2017 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB885)

For:	**John Nygren (608) 266-2343**	Drafter:	**tdodge**
By:	**Zach**	Secondary Drafters:	
Date:	**2/12/2018**	May Contact:	

Same as LRB:

Submit via email:	**YES**
Requester's email:	**Rep.Nygren@legis.wisconsin.gov**
Carbon copy (CC) to:	**tamara.dodge@legis.wisconsin.gov**
	Aaron.McKean@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

Various changes to healthcare stability plan; require legislative approval for Medical Assistance expansion; subsequent waiver requests; remove lapse

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Submitted	Jacketed	Required
/?	tdodge 2/12/2018	kmochal 2/12/2018			
/P1	tdodge 2/13/2018	eweiss 2/13/2018	jmurphy 2/12/2018		
/1			mbarman 2/13/2018	mbarman 2/13/2018	

FE Sent For: **<END>**

Dodge, Tamara

From: Bemis, Zach
Sent: Monday, February 12, 2018 10:52 AM
To: Dodge, Tamara
Cc: Dyck, Jon
Subject: amendments to AB 885

Hi Tami,

I'm following up on amendments for AB 885. We would like a substitute drafted for tomorrow that includes the following:

LRB a2053/p2 – Recommendations for 2nd 1332 waiver
LRB a2052/P1 – clarifying 5 changes
LRB a2057/p1 – full legislative approval of Medicaid expansion

Additionally, we spoke with Jon at LFB and are supportive of several other changes that he has drafted to some extent. Those are:

- Removal of the lapse
- Cap program at $200M, with to request JFC increase the cap.
- Possibly remove PR transfer (this one requires additional conversation, but wanted to make you aware of now, given the tight turn around.)

Please call if you have questions.

Thanks,

Zach

Zach Bemis
Chief of Staff
Office of Representative John Nygren
Co-Chair, Joint Committee on Finance
89th Assembly District

Dodge, Tamara

From: Bemis, Zach
Sent: Friday, February 09, 2018 9:49 AM
To: Dodge, Tamara
Subject: First item
Attachments: 201802090936.pdf

Zach Bemis
Chief of Staff
Office of Representative John Nygren
Co-Chair, Joint Committee on Finance
89th Assembly District

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

TO: Representative Nygren and Senator Darling

FROM: Wisconsin Association of Health Plans

RE: Requested Changes to AB 885/SB 770

Wisconsin's community-based health plans support a state-based individual market reinsurance program, like the program proposed in Assembly Bill 885/Senate Bill 770. A Wisconsin-based reinsurance program would lead to a more stable, affordable health insurance market for individuals and families.

Health plans have some concerns with the bill as drafted, several of which are technical, and could be resolved through an amendment. These issues are outlined in greater detail below and have been shared with the Office of the Commissioner of Insurance (OCI).

Promulgation of Rules (Section 7(1)(g), page 8)
Under the bill, OCI has broad rulemaking authority to implement the reinsurance program. Health plans want to ensure rules promulgated by OCI will maximize federal funding and minimize the state's funding liability.

Health plans request the following revision: 'The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section. The commissioner shall promulgate the rules with the goal of maximizing federal funding for the healthcare stability plan. 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 paragraph.'

Allocation of Payments in the Event of Insufficient Funds (Section 7(3)(c), pages 9-10)
The methodology as currently drafted does not match the stated intent of the reinsurance program. The technical change below would establish a more appropriate methodology that is simple, transparent, and treats all health plans equally.

Health plans request the following revision: '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 individual health plan claims costs eligible for reinsurance payments ~~premiums from residents of this state for all health benefit plans~~ during the given benefit year, as determined by the commissioner.'

Health Plans' Ability to Sue (Section 7(5)(h), page 12)
The current language does not specify against whom a health plan may not bring suit. Health plans would like to reserve the right to sue the federal government, if necessary.

Health plans request the following revision: 'A health carrier is not eligible to receive a reinsurance payment unless the health carrier agrees not to bring a lawsuit against the commissioner or the state over any delay in reinsurance payments or any reduction in reinsurance payments in accordance with sub. (3) (c).'

Data Collection and Use (Section 7(6), page 12)
Health plans would like to ensure OCI's use of data submitted under the reinsurance program is only used for the purposes of running the program.

Health plans request the following revision: 'Information submitted by an eligible health carrier or obtained by the commissioner for the purposes of the healthcare stability plan is proprietary and confidential under s. 601.465 and shall be used only to the extent permitted by this act.'

Fiscal Changes (Section 12, page 14)
The language requiring a lapse of Medical Assistance dollars does not specifically state the lapsed funds must be used for the Wisconsin reinsurance program.

Health plans request the following revision: 'The secretary of health services shall ensure that there is lapsed to the general fund from the appropriation under section 20.435 (4) (b) of the statutes an amount up to $80,000,000 for the purposes of the Wisconsin Healthcare Stability Plan, as determined by the secretary of administration.'

Dodge, Tamara

From: Bemis, Zach
Sent: Friday, February 09, 2018 9:50 AM
To: Dodge, Tamara
Subject: Second item...

Second item...

From: Wieske, JP - OCI
Sent: Thursday, February 08, 2018 5:48 PM
To: Bemis, Zach <Zach.Bemis@legis.wisconsin.gov>
Subject: potential language 1st draft

Thoughts:

601.85(4) 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. In developing the recommendations, the report shall include the impacts of creating a high risk pool, an invisible high risk pool, funding of consumer health savings accounts, reviewing essential health benefit requirements, expanding plan consumer plan choices including new low-cost plan options, and any other approach which will lower consumer costs, stabilize the insurance market, or expand the availability of private coverage.

J.P. Wieske
Deputy Commissioner
Office of the Commissioner of Insurance
jp.wieske@wisconsin.gov
(608) 266-2493

Dodge, Tamara

From: Bemis, Zach
Sent: Friday, February 09, 2018 2:59 PM
To: Dodge, Tamara
Subject: FW: Draft review: LRB a2053/P1
Attachments: 17a2053/P1.pdf

Hi Tami,

Can we have this redrafted to remove this line: "reviewing essential health benefit requirements;"

Thanks,

Zach

From: Rep.Nygren
Sent: Friday, February 09, 2018 11:09 AM
To: Bemis, Zach <Zach.Bemis@legis.wisconsin.gov>
Subject: FW: Draft review: LRB a2053/P1

From: LRB.Legal
Sent: Friday, February 09, 2018 11:08 AM
To: Rep.Nygren <Rep.Nygren@legis.wisconsin.gov>
Subject: Draft review: LRB a2053/P1

Following is the PDF version of draft LRB a2053/P1.

State of Wisconsin
2017 - 2018 LEGISLATURE

LRBa2052/P1
TJD:emw

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 885

At the locations indicated, amend the bill as follows:

1. Page 8, line 19: delete "section." and substitute "section, except that any rules promulgated under this paragraph shall seek to maximize federal funding for the healthcare stability plan.".

2. Page 9, line 25: delete the material beginning with "aggregate" and ending with "plans" on page 10, line 1, and substitute "aggregate claims costs for individual health plans eligible for reinsurance payments".

3. Page 12, line 11: after "lawsuit" insert "against the commissioner or a state agency or employee".

4. Page 12, line 14: after "plan" insert "shall be used only for purposes of this subchapter and".

5. Page 14, line 9: after "administration" insert "for the purposes of funding the healthcare stability plan under subchapter VII of chapter 601 of the statutes".

(END)

Dodge, Tamara

From: Bemis, Zach
Sent: Monday, February 12, 2018 2:24 PM
To: Dodge, Tamara
Cc: Dyck, Jon
Subject: Re: amendments to AB 885

Can we also have a reference to catastrophic plans or coverage included in the round 2/OCI study language? I'm open on what the best way to draft is, but we had a request from some members to mention it specifically.

Thanks,

Zach

Sent from my iPhone

On Feb 12, 2018, at 2:21 PM, Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov> wrote:

> Will do.
>
> **Tamara J. Dodge**
> Senior Legislative Attorney
> Wisconsin Legislative Reference Bureau
> P.O. Box 2037
> Madison, WI 53701-2037
> (608) 267 - 7380
> tamara.dodge@legis.wisconsin.gov
>
> ---
>
> **From:** Bemis, Zach
> **Sent:** Monday, February 12, 2018 2:17 PM
> **To:** Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
> **Cc:** Dyck, Jon <Jon.Dyck@legis.wisconsin.gov>
> **Subject:** Re: amendments to AB 885
>
> Let's please have the rest of the items identified by LFB included.
>
> Sent from my iPhone
>
> On Feb 12, 2018, at 1:23 PM, Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov> wrote:
>
> > Zach,
> >
> > Do you mind if I copy Jon from LFB on the substitute amendment when I send it to you? I expect it will be more sane in the long run if we are all working off the same substitute amendment.
> >
> > Tami
> >
> > **Tamara J. Dodge**
> > Senior Legislative Attorney
> > Wisconsin Legislative Reference Bureau
> > P.O. Box 2037

Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Bemis, Zach
Sent: Monday, February 12, 2018 10:52 AM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Cc: Dyck, Jon <Jon.Dyck@legis.wisconsin.gov>
Subject: amendments to AB 885

Hi Tami,

I'm following up on amendments for AB 885. We would like a substitute drafted for tomorrow that includes the following:

LRB a2053/p2 – Recommendations for 2nd 1332 waiver
LRB a2052/P1 – clarifying 5 changes
LRB a2057/p1 – full legislative approval of Medicaid expansion

Additionally, we spoke with Jon at LFB and are supportive of several other changes that he has drafted to some extent. Those are:

- Removal of the lapse
- Cap program at $200M, with to request JFC increase the cap.
- Possibly remove PR transfer (this one requires additional conversation, but wanted to make you aware of now, given the tight turn around.)

Please call if you have questions.

Thanks,

Zach

Zach Bemis
Chief of Staff
Office of Representative John Nygren
Co-Chair, Joint Committee on Finance
89th Assembly District

Dodge, Tamara

From: Bemis, Zach
Sent: Monday, February 12, 2018 2:17 PM
To: Dodge, Tamara
Cc: Dyck, Jon
Subject: Re: amendments to AB 885

Let's please have the rest of the items identified by LFB included.

Sent from my iPhone

On Feb 12, 2018, at 1:23 PM, Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov> wrote:

> Zach,
>
> Do you mind if I copy Jon from LFB on the substitute amendment when I send it to you? I expect it will be more sane in the long run if we are all working off the same substitute amendment.
>
> Tami
>
> **Tamara J. Dodge**
> Senior Legislative Attorney
> Wisconsin Legislative Reference Bureau
> P.O. Box 2037
> Madison, WI 53701-2037
> (608) 267 - 7380
> tamara.dodge@legis.wisconsin.gov
>
> ---
>
> **From:** Bemis, Zach
> **Sent:** Monday, February 12, 2018 10:52 AM
> **To:** Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
> **Cc:** Dyck, Jon <Jon.Dyck@legis.wisconsin.gov>
> **Subject:** amendments to AB 885
>
> Hi Tami,
>
> I'm following up on amendments for AB 885. We would like a substitute drafted for tomorrow that includes the following:
>
> LRB a2053/p2 – Recommendations for 2nd 1332 waiver
> LRB a2052/P1 – clarifying 5 changes
> LRB a2057/p1 – full legislative approval of Medicaid expansion
>
> Additionally, we spoke with Jon at LFB and are supportive of several other changes that he has drafted to some extent. Those are:
>
> - Removal of the lapse
> - Cap program at $200M, with to request JFC increase the cap.
> - Possibly remove PR transfer (this one requires additional conversation, but wanted to make you aware of now, given the tight turn around.)
>
> Please call if you have questions.

Thanks,

Zach

Zach Bemis
Chief of Staff
Office of Representative John Nygren
Co-Chair, Joint Committee on Finance
89th Assembly District

Dodge, Tamara

From: Dyck, Jon
Sent: Thursday, February 08, 2018 5:05 PM
To: Dodge, Tamara
Cc: Morgan, Charlie
Subject: AB 885/SB 770 amendment

Tammy,

We'd like to get a preliminary amendment draft started in anticipation that the executive session in Finance will be scheduled soon. These instructions are based on some of what we expect that the Committee may want to do, but we don't know for sure what they'll want. Draft it as a simple amendment. Here's what we want:

1. I think we need to clarify that the reduction in compensation reserves (On page 4, line 3) is only the amount associated with savings to the group health plan. That is, the savings calculated under sub (2) is both the MA savings and the group health savings, but the MA savings shouldn't be taken out of compensation reserves. Add another paragraph (or perhaps a subdivision) that authorizes DOA to reduce the GPR MA appropriation by the amount of the savings if the Secretary determines that doing so would not result in a deficit in the program (or something like that--I'm open to your suggestions).

2. Delete the Chapter 20 schedule entries for the GPR and FED appropriations.

3. Delete the PR appropriation for the program.

4. Create a maximum size of program. In 2019, make it $200 million. In future years, adjust this amount by the medical inflation index. I think there are federal references to medical cost index, but I don't know where exactly. I think perhaps Medicare might use an index like that.

5. Delete the MA lapse provision.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

Dodge, Tamara

From: Dyck, Jon
Sent: Friday, February 09, 2018 3:06 PM
To: Dodge, Tamara
Subject: a2051/P1

Tami,

I have one addition to the amendment. On page 3, line 8...I think we should clarify that calculation of savings would include amounts that were budgeted for, but not needed for expenditure because of the avoidance of the fee.

By way of background, during the 2017-19 budget deliberations, we already knew that the fee was suspended for CY 2017, so the budget didn't include funding in 2017-18 for paying the fee. But because the 2018 fee was not suspended, we budgeted for it in 2018-19 (which the program will have to pay). The same is true for the group health insurance plan, although in that case, the budget didn't include funding for either year. As introduced, I think it is possible to read the bill that whether or not it was budgeted for, DOA would have to make the budget adjustments. Thus, I think it would be a good idea to clarify that we would only be reducing funding it funding was actually put in for the fee.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

Dodge, Tamara

From: Dyck, Jon
Sent: Friday, February 09, 2018 8:25 AM
To: Dodge, Tamara
Subject: RE: AB 885/SB 770 amendment

Yes, that's okay. We point out in our paper that the savings from the compensation reserves is in the general fund or is transferred to the general fund from PR accounts. There's no difference to the general fund between leaving it there (available for the GPR reinsurance appropriation) and transferring it to the PR for use on the reinsurance program.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

From: Dodge, Tamara
Sent: Thursday, February 08, 2018 5:37 PM
To: Dyck, Jon
Cc: Morgan, Charlie
Subject: RE: AB 885/SB 770 amendment

Jon,

If I eliminate the program revenue account, I will have to eliminate page 4, lines 10-12. I assume then that the GPR-S appropriation will accomplish the objective of the savings transfer in the bill because there will be no PR account for the reinsurance program at all. Unless you let me know otherwise, I will assume this is okay and get you a preliminary amendment that contains these changes.

Tami

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

From: Dyck, Jon
Sent: Thursday, February 08, 2018 5:05 PM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Cc: Morgan, Charlie <Charlie.Morgan@legis.wisconsin.gov>
Subject: AB 885/SB 770 amendment

Tammy,

We'd like to get a preliminary amendment draft started in anticipation that the executive session in Finance will be scheduled soon. These instructions are based on some of what we expect that the Committee may want to do, but we don't know for sure what they'll want. Draft it as a simple amendment. Here's what we want:

1. I think we need to clarify that the reduction in compensation reserves (On page 4, line 3) is only the amount associated with savings to the group health plan. That is, the savings calculated under sub (2) is both the MA savings and the group health savings, but the MA savings shouldn't be taken out of compensation reserves. Add another paragraph (or perhaps a subdivision) that authorizes DOA to reduce the GPR MA appropriation by the amount of the savings if the Secretary determines that doing so would not result in a deficit in the program (or something like that--I'm open to your suggestions).

2. Delete the Chapter 20 schedule entries for the GPR and FED appropriations.

3. Delete the PR appropriation for the program.

4. Create a maximum size of program. In 2019, make it $200 million. In future years, adjust this amount by the medical inflation index. I think there are federal references to medical cost index, but I don't know where exactly. I think perhaps Medicare might use an index like that.

5. Delete the MA lapse provision.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

Dodge, Tamara

From: Dyck, Jon
Sent: Monday, February 12, 2018 10:36 AM
To: Dodge, Tamara
Subject: RE: Another addition to the a2051

I've just spoken with one of the co-chairs. They want a slight variation to the $200 million cap. They want to allow the Joint Committee on Finance to adjust the cap under s. 13.10 if OCI makes a request to do so. Take out the CPI adjustment. That may be a bit different that how an Finance process is normally written, since I think you'd typically see the statute give the agency authority to make the adjustment with Finance approval. In this case, Finance would have the authority to make the adjustment. Does that make sense?

There will likely be some other changes before we're done. I expect that the Committee will pick and choose among the various items in this amendment and then probably roll it into a substitute amendment, along with some of their own ideas.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

From: Dodge, Tamara
Sent: Monday, February 12, 2018 10:15 AM
To: Dyck, Jon
Subject: RE: Another addition to the a2051

Jon,

Got it. I'll get to it in just a bit.

Tami

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

From: Dyck, Jon
Sent: Monday, February 12, 2018 8:41 AM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Subject: Another addition to the a2051

Tami,

Could you please add a Joint Committee on Finance 14-day passive review to any reduction to available PR appropriation accounts associated with the suspension of the health insurer fee? Thanks.

Jon Dyck
Supervising Analyst
Legislative Fiscal Bureau
1 East Main, Suite 301
Madison, WI 53703
(608) 266-7044
jon.dyck@legis.wisconsin.gov

State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5154/1
TJD:ahe&wlj

In. 2/12

Due ASAP

2017 ASSEMBLY BILL 885

Inserts

January 30, 2018 - Introduced by Representative NOVAK, by request of Governor Scott Walker. Referred to Committee on Insurance.

AN ACT ***to repeal*** subchapter VI (title) of chapter 601 [precedes 601.93]; ***to amend*** 601.45 (1); 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, providing an exemption from emergency rule procedures, granting rule-making authority, and making appropriations.

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

Claims costs for individual health plans eligible for reinsurance payments

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 rates the carrier would have charged for a benefit year if WIHSP was not established and submit those rates as part of its rate filing.

substitute amendment

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.

against the commissioner or a state agency or employee

substitute amendment

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.

substitute amendment

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. The bill specifies the 2019 benefit year payment parameters to be used for submitting the waiver but allows the commissioner to adjust the payment parameters to secure federal approval of the waiver request. 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

ASSEMBLY BILL 885

Insert A-1

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 up to $80,000,000, as determined by the secretary of administration, 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 transfer, in the biennium in which the savings calculation is made, to the general fund the 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 or both. The secretary may transfer any program revenue transferred based on calculated savings to an appropriation account to be used for WIHSP or reinsurance.

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) 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) or the Medical Assistance program under subch. IV of ch. 49, 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 or more 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), and transfer to the general fund the related available balances in program revenue appropriation accounts related to the savings under sub. (2) 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.

(4) The secretary may transfer any amounts transferred under sub. (3) (a) related to the savings under sub. (2) to the appropriation account under s. 20.145 (5) (k).

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	S		-0-	50,000,000
(m) Federal funds; reinsurance plan	PR-F	C		-0-	150,000,000

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

20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state subsidy.* A sum sufficient for the state subsidy of reinsurance payments for the reinsurance program under subch. VII of ch. 601.

(k) *Interagency and intra-agency programs; reinsurance plan.* All moneys received from other state agencies and all moneys transferred under s. 16.5285 (4) for the purposes of the healthcare stability plan under subch. VII of ch. 601 or for reinsurance.

Insert a2057

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

SECTION 4. 601.45 (1) of the statutes is amended to read:

601.45 **(1)** COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations and audits under ss. 601.43 ~~and~~, 601.44, and 601.83 (5) (f) shall be paid by examinees except as provided in sub. (4), either on the basis of a system of billing for actual salaries and expenses of examiners and other apportionable expenses, including office overhead, or by a system of regular annual billings to cover the costs relating to a group of companies, or a combination of such systems, as the commissioner may by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The commissioner shall schedule annual hearings under s. 601.41 (5) to review current problems in the area of examinations.

SECTION 5. Subchapter VII (title) of chapter 601 [precedes 601.80] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

SECTION 6. 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) 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) 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) 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 7. 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 may submit a request to the federal department of health and human services for one or more waivers under 42 USC 18052 to implement the healthcare stability plan for benefit years beginning January 1, 2019. 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) 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.

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

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

(f) 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 amounts of 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.

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

, except that any rules promulgated under this paragraph shall seek to maximize federal funding for the healthcare stability plan

Insert 9-1

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

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

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

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

(d) Mitigate the impact high-risk individuals have on premium rates in the individual market.

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

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

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than March 30 of the calendar year before the applicable benefit year or, if the commissioner specifies a different date by rule, the date specified by the commissioner by rule.

(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.

(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 claims costs for individual health plans eligible for reinsurance payments

premiums from residents of this state for all health benefit plans during the given benefit year, as determined by the commissioner. The commissioner shall notify eligible health carriers if there are insufficient funds available to make reinsurance payments in full and the estimated amount of payment as soon as practicable after the commissioner becomes aware of the insufficiency.

(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), 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 claim. For purposes of this paragraph, the total amount paid of a 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 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 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.

against the commissioner or a state agency or employee

(g) The commissioner may recover from an eligible health carrier any overpayment of reinsurance payments as determined under the audit under par. (f).

(h) 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 any reduction in reinsurance payments in accordance with sub. (3) (c).

(6) ACCESS TO INFORMATION. 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.

SECTION 8. 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.

Shall be used only for purposes of this Subchapter and

(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 healthcare stability 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) 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. Insert a2053

SECTION 9. Subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

SECTION 10. Subchapter VI (title) of chapter 601 [precedes 601.93] of the statutes is repealed.

SECTION 11. Nonstatutory provisions.

(1) 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 between 50 and 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.

SECTION 12. 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 section 20.435 (4) (b) of the statutes an amount up to $80,000,000, as determined by the secretary of administration.

(END)

INSERT A-1

The substitute amendment prohibits the Department of Health Services from expanding the Medical Assistance program under the federal Patient Protection and Affordable Care Act unless legislation is in effect allowing the expansion.

END INSERT A-1

INSERT 4-3

savings calculated under sub. (2) to the state's group health insurance program; subject to sub. (4), transfer to the general fund the related available balances in program revenue appropriation accounts related to the savings under sub. (2) to the state's group health insurance program in an amount equal to the calculated program revenue saved under sub. (2) to the state's group health insurance program; and, if the secretary of health services finds that a reduction would not result in a deficit to the Medical Assistance program, reduce the general purpose revenue expenditure amounts for the Medical Assistance program under s. 20.435 (4) (b) by an amount that is no greater than the amount of the savings calculated under sub. (2) to the Medical Assistance program.

END INSERT 4-3

INSERT 4-10

(4) If the secretary intends to transfer to the general fund the related available balances in program revenue appropriation accounts related to the savings under sub. (2) to the state's group health insurance program, the secretary shall submit a request to the joint committee on finance stating the amounts the secretary calculates would be transferred from each program revenue appropriation account. If, within 14 days after the date of the secretary's request, the cochairpersons of the committee do not notify the department that the committee has scheduled a meeting

within 14 days after the date of the secretary's request

to review the request, the transfers submitted are considered approved. If the cochairpersons notify the department that the committee has scheduled a meeting to review the request, a transfer may be made only upon approval of the committee.

END INSERT 4-10

INSERT 9-1

(h) In 2019 and in each subsequent year, the commissioner may expend no more than $200,000,000 from all revenue sources for the healthcare stability plan under this section, unless the joint committee on finance under s. 13.10 has increased this amount upon request by the commissioner.

END INSERT 9-1

Insert

State of Wisconsin
2017 - 2018 LEGISLATURE

LRBa2053/P2
TJD:ahe

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 885

Insert a2053

At the locations indicated, amend the bill as follows:

1. Page 13, line 13: after "state." insert "In developing the recommendations, the commissioner shall consider and include in the report the impacts of creating a high-risk pool or an invisible high-risk pool; funding of consumer health savings accounts; expanding consumer plan choices, including new low-cost plan options; and implementing any other approach that will lower consumer costs, stabilize the insurance market, or expand the availability of private insurance coverage.

(END) Insert a2053

Catastrophic plans or coverage and

Insert

State of Wisconsin
2017 - 2018 LEGISLATURE

LRBa2057/P1
TJD:amn

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY AMENDMENT ,

TO ASSEMBLY BILL 885

At the locations indicated, amend the bill as follows:

1. Page 5, line 6: after that line insert:

Insert a2057

"**SECTION 3m.** 49.45 (2p) of the statutes is created to read:

49.45 **(2p)** APPROVAL OF MEDICAL ASSISTANCE PROGRAM CHANGES. After the effective date of this subsection .... [LRB inserts date], the department may not expand eligibility under section 2001 (a) (1) (C) of the Patient Protection and Affordable Care Act, P.L. 111-148, for the Medical Assistance program under this subchapter unless the state legislature has passed legislation to allow the expansion and that legislation is in effect.".

(END) Insert a2057

Dodge, Tamara

From: Dodge, Tamara
Sent: Tuesday, February 13, 2018 7:44 AM
To: Bemis, Zach
Subject: RE: Amendment Issue

Zach,

Will do. Do you want another version of the amendment right now or might there be more changes?

Tami

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

From: Bemis, Zach
Sent: Tuesday, February 13, 2018 7:40 AM
To: Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>
Cc: Dyck, Jon <Jon.Dyck@legis.wisconsin.gov>
Subject: Re: Amendment Issue

I agree with both of you. But please make that change back to the language as provided.

Sent from my iPhone

On Feb 12, 2018, at 6:54 PM, Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov> wrote:

> Zach,
>
> I assumed from the language they requested, which was a real brain twister with the "aggregate individual" phrase, that they wanted the aggregate claims costs eligible for reinsurance payments from plans on the individual health plan market. If that is what they meant, I'm not sure how my wording changes that, but I could change it to say what I just said if that is better.
>
> Tami
>
> **Tamara J. Dodge**
> Senior Legislative Attorney
> Wisconsin Legislative Reference Bureau
> P.O. Box 2037
> Madison, WI 53701-2037
> (608) 267 - 7380
> tamara.dodge@legis.wisconsin.gov
>
> ---
>
> **From:** Bemis, Zach
> **Sent:** Monday, February 12, 2018 6:35 PM
> **To:** Dodge, Tamara <Tamara.Dodge@legis.wisconsin.gov>; Dyck, Jon <Jon.Dyck@legis.wisconsin.gov>

Subject: FW: Amendment Issue
Importance: High

Hi Tami and Jon,

WAHP is raising concerns that the language on page 10, line 20, related to proporational payments, is still ambiguous. As I understand the issue, they are concerned that as drafted, it is still unclear whether or not the payment applies to payments "within the corridor" or some outside the corridor.

I'm not sure I see their concerns, but wanted to run them by all of you to see what you think. Is it ambiguous as drafted in the substitute? Is there a problem with the language as provided below? I'm going to reach out to OCI as well and confirm their understanding.

Thanks,

Zach

From: Tim Lundquist [mailto:Tim@wihealthplans.org]
Sent: Monday, February 12, 2018 6:22 PM
To: Bemis, Zach <Zach.Bemis@legis.wisconsin.gov>
Subject: Amendment Issue
Importance: High

Hi Zach,

There is an issue with the way the amendment (LRBa2052/P1) was drafted in section 2 (lines 5-7 of the amendment).

In this draft, LRB changed the suggested wording in a way that has material impact on the effect of the language.

We request that the amendment offered tomorrow include the language originally requested:

Allocation of Payments in the Event of Insufficient Funds (Section 7(3)(c), pages 9-10)

'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 individual health plan claims costs eligible for reinsurance payments ~~premiums from residents of this state for all health benefit plans~~ during the given benefit year, as determined by the commissioner.'

This original language was vetted by OCI and other industry groups.

Let me know if you have any questions.

Thanks!

Tim Lundquist
Director of Government and Public Affairs
Wisconsin Association of Health Plans
tim@wihealthplans.org

ph: (608) 255-0921

Follow us on Twitter @wihealthplans

State of Wisconsin
2017 - 2018 LEGISLATURE

LRBs0317/P1
TJD:all

Now

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY SUBSTITUTE AMENDMENT ,

TO ASSEMBLY BILL 885

AN ACT ***to repeal*** subchapter VI (title) of chapter 601 [precedes 601.93]; ***to amend*** 601.45 (1); and ***to create*** 16.5285, 20.145 (5), 49.45 (2p), 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, providing an exemption from emergency rule procedures, granting rule-making authority, and making appropriations.

Analysis by the Legislative Reference Bureau

This substitute amendment 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 substitute amendment. 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 claims costs for individual health plans eligible for reinsurance payments, as determined by the commissioner. Under the substitute amendment, health carriers are required to calculate the rates the carrier would have charged for a benefit year if WIHSP was not established and submit those rates as part of its rate filing.

The commissioner must calculate a reinsurance payment to be made to a health carrier as specified in the substitute amendment. 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 substitute amendment 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 against the commissioner or a state agency or employee 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 substitute amendment 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 substitute amendment. The commissioner is required to keep an accounting of certain payments and moneys available for payments as specified in the substitute amendment.

The substitute amendment 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. The substitute amendment specifies the 2019 benefit year payment parameters to be used for submitting the waiver but allows the commissioner to adjust the payment parameters to secure federal approval of the waiver request. 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 substitute amendment, 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 adjust appropriations and transfer, in the biennium in which the savings calculation is made, to the general fund the program revenue based on the savings calculated, subject to limitations in the substitute amendment, or adjust state agency employer contributions for state employee fringe benefit costs in the biennium following the biennium in which the savings is calculated or both.

The substitute amendment prohibits the Department of Health Services from expanding the Medical Assistance program under the federal Patient Protection and Affordable Care Act unless legislation is in effect allowing the expansion.

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) 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) or the Medical Assistance program under subch. IV of ch. 49 and if the state budget allocated an amount to expend on the annual insurer fee, 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 or more 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) to the state's group health insurance program; subject to sub. (4), transfer to the general fund the related available balances in program revenue appropriation accounts related to the savings under sub. (2) to the state's group health insurance program in an amount equal to the calculated program revenue saved under sub. (2) to the state's group health insurance program; and, if the secretary of health services finds that a reduction would not result in a deficit to the Medical Assistance program, reduce the general purpose revenue expenditure amounts for the Medical Assistance program under s. 20.435 (4) (b) by an amount that is no greater than the amount of the savings calculated under sub. (2) to the Medical Assistance program.

(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.

(4) If the secretary intends to transfer to the general fund the related available balances in program revenue appropriation accounts related to the savings under sub. (2) to the state's group health insurance program, the secretary shall submit a request to the joint committee on finance stating the amounts the secretary calculates would be transferred from each program revenue appropriation account. If, within 14 days after the date of the secretary's request, the cochairpersons of the

committee do not notify the department that the committee has scheduled a meeting to review the request, the transfers submitted are considered approved. If the cochairpersons notify the department within 14 days after the date of the secretary's request that the committee has scheduled a meeting to review the request, a transfer may be made only upon approval of the committee.

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

20.145 **(5)** WISCONSIN HEALTHCARE STABILITY PLAN. (b) *Reinsurance plan; state subsidy.* A sum sufficient 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 reinsurance for the purposes for which received.

SECTION 3. 49.45 (2p) of the statutes is created to read:

49.45 **(2p)** APPROVAL OF MEDICAL ASSISTANCE PROGRAM CHANGES. After the effective date of this subsection .... [LRB inserts date], the department may not expand eligibility under section 2001 (a) (1) (C) of the Patient Protection and Affordable Care Act, P.L. 111-148, for the Medical Assistance program under this subchapter unless the state legislature has passed legislation to allow the expansion and that legislation is in effect.

SECTION 4. 601.45 (1) of the statutes is amended to read:

601.45 **(1)** COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations and audits under ss. 601.43 ~~and~~, 601.44, and 601.83 (5) (f) shall be paid by examinees except as provided in sub. (4), either on the basis of a system of billing for actual salaries and expenses of examiners and other apportionable expenses, including office overhead, or by a system of regular annual billings to cover the costs relating to a group of companies, or a combination of such systems, as the commissioner may

by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The commissioner shall schedule annual hearings under s. 601.41 (5) to review current problems in the area of examinations.

SECTION 5. Subchapter VII (title) of chapter 601 [precedes 601.80] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

SECTION 6. 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) 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) 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) 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 7. 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 may submit a request to the federal department of health and human services for one or more waivers under 42 USC 18052 to

implement the healthcare stability plan for benefit years beginning January 1, 2019. 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) 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.

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

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

(f) 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 amounts of 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.

(g) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section, except that any rules promulgated under this paragraph shall seek to maximize federal funding for the healthcare stability plan. 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 paragraph.

(h) In 2019 and in each subsequent year, the commissioner may expend no more than $200,000,000 from all revenue sources for the healthcare stability plan under this section, unless the joint committee on finance under s. 13.10 has increased this amount upon request by the commissioner.

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

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

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

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

(d) Mitigate the impact high-risk individuals have on premium rates in the individual market.

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

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

(3) OPERATION. (a) The commissioner shall set the payment parameters as described under sub. (2) by no later than March 30 of the calendar year before the applicable benefit year or, if the commissioner specifies a different date by rule, the date specified by the commissioner by rule.

(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.

(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 claims costs for individual health plans eligible for reinsurance payments during the given benefit year, as determined by the commissioner. The commissioner shall notify eligible health carriers if there are insufficient funds available to make reinsurance payments in full and the estimated amount of payment as soon as practicable after the commissioner becomes aware of the insufficiency.

(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), 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 claim. For purposes of this paragraph, the total amount paid of a 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 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 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.

(g) The commissioner may recover from an eligible health carrier any overpayment of reinsurance payments as determined under the audit under par. (f).

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

(6) ACCESS TO INFORMATION. Information submitted by an eligible health carrier or obtained by the commissioner for purposes of the healthcare stability plan shall be used only for purposes of this subchapter and is proprietary and confidential under s. 601.465.

SECTION 8. 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 healthcare stability 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) 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. In developing the recommendations, the commissioner shall consider and include in the report the impacts of creating a high-risk pool or an invisible high-risk pool; funding of consumer health savings accounts; expanding consumer plan choices, including catastrophic plans or coverage and new low-cost plan options; and implementing any other approach that will lower consumer costs, stabilize the insurance market, or expand the availability of private insurance coverage.

SECTION 9. Subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes is created to read:

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

SECTION 10. Subchapter VI (title) of chapter 601 [precedes 601.93] of the statutes is repealed.

SECTION 11. Nonstatutory provisions.

(1) 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 between 50 and 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.

(END)