Wisconsin Office of the
COMMISSIONER
OF INSURANCE

Tony Evers, Governor of Wisconsin
Mark Afable, Commissioner of Insurance

TO: Legislative Reference Bureau
1 East Main Street, Suite 200
Madison, WI 53701-2037

FROM: Richard Wicka, Chief Legal Counsel
Office of the Commissioner of Insurance

DATE: June 11, 2021

SUBJECT: Chapter Ins 19, Wis. Adm. Code, relating to the Wisconsin Healthcare Stability Plan.
Clearinghouse Rule No. CR-19-088

This rule is in final draft form and has been submitted to the chief clerk of each house of the legislature. Please publish a statement to this effect in the Wisconsin Administrative Register, pursuant to s. 227.19 (2), Wis. Stat. We have e-mailed you an electronic copy of the text of the rule.

For additional information or if you do not receive the e-mail, please contact Karyn Culver at karyn.culver@wisconsin.gov.

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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.

The proposed rule was approved by the Governor on June 10, 2021, to submit to the legislature, and submitted to the legislature on June 11, 2021.

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

Statutes interpreted:

Section 601.83 (1)(g), Stats.

Statutory authority:

Sections 601.42 (1g) and (2), 601.83 (1) (g), 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 who are 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 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 that is established and published annually following a public hearing and comment period. 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, 2020, and April 30, 2021, 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:

Section 1341 of the ACA established a transitional reinsurance program to stabilize premiums in the individual market on and off the federal marketplace exchange. The transitional reinsurance program collected contributions from contributing entities to fund the reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual marketplace for the plan years 2014 through 2016. The WIHSP program is similar to the extent that it is intended to help stabilize premiums in the Wisconsin individual market on and off the federal exchange.

Summary of any public comments and feedback on the statement of scope of the proposed rule that the agency received at any preliminary public hearing and comment period held under s. 227.136, Stat., and a description of how and to what extent the agency took those comments and that feedback into account in drafting the proposed rule.

The overall comments were positive for the WIHSP rule draft and program. Commenters sought clarifications on the following components of the statute and rule: data collection and aggregate dissemination, EDGE server data capabilities and formats, confirmation

on proportional payment distribution process, timing of payments from the WIHSP, setting and timing of future payment parameters, and additional information on audit processes. In response to comments the Office modified several of the reporting forms, affirmed and followed the separate payment parameters process for future plan years including for plan year 2020, and have modified timeframes for final data collection and reconciliation. A second public hearing was held on April 5, 2021, with the Office receiving a supportive letter from the Wisconsin Association of Health Plans stating that the WISHP has been "well-run, effective program and has contributed to year-over-year reductions in average premiums." Further that comment stated that "the WISHP is a documented success that continues to be a valuable tool for lending stability to the individual market."

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 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.

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:

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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 was held in compliance with s. 227.14 (4m), Stats., on July 24, 2019, in room 250 at the Office of the Commissioner of Insurance. Deadline for submitting comments was 4:00 pm on August 2, 2019.

A second public hearing was held on April 5, 2021, at 11:00 am with a deadline for submitting comments on April 15, 2021 by 4:00 pm.

Mailing address:

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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. The commissioner will seek to maximize federal funding for the Wisconsin Healthcare Stability Plan. 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), Stats., and includes a verification and compliance audit conducted by OCI.

(2) "CMS" means the Centers for Medicare & Medicaid Services within the U.S. department of health and human services.

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

(4) "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.

(5) "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 CMS and guidance issued by the Office. A grandfathered plan is

a health plan that has been continuously offered since March 23, 2010 and in compliance with CMS.

(6) "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.

(7) "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.

(8) "Secure file transfer portal" or "FTP" means a manner of securely transferring requested information from the eligible health carrier to the commissioner in a manner specified by the commissioner.

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

(10) "Wisconsin Healthcare Stability Plan" or "WIHSP" means the Wisconsin healthcare stability plan created under s. 601.83, Stats.

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

(1) 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.

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

(3) 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.

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

19.07 Eligible Claims. 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 the following criteria:

(1) The claims that were paid for as covered benefits by the eligible health carrier under the terms and conditions of the carrier's compliant plan for the applicable benefit year including but not limited to medical, surgical, and prescription drug services and treatments.

(2) 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.

(3) 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 any of the following; deductibles, co-insurance, co-payment, visit fees, or similar costs.

(4) 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 ss. Ins 19.07 and 19.11, 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 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 dollar 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 dollar 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, or a date established by the commissioner. 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 dollar 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, or a date established by the commissioner.

(c) The final dollar 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 server business rules and s. 601.83, Stats. The affirmation shall be transmitted to the

commissioner by or before May 15, or a date established by the commissioner, 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 carrier 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 carrier 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, or by a date established by the commissioner.

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 that includes the following information:

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 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 information provided by the health carrier in the quarterly and annual reports and with the required affirmations or attestations confirming the accuracy of the information.

(4) Eligible health carriers shall retain all supporting information and 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 dollar amounts eligible for reinsurance payment under s. 601.83 (4) (a), Stats., utilizing the information provided by the eligible health carriers. The commissioner shall consider all of the following information:

(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 payment 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. The following provisions apply during the reconciliation period:

(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, the amount of overpayment, and either of the following as applicable:

(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 notify the commissioner of the claim adjustments and data correction with supporting documentation as soon as possible. The commissioner may, at the commissioner's sole discretion, provide additional reinsurance payments to the eligible health carrier for the

applicable benefit year based on such factors as the reason for the underreporting, the timing of the underreporting and the availability of funds for distribution.

(3) If the commissioner identifies an overpayment has occurred to any eligible health carrier the commissioner may order, at the commissioner's sole discretion, either repayment of the amount of the overpayment or may reduce future reinsurance payments to applicable eligible carriers in the amount of the 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 determine, at the commissioner's sole discretion, 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 in the Wisconsin Administrative Register as provided in s. 227.22 (2), Stats.

Dated at Madison, Wisconsin, this 11th day of June, 2021.

Mark V. Afable
Commissioner of Insurance

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-2049 (R03/2012)

DIVISION OF EXECUTIVE BUDGET AND FINANCE
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ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis
x Original ☐ Updated ☐ Corrected

2. Administrative Rule Chapter, Title and Number
145 INS Ch. 19 – SS 027-19

3. Subject
The Wisconsin Healthcare Stability Plan

4. Fund Sources Affected
x GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

5. Chapter 20, Stats. Appropriations Affected
s. 20.145 (5), Stats.

6. Fiscal Effect of Implementing the Rule
X No Fiscal Effect ☐ Increase Existing Revenues ☐ Increase Costs
☐ Indeterminate ☐ Decrease Existing Revenues ☐ Could Absorb Within Agency's Budget
☐ Decrease Cost

7. The Rule Will Impact the Following (Check All That Apply)
☐ State's Economy ☐ Specific Businesses/Sectors
☐ Local Government Units ☐ Public Utility Rate Payers
☐ Small Businesses **(if checked, complete Attachment A)**

8. Would Implementation and Compliance Costs Be Greater Than $20 million?
☐ Yes x No

9. Policy Problem Addressed by the Rule
The rule implements s. 601.83, Stats., that has a stated purpose of maintaining and enhancing the stability, affordability and accessibility of health care for individuals in the State.

10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

The request for comment on the proposed rule was sent to over 50 organizations that are primarily related to the health care or health insurance fields and individuals who indicated to the office that they would like to receive notice of any information related to life or health insurance. Additionally, the Office of the Commissioner of Insurance (OCI), posted the Request for Comment on its public website.

The OCI received one comment from Quartz Health Benefit Plans Corporation, ("Quartz"). Quartz indicated that it has one health insurance company offering individual health insurance on the federal exchange and off the exchange to Wisconsin consumers. The corporation identified that the Wisconsin Healthcare Stability Plan and the current payment parameters allowed the carrier to decrease insurance premiums by approximately 9.5% across all levels, to more than 22,000 members throughout the state. Importantly, the comment noted that those individuals not eligible for federal assistance whose incomes exceeds 400% of the poverty level experienced meaningful savings. Quartz further commented that the WIHSP programs has provided stability to a vulnerable market and adds protection against adverse selection.

The rule has had a positive effect on licensed insurers offering individual health insurance based on the 2019 benefit year payment parameters established under the statute and emergency rule. Individual health insurance offered is required to meet the requirements of the Patient Protection and Affordable Care Act of 2010, as amended. Additionally, the emergency rule and the WIHSP reinsurance program have, to date, positively affected Wisconsin consumers purchasing individual health insurance either off the exchange or through the federal exchange. The proposed permanent rule codifies the emergency rule with a few requested clarifications. It is anticipated that the proposed rule will have a continuing positive impact for insurers and Wisconsin consumers.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DOA-2049 (R03/2012)

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ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis

11. Identify the local governmental units that participated in the development of this EIA.
None

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)
There are no costs expected to be incurred by businesses, public utilities, or local units of government as the rule pertains to individual health insurance coverage. The statute and rule will continue to lower costs for insurers offering individual health insurance and for, individuals purchasing health insurance coverage either through the federal exchange or the individual marketplace. There may be a benefit to the State's economy when consumers are able to better afford health insurance through fewer lost work hours and the potential for individuals to have increased discretionary spending capabilities.

13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule
The statute and emergency rule are credited for increased stability in the individual market, reducing premiums costs and attracting insurers to return to the individual marketplace both on and off the federal exchange. The proposed permanent rule mirrors the emergency rule with a few requested clarifications and is anticipated to continue positively impacting the individual marketplace in Wisconsin. The statute, proposed permanent rule and 1332 waiver, access federal funds that previously were available to insurers providing coverage through the federal exchange. They also allow the State to establish parameters for high-cost claims to be partially reimbursed by the WIHSP, which is funded primarily with federal funds and backed up by State general purpose funds through a sum-sufficient appropriation. The alternative occurred prior to Wisconsin being granted the 1332 waiver, uncompensated, high costs born by insurers that were part of a state and a national upward trend in premium costs. This upward trend was making the cost of health insurance unaffordable particularly for those without access to cost sharing reductions or advanced premium tax credits due to their income level and required selection of a federal exchange insurance plan.

14. Long Range Implications of Implementing the Rule
The statute contemplates the WIHSP to be in place for five years through a waiver with the federal government. The goal is to provide affordable access to comprehensive individual health insurance, increase stability in the individual health insurance market, and increase consumer options within the individual market. Assuming continued funding under the waiver, the proposed rule complies with the statutory requirement to maximize federal funding that will minimize the portion of funds needed from the state GPR fund.

15. Compare With Approaches Being Used by Federal Government
The proposed rule utilizes the federal reporting format, the EDGE server, that previously provided reinsurance for eligible claims. The waiver Wisconsin received provides continued reinsurance with a majority of funds provided by the federal government since the federal government no longer provides reinsurance to federal exchange participating insurers. Additionally, the WIHSP extends reinsurance not only to those insurers participating on the federal exchange, but also to eligible insurers offering compliant individual insurance products off the exchange.

16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)
Wisconsin's Healthcare Stability Plan is modeled after the Minnesota Premium Security Plan. Illinois, Iowa, and Michigan do not have a similar approach.

17. Contact Name	18. Contact Phone Number
Julie E. Walsh	(608) 264-8101

This document can be made available in alternate formats to individuals with disabilities upon request.

Tony Evers
Office of the Governor | State of Wisconsin

June 10, 2021

By Electronic Mail Only

Dear Secretaries and Agency Heads:

On this day, I approved the following statements of scope pursuant to Wis. Stat. § 227.135(2):

- A statement of scope by the Department of Natural Resources, submitted May 27, 2021, relating to wild rice harvest (Wis. Admin. Code ch. NR 19); and
- Both an emergency and permanent statement of scope by the Department of Health Services, submitted June 10, 2021, relating to Medicaid eligibility requirements (Wis. Admin. Code chs. DHS 102, 103 and 109).

On this day, I approved the following proposed administrative rules pursuant to Wis. Stat. § 227.185:

- A proposed rule by the Office of the Commissioner of Insurance, submitted May 3, 2021, relating to the Wisconsin Healthcare Stability Plan (Wis. Admin. Code ch. INS 145); and
- A proposed emergency rule by the Department of Workforce Development, submitted June 8, 2021, relating to employer contribution rates for 2022 (Wis. Admin. Code ch. DWD 102); and
- A proposed rule by the Department of Workforce Development, submitted May 19, 2021, relating to technical education equipment grants under the Wisconsin Fast Forward program (Wis. Admin. Code ch. DWD 802); and
- A proposed rule by the Department of Health Services, submitted April 15, 2021, relating to the Department's biennial review of rules (Wis. Admin. Code chs. DHS 12-199); and
- A proposed rule by the Department of Health Services, submitted April 15, 2021, relating to Medicaid-covered services (Wis. Admin. Code ch. DHS 107); and
- A proposed rule by the Department of Health Services, submitted April 15, 2021, relating to the use of inclusive language under 2019 Executive Order 15 (Wis. Admin. Code chs. DHS 5-152); and
- A proposed rule by the Department of Health Services, submitted April 21, 2021, relating to adult day care centers (Wis. Admin. Code ch. DHS 105); and

- A proposed rule by the Public Service Commission, submitted May 6, 2021, relating to the provisions and administration of the Universal Service Fund (Wis. Admin. Code ch. PSC 160).

Please direct any questions about this letter to my policy director, Jenni Dye.

Sincerely,

Tony Evers
Governor

cc: Ryan Nilsestuen, chief legal counsel (ryan.nilsestuen1@wisconsin.gov)
Jenni Dye, policy director (jenni.dye@wisconsin.gov)
DOA State Budget Office (SBOAdminRules@spmail.wi.gov)
Emma Esch, DNR (emma.esch@wisconsin.gov)
Jackson Keuler, DHS (jackson.keuler@dhs.wisconsin.gov)
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Mark Kunkel, DWD (markd.kunkel@dwd.wisconsin.gov)
Kara Koonce, PSC (kara.koonce@wisconsin.gov)

LCRC
FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Scott Grosz
Clearinghouse Director

Anne Sappenfield
Legislative Council Director

Margit S. Kelley
Clearinghouse Assistant Director

Jessica Karls-Ruplinger
Legislative Council Deputy Director

CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **19-088**

AN ORDER to create ch. Ins 19, relating to the Wisconsin Healthcare Stability Plan.

Submitted by **OFFICE OF THE COMMISSIONER OF INSURANCE**

06-21-2019 RECEIVED BY LEGISLATIVE COUNCIL.
07-18-2019 REPORT SENT TO AGENCY.

MSK:BL

LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☐ NO ☑

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

WISCONSIN LEGISLATIVE COUNCIL
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CLEARINGHOUSE RULE 19-088

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Legislative Reference Bureau and the Legislative Council Staff, dated December 2014.]

2. Form, Style and Placement in Administrative Code

a. In the rule summary's listing of statutes interpreted, the citation to s. 601.41 (3), Stats., could be removed, as that provision grants general rulemaking authority and does not address the specific program that is implemented in the proposed rule.

b. In the rule summary's listing of statutory authority, the citation to s. 601.83, Stats., could more precisely cite to sub. (1) (g) of that provision, as noted in the explanation of authority to promulgate the rule. The explanation also includes a reference to s. 601.42 (1g) and (2), Stats., which could be added to the listing of statutory authority.

c. In the rule summary's listing of federal statutes or regulations, the entry is listed as "none". However, the text of the proposed rule cites the Affordable Care Act and CMS requirements. Those sources should be identified and described in the rule summary.

d. In the rule summary, if a preliminary hearing and comment period was held on the scope statement for the proposed rule, a heading and entry should be inserted to provide a summary of the public comments received and a description of how the feedback was taken into account in drafting the proposed rule. [s. 227.14 (2) (a) 3m., Stats.]

e. The rule summary's entry for the deadline to submit comments on the proposed rule should be updated to reflect the hearing and deadline dates that are given in the notice of public hearing.

f. In s. Ins 19.01, the parentheses and the enclosed acronym "WIHSP" should be removed. Because the acronym is used elsewhere in the proposed rule, the acronym should be

added to the definitions in s. Ins 19.02. The same comment applies to the use of the acronym "CMS" in s. Ins 19.02 (4), and "FTP" in s. Ins 19.11 (2) (intro.). [s. 1.01 (6) and (8), Manual.]

g. In s. Ins 19.03, the provision is subdivided unnecessarily, as there is no sub. (2) following sub. (1). When a provision is divided into smaller subunits, at least two subunits must be created. Accordingly, the designation for sub. (1) should be removed and pars. (a) to (d) should be revised to subs. (1) to (4). The same comment applies to s. Ins 19.07. [s. 1.03 (1), Manual.]

h. In s. Ins 19.21 (intro.), introductory language should be inserted to explain the applicability of the subunits, and the introduction should end in a colon. The same comment applies to s. Ins 19.22 (intro.) and (1) (intro.). [s. 1.03 (3), Manual.]

i. In SECTION 2 of the proposed rule, the phrase "in the Wisconsin Administrative Register" should be inserted after the word "publication". [s. 1.02 (4) (a) (Example), Manual.]

4. Adequacy of References to Related Statutes, Rules and Forms

In s. Ins 19.10, the provision specifies that information collected under s. Ins 19.04 (1) may be used to satisfy federal and state reporting requirements. However, the rule does not contain s. Ins 19.04. Instead, was this intended as a reference to s. Ins 19.07 or 19.11, or some other provision? The cross-reference should be reviewed and corrected as appropriate.

5. Clarity, Grammar, Punctuation and Use of Plain Language

In s. Ins 19.02 (4), it appears that the reference to guidance from the "office" means guidance from CMS. However, the word "office" is a defined term that means OCI. Consider rephrasing this provision to avoid any confusion.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tony Evers, *Governor*
Mark V. Afable*, Commissioner*

Wisconsin.gov

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May 3, 2021

Report on Chapter Ins 19, Wis. Adm. Code, relating to Wisconsin Healthcare Stability Plan.

Clearinghouse Rule No. 19-088
Submitted Under s. 227.19 (3), Stats.

(The proposed rule-making order is attached.)

(a) A detailed statement of basis for the proposed rule and how the rule advances relevant statutory goals or purposes:

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 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 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 that is established for each benefit year. 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, 2020, and April 30, 2021, 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.

(b) Summary of the public comments and the agency's responses to those comments:

Comment: Rule draft requires claims reported be reduced by any reimbursement received through subrogation, recoupment of overpayments, application of negotiated rate reductions and recoupment from third parties. The concern is these are not part of the

EDGE server data and will add complexity to the year-end data reporting with a tight timeframe.

Response: The OCI recognizes that this data is not in the EDGE server data, however, ensuring proper payments without overpaying insurers is vital to the integrity of the WIHSP program. No changes to the rule were made.

Comment: The final report due by May 15 of every year is 15 days after final EDGE server submission to CMS, would prefer to not report until May 31.

Response: The OCI appreciates the tight timeframe, however, the Office must verify all data submitted and provide an estimated distribution by June 30 for payment by August 15. The Office has maintained the reporting date, however, but also added the ability to change the date at the commissioner's discretion.

Comment: Request for additional information from OCI on the verification audit.

Response: The Office completed the first year of review and payments. The entire process was reviewed and minor modifications, primarily adding timing discretion, were made. At this time, the process established by the proposed rule was overall successful and the Office had not identified that further changes are necessary.

Comment: Information requested on the distribution of the reinsurance payments, timing and estimates.

Response: The proposed rule and statute provide that the Office will provide updates throughout the plan year on the aggregate of estimated payments and sharing estimated payments by the end of June. Changes made to the rule increased timing discretion to increase flexibility in the review and audit process.

Comment: Request that the Office provide quarterly updates on submitted claims and request advance on whether based upon submissions the Office anticipates having sufficient funds in the WIHSP to cover all eligible claims.

Response: The proposed rule reflects that the Office will provide updates throughout the plan year on aggregate of potential claims payments and sharing estimated payments by the end of June. No changes to the rule were made.

Comment: Suggestion that the Office provide additional guidance to insurers prior to setting rates that could reflect whether the Office believes there will be sufficient funds to cover anticipated claims and claims from the prior plan year.

Response: The Office will consider whether additional guidance is necessary. No changes to the rule were made.

(c) An explanation of any modifications made in proposed rule as a result of public comments or testimony received at a public hearing:

The Office made revisions based upon comments received at both the first and second public hearings and during the comment periods. Additionally, the rule reflects the commissioner's experience from the first full cycle of the reinsurance program and added revisions based upon the office's experience. Changes to the WIHSP rule include technical corrections to dates, amended definitions and data reporting forms.

(d) Persons who appeared or registered for the first public hearing regarding the proposed rule:

Appearances for:
None

Appearances against:
None

Appearances for information:
Kelsey Avery, Wisconsin Association of Health Plans

Registrations for:
Melissa Duffy, Common Ground Healthcare Cooperative

Registrations against:
None

Registrations neither for nor against:
Chris Rochester, The MacIver Institute
Kara Koonce, Wisconsin Physicians Service Insurance Corp.
Stephanie Maslowski, Dean Health Plan
Nick Tanner, ABC for Health

Letters received:
Kelsey Avery, WAHP

Persons who appeared or registered for the second public hearing regarding the proposed rule:

Persons who appeared or registered for the first public hearing regarding the proposed rule:

Appearances for:
None

Appearances against:
None

Appearances for information:
None

Registrations for:
None

Registrations against:
None

Registrations neither for nor against:
Kelsey Avery Wisconsin Association of Health Plans
Melissa Duffy, Common Ground Healthcare Cooperative
Joanne Alig, Wisconsin Hospital Association
Natalie White
Mark Osia, WellPoint Anthem
Trevor Harrison, Health Traditions

Jonathon Moody, Quartz Health Plan
Seth Quiggle, Health Traditions

Letters received:
Kelsey Avery, WAHP

(e) An explanation of any changes made to the plain language analysis of the rule under s. 227.14 (2), Stats., or to any fiscal estimate prepared under s. 227.14 (4), Stats.

The plain language was reviewed to ensure consistency with the modification made to the rule in light of the Legislative Council recommendation and public comment received.

(f) The response to the Legislative Council staff recommendations indicating acceptance of the recommendations and a specific reason for rejecting any recommendation:

All comments were complied with and corrected with the exception of the suggestion to change the reference in s. 19.02 (4) to CMS, however the reference to office is correct.

(g) The response to the report prepared by the small business regulatory review board:

The small business regulatory review board did not prepare a report.

(h) Final Regulatory Flexibility Analysis

A Final Regulatory Flexibility Analysis is Not Required because the rule will not have a significant economic impact on a substantial number of small businesses.

(i) Fiscal Effect

See fiscal estimate attached to proposed rule.

Attachment: Legislative Council Staff Recommendations