2017 DRAFTING REQUEST

Bill

For: **Administration**

By: **Ames**

Date: **1/2/2018**

Same as LRB: **-5325**

Drafter: **tdodge**

Secondary Drafters:

May Contact:

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Pre Topic:

No specific pre topic given

Topic:

Reinsurance program; waiver of Affordable Care Act

Assembly per TJD

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/?	tdodge 1/5/2018	aernsttr 1/8/2018			
/P1	tdodge 1/12/2018	aernsttr 1/12/2018	dwalker 1/8/2018		State
/P2	tdodge 1/16/2018	wjackson 1/16/2018	lparisi 1/12/2018		State
/P3	tdodge 1/18/2018	aernsttr 1/18/2018	dwalker 1/16/2018		State

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/P4	tdodge 1/19/2018	aernsttr 1/19/2018	lparisi 1/18/2018		State
/P5	tdodge 1/22/2018	aernsttr 1/22/2018	mbarman 1/19/2018		State
/P6			lparisi 1/22/2018		State
/1			lparisi 1/22/2018	mbarman 1/23/2018	State

FE Sent For:

<END>

At Intro.

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Tuesday, January 02, 2018 3:36 PM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Drafted Stat Language
Attachments: MN Reinsurance Program Bill.pdf

Tami:

Per our conversation, we are looking to establish the Wisconsin healthcare stability plan (WIHSP) to mirror the Minnesota premium security plan. Below you will find Wisconsin specific changes:

Create a Wisconsin Reinsurance Program administered by the Office of the Commissioner of Insurance. Using the attached MN bill as reference

- More specifically this program will be run in house, so unlike in Minnesota, the program will not be administered by an appointed board
- Continue with equivalent payment parameters—OCI would like to use the same attachment points, coinsurance rates, and reinsurance cap as MN for now. I suspect that these will change once they receive the official data from the vendor.

Language must include the requirement for OCI to submit a 1332 state innovation waiver (and program contingent on bill passage):

- "The commissioner of insurance shall apply to the secretary of health and human services under United States Code, title 42, section 18052, for a state innovation waiver to implement the Wisconsin healthcare stability plan for benefit years beginning January 1, 2019, and future years, to maximize federal funding. The waiver application must clearly state that operation of the Plan is contingent on approval of the waiver request."

Create a new program (5) under OCI (20.145) [Wisconsin healthcare stability plan]

- Create 1 GPR annual appropriation under 20.145 for the state subsidy and fund it with $50M [State Reinsurance Fund]
- Create 1 FED continuing all$ received appropriation for the FED funds [Federal Aid Reinsurance Fund]: all federal pass through funds received as a result of federal savings
    - All funding for the program will be appropriated under these funds

Require that all rates are "actuarily justified".

This is pretty broad guidance, and I expect it to tighten up in the coming weeks once we receive further direction and more precise data. As mentioned, this is a priority so, please do not hesitate to call.

r/
Kyle x6-2214

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CHAPTER 13--H.F.No. 5

An act relating to insurance; health; creating the Minnesota premium security plan; providing funding; establishing a legislative working group; regulating health care provider system access; modifying premium subsidy program provisions; appropriating money; amending Minnesota Statutes 2016, sections 62E.10, subdivision 2; 62K.10, by adding a subdivision; Laws 2013, chapter 9, section 15; Laws 2017, chapter 2, article 1, sections 1, subdivision 3; 2, subdivision 4, by adding a subdivision; 3; article 2, section 13; proposing coding for new law in Minnesota Statutes, chapter 62E.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

MINNESOTA PREMIUM SECURITY PLAN

Section 1. Minnesota Statutes 2016, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of ~~eleven~~ 13 members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers; five public directors selected by the commissioner, at least two of whom must be ~~plan enrollees, two of whom are covered under an individual plan subject to assessment under section 62E.11 or group plan offered by an employer subject to assessment under section 62E.11,~~ enrollees in the individual market and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. ~~The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner.~~ In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. ~~The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.~~

Sec. 2. **[62E.21] DEFINITIONS.**

Subdivision 1. **Application.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

Sec. 3. **[62E.22] DUTIES OF COMMISSIONER.**

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

Sec. 4. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

(b) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(f) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivisions 9 or 12.

Sec. 5. **[62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.**

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each benefit year by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association Web site and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

Sec. 6. **[62E.25] ACCOUNTS.**

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.

Sec. 7. Laws 2013, chapter 9, section 15, is amended to read:

Sec. 15. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION TERMINATION.**

(a) The commissioner of commerce, in consultation with the board of directors of the Minnesota Comprehensive Health Association, has the authority to develop and implement the phase-out and eventual appropriate termination of coverage provided by the Minnesota Comprehensive Health Association under Minnesota Statutes, chapter 62E. The phase-out of coverage shall begin no sooner than January 1, 2014, or upon the effective date of the operation of the Minnesota Insurance Marketplace and the ability to purchase qualified health plans through the Minnesota Insurance Marketplace, whichever is later, and shall, to the extent practicable, ensure the least amount of disruption to the enrollees' health care coverage. The member assessments established under Minnesota Statutes, section 62E.11, shall take into consideration any phase-out of coverage implemented under this section.

(b) Nothing in paragraph (a) applies to the Minnesota premium security plan, as defined in Minnesota Statutes, section 62E.21, subdivision 12.

Sec. 8. **STATE INNOVATION WAIVER.**

Subdivision 1. **Submission of waiver application.** The commissioner of commerce shall apply to the secretary of health and human services under United States Code, title 42, section 18052, for a state innovation waiver to implement the Minnesota premium security plan for benefit years beginning January 1, 2018, and future years, to maximize federal funding. The waiver application must clearly state that operation of the Minnesota premium security plan is contingent on approval of the waiver request.

Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall consult with the commissioner of human services, the commissioner of health, and the MNsure board.

Subd. 3. **Application timelines; notification.** The commissioner shall submit the waiver application to the secretary of health and human services on or before June 15, 2017. The commissioner shall make a draft application available for public review and comment by May 15, 2017. The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance, and the board of directors of the Minnesota Comprehensive Health Association of any federal actions regarding the waiver request.

Sec. 9. **COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**

A state agency that incurs administrative costs to implement any provision of this act and does not receive an appropriation for administrative costs of this act must implement the act within the limits of existing appropriations.

Sec. 10. **PREMIUM SECURITY PLAN CONTINGENT ON FEDERAL WAIVER.**

If the state innovation waiver request in article 1, section 8, is not approved, the Minnesota Comprehensive Health Association and its board of directors shall not administer the Minnesota premium security plan and provide reinsurance payments to eligible health carriers.

Sec. 11. **PAYMENT PARAMETERS FOR 2018.**

(a) Notwithstanding Minnesota Statutes, section 62E.23, and subject to paragraph (b), the Minnesota premium security plan payment parameters for benefit year 2018 are:

(1) an attachment point of $50,000;

(2) a coinsurance rate of 80 percent; and

(3) a reinsurance cap of $250,000.

(b) The board of directors of the Minnesota Comprehensive Health Association may alter the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Sec. 12. **DEPOSIT OF FUNDS.**

(a) Within ten days of the effective date of this section, the Minnesota Comprehensive Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, shall deposit all money, including monetary reserves, the association holds into the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1.

(b) Notwithstanding paragraph (a), the Minnesota Comprehensive Health Association may retain funds necessary to fulfill medical needs and contractual obligations in place for former Minnesota Comprehensive Health Association enrollees until December 31, 2018.

Sec. 13. **DISPOSITION AND SETTLEMENTS.**

Notwithstanding Minnesota Statutes, section 62E.09, and any other law to the contrary, the board of directors of the Minnesota Comprehensive Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, shall have authority:

(1) over the disposition and settlement of all funds held by the association, including prior assessments, to the extent funds have not been transferred pursuant to article 1, section 12; and

(2) to settle and make determinations regarding litigation pending on the effective date of this act, including litigation that impacts funds held by the association.

Sec. 14. **LEGISLATIVE WORKING GROUP.**

A legislative working group is established consisting of the chairs and ranking minority members of the senate committees with jurisdiction over commerce, health and human services finance and policy, and

human services reform finance and policy and the chairs and ranking minority members of the house of representatives committees with jurisdiction over commerce and regulatory reform, health and human services finance, and health and human services reform. The purpose of the working group is to advise the board of the Minnesota Comprehensive Health Association on the adoption of payment parameters and other elements of a reinsurance plan for benefit year 2019. The commissioner of commerce must provide technical assistance for the working group, and must review and monitor the following to serve as a resource for the working group:

(1) the effectiveness of reinsurance models adopted in Alaska and other states in stabilizing premiums in the individual market and the related costs thereof;

(2) the effect of federal health reform legislation on the Minnesota premium security plan, including but not limited to funding for the plan; and

(3) the status of the health care access fund, and issues relating to its potential continued use as a source of funding for the Minnesota premium security plan.

Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

(a) The Minnesota Comprehensive Health Association shall fund the operational and administrative costs and reinsurance payments of the Minnesota security plan and association using the following amounts deposited in the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, in the following order:

(1) any federal funding available;

(2) funds deposited under article 1, sections 12 and 13;

(3) any state funds from the health care access fund; and

(4) any state funds from the general fund.

(b) The association shall transfer from the premium security plan account any general fund amount not used for the Minnesota premium security plan by June 30, 2021, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the general fund.

(c) The association shall transfer from the premium security plan account any health care access fund amount not used for the Minnesota premium security plan by June 30, 2021, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the health care access fund in Minnesota Statutes, section 16A.724.

(d) The Minnesota Comprehensive Health Association may not spend more than $271,000,000 for benefit year 2018 and not more than $271,000,000 for benefit year 2019 for the operational and administrative costs of, and reinsurance payments under, the Minnesota premium security plan.

Sec. 16. **TRANSFERS.**

(a) The commissioner of management and budget shall transfer $200,000,000 in fiscal year 2018 and $200,000,000 in fiscal year 2019 from the health care access fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

(b) The commissioner of management and budget shall transfer $71,000,000 in fiscal year 2018 and $71,000,000 in fiscal year 2019 from the general fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

EFFECTIVE DATE. This section is effective upon federal approval of the state innovation request in article 1, section 8. The commissioner of commerce shall inform the revisor of statutes when federal approval is obtained.

Sec. 17. **TRANSFER; 2018.**

The commissioner of management and budget shall transfer $750,000 in fiscal year 2018 from the health care access fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

Sec. 18. **APPROPRIATION.**

$155,000 in fiscal year 2018 is appropriated from the general fund to the commissioner of commerce to prepare and submit the state innovation waiver in article 1, section 8.

Sec. 19. **EFFECTIVE DATE.**

Sections 1 to 15, 17, and 18 are effective the day following final enactment.

ARTICLE 2

HEALTH POLICY

Section 1. Minnesota Statutes 2016, section 62K.10, is amended by adding a subdivision to read:

Subd. 1a. **Health care provider system access.** For those counties in which a health carrier actively markets an individual health plan, the health carrier must offer, in those same counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system. This subdivision is applicable only for the year in which the health carrier actively markets an individual health plan.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to individual health plans offered, issued, or renewed on or after that date.

Sec. 2. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

(1) is not receiving ~~a~~ an advance premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, ~~as of the date~~ in a month in which their coverage is ~~effectuated~~ effective;

(2) is not enrolled in public program coverage under Minnesota Statutes, section 256B.055, or 256L.04; and

(3) purchased an individual health plan from a health carrier in the individual market.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 3. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

(c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on an enrollee or health carrier under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later. This paragraph does not apply to data maintained by the legislative auditor.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 4. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to read:

Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, government entities are permitted to share or disseminate data as follows:

(1) the commissioner of human services and the board of directors of MNsure must share data on public program enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, as well as data on an enrollee's receipt of a premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, with the commissioner of management and budget; and

(2) the commissioner of management and budget must disseminate data on an enrollee's public program coverage enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, to health carriers to the extent the commissioner determines is necessary for determining the enrollee's eligibility for the premium subsidy program authorized by this act.

(b) Data shared under this subdivision may be collected, stored, or used only for the purposes of administration of the premium subsidy program authorized by this act and may not be further shared or disseminated except as otherwise provided by law.

(c) By June 30, 2018, a health carrier must destroy any data it received pursuant to this subdivision.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 5. Laws 2017, chapter 2, article 1, section 3, is amended to read:

Sec. 3. **AUDITS.**

(a) The legislative auditor shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The commissioner of human services shall provide data as necessary to the legislative auditor to complete the audit. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the audit.

(b) The legislative auditor shall audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The commissioner, in consultation with the commissioners of commerce and ~~health~~ human services, shall develop and implement a process to recover from health carriers the amount of premium subsidies received for enrollees determined to be ineligible for premium subsidies by the legislative auditor. The legislative auditor, when conducting the required audit, and the commissioner, when determining the amount of premium subsidy to be recovered, may take into account the extent to which a health carrier makes use of the Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision 1.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 6. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~90 days following final enactment~~ January 1, 2018, and applies to provider services provided on or after that date.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Presented to the governor March 30, 2017

Became law without the governor's signature April 4, 2017

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Thursday, January 04, 2018 9:29 AM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Reinsurance Program
Attachments: 1332 ACA Waiver Bill Draft_HIT.docx

Tami:

Could you please incorporate the attached draft in the reinsurance program language?

Please let me know if you have any feedback or questions.

r/
Kyle

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(1) Beginning Jan. 1, 2019, if the annual fee imposed under section 9010 of the federal Patient Protection and Affordable Care Act, P.L. 111-148 is no longer applicable to insurers participating in the state group health insurance program, the Secretary of Administration shall calculate the potential state agency savings related to the avoidance of the fee.

(2) Based on the state agency savings calculated under (1), require the DOA secretary to: 1) in the current biennium, reduce the estimated general purpose revenue and program revenue, excluding tuition and fee monies from the University of Wisconsin system, for "Compensation Reserves" shown in the schedule under s. 20.005(1) and transfer the related PR balances and lapse the GPR to the general fund or 2) in the subsequent biennium, adjust agency fringe benefit rates.

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/?
TJD:

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

reallocating savings from health insurer fee;

AN ACT ...; **relating to:** Wisconsin Healthcare Stability Plan for reinsurance of health carriers, granting rulemaking authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

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

SECTION 1. 16.5285 of the statutes is created to read:

16.5285 Health insurer fee savings. (1) In this section, "Affordable Care Act" has the meaning given in s. 601.80 (1).

(2) Beginning January 1, 2019, if the annual fee imposed under section 9010 of the Affordable Care Act is not longer applicable to insurers participating in the state's group health insurance program under s. 40.51 (6), the secretary shall calculate the expected state agency savings related to the avoidance of the fee.

(3) Based on the savings calculated under sub. (2), the secretary shall do one of the following:

(a) In the fiscal biennium in which the savings are calculated, reduce the estimated general purpose revenue and program revenue expenditures, excluding tuition and fee moneys from the University of Wisconsin System, for "Compensation Reserves" shown in the schedule under s. 20.005 (1) by an amount equal to the savings calculated under sub. (2), lapse to the general fund from the general purpose revenue appropriations an amount equal to the calculated general purpose revenue saved under sub. (2), and transfer to the general fund the related program revenue appropriation account balances in an amount equal to the calculated program revenue saved under sub. (2).

(b) In the fiscal biennium following the fiscal biennium in which the savings are calculated, adjust state agency employer contributions for state employee fringe benefit costs.

SECTION 2. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

			2017-18	**2018-19**
20.145 Insurance, Office of the Commissioner of				
(5)	WISCONSIN HEALTHCARE STABILITY PLAN			
(b)	Reinsurance plan; state subsidy	GPR A		50,000,000

SECTION 3. 20.145 (5) of the statutes is created to read:

20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state subsidy.* The amounts in the schedule for the state subsidy of reinsurance payments for the reinsurance program under subch. VII of ch. 601.

(m) *Federal funds; reinsurance plan.* All moneys received from the federal government for the reinsurance plan under subch. VII of ch. 601 for the purposes for which received.

SECTION 4. Subchapter VII (title) of chapter 601 [precedes 601.80] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

SECTION 5. 601.80 of the statutes is created to read:

601.80 Definitions; healthcare stability plan. In this subchapter:

(1) "Affordable Care 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 to or regulations or guidance issued under those acts.

(2) "Attachment point" means the amount set under s. 601.83 (2) (b) for the healthcare stability plan that is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

(4) "Coinsurance rate" means the rate set under s. 601.83 (2) (c) for the healthcare stability plan that is the rate at which the commissioner will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(5) "Eligible health carrier" means an insurer, as defined in s. 632.745 (15) of the following that offers an individual health plan and incurs claims costs for an individual enrollee's enrolled individual's covered benefits in the applicable benefit year.

(6) "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act.

(7) "Health benefit plan" has the meaning given in s. 632.745 (11).

(8) "Individual health plan" means a health benefit plan that is not a group health plan, as defined in s. 632.745 (10), or a grandfathered plan.

(9) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the healthcare stability plan.

(11) "Reinsurance cap" means the threshold amount set under s. 601.83 (2) (d) for the healthcare stability plan for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(12) "Reinsurance payment" means an amount paid by the commissioner to an eligible health carrier under the healthcare stability plan.

(10) "Healthcare stability plan" means the state-based reinsurance program known as the Wisconsin Healthcare Stability Plan administered under s. 601.83 (1).

SECTION 6. 601.83 of the statutes is created to read:

601.83 Healthcare stability plan; administration. (1) PLAN ESTABLISHED; GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer a state-based reinsurance program known as the healthcare stability plan.

(b) 1. The commissioner shall submit a request to the federal department of health and human services for a waiver under 42 USC 18052 to implement the

healthcare stability plan for benefit years beginning January 1, 2019. The commissioner shall include in the waiver request that the operation of the healthcare stability plan is contingent on approval by the federal department of health and human services. The commissioner shall seek the maximum federal funding available to implement and maintain the healthcare stability plan. In the waiver submission under this subdivision, the commissioner shall include as the payment parameters for the healthcare stability plan for benefit year 2019 an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000. The commissioner may adjust the payment parameters under sub. (2) to the extent necessary to secure federal approval of the waiver request under this paragraph.

2. If the federal department of health and human services does not approve the healthcare stability plan in the waiver request submitted under this subd. 1. or a substantially similar healthcare stability plan, the commissioner may not implement the healthcare stability plan.

(c) In accordance with sub. (5) (c), the commissioner shall collect the data from an eligible health carrier as necessary to determine reinsurance payments.

(d) Beginning on a date determined by the commissioner, the commissioner shall require each eligible health carrier to calculate the premium amount the eligible health carrier would have charged for a benefit year if the healthcare stability plan had not been established and submit the calculated premium amount as part of its rate filing submitted to the commissioner. The commissioner shall consider the calculated premium amount information provided under this paragraph as part of the rate filing review.

(e) 1. For each applicable benefit year, the commissioner shall notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the calendar year following the applicable benefit year.

2. Quarterly during the applicable benefit year, the commissioner shall provide each eligible health carrier with the calculation of total reinsurance payment requests.

3. By August 15 of the calendar year following the applicable benefit year, the commissioner shall disburse all applicable reinsurance payments to an eligible health carrier.

(f) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section.

(2) PAYMENT PARAMETERS. (a) Subject to the limitations under pars. (b), (c), and (d), the commissioner shall design and adjust payment parameters to ensure that the payment parameters will do all of the following:

1. Stabilize or reduce premium rates in the individual market.

2. Increase participation by health carriers in the individual market.

3. Improve access to health care providers and services for individuals purchasing coverage in the individual market.

4. Mitigate the impact high-risk individuals have on premium rates in the individual market.

5. Take into account any federal funding available for the plan.

6. Take into account the total amount available to fund the plan.

(b) The commissioner shall set the attachment point for the healthcare stability plan at $50,000 or more, but not exceeding the reinsurance cap.

(c) The commissioner shall set the coinsurance rate at a rate between 50 and 80 percent.

(d) The commissioner shall set the reinsurance cap at $250,000 or less.

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than January 30 of the calendar year before the applicable benefit year.

(b) If the amount available for expenditure for the healthcare stability plan is not anticipated to be adequate to fully fund the payment parameters set under par. (a) as of July 1 of the calendar year before the applicable benefit year, the commissioner shall adjust the payment parameters in accordance within the moneys available to expend for the healthcare stability plan. The commissioner shall allow an eligible health carrier to revise its rate filing based on the final payment parameters for the applicable benefit year.

(4) REINSURANCE PAYMENT CALCULATION. (a) The commissioner shall calculate a reinsurance payment with respect to each eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs for an individual enrollee do not exceed the attachment point set under sub. (2) (b), the commissioner may not make a reinsurance payment with respect to that enrollee. If the claims costs for an individual enrollee exceed the attachment point, subject to par. (b), the commissioner shall make a reinsurance payment that is calculated as the product of the coinsurance rate and whichever of the following is less:

1. The claims costs minus the attachment point.

2. The reinsurance cap minus the attachment point.

(b) The commissioner shall ensure that any reinsurance payment made to an eligible health carrier does not exceed the total amount paid by the eligible health carrier for any eligible claim. For purposes of this paragraph, the total amount paid of an eligible claim is the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or copayment paid by another person as of the time the data are submitted or made accessible under sub. (5) (c).

(5) REINSURANCE PAYMENT REQUESTS. (a) An eligible health carrier may request reinsurance payments from the commissioner when the eligible health carrier meets the requirements of this subsection and sub. (4).

(b) An eligible health care shall make any requests for a reinsurance payment in accordance with any requirements established by the commissioner.

(c) Each eligible health carrier shall provide the commissioner with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 USC 18063. Each eligible health carrier shall submit to the commissioner attesting to compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) Each eligible health carrier shall provide the access under par. (c) for each applicable benefit year by April 30 of the calendar year following the end of the applicable benefit year.

(e) Each eligible health carrier shall maintain for at least 6 years documents and records, by paper, electronic, or other media, sufficient to substantiate a request for a reinsurance payment made under this section. An eligible health carrier shall make the documents and records available to the commissioner, upon request, for

purposes of verification, investigation, audit, or other review of a reinsurance payment request.

(f) The commissioner may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier shall ensure that its contractors, subcontractors, or agents cooperate with any audit under this paragraph. Within 30 days of receiving notice that an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall do all of the following:

1. Provide a written corrective action plan to the commissioner for approval.

2. Implement the corrective action plan under subd. 1. as approved by the commissioner.

3. Provide the commissioner with written documentation of the corrective action after implementation.

****NOTE: As this provision is written, the submission of the corrective action plan, approval by the commissioner, implementation of the plan, and documentation of the correction all must occur within 30 days. Is this time period long enough for all of those steps to occur?

(6) ACCESS TO INFORMATION. Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the premiums security plan is not available for inspection and copying under s. 19.35 (1).

SECTION 7. 601.85 of the statutes is created to read:

601.85 Accounting, reports, and audits. (1) ACCOUNTING. The commissioner shall keep an accounting for each benefit year of all of the following:

(a) Funds appropriated for reinsurance payments and administrative and operational expenses.

(b) Requests for reinsurance payments received from eligible health carriers.

(c) Reinsurance payments made to eligible health carriers.

(d) Administrative and operational expenses incurred for the healthcare stability plan.

(2) REPORTS. By November 1 of the calendar year following the applicable benefit year or by 60 days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the commissioner shall make available to the public a report summarizing the premiums security plan's operations for each benefit year by posting the summary on the office's Internet site.

(3) LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the legislative audit bureau. The commissioner shall ensure that its contractors, subcontractors, or agents cooperate with any audit of the healthcare stability plan performed by the legislative audit bureau.

(4) INDEPENDENT EXTERNAL AUDIT. (a) The commissioner shall engage and cooperate with an independent certified public accountant firm to perform an audit for each benefit year of the healthcare stability plan, in accordance with generally accepted auditing standards. The audit under this paragraph shall include all of the following:

1. An assessment of compliance with the requirements of this subchapter.

2. Identification of any material weaknesses or significant deficiencies and address the manner in which to correct the weaknesses or deficiencies.

(b) The commissioner, after receiving the completed audit report, shall make public the results of the audit by posting on the office's Internet site, to the extent the

audit contains information subject to disclosure to the public, including any material weakness or significant deficiency and how the commissioner intends to correct the material weakness or deficiency.

(c) By December 1 of each year, the commissioner shall submit under s. 13.172 (3) a report to all standing committees of the legislature with jurisdiction over health, human services, or insurance regarding any finding of material weakness or significant deficiency found in an audit conducted under this subsection.

SECTION 8. Subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

SECTION 9. Subchapter VI (title) of chapter 601 [precedes 601.93] of the statutes is repealed.

(END)

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/P1
TJD:ahe

In: 1/8

Due Today (H)

keep

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

Insert analysis

AN ACT ***to repeal*** subchapter VI (title) of chapter 601 [precedes 601.93]; and ***to create*** 16.5285, 20.145 (5), subchapter VII (title) of chapter 601 [precedes 601.80], 601.80, 601.83, 601.85 and subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes; **relating to:** Wisconsin Healthcare Stability Plan, reinsurance of health carriers, reallocating savings from health insurer fee, granting rule-making authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

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

SECTION 1. 16.5285 of the statutes is created to read:

16.5285 Health insurer fee savings. (1) In this section, "Affordable Care Act" has the meaning given in s. 601.80 (1).

(2) Beginning January 1, 2019, if the annual fee imposed under section 9010 of the Affordable Care Act is no longer applicable to insurers participating in the

state's group health insurance program under s. 40.51 (6), the secretary shall calculate the expected state agency savings related to the avoidance of the fee.

(3) Based on the savings calculated under sub. (2), the secretary shall do one of the following:

(a) In the fiscal biennium in which the savings are calculated, reduce the estimated general purpose revenue and program revenue expenditures, excluding tuition and fee moneys from the University of Wisconsin System, for "Compensation Reserves" shown in the schedule under s. 20.005 (1) by an amount equal to the savings calculated under sub. (2), lapse to the general fund from the general purpose revenue appropriations an amount equal to the calculated general purpose revenue saved under sub. (2), and transfer to the general fund the related program revenue appropriation account balances in an amount equal to the calculated program revenue saved under sub. (2).

(b) In the fiscal biennium following the fiscal biennium in which the savings are calculated, adjust state agency employer contributions for state employee fringe benefit costs.

SECTION 2. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

			2017-18	**2018-19**
20.145 Insurance, office of the commissioner of				
(5) WISCONSIN HEALTHCARE STABILITY PLAN				
(b) Reinsurance plan; state subsidy	GPR	A		50,000,000

SECTION 3. 20.145 (5) of the statutes is created to read:

20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state subsidy.* The amounts in the schedule for the state subsidy of reinsurance payments for the reinsurance program under subch. VII of ch. 601.

(m) *Federal funds; reinsurance plan.* All moneys received from the federal government for the reinsurance plan under subch. VII of ch. 601 for the purposes for which received.

SECTION 4. Subchapter VII (title) of chapter 601 [precedes 601.80] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

SECTION 5. 601.80 of the statutes is created to read:

601.80 Definitions; healthcare stability plan. In this subchapter:

(1) "Affordable Care 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 to or regulations or guidance issued under those acts.

(2) "Attachment point" means the amount set under s. 601.83 (2) (b) for the healthcare stability plan that is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

(4) "Coinsurance rate" means the rate set under s. 601.83 (2) (c) for the healthcare stability plan that is the rate at which the commissioner will reimburse

an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(5) "Eligible health carrier" means an insurer, as defined in s. 632.745 (15) that offers an individual health plan and incurs claims costs for an enrolled individual's covered benefits in the applicable benefit year.

(6) "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act.

(7) "Health benefit plan" has the meaning given in s. 632.745 (11).

(8) "Healthcare stability plan" means the state-based reinsurance program known as the Wisconsin Healthcare Stability Plan administered under s. 601.83 (1).

(9) "Individual health plan" means a health benefit plan that is not a group health plan, as defined in s. 632.745 (10), or a grandfathered plan.

(10) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the healthcare stability plan.

(12) "Reinsurance cap" means the threshold amount set under s. 601.83 (2) (d) for the healthcare stability plan for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(13) "Reinsurance payment" means an amount paid by the commissioner to an eligible health carrier under the healthcare stability plan.

SECTION 6. 601.83 of the statutes is created to read:

601.83 Healthcare stability plan; administration. (1) PLAN ESTABLISHED; GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer a state-based reinsurance program known as the healthcare stability plan.

(b) 1. The commissioner shall submit a request to the federal department of health and human services for a waiver under 42 USC 18052 to implement the healthcare stability plan for benefit years beginning January 1, 2019. The commissioner shall include in the waiver request that the operation of the healthcare stability plan is contingent on approval by the federal department of health and human services. The commissioner shall seek the maximum federal funding available to implement and maintain the healthcare stability plan. In the waiver submission under this subdivision, the commissioner shall include as the payment parameters for the healthcare stability plan for benefit year 2019 an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000. The commissioner may adjust the payment parameters under sub. (2) to the extent necessary to secure federal approval of the waiver request under this paragraph.

2. If the federal department of health and human services does not approve the healthcare stability plan in the waiver request submitted under subd. 1. or a substantially similar healthcare stability plan, the commissioner may not implement the healthcare stability plan.

(c) In accordance with sub. (5) (c), the commissioner shall collect the data from an eligible health carrier as necessary to determine reinsurance payments.

(d) Beginning on a date determined by the commissioner, the commissioner shall require each eligible health carrier to calculate the premium amount the eligible health carrier would have charged for a benefit year if the healthcare stability plan had not been established and submit the calculated premium amount as part of its rate filing submitted to the commissioner. The commissioner shall consider the calculated premium amount information provided under this paragraph as part of the rate filing review.

(e) 1. For each applicable benefit year, the commissioner shall notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the calendar year following the applicable benefit year.

2. Quarterly during the applicable benefit year, the commissioner shall provide each eligible health carrier with the calculation of total reinsurance payment requests.

3. By August 15 of the calendar year following the applicable benefit year, the commissioner shall disburse all applicable reinsurance payments to an eligible health carrier.

(f) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section.

(2) PAYMENT PARAMETERS. (a) Subject to the limitations under pars. (b), (c), and (d), the commissioner shall design and adjust payment parameters to ensure that the payment parameters will do all of the following:

1. Stabilize or reduce premium rates in the individual market.

2. Increase participation by health carriers in the individual market.

3. Improve access to health care providers and services for individuals purchasing coverage in the individual market.

4. Mitigate the impact high-risk individuals have on premium rates in the individual market.

5. Take into account any federal funding available for the plan.

6. Take into account the total amount available to fund the plan.

(b) The commissioner shall set the attachment point for the healthcare stability plan at $50,000 or more, but not exceeding the reinsurance cap.

(c) The commissioner shall set the coinsurance rate at a rate between 50 and 80 percent.

(d) The commissioner shall set the reinsurance cap at $250,000 or less.

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than January 30 of the calendar year before the applicable benefit year.

(b) If the amount available for expenditure for the healthcare stability plan is not anticipated to be adequate to fully fund the payment parameters set under par. (a) as of July 1 of the calendar year before the applicable benefit year, the commissioner shall adjust the payment parameters in accordance within the moneys available to expend for the healthcare stability plan. The commissioner shall allow an eligible health carrier to revise its rate filing based on the final payment parameters for the applicable benefit year.

(4) REINSURANCE PAYMENT CALCULATION. (a) The commissioner shall calculate a reinsurance payment with respect to each eligible health carrier's incurred claims costs for an enrolled individual's covered benefits in the applicable benefit year. If the claims costs for an enrolled individual do not exceed the attachment point set under sub. (2) (b), the commissioner may not make a reinsurance payment with respect to that enrollee. If the claims costs for an enrolled individual exceed the attachment point, subject to par. (b), the commissioner shall make a reinsurance payment that is calculated as the product of the coinsurance rate and whichever of the following is less:

1. The claims costs minus the attachment point.

2. The reinsurance cap minus the attachment point.

(b) The commissioner shall ensure that any reinsurance payment made to an eligible health carrier does not exceed the total amount paid by the eligible health carrier for any eligible claim. For purposes of this paragraph, the total amount paid of an eligible claim is the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or copayment paid by another person as of the time the data are submitted or made accessible under sub. (5) (c).

(5) REINSURANCE PAYMENT REQUESTS. (a) An eligible health carrier may request reinsurance payments from the commissioner when the eligible health carrier meets the requirements of this subsection and sub. (4).

(b) An eligible health care shall make any requests for a reinsurance payment in accordance with any requirements established by the commissioner.

(c) Each eligible health carrier shall provide the commissioner with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 USC 18063. Each eligible health carrier shall submit to the commissioner attesting to compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) Each eligible health carrier shall provide the access under par. (c) for each applicable benefit year by April 30 of the calendar year following the end of the applicable benefit year.

(e) Each eligible health carrier shall maintain for at least 6 years documents and records, by paper, electronic, or other media, sufficient to substantiate a request for a reinsurance payment made under this section. An eligible health carrier shall make the documents and records available to the commissioner, upon request, for

purposes of verification, investigation, audit, or other review of a reinsurance payment request.

(f) The commissioner may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier shall ensure that its contractors, subcontractors, or agents cooperate with any audit under this paragraph. Within 30 days of receiving notice that an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall do all of the following:

1. Provide a written corrective action plan to the commissioner for approval.

2. Implement the corrective action plan under subd. 1. as approved by the commissioner.

3. Provide the commissioner with written documentation of the corrective action after implementation.

****NOTE: As this provision is written, the submission of the corrective action plan, approval by the commissioner, implementation of the plan, and documentation of the correction all must occur within 30 days. Is this time period long enough for all of those steps to occur?

(6) ACCESS TO INFORMATION. Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the premiums security plan is not available for inspection and copying under s. 19.35 (1).

SECTION 7. 601.85 of the statutes is created to read:

601.85 Accounting, reports, and audits. (1) ACCOUNTING. The commissioner shall keep an accounting for each benefit year of all of the following:

(a) Funds appropriated for reinsurance payments and administrative and operational expenses.

(b) Requests for reinsurance payments received from eligible health carriers.

(c) Reinsurance payments made to eligible health carriers.

(d) Administrative and operational expenses incurred for the healthcare stability plan.

(2) REPORTS. By November 1 of the calendar year following the applicable benefit year or by 60 days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the commissioner shall make available to the public a report summarizing the premiums security plan's operations for each benefit year by posting the summary on the office's Internet site.

(3) LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the legislative audit bureau. The commissioner shall ensure that its contractors, subcontractors, or agents cooperate with any audit of the healthcare stability plan performed by the legislative audit bureau.

(4) INDEPENDENT EXTERNAL AUDIT. (a) The commissioner shall engage and cooperate with an independent certified public accountant firm to perform an audit for each benefit year of the healthcare stability plan, in accordance with generally accepted auditing standards. The audit under this paragraph shall include all of the following:

1. An assessment of compliance with the requirements of this subchapter.

2. Identification of any material weaknesses or significant deficiencies and address the manner in which to correct the weaknesses or deficiencies.

(b) The commissioner, after receiving the completed audit report, shall make public the results of the audit by posting on the office's Internet site, to the extent the

audit contains information subject to disclosure to the public, including any material weakness or significant deficiency and how the commissioner intends to correct the material weakness or deficiency.

(c) By December 1 of each year, the commissioner shall submit under s. 13.172 (3) a report to all standing committees of the legislature with jurisdiction over health, human services, or insurance regarding any finding of material weakness or significant deficiency found in an audit conducted under this subsection.

SECTION 8. Subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

SECTION 9. Subchapter VI (title) of chapter 601 [precedes 601.93] of the statutes is repealed.

(END)

INSERT ANALYSIS

This bill creates the Wisconsin Healthcare Stability Plan (WIHSP), which is a state-based reinsurance program for health carriers, subject to the approval of a waiver of the federal Patient and Protection and Affordable Care Act. The WIHSP makes a reinsurance payment to a health carrier if the claims for an individual who is enrolled in a health benefit plan of the carrier plan exceed a threshold amount, known as the attachment point, in a benefit year. The commissioner of the Office of the Insurance Commissioner in this state administers WIHSP. The commissioner sets the payment parameters for the reinsurance payment as specified under the bill. The bill sets certain limits for the payment parameters for a benefit year as follows: 1) the attachment point must be $50,000 or more, but may not exceed the reinsurance cap; 2) the reinsurance cap, which is the maximum amount of claims eligible for a reinsurance payment, may not exceed $250,000; and 3) the coinsurance rate, which is the percent of the claim amount eligible for a reinsurance payment, must be between 50 and 80 percent. Within those limits, the commissioner must ensure that the payment parameters for the reinsurance payments stabilize or reduce premium rates in the individual health insurance market, increase participation by health carriers in the individual market, improve access to health care providers and services for individual purchasing individual health insurance coverage, mitigate the impact high-risk individuals have on premium rates in the individual market, and take into account any federal funding and the total amount of funding available for the plan. The commissioner must set the payment parameters for a benefit year by January 30 of the year before. If the funding amounts available for expenditure are not anticipated to fully fund the reinsurance payments as of July 1 of the year before the applicable benefit year, the commissioner must adjust the payment parameters and then allow the health carrier to adjust its filing of insurance premium rates. Under the bill, health carriers are required to calculate the premium amount the carrier would have charged for a benefit year if WIHSP was not established and submit that amount as part of its premium rate filing.

The commissioner must calculate a reinsurance payment to be made to a health carrier as specified in the bill. If the claims cost amounts for an individual enrollee of the health benefit plan do not exceed the attachment point threshold, the commissioner may not make a reinsurance payment. If the costs exceed the attachment point, then the commissioner makes a reinsurance payment that is the coinsurance rate multiplied by whichever of the following is less 1) the claims cost minus the attachment point or 2) the reinsurance cap minus the attachment point. When a health carrier meets criteria set in the bill and any requirements set by the commissioner, the carrier may request a reinsurance payment. The commissioner must notify the carrier of any reinsurance payments for the benefit year no later than June 30 of the year following that benefit year.

The bill requires health carriers to provide access to certain data. The commissioner may also have a health carrier audited to assess the carrier's compliance with requirements in this bill. The commissioner is required to keep an

accounting of certain payments and moneys available for payments as specified in the bill. The commissioner is also required to engage and cooperate with an independent accountant firm to perform an audit of WIHSP.

The bill requires the commissioner to submit a request for a state innovation waiver under the federal Affordable Care Act, known as a 1332 waiver, to implement WIHSP. The commissioner must seek the maximum federal funding available to implement and maintain the WIHSP. In the waiver, the commissioner must include payment parameters of $50,000 for attachment point, $250,000 for the reinsurance cap, and a coinsurance rate of 80 percent. If the federal government does not approve WIHSP as submitted or a substantially similar plan, the commissioner may not implement WIHSP. Current federal law allows a state to apply for a waiver of certain provisions of the Affordable Care Act, and the state is then eligible to receive moneys from the federal government, known as pass-through funding, that the federal government would have paid in premium tax credits, cost-sharing reductions, or small business credits if the waiver had not been approved.

Under the bill, if a fee imposed under the Affordable Care Act is no longer applicable to insurers participating in the state' s group health insurance program, the secretary of administration must calculate the expected savings to state agencies from avoiding the fee. The secretary must then either lapse or transfer, in the biennium in which the savings calculation is made, to the general fund the general purpose revenue and program revenue based on the savings calculated or adjust state agency employer contributions for state employee fringe benefit costs in the biennium following the biennium in which the savings is calculated.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

END INSERT ANALYSIS

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Wednesday, January 10, 2018 5:27 PM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Reinsurance Plan Draft Edits
Attachments: 1332 Draft edits_1.docx

Tami:

I have attached our requested changes to the draft. Please give me a call at your leisure tomorrow to discuss the changes. I will be in by 0815.

r/
Kyle

KYLE AMES | Budget and Policy Analyst
Department of Administration
Division of Executive Budget and Finance
Kyle.Ames@wisconsin.gov
Main: (608) 266-2214 | Direct: (267) 377-9059

- [x] Provide language that prohibits insurers having the ability to sue the government for delayed payments (they are currently suing the feds for the risk corridor program).

- [ ] In the event that rates are under estimated and funding is not available for a given year, create language (in Section 3?) that states HMOs will be paid in proportion of the insurer's share of aggregate Wisconsin health insurance premiums for all participating insurers during the given calendar year, as determined by OCI.

- [x] OCI would like a 60-day review period in response to the drafting question on page 11 that prescribes a 30-day period.

- [x] Regarding the payment parameters, to include the attachment point, reinsurance cap and coinsurance rates, rework language on page 6, lines 23-24, page 7, lines 1-2 and page, lines 13-19 to give the Commissioner the authority to determine payment parameters but requires consultation with an actuary firm. Eliminate prescribed parameters.

- [x] Since it takes time to promulgate rules, we need language to grant OCI the authority to set emergency rules in the absence of the determination of an emergency (after page 8, line 2)

- [x] Eliminate (on page 8, line 4) starting with "to ensure...following" and replace "with the goals to" or substantively similar language.

- [x] Draft nonstat language to require the secretary of the department of health services to lapse $100 million GPR from the appropriation under s. 20.435(4)(b) to the general fund.

- [x] Future federal funding: in the event that the Collins-Nelson bill passes, we would like the program to be able to receive those funds.

- [x] Change the placeholder appropriation of $50M (page 4, line 10) to $170M.

- [x] Page 9, line 24 change "care" to "carrier"

- [ ] Before "Section 8" on page 12 draft language that states, "By Dec. 31, 2018, require OCI to make a recommendation on this waiver, additional waivers and/or any other options to stabilize the individual healthcare marketplace in Wisconsin."

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Thursday, January 11, 2018 4:27 PM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: 1332 Edits

Tami:

In addition to the edits I sent yesterday, could you please eliminate the word "shall" on page 6, line 15, and insert the words "has authority to"? Also, could you please eliminate subsequent words starting with the word "The" on line 17, page 6 through line 24, ending with "$250,000"?

Please let me know if you have any questions as this may affect some of the previous changes.

Kyle

KYLE AMES | Budget and Policy Analyst
Department of Administration
Division of Executive Budget and Finance
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Main: (608) 266-2214 | Direct: (267) 377-9059

Dodge, Tamara

From: Dombrowski, Cynthia A - DOA
Sent: Thursday, January 11, 2018 4:52 PM
To: Ames, Kyle - DOA; Dodge, Tamara
Subject: RE: 1332 Edits

Tami,

We need 1 more change: where we reference "the waiver" can we change it to say "one or more waivers" ?

Thanks!
Cindy

From: Ames, Kyle - DOA
Sent: Thursday, January 11, 2018 4:27 PM
To: Dodge, Tami - LEGIS <tamara.dodge@legis.wisconsin.gov>
Cc: Dombrowski, Cynthia A - DOA <Cynthia.Dombrowski@wisconsin.gov>
Subject: 1332 Edits

Tami:

In addition to the edits I sent yesterday, could you please eliminate the word "shall" on page 6, line 15, and insert the words "has authority to"? Also, could you please eliminate subsequent words starting with the word "The" on line 17, page 6 through line 24, ending with "$250,000"?

Please let me know if you have any questions as this may affect some of the previous changes.

Kyle

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State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/P1
TJD:ahe

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** subchapter VI (title) of chapter 601 [precedes 601.93]; and ***to create*** 16.5285, 20.145 (5), subchapter VII (title) of chapter 601 [precedes 601.80], 601.80, 601.83, 601.85 and subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes; **relating to:** Wisconsin Healthcare Stability Plan, reinsurance of health carriers, reallocating savings from health insurer fee, granting rule-making authority, and making an appropriation.

Analysis by the Legislative Reference Bureau

This bill creates the Wisconsin Healthcare Stability Plan (WIHSP), which is a state-based reinsurance program for health carriers, subject to the approval of a waiver of the federal Patient Protection and Affordable Care Act. WIHSP makes a reinsurance payment to a health carrier if the claims for an individual who is enrolled in a health benefit plan of the carrier exceed a threshold amount, known as the attachment point, in a benefit year. The commissioner of the Office of the Commissioner of Insurance in this state administers WIHSP. The commissioner sets the payment parameters for the reinsurance payment as specified under the bill. The bill sets certain limits for the payment parameters for a benefit year as follows: 1) the attachment point must be $50,000 or more, but may not exceed the reinsurance cap; 2) the reinsurance cap, which is the maximum amount of claims eligible for a reinsurance payment, may not exceed $250,000; and 3) the coinsurance rate, which is the percent of the claim amount eligible for a reinsurance payment, must be

between 50 and 80 percent. Within those limits, the commissioner must ensure that the payment parameters for the reinsurance payments stabilize or reduce premium rates in the individual health insurance market, increase participation by health carriers in the individual market, improve access to health care providers and services for individuals purchasing individual health insurance coverage, mitigate the impact high-risk individuals have on premium rates in the individual market, and take into account any federal funding and the total amount of funding available for the plan. The commissioner must set the payment parameters for a benefit year by January 30 of the year before. If the funding amounts available for expenditure are not anticipated to fully fund the reinsurance payments as of July 1 of the year before the applicable benefit year, the commissioner must adjust the payment parameters and then allow the health carrier to adjust its filing of insurance premium rates. Under the bill, health carriers are required to calculate the premium amount the carrier would have charged for a benefit year if WIHSP was not established and submit that amount as part of its premium rate filing.

The commissioner must calculate a reinsurance payment to be made to a health carrier as specified in the bill. If the claims cost amounts for an individual enrollee of the health benefit plan do not exceed the attachment point threshold, the commissioner may not make a reinsurance payment. If the costs exceed the attachment point, then the commissioner makes a reinsurance payment that is the coinsurance rate multiplied by whichever of the following is less 1) the claims cost minus the attachment point or 2) the reinsurance cap minus the attachment point. When a health carrier meets criteria set in the bill and any requirements set by the commissioner, the carrier may request a reinsurance payment. The commissioner must notify the carrier of any reinsurance payments for the benefit year no later than June 30 of the year following that benefit year.

The bill requires health carriers to provide access to certain data. The commissioner may also have a health carrier audited to assess the carrier's compliance with requirements in this bill. The commissioner is required to keep an accounting of certain payments and moneys available for payments as specified in the bill. The commissioner is also required to engage and cooperate with an independent accounting firm to perform an audit of WIHSP.

The bill requires the commissioner to submit a request for a state innovation waiver under the federal Affordable Care Act, known as a "1332 waiver," to implement WIHSP. The commissioner must seek the maximum federal funding available to implement and maintain WIHSP. In the waiver, the commissioner must include payment parameters of $50,000 for attachment point, $250,000 for the reinsurance cap, and a coinsurance rate of 80 percent. If the federal government does not approve WIHSP as submitted or a substantially similar plan, the commissioner may not implement WIHSP. Current federal law allows a state to apply for a waiver of certain provisions of the Affordable Care Act, and the state is then eligible to receive moneys from the federal government, known as pass-through funding, that the federal government would have paid in premium tax credits, cost-sharing reductions, or small business credits if the waiver had not been approved.

separate ¶ The bill requires the secretary of health services to ensure a lapse is made to the general fund of $100,000,000 from the general purpose revenue appropriation for the Medical Assistance program.

Under the bill, if a fee imposed under the Affordable Care Act is no longer applicable to insurers participating in the state' s group health insurance program, the secretary of administration must calculate the expected savings to state agencies from avoiding the fee. The secretary must then either lapse or transfer, in the biennium in which the savings calculation is made, to the general fund the general purpose revenue and program revenue based on the savings calculated or adjust state agency employer contributions for state employee fringe benefit costs in the biennium following the biennium in which the savings is calculated.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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

SECTION 1. 16.5285 of the statutes is created to read:

16.5285 Health insurer fee savings. (1) In this section, "Affordable Care Act" has the meaning given in s. 601.80 (1).

(2) Beginning January 1, 2019, if the annual fee imposed under section 9010 of the Affordable Care Act is no longer applicable to insurers participating in the state's group health insurance program under s. 40.51 (6), the secretary shall calculate the expected state agency savings related to the avoidance of the fee.

(3) Based on the savings calculated under sub. (2), the secretary shall do one of the following:

(a) In the fiscal biennium in which the savings are calculated, reduce the estimated general purpose revenue and program revenue expenditures, excluding tuition and fee moneys from the University of Wisconsin System, for "Compensation Reserves" shown in the schedule under s. 20.005 (1) by an amount equal to the savings calculated under sub. (2), lapse to the general fund from the general purpose revenue appropriations an amount equal to the calculated general purpose revenue saved under sub. (2), and transfer to the general fund the related program revenue

appropriation account balances in an amount equal to the calculated program revenue saved under sub. (2).

(b) In the fiscal biennium following the fiscal biennium in which the savings are calculated, adjust state agency employer contributions for state employee fringe benefit costs.

SECTION 2. 20.005 (3) (schedule) of the statutes: at the appropriate place, insert the following amounts for the purposes indicated:

				2017-18	2018-19
20.145 Insurance, office of the commissioner of					
(5)	WISCONSIN HEALTHCARE STABILITY PLAN				
(b)	Reinsurance plan; state subsidy	GPR	A		50,000,000

SECTION 3. 20.145 (5) of the statutes is created to read:

20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state subsidy.* The amounts in the schedule for the state subsidy of reinsurance payments for the reinsurance program under subch. VII of ch. 601.

(m) *Federal funds; reinsurance plan.* All moneys received from the federal government for the reinsurance plan under subch. VII of ch. 601 for the purposes for which received.

SECTION 4. Subchapter VII (title) of chapter 601 [precedes 601.80] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

SECTION 5. 601.80 of the statutes is created to read:

601.80 Definitions; healthcare stability plan. In this subchapter:

(1) "Affordable Care 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 to or regulations or guidance issued under those acts.

(2) "Attachment point" means the amount set under s. 601.83 (2) (b) for the healthcare stability plan that is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

(4) "Coinsurance rate" means the rate set under s. 601.83 (2) (c) for the healthcare stability plan that is the rate at which the commissioner will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(5) "Eligible health carrier" means an insurer, as defined in s. 632.745 (15) that offers an individual health plan and incurs claims costs for an enrolled individual's covered benefits in the applicable benefit year.

(6) "Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act.

(7) "Health benefit plan" has the meaning given in s. 632.745 (11).

(8) "Healthcare stability plan" means the state-based reinsurance program known as the Wisconsin Healthcare Stability Plan administered under s. 601.83 (1).

(9) "Individual health plan" means a health benefit plan that is not a group health plan, as defined in s. 632.745 (10), or a grandfathered plan.

(10) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the healthcare stability plan.

(12) "Reinsurance cap" means the threshold amount set under s. 601.83 (2) (d) for the healthcare stability plan for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(13) "Reinsurance payment" means an amount paid by the commissioner to an eligible health carrier under the healthcare stability plan.

SECTION 6. 601.83 of the statutes is created to read:

601.83 Healthcare stability plan; administration. (1) PLAN ESTABLISHED; GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer a state-based reinsurance program known as the healthcare stability plan.

(b) 1. The commissioner shall submit a request to the federal department of health and human services for a waiver under 42 USC 18052 to implement the healthcare stability plan for benefit years beginning January 1, 2019. The commissioner shall include in the waiver request that the operation of the healthcare stability plan is contingent on approval by the federal department of health and human services. The commissioner shall seek the maximum federal funding available to implement and maintain the healthcare stability plan. In the waiver submission under this subdivision, the commissioner shall include as the payment parameters for the healthcare stability plan for benefit year 2019 an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000.

The commissioner may adjust the payment parameters under sub. (2) to the extent necessary to secure federal approval of the waiver request under this paragraph.

2. If the federal department of health and human services does not approve the healthcare stability plan in the waiver request submitted under subd. 1. or a substantially similar healthcare stability plan, the commissioner may not implement the healthcare stability plan.

Insert 7-7

(d) ~~(c)~~ In accordance with sub. (5) (c), the commissioner shall collect the data from an eligible health carrier as necessary to determine reinsurance payments.

(e) ~~(d)~~ Beginning on a date determined by the commissioner, the commissioner shall require each eligible health carrier to calculate the premium amount the eligible health carrier would have charged for a benefit year if the healthcare stability plan had not been established and submit the calculated premium amount as part of its rate filing submitted to the commissioner. The commissioner shall consider the calculated premium amount information provided under this paragraph as part of the rate filing review.

(f) ~~(e)~~ 1. For each applicable benefit year, the commissioner shall notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the calendar year following the applicable benefit year.

2. Quarterly during the applicable benefit year, the commissioner shall provide each eligible health carrier with the calculation of total reinsurance payment requests.

3. By August 15 of the calendar year following the applicable benefit year, the commissioner shall disburse all applicable reinsurance payments to an eligible health carrier.

Insert 8-2

, after consulting with an actuarial firm,

(f) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section.

(2) PAYMENT PARAMETERS. (a) Subject to the limitations under pars. (b), (c), and (d), the commissioner shall design and adjust payment parameters to ensure that the payment parameters will with the goal to do all of the following:

1. Stabilize or reduce premium rates in the individual market.
2. Increase participation by health carriers in the individual market.
3. Improve access to health care providers and services for individuals purchasing coverage in the individual market.
4. Mitigate the impact high-risk individuals have on premium rates in the individual market.
5. Take into account any federal funding available for the plan.
6. Take into account the total amount available to fund the plan.

(b) The commissioner shall set the attachment point for the healthcare stability plan at $50,000 or more, but not exceeding the reinsurance cap.

(c) The commissioner shall set the coinsurance rate at a rate between 50 and 80 percent.

(d) The commissioner shall set the reinsurance cap at $250,000 or less.

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than January 30 of the calendar year before the applicable benefit year.

(b) If the amount available for expenditure for the healthcare stability plan is not anticipated to be adequate to fully fund the payment parameters set under par. (a) as of July 1 of the calendar year before the applicable benefit year, the commissioner shall adjust the payment parameters in accordance within the moneys

Insert 9-4

available to expend for the healthcare stability plan. The commissioner shall allow an eligible health carrier to revise its rate filing based on the final payment parameters for the applicable benefit year.

(4) REINSURANCE PAYMENT CALCULATION. (a) The commissioner shall calculate a reinsurance payment with respect to each eligible health carrier's incurred claims costs for an enrolled individual's covered benefits in the applicable benefit year. If the claims costs for an enrolled individual do not exceed the attachment point set under sub. (2) (b), the commissioner may not make a reinsurance payment with respect to that enrollee. If the claims costs for an enrolled individual exceed the attachment point, subject to par. (b), the commissioner shall make a reinsurance payment that is calculated as the product of the coinsurance rate and whichever of the following is less:

1. The claims costs minus the attachment point.

2. The reinsurance cap minus the attachment point.

(b) The commissioner shall ensure that any reinsurance payment made to an eligible health carrier does not exceed the total amount paid by the eligible health carrier for any eligible claim. For purposes of this paragraph, the total amount paid of an eligible claim is the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or copayment paid by another person as of the time the data are submitted or made accessible under sub. (5) (c).

(5) REINSURANCE PAYMENT REQUESTS. (a) An eligible health carrier may request reinsurance payments from the commissioner when the eligible health carrier meets the requirements of this subsection and sub. (4).

(b) An eligible health care carrier shall make any requests for a reinsurance payment in accordance with any requirements established by the commissioner.

(c) Each eligible health carrier shall provide the commissioner with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 USC 18063. Each eligible health carrier shall submit to the commissioner attesting to compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) Each eligible health carrier shall provide the access under par. (c) for each applicable benefit year by April 30 of the calendar year following the end of the applicable benefit year.

(e) Each eligible health carrier shall maintain for at least 6 years documents and records, by paper, electronic, or other media, sufficient to substantiate a request for a reinsurance payment made under this section. An eligible health carrier shall make the documents and records available to the commissioner, upon request, for purposes of verification, investigation, audit, or other review of a reinsurance payment request.

(f) The commissioner may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier shall ensure that its contractors, subcontractors, or agents cooperate with any audit under this paragraph. Within 30 days of receiving notice that an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding. Within ~~30~~ 60 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall do all of the following:

1. Provide a written corrective action plan to the commissioner for approval.

2. Implement the corrective action plan under subd. 1. as approved by the commissioner.

3. Provide the commissioner with written documentation of the corrective action after implementation.

Insert 11-5

****NOTE: As this provision is written, the submission of the corrective action plan, approval by the commissioner, implementation of the plan, and documentation of the correction all must occur within 30 days. Is this time period long enough for all of those steps to occur?

(6) ACCESS TO INFORMATION. Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the premiums security plan is not available for inspection and copying under s. 19.35 (1).

SECTION 7. 601.85 of the statutes is created to read:

601.85 Accounting, reports, and audits. (1) ACCOUNTING. The commissioner shall keep an accounting for each benefit year of all of the following:

(a) Funds appropriated for reinsurance payments and administrative and operational expenses.

(b) Requests for reinsurance payments received from eligible health carriers.

(c) Reinsurance payments made to eligible health carriers.

(d) Administrative and operational expenses incurred for the healthcare stability plan.

(2) REPORTS. By November 1 of the calendar year following the applicable benefit year or by 60 days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, the commissioner shall make available to the public a report summarizing the premiums security plan's operations for each benefit year by posting the summary on the office's Internet site.

(3) LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the legislative audit bureau. The commissioner shall ensure that its contractors,

subcontractors, or agents cooperate with any audit of the healthcare stability plan performed by the legislative audit bureau.

(4) INDEPENDENT EXTERNAL AUDIT. (a) The commissioner shall engage and cooperate with an independent certified public accountant firm to perform an audit for each benefit year of the healthcare stability plan, in accordance with generally accepted auditing standards. The audit under this paragraph shall include all of the following:

1. An assessment of compliance with the requirements of this subchapter.

2. Identification of any material weaknesses or significant deficiencies and address the manner in which to correct the weaknesses or deficiencies.

(b) The commissioner, after receiving the completed audit report, shall make public the results of the audit by posting on the office's Internet site, to the extent the audit contains information subject to disclosure to the public, including any material weakness or significant deficiency and how the commissioner intends to correct the material weakness or deficiency.

(c) By December 1 of each year, the commissioner shall submit under s. 13.172 (3) a report to all standing committees of the legislature with jurisdiction over health, human services, or insurance regarding any finding of material weakness or significant deficiency found in an audit conducted under this subsection.

Insert 12-20

SECTION 8. Subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

SECTION 9. Subchapter VI (title) of chapter 601 [precedes 601.93] of the statutes is repealed.

(END)

Insert 13-3

INSERT 7-7

(c) If the federal government enacts into law Senate Bill 1835 of the 115th Congress or a similar bill providing support to states to establish reinsurance programs, the commissioner shall seek, if necessary, and receive federal moneys for the purpose of reinsurance programs that result from that enacted law to expend for the purposes of this subchapter.

END INSERT 7-7

INSERT 8-2

The commissioner may promulgate rules necessary to implement this section as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this ~~subsection~~ paragraph.

END INSERT 8-2

INSERT 9-4

(c) If funding is not available to make all reinsurance payments to eligible health carriers in a benefit year, the commissioner shall make reinsurance payments in proportion to the eligible health carrier's share of aggregate health benefit plan premiums from residents of this state for all health benefit plans during the given benefit year, as determined by the commissioner.

END INSERT 9-4

INSERT 11-5

(g) A health carrier is not eligible to receive a reinsurance payment unless the health carrier agrees not to bring a lawsuit for any delay in reinsurance payments.

END INSERT 11-5

INSERT 12-20

(5) REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the commissioner shall submit to the governor recommendations on implementing a waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and any other options to stabilize the individual health care market in this state.

END INSERT 12-20

INSERT 13-3

SECTION 1. Fiscal changes.

(1) LAPSE FROM MEDICAL ASSISTANCE GENERAL PURPOSE REVENUE APPROPRIATION. The secretary of health services shall ensure that there is lapsed to the general fund from the appropriation under 20.435 (4) (b) of the statutes an amount equal to $100,000,000.

END INSERT 13-3

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Tuesday, January 16, 2018 11:44 AM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Draft Edits

Tami:

Here are some edits we have for the latest draft. I expect there to be more either later today or tomorrow morning after we speak with the actuary regarding the final cost of the program.

That being said, I want to get these changes in as we receive them:

- ✓ Can we please eliminate the "Beginning January 1, 2019" language from page 3, line 4?
- ✓ Can we please add "or medical assistance" after "40.51 (6)" on page 3, line 6?
- ✓ Can we please grant OCI the authority to set the submission date for payment parameters by rule? (reference language on page 8, line 17)
- ✓ Can we please add an "interagency and intra-agency programs" PR-S appropriation under the reinsurance program with language modeled after 20.435(1)(kx)
    - *Interagency and intra-agency programs.* All moneys received from other state agencies…[add] "for the healthcare stability plan" [or purposes of the state reinsurance program]

Thank you for the quick turnaround! As always, please let me know if you have any question.

Kyle

KYLE AMES | Budget and Policy Analyst
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Division of Executive Budget and Finance
Kyle.Ames@wisconsin.gov
Main: (608) 266-2214 | Direct: (267) 377-9059