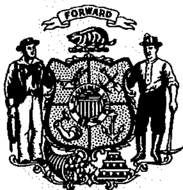

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/P2 P3
TJD:ahe

In: 1/16 Due Today ASAP +WLJ

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

1 AN ACT ***to repeal*** subchapter VI (title) of chapter 601 [precedes 601.93]; and ***to*** 2 ***create*** 16.5285, 20.145 (5), subchapter VII (title) of chapter 601 [precedes 3 601.80], 601.80, 601.83, 601.85 and subchapter VIII (title) of chapter 601 4 [precedes 601.93] of the statutes; **relating to:** Wisconsin Healthcare Stability 5 Plan, reinsurance of health carriers, reallocating savings from health insurer 6 fee, providing an exemption from emergency rule procedures, granting 7 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. After consulting with an actuarial firm, the commissioner sets the payment parameters for the reinsurance payment as specified under the bill. In addition to the attachment point, the other payment parameters are the reinsurance cap, which is the maximum amount of claims eligible for a reinsurance payment, and the coinsurance rate, which

is the percent of the claim amount eligible for a reinsurance payment. The commissioner must design and adjust the payment parameters with the goal to 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. If funding is not available to make all reinsurance payments in a benefit year, reinsurance payments will be made proportional to the health carrier's share of aggregate state resident premiums, as determined by the commissioner. 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. A health carrier, however, is not eligible to receive a reinsurance payment unless the carrier agrees not to bring a lawsuit over any delay in reinsurance payments. 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 allows the commissioner to submit one or more requests for a state innovation waiver under the federal Affordable Care Act, known as a "1332 waiver," to implement WIHSP. 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.

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

1 revenue appropriations an amount equal to the calculated general purpose revenue
2 saved under sub. (2), and transfer to the general fund the related program revenue
3 appropriation account balances in an amount equal to the calculated program
4 revenue saved under sub. (2).

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

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

					2017-18	2018-19
10	**20.145 Insurance, office of the commissioner of**					
11	(5)	WISCONSIN HEALTHCARE STABILITY PLAN				
12	(b)	Reinsurance plan; state subsidy	GPR	A		170,000,000

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

14 20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state*
15 *subsidy.* The amounts in the schedule for the state subsidy of reinsurance payments
16 for the reinsurance program under subch. VII of ch. 601.

17 (m) *Federal funds; reinsurance plan.* All moneys received from the federal
18 government for reinsurance for the purposes for which received.

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

21 **CHAPTER 601**

22 SUBCHAPTER VII

23 HEALTHCARE STABILITY PLAN

Insert 4-17

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

2 **601.80 Definitions; healthcare stability plan.** In this subchapter:

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

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

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

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

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

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

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

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

1 **(9)** "Individual health plan" means a health benefit plan that is not a group
2 health plan, as defined in s. 632.745 (10), or a grandfathered plan.
3 **(10)** "Payment parameters" means the attachment point, reinsurance cap, and
4 coinsurance rate for the healthcare stability plan.
5 **(12)** "Reinsurance cap" means the threshold amount set under s. 601.83 (2) for
6 the healthcare stability plan for claims costs incurred by an eligible health carrier
7 for an enrolled individual's covered benefits, after which the claims costs for benefits
8 are no longer eligible for reinsurance payments.
9 **(13)** "Reinsurance payment" means an amount paid by the commissioner to an
10 eligible health carrier under the healthcare stability plan.
11 **SECTION 6.** 601.83 of the statutes is created to read:
12 **601.83 Healthcare stability plan; administration. (1)** PLAN ESTABLISHED;
13 GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer
14 a state-based reinsurance program known as the healthcare stability plan.
15 (b) 1. The commissioner may submit a request to the federal department of
16 health and human services for one or more waivers under 42 USC 18052 to
17 implement the healthcare stability plan for benefit years beginning January 1, 2019.
18 The commissioner may adjust the payment parameters under sub. (2) to the extent
19 necessary to secure federal approval of the waiver request under this paragraph.
20 2. If the federal department of health and human services does not approve the
21 healthcare stability plan in the waiver request submitted under subd. 1. or a
22 substantially similar healthcare stability plan, the commissioner may not
23 implement the healthcare stability plan.
24 (c) If the federal government enacts into law Senate Bill 1835 of the 115th
25 Congress or a similar bill providing support to states to establish reinsurance

1 programs, the commissioner shall seek, if necessary, and receive federal moneys for
2 the purpose of reinsurance programs that result from that enacted law to expend for
3 the purposes of this subchapter.

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

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

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

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

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

22 (g) The commissioner may promulgate any rules necessary to implement the
23 healthcare stability plan under this section. The commissioner may promulgate
24 rules necessary to implement this section as emergency rules under s. 227.24.
25 Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide

1 evidence that promulgating a rule under this paragraph as an emergency rule is
2 necessary for the preservation of the public peace, health, safety, or welfare and is
3 not required to provide a finding of emergency for a rule promulgated under this
4 paragraph.

5 **(2)** PAYMENT PARAMETERS. The commissioner, after consulting with an actuarial
6 firm, shall design and adjust payment parameters with the goal to do all of the
7 following:

8 (a) Stabilize or reduce premium rates in the individual market.

9 (b) Increase participation by health carriers in the individual market.

10 (c) Improve access to health care providers and services for individuals
11 purchasing coverage in the individual market.

12 (d) Mitigate the impact high-risk individuals have on premium rates in the
13 individual market.   , if the commission specifies a different date by rule,

14 (e) Take into account any federal funding available for the plan.

15 (f) Take into account the total amount available to fund the plan.

16 **(3)** OPERATION. (a) The commissioner shall set the payment parameters as
17 described under sub. (2) by no later than January 30 of the calendar year before the
18 applicable benefit year. or the date specified by the commissioner by rule.

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

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

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

15 1. The claims costs minus the attachment point.

16 2. The reinsurance cap minus the attachment point.

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

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

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

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

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

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

18 (f) The commissioner may have an eligible health carrier audited to assess the
19 health carrier's compliance with the requirements of this section. The eligible health
20 carrier shall ensure that its contractors, subcontractors, or agents cooperate with
21 any audit under this paragraph. Within 30 days of receiving notice that an audit
22 results in a proposed finding of material weakness or significant deficiency with
23 respect to compliance with any requirement of this section, the eligible health carrier
24 may provide a response to the proposed finding. Within 60 days of the issuance of

1 a final audit report that includes a finding of material weakness or significant
2 deficiency, the eligible health carrier shall do all of the following:
3 1. Provide a written corrective action plan to the commissioner for approval.
4 2. Implement the corrective action plan under subd. 1. as approved by the
5 commissioner.
6 3. Provide the commissioner with written documentation of the corrective
7 action after implementation.
8 (g) A health carrier is not eligible to receive a reinsurance payment unless the
9 health carrier agrees not to bring a lawsuit over any delay in reinsurance payments.
10 **(6)** ACCESS TO INFORMATION. Information submitted by an eligible health carrier
11 or obtained by the commissioner for purposes of the premiums security plan is not
12 available for inspection and copying under s. 19.35 (1).
13 **SECTION 7.** 601.85 of the statutes is created to read:
14 **601.85 Accounting, reports, and audits. (1)** ACCOUNTING. The
15 commissioner shall keep an accounting for each benefit year of all of the following:
16 (a) Funds appropriated for reinsurance payments and administrative and
17 operational expenses.
18 (b) Requests for reinsurance payments received from eligible health carriers.
19 (c) Reinsurance payments made to eligible health carriers.
20 (d) Administrative and operational expenses incurred for the healthcare
21 stability plan.
22 **(2)** REPORTS. By November 1 of the calendar year following the applicable
23 benefit year or by 60 days following the final disbursement of reinsurance payments
24 for the applicable benefit year, whichever is later, the commissioner shall make

1 available to the public a report summarizing the premiums security plan's
2 operations for each benefit year by posting the summary on the office's Internet site.
3 **(3)** LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the
4 legislative audit bureau. The commissioner shall ensure that its contractors,
5 subcontractors, or agents cooperate with any audit of the healthcare stability plan
6 performed by the legislative audit bureau.
7 **(4)** INDEPENDENT EXTERNAL AUDIT. (a) The commissioner shall engage and
8 cooperate with an independent certified public accountant firm to perform an audit
9 for each benefit year of the healthcare stability plan, in accordance with generally
10 accepted auditing standards. The audit under this paragraph shall include all of the
11 following:
12 1. An assessment of compliance with the requirements of this subchapter.
13 2. Identification of any material weaknesses or significant deficiencies and
14 address the manner in which to correct the weaknesses or deficiencies.
15 (b) The commissioner, after receiving the completed audit report, shall make
16 public the results of the audit by posting on the office's Internet site, to the extent the
17 audit contains information subject to disclosure to the public, including any material
18 weakness or significant deficiency and how the commissioner intends to correct the
19 material weakness or deficiency.
20 (c) By December 1 of each year, the commissioner shall submit under s. 13.172
21 (3) a report to all standing committees of the legislature with jurisdiction over health,
22 human services, or insurance regarding any finding of material weakness or
23 significant deficiency found in an audit conducted under this subsection.
24 **(5)** REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the
25 commissioner shall submit to the governor recommendations on implementing a

1 waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and
2 any other options to stabilize the individual health care market in this state.

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

5 **CHAPTER 601**

6 SUBCHAPTER VIII

7 FIRE DEPARTMENT DUES

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

10 **SECTION 10. Fiscal changes.**

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

15 **(END)**

1 INSERT 4-17

2 **SECTION 1.** 20.145 (5) (k) of the statutes is created to read:

3 20.145 **(5)** (k) *Interagency and intra-agency programs; reinsurance plan.* All

4 moneys received from other state agencies for the purposes of the healthcare stability

5 plan under subch. VII of ch. 601 or for reinsurance.

6 END INSERT 4-17

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Wednesday, January 17, 2018 3:08 PM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Reinsurance Program Draft Edits
Attachments: Summary_of_changes_3.docx

Good afternoon Tami!

Attached is the latest round of edits. I am hopeful that these are the last...

Please let me know if you have any questions.

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

p. 4, line 13, set appropriation to $50M GPR sum-sufficient.

p4, line 13, add fed appropriation set to $150M continuing in 2018-2019

√p.7, line 23, add "amounts of" so that the language reads "total amounts of reinsurance payments requests"

p.9, after line 14, At the end of section (c) add language: "The commissioner shall notify eligible health carriers if there is insufficient funds available to pay reinsurance payments in full and the estimated amount of payment as soon as practicable after the commissioner becomes aware of any shortfall."

p.10, line 18, generally companies must pay for any exam

Possible edit to 601.45(1)

The reasonable costs of examinations under ss. 601.43, ~~and~~ 601.44, and 601.83(5)(f)

p.11, line 10-13, add a recovery mechanism in the event that OCI overpays insurers

p. 11, line 17-18, add language so text reads: "(g) A health carrier is not eligible to receive a reinsurance payment unless the health carrier agrees not to bring a lawsuit over any delay in reinsurance payments or reduction in reinsurance payments pursuant to sub. (3)(c)."

p.11, line 19-21, replace language with a cross reference to 601.465, "Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the healthcare stability plan is proprietary and confidential under s. 601.465, Wis.Stat."

p. 12, line 16, remove external audit language

p. 13, line 23, change language to read "an amount up to $80M."

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/P3
TJD:ahe&wlj

P4

Due ASAP

In: 1/18

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

regen

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2 *create* 16.5285, 20.145 (5), subchapter VII (title) of chapter 601 [precedes
3 601.80], 601.80, 601.83, 601.85 and subchapter VIII (title) of chapter 601
4 [precedes 601.93] of the statutes; **relating to:** Wisconsin Healthcare Stability
5 Plan, reinsurance of health carriers, reallocating savings from health insurer
6 fee, providing an exemption from emergency rule procedures, granting
7 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. After consulting with an actuarial firm, the commissioner sets the payment parameters for the reinsurance payment as specified under the bill. In addition to the attachment point, the other payment parameters are the reinsurance cap, which is the maximum amount of claims eligible for a reinsurance payment, and the coinsurance rate, which

is the percent of the claim amount eligible for a reinsurance payment. The commissioner must design and adjust the payment parameters with the goal to 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. 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. If funding is not available to make all reinsurance payments in a benefit year, reinsurance payments will be made proportional to the health carrier's share of aggregate state resident premiums, as determined by the commissioner. 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. A health carrier, however, is not eligible to receive a reinsurance payment unless the carrier agrees not to bring a lawsuit over any delay in reinsurance payments or reduction in the payments for insufficient funding. 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 allows the commissioner to submit one or more requests for a state innovation waiver under the federal Affordable Care Act, known as a "1332 waiver," to implement WIHSP. 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.

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 or the Medical Assistance 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:

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

2 **16.5285 Health insurer fee savings. (1)** In this section, "Affordable Care
3 Act" has the meaning given in s. 601.80 (1).

4 **(2)** If the annual fee imposed under section 9010 of the Affordable Care Act is
5 no longer applicable to insurers participating in the state's group health insurance
6 program under s. 40.51 (6) or the Medical Assistance program under subch. IV of ch.
7 49, the secretary shall calculate the expected state agency savings related to the
8 avoidance of the fee.

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

11 (a) In the fiscal biennium in which the savings are calculated, reduce the
12 estimated general purpose revenue and program revenue expenditures, excluding
13 tuition and fee moneys from the University of Wisconsin System, for "Compensation
14 Reserves" shown in the schedule under s. 20.005 (1) by an amount equal to the

1 savings calculated under sub. (2), lapse to the general fund from the general purpose
2 revenue appropriations an amount equal to the calculated general purpose revenue
3 saved under sub. (2), and transfer to the general fund the related program revenue
4 appropriation account balances in an amount equal to the calculated program
5 revenue saved under sub. (2).

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

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

				2017-18	2018-19
11	**20.145 Insurance, office of the commissioner of**				
12	(5) WISCONSIN HEALTHCARE STABILITY PLAN				
13	(b) Reinsurance plan; state subsidy	GPR	A	-0-	170,000,000

Insert 4-14

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

15 20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state*
16 *subsidy.* The amounts in the schedule for the state subsidy of reinsurance payments
17 for the reinsurance program under subch. VII of ch. 601.

A sum sufficient

18 (k) *Interagency and intra-agency programs; reinsurance plan.* All moneys
19 received from other state agencies for the purposes of the healthcare stability plan
20 under subch. VII of ch. 601 or for reinsurance.

21 (m) *Federal funds; reinsurance plan.* All moneys received from the federal
22 government for reinsurance for the purposes for which received.

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

3 **CHAPTER 601**

4 SUBCHAPTER VII

5 HEALTHCARE STABILITY PLAN

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

7 **601.80 Definitions; healthcare stability plan.** In this subchapter:

8 **(1)** "Affordable Care Act" means the federal Patient Protection and Affordable
9 Care Act, P.L. 111-148, as amended by the federal Health Care and Education
10 Reconciliation Act of 2010, P.L. 111-152, and any amendments to or regulations or
11 guidance issued under those acts.

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

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

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

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

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

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

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

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

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

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

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

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

18 **601.83 Healthcare stability plan; administration. (1)** PLAN ESTABLISHED;
19 GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer
20 a state-based reinsurance program known as the healthcare stability plan.

21 (b) 1. The commissioner may submit a request to the federal department of
22 health and human services for one or more waivers under 42 USC 18052 to
23 implement the healthcare stability plan for benefit years beginning January 1, 2019.
24 The commissioner may adjust the payment parameters under sub. (2) to the extent
25 necessary to secure federal approval of the waiver request under this paragraph.

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

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

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

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

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

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

1 3. By August 15 of the calendar year following the applicable benefit year, the
2 commissioner shall disburse all applicable reinsurance payments to an eligible
3 health carrier.
4 (g) The commissioner may promulgate any rules necessary to implement the
5 healthcare stability plan under this section. The commissioner may promulgate
6 rules necessary to implement this section as emergency rules under s. 227.24.
7 Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide
8 evidence that promulgating a rule under this paragraph as an emergency rule is
9 necessary for the preservation of the public peace, health, safety, or welfare and is
10 not required to provide a finding of emergency for a rule promulgated under this
11 paragraph.
12 **(2)** PAYMENT PARAMETERS. The commissioner, after consulting with an actuarial
13 firm, shall design and adjust payment parameters with the goal to do all of the
14 following:
15 (a) Stabilize or reduce premium rates in the individual market.
16 (b) Increase participation by health carriers in the individual market.
17 (c) Improve access to health care providers and services for individuals
18 purchasing coverage in the individual market.
19 (d) Mitigate the impact high-risk individuals have on premium rates in the
20 individual market.
21 (e) Take into account any federal funding available for the plan.
22 (f) Take into account the total amount available to fund the plan.
23 **(3)** OPERATION. (a) The commissioner shall set the payment parameters as
24 described under sub. (2) by no later than January 30 of the calendar year before the

1 applicable benefit year or, if the commission specifies a different date by rule, the
2 date specified by the commissioner by rule.

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

10 (c) If funding is not available to make all reinsurance payments to eligible
11 health carriers in a benefit year, the commissioner shall make reinsurance payments
12 in proportion to the eligible health carrier's share of aggregate health benefit plan
13 premiums from residents of this state for all health benefit plans during the given
14 benefit year, as determined by the commissioner. Insert 9-14

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

24 1. The claims costs minus the attachment point.

25 2. The reinsurance cap minus the attachment point.

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

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

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

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

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

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

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

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

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

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

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

Insert 11-17

17 (h) (g) A health carrier is not eligible to receive a reinsurance payment unless the
18 health carrier agrees not to bring a lawsuit over any delay in reinsurance payments or any reduction in reinsurance payments in accordance with sub. (3)(c).

19 **(6)** ACCESS TO INFORMATION. Information submitted by an eligible health carrier
20 or obtained by the commissioner for purposes of the premiums security plan is not
21 available for inspection and copying under s. 19.35 (1). Insert 11-20

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

23 **601.85 Accounting, reports, and audits. (1)** ACCOUNTING. The
24 commissioner shall keep an accounting for each benefit year of all of the following:

1 (a) Funds appropriated for reinsurance payments and administrative and
2 operational expenses.
3 (b) Requests for reinsurance payments received from eligible health carriers.
4 (c) Reinsurance payments made to eligible health carriers.
5 (d) Administrative and operational expenses incurred for the healthcare
6 stability plan.
7 **(2)** REPORTS. By November 1 of the calendar year following the applicable
8 benefit year or by 60 days following the final disbursement of reinsurance payments
9 for the applicable benefit year, whichever is later, the commissioner shall make
10 available to the public a report summarizing the premiums security plan's
11 operations for each benefit year by posting the summary on the office's Internet site.
12 **(3)** LEGISLATIVE AUDITOR. The healthcare stability plan is subject to audit by the
13 legislative audit bureau. The commissioner shall ensure that its contractors,
14 subcontractors, or agents cooperate with any audit of the healthcare stability plan
15 performed by the legislative audit bureau.
16 **(4)** INDEPENDENT EXTERNAL AUDIT. (a) The commissioner shall engage and
17 cooperate with an independent certified public accountant firm to perform an audit
18 for each benefit year of the healthcare stability plan, in accordance with generally
19 accepted auditing standards. The audit under this paragraph shall include all of the
20 following:
21 1. An assessment of compliance with the requirements of this subchapter.
22 2. Identification of any material weaknesses or significant deficiencies and
23 address the manner in which to correct the weaknesses or deficiencies.
24 (b) The commissioner, after receiving the completed audit report, shall make
25 public the results of the audit by posting on the office's Internet site, to the extent the

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

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

8 (4) (5) REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the
9 commissioner shall submit to the governor recommendations on implementing a
10 waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and
11 any other options to stabilize the individual health care market in this state.

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

14 **CHAPTER 601**

15 SUBCHAPTER VIII

16 FIRE DEPARTMENT DUES

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

19 **SECTION 10. Fiscal changes.**

20 (1) LAPSE FROM MEDICAL ASSISTANCE GENERAL PURPOSE REVENUE APPROPRIATION.
21 The secretary of health services shall ensure that there is lapsed to the general fund
22 from the appropriation under section 20.435 (4) (b) of the statutes an amount equal up
23 to $100,000,000 8, as determined by the secretary of administration.

24 **(END)**

2017-2018 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-5154/P4ins
TJD:...

1 INSERT 4-14 Federal funds; reinsurance plan

2 (m) Reinsurance plan; state subsidy PR-F C -0- 150,000,000

3 END INSERT 4-14

4 INSERT 5-1

5 **SECTION 1.** 601.45 (1) of the statutes is amended to read:

6 601.45 **(1)** COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations

7 and audits under ss. 601.43 ~~and~~, 601.44, and 601.83 (5) (f) shall be paid by examinees

8 except as provided in sub. (4), either on the basis of a system of billing for actual

9 salaries and expenses of examiners and other apportionable expenses, including

10 office overhead, or by a system of regular annual billings to cover the costs relating

11 to a group of companies, or a combination of such systems, as the commissioner may

12 by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The

13 commissioner shall schedule annual hearings under s. 601.41 (5) to review current

14 problems in the area of examinations.

History: 1977 c. 29; 1979 c. 102; 1981 c. 20; 2003 a. 33; 2007 a. 20; 2011 a. 32.

Cross-reference: See also s. Ins 16.01, Wis. adm. code.

15 END INSERT 5-1

16 INSERT 9-14

17 The commissioner shall notify eligible health carriers if there are insufficient

18 funds available to make reinsurance payments in full and the estimated amount of

19 payment as soon as practicable after the commissioner becomes aware of the

20 insufficiency.

21 END INSERT 9-14

22 INSERT 11-17

1 (g) The commissioner may recover from an eligible health carrier any
2 overpayment of reinsurance payments as determined under the audit under par. (f).
3 END INSERT 11-17
4 INSERT 11-20
5 healthcare stability plan is proprietary and confidential under s. 601.465
6 END INSERT 11-20
7

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Friday, January 19, 2018 10:40 AM
To: Dodge, Tamara
Cc: Dombrowski, Cynthia A - DOA
Subject: Draft Edits
Attachments: 1332 Draft edits_4.docx

Tami:

Here are some additional edits for the reinsurance program. I am going to give you a call to walk through some of them.

Thanks again for all of your help! This one should be done soon..

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

Non-stat edit:

Please add a section that outlines payment parameter values, to include attachment point, reinsurance cap and coinsurance rate, that were in P1, to the non-stat language for benefit year 2019. For subsequent benefit years, you can add similar language that is found in the bill that explains that OCI will actuarily justify the parameters (pg. 8, line 20)

Health Insurer fee savings edits:

Pg. 3, line 9: Please insert "or more" so the language reads "do one ore more of the following"

Pg. 4, line 1: Eliminate language starting with "lapse" and ending with "sub (2)" on line 3.

Pg. 4, line 3: Please insert "available" so the language reads "related available program revenue"

Pg. 4, line 4: Please insert "related to the savings under sub. (2)" after "account balances"

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

Pg. 4: Please insert a sub. 4 that allows DoA Sec to transfer savings to the PR appropriation 145(5)(k)

P4. Line 19: Please reference the savings transferred under sub. 4. In the appropriation

Dodge, Tamara

From: Ames, Kyle - DOA
Sent: Friday, January 19, 2018 11:34 AM
To: Dodge, Tamara
Subject: RE: Draft Edits

Perfect.

Thanks Tami.

From: Dodge, Tami - LEGIS [mailto:tamara.dodge@legis.wisconsin.gov]
Sent: Friday, January 19, 2018 11:13 AM
To: Ames, Kyle - DOA <Kyle.Ames@wisconsin.gov>
Cc: Dombrowski, Cynthia A - DOA <Cynthia.Dombrowski@wisconsin.gov>
Subject: RE: Draft Edits

Kyle,

Here is the nonstat language I came up with. I thought it may be quicker for you to take a quick look at it before I send it through our process.

Tami

(0) PAYMENT PARAMETERS. For the 2019 benefit year, the commissioner of insurance shall set as payment parameters for the healthcare stability plan under subchapter VII of chapter 601 an attachment point of \$50,000, a coinsurance rate of 80 percent, and a reinsurance cap of \$250,000. The commissioner of insurance may adjust the payment parameters to the extent necessary to secure federal approval of the waiver request under section 601.83 (1) (b) of the statutes. For subsequent benefit years, the commissioner of insurance may adjust the payment parameters in accordance with section 601.83 (2) of the statutes.

Tamara J. Dodge
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P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
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From: Ames, Kyle - DOA
Sent: Friday, January 19, 2018 10:40 AM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Cc: Dombrowski, Cynthia A - DOA <Cynthia.Dombrowski@wisconsin.gov>
Subject: Draft Edits

Tami:

Here are some additional edits for the reinsurance program. I am going to give you a call to walk through some of them.

Thanks again for all of your help! This one should be done soon..

Kyle

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Dodge, Tamara

From: Dodge, Tamara
Sent: Friday, January 19, 2018 12:34 PM
To: Ames, Kyle - DOA
Subject: RE: Draft Edit

Kyle,

The draft is still in process here so I can make that change in this version.

Tami

Tamara J. Dodge
Senior Legislative Attorney
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P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Ames, Kyle - DOA
Sent: Friday, January 19, 2018 12:30 PM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Subject: Draft Edit

Tami:

Waylon did get back to me, but we could save this for the next round of edits.

He just wanted to change the coinsurance rate to read "between 50 and 80 percent".

KYLE AMES | Budget and Policy Analyst
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Division of Executive Budget and Finance
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