2011 DRAFTING REQUEST

Bill

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Wanted: **As time permits**

Companion to LRB:

For: **Kathleen Vinehout (608) 266-8546**

By/Representing: **Linda Kleinschmidt**

May Contact:

Drafter: **tdodge**

Subject: **Insurance - health**

Addl. Drafters: **pkahler**

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Vinehout@legis.wisconsin.gov**

Carbon copy (CC:) to: **tamara.dodge@legis.wisconsin.gov**

Pre Topic:

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Topic:

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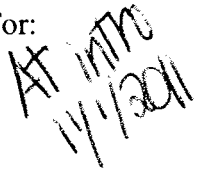

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Dodge, Tamara

From: Kleinschmidt, Linda
Sent: Friday, December 17, 2010 4:42 PM
To: Kahler, Pam; Dodge, Tamara
Subject: Model legislation for the SHOP Act (SB 707)

Follow Up Flag: Follow up
Flag Status: Red

Attachments: Stegal_1209155927_001.pdf

Hi Pam and Tamara,

Kathleen requests 2009 SB 707 be redrafted for the upcoming session. She would like you to look at the attached model legislation and determine how we can add that to the new version of SB 707.

Kathleen will be in Madison next week if you would like to discuss this with her.

Thank you.

Linda Kleinschmidt
Chief of Staff
Office of State Senator Kathleen Vinehout
3 South State Capitol - PO Box 7882
Madison, WI 53707-7882
608-266-8546
1-877-763-6636

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SECTION #. CR; Chapter 636

CHAPTER 636
HEALTH BENEFIT PLAN EXCHANGE

SUBCHAPTER I
GENERAL PROVISIONS

(B)
636.01 Definitions. In this chapter:
(B) (1) "Authority" means the Small Business Health Options Program Authority.

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-0760/P1
TJD&PJK:../..:rs&jf

In: 3/16/11

g's

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

PWF

Gen Cat

D-note

the health benefit plan authority; health benefit exchange operations; and granting rule-making authority

AN ACT ...; **relating to:** ???

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a later version.

Insert 1-2-TD

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. Chapter 636 of the statutes is created to read:

CHAPTER 636

HEALTH BENEFIT PLAN EXCHANGE

SUBCHAPTER I

GENERAL PROVISIONS

636.01 Definitions. In this chapter:

Benefit Plan

(1) "Authority" means the Small Business Health Options Program Authority.

(2) "Educated health care consumer" means an individual who is knowledgeable about the health care system and who has background or experience in making informed decisions regarding health, medical, and scientific matters.

(3) "Federal act" means the Federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and any amendments thereto, or regulations or guidance issued under, those acts.

(4) (a) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) "Health benefit plan" does not include any of the following:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Worker's compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; or

8. Other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(c) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or of those.

3. Other similar, limited benefits specified in federal regulations issued pursuant to under P.L. 104-191.

(d) "Health benefit plan" does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

1. Coverage only for a specified disease or illness; or.

2. Hospital indemnity or other fixed indemnity insurance.

(e) "Health benefit plan" does not include any of the following if offered as a separate policy, certificate, or contract of insurance:

1. Medicare supplemental health insurance as defined under section 1882 (g) (1) of the Social Security Act; federal.

2. Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or.

10 USC ch. 55

3. Similar supplemental coverage provided to coverage under a group health plan.

(5) "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse

LPS: please keep both close-parens here.

any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(6) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E.636.42 (5) of this act.

(7) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange and at the option of the employer, some or all of its part-time employees, provided that the employer:

(a) Has its principal place of business in this state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or.

(b) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

(8) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311 (c) of the federal act and section 7.636.42 of this act.

(9) "Qualified individual" means an individual, including a minor, who:

(a) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange; authority.

(b) Resides in this state.

(c) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and.

(d) Is, and is reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(10) "Secretary" means the secretary of the federal Department of Health and Human Services.

(11) "SHOP Exchange" means the Small Business Health Options Program established under section 6 (636.30) of this act.

(12) (a) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

(b) For purposes of this subsection, all of the following apply

1. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer.

2. An employer and any predecessor employer shall be treated as a single employer.

3. All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

4. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that it is reasonably expected that employer will employ on business days in the current calendar year; and.

5. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and that would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated

as a small employer for purposes of this act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

636.25 General matters. (1) The authority shall do all of the following:

(a) Facilitate the purchase and sale of qualified health plans.

(b) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and.

(c) Meet the requirements of this act and any regulations implemented under this act.

(2) The Exchange may contract with an eligible entity for any of its functions described in this act. An eligible entity includes, but is not limited to, the department of health services or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

(3) The Exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

(4) The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

(5) (a) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(b) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832 (c) (2) (A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302 (b) (1) (J) of the federal act.

(5) Neither the Exchange nor the carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B (c) (2) (C) of the Internal Revenue Code of 1986.

636.30 Duties. In addition to all other duties imposed under this chapter, the authority shall do all of the following:

(1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311 (c) of the federal act and section 7 (636.42) of this act, of health benefit plans as qualified health plans.

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(3) Provide for enrollment periods, as provided under section 1311 (c) (6) of the federal act.

(4) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain a standardized comparative information on such plans.

(5) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the secretary under section 1311 (c) (3) of the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302 (d) (2) (A) of the federal act.

(6) Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA; federal Public Health Service Act.

(7) In accordance with section 1413 of the federal act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable state or local public program and if, through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program.

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the federal act.

(9) Establish a SHOP Exchange through which qualified employers may access health care coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage.

(10) Subject to section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the

Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(a) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or.

(b) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(11) Transfer to the federal secretary of the treasury the following:

(a) A list of the individuals who are issued a certification under subsection ... including the name and taxpayer identification number of each individual.

(b) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

1. The employer did not provide minimum essential coverage; or.

2. The employer provided the minimum essential coverage, but it was determined under section 36B (c) (2) (C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value.

and

(c) The name and taxpayer identification number of:

1. Each individual who notifies the Exchange under section 1411 (b) (4) of the federal act that he or she has changed employers; and.

2. Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(12) Provide to each employer the name of each employee of the employer described in subsection K(2) (636.30(11) (b)) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(13) Perform duties required of the Exchange by the secretary or the secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

(14) Select entities qualified to serve as navigators in accordance with section 1311 (i) of the federal act and standards developed by the secretary, and award grants to enable navigators to:

(a) Conduct public education activities to raise awareness of the availability of qualified health plans.

(b) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the federal act.

(c) Facilitate enrollment in qualified health plans.

(d) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health benefit plan, coverage, or determination under that plan or coverage; and.

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(15) Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(16) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the federal act, and collect the amount credited from the offering employer.

(17) Consult with stakeholders relevant to carrying out the activities required under this act, including but not limited to:

(a) Educated health care consumers who are enrollees in qualified health plans.

(b) Individuals and entities with experience in facilitating enrollment in qualified health plans.

(c) Representatives of small businesses and self-employed individuals.

(d) The Department of Health Services; and

(e) Advocates for enrolling hard to reach populations; and

(18) Meet the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the secretary, the governor, the commissioner, and the legislature a report concerning such accountings.

(b) Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal act and allow the secretary, in coordination with the inspector general of the U.S. Department of Health and Human Services, to:

1. Investigate the affairs of the Exchange;

2. Examine the properties and records of the Exchange; and

3. Require periodic reports in relation to the activities undertaken by the Exchange; and

(c) In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications.

636.42 Health benefit plan certification.

(1) The exchange may certify a health benefit plan as a qualified health plan if:

(a) The plan provides the essential health benefits package described in section 1302 (a) of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E (5?) if:

1. The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

2. The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange.

(b) The premium rates and contract language have been approved by the commissioner;

(c) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E (636.30 (5)?) of this act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(d) The plan's cost-sharing requirements do not exceed the limits established under section 1302 (c) (1) of the federal act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302 (c) (2) of the federal act.

(e) The health carrier offering the plan satisfies all of the following:

1. Is licensed and in good standing to offer health insurance coverage in this state.

2. Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage. In this subdivision,

Insert 13-11 →

3. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer; intermediary.

4. Does not charge any cancellation fees or penalties in violation of section 5C 636.25 (5) of this act; and

5. Complies with the regulations developed by the secretary under section 1311 (d) of the federal act and such other requirements as the Exchange may establish.

(f) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 (636.46) of this act and by the secretary under section 1311 (c) of the federal act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement,

uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and.

(g) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this state.

(2) The Exchange shall not exclude a health benefit plan: insert 14-6

(a) On the basis that the plan is a fee-for-service plan;.

(b) Through the imposition of premium price controls by the Exchange; or.

(c) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(3) The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to: → do all of the following:

(a) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet Web site. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794 (b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;.

(b) 1. Make available to the public, in the format described in subd. 2. subparagraph (b) (2.?) of this paragraph, and submit to the Exchange, the secretary, and the commissioner, accurate and timely disclosure of the following: → all of

a. Claims payment policies and practices;.

b. Periodic financial disclosures;.

c. Data on enrollment;.

authority

authority

federal Public Health Services Act

d. Data on disenrollment;

e. Data on the number of claims that are denied;

f. Data on rating practices;

g. Information on cost-sharing and payments with respect to any out-of-network coverage;

h. Information on enrollee and participant rights under title I of the federal act; and

i. Other information as determined appropriate by the secretary; and

2. The information required in subparagraph (a) ((3) (b)?) of this paragraph → subd. 1. shall be provided in plain language, as that term is defined in section 1311 (e) (3) (B) of the federal act; and

(c) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(4) The Exchange = authority shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

(5) (a) The provisions of this act → chapter that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified

in accordance with the provisions of paragraphs (2), (3), and (4) ((5) (b), (c), and(d)?) of this subsection or by regulations adopted by the Exchange.

(b) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(c) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302 (b) (1) (J) of the federal act, and such other dental benefits as the Exchange or the secretary may specify by regulation; and

(d) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

636.44 Funding; publication of costs. **(1)** The exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this act.

(2) The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

636.46 Regulations. The Exchange may promulgate regulations to implement the provisions of this act. Regulations promulgated under this section

shall not conflict with or prevent the application of regulations promulgated by the secretary under the federal act.

636.48 Relation to other laws. Nothing in this act and no action taken by the Exchange pursuant to this act shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contrary in this act, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.

(END)

chapter

chapter

rules promulgated

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authority under this chapter

D-note

(2) (a) The commissioner shall determine the initial plan designs, including minimum benefit levels, for the health benefit plans that may be offered through the exchange. Thereafter, the authority may modify the plan designs as it determines necessary or appropriate. Both the commissioner and the authority, in specifying plan designs under this subsection, shall attempt to limit the degree of variation among plans and the number of different plan choices for exchange participants.

(b) Only health benefit plans that satisfy the requirements under par. (a) and that are approved by the authority may be offered by insurers through the exchange. Each plan offered through the exchange shall contain a detailed description of the benefits provided, including any maximum or minimum amounts, limitations, or exclusions.

(3) The authority shall rank the health benefit plans that are offered through the exchange according to the benefits provided and place each one into one of the following 3 tiers:

(a) A plan with full benefits shall be designated as a "gold" plan.

(b) A plan providing 75 percent of the actuarial value of a "gold" plan shall be designated as a "silver" plan.

(c) A plan providing 60 percent of the actuarial value of a "gold" plan shall be designated as a "bronze" plan.

(4) The authority may eliminate a plan from the exchange only after notice to the insurer offering the plan.

635.35 Participation in exchange. (1) All of the following shall be eligible to purchase coverage under a health benefit plan offered through the exchange:

(a) A small employer.

(b) A state employee who is a limited term employee and who is not eligible for coverage under a health care coverage plan under subch. IV of ch. 40.

(c) An individual who contracts with this state for the performance of services for the state and who is not eligible for coverage under a health care coverage plan under subch. IV of ch. 40.

(2) The authority shall accept for enrollment through the exchange any small employer under sub. (1) (a) and any individual under sub. (1) (b) or (c) who applies for enrollment. An individual under sub. (1) (b) or (c) and an employee of a small employer under sub. (1) (a) may select coverage under any health benefit plan offered through the exchange, except that all employees of a single small employer must select coverage under health benefit plans that have been placed in the same tier under s. 635.30 (3) (a), (b), or (c).

(3) The authority shall collect initial premiums for coverage under each health benefit plan from enrollees in the plan and disburse the initial premium collected to the insurer offering the plan, along with enrollment information about each individual or employee enrolled in the plan.

635.37 Insurer requirements. (1) (a) Any insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, may offer coverage through the exchange. No insurer may offer or issue a health benefit plan to a small employer except through the exchange. An insurer that offers coverage through the exchange may offer only health benefit plans that satisfy the requirements under s. 635.30 (2) (a) and that are approved for the exchange by the authority. An insurer that offers coverage through the exchange must offer at least one health benefit plan in each tier under s. 635.30 (3) (a), (b), and (c).

(b) Notwithstanding ss. 631.36 (4) and 632.749 (1) and (2), a health benefit plan issued to a small employer that is in effect on the day that the exchange begins operating may remain in effect until the end of its term but may not be renewed.

(2) Premiums for coverage through the exchange may be based only on age, sex, geographic location, whether coverage is single or family, and plan design. For the purpose of determining premiums, an insurer shall pool together all individuals and employees who have coverage under all of the plans issued by the insurer through the exchange.

(3) An insurer may not impose any annual or lifetime limits or any preexisting condition exclusions under any plan offered through the exchange. An insurer offering coverage through the exchange shall accept for enrollment any individual under s. 635.35 (1) (b) or (c) and any employee of a small employer under s. 635.35 (1) (a) who applies for enrollment in a health benefit plan offered by the insurer through the exchange. Section 632.7495 applies to the renewability of an individual's or employee's coverage under a health benefit plan offered through the exchange.

(4) An insurer that offers health benefit plans through the exchange shall establish a toll-free hotline for providing information to enrollees and other individuals and shall furnish such reasonable reports as the authority determines necessary for the administration of the exchange.

(5) The authority may audit any insurer that provides coverage under a health benefit plan through the exchange for the purpose of ensuring that the insurer is providing covered individuals with the benefits provided for under this subchapter in a manner that does all of the following:

(a) Complies with the provisions of this chapter.

(b) Promotes positive health outcomes.

(c) Advances value–based and evidence–based medical practices.

(d) Avoids unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess care delivery capacity.

(e) Holds down the growth of health care costs.

635.40 Intermediaries. An insurance intermediary that enrolls an individual under s. 635.35 (1) (b) or (c) in a health benefit plan through the exchange shall be paid a commission by the insurer offering the health benefit plan. An insurance intermediary that enrolls the employees of a small employer under s. 635.35 (1) (a) in one or more health benefit plans through the exchange shall be paid a commission by each insurer offering a health benefit plan selected by an employee of the small employer. The authority shall determine the commission amounts that must be paid to intermediaries under this section after considering information provided to the commissioner under s. 628.81 with respect to health insurance.

635.45 Administration; rules. (1) For payment of administrative expenses, the authority may impose a surcharge on each insurer offering health benefit plans through the exchange. The surcharge shall be based on an insurer's total premium collected through the exchange.

(2) For administering the exchange the authority shall do all of the following:

(a) In consultation with the commissioner, establish procedures for approving plans that may be offered through the exchange, for ranking plans into the tiers under s. 635.30 (3), and for determining whether a plan should continue to be offered or should be eliminated from the exchange.

(b) Establish quality improvement standards for plans offered through the exchange.

(c) Establish a system for enrolling eligible groups and individuals, using a standard application form developed by the commissioner under sub. (5) (a).

(d) Establish procedures for collecting premiums and remitting premium payments and providing enrollment information to insurers.

(e) Establish, in consultation with the commissioner, the method for determining the amount of the surcharge under sub. (1) and establish the procedure for imposing and collecting the surcharge.

(f) Establish a plan for publicizing the exchange and the eligibility requirements and enrollment procedures.

(g) Establish and operate a service center to provide information to small employers, individuals, enrollees, and insurance intermediaries about the exchange.

(h) Establish a mechanism for regular communication and cooperation with insurance intermediaries.

(i) Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the authority.

(3) The authority may do all of the following:

(a) Contract with a 3rd–party administrator for the provision of services on behalf of the exchange.

(b) Establish risk adjustment mechanisms for the exchange.

(c) Enter into agreements with or establish sub–exchanges.

(4) The authority shall seek grants or other funding from the federal or state government for which it may be eligible and from private foundations. The authority

may begin operating the exchange only if it receives federal grant moneys or other funds for that purpose.

(5) (a) The commissioner shall develop a standard application form for use in the exchange.

(b) The commissioner may promulgate rules, with the approval of the authority, for the administration of this subchapter.

SECTION 52. Subchapter III of chapter 635 [precedes 635.70] of the statutes is created to read:

CHAPTER 635

SUBCHAPTER III

SMALL BUSINESS HEALTH OPTIONS PROGRAM AUTHORITY

635.70 Creation and organization of authority. (1) There is created a public body corporate and politic to be known as the "Small Business Health Options Program Authority." The board of directors of the authority shall consist of the commissioner, or his or her designee; the secretary of employee trust funds, or his or her designee; the person who is appointed by the secretary of health services to be the director of the Medical Assistance program, or his or her designee; the executive director of the Health Insurance Risk–Sharing Plan Authority, or his or her designee; and all of the following members, who shall be nominated by the governor, and with the advice and consent of the senate appointed for 3–year terms, and none of whom shall be an employee of an insurer that is authorized to do business in the state:

(a) A member in good standing of the American Academy of Actuaries.

(b) A health economist.

(c) An employee benefits specialist.

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(d) A representative of small employers.

(e) A representative of an organization that represents consumer interests.

(f) A representative of organized labor.

(2) A vacancy on the board shall be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

(3) A member of the board shall receive no compensation for services under this chapter but shall be reimbursed for actual and necessary expenses, including travel expenses, incurred in the discharge of the member's duties under this chapter.

(4) The commissioner or the commissioner's designee shall be the chairperson of the board. Five Six members of the board constitute a quorum for the purpose of conducting the business and exercising the powers of the authority, notwithstanding the existence of any vacancy. The board may take action upon a vote of a majority of the members present, unless the bylaws of the authority require a larger number.

(5) The chairperson shall appoint an executive director who shall not be a member of the board and who shall serve at the pleasure of the board. The executive director shall receive compensation commensurate with the duties of the office, as determined by the board. The executive director shall serve as secretary of the authority and shall keep a record of the proceedings of the authority and shall be custodian of all books, documents, and papers filed with the authority, the minute book or journal of the authority, and its official seal. The executive director or other person may cause copies to be made of all minutes and other records and documents of the authority and may give certificates under the official seal of the authority to the effect that such copies are true copies, and all persons dealing with the authority may rely upon such certificates. The executive director shall have all of the following duties:

(9) ~~Xxx~~Note: I changed the number of members constituting a quorum to more closely resemble the quorum of other authorities.

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(a) Supervising the administrative affairs and the general management and operation of the authority.

(b) Planning, directing, coordinating, and executing administrative functions in conformity with the policies and directives of the board.

(c) Employing professional and clerical staff, as necessary.

(d) Reporting to the board on all operations under his or her control and supervision.

(e) Preparing an annual budget and managing the administrative expenses of the authority.

(f) Undertaking any activities necessary to implement the powers and duties set forth in this chapter.

Authority

635.72 Duties. In addition to all other duties imposed under this chapter, the authority shall do all of the following:

(1) Establish its annual budget and monitor its fiscal management.

(2) No later than two years after ~~the~~ an exchange under subch. II begins operation, and annually thereafter, submit a report to the legislature under s. 13.172 (2) and to the governor on the operation of ~~the~~ any exchange under subch. II, including a review of all of the following:

(a) Progress toward the goals of the exchange.

(b) The operations and administration of the exchange.

(c) The types of health insurance plans available to eligible individuals and groups and the percentage of the total exchange enrollees served by each plan.

(d) Surveys and reports on the insurers' experiences with different plans, including aggregated data on enrollees, claims, statistics, complaint data, and enrollee satisfaction data.

(e) Significant observations regarding utilization and adoption of the exchange.

(3) Annually submit to the governor and the legislative audit bureau a statement of its activities and financial condition.

(4) Approve the use of any trademarks, seals, or logos by participating insurers and small employers.

(13) 6 Authority

635.74 Powers. The authority has all of the powers necessary or convenient to carry out its duties under this chapter, except that it may not acquire or hold title to real estate or issue bonds. In addition, the authority may do any of the following:

(1) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.

(2) Have a seal and alter the seal at pleasure; have perpetual existence; and maintain an office.

(3) Hire employees, define their duties, and fix their rate of compensation.

(4) Delegate by resolution to one or more of its members any powers and duties that it considers proper.

(5) Incur debt.

(6) Appoint any technical or professional advisory committee that the authority finds necessary to assist the authority in exercising its duties and powers. If the authority appoints a committee, the authority shall define the duties of the committee and provide reimbursement for the expenses of the committee.

(7) Accept gifts, grants, loans, or other contributions from private or public sources.

(8) Procure liability insurance.

(9) Sue and be sued in its own name and plead and be impleaded.

(10) Execute contracts and other instruments, including contracts for professional or technical services required for the authority or the operation of the exchange under subch. II.

63.76 Contracting for professional services. (1) Whenever contracting for professional services, the authority shall solicit competitive sealed bids or competitive sealed proposals, whichever is appropriate. Each request for competitive sealed proposals shall state the relative importance of price and other evaluation factors.

(2) (a) When the estimated cost exceeds $25,000, the authority may invite competitive sealed bids or proposals by publishing a class 2 notice under ch. 985 or by posting notice on the Internet at a site determined or approved by the authority. The notice shall describe the contractual services to be purchased, the intent to make the procurement by solicitation of bids or proposals, any requirement for surety, and the date the bids or proposals will be opened, which shall be at least 7 days after the date of the last insertion of the notice or at least 7 days after the date of posting on the Internet.

(b) When the estimated cost is $25,000 or less, the authority may award the contract in accordance with simplified procedures established by the authority for such transactions.

(c) For purposes of clarification, the authority may discuss the requirements of the proposed contract with any person who submits a bid or proposal and shall permit any offerer to revise his or her bid or proposal to ensure its responsiveness to those requirements.

(3) (a) The authority shall determine which bids or proposals are reasonably likely to be awarded the contract and shall provide each offerer of such a bid or

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proposal a fair and equal opportunity to discuss the bid or proposal. The authority may negotiate with each offerer in order to obtain terms that are advantageous to the authority. Prior to the award of the contract, any offerer may revise his or her bid or proposal. The authority shall keep a written record of all meetings, conferences, oral presentations, discussions, negotiations, and evaluations of bids or proposals under this section.

(b) In opening, discussing, and negotiating bids or proposals, the authority may not disclose any information that would reveal the terms of a competing bid or proposal.

(4) (a) After receiving each offerer's best and final offer, the authority shall determine which proposal is most advantageous and shall award the contract to the person who offered it. The authority's determination shall be based only on price and the other evaluation factors specified in the request for bids or proposals. The authority shall state in writing the reason for the award and shall place the statement in the contract file.

(b) Following the award of the contract, the authority shall prepare a register of all bids or proposals.

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635.78 Political activities. (1) No employee of the authority may directly or indirectly solicit or receive subscriptions or contributions for any partisan political party or any political purpose while engaged in his or her official duties as an employee. No employee of the authority may engage in any form of political activity calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office while engaged in his or her official duties as an employee or engage in any political activity while not engaged in his or her official duties as an employee to such an extent that the person's efficiency during

working hours will be impaired or that he or she will be tardy or absent from work. Any violation of this section is adequate grounds for dismissal.

(2) If an employee of the authority declares an intention to run for partisan political office, the employee shall be placed on a leave of absence for the duration of the election campaign and if elected shall no longer be employed by the authority on assuming the duties and responsibilities of such office.

(3) An employee of the authority may be granted, by the executive director, a leave of absence to participate in partisan political campaigning.

(4) Persons on leave of absence under sub. (2) or (3) shall not be subject to the restrictions of sub. (1), except as they apply to the solicitation of assistance, subscription, or support from any other employee in the authority.

63.0180 Liability; expenses; limitations. (1) Neither the state, nor any political subdivision of the state, nor any officer, employee, or agent of the state or a political subdivision who is acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

(2) All of the expenses incurred by the authority in exercising its duties and powers under this chapter shall be payable only from funds of the authority.

(3) A cause of action may arise against and civil liability may be imposed on the authority for its acts or omissions or for any act or omission of a member of the board, the executive director, or an employee of the authority in the performance of his or her powers and duties under this chapter.

(4) A cause of action may not arise against and civil liability may not be imposed on a member of the board, the executive director, or an employee of the authority for any act or omission in the performance of his or her powers and duties under this chapter, unless the person asserting liability proves that the act or omission

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constitutes willful misconduct or intentional violation of the law. The member of the board, executive director, or employee who performed the act or omission that formed the basis of liability shall be jointly liable with the authority if that board member, executive director, or employee fails to cooperate with the authority in defense of the claim and if the failure to cooperate affects the defense of the action.

(5) The amount recoverable by any person for any damages, injuries, or death in any civil action or civil proceeding against the authority, including any such action or proceeding based on contribution or indemnification, shall not exceed $100,000.

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Insert 8-11-TJDINS

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Section #. 16.417 (1) (a) of the statutes, as affected by 2011 Wisconsin Act 7, section 20, and 2011 Wisconsin Act ... (this act), is amended to read:

Plain

or subch. III of ch. 636

~~A under ch. 238~~

repealed and recreated

16.417 **(1)** (a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority or the body created under subch. III of ch. 149.

NOTE: Par. (a) is shown as amended eff. 1–1–12 by 2011 Wis. Act 7. Prior to 1–1–12 it reads:

(a) "Agency" means an office, department, independent agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law, that is entitled to expend moneys appropriated by law, including the legislature and the courts, but not including an authority or the body created under subch. III of ch. 149 or under ch. 238.

History: 1987 a. 365 ss. 1, 4m; 1987 a. 399; 1989 a. 56 s. 259; 1993 a. 362; 1997 a. 27; 2001 a. 16; 2005 a. 74, 335; 2007 a. 20; 2009 a. 28; 2011 a. 7.

INSERT 35-9-TJDINS

(B) (S) (¶) SECTION #. Effective dates. This act takes effect (B) on the day after publication, except as follows:

(¶) (#) The treatment of section 16.417 (1)(a) (S) of the statutes takes effect on July 1, 2012.

repeal and recreation

January

or on the day after publication, whichever is later

INSERT 5-9

****NOTE: For plan years beginning before January 1, 2016, "small employer" may be an employer with not more than 50 employees. Would you like this to be the case in this draft?

(END OF INSERT 5-9)

INSERT 13-11

****NOTE: This is a good example of the terminology problem with the NAIC model. Since it wouldn't make sense to change any of the "exchange" references to "authority," I left them all as is.

(END OF INSERT 13-11)

INSERT 14-6

for any of the following reasons or in any of the following ways

(END OF INSERT 14-6)

Insert 4-4

(4) (5m) (B) "Minimum essential coverage" has the meaning given in 26 USC 5000A (f) (1).

(and renum. 4-4)

insert 6-2

Use text.title:subchap

SUBCHAPTER II hard return } all caps center text

~~OPERATION OF EXCHANGE~~ } all caps center text

(end of insert 6-2)

~~insert 8-8~~

~~XXXXNOTE:~~