



FH
[REDACTED]

**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

BCS/161030

PRELIMINARY RECITALS

Pursuant to a petition filed October 01, 2014, under Wis. Stat. § 49.45(5)(a), to review a decision by the Milwaukee Enrollment Services in regard to Medical Assistance, a telephonic hearing was held on October 23, 2014.

The issue for determination is whether the agency correctly discontinued BadgerCare Plus for petitioner's children due to access to other health insurance.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: Jose Silvestre, IM Spec. Adv.
Milwaukee Enrollment Services
1220 W Vliet St, Room 106
Milwaukee, WI 53205

ADMINISTRATIVE LAW JUDGE:

Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Milwaukee County. Her household of 4 has a monthly gross income of \$4699.84.
2. The petitioner is offered health insurance through her employer. Her employer pays 80% of the premium. See Exhibit 2.
3. On September 30, 2014 the agency issued a notice to petitioner stating that her children's BCP was denied effective October 1, 2014 because they had access to other health insurance.

DISCUSSION

BadgerCare Plus (BC+) is a state/federal program that provides health insurance for Wisconsin families and individuals living in poverty. BC+ replaced the former AFDC-Medicaid, Healthy Start and BadgerCare programs.

Petitioner's children have been denied BC+ due to access to other health insurance. The agency has set forth its policy concerning BC+ eligibility for families with access to employer sponsored insurance. See BC+ Handbook, §7.1.2, available online at <http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm>. Under the policy, if an employer provides health insurance, members of the household are ineligible for BC+ under certain circumstances. *Id.* The policy provides:

To prevent the crowd out of private insurance, BC+ benefits may be denied or terminated for individuals who have eligibility determined under MAGI rules and have access to certain employer sponsored health insurance policies when those individuals:

1. Are children ages 1 through 5 with household incomes over 191% of the FPL and children ages 6 through 18 with household incomes over 156% of the FPL,
2. Are pregnant women eligible under the BC+ Prenatal Program at any income level,
3. Are not in an exempt category (see list below) and,
4. Do not have a good cause [*The circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.*] reason for failure to enroll in an employer sponsored health insurance plan.

Individuals exempt from the policies related to health insurance access and coverage are:

1. Continuously Eligible Newborns,
2. Children under age 19 who have met a deductible (exempt only during the deductible period),
3. Infants less than 1 year old with household income at or below 306% of the FPL,
4. Children ages 1 through 5 (up to age 6) with household income at or below 191% of the FPL,
5. Children ages 6 to 18 with household income at or below 156% of the FPL,
6. Former Foster Care Youth,
7. Pregnant women, other than those in the BC+ Prenatal Program,
8. Parents and caretaker relatives, including those who are blind or disabled (including MAPP Disabled), as determined by the DDB, or through the Presumptive Disability process ([MEH 5.9](#)),
9. Childless adults, and
10. Parents, caretaker relatives, and children who are in an Extension.

BC+ Prenatal Program members are subject to different policies related to health insurance coverage. Refer to [\(7.4.1\)](#) [\(7.5\)](#) for the policies regarding the rules for current coverage and dropping coverage under the BC+ Prenatal Program.

Access to health insurance includes:

1. Past Access. ([7.2](#))
2. Current Access. ([7.3](#))
3. Coverage. ([7.4](#))
4. Dropped Coverage. ([7.5](#))

Policy also provides the following:

Children and any BC+ Prenatal Program members who had access to health insurance, including access due to a *qualifying event* *A qualifying event allows an employee to enroll in the employer's health insurance plan outside the designated open enrollment period. Qualifying events include; obtaining a new dependent through marriage, birth, adoption or placement for adoption and loss of other insurance coverage the employee was covered under at the time of the last open enrollment period. The employee has 30 days from the qualifying event to enroll in the insurance. This applies to permanent employees who have a normal work week of thirty or more hours.*, 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,

1. The access was to a *HIPAA*  *HIPAA is the Health Insurance Portability and Accountability Act. A HIPAA Standard Plan is any group health care plan that provides medical care to covered individuals and/or their dependents directly or through insurance, reimbursement, or by some other means. Medical care means amounts paid for diagnosis, cure, mitigation (moderation), treatment or prevention of disease; or amounts paid for the purpose of affecting any structure or function of the body. A policy that pays for a doctor's services in either an in-patient or outpatient setting qualifies as a HIPAA plan. The amount or type of benefits paid; co-insurance, deductibles, caps, etc., do not matter as long as the plan meets the HIPAA Standard Plan criteria. The health care plan cannot be limited to a single type of covered service or only accessible in a very defined circumstance. Plans limited to accident, disability, vision, long term care or dental are not examples of HIPAA plans.* health insurance plan through a current employer for which the employer paid at least 80% of the premium, or through the State of Wisconsin's health care plan (regardless of plan type, or premium amount contributed by the employer); and
2. The *applicant*  *A request for BadgerCare Plus coverage. The request must be on the Department's or Federally-facilitated Marketplace's application, registration form or account transfer (from Federally-facilitated Marketplace) and must contain name, address, and a valid signature . The applicant must submit a signed and completed application form to complete the application process.* is a child under age 19 and child is not exempt; **and**
3. There is no *good cause*  *The circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.* reason for not signing up for the coverage.

The child or BC+ Prenatal Program member is ineligible for BC+ for twelve calendar months from the date the health insurance would have begun.

Example 1: Marilyn applied for BC+ in April 2014 for herself and her children, ages 10 and 8; they have family income that exceeds 156% of the FPL. She could have enrolled in a family health insurance plan through her current employer in October 2013, and her employer pays 80% of the premium for that plan. Marilyn didn't sign up because she felt the premiums, co-payments and deductibles would be unaffordable. If she had signed up, coverage would have begun in December 2013.

Since Marilyn did not sign up for employer-provided coverage within the last twelve months when it was available, and she does not have good cause. Her children are ineligible for BC + through November 2014, 12 months from the date the coverage would have begun, unless they become

exempt during that time. Marilyn is not eligible because her income is over the 100% FPL limit for the parent and caretaker coverage group.

BC+ Handbook, §7.2.1.1.

There is no evidence to suggest that petitioner's children qualify as individuals exempt from the policies related to health insurance access and coverage, nor are there good cause exemptions under this scenario. Petitioner credibly explained that she wanted the BC+ because her employer's health insurance did not provide the mental health coverages that her kids needed. However, I cannot deviate from what law and policy dictate because it would be fair. I do not have equitable powers. See Oneida County v. Converse, 180 Wis.2nd 120, 125, 508 N.W.2d 416 (1993). Thus, I must find the agency acted correctly to deny the BC+ coverage.

CONCLUSIONS OF LAW

The petitioner's children's BC+ coverage was correctly denied due to access to other health insurance.

THEREFORE, it is

ORDERED

That the petition for review herein be dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

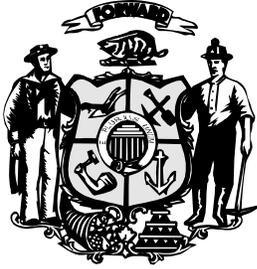
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 26th day of November, 2014

\sKelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on November 26, 2014.

Milwaukee Enrollment Services
Division of Health Care Access and Accountability