



State of Wisconsin
2017 - 2018 LEGISLATURE

LRB-5325/1
TJD:ah&wlj

2017 SENATE BILL 770

February 5, 2018 - Introduced by COMMITTEE ON SENATE ORGANIZATION, by request of Governor Scott Walker. Referred to Joint Committee on Finance.

1 **AN ACT to repeal** subchapter VI (title) of chapter 601 [precedes 601.93]; **to**
2 **amend** 601.45 (1); and **to create** 16.5285, 20.145 (5), subchapter VII (title) of
3 chapter 601 [precedes 601.80], 601.80, 601.83, 601.85 and subchapter VIII
4 (title) of chapter 601 [precedes 601.93] of the statutes; **relating to:** Wisconsin
5 Healthcare Stability Plan, reinsurance of health carriers, reallocating savings
6 from health insurer fee, providing an exemption from emergency rule
7 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

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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.

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 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

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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:

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 or more 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

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SECTION 1

1 tuition and fee moneys from the University of Wisconsin System, for “Compensation
 2 Reserves” shown in the schedule under s. 20.005 (1) by an amount equal to the
 3 savings calculated under sub. (2), and transfer to the general fund the related
 4 available balances in program revenue appropriation accounts related to the savings
 5 under sub. (2) in an amount equal to the calculated program revenue saved under
 6 sub. (2).

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

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

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

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15 **20.145 Insurance, office of the commissioner of**

16 (5) **WISCONSIN HEALTHCARE STABILITY PLAN**

17 (b) Reinsurance plan; state subsidy GPR S -0- 50,000,000

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

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

20 20.145 (5) **WISCONSIN HEALTHCARE STABILITY PLAN.** (b) *Reinsurance plan; state*
 21 *subsidy.* A sum sufficient for the state subsidy of reinsurance payments for the
 22 reinsurance program under subch. VII of ch. 601.

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1 Reconciliation Act of 2010, P.L. 111-152, and any amendments to or regulations or
2 guidance issued under those acts.

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

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

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

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

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

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

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

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

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

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1 **(12)** “Reinsurance cap” means the threshold amount set under s. 601.83 (2) for
2 the healthcare stability plan for claims costs incurred by an eligible health carrier
3 for an enrolled individual’s covered benefits, after which the claims costs for benefits
4 are no longer eligible for reinsurance payments.

5 **(13)** “Reinsurance payment” means an amount paid by the commissioner to an
6 eligible health carrier under the healthcare stability plan.

7 **SECTION 7.** 601.83 of the statutes is created to read:

8 **601.83 Healthcare stability plan; administration.** **(1)** PLAN ESTABLISHED;
9 GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer
10 a state-based reinsurance program known as the healthcare stability plan.

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

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

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

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

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

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

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

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

18 (g) The commissioner may promulgate any rules necessary to implement the
19 healthcare stability plan under this section. The commissioner may promulgate
20 rules necessary to implement this section as emergency rules under s. 227.24.
21 Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide
22 evidence that promulgating a rule under this paragraph as an emergency rule is
23 necessary for the preservation of the public peace, health, safety, or welfare and is
24 not required to provide a finding of emergency for a rule promulgated under this
25 paragraph.

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

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

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

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

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

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

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

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

16 (b) If the amount available for expenditure for the healthcare stability plan is
17 not anticipated to be adequate to fully fund the payment parameters set under par.

18 (a) as of July 1 of the calendar year before the applicable benefit year, the
19 commissioner shall adjust the payment parameters in accordance within the moneys
20 available to expend for the healthcare stability plan. The commissioner shall allow
21 an eligible health carrier to revise its rate filing based on the final payment
22 parameters for the applicable benefit year.

23 (c) If funding is not available to make all reinsurance payments to eligible
24 health carriers in a benefit year, the commissioner shall make reinsurance payments
25 in proportion to the eligible health carrier's share of aggregate health benefit plan

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

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).

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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

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

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

13 **(6) ACCESS TO INFORMATION.** Information submitted by an eligible health carrier
14 or obtained by the commissioner for purposes of the healthcare stability plan is
15 proprietary and confidential under s. 601.465.

16 **SECTION 8.** 601.85 of the statutes is created to read:

17 **601.85 Accounting, reports, and audits. (1) ACCOUNTING.** The
18 commissioner shall keep an accounting for each benefit year of all of the following:

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

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

22 (c) Reinsurance payments made to eligible health carriers.

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

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

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

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

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

CHAPTER 601**SUBCHAPTER VIII****FIRE DEPARTMENT DUES**

16
17
18
19 **SECTION 10.** Subchapter VI (title) of chapter 601 [precedes 601.93] of the
20 statutes is repealed.

SECTION 11. Nonstatutory provisions.

21
22 **(1) PAYMENT PARAMETERS.** For the 2019 benefit year, the commissioner of
23 insurance shall set as payment parameters for the healthcare stability plan under
24 subchapter VII of chapter 601 an attachment point of \$50,000, a coinsurance rate of
25 between 50 and 80 percent, and a reinsurance cap of \$250,000. The commissioner

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1 of insurance may adjust the payment parameters to the extent necessary to secure
2 federal approval of the waiver request under section 601.83 (1) (b) of the statutes. For
3 subsequent benefit years, the commissioner of insurance may adjust the payment
4 parameters in accordance with section 601.83 (2) of the statutes.

5 **SECTION 12. Fiscal changes.**

6 (1) LAPSE FROM MEDICAL ASSISTANCE GENERAL PURPOSE REVENUE APPROPRIATION.

7 The secretary of health services shall ensure that there is lapsed to the general fund
8 from the appropriation under section 20.435 (4) (b) of the statutes an amount up to
9 \$80,000,000, as determined by the secretary of administration.

10 (END)