PROPOSED ORDER OF THE COMMISSIONER OF INSURANCE

TO CREATE A RULE.

The Commissioner of Insurance proposes the following rule to create ch. Ins 19, relating to the Wisconsin Healthcare Stability Plan.

The statement of scope for this rule SS 027-19, was approved by the Governor on February 22, 2019, was published in the Wisconsin Administrative Register No. 759A2 on March 11, 2019. The public hearing was held on March 21, 2019 and approved by the Commissioner on April 2, 2019.

Analysis prepared by the Office of the Commissioner of Insurance (OCI).

Statutes interpreted:

Sections 601.41 (3), 601.83, Stats.

Statutory authority:

Sections 601.41 (3), 601.83, Stats.

Explanation of OCI's authority to promulgate the proposed rule:

2017 Wis. Act 138 requires the commissioner to establish through regulations the Wisconsin Healthcare Stability Plan (WIHSP). Specifically, s. 601.83 (1) (g), Stats., allows the Commissioner to promulgate any rules necessary to implement the WIHSP including establishment of the payment parameters. Further, s. 601.41 (3) (a), Stats., grants the Commissioner "rule-making authority under s. 227.11 (2)." Section 601.42 (1g), Stats., gives the Commissioner the authority to require from those subject to this regulation, among other things, "statements, reports, answers to questionnaires, and other information, and evidence thereof, in whatever reasonable form the commissioner designates, and at such reasonable intervals as the commissioner chooses, or from time to time." Finally, s. 601.42 (2), Stats., states that [T]he commissioner may prescribe forms from the reports under subs. (1g) and (1r) and specify who shall execute or certify such reports." The proposed rule will require insurers to provide OCI with the necessary enrollment data and aggregate claims data in a timely manner and in a specific form prescribed by the Commissioner in order for OCI to comply with the statutory requirements contained in 2017 Wis. Act 138. These provisions both permit and require the commissioner to promulgate rules governing the WIHSP.

Related statutes or rules:

2017 Wis. Act 138 created ch. 601 subchpt. VII, to permit OCI to submit a 1332 State Innovation Waiver allowing for the operation of a state-based reinsurance plan. The waiver was approved by the US Department of Health and Human Services and the US Department of the Treasury on July 29, 2018 and is effective beginning January 1, 2019.

Plain language analysis:

The proposed rule implements 2017 Wis. Act 138 by establishing the process by which the payment parameters will be set in future years. The OCI will receive claims information and other utilization data from insurers doing health insurance business in the state that will be analyzed with the assistance of the OCI's consultants to develop preliminary and final payment

parameters. The OCI will issue public notice and invite public input prior to establishing and publishing the final parameters for each benefit year.

Consistent with the authorizing statute, the proposed rule clarifies the OCI's requirements for insurers offering individual comprehensive health insurance on the federally facilitated marketplace and offered generally in the state. The benefits covered by compliant plans must provide ACA compliant benefits including; coverage of preexisting conditions, essential health benefits, and Wisconsin health insurance requirements, without discrimination or imposition of annual or lifetime limitations. Additionally, to be eligible for reinsurance payments, the claims paid by the eligible carriers on behalf of an insured individual must exceed the attachment point of $50,000. In determining the eligible amount of claims, the insurer must comply with the cost sharing provisions of the plan and apply provider contracted rates.

The proposed rule delineates the claim submission process by setting forth the claim reporting requirements, timing and content of quarterly and annual reports, and final reconciliation of claims data. The proposed rule also identifies the review and audit process of submitted claims and establishes timelines for submission of data and other information required by the commissioner. The information gathered by the commissioner will be used in aggregate to complete required reporting to the federal government and notices to eligible carriers. Claims paid by the carriers between January 1, 2019, and April 30, 2020, may be submitted to the commissioner for reinsurance payment in accordance with the payment parameters and payment calculation set forth in s. 601.83 (4), Stats. Reinsurance payments to eligible carriers for compliant claims will be issued by August 15 of the year following the applicable benefit year.

Summary of and comparison with any existing or proposed federal statutes and regulations:

None

Comparison with rules in adjacent states:

Illinois: NA

Iowa: NA

Michigan: NA

Minnesota: Minn. Stat. s. 62E.23 (2018) contains the law creating the Minnesota Premium Security Plan on which the Wisconsin law was based.

A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule:

The OCI, with the assistance of its consultants, surveyed insurers doing individual health insurance business in the state and analyzed state and national data to ascertain the benefit to Wisconsin's individual health insurance marketplace from implementation of the Wisconsin Healthcare Stability Plan.

Analysis and supporting documentation that OCI used in support of the OCI's determination of the rule's effect on small business or in preparation of an economic impact analysis:

The OCI, with the assistance of its consultants, surveyed insurers doing individual health insurance business in the state and analyzed state and national data to ascertain the economic impact of implementing the 1332 waiver as to consumers and insurers. Maximizing the funds from the federal government will minimize financial impact on the state, will assist consumers by

reducing premium increases from insurers who can offset high-cost claims with reinsurance dollars rather than through use of premium dollars.

Effect on small business:

No effect on small business is anticipated by this rule. The rule provides reinsurance to insurers offering compliant, comprehensive individual health insurance. The insurers do not meet the definition of a small business. Further the intended benefit of this rule is to make individual health insurance coverage more affordable for individuals in Wisconsin and is not targeted for small employer health insurance coverage nor is an impact on small business employers anticipated.

A copy of any comments and opinion prepared by the Board of Veterans Affairs under s. 45.03 (2m), Stats., for rule proposed by the Department of Veterans Affairs.

None.

Agency contact person:

A copy of the full text of the proposed rule changes, analysis and fiscal estimate may be obtained from the website at:

http://oci.wi.gov/Pages/Regulation/RulesCurrentlyPending.aspx

or by contacting Karyn Culver, Paralegal, at:

Phone:	(608) 267-9586
Email:	karyn.culver@wisconsin.gov
Address:	125 South Webster St – 2nd Floor, Madison WI 53703-3474
Mail:	PO Box 7873, Madison, WI 53707-7873

Place where comments are to be submitted and deadline for submission:

A public hearing will be held in compliance with s. 227.14 (4m), Stats., on March 21, in room 250 at the Office of the Commissioner of Insurance.

Deadline for submitting comments was 4:00 pm on April 1, 2019.

Mailing address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule ch. Ins 19
Office of the Commissioner of Insurance
PO Box 7873
Madison WI 53707-7873

Street address:

Julie E. Walsh
Legal Unit - OCI Rule Comment for Rule ch. Ins 19
Office of the Commissioner of Insurance
125 South Webster St – 2nd Floor
Madison WI 53703-3474

Email address:

Julie E. Walsh

Julie.walsh@wisconsin.gov
Website: **http://oci.wi.gov/Pages/Regulation/RulesCurrentlyPending.aspx**

The proposed rule changes are:

SECTION 1. Chapter Ins 19 (title) and ch. Ins 19 are created to read:

CHAPTER INS 19

WISCONSIN HEALTHCARE STABILITY PLAN.

Ins 19.01 Purpose. The commissioner implements 2017 Wis. Act 138 for the purposes of establishing the Wisconsin Healthcare Stability Plan (WIHSP). The commissioner will seek to maximize federal funding for the WIHSP. The commissioner shall design and adjust the payment parameters with the goal to stabilize or reduce premium rates, increase participation by health insurers, improve access to health care providers and services, and mitigate the impact of high-risk individuals participating in the individual health insurance market.

19.02 Definitions. In addition to definitions contained in s. 601.80, Stats., the following definitions shall apply in this chapter:

(1) "Audit" has the meaning provided under s. 601.83 (5) (f), and includes a verification and compliance audit conducted by the office.

(2) "Commissioner" has the meaning provided under s. 600.03 (11), Stats.

(3) "Compliant plan" means an individual health benefit plan offered by an eligible health carrier that conforms with regulations set forth in the Affordable Care Act, as applicable, or an individual health benefit plan that provides substantially similar benefits as required by the Affordable Care Act effective July 1, 2018, as defined by the office.

(4) "Eligible health carrier" means an insurer offering a compliant plan either on or off the federally-facilitated marketplace that was issued after January 1, 2014, and is not a grandfathered plan or transitional plan. A transitional plan is a health plan in effect on October 1, 2013, and is in compliance with the Centers for Medicare and Medicaid Services (CMS) and

guidance issued by the office. A grandfathered plan is a health plan that has been continuously offered since March 23, 2010 in compliance with CMS.

(5) "Enrolled individual" means an insured member of an eligible health carrier during the applicable benefit year for at least one day and who has paid all premium owed for the period in which claims eligible for reinsurance payment were incurred or the eligible health carrier is obligated to pay under law.

(6) "External Data Gathering Environment" or "EDGE server" means the server developed by the CMS in conjunction with the federally facilitated marketplace for health care insurers to submit claims information on enrolled individuals for claims paid for covered services or treatments.

(7) "Office" or "OCI" has the meaning provided under s. 600.03 (34), Stats.

19.03 Payment Parameters. (1) The commissioner shall annually establish the payment parameters for future benefit years through an established procedure that includes all of the following components:

(a) The commissioner shall request, under s. 601.42, Stats., all eligible health carriers to submit data and information from prior and current benefit years including: compliant plan membership, premium experience at a metal and federally-facilitated marketplace status level, advanced premium tax credit enrollee information, and other information as requested by the commissioner.

(b) The commissioner shall publish the preliminary payment parameters and a public hearing notice in the Wisconsin Administrative Register and to the office website. The commissioner shall hold a public hearing seeking public comment regarding the preliminary payment parameters for the subsequent benefit year.

(c) The commissioner shall set the final payment parameters after consultation with an actuarial firm, consideration of comments received from the public hearing, the goals established in s. 601.83 (2), Stats., and any additional information as appropriate.

(d) The commissioner shall publish the final payment parameters in the Wisconsin Administrative Register and to the office website by May 15, of the calendar year prior to the applicable benefit year.

19.07 Eligible Claims. (1) For claims to be eligible for reinsurance payment, the eligible health carrier shall comply with s. 601.83, Stats., and submit claims that comply with all the following criteria:

(a) The claims that were paid for services or treatments as covered benefits by the eligible health carrier under the terms and conditions of the carrier's compliant plan for the applicable benefit year.

(b) The claims that were paid by the eligible health carrier after January 1, of the applicable benefit year and before April 30, of the following calendar year, or a date established by the commissioner.

(c) The cumulative amount of the claims paid that exceeds the applicable attachment point. Claims reported shall not include any amount of cost sharing required to be paid by the enrolled individual or the person responsible for the payment of the enrolled individual's cost sharing. Cost sharing may include: deductibles, co-insurance, co-payment, visit fees, or similar costs.

(d) The cumulative amount of paid claims shall be reduced by any reimbursement received by the eligible health carrier for the enrolled individual through subrogation, recoupment of overpayments from providers, application of negotiated rates reductions with providers, or recoupment of third-party payment including workers compensation or civil litigation.

19.10 Reporting requirements. All eligible health carriers shall provide all requested information as ordered by the commissioner pursuant to s. 601.42, Stats. Information collected under s. Ins 19.04 (1), may be used on an aggregate basis by the commissioner to satisfy federal and state reporting requirements. Additional data may be requested to inform federal

and state reports including: second lowest cost silver rates by rating area demonstrating rates with and without reinsurance payments, actual average premium rates for compliant plans, and actual enrollment for compliant plans.

19.11 Quarterly reporting requirements. (1) Eligible health carriers shall provide the information required by this section to the commissioner within 45-days from the end of each financial quarter. The data shall be extracted from the health carrier's claims systems or similar database that tracks enrolled individual's claims.

(2) Each quarterly report shall be transmitted to the commissioner, pursuant to s. 601.42, Stats., through a secure file transfer portal (FTP) in a format designated by the commissioner. Instructions for submission of required information shall be provided to the eligible health carriers by the commissioner. Information in the report shall include all of the following:

(a) The total number of enrolled individuals as of the last day of the applicable quarter.

(b) The total amount of claims paid by the eligible health carrier in the applicable quarter.

(c) A unique identifier for each enrolled individual whose claims are submitted for reinsurance.

(d) For each identified enrolled individual, the total amount of eligible claims paid, consistent with s. Ins 19.07.

(e) The amount of paid claims eligible for reinsurance payment for each identified enrolled individual.

(f) Any additional information requested by the commissioner.

(3) The eligible health carrier shall use the same enrolled individual's unique identifier in each quarterly and annual report to the commissioner. For enrolled individuals with claims in more than one quarter, the amounts submitted shall reflect the cumulative amount of eligible claims for that enrolled individual.

(4) The eligible carrier shall report the information required by sub. (2) (a) and (b), and all applicable information for that reporting quarter even if an eligible health carrier does not have updated or eligible claims to identify.

(5) All eligible health carriers who submit quarterly reports in accordance with this section shall retain a copy of the data and all supporting claims and enrollment data in an auditable format for 6 years from the last day of the applicable benefit year.

(6) An authorized representative of the eligible health carrier shall complete an affirmation that the data submitted is accurate, complete, and in compliance with s. Ins 19.07. The affirmation shall be transmitted to the commissioner on the same date as the data file transfer in a format designated by the commissioner. Instructions for submission of required information shall be provided to the eligible health carriers by the commissioner.

19.12 Final annual report and affirmations. (1) Eligible health carriers shall provide a final annual report to the commissioner by or before May 15, of each calendar year after the applicable benefit year. The final annual report shall be completed using data as submitted to CMS through the health carrier's EDGE server that is compliant with all applicable EDGE server requirements. In the event the EDGE server data is no longer available, the eligible health carrier shall use data extracted from the health carrier's claims systems or similar database that tracks enrolled insured's validated claims.

(2) The final annual report shall be transmitted to the commissioner through a secure FTP in a format designated by the commissioner. Instructions for submission of required information shall be provided to the eligible health carriers by the commissioner. The information shall include all of the following:

(a) The final total number of enrolled individuals for the applicable benefit year utilizing the same unique identifiers as contained in quarterly reports.

(b) The final total amount of claims incurred in the applicable benefit year that were paid by the eligible health carrier no later than April 30 of the next calendar year.

(c) The final amount of eligible claims for each identified enrolled individual.

(d) Any additional information requested by the commissioner.

(3) An authorized representative of the eligible health carrier shall complete a report affirming the data was derived from the EDGE server and is accurate, in compliance with the EDGE business rules and s. 601.83, Stats. The affirmation shall be transmitted to the commissioner by or before May 15, of each calendar year after the applicable benefit year in a format designated by the commissioner. Instructions for submission of required information shall be provided to the eligible health carriers by the commissioner.

(4) (a) An authorized officer of the eligible health carriers shall attest to the carrier's compliance with s. 601.83, Stats., in a format designated by the commissioner. Instructions for submission of required information shall be provided to the eligible health carriers by the commissioner. The information shall include all of the following:

1. An attestation that the information provided to the commissioner is accurate, included only eligible claims and was derived from EDGE server data.

2. An attestation that the information contained the same unique identifiers for enrolled individuals as reported in quarterly or annual reports.

3. A copy of the Attestation and Discrepancy Reporting Summary confirmation page as reported to CMS. If the Attestation and Discrepancy Reporting Summary contained a dispute, the eligible health carrier shall provide documentation of the disputed data and identify the claims in dispute with the enrolled individual's unique identifier.

4. An acknowledgment that the eligible health carrier will not receive a reinsurance payment in the event that WIHSP authorizing statute is amended in a manner that no reinsurance payment is due to any carriers.

5. An acknowledgment, in accordance with s. 601.83 (5) (h), Stats., that the eligible health carrier shall not bring a lawsuit over any delay in reinsurance payments or reduction in expected reinsurance payments.

6. Any additional information required by the commissioner.

(b) The eligible health carrier shall transmit the information to the commissioner by or before May 15, of each calendar year after the applicable benefit year.

19.20 Verification audit. (1) The commissioner shall conduct a verification audit of the data submitted for reinsurance payment. The commissioner shall request eligible health carriers to provide information, pursuant to s. 601.42, Stats., including all of the following:

(a) Supporting claims information including the following:

1. A sample number of claims and specific claims documentation supporting the claim for reinsurance payment. The sample of underlying claims data shall demonstrate that the claims were eligible for reinsurance payment.

2. Additional documentation for a select number of claims, including proof of payment and payment invoices for certain identified claims as specified by the commissioner.

(b) The information provided shall be masked as to any enrollee and provider other than the specific claims data requested.

(c) The requested data shall use the same enrolled individual unique identifier for eligible claims as contained in quarterly or annual reports provided to the commissioner.

(2) If, as a result of the commissioner's verification audit, a discrepancy is identified the eligible health carriers shall be notified by the commissioner. The health carrier shall respond within 10 days either affirming the commissioner's finding or providing documents to substantiate the filed data.

(3) Prior to release of the reinsurance payment, the commissioner shall review the claims data requested for verification and the quarterly and annual reports with required affirmations or attestations confirming the accuracy of the data.

(4) Eligible health carriers shall retain all supporting data in an auditable format for 6 years from the last day of the applicable benefit year.

19.21 Reinsurance payment calculation. The commissioner shall calculate the amounts eligible for reinsurance payment under s. 601.83 (4) (a), Stats., utilizing the information provided by the eligible health carriers.

(1) The commissioner shall calculate the reinsurance payment by applying the payment parameters as contained in s. 601.83 (4) (a), Stats., to each eligible claim. The commissioner shall provide a preliminary estimate of the reinsurance payments by or before June 30, in the calendar year following the applicable benefit year.

(2) In accordance with s. 601.83 (3) (c), Stats., the aggregate reinsurance payments shall not exceed $200,000,000, or the amount available for the applicable benefit year. If the cumulative total amount of claims across all participating eligible health carriers exceeds $200,000,000, or the amount available for the given benefit year under s. 601.83 (1) (h), Stats., the commissioner shall make reinsurance payments in accordance with s. 601.83 (3) (c), Stats., to each eligible health carrier as follows:

(a) The commissioner shall calculate each carrier's eligible claims after application of the applicable payment parameters and s. 601.83 (4), Stats.

(b) The commissioner shall distribute reinsurance payments in an amount that is directly proportional to the total available amount then apply the proportion to every participating carrier's eligible paid claims amounts.

EXAMPLE: If the office receives eligible paid claims that aggregate $400,000,000.00 after application of the payment parameters, the office shall pay 50% of each participating eligible health carrier's submitted paid claims.

19.22 WIHSP overpayment reconciliation. The reconciliation period in this section means the time between June 30, or the date the commissioner notifies eligible health carriers of reinsurance payments, through December 31, of the calendar year following the applicable benefit year. For example, the reconciliation period for benefit year 2019 starts June 30, 2020, and continues through December 31, 2020.

(1) Eligible health carriers that receive additional adjustments in claim payments or identify additional data corrections during the reconciliation period shall notify the commissioner within 30 days of identifying the overpayment or no later than December 31. If the adjustment or data correction resulted in a WIHSP overpayment, the eligible health carrier shall fully identify the claim and the amount of overpayment.

(a) For eligible health carriers submitting claims for reinsurance payment during the benefit year in which the reconciliation occurs, the commissioner may reduce that benefit year's reinsurance payment by the amount of overpayment.

(b) If a health carrier does not submit claims for reinsurance payment during the benefit year in which the reconciliation occurs, the amount of overpayment shall be remitted to the commissioner at the commissioner's request.

(2) If, after June 30, of the reconciliation period, the eligible health carrier determines it underreported eligible claims as a result of claim adjustments or data corrections, the eligible health carrier shall not be eligible for additional reinsurance payments for the applicable benefit year.

(3) If, as a result of a verification or compliance audit, the commissioner identifies an overpayment occurred because the eligible health carrier erred in its reinsurance claim submissions, the commissioner may either reduce future reinsurance payments to that carrier in the amount of the overpayment or order the health carrier to repay the amount of overpayment.

19.24. Compliance Audit. (1) The commissioner may, at the commissioner's sole discretion, conduct an audit in accordance with s. 601.83 (5) (f), Stats., with the reasonable audit costs paid by the audited carrier pursuant to s. 601.45 (1), Stats. The commissioner shall give the carrier reasonable notice and identify the scope of the audit to be conducted.

(2) Upon findings by the commissioner that an eligible health carrier provided falsified data or intentionally provided incomplete data, the commissioner may, at the commissioner's sole discretion, determine that health carrier is ineligible for reinsurance payments for

subsequent benefit years. The health carrier shall be issued an order of the commissioner with administrative hearing rights as contained in s. 227.44, Stats.

SECTION 2. EFFECTIVE DATE. These proposed rule changes will take effect on the date of publication as provided in s. 227.22 (2), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2019.

_____
Nathan D. Houdek
Deputy Commissioner