Hub, if applicable.

Reported Changes and Account Transfers to States: Scenario 3

Scenario: The FFM assessed or determined an individual as eligible for Medicaid/CHIP, the applicant reports a change which results in the applicant being assessed or determined ineligible for Medicaid/CHIP.

Next Steps:

- Because it has already been flagged for transfer, the FFM transfers the first account to the state. The FFM does not transfer the second account to the state with the new information, as the account transfer logic is generally set up to communicate to a state when someone is assessed, determined, or referred to Medicaid or CHIP based on the current eligibility determination. We are currently working to add functionality to communicate Medicaid/CHIP denials to states when they result from consumer reported changes.

Reported Changes and Account Transfers to States: Scenario 3

Next Steps:

- Upon receiving the first transfer, the state agency determines if the applicant already has a record and creates/updates the applicant's record.
- Assessment states apply additional eligibility rules and verification procedures, as applicable, and makes an eligibility determination based on the initial account that was transferred.
- The state agency sends eligibility decision/enrollment information back to the FFM, through the Hub, if applicable.
- The FFM will terminate QHP eligibility if the applicant is found by the state to be eligible for Medicaid.
- States that receive updated accounts for a family member of a beneficiary or a transferred applicant may use the updated household information to trigger a redetermination of eligibility for other family members who were not transferred themselves with updated information in accordance with 42 CFR 435.916.

Q&A on Medicaid Block

Q1: Will applicants who are blocked from Medicaid and CHIP receive a Medicaid and CHIP denial with appeal rights?

A1: No. Applicants who are blocked from Medicaid and CHIP should have already received an appealable denial from the state agency. That is why they are being blocked from Medicaid and CHIP at the FFM.

Q2: Which applicants should State Medicaid and CHIP agencies direct to call or log on to the FFM in order to report a change and answer the "Medicaid block" question?

A2: Applicants who were transferred from the FFM to the state, but who the state finds to be ineligible, should be directed to report a change and check their name on the Medicaid block question in order to get an APTC determination and select a plan before the end of open enrollment. Other applicants, when denied by the state Medicaid or CHIP agency, and potentially eligible for APTC, may be advised to pay attention to this question if they begin a new application at the FFM, or had already started an application at the FFM.

Q&A on Medicaid Block

Q3: Will children be able to enroll in one Qualified Health Plan (QHP) with their parents if such children are newly assessed APTC eligible after reporting a recent Medicaid and CHIP denial?

A3: Yes. The new functionality would allow all members on the application to select the same plan or change plans, and would ensure that children who have been denied Medicaid and CHIP would be able to join their parents.

Q&A on Reported Changes

Q4: Does the Medicaid/CHIP block question replace the processing of account transfers from states to the FFM?

A4: No, this question is a temporary mitigation due to unforeseen delays in account transfer processing at the FFM. The FFM will begin processing inbound Account Transfers imminently, and when inbound account transfers are processed, they will automatically trigger a block on Medicaid and CHIP eligibility so the applicant is only considered for APTC and QHP eligibility.

Q5: Does an application retain the same Application ID after a change is reported?

A5: Yes.

Q&A on Reported Changes

Q6: What is the full list of changes which do not cause the FFM to re-run eligibility, such as address and phone number changes?

A6: Currently: name, email, phone #, address within same zip code/county, contact method preference, authorized rep changes

Q7: What FMAP would states receive for applicants who were transferred to the state twice, at two different income levels?

A7: Whatever the corresponding FMAP is for the eligibility group that the applicant was enrolled for, respectively.

Q&A on Reported Changes

Q8: If the state enrolls someone based on information in the AT, and it turns the AT had wrong information and that person should not have qualified for Medicaid, will the federal government pay 100% of the costs of that temporary enrollment? Or will they only pay at the FMAP that would apply for that eligibility category?

A8. States that use federally supplied data to enroll individuals will receive federal Medicaid match based on that data (and any additional data collection or verification they do as part of their eligibility process, if an assessment state). If that federal data results in a person being enrolled in the new adult category, and their expenditures are claimed at either the 100 percent "newly eligible" match or the enhanced "expansion state" match based on that information, federal funding is not at risk. So long as states follow appropriate procedures to enroll and claim relying on that information, the federal government will take no reduction in the match even if the assessment or determination is ultimately determined to be incorrect (including that the individual should have been enrolled at regular match in another category, or was ineligible).

If the federal data results in an individual being enrolled in a category receiving regular match, and later information determines that the individual should have been enrolled as an adult receiving newly eligible match, the state may revise its claiming to receive the higher matching rate. If, however, later information reveals the individual was actually ineligible for Medicaid, no change in federal match would occur. At all times, if information comes to the attention of the state that errors in account processing have occurred (whether generated by federal or state systems or processes), timely action should be taken to act on that information so as to ensure proper program enrollment and federal claiming.

Next Steps

- Additional updates on defects
- Guidance on processing of outbound ATs
- More information about FFM AT processing

HHS Intergovernmental and External Affairs Notification

March 26, 2014

From: Paul Dioguardi
Director, Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services

RE: Special Enrollment Periods in the Marketplace -- Countdown to Coverage/End of Open Enrollment

The deadline for open enrollment is March 31st. As the Administration said previously, those consumers who are in line by the March 31st deadline to complete enrollment, we will make sure you get covered. Just like Election Day, if you are in line when the polls close, you get to vote. We won't close the door on those who tried to get covered and were unable to do so through no fault of their own. So, those who were in line or had technical problems with the website can quickly come back and sign up as soon as possible.

Additionally, CMS also is clarifying that under limited circumstances, people with complex cases may qualify for a special enrollment period. These include, for example, victims of domestic abuse and consumers who were found ineligible for Medicaid, but whose accounts were not transferred to the Marketplace in a timely way before March 31. These special cases are for specific situations where a consumer was not able to successfully complete enrollment during the open enrollment period despite their efforts to do so and through no fault of their own.

Guidance for Issuers on People "In Line": http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf
Guidance for Issuers on Complex Cases: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf
Assister Tips In Line: http://marketplace.cms.gov/help-us/assisting-consumers-march-31.pdf
Assister Tips Complex Cases: http://marketplace.cms.gov/help-us/complex-cases-sep.pdf

Date: March 26, 2014

From: Center for Consumer Information and Insurance Oversight,
Centers for Medicare & Medicaid Services

Title: Affordable Exchanges Guidance

Subject: Guidance for Issuers on People "In Line" for the Federally-facilitated Marketplace at the end of the Initial Open Enrollment Period

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The law and regulations provide for special enrollment periods (SEPs), which are described in 45 CFR 155.420(d) and include, for example, life changes and errors in enrollment. Special enrollment periods permit individuals to enroll in a qualified health plan outside of open enrollment. This guidance describes treatment for consumers in the Federally-facilitated Marketplaces who are "in line" as of March 31.

CMS anticipates that high consumer traffic across various consumer enrollment channels (such as HealthCare.gov or the Marketplace call center) leading up to the March 31 deadline could potentially keep consumers from completing the enrollment process despite their efforts to meet the deadline. Should this occur, CMS will provide consumers who tried to enroll during the open enrollment period, but did not complete the process by March 31, a limited amount of additional time to finish the application and enrollment process.

Provided that consumers who were "in line" pay their first month's premium by the deadline set by their chosen insurance company, we anticipate that enrollments made in the limited time after March 31 will have a May 1 coverage effective date. This is the coverage effective date that consumers would have had if they were able to complete enrollment by March 31 and is the normal effective date for enrollments between March 16 and April 15. As noted above, existing regulations allow consumers who have life changes, who have experienced errors, or who meet other criteria to be granted SEPs, allowing them to enroll or change coverage.

CMS will process information related to paper applications received by April 7 to capture those consumers who were "in line" with paper applications or whose applications were pending submission or review of supporting documentation on March 31. These consumers will be able to select a plan through April 30 to allow them time to receive an eligibility notice, and the coverage will also be effective May 1. Issuers will receive direction to effectuate accelerated effective dates for this group of consumers through the Health Insurance Casework System (HICS).

Consistent with previous CMS guidance, consumers who receive a special enrollment period for being "in line" by March 31 and select new coverage within the timeframes outlined in this guidance will be able to claim a hardship exemption from the shared responsibility payment for the months

prior to the effective date of their coverage, because they will be treated as if they had enrolled in coverage by March 31.

This guidance applies to the Federally-facilitated Marketplace, including State Partnership Marketplaces, and works in conjunction with previously published guidance on SEPs. State-based Marketplaces may elect to offer similar SEPs.

Date: March 26, 2014

From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Affordable Exchanges Guidance

Subject: Guidance for Issuers on Special Enrollment Periods for Complex Cases in the Federally-facilitated Marketplace after the Initial Open Enrollment Period

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CMS will provide the following special enrollment periods for consumers to enroll in Marketplace coverage after open enrollment closes on March 31. These special enrollment periods include special enrollment periods the Federally-facilitated Marketplace (FFM) is currently processing that allow a consumer to select a plan outside of the open enrollment period, including life changes, benefit display errors, misrepresentation and some exceptional circumstances. Special enrollment periods are authorized under 45 CFR 155.420.

The special enrollment periods in the chart below represent categories of individuals that CMS has determined eligible for an special enrollment period under paragraphs (d)(4), (d)(9), and (d)(10) of 45 CFR 155.420. Categories that warrant special enrollment periods may be added in the future if other appropriate circumstances, as determined by CMS, become known.

Limited Circumstance Special Enrollment Periods	Description	Examples
Exceptional Circumstances	A consumer faces exceptional circumstances as determined by CMS, such as a natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.	• A natural disaster, such as an earthquake, massive flooding, or hurricane. • A serious medical condition, such as an unexpected hospitalization or a temporary cognitive disability • A planned Marketplace system outage, such as SSA system outage
Misinformation, Misrepresentation, or Inaction	Misconduct by individuals or entities providing formal enrollment assistance (like an insurance company, Navigator, certified	• Representative enrolled a consumer in a plan that the consumer did not want to enroll in

	application counselor, Call Center Representative, or agent or broker) resulted in one of the following: • A failure to enroll the consumer in a plan • Consumers being enrolled in the wrong plan against their wish • The consumer did not receive advanced premium tax credits or cost-sharing reductions for which they were eligible.	
Enrollment Error	Consumers enrolled through the Marketplace, but the insurance company didn't get their information due to technical issues.	• Consumer's information is received by the insurance company and may be processed, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer. • Consumer's application may have been rejected by the issuer's system because of errors in reading the data.
System errors related to immigration status	An error in the processing of applications submitted by immigrants caused the consumer to get an incorrect eligibility result when they tried to apply for coverage.	• Immigrants with income under 100% of the poverty line who are eligible for premium tax credits and cost-sharing reductions did not receive the proper determination.
Display Errors on Marketplace website	Incorrect plan data was displayed at the time the consumer selected the QHP, such as plan benefit and cost-sharing information.	• Data errors on premiums, benefits, or co-pay/deductibles. • Errors that resulted in the display of a QHP to applicants that were outside of the QHP's service area or that were in ineligible enrollment groups. • Errors that didn't allow consumers with certain categories of family relationships to enroll together in a single plan with their family members.
Medicaid/CHIP - Marketplace transfer	Consumers who were found ineligible for Medicaid or CHIP and their applications weren't transferred between the State Medicaid or CHIP agency and the Marketplace in time for the consumer to enroll in a plan during open enrollment.	• Consumers, who applied at the FFM, were assessed eligible for Medicaid or CHIP, were found ineligible for Medicaid or CHIP by the state agency and then weren't transferred back in time for an FFM determination during open

		enrollment. • Consumers who applied at the state Medicaid or CHIP agency during open enrollment and ended up having their cases referred to the Marketplace after a denial of Medicaid or CHIP.
Error messages	A consumer is not able to complete enrollment due to error messages.	• Error or box screen indicating that the data sources were down and they could not proceed with enrollment.
Unresolved casework	A consumer is working with a caseworker on an enrollment issue that is not resolved prior to March 31st.	• Consumers who began the case work process but it was not resolved prior to the end of open enrollment.
Victims of domestic abuse	A consumer who is married, and is a victim of domestic abuse. Consumers who are in this category can apply and select a plan through May 31, 2014.	• Prior to clarifying guidance from Treasury and HHS, consumer assumed or was informed that APTC were unavailable to consumers who are married and not filing a joint tax return. Consumer may or may not have attempted to apply.
Other system errors	Other system errors, as determined by CMS, which hindered enrollment completion.	

Generally, CMS has determined that these special enrollment periods will result in prospective coverage effective dates.[1] For the SEPs addressed here, 45 CFR 155.420(b)(2)(iii) allows for SEP coverage effective dates to be based on either the date of the event that triggered the SEP or the regular prospective effective dates described under 45 CFR 155.420(b)(1), in accordance with guidelines issued by HHS. In cases where it is unknown when a consumer would have effectuated coverage, CMS believes that providing coverage according to the regular effective dates is appropriate.[2]

[1] See 155.420(b) and 155.420(b)(2)(iii)(B).

[2] CMS has no way to definitively know when a consumer impacted by these errors would have effectuated coverage had they not faced the barrier triggering the SEP since there are various steps that need to occur after plan selection before coverage is effectuated (i.e., paying premiums).

Assisting consumers who are trying to enroll by March 31? We can help.

We know you are working hard to finish enrolling consumers for coverage in the Health Insurance Marketplace. Although we are enrolling more consumers every day, CMS anticipates that high traffic across consumer enrollment channels (i.e., HealthCare.gov, CuidadoDeSalud.gov, or the Marketplace Call Center) leading up to the March 31 deadline could potentially keep consumers from completing the enrollment process despite their efforts to meet the deadline. If a consumer is "in line" and has tried to enroll through the website, our Call Center, or a state Medicaid or Children's Health Insurance Program (CHIP) agency by the March 31 enrollment deadline for coverage in 2014, we will help make sure they can complete the application process in order to get covered.

Sometimes, despite your best efforts, you may run into delays caused by heavy traffic to HealthCare.gov or our Call Center, maintenance periods, or another issue that prevents you from helping consumers finish the process on time. If this happens, don't worry – we will take steps to get individuals affected by these issues insured in 2014.

If you are still in the process of trying to enroll consumers when Open Enrollment ends on March 31 and can't finish, keep trying. If consumers are "in line" working on the application process by March 31, they will have a chance to complete their enrollment.

After March 31, assisters should help these "in line" consumers complete their applications either online at HealthCare.gov or CuidadoDeSalud.gov or through the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). Individuals applying online must attest that they tried to enroll in coverage through either the Health Insurance Marketplace or a state Medicaid or CHIP agency, either online or over the phone, by March 31, 2014, and didn't complete enrollment in Marketplace coverage because of a problem that wasn't their own fault. If people you are assisting call the Call Center, be sure that they tell the customer service representative that they've been trying to enroll the consumer and explain why they couldn't finish by the March 31 deadline. Information related to paper applications will be processed if they are received by April 7 to ensure that consumers who were "in line" with paper applications and supporting documentation on March 31 are able to complete enrollment.

Other reminders:

- If you continue to experience difficulty enrolling consumers due to system errors, please contact the Call Center and continue to keep a record of those issues and tell the Marketplace about them, as you have been doing for the past several months.
- If you are assisting a consumer who is waiting to receive an eligibility notice via U.S. mail, we suggest that consumers utilize the Call Center to learn the status of their application. If the Call Center is not able to identify the status of the application, consumers should consider starting a new application online or through the Call Center, attesting that they had problems doing so on or before March 31. These consumers are considered "in line" by March 31.
- Finally, if you are assisting a consumer who is not able to successfully pass identity proofing by answering the identity proofing questions on HealthCare.gov or by working with the Experian Help Desk, we recommend the consumer upload documents to their HealthCare.gov My Account as soon as possible. These consumers are considered "in line" by March 31.

Thank you again for your dedication and support in enrolling consumers, many for the first time, in health coverage.

Helping Consumers with Complex Cases Enroll in Special Enrollment Periods in the Health Insurance Marketplace

Open enrollment for 2014 Marketplace coverage will end on March 31, 2014. A Special Enrollment Period allows a consumer to enroll in health coverage outside of the open enrollment period and have it be effective for that coverage year. For instance, if a consumer has a qualifying life event like having a baby or getting married, they can enroll in or change coverage outside of the open enrollment period. Visit www.healthcare.gov/how-can-i-get-coverage-outside-of-open-enrollment to learn more about these qualifying life events.

This fact sheet describes other limited circumstances, beyond qualifying life events, which consumers may experience related to system errors which make them eligible for an SEP. Depending on a consumer's situation they may be eligible for a Special Enrollment Period in specific circumstances that blocked them from enrolling in coverage.

Limited Circumstances Special Enrollment Period Descriptions

There are several systems issues that may have prevented timely application submission, produced incorrect eligibility determinations, or hindered enrollment in the Marketplace during the initial open enrollment period. A consumer's problem may not have been resolved in time to allow enrollment before March 31. Special Enrollment Periods for these issues will ensure that consumers will have an opportunity to get Marketplace coverage for 2014.

If a consumer experiences any of these circumstances, the Marketplace may be able to provide a Special Enrollment Period allowing the consumer to enroll in coverage through the Marketplace. Circumstances that may allow for a Limited Circumstance Special Enrollment Period include:

Limited Circumstance Special Enrollment Periods	Description	Examples
Exceptional Circumstances	A consumer faces exceptional circumstances as determined by CMS, such as a natural disaster, medical emergency, and planned system outages that occur on or around plan selection deadlines.	• A natural disaster, such as an earthquake, massive flooding, or hurricane. • A serious medical condition, such as an unexpected hospitalization or a temporary cognitive disability • A planned Marketplace system outage, such as SSA system outage

Health Insurance Marketplace

Misinformation, Misrepresentation, or Inaction	Misconduct by individuals or entities providing formal enrollment assistance (like an insurance company, Navigator, certified application counselor, Call Center Representative, or agent or broker) resulted in one of the following: • A failure to enroll the consumer in a plan • Consumers being enrolled in the wrong plan against their wish • The consumer did not receive advanced premium tax credits or cost-sharing reductions for which they were eligible	• Representative enrolled a consumer in a plan that the consumer did not want to enroll in
Enrollment Error	Consumers enrolled through the Marketplace, but the insurance company didn't get their information due to technical issues.	• Consumer's information is received by the insurance company and may be processed, but the enrollment file contains defective or missing data which makes the insurance company unable to enroll the consumer. • Consumer's application may have been rejected by the issuer's system because of errors in reading the data.
System errors related to immigration status	An error in the processing of applications submitted by immigrants caused the consumer to get an incorrect eligibility result when they tried to apply for coverage.	• Immigrants with income under 100% of the poverty line who are eligible for premium tax credits and cost-sharing reductions did not receive the proper determination.
Display Errors on Marketplace website	Incorrect plan data was displayed at the time the consumer selected the QHP, such as plan benefit and cost-sharing information.	• Data errors on premiums, benefits, or co-pay/deductibles. • Errors that resulted in the display of a QHP to applicants that were outside of the QHP's service area or that were in ineligible enrollment groups. • Errors that didn't allow consumers with certain categories of family relationships to enroll together in a single plan with their family members.

Medicaid/CHIP – Marketplace transfer	Consumers who were found ineligible for Medicaid or CHIP and their applications weren't transferred between the State Medicaid or CHIP agency and the Marketplace in time for the consumer to enroll in a plan during open enrollment.	• Consumers, who applied at the FFM, were assessed eligible for Medicaid or CHIP, were found ineligible for Medicaid or CHIP by the state agency and then weren't transferred back in time for an FFM determination during open enrollment. • Consumers who applied at the state Medicaid or CHIP agency during open enrollment and ended up having their cases referred to the Marketplace after a denial of Medicaid or CHIP.
Error messages	A consumer is not able to complete enrollment due to error messages.	• Error or box screen indicating that the data sources were down and they could not proceed with enrollment.
Unresolved casework	A consumer is working with a caseworker on an enrollment issue that is not resolved prior to March 31st.	• Consumers who began the case work process but it was not resolved prior to the end of open enrollment.
Victims of domestic abuse	A consumer who is married, and is a victim of domestic abuse. Consumers who are in this category can apply and select a plan through May 31, 2014.	• Prior to clarifying guidance from Treasury and HHS, consumer assumed or was informed that APTC were unavailable to consumers who are married and not filing a joint tax return. Consumer may or may not have attempted to apply.
Other system errors	Other system errors, as determined by CMS, which hindered enrollment completion.	

Process to Initiate a Limited Circumstance Special Enrollment Period

1. In general, a consumer who wants a Limited Circumstance Special Enrollment Period based on the circumstances outlined above must call the Marketplace Call Center at 1-800-318-2596 and ask the Call Center to request the Special Enrollment Period. TTY users should call 1-855-889-4325.
2. The Call Center will ask the consumer a variety of questions to help understand if the consumer is eligible for a Special Enrollment Period.
    - The Call Center will forward cases that need additional review to CMS caseworkers. The consumer's situation will be evaluated by a caseworker to determine whether to grant a Special Enrollment Period.

- The consumer will be notified if the Special Enrollment Period was approved or denied. If approved from a caseworker, the consumer will have to call the Call Center to "activate" the Special Enrollment Period.

3. If the Special Enrollment Period is granted, the Call Center will activate the Special Enrollment Period and allow the consumer to complete enrollment.
4. The consumer should receive information from the issuer once they are enrolled.
5. If the Special Enrollment Period is denied, the consumer can appeal the decision, as described below.

- **Please note that for some circumstances, the Marketplace or issuer may reach out to the consumer to tell them about their potential Special Enrollment Period.**
  - **Please note that for benefit display errors,** the consumer may also receive a notice from the insurance company informing the consumer that there was a display error and they are eligible for a Special Enrollment Period.
- **Please note that for any system defects that hinder the completion of enrollment,** assisters and consumers should be vigilant in monitoring when the defect is resolved and to call the Call Center to request the appropriate Special Enrollment Period. Consumers and assisters can monitor the status of defect fixes by continuing to try to reprocess their applications. Consumers will then have 60 days from the time the defect is fixed and the Call Center approves of the Special Enrollment Period.

If a consumer is enrolling through their state's Marketplace and wants to request a Special Enrollment Period, the consumer should contact that state. Visit HealthCare.gov/how-can-i-get-consumer-help-if-i-have-insurance to get information for state-based Marketplaces.

Plan Selection for Limited Circumstance Special Enrollment Period

After following the process above, in most cases consumers will have 60 days to select a plan from the date they are granted the Special Enrollment Period, which could be one of the following:

- The **date that the consumer receives a letter** informing them that they are eligible for a Special Enrollment Period;
- The **date that the consumer contacts the Call Center and is found eligible** for a Special Enrollment Period; or
- The **date that the caseworker finds an individual eligible** for a Special Enrollment Period.

If a consumer experienced any of these limited circumstances, or others deemed by the Marketplace, prior to the end of open enrollment they may be able to complete their enrollment for the first time. If a consumer has already enrolled in coverage and then receives a Limited Circumstance Special Enrollment Period, they have the option to change plans or stay in their current plan, depending on what is offered to them on the Marketplace.

Limited Circumstance Special Enrollment Period Coverage Effective Dates

Coverage effective dates will generally follow the regular effective dates.

Filing an Appeal

If a request for a Special Enrollment Period is denied, a consumer has the right to file an appeal. A consumer has 90 days to request an appeal with the Marketplace from the date of a Special Enrollment Period denial notice or 90 days from the date of the eligibility determination. Each Special Enrollment Period appeal request will be reviewed on a case-by-case basis, in accordance with the regulations governing appeals, 45 C.F.R., Sections 155.500-155.545, and decisions will be promulgated ordering coverage retroactive to the date of the incorrect determination if appropriate, see 155.545(c)(1)(ii). If the determination to deny a request for a Special Enrollment Period is found to have been incorrect on appeal, the consumer has the option to get coverage retroactive to the date of the incorrect determination. The consumer can file an appeal in one of these ways:

- Visit HealthCare.gov/can-i-appeal-a-marketplace-decision/ to find and complete the appeal request form for the consumer's state.
- Mail appeal documents to:
  Health Insurance Marketplace
  465 Industrial Blvd.
  London, KY 40750-0061

Additionally, when possible, it is preferable but not required, that consumers requesting an eligibility appeal to include a copy of the Special Enrollment Period denial notice and any other eligibility determination documentation the consumer may have received.

When mailing the appeal request to the Health Insurance Marketplace, it is preferable, but not required, that consumers include the last four digits of the London, KY zip code (40750-0061) to ensure efficient processing of the appeal request.