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Division of Health Care Access and Accountability
1 West Wilson Street
Madison, WI 53703

To: BadgerCare Plus Eligibility Handbook Users

From: Shawn Smith, Bureau Director
Bureau of Enrollment Policy and Systems

RE: **BadgerCare Plus Release 13-02**

Release Date: 10/25/2013

Effective Date: 10/25/2013

Please note that CMS has not yet issued final approval of Wisconsin's waiver to provide coverage to childless adults as well as impose premiums and restrictive reenrollment periods on adults in extensions. The handbook reflects the policy as currently defined in the waiver, but the final version of the waiver may result in changes to Chapters 19.1, 19.11, and policies pertaining to coverage of childless adults.

EFFECTIVE DATE The following policy additions or changes are effective 10/25/2013 unless otherwise noted. Yellow highlighting denotes new text. Text with a strike through it denotes deleted text.

General Updates The following changes have been made throughout the entire handbook and may not be listed as an entry on this cover sheet.

- Yearly reviews for eligibility will now be referred to as "renewals."
- BC+ Prenatal Services will now be referred to as the "BC+ Prenatal Program."
- Youth Exiting Out-of-Home Care (YEOHC) will now be referred to as "Former Foster Care Youth" or "FFCY."

1.1 BC+ Introduction Through December 31, 2013, potential BC+ members include:

- Children under 19 years of age,
- Pregnant women,
- Parents and caretakers of children under 19,
- Young adults under 21 leaving out of home care (such as foster care),
- Parents and caretaker relatives whose children have been removed from the home and placed in out of home care.
-

Effective January 1, 2014, potential BC+ members will include:

- Children under 19 years of age,
- Pregnant women,
- Parents and caretakers of children under 18 and dependent 18 year olds,
- Former foster care youth under age 26 who were in out-of-home care when they turned 18,
- Parents and caretaker relatives whose children have been removed from the home and placed in out of home care, and
- Certain adults ages 19-64 without dependent children.

1.1.1 Organization of the BC+ Handbook

This subsection is new with this release.

This handbook outlines eligibility policy for Wisconsin's BadgerCare Plus program. This version documents multiple policy changes that will affect the BC+ program in 2014 as a result of changes in State law and the federal Affordable Care Act. Accordingly, this handbook contains policy for the BadgerCare Plus program that is currently in effect and policy that will take effect after January 1, 2014. Policy that is time-limited or time-dependent will be modified with the appropriate effective date. Policy that is not identified as having an effective or end date is currently in place and will continue to exist in 2014.

Beginning in 2014, the BadgerCare Plus program will use a different set of eligibility rules to determine household size and countable income. This version of the handbook addresses two forms of budgeting rules. More information about these budgeting methodologies is found in Chapter 2. The new budgeting rules that will be applied to applicants and members in 2014 will be referred to as Modified Adjusted Gross Income (MAGI) rules. The rules currently in place for BadgerCare Plus will be referred to as "non-MAGI rules."

1.1.2 BadgerCare Plus Health Plans

Through December 31, 2013, BC+ has members will have one of two major health care benefit plans: Standard Plan and Benchmark Plan. The Standard Plan is for families with household income at or below 200% of the Federal Poverty Level (FPL). The Benchmark Plan which provides more limited services than the Standard Plan, is for families with income above 200% of the FPL, and for self-employed parents and Caretakers. (See Table 50.1 for FPL limits)

~~In addition,~~ BadgerCare Plus also has several limited health plans. These include:

- Family Planning Only Services
- BC+ Prenatal ~~Care Services~~ Program, and
- BC+ Emergency Services

See the chart below for BC+ benefit plans through December 31, 2013. Beginning January 1, 2014, all BadgerCare Plus members will receive coverage under the Standard Plan.

1.1.3 Health Care Choice

It is possible for individuals to qualify for both BadgerCare Plus and Elderly, Blind and Disabled Medicaid (EBD MA) based on financial and non-financial eligibility criteria.

Through December 31, 2013, when a person is eligible for both BC+ and EBD MA, ~~in some circumstances,~~ CARES will automatically enroll the individual in the program with the best benefit plan and lowest cost share. The individual has the right to request coverage under the program not chosen by CARES. See (49.1 Health Plan Choice). The change ~~is~~ will be effective in the next possible payment following Adverse Action, unless the member requests the change be effective in the month the request to change the health plan was made.

Effective January 1, 2014, federal law requires that once an individual has been determined eligible for EBD Medicaid, s/he must be enrolled in EBD MA, even if they are also eligible for BC+, unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BC+. In these instances, the pregnant woman will be enrolled in the BadgerCare Plus program.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD Medicaid and can enroll in BadgerCare Plus. Pending for EBD MA includes, but is not limited to, waiting for an official disability determination from DDB and being subject to the 24 month Medicare waiting period. If an individual enrolled in EBD MA is determined ineligible for EBD Medicaid for any reason, including going over the asset limit or failing to pay a MAPP premium, s/he can enroll in BC+ if s/he is still eligible to do so.

1.1.4 How to Apply

The following application options are available for anyone who is applying for BC+:

1. ACCESS online application at <https://access.wisconsin.gov/>
2. Face-to-Face Interview at the local county/tribal office.
3. Mail-In: Paper Application.
4. Telephone Interview.
5. An application submitted to the Federally Facilitated Marketplace.

2.1 BC+ Non-Financial Program Requirements

Through December 31, 2013, the following individuals are non-financially eligible for BC+ :

4. Young adults exiting out of home care (such as foster care) under age 21.

Beginning January 1, 2014, the following individuals are non-financially eligible for BC+:

1. Children under 19,
2. Pregnant Women,
3. Parents/Caretaker Relatives of children under 18 years of age or dependent 18 year olds, including some parents and caretaker relatives whose children have been removed from the home and are in the care of the child welfare system (Chapter 10),
4. Former foster care youth under age 26 who were in out-of-home care when they turned 18, and
5. Adults ages 19-64, not receiving Medicare, who do not meet any of the conditions listed above.

2.2 BC+ Test Group Coverage Group Definitions

The BC+ Test Group includes the primary person and any individuals living in his/her household whose income and/or needs are considered when determining financial eligibility. Inclusion in the Test Group is determined by qualifying relationships and legal responsibility.

Anyone in the home who meets the criteria of being in the BC+ Test Group, is always included in the group whether or not s/he requested BC+.

Persons in the home who do not meet the criteria to be in a BC+ Test Group must be excluded. However, they may be included in a BC+ Test Group in another case.

The primary person who applies for BC+ must meet one of the following requirements in order to form a BC+ Test Group. The primary person must either be:

1. A parent residing with his or her child under age 19 or residing with a

- ~~spouse and his or her child who is under age 19.~~
- ~~2. A qualified relative caretaker relative residing with a child in the home who is under age 19, or residing with a spouse who is a qualified relative caretaker relative of a child in the home who is under age 19. (caretaker relative)~~
- ~~3. A pregnant woman, or the spouse of a pregnant woman,~~
- ~~4. A Youth under age 21 who was in out-of-home care (e.g., foster care) at age 18, or~~
- ~~5. A child.~~

The following are the relationships and legal responsibility which determine who is in the BC+ Test Coverage Groups:

2.2.1 Parents

A parent is any natural, legally adoptive, or step mother or father. A parent can be any age. There can be more than one parent of a certain gender in a household. To be considered a parent of a child under age 19 for BC+ purposes, the child must be under the care of that individual at least 40% of the time. For example, in families where parents are divorced, if the child does not live with Parent B at least 40% of the time, Parent B would have his/her eligibility considered under the Childless Adults coverage group, rather than the Parents/Caretakers coverage group.

Note: Children under 19, who are applying for FPOS, are a group of one unless she is married and/or has children. Parents are not included in the group.

The BC+ Test Group for a primary person who is residing with his or her own child or with a spouse and the spouse's child will include the following individuals:

- ~~1. The primary person and the primary person's spouse.~~
- ~~2. A child under age 19 of the primary person or the primary person's spouse.~~
- ~~3. A co-parent of a primary person's child or the co-parent of the spouse's child.~~
- ~~4. Any spouse of a co-parent.~~
- ~~5. Any child under age 19 of a co-parent.~~
- ~~6. The other parent of a co-parent's child.~~
- ~~7. A child of the primary person's child or the spouse's child.~~
- ~~8. The spouse of an included child, if that child is a parent, or the spouse is under age 19.~~
- ~~9. The co-parent of an included grandchild.~~
- ~~10. A child under age 19 who is a qualified relative of, and residing with, the primary person, the primary person's spouse or another included adult.~~
- ~~11. An essential person (2.2.1.3)~~

~~A parent residing with his or her child under the age of 19 must be in the same BC+ Test Group. This is true even when the legal custody of the child has been transferred to someone living outside of the home. The only exception is when someone's parental rights have been legally terminated.~~

~~When a child moves from the home of a parent or caretaker relative who was eligible for BC+ to the home of another caretaker relative or caretaker relative who applies for BC+ in the same month, the new caretaker relative can be eligible as of the application date. The child, however, isn't eligible in the new household until the 1st of the month after the move.~~

2.2.1.3 Dependent 18 Year Old

This subsection is new with this release.

Effective January 1, 2014, when an adult is eligible as a parent or caretaker because they are caring for an 18 year old child, and that child is the only child in the home, the child must meet the following conditions in order for the parent or caretaker to be eligible for BC+ as a parent or caretaker of a dependent 18 year old:

- Be enrolled in high school, and
- Be expected to graduate high school before turning 19.

The child does not have to be enrolled full time in high school in order to meet this definition of dependent child.

The 18 year old remains eligible as a child until he or she turns 19, regardless of school enrollment or expected date of graduation.

2.2.2 Caretaker Relative

NOTE: If a child lives with his/her parent(s), as well as an caretaker relative with legal custody, the child and parents are still part of the same BC+ Test Group, and the parents' income will be used to determine the child's eligibility. The parent(s) and child will not however, have their income counted when determining the caretaker relative's eligibility.

Example: Alice, age six, and her mother, Jane, live with Jane's parents. The grandparents have legal custody of Alice. Alice is considered to be under the care of her grandparents, not of her mother. Since the grandparents are the caretakers of Alice, they may apply for BC+ for Alice. In addition, Jane, as a parent of a child in the BC+ Test Group, must also be included in the Group.

If the primary person is a caretaker relative of a child under age 19 or the spouse of a caretaker relative of a child under age 19, the BC+ Test Group will include the following individuals:

1. The caretaker relative,
2. The caretaker relative's spouse,
3. The child under age 19 who is under the care of the caretaker relative.
4. A parent of the child, if the caretaker relative has legal custody of the child, and
5. Any essential person (2.2.1.3).

<http://dcf.wi.gov/children/Kinship/INDEX.HTM>

2.2.3 Child Welfare Parents/Caretakers

This subsection was formerly listed as **2.3.4 Child Welfare Parents/Caretakers.**

Through December 31, 2013:

Parents and caretaker relatives whose children have been placed in out of home care and who meet the criteria listed in (Chapter 10) are still considered caretaker relatives of the child. The child is considered temporarily absent from the home. The child(ren) is included in the BC+ test group and any unearned income the child has is budgeted. However, unlike others who are considered temporarily absent from the home, a child in a child welfare placement is not eligible for BC+ in the household that s/he was removed from.

On or after January 1, 2014:

Parents and caretakers whose children have been placed in out of home care

and who are having their eligibility determined or renewed will still be considered parents or caretakers, as the child will be considered temporarily absent. However, the inclusion of the child in the parent's group will be dependent upon MAGI budgeting rules. If the child has been placed with a caretaker relative, the relative will be considered a childless adult for purposes of BC+ eligibility. Inclusion of the child in the caretaker relative's group will also be dependent upon MAGI rules. See Chapter 10 for more information.

2.2.4 Pregnant Woman

If the primary person is:

- a pregnant woman or her spouse,
- not a parent or a caretaker relative and
- if under age 19, not residing with a parent or a caretaker relative,

The BC+ Test Group will include the pregnant woman and her spouse.

If the pregnant woman is under 19 and residing with a parent or caretaker, the parent or caretaker would be the primary person and the BC+ Test Group would be built around the parent or caretaker.

Also include in the BC+ Test Group size each verified fetus the pregnant woman is carrying. If there is no verification on the number of fetus, add 1 to the group size.

2.2.5 Former Foster Care Youth (Formerly known as Youth Exiting out of Home Care)

If the primary person is

- a YEOHC,
- not a parent or a caretaker relative of a child, and
- if under age 19, is not residing with a parent or caretaker relative

The BC+ test group will include the YEOHC and his/her spouse if the spouse is also a YEOHC.

If the YEOHC is under 19 and residing with a parent or caretaker, the parent or caretaker would be the primary person and the BC+ Test Group would be built around the parent or caretaker.

This category was formerly referred to as Youth Exiting Out of Home Care.

BadgerCare Plus benefits are available to certain individuals who were in out-of-home care, including foster care, court ordered kinship care, and subsidized guardianship, as of their 18th birthday. These individuals are categorically eligible for BadgerCare Plus. The individual did not have to be in foster care in Wisconsin when he or she was 18 in order to be eligible for this coverage group. Through December 31, 2013, FFCY will only be eligible for BC+ benefits until they are age 21. After January 1, 2014, benefits will be available to all former foster care youth under age 26. See Chapter 11 for additional eligibility criteria for Former Foster Care Youth.

2.2.6 Child

If the primary person is a child under age 19, is not a parent or a caretaker relative of a child in the home, and is not residing with a parent or caretaker relative, the BC+ group consists solely of the child and his or her spouse if they are residing together. In this situation, the spouse of the child under 19 is not eligible for BC+ unless s/he is also under age 19 or there are other children in the household under the care of either the child who is the primary person or the spouse.

A child under age 19 is non-financially eligible for BC+. Marital status and

school enrollment status have no effect on his/her non-financial eligibility. The child does not have to be under the care of or related to the caretaker to be eligible for BC+.

Note: A child under age 19 residing with a caretaker relative may not apply as the primary person for the relative's benefits. For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BC+. A child under age 19 residing with a parent may not apply separately from his or her parent. In addition, the parent must apply as the primary person for the case, unless the child filing the application is age 18. **Children over age 19 must always apply separately from their parents or caretakers, irrespective of their living arrangement or tax dependency.**

2.2.7 Childless Adults

This subsection is new with this release.

A childless adult is an individual aged 19 to 64 who does not have any dependent children under age 19 who reside with them at least 40% of the time. Their marital status has no effect on their BadgerCare Plus eligibility. In 2013, childless adults are covered under BadgerCare Plus through the Core Plan. Enrollment in the Core Plan has been closed since 2009. Beginning January 1, 2014, childless adults who are not eligible for Medicare will be non-financially eligible for regular BC+ under the Standard Plan.

2.3 BC+ Test Group

This entire section is new with this release. The text changes are too numerous to list.

2.4.1 Not Living in the Household

Do not consider the following to be living in the household **regardless of the whether non-MAGI rules or MAGI rules were used to determine a member's BC+ group:**

2.4.2 Temporary Absence

2. The caretaker relative continues to exercise responsibility for the care and control of the child. **See Chapter 10 for more information about Child Welfare.**

The following children are not considered temporarily absent:

- Children who are inmates of public institutions. (3.6) ~~are not temporarily absent.~~
- Children who are placed in an institution for 30 or more days, ~~are not temporarily absent,~~ unless they were placed there by a child welfare agency.
- Children who are placed in an IMD, ~~are not temporarily absent,~~ unless they were placed there by a child welfare agency.

2.4.3 Students

When a child under age 19 who is a student living away from their parent's home applies for BC+, the child and his/her family can determine whether the student will be ~~a group of 4~~ on his/her own case, or a temporarily absent individual included in his/her parent's case.

Students over age 19 will need to apply for BadgerCare Plus with their own application.

2.5 BC+ Assistance Groups

A new table has been added for MAGI Assistance Groups. The text changes are too numerous to list.

2.6 Participation Status Codes

The table has been updated to include non-MAGI or MAGI budgeting rules. The text changes are too numerous to list.

2.7.2 BC+ Group Examples using MAGI Rules

This subsection is new with this release. The text changes are too numerous to list.

2.8 BC+ Test Group Financial Rules

This chapter has been split into two separate sections.

2.8.1 Non-MAGI Financial Rules

2.8.2 MAGI Income Counting Rules – This subsection is new with this release.

3.1 Residence

A person must be a Wisconsin resident to be eligible for BC+. S/he must:

2. Express intent to reside in Wisconsin. (3.2). Effective January 1, 2014, an individual can also 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.

3.2 Intent To Reside

~~If the applicant/member is incapable of indicating intent, the guardian or person acting on behalf of the applicant/member can indicate the applicant's/member's intent to reside.~~

“Intent to reside” does not mean an intent to stay permanently or indefinitely in the State, nor does it require an intent to reside at a fixed address.

3.3.1 Under Age 21

Not in an institution

A person under age 21 and not residing in an institution is a Wisconsin resident if s/he is:

- Age 18 or under age 18 and emancipated from his or her parents, or married, and is:
 1. Living in Wisconsin with the intent to remain living in Wisconsin, or
 2. Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.
- Under age 18 and not emancipated from his or her parents and not married, and is living in Wisconsin.

Note: For individuals received Medicaid based on receipt of Title IV-E assistance or if the individual receives State SSI, see section 3.4.

In an institution

The residence of a institutionalized person under age 21 living in a Wisconsin institution when his/her parents or legal guardian lives outside of Wisconsin is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.

3.3.2 Age 21 and Over

Not in an Institution

The residence of an individual over age 21 who is not institutionalized is Wisconsin if s/he is:

- Living in Wisconsin with the intent to remain living in Wisconsin, or
- Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

If s/he is incapable of expressing intent, an individual is a resident if s/he is

living in Wisconsin.

In an Institution

The residence of an institutionalized person age 21 or over is the state in which s/he is residing with the intent to remain there.

If s/he is incapable of indicating intent, his/her residence is determined in the same way as the residence of an institutionalized person under age 21.

The residence of a person who became incapable of indicating intent before age 21 is determined in the same way as the residence of an institutionalized person under age 21.

The residence of a person who became incapable of indicating intent at age 21 or older is Wisconsin, unless the placement was arranged by another state.

For all others, the person is a Wisconsin resident if s/he intends to reside in Wisconsin

3.4.4 Homeless Persons

The table titled "Homeless Definition" has been removed. There is no longer any BC+ populations that require a specific definition of homeless.

3.6 Inmates

Individuals who are inmates of a public institution are not eligible for BC+. An inmate is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate. An individual who is legally confined to his/her home by a monitoring device, such as an ankle bracelet, is not considered an inmate for purposes of BC+.

4.2 Documenting Citizenship and Identity

The applicant will have 90 95 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 90 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 90 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.

4.2.1.1 Exempt Populations

Former SSI and Medicare Recipients

Note: Confirm the receipt of SSI, SSDI, and Medicare through SOLQ or DXSA. the following data exchanges:

- For SSI: use DXSX
- For SSDI: use DXSA
- For Medicare: DXSA

4.2.4 Hierarchy of Documentation

If an individual needs to verify citizenship and/or identity at the point of application or renewal s/he should try to fulfill the requirement with proof s/he already has available. Beginning in 2014, eligibility workers can also use the State's data exchange with CHIP to verify citizenship and identity for individuals who have attested that they are US citizens in real time. If an applicant/member contacts the agency, work with him/her to check Documentation Levels 1

through 5 to determine if anything on the list is readily available to the applicant/member. If an applicant/member was born in Wisconsin, use the online Birth Query to verify citizenship.

4.3.4 Immigration Status Chart

The chart has been updated to include the immigrant status of "Lawfully Residing."

5.2.1 Introduction

Unless the person is exempt **or** has good cause for refusal to cooperate (see 5.3), each applicant /member that is referred, must, as a condition of eligibility, cooperate in:

5.2.2 Failure to Cooperate

The following individuals are not sanctioned for non-cooperation:

1. Pregnant women,
2. Minors, and
3. **Parents or** caretaker relatives while the family is in a BC+ Extension.

6.1 SSN Requirements

Do not require an SSN for:

- a) Continuously eligible newborns.
- b) Pre-adoptive infants living in a foster home.
- c) ~~Unqualifying~~ **Non-qualifying** immigrants receiving emergency services **or BC+ Prenatal Program services**
- d) ~~Women applying for BC+ Prenatal Program (BC+PP).~~ **Someone without an SSN and may only be issued one for a valid non-work reason.**
- e) **Someone who refuses to obtain an SSN because of well-established religious objections*.**
- f) **Tax dependents or tax filers living outside of the home.**

~~BC+ applicants and members who belong to a recognized religious sect that conscientiously opposes applying for or using a social security number are exempt from meeting the SSN requirements.~~

"Well-established religious objects" means that the applicant/member:

1. **Is a member of a recognized religious sect or division of the sect, and**
2. **Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.**

A person who refuses to apply for or use a social security number due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

7 Health Insurance Access and Coverage Requirements

This text has been updated on every Introduction section of this chapter.

~~The 9.5% Past Access/Current Test policy will be applied on or after July 1, 2012, but only to adult parents and caretakers and only when:~~

- ~~• A new application or program request is submitted,~~
- ~~• New employment is reported,~~
- ~~• The next review/renewal is completed, or~~
- ~~• A parent or caretaker with employment is added to the assistance group.~~

~~Until one of the above circumstances occurs, the 80% Past/Current Access Test policies will continue to apply to all non-pregnant, non-disabled parents~~

~~and caretakers with household income above 150% of the FPL.~~

7.1 Health Insurance Conditions of Eligibility

This section has been split into two subsections. The text changes are too numerous to list.

7.1.1 Health Insurance Conditions of Eligibility Through December 31, 2013

7.1.2 Health Insurance Conditions of Eligibility Effective January 1, 2014 –
This subsection is new with this release.

7.2.1 Introduction

The 80% Past Access Test policies ~~will continue to~~ applies to non-exempt children (See 7.1). **The 9.5% test applies to adult parents and caretakers until December 31, 2013. After January 1, 2014, parents and caretakers are no longer subject to a Past Access Test.**

7.2.1.1 The 80 % Past Access Test

~~Individuals~~ **Children and any BC+ Prenatal Program members** who had access to health insurance, including access due to a qualifying event , in the twelve months prior to the application or renewal date 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,

- ~~2. The applicant is a caretaker relative or child under age 19 and the caretaker relative or child is not exempt; and~~

The **child or BC+ Prenatal Program Member is** ~~employed BC+ applicant/member and anyone else in the household that could have been covered by the health insurance are~~ ineligible for BC+ for twelve calendar months from the date the health insurance would have begun.

Example 1 has been updated.

7.2.1.2 The 9.5% Past Access Test

Note: The 9.5% Past Access Test will no longer be effective beginning January 1, 2014.

7.2.3 Good Cause for the 80% "Past Access Test" Effective January 1, 2014

This subsection is new with this release.

7.3.1 Introduction, 7.4.1 Introduction

The 80% Current Access Test ~~will continue to~~ applies to non-exempt (See 7.1) children. **The 9.5% Current Access Test will no longer be in effect beginning January 1, 2014.**

7.3.2 The 80% Current Access Test

~~Individuals~~ **Children and any BC+ Prenatal Program members** with access to health insurance, including access due to a qualifying event, through an employed family member who is currently living in the household are not eligible for BC+ benefits if:

- ~~2. The applicant/member is a caretaker relative or child under age 19 and the caretaker relative or child is not exempt; and~~

The coverage would begin within three calendar months following:

- ~~a) The month of BC+ application filing date; or~~
- ~~b) Annual renewal month; or~~

c) Employment start date

The **child or BC+ Prenatal Program Member** employed BC+ member and ~~anyone else~~ who could have been covered by the health insurance plan are ineligible for BC+ benefits. However, children ~~under 19 years of age~~ can become eligible by meeting a deductible. (See Ch. 17)

Examples 1 and 2 have been updated.

7.4.2 The 80% Coverage Test

~~An individual~~ **Certain children** who currently have individual or family health insurance coverage through an employed family member ~~who is currently living in the household AND~~ who meet the following criteria are not eligible for BadgerCare Plus:

1. The ~~person~~ **child** is not exempt from access and coverage policies (See 7.1); and

Example 1 has been updated.

7.4.3 The 9.5% Current Coverage Test

Note: This policy will only be effective until December 31, 2013.

7.5.1 Introduction

The 80% Dropped Coverage policies will continue to apply to non-exempt children (See 7.1). **The 9.5% Dropped Coverage Test applies to non-pregnant, non-disabled adult parents and caretakers until December 31, 2013.**

7.5.2 The 80% Dropped Coverage Test

~~With policy exceptions for pregnant women, (See 7.5.4)~~ individuals **Children** are ineligible for BadgerCare Plus (BC+) benefits for three calendar months following the month in which coverage through an employer-provided health insurance plan, which meets the standards of a HIPAA standard plan, ended if:

2. The applicant is a ~~caretaker relative or~~ child under age 19 and the ~~caretaker relative or~~ child is not exempt; and

Examples 1 and 2 have been updated.

7.5.3 The 9.5% Dropped Coverage Test

Note: **The 9.5% Dropped Coverage Test will no longer be in effect beginning January 1, 2014.**

7.7.1 Introduction

HIPP will be considered for BadgerCare Plus members when it is cost effective to do so.

- ~~Children and parents with incomes at or below 150 percent of the FPL even when the employer pays 80 percent or more of the premium.~~
- ~~Children and parents with incomes above 150 percent of the FPL when the employer pays less than 80 percent of the premium.~~
- ~~Pregnant women with incomes up to 300 percent of the FPL when the employer pays 80 percent or more of the premium (wrap-around benefits).~~

In addition to families with employer sponsored health insurance plans, **the following** BC+ families ~~that meet the above criteria with the following types of insurance plans~~ may also be considered for HIPP:

- Farm and other self-employed families or
- Members with Self-funded insurance plans,

Access to HIPP coverage will be allowed even if single or "plus one" coverage is the only coverage offered by an employer.

7.7.2 Cost Effectiveness

~~For individuals and families with incomes under 200 percent of the FPL, The HIPP Unit will identify the cost of wrapping around the Medicaid services with the employer-sponsored plan and then determine cost effectiveness of buy-in on that calculation of cost comparability.~~

~~For individuals and families with incomes between 200 and 300 percent of the FPL, if the employer plan has benefits equal to the BadgerCare Plus Benchmark Plan, the State will buy-in to the employer plan when it is cost effective to do so. In this instance, the HIPP Unit will not look at the comparability of the cost sharing, e.g., amounts of co-pays but will determine the cost effectiveness based on comparability of the covered benefits~~

7.8 Access/Coverage Overview

This section has been split into 3 subsections. The text changes are too numerous to list.

7.8.1 Access/Coverage Overview prior to December 31, 2013

7.8.2 Access/Coverage Overview after January 1, 2014 – This subsection is new with this release.

7.8.3 BC+ Prenatal Program Access/Coverage Overview

8.1 Pregnant Women

Note: This chapter does not apply to pregnant women in the BC+ Prenatal Program.

If a pregnant woman is covered under the Standard Plan at any time during her pregnancy she will remain in the Standard Plan while she is eligible as a pregnant woman, regardless of changes in income or other eligibility factors. As of January 1, 2014, every pregnant woman in BC+ will be enrolled in the Standard Plan, including someone who has become eligible by meeting a deductible.

A pregnant woman with income over 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules) at the time of application can become eligible for BC+ by meeting a deductible. (See section 17.2)

A pregnant woman does not have to pay a premium. (see section 19.1)

~~See (7.5) for the policy on dropping insurance coverage for pregnant women.~~

8.2 Continuously Eligible Newborns

2. The natural mother was determined eligible, in the State of Wisconsin, for one of the following programs:

Note: Children born to incarcerated mothers or pregnant minors with family income over 300% of the FPL who were eligible for BC+ are still will not be eligible as a CEN.

Through December 31, 2013, children born to pregnant minors with family income over 300% FPL who were eligible for BC+ are not eligible as CENs.

~~The child is not required to have an SSN.~~

Through December 31, 2013, the child will be covered under either the Standard or the Benchmark Plan, depending on the plan the mother was

covered by at the time of the baby's birth. All infants eligible for BadgerCare Plus as a CEN will be covered under the Standard Plan effective January 1, 2014.

9.2 Application

The time period for processing an application for BC+ is 30 days from the application filing date or from the date the application is received from the Federally-facilitated Marketplace. Advise the applicant of the specific verification required within the 30 day processing time. Give the applicant a minimum of ten calendar days to provide any necessary verification.

Wisconsin will begin receiving referrals from the Marketplace in November 2013.

9.3 Eligibility Reviews-Renewals

The group's eligibility should not be denied for failure to provide the required verification until the 10th day after requesting verification or the end of the review/renewal month whichever is later.

Note: After an individual transitions to MAGI rules, requested verification turned in within 90 days of the renewal due date should be processed as timely. See [Process Help 4.6](#).

9.5 Documentation

Documentation also includes adding notations to case comments when copying is not possible. Notations must include enough information to verify eligibility, ineligibility, and benefit level, and coverage group determinations.

9.9 Mandatory Verification Items

The following items must be verified for BC+:

4. Pregnancy, if eligibility is based on the pregnancy ([9.9.3](#))

Note: Effective January 1, 2014, pregnancy is no longer required to be verified.

12. The placement status of a ~~YEOHC~~ FFCY ([Chapter 11](#)) on his/her 18th birthday.

14. Pre-tax Deductions* ([9.9.8](#))

15. MAGI Tax Deductions* ([9.9.9](#))

*These mandatory verification requirements are effective for BadgerCare Plus determinations effective January 1, 2014.

9.9.3 Pregnancy

Verification of pregnancy is only required until December 31, 2013. Beginning January 1, 2014, verification is no longer required for pregnancy unless the worker has information that contradicts the applicant or member's statement.

Through December 31, 2013, if a woman wants to be considered pregnant for the BC+ Pregnant Women group or the BC+ Prenatal Program (Chapter 39) eligibility determination, documentation from a health care professional attesting to the pregnancy is required. Fetus count and the expected pregnancy end date are not mandatory verification items.

When pregnancy must be verified, acceptable verification sources for pregnancy are: (no changes made to list)

9.9.6 Access to Employer-Sponsored

4. When a change is processed causing total household income to exceed the following FPL thresholds:

Health Insurance

- Infants less than 1 year old, 300% of the FPL,

Note: The requirement for infants over 300% of the FPL and parents and caretakers are only effective until December 31, 2013.

9.9.7 Tribal Membership

Tribal members are exempt from paying BC+ premiums and may be exempt for certain benefit copayments. Effective January 1, 2014, tribal members eligible for BC+ will also be exempt from co-pays.

To receive these exemptions, verification of tribal membership or descent from a tribal member is required. Verification may be done with a:

9.9.8 Pre-Tax Deductions

This subsection is new with this release.

Individuals whose eligibility is determined using MAGI rules can claim pre-tax deductions in order to determine their MAGI taxable income. In order to claim a pre-tax deduction, verification of the amount is required. Verification sources such as pay stubs or other documentation from the individual's employer can serve as acceptable documentation.

9.9.9 MAGI Tax Deductions

This subsection is new with this release.

Individuals whose eligibility is determined using MAGI rules can claim certain tax deductions from the IRS 1040 Form, regardless of whether or not the individual files taxes. Individuals who claim such deductions must provide proof that the expense is or was incurred.

Forms of verification for MAGI tax deductions could include:

- receipts,
- bank statements,
- check stubs, or
- previous years' tax forms.

9.10 Questionable Items

Information is questionable for BC+ when:

6. The information provided is unclear or vague (i.e., information provided, but not clear).

10.1 Child Welfare Parent or Caretaker Relative

The text changes are too numerous to list.

11.1 Out of Home Care (i.e., Foster Care) and Youths Exiting Out of home care (YEOHC) Former Foster Care Youth (FFCY)

The title of this section has been updated. There have been no other changes in this section.

11.2 Exiting Out of Home Care Former Foster Care Youth

Effective January 1, 2014, the age limit for the FFCY coverage group is 26 years. Until December 31, 2013 the age limit is 21 years.

Youths who were in foster care, subsidized guardianships or court-ordered Kinship Care on their 18th birthday, qualify for a special status under BC+ when

they leave out of home care if all the following conditions are met:

2. The youth turned 18 on or after January 1, 2008 and is:
 - Under age 21 for eligibility determinations made prior to December 31, 2013, OR
 - Under age 26 for eligibility determination made on or after January 1, 2014.

There is no income or resource test for these youths while they are eligible under this status. In addition, they are not subject to the BC+ insurance access or coverage policy and they are not required to pay any premiums for themselves. Regardless of income, they are eligible for the BC+ Standard Plan unless they are found otherwise ineligible or until the end of the month in which they:

~~turn 21 or they are otherwise ineligible, whichever is sooner~~

- Turn age 21 (prior to December 31, 2013) or
- Turn age 26 (on or after January 1, 2014).

12.1 Migrant Workers When determining a migrant family's eligibility for BC+ use the appropriate rules as outlined in Chapter 2, depending on whether budgeting with non-MAGI rules or with MAGI rules is used. ~~include the adults (including non-marital co-parents) and their dependent children living in the migrant household~~

16.1 Income This section has been split into 2 subsections. The text changes are too numerous to list.

16.1.1 Income Under non-MAGI Rules

16.1.2 Income Under MAGI Rules – This subsection is new with this release.

16.2 Income Types Not Counted The following Income Types Not Counted have been updated and may be counted differently depending on whether non-MAGI or MAGI rules are used. Please refer to the Handbook for specific details.

4. Other Military Pay [This is new with this release.]
7. Earned income (non-MAGI only)
10. Jury Duty Payments
14. Payments to Native Americans from:
22. Special Programs
25. Student Financial Aids
35. Interest and Dividend Income
36. Lump Sums Payments

16.3.1 Support Payments Under non-MAGI rules, deduct the amount of court ordered support a BC+ applicant/member is obligated to pay for the support or maintenance of another person. Non-court ordered payments are not deducted. Under MAGI rules, child support payments will not be allowed as an income deduction.

16.3.2 Pre-Tax Deductions This subsection is new with this release.

The following deductions will be allowed if the payments are taken out of the individual's paycheck on a pre-tax basis:

- a. Health Insurance premium payments
- b. Health Savings Account (including flexible spending accounts) contributions

- c. Retirement contributions
- d. Parking & Transit costs
- e. Child Care Savings Account contributions
- f. Group Life Insurance premium payments

16.3.3 Tax Deductions

This subsection is new with this release. The changes are too numerous to list.

16.4 Earned Income

Earned income is income from gainful employment.

Under non-MAGI rules, earned income for individuals under 18 years of age is not counted. The gross earned income before any deductions are taken out is counted.

Under MAGI rules, earned income after pre-tax deductions will be counted. See 16.3.2 for more information on pre-tax deductions.

5. Worker's Compensation

Under non-MAGI rules, count Worker's Compensation as earned income.

Under MAGI rules, do not count Worker's Compensation as earned income.

16.4.1 Specially Treated Wages

The following Specially Treated Wages have been updated and may be counted differently depending on whether non-MAGI or MAGI rules are used. Please see the Handbook for more details.

- 1. Income Received by Members of a Religious Order
- 2. Housing Allowances for Members of the Clergy
- ~~2. Census 2010~~
- 3. Jury Duty Payments
- 4. AmeriCorps
- ~~5. Governor's City Initiative~~

16.4.2 Room and Board Income

Under non-MAGI rules, calculate net amount by deducting one of the following from the gross amount received from each roomer/boarder: \$15 roomer only, \$111 Boarder only, \$126 roomer and boarder.

Under MAGI rules, these deductions are no longer used if this income is reported as room and board income. If room and board income is reported as self-employment income, see section 16.4.3 for more information on counting self-employment income.

16.4.3 Self Employment Income

Calculating Self Employment Income

~~All self-employment income is earned income, except royalty income and some rental income (16.4.3.1 #3).~~

16.4.3.1 Income Sources

- 2. **Capital Gains.** Business income from selling securities and other property is counted. **Under non-MAGI rules**, personal capital gains are not counted as income. **Under MAGI rules**, personal capital gains and ordinary gains or losses are counted as income. See section 16.5 for more information.
- 4. **Royalties.** Royalty income is unearned income received for granting

the use of property owned or controlled. Examples are patents, copyrighted materials or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced. See section 16.5 for more information on counting royalty income.

16.4.3.2.2 Worksheets

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Don't apply a loss from unearned income to a gain in earned income. Under non-MAGI rules, losses from self-employment can't be used to offset other earned or unearned income. Under MAGI rules, losses from self-employment can be used to offset other income types.

16.4.3.2.3 Disallowed Expenses

Generally, expenses that are allowed by the IRS on business tax forms are considered allowed expenses for BadgerCare Plus. However, under non-MAGI rules, some specific expenses allowed in the calculation of Self Employment Income on the IRS tax forms but are not allowed for BadgerCare Plus. Under MAGI rules, countable self-employment income will be the same as the net self-employment taxable income.

Depreciation and Depletion

Through December 31, 2013, depreciation expenses will be handled using the follow process:

[This process has not changed with this release. See Handbook for details.]

Effective January 1, 2014, depreciation and depletion expenses will be allowable expenses.

Under non-MAGI rules the following expenses are not allowed for BadgerCare Plus:

[The disallowed expenses have not changed with this release. See Handbook for listing.]

Under MAGI rules, the following expenses will continue to not be allowed for BadgerCare Plus:

1. Charitable donations
2. Work-related personal expenses, such as transportation to and from work
3. Employer work-related personal expenses such as pensions, employee benefit and retirement programs and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not).

16.4.3.3 Losses Offsetting Other Income (MAGI Rules Only)

This subsection is new with this release.

Under MAGI rules, losses from self-employment can be used to offset the individual's other income types. In situations where an individual is planning to file a joint tax return with his or her spouse, losses from self-employment may offset the spouse's income.

16.5 Other Income

The following Other Income Types have been updated and may be counted differently depending on whether non-MAGI or MAGI rules are used. Please

see the Handbook for more details.

2. Child Support
3. Social Security Benefits
4. Federal Match Grants for Refugees
5. Gifts
8. Profit Sharing
9. Retirement Benefits
10. Sick Benefits
12. Gambling Winnings
13. Royalties
14. Capital and Ordinary Gains and Losses

17.1 Deductibles

Through December 31, 2013, children (under age 19) with income above 150% of the FPL who have access to insurance can qualify for BC+ by meeting a deductible. Effective January 1, 2014, children (under age 19) with income over 300% FPL (non-MAGI rules) or 306% FPL (MAGI rules)* may become eligible for BC+ by meeting a deductible. Children with income over 150% FPL (non-MAGI rules) or 156% FPL (MAGI rules)* who are denied BC+ solely due to access to health insurance may also become eligible for BC+ by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150% FPL (non-MAGI rules) or 156% FPL (MAGI rules)*.

Pregnant women with incomes above 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules)* can qualify for BC+ by meeting a deductible. The deductible amount is calculated for a six month period using the amount of income that exceeds either 450% FPL for children or 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules)* for pregnant women. The deductible is met by incurring medical expenses that equal the deductible amount.

*See section 16.1.2 for more information on income disregards.

17.2.1 Introduction

The deductible amount for a pregnant woman is the amount of countable income above 300% FPL for a six month period. To meet the deductible she or other family members included in the BC+ group must incur medical bills equal to her deductible amount. Once the deductible is met she will be covered under the Benchmark plan through December 31, 2013 with no premium until two months after giving birth. Effective January 1, 2014, all pregnant women, including those eligible through deductibles, will be covered under the Standard Plan.

Through December 31, 2013, a self-employed pregnant woman with assistance group income over 300% FPL, who is also the parent or caretaker relative of a child, does not have to meet a deductible. She is eligible with no premium under the benchmark plan. If she is not the parent or caretaker relative of a born child, she would have to meet a deductible to become eligible for BC+. Beginning January 1, 2014, she will be eligible for coverage under the Standard Plan once she meets the deductible.

Effective January 1, 2014, a pregnant minor with family assistance group income over 300% FPL (under non-MAGI rules) or 306% FPL (under MAGI rules) has the option to either prepay the pregnancy deductible or to wait to meet the deductible, or be enrolled as a child with a monthly premium.

17.3.1 Deductible Period

~~The deductible period for a child under 19 begins with the month the request for a deductible was made. There is no backdating option for a child under 19.~~

The child under 19 can choose to begin the BC+ deductible period as early as three months prior to the month of application and as late as the month of application.

Example 1 has been updated.

17.3.2 Calculating the Deductible Amount

Example 2 has been updated.

17.4.3 Expenses that cannot be counted toward a Deductible

Do not count the following toward the deductible:

- ~~2. Medicare Supplemental Medical Insurance (Plan B) premiums since they are deducted from the income prior to the deductible calculation~~

17.9.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, and the deductible is not met, you must recalculate the deductible. Compare the new group's countable monthly income with the new group's 150% FPL limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes.

18.1.1 BC+ Extensions Introduction

This subsection has been rewritten. The changes are too numerous to list.

18.1.2 Pregnant Women

Through December 31, 2013, a Pregnant woman who is not a parent or caretaker relative of a child during her pregnancy, can only become eligible for an extension if she was enrolled in BC+, with income at or below 100% of the FPL, for 3 months once her pregnancy reaches the 8th month. Look back 60 days from her due date or the date the pregnancy ended to determine the 8th month. If she was a parent or caretaker relative and enrolled with income at or below 100% FPL in 3 of the past 6 months she would be eligible for an extension.

Beginning January 1, 2014, a pregnant woman whose income increases to over 100% of the FPL will be able to enter an extension if she was eligible for BC+ as a pregnant woman, a parent or caretaker relative at any time during the pregnancy with income at or below 100%FPL in 3 of the past 6 months.

18.1.3 Children

This subsection is new with this release. The changes are too numerous to list.

18.2.1 Extensions Prior to 2014

Extensions due to an increase in earnings beginning prior to December 31, 2013, will be 12 months. Effective January 1, 2014, extensions due to an increase in earnings will be 4 months for AGs using non-MAGI and/or MAGI rules.

To receive a ~~12-month~~ BC+ extension due to an increase in earnings a person must meet the following requirements:

5. S/he verified his or her income, unless s/he is exempt from paying a premium.

For AG's in a 12 month extension, at least one member of the BC+ group must remain employed throughout the ~~12-month~~ extension. If s/he loses employment,

end the extension, unless the loss of employment is temporary. Temporary loss of employment occurs for reasons such as equipment break-downs, slack periods, weather restrictions, fire, and retooling of work areas and if the worker is laid off for a definite period of time, or for an unspecified period, but the employer states s/he will be called back to work eventually.

For AGs in a 4 month extension, there is no requirement for a member of the BC+ group to remain employed.

A pregnant woman with no born children under her care may be eligible for a 12 month extension, if she was enrolled in BC+ with income at or below 100% FPL for three months beginning with the 8th month of her pregnancy.

18.2.2 Earnings Extensions beginning 2014

This subsection is new with this release. The changes are too numerous to list.

18.3 Increase in Child Support or Spousal Support Income Extensions

This section has been split into several subsections. The changes are too numerous to list.

18.3.1 Support Extensions prior to December 31, 2013

18.3.1.1 Four Month Extension

18.3.1.2 Twelve Month Extension

18.3.2 Support Extensions after January 1, 2014

18.5.1 Introduction

A BC+ member loses an extension if one or more of following happens:

2. S/he loses employment when the 12 month extension requires that someone in the group remain employed.
3. All children under the parent's or caretaker relative's care have either left the household or turned 19. This does not apply to extensions that begin on or after January 1, 2014.
4. S/he fails to provide verification of income and at least one parent/caretaker in the extension AG is not disabled, a tribal member, or pregnant. Only the non-disabled, non-tribal, non-pregnant parents/caretakers are ineligible for failure to provide verification. The other members of the family in the extension remain eligible for the duration of the extension.

Note: Children in an extension who turn 19 do not lose the extension just for turning 19.

19.1 BC+ Premiums

The section has been split to provide policies that will continue through December 31, 2013 and new policies effective January 1, 2014. The changes are too numerous to list.

19.2 Premium Calculations

This section has been split into 2 subsections. The changes are too numerous to list.

19.2.1 Premium Calculations Through December 31, 2013

19.2.2 Premium Calculations Effective January 1, 2014 – This subsection is new with this release.

19.3 Premium Limits

Beginning January 1, 2014, children with assistance group income above 201.00% of the FPL will be required to pay premiums, which will be capped at 5%. Parents and caretakers in Extensions will pay premiums based on the

sliding scale discussed above, without a 5% cap applied. Non-exempt children with incomes above 201% of the FPL will not be required to pay premiums when the adults in the household are paying premiums in an Extension. If the parents enter a restrictive re-enrollment period (RRP) for failure to pay a premium or are otherwise ineligible, non-exempt children with income above 201% will be required to pay a premium.

The 5% cap methodology for children with premiums will be effective as soon as one child on the case who is subject to premiums has his or her eligibility determined using MAGI rules.

An example has been added for clarification.

19.7 Advance Payments

Through December 31, 2013, payments can be made in advance (further than the next month), but the payment cannot exceed the current certification period.

Effective January 1, 2014, premium payments can no longer be made in advance.

19.8.1 Non-Payment Introduction

The failure to pay a premium does not affect the eligibility of any person in the household who does not have a premium obligation. If an individual or family with a premium obligation fails to pay the premium by adverse action of the benefit month, BC + will close for those individuals who owed a premium. Through December 31, 2013 if those individual(s) are children under age 19, they are not eligible for six calendar months following the date on which their coverage terminated, unless there was good cause.

Effective with RRP's beginning January 1, 2014 (for failure to pay December 2013 premiums), children under age 19 who do not pay their premiums will not be eligible for BC+ for three calendar months. See 19.11 for more information. If those individuals are adults age 19 and older, they are not eligible for 12 calendar months following the date on which their coverage terminated, unless there was good cause.

~~If a late payment is received by the end of the month after the benefit month, lift the Restrictive Re-enrollment Period (RRP) (19.11) and reinstate eligibility.~~
For more information on how RRP's can be lifted and BC+ eligibility reinstated, see 19.11.

19.9 Late Payments

Through December 31, 2013, if the member pays in the second month after the benefit month, it's considered a non-payment. Effective January 1, 2014, the current non-payment policy will continue for adult parents and caretakers who owe premiums. However, children can make late premium payments at any time during their three month RRP (see 19.11).

19.10.2.1 Person adds:

If the person add will cause an increase in the premium, CARES will not allow eligibility confirmation if the notice requirement cannot be met. Certify eligibility for new members through the ForwardHealth Portal. If unable to certify through the ForwardHealth Portal, complete and return the F-10110 (formerly DES 3070) for the days that cannot be confirmed in CARES (See Process Help 81).

19.10.2.3 Effective dates of premium increase (other than person adds)

The following situations qualify for this treatment:

- A person becomes eligible for BC+ for any non-financial reason except late payment of the previous month's premium, failure to verify a

reported change that resulted in the premium increase, or failure to complete a renewal.

- Effective January 1, 2014, a case reports a decrease in income from above 300% to below 300% and the child(ren) are now eligible with a premium.

In a situation where other members in the AG or in another BC+ AG may owe a premium, treat their premium separately from the newly eligible members and/or AG.

For example, Through December 31, 2013, a family that owes a small premium for the children but then has an income decrease to below 200% of the Federal Poverty Level (FPL) that causes the parents to be eligible for a larger premium. With the income change, the children no longer owe a premium. If the premium was already paid for the children, that amount must be refunded. If the premium was not paid, the children should not be sanctioned for non-payment since they no longer owe a premium.

Example 5 is new with this release.

19.11 BadgerCare Plus Restrictive Re-enrollment Period (RRP)

A member for whom a premium is owed for the current month who leaves BC+ by quitting or not paying 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 a certain number of months from the termination date while their income remains high enough to owe a premium, unless they meet a good cause exemption or the RRP is lifted. For adult BadgerCare Plus members aged 19 and older, the RRP is 12 months; for children under age 19 the RRP lasts 6 months if the RRP begins prior to December 31, 2013 or the RRP will last 3 months if it begins after January 1, 2014.

Note: An individual's RRP status for BC+ does not impact his or her eligibility to purchase health insurance through the Marketplace.

19.11.1 Household Changes

End the RRP when an adult member of the former BC+ group leaves the home during the RRP for one full calendar month and all arrears are paid.

19.11.2 Reapplying

Children under age 19

Through December 31, 2013, The individual must serve the full six month penalty period. Eligibility may begin again in month seven provided the arrears are paid in full. The arrears must be paid for all months s/he was eligible with a premium. In addition, if another group in the case has unpaid premiums and are in a different RRP, no one is eligible after the RRP until all the arrears for the case are paid.

Beginning January 1, 2014, the individual will serve a three month RRP for failure to pay a premium. However, the individual can become eligible for BC+ again at any time during the three month RRP if s/he pays his or her arrears. The child's eligibility will be restored back to the beginning of the RRP. If the individual serves the full three month penalty period, s/he will become eligible for BC+ again without paying arrears on the first of the following month after the RRP ends, if s/he continues to meet the program eligibility criteria.

If a child enters a six month RRP prior to December 31, 2013 and the RRP would end in 2014, s/he must serve the full six month RRP before becoming eligible for BC+ again. This child's RRP cannot be lifted in 2014 by paying his or her arrears prior to the end of the RRP.

Examples 4, 6, and 7 are new with this release.

19.11.3 Quitting BC+

In order for BC+ to be cost-effective, premium-paying members will not be able to pick and choose when they want to pay premiums and receive BC+ benefits. Therefore, if a premium-paying BC+ member decides to quit the program, they will remain ineligible for:

- 6 months if they are a child under age 19 and they quit prior to Adverse Action in November 2013,

Example 8 has been updated.

25.2 Application Types/Methods

BC+ applicants have the choice of one of the following application methods:

5. Use of the paper or online application available through the Marketplace.
6. Telephone application with the Marketplace.

25.3.1 Where to Apply Introduction

The agency (county/tribe or consortia) of the applicant's county of residence should process the individual's application.

25.3.4 Applications Received from the Federal Marketplace

(This subsection is new with this release).

Starting Fall 2013, the Federally-facilitated Marketplace (the Marketplace or the Exchange) will begin sending applications to DHS through an account transfer process for individuals the Marketplace assesses as potentially eligible for BadgerCare Plus or Medicaid. Such applications are considered full applications for all "insurance affordability programs" including BadgerCare Plus and should be appropriately processed. The 30 day processing requirement begins on the day that the account is received by DHS or the next business day if received after normal operating hours or on weekends or holidays. If eligible, the individual's benefits will begin on the first day of the month the application was filed at the Marketplace, not the date that the application was received by the agency. If the individual requests backdating, their eligibility will be backdated for up to three months from the first day of the month the application was filed at the Marketplace.

If a paper application from the Marketplace is mailed to a consortium or tribal agency, the IM worker should consider that application as an application for BadgerCare Plus and/or Medicaid and process it.

25.4 Valid Application

A valid application for BC+ must include the applicant's:

3. Signature in the Rights and Responsibilities section of one of the following forms:
 - Wisconsin Medicaid for the Elderly, Blind and Disabled Application / Review Packet (F-10101),
 - Medicaid, BadgerCare Plus and Family Planning Services Registration Application (F-10129),
 - BadgerCare Plus Application Packet (F-10182),
 - BadgerCare Plus Supplement to FoodShare Wisconsin Application (F-10138)
 - [Health Coverage & Help Paying Costs Application](#) from the Federally-facilitated Marketplace,

- Telephonic signature in CARES,
- Electronic signature in ACCESS, or
- Electronic signature in an account transfer from the Marketplace.

25.5 Valid Signature

The applicant or the applicant's caretaker relative must sign (using his/her own signature):

1. The paper application form,
2. The signature page of the CAF (telephone or face to face),
3. The ACCESS application form with an electronic signature, or
4. The online or paper **Health Coverage & Help Paying Costs Application** from the Federally-facilitated Marketplace.

Except when:

2. An authorized representative signs for the applicant. The applicant may authorize someone to represent him/her (IMM, Ch. I, Part A, 18.3.0). An authorized representative must be an individual, not an organization.

When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.

25.5.2 Telephone Signature Requirements

Note: Applications that are submitted through ACCESS or transferred from the Marketplace are signed electronically, so an additional signature (telephone or pen-and-paper) is not needed.

25.6 Filing Date

For applications submitted to the local agency, the filing date is the day a signed valid application /registration form is delivered to the Income Maintenance agency or the next business day if it is delivered after the agency's regularly scheduled business hours.

The filing date on an ACCESS application or an application submitted to the Marketplace is the date the application is electronically submitted or the next business day if submitted after 4:30 PM or on a weekend or holiday.

When an application is submitted by mail or fax, record the date that the IM agency received the valid application form.

When a request for assistance is made by phone, the filing date is not set until a signed application and/or page one valid signature is received by the agency.

25.7.1 Timeframes Introduction

All applications received by an agency must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from:

- The filing date for applications submitted directly to the local tribal or consortium agency,
- OR**
- The date the local agency received the application(s) from the Marketplace.

This includes issuing a notice of decision.

Example 3: A signed application was submitted to the Marketplace on January 2nd. The Marketplace assessed the individual as potentially eligible for BC+ and transferred the individual's account to the agency on January 5th. The first day of the 30-day period for processing requirements was January 6th. The end of the 30-day period would have been February 4th. The application was approved on January 31st, and the applicant is determined eligible beginning January 1st.

25.8 Begin Dates

BC+ eligibility begins the first day of the month in which the valid application is submitted and all eligibility requirements are met, with the following exceptions. Those begin dates are the date a valid application is submitted, all eligibility requirements are met, and:

5. BC+ Prenatal Program - The first of the month in which a completed application is received and the pregnancy is verified.

Note: As of January 1, 2014, pregnancy for the BC+ Prenatal Program will only be verified if the worker has information that contradicts the individual's self-declaration.

25.8.1 Backdated Eligibility

The text changes are too numerous to list.

25.9.1 Termination

Starting with renewals due March 31, 2014, if a case is determined under MAGI rules and is closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the individual can be reopened for BC+ without filing a new application if s/he provides the necessary information within 90 days of the renewal date.

26.1.1 Reviews Renewals

Agency Option

For individuals whose eligibility is determined under non-MAGI rules, the agency may review any case at any other time when the agency can justify the need. Examples include:

- Loss of contact
- Member request

Note: Shortening certification periods in an attempt to balance agency workload is not permissible.

Effective January 1, 2014, BC+ members whose eligibility is determined using MAGI rules are required to complete a renewal no earlier or no later than 12 months from their certification period. Individuals whose benefits are time-limited, such as CENs or pregnant women, will not be required to do a renewal at the end of their time limited benefit if the individual is on a case with other open BC+ assistance groups.

Once individuals' BC+ eligibility is determined under MAGI rules, workers can complete an early renewal only if the member requests an early renewal. Once the member requests an early renewal, the renewal must be completed.

26.1.2 Administrative Renewals

This section has been split into:

Administrative Renewals through December 31, 2013

and

Administrative Renewals Effective January 1, 2014

Effective January 1, 2014, administrative renewals will be suspended for BC+ and FPOS cases.

27.2 Non- financial Change Reporting Requirements

BadgerCare Plus members whose eligibility is determined under non-MAGI rules must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy and changes to the pregnancy of a BC+ member
- Living arrangement (e.g. institutionalization, incarceration, etc.)
- Change in marital status

BadgerCare Plus members whose eligibility is determined under MAGI rules must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy and changes to the pregnancy of a BC+ member
- Living arrangement (e.g. institutionalization, incarceration, etc.)
- Change in marital status
- Change in insurance coverage
- Change in expected tax filing status
- Change in tax dependents
- No longer receiving a tax-related deduction

27.3 Income Change Reporting Requirements

Through December 31, 2013, BadgerCare Plus members must report income changes when their total monthly gross income exceeds the following percentages of the Federal Poverty Level (FPL) for their assistance group size:

[See listing in the Handbook]

Effective January 1, 2014, income changes must be reported when the total monthly income of the assistance group with the highest monthly income amount exceed the following FPL percentages for their assistance group size:

[See listing in the Handbook]

Adults in a BadgerCare Plus Extension who are required to pay a premium must also report and verify income changes during the extension certification period. Eligibility for adult members who would be required to pay premiums will be terminated for failure to submit requested verification. Effective January 1, 2014, all non-exempt parents and caretakers in BC+ Extensions will be required to pay a premium.

For members whose eligibility is determined under non-MAGI rules, the CARES notice will indicate the dollar amount associated with each FPL level, for the BC+ group size.

28.1 Overpayments

Note: Overpayments can only be recovered if the member failed to report a change for which they were notified they were required to report.

28.4.3 Overpayments for Individuals Eligible for Family Planning Only Services (FPOS)

2. If the incorrect /overpaid BC+ benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the member may have paid and the “average” (currently \$19.04) monthly cost of the FPOS.

28.6 Refer to District Attorney

See IMM Chapter 11 Program Fraud Overview for referral criteria when fraud is suspected. The agency may refer the case to ~~the state fraud investigation service provider~~ the Department Of Health Services (DHS) Office of the Inspector General (OIG) where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney, corporation counsel for investigation, **or OIG**. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

29.1 Notices

A member must receive a notice at least ten days prior to a negative action such as a termination of benefits, a change from the Standard plan to the Benchmark plan (only until December 31, 2013) or an increase in premium.

31.1 Interagency Transfer

~~CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of the certification period that was in effect at the time of the transfer. Run eligibility in CARES.~~

The renewal date will remain the same after case transfer.

38.1 Covered Services

A covered service is any ~~medical~~ health care service that BC+ will pay for an eligible member, if billed. The Division of Health Care Access and Accountability (DHCAA) certifies enrolls qualified health care providers and reimburses them for providing BC+ covered services to eligible BC+ members. Members may receive BC+ services only from certified enrolled providers, except in medical emergencies. BC+ reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-certified enrolled provider.

38.2.1 Introduction

The table of Covered Services under the BC+ Standard Plan or BC+ Benchmark Plan has been updated.

38.2.2 Copayment

This subsection has been updated with co-payment policy through December 31, 2013 and co-payment policy effective January 1, 2014. The changes are too numerous to list.

38.3 Transportation

This entire section has been rewritten with this release.

38.4 HMO Enrollment

2. If the member lives in an area covered by two or more HMOs, enrollment is mandatory, does not choose an HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card.

~~Members~~ In areas with only one available HMO will stop here enrollment is voluntary and the process stops here. They do not have to enroll in an HMO.

3. If the member lives in a mandatory area and does not choose and HMO, has not chosen an HMO after four weeks, and lives in an area covered by two or more HMO's, s/he will be assigned an HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

38.4.2 Disenrollment

Members can be disenrolled by the HMO's request in the following situations:

1. They become inmates of a public institution.
2. They need an experimental transplant.

HMO disenrollment is not automatic in these situations.

39.1 Emergency Services Income Limits

An immigrant who only meets the eligibility criteria for the BadgerCare Plus Core Plan is not eligible for Emergency Services. Immigrants who meet the criteria for BadgerCare Plus under the childless adults' coverage group under MAGI rules will also be ineligible for Emergency Services.

BC+ Emergency Services Income Limit Through December 31, 2013
[Table]

BC+ Emergency Services income Limit Effective January 1, 2014
A 5% income disregard and 1% conversion factor will be applied to the Emergency Services income limit for pregnant women and children effective January 1, 2014.

[Table] This table is new. The changes are too numerous to list.

39.2 Determining if an emergency exists

Certification of Emergency Services is not done through CARES and must be done manually. However, all applications should be processed through CARES to determine BC+ eligibility. If the immigrant does not have an SSN, CARES will assign a pseudo SSN. That pseudo SSN should be used when submitting the manual certification. When an immigrant is determined eligible for Emergency Services, complete and submit a manual certification (F-10110). See [Process Help 81.3](#). form F-10110 (formerly DES 3070). The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

Note: The Federally-facilitated Marketplace will send accounts to State consortia and tribal agencies for individuals who have been assessed as potentially eligible for BC+ Emergency Services.

39.3 Emergency Services For Pregnant Women

A pregnant non-qualifying immigrant may apply for emergency services up to one calendar month before her due date (See 39.5 for pregnant non-qualifying immigrants who lose eligibility for the BC+ Prenatal Services). Certify an eligible pregnant non-qualifying immigrant from the date of application, if she applies no more than one calendar month prior to her due date, through the end of the month in which the 60th day occurs following her due date. Adjust the certification period based on the actual pregnancy end date, once it is known.

Note: As of January 1, 2014, pregnancy is no longer required to be verified.

Example 4 updated.

40.1 Family Planning Only Services Program, 40.8 FPOS Changes,

BC+ Family Planning Only Services program (FPOS) provides limited benefits for family planning services for women and men with income at or below 300% of the FPL (under non-MAGI rules) or 306% FPL (under MAGI rules) and who are:

2. Not enrolled in BC+ ~~without a premium~~ or receiving other full benefit Medicaid.

40.2.1 Introduction

FPOS temporary enrollment through a presumptive eligibility determination provides family planning services beginning on the day that a qualified provider determines that the individual has income at or below 300% of the FPL (under non-MAGI rules) or 306% FPL (under MAGI rules), and is:

1. 15 years of age or older, and
2. A Wisconsin resident, and
3. A citizen of the U.S., and
4. Not enrolled in BC+ ~~without a premium~~ or receiving other full benefit Medicaid.

40.4 FPOS Non-financial Requirements

The following are FPOS specific non-financial requirements:

1. Be 15 years of age or older.
2. Not be enrolled in BC+ ~~without a premium~~ or receiving other full benefit Medicaid.
3. Meet all BC+ non-financial program requirements (See [Section 2.1](#)) criteria listed in the Non-Financial Chapter with the exceptions listed below:

40.5.2 Income Under MAGI Rules

This subsection is new with this release.

Because FPOS eligibility is determined based on a group size of one, the applicant's taxable earned and unearned income is the only income that should be used when calculating their income for purposes of FPOS eligibility under MAGI rules. When a child under 19 is applying, their parents' income is not included in his or her eligibility determination. If a married individual is applying for FPOS coverage, do not include the income of the spouse, even if he or she is living with his or her spouse.

40.6.1 Fetus

For non-MAGI based FPOS groups, increase the FPOS group by one for each fetus a pregnant woman in the FPOS group is carrying.

40.6.2 Children 18 years of Age

For non-MAGI based FPOS groups, children under 19 who are applying for FPOS are a group of one, unless s/he is married and/or has children. Parents are not included in the group.

40.6.3 FPOS Group under MAGI Rules

This subsection is new with this release.

For all individuals, including children under 19, whose eligibility for FPOS is determined under MAGI rules, the group size of the applicant will always be one, regardless of his/her marital status, pregnancy status, and whether or not s/he has children or tax dependents.

40.6.4 Transitioning to MAGI Rules

This subsection is new with this release.

Current FPOS members whose eligibility for the program is based on non-MAGI rules will transition to MAGI rules in the same manner as BC+ members: on March 31, 2014 or their regularly scheduled 2014 renewal, whichever is later.

All applicants to the FPOS program who apply on or after January 1, 2014 will have his or her eligibility determined under MAGI rules.

40.7 FPOS Program Choice

An individual applying for both BC+ and FPOS is not given a choice at the time of confirmation if s/he meets the eligibility for both benefits. S/he will be enrolled in BC+.

An individual found to be eligible for a deductible may also be eligible for FPOS benefits during a deductible period. The member may receive FPOS benefits until s/he has met a deductible. The member can report any out-of-pocket medical bills incurred while s/he is receiving services through FPOS, in order to meet a deductible. Once a deductible has been met, s/he is receiving full-benefit BC+/ MA, and is no longer eligible for FPOS. ~~but~~ However, s/he will continue to receive the same family planning services through BC+/MA.

(The example has been updated.)

40.8 FPOS Changes

Changes reported in ~~income or~~ household composition or income resulting in ineligibility will not affect FPOS benefits for the remainder of the 12-month certification period. Eligibility is put into an extension phase until the end of the 12-month certification period or until the member reports an income decrease that is again below the FPOS income limit.

Note: Household composition changes will not affect eligibility when the member's eligibility is determined using MAGI rules in 2014, as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

40.9 FPOS BC+ Extension Phase

An FPOS member enters into a FPOS extension phase if a change is reported at any time during the 12-month certification period in income or household composition that results in income that exceeds the FPOS income limit.

The extension continues until the ~~review~~ renewal date that was originally set for the FPOS eligibility.

Note: Household composition changes will not affect eligibility when the member's eligibility is determined using MAGI rules in 2014, as all FPOS assistance groups will only include the member in the household composition, regardless of his or her living arrangement.

40.10 FPOS Renewals, Reviews and Recertifications

Through December 31, 2013, FPOS cases can be selected for administrative renewal (26.1.2). These cases must meet all the following criteria to be selected for this process:

1. No child in household turning 18 in current or next month
2. Countable income of individuals age 18 and above at or below 275% of the FPL.

Administrative renewals for FPOS case will not be allowed in 2014.

41.1 BC+ Prenatal Program

The BC+ Prenatal Program (BC+PP) provides coverage for women who:

- Meet the non-financial and financial eligibility requirements for BC+ **outside of incarceration or immigration status**
- Have verified pregnancies, and
- Are not eligible for BC+ because they are either inmates of a public institution or non-qualifying immigrants.

Note: Pregnancy will no longer be verified for the BC+ Prenatal Program beginning on January 1, 2014. Only verify pregnancy if the worker has information that contradicts the member or applicant's self-declared information.

41.2 BC+ Prenatal Program Eligibility Requirements

2. The applicant must not have current or past access to an employer's health insurance benefit where the employer pays 80% or more of the premium cost **or to any State of Wisconsin health insurance plan.**
3. The applicant must provide any **required** verifications. ~~of pregnancy and any other required verification.~~

Note: For eligibility beginning on or after January 1, 2014, pregnancy will only be verified if the worker has information that contradicts the applicant's self-declared information.

4. The applicant must not have health insurance coverage (Chapter 7) **through any HIPAA standard plan** now or in the three calendar months prior to the BC+ Prenatal request.

41.2.1 Unique Aspects of BC+ Prenatal Program

3. Unlike regular BC+ which locks in eligibility throughout the pregnancy, BC+PP eligibility may be terminated with timely notice ~~for these pregnant women~~ for failure to meet any of the BC+ eligibility requirements listed in 41.1.
4. There is no Presumptive Eligibility for the BC+PP. Eligibility for the BC+ Prenatal Program may only be determined by the IM agencies.
5. **There is no 3-month backdating option available for Prenatal Program members.**
6. **Unlike BC+ for Pregnant Women, Prenatal Program members are not eligible for the 60-day pregnancy extension, but are eligible for Emergency Services during that time.**

41.5 BC+ Prenatal Program Eligibility Begin Date

BC+ Prenatal Program eligibility begins no sooner than the first of the month in which a valid application is received. ~~and the pregnancy is verified.~~ **For applicants whose eligibility begins prior to December 31, 2013 the pregnancy must be verified before eligibility can begin.**

The example has been updated.

41.7 Determining BC+ Prenatal Group

This section has been split to accommodate eligibility rules prior to December 31, 2013 and after January 1, 2014.

41.7.1 The BC+ Prenatal Group through December 31, 2013

41.7.2 The BC+ Prenatal Group after January 1, 2014

Section 41.7.1 is new. The changes are too numerous to list.

42 Well Women Medicaid

This chapter has been marked as reserved for future updates.

43.1 Core Plan

The BC+ Core Plan will be ending on December 31, 2013. Core Plan members

Introduction	with AG income at or below 100% FPL will be transitioned to the BC+ Childless Adults coverage group without have to reapply. Coverage for Core Plan members with AG income over 100% of the FPL will be terminated effective December 31, 2013. These individuals may be eligible to receive advanced premium tax credits and cost-sharing reductions available through the Federally-facilitated Marketplace.
43.4.2 Processing Fee	Effective September 28, 2013, Core Plan applicants and/or members completing a renewal will no longer be required to pay the \$60 processing fee or complete the HNA.
43.5.1 Filing Date	<p>Note: The EBD Medicaid application filing date can be used as the Core Plan filing date, if:</p> <ul style="list-style-type: none"> • A Core Plan application is received and the application fee is paid within 30 days after the EBD Medicaid denial notice is issued; and • All required verification is submitted prior to the deadline. <p>Any EBD applicant with a file date prior to October 10th, who meets the above criteria, will be able to enroll in the Core Plan without being put on the waitlist.</p>
43.5.2.2 Late Processing	<p>Reapplication</p> <p>Upon request from the applicant/member, a reapplication will be processed without an additional processing fee if the request is made within:</p> <ul style="list-style-type: none"> • Thirty days of the date after an initial application was denied; or • One calendar month after an early disenrollment date. <p>The request establishes a new filing date and a new 30-day processing period. If the individual is determined eligible through the reapplication process, the enrollment start date is determined according to the next available enrollment period after eligibility is confirmed.</p> <p>This policy does not apply to annual renewals or subsequent applications.</p>
43.5.3 Certification Period	Changes in income and/or marital status do not affect a member's eligibility during the 12 month certification period. This policy ends when the Core Plan ends on December 31, 2013.
43.6.3 Health Needs Assessment	This subsection has been removed.
43.6.4 Physical Exam	This subsection has been removed.
43.7.3.4 Initial Payments	Note: The \$60 processing fee for Core Plan renewals will no longer be collected for renewals completed on or after September 28, 2013, regardless of the month the renewal is due. The below policy will only apply to renewals completed prior to September 28, 2013.
43.7.3.10 Restrictive Re-enrollment Period (RRP)	<p>RRPs will be tracked separately for BadgerCare Plus for Families and the Core Plan. If an individual who is under an RRP due to no-payment of premiums for Core Plan becomes eligible for BadgerCare Plus for Families, the Core Plan RRP will not affect eligibility for BadgerCare Plus.</p> <p>Core Plan RRP do not affect eligibility for BC+ effective January 1, 2014.</p>

43.8.3 Core Plan Ending	<p>This subsection is new with this release.</p> <p>The BC+ Core Plan is ending effective December 31, 2013. Core Plan members at or below 100% FPL will be transitioned to the new BC+ childless adults category and those over 100% FPL will be referred to the Marketplace.</p>
43.10 Core Plan Enrollment Cap (Waitlist)	<p>Core Plan applications received after 5:00 P.M. on October 9, 2009, will not be processed. A Waitlist was established on October 9, 2009 because the total number of applications received is greater than the amount of funding available. The Waitlist will end as of September 28, 2013. Individuals on the Waitlist, regardless of their household income, will need to reapply for coverage, either through BC+ or the Marketplace, for eligibility beginning January 1, 2014.</p>
43.12 Core Plan Covered Services	<p>Covered services and co-payment information can be found on the BadgerCare Plus Covered Services Comparison Chart (PDF) on the ForwardHealth Provider Home Page. at http://www.dhs.wisconsin.gov/badgercareplus/core/pdf/p-40494.pdf</p>
44 BC+ Core Plan Transitional Childless Adults	<p>This chapter has been marked as reserved for future updates.</p>
45.1.3 BC+ Basic Plan Ending	<p>This subsection is new with this release.</p> <p>Due to the restructuring of the BadgerCare Plus program effective January 1, 2014, the BadgerCare Plus Basic Plan will be ending on December 31, 2013. Members enrolled in the Basic Plan will be given timely notice of termination of their coverage and may apply for BadgerCare Plus or for advanced premium tax credits and cost sharing reductions available through the Marketplace.</p>
45.2.1 BC+ Basic Eligibility Ending Introduction	<p>(This subsection will be removed with this release).</p> <p>Effective March 19, 2011, requests to enroll in the Basic Plan will be denied because new enrollment in the program has been closed. See 45.1.2 BC+ Basic Enrollment Ending.</p>
45.3 BadgerCare Plus Basic Enrollment Process	<p>New enrollment in the BC+ Basic program ended effective March 19, 2011. See 45.1.2 Enrollment Ending.</p> <p>Note: The BC+ Basic Plan is ending effective December 31, 2013.</p>
45.3.1 Introduction and Premiums	<p>(This subsection will be removed with this release).</p> <p>New enrollment in the BC+ Basic program ended effective March 19, 2011. See 45.1.2 Enrollment Ending.</p> <p>There is no other application process for the Basic Plan. No paper applications designed as applications for other BadgerCare Plus or Medicaid programs will be accepted and processed as a Basic Plan application. There is no signature required to enroll in the Basic Plan. An SSN is required before a Basic Plan enrollment request can be processed. If an individual on the Waitlist makes the initial premium payment online, s/he will not be able to complete the process without entering an SSN if one was not provided when the individual applied for the Core Plan.</p>
45.4 BadgerCare	<p>This chapter has been marked as Reserved.</p>

**Plus Basic
Notification
Reserved**

Effective March 19, 2011, requests to enroll in the Basic Plan will be denied because new enrollment in the program has been closed. See 45.1.2 Enrollment Ending.

**45.5 BadgerCare
Plus Basic
Enrollment
Termination**

If it is determined that a Basic Plan enrollee no longer meets the Core Plan criteria (e.g. income is verified to be over 200% of the FPL) eligibility for the Basic Plan will be terminated. and s/he will also be removed from the Core Plan Waitlist.

Please note, the BC+ Basic Plan is ending effective December 31, 2013 and that termination of coverage due to the end of the Basic Plan cannot be appealed. See 45.1.3 BC+ Basic Plan Ending.

**45.6 BadgerCare
Plus basic
verification
requirements**

Verification of income and health insurance coverage will be is required for the Basic Plan. The Bureau of Enrollment Policy and Systems will use automated data exchanges to verify income and identify discrepancies or inconsistencies between the information provided by the enrollee and the third party source which could impact eligibility. A discrepancy report will be generated on a regular basis and provided to the Enrollment Services Center. Customers will be required to provide verification of income or health insurance coverage when a discrepancy that may impact eligibility exists.

**45.7.1 Online
Payments**

The ACCESS online payment tool can be used to make the initial and ongoing monthly premium payments. The online payment tool cannot be used to set up automatic withdrawals or payments for multiple months. See ACCESS handbook 10.7. BC+ Basic members will be unable to pay Basic premiums online after November 16, 2013.

**45.7.2 Phone
Payments**

Waitlist Members can pay their premium over the phone by calling the ESC BC+ Basic Plan Processing Unit at 1-800-291-2002, Option 2. Designated ESC BC+ Basic Plan Processing Unit staff will assist Waitlist members who call the ESC to pay a Basic premium.

**48.1.1 Premiums for
Children**

The table below is for the individual Child premium amounts. Under non-MAGI rules, group premiums (the total of the premiums of the children in the group) will be capped at 5% of the group's countable household income for families with incomes at or below 300% of the FPL.

The table below outlines the premium amounts for children whose income is determined under non-MAGI rules.

[See table in Handbook.]

Under MAGI rules, non-exempt children whose BadgerCare Plus eligibility is determined under MAGI rules and with an assistance group income above 201% of the FPL will be required to pay premiums. Each child's premium will be based on their own assistance group's size and income. The 5% cap for the cost of total household premiums for children will continue to apply. The cap will be 5% of the income of the premium paying assistance group with the highest countable income amount. The total household's premiums will be determined based on the combined amount of all children's premiums or the 5% cap, whichever amount is less. See sections 19.2 and 19.3 for more information on premium caps.

The below table outlines the premium amounts for children whose income is

determined under MAGI rules.

[See table in Handbook.]

Note: Children in extensions are not required to pay premiums (see section 19.1). If a parent in the household is in an extension, the children are exempt from paying premiums regardless of their income.

48.1.2 Premiums for Adults

Note: The BC+ Core Plan ends on December 31, 2013. See chapter 43.

Effective January 1, 2014, BC+ parents, caretakers and childless adults will not be subject to premiums unless they are in an extension. These premiums will be required of non-exempt adults in extensions regardless of whether non-MAGI or MAGI rules was used to determine BC+ eligibility.

Note: The rows for 100.00% – 132.99% FPL on each table are only effective beginning January 1, 2014.

All the tables for the various family sizes have been updated.

48.1.3 Premiums for Adult Caretaker Families with Self Employment Income

Effective January 1, 2014, depreciation will be an allowable expense when calculating income, regardless of the methodology used to determine eligibility (see section 16.4). Also effective January 1, 2014, self-employed parents and caretakers will no longer be charged a 5% premium. See Chapter 19 for more information on premiums.

49.1 Health Care Choice

For individuals whose eligibility is determined under non-MAGI rules:
[See table]

Note: The BadgerCare Plus Benchmark Plan ends on December 31, 2013.

For individuals whose eligibility is determined under MAGI rules:

Effective January 1, 2014, once an individual has been determined eligible for EBD MA, s/he must be enrolled in EBD MA, even if they are also eligible for BC+, unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BC+. In these instances, the pregnant woman will be enrolled in BC+.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD MA and can enroll in BC+. Pending for EBD MA includes, but is not limited to, waiting for a disability determination from DDB or not eligible for Medicare. If an individual enrolled in EBD MA becomes ineligible for EBD MA for any reason, including going over the asset limit or failure to pay a MAPP premium, s/he can enroll in BC+ if s/he is still eligible to do so.

51.1 BadgerCare Plus Medical Status Codes

Two new med stat tables have been added:

Med Stat Codes Added January 1, 2014
Med Stat Codes Eliminated January 1, 2014

52.1 Core Plan Health Insurance

Please note that the BadgerCare Plus Core Plan will end on December 31, 2013. See Chapter 43 for more information.

