

ATTACHMENT 2

SENATE SUBSTITUTE AMENDMENT 1 TO SENATE BILL 770

2017 SB 770 ENACTED AS 2017 WISCONSIN ACT 138



State of Wisconsin
2017 - 2018 LEGISLATURE

LRBs0320/1
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**SENATE SUBSTITUTE AMENDMENT 1,
TO SENATE BILL 770**

February 13, 2018 - Offered by 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), 49.45 (2p), subchapter VII
3 (title) of chapter 601 [precedes 601.80], 601.80, 601.83, 601.85 and subchapter
4 VIII (title) of chapter 601 [precedes 601.93] of the statutes; **relating to:**
5 Wisconsin Healthcare Stability Plan, reinsurance of health carriers,
6 reallocating savings from health insurer fee, providing an exemption from
7 emergency rule procedures, granting rule-making authority, and making
8 appropriations.

Analysis by the Legislative Reference Bureau

This substitute amendment creates the Wisconsin Healthcare Stability Plan (WIHSP), which is a state-based reinsurance program for health carriers, subject to the approval of a waiver of the federal Patient Protection and Affordable Care Act. WIHSP makes a reinsurance payment to a health carrier if the claims for an individual who is enrolled in a health benefit plan of the carrier exceed a threshold amount, known as the attachment point, in a benefit year. The commissioner of the Office of the Commissioner of Insurance in this state administers WIHSP. After

consulting with an actuarial firm, the commissioner sets the payment parameters for the reinsurance payment as specified under the substitute amendment. In addition to the attachment point, the other payment parameters are the reinsurance cap, which is the maximum amount of claims eligible for a reinsurance payment, and the coinsurance rate, which is the percent of the claim amount eligible for a reinsurance payment. The commissioner must design and adjust the payment parameters with the goal to stabilize or reduce premium rates in the individual health insurance market, increase participation by health carriers in the individual market, improve access to health care providers and services for individuals purchasing individual health insurance coverage, mitigate the impact high-risk individuals have on premium rates in the individual market, and take into account any federal funding and the total amount of funding available for the plan. If the funding amounts available for expenditure are not anticipated to fully fund the reinsurance payments as of July 1 of the year before the applicable benefit year, the commissioner must adjust the payment parameters and then allow the health carrier to adjust its filing of insurance premium rates. If funding is not available to make all reinsurance payments in a benefit year, reinsurance payments will be made proportional to the health carrier's share of aggregate individual health plan claims costs eligible for reinsurance payments, as determined by the commissioner. Under the substitute amendment, health carriers are required to calculate the rates the carrier would have charged for a benefit year if WIHSP was not established and submit those rates as part of its rate filing.

The commissioner must calculate a reinsurance payment to be made to a health carrier as specified in the substitute amendment. If the claims cost amounts for an individual enrollee of the health benefit plan do not exceed the attachment point threshold, the commissioner may not make a reinsurance payment. If the costs exceed the attachment point, then the commissioner makes a reinsurance payment that is the coinsurance rate multiplied by whichever of the following is less 1) the claims cost minus the attachment point or 2) the reinsurance cap minus the attachment point. When a health carrier meets criteria set in the substitute amendment and any requirements set by the commissioner, the carrier may request a reinsurance payment. A health carrier, however, is not eligible to receive a reinsurance payment unless the carrier agrees not to bring a lawsuit against the commissioner or a state agency or employee over any delay in reinsurance payments or reduction in the payments for insufficient funding. The commissioner must notify the carrier of any reinsurance payments for the benefit year no later than June 30 of the year following that benefit year.

The substitute amendment requires health carriers to provide access to certain data. The commissioner may also have a health carrier audited to assess the carrier's compliance with requirements in this substitute amendment. The commissioner is required to keep an accounting of certain payments and moneys available for payments as specified in the substitute amendment.

The substitute amendment allows the commissioner to submit one or more requests for a state innovation waiver under the federal Affordable Care Act, known as a "1332 waiver," to implement WIHSP. The substitute amendment specifies the

2019 benefit year payment parameters to be used for submitting the waiver but allows the commissioner to adjust the payment parameters to secure federal approval of the waiver request. If the federal government does not approve WIHSP as submitted or a substantially similar plan, the commissioner may not implement WIHSP. Current federal law allows a state to apply for a waiver of certain provisions of the Affordable Care Act, and the state is then eligible to receive moneys from the federal government, known as pass-through funding, that the federal government would have paid in premium tax credits, cost-sharing reductions, or small business credits if the waiver had not been approved.

Under the substitute amendment, if a fee imposed under the Affordable Care Act is no longer applicable to insurers participating in the state's group health insurance program or the Medical Assistance program, the secretary of administration must calculate the expected savings to state agencies from avoiding the fee. The secretary must then adjust appropriations and transfer, in the biennium in which the savings calculation is made, to the general fund the program revenue based on the savings calculated, subject to limitations in the substitute amendment, or adjust state agency employer contributions for state employee fringe benefit costs in the biennium following the biennium in which the savings is calculated or both.

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

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

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 and if the state budget allocated an amount to expend on the annual insurer fee,
8 the secretary shall calculate the expected state agency savings related to the
9 avoidance of the fee.

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

1 (a) In the fiscal biennium in which the savings are calculated, reduce the
2 estimated general purpose revenue and program revenue expenditures, excluding
3 tuition and fee moneys from the University of Wisconsin System, for “Compensation
4 Reserves” shown in the schedule under s. 20.005 (1) by an amount equal to the
5 savings calculated under sub. (2) to the state’s group health insurance program;
6 subject to sub. (4), transfer to the general fund the related available balances in
7 program revenue appropriation accounts related to the savings under sub. (2) to the
8 state’s group health insurance program in an amount equal to the calculated
9 program revenue saved under sub. (2) to the state’s group health insurance program;
10 and, if the secretary of health services finds that a reduction would not result in a
11 deficit to the Medical Assistance program, reduce the general purpose revenue
12 expenditure amounts for the Medical Assistance program under s. 20.435 (4) (b) by
13 an amount that is no greater than the amount of the savings calculated under sub.
14 (2) to the Medical Assistance program.

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

18 (4) If the secretary intends to transfer to the general fund the related available
19 balances in program revenue appropriation accounts related to the savings under
20 sub. (2) to the state’s group health insurance program, the secretary shall submit a
21 request to the joint committee on finance stating the amounts the secretary
22 calculates would be transferred from each program revenue appropriation account.
23 If, within 14 days after the date of the secretary’s request, the cochairpersons of the
24 committee do not notify the department that the committee has scheduled a meeting
25 to review the request, the transfers submitted are considered approved. If the

1 cochairpersons notify the department within 14 days after the date of the secretary's
2 request that the committee has scheduled a meeting to review the request, a transfer
3 may be made only upon approval of the committee.

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

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

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

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

11 49.45 (2p) APPROVAL OF MEDICAL ASSISTANCE PROGRAM CHANGES. After the
12 effective date of this subsection [LRB inserts date], the department may not
13 expand eligibility under section 2001 (a) (1) (C) of the Patient Protection and
14 Affordable Care Act, P.L. 111-148, for the Medical Assistance program under this
15 subchapter unless the state legislature has passed legislation to allow the expansion
16 and that legislation is in effect.

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

18 601.45 (1) COSTS TO BE PAID BY EXAMINEES. The reasonable costs of examinations
19 and audits under ss. 601.43 and, 601.44, and 601.83 (5) (f) shall be paid by examinees
20 except as provided in sub. (4), either on the basis of a system of billing for actual
21 salaries and expenses of examiners and other apportionable expenses, including
22 office overhead, or by a system of regular annual billings to cover the costs relating
23 to a group of companies, or a combination of such systems, as the commissioner may
24 by rule prescribe. Additional funding, if any, shall be governed by s. 601.32. The

1 commissioner shall schedule annual hearings under s. 601.41 (5) to review current
2 problems in the area of examinations.

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

5 **CHAPTER 601**

6 **SUBCHAPTER VII**

7 **HEALTHCARE STABILITY PLAN**

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

9 **601.80 Definitions; healthcare stability plan.** In this subchapter:

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

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

18 (3) “Benefit year” means the calendar year for which an eligible health carrier
19 provides coverage through an individual health plan.

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

1 (5) “Eligible health carrier” means an insurer, as defined in s. 632.745 (15) that
2 offers an individual health plan and incurs claims costs for an enrolled individual’s
3 covered benefits in the applicable benefit year.

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

7 (7) “Health benefit plan” has the meaning given in s. 632.745 (11).

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

10 (9) “Individual health plan” means a health benefit plan that is not a group
11 health plan, as defined in s. 632.745 (10), or a grandfathered plan.

12 (10) “Payment parameters” means the attachment point, reinsurance cap, and
13 coinsurance rate for the healthcare stability plan.

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

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

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

21 **601.83 Healthcare stability plan; administration.** (1) PLAN ESTABLISHED;
22 GENERAL ADMINISTRATION. (a) Subject to par. (b), the commissioner shall administer
23 a state-based reinsurance program known as the healthcare stability plan.

24 (b) 1. The commissioner may submit a request to the federal department of
25 health and human services for one or more waivers under 42 USC 18052 to

1 implement the healthcare stability plan for benefit years beginning January 1, 2019.
2 The commissioner may adjust the payment parameters under sub. (2) to the extent
3 necessary to secure federal approval of the waiver request under this paragraph.

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

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

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

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

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

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

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

7 (g) The commissioner may promulgate any rules necessary to implement the
8 healthcare stability plan under this section, except that any rules promulgated
9 under this paragraph shall seek to maximize federal funding for the healthcare
10 stability plan. The commissioner may promulgate rules necessary to implement this
11 section as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (a) and
12 (3), the commissioner is not required to provide evidence that promulgating a rule
13 under this paragraph as an emergency rule is necessary for the preservation of the
14 public peace, health, safety, or welfare and is not required to provide a finding of
15 emergency for a rule promulgated under this paragraph.

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

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

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

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

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

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

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

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

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

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

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

18 (c) If funding is not available to make all reinsurance payments to eligible
19 health carriers in a benefit year, the commissioner shall make reinsurance payments
20 in proportion to the eligible health carrier's share of aggregate individual health plan
21 claims costs eligible for reinsurance payments during the given benefit year, as
22 determined by the commissioner. The commissioner shall notify eligible health
23 carriers if there are insufficient funds available to make reinsurance payments in
24 full and the estimated amount of payment as soon as practicable after the
25 commissioner becomes aware of the insufficiency.

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

- 10 1. The claims costs minus the attachment point.
- 11 2. The reinsurance cap minus the attachment point.

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

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

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

23 (c) Each eligible health carrier shall provide the commissioner with access to
24 the data within the dedicated data environment established by the eligible health
25 carrier under the federal risk adjustment program under 42 USC 18063. Each

1 eligible health carrier shall submit to the commissioner attesting to compliance with
2 the dedicated data environments, data requirements, establishment and usage of
3 masked enrollee identification numbers, and data submission deadlines.

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

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

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

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

23 2. Implement the corrective action plan under subd. 1. as approved by the
24 commissioner.

1 3. Provide the commissioner with written documentation of the corrective
2 action after implementation.

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

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

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

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

14 **601.85 Accounting, reports, and audits.** **(1) ACCOUNTING.** The
15 commissioner shall keep an accounting for each benefit year of all of the following:

16 (a) Funds appropriated for reinsurance payments and administrative and
17 operational expenses.

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

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

20 (d) Administrative and operational expenses incurred for the healthcare
21 stability plan.

22 **(2) REPORTS.** By November 1 of the calendar year following the applicable
23 benefit year or by 60 days following the final disbursement of reinsurance payments
24 for the applicable benefit year, whichever is later, the commissioner shall make

1 available to the public a report summarizing the healthcare stability plan's
2 operations for each benefit year by posting the summary on the office's Internet site.

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

7 (4) REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the
8 commissioner shall submit to the governor recommendations on implementing a
9 waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and
10 any other options to stabilize the individual health care market in this state. In
11 developing the recommendations, the commissioner shall consider and include in the
12 report the impacts of creating a high-risk pool or an invisible high-risk pool; funding
13 of consumer health savings accounts; expanding consumer plan choices, including
14 catastrophic plans or coverage and new low-cost plan options; and implementing
15 any other approach that will lower consumer costs, stabilize the insurance market,
16 or expand the availability of private insurance coverage.

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

19 **CHAPTER 601**

20 **SUBCHAPTER VIII**

21 **FIRE DEPARTMENT DUES**

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

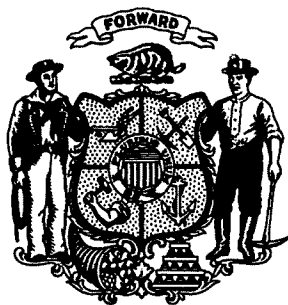
24 **SECTION 11. Nonstatutory provisions.**

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

9

(END)

State of Wisconsin



2017 Senate Bill 770

Date of enactment: **February 27, 2018**
Date of publication*: **February 28, 2018**

2017 WISCONSIN ACT 138

AN ACT to *repeal* subchapter VI (title) of chapter 601 [precedes 601.93]; to *amend* 601.45 (1); and to *create* 16.5285, 20.145 (5), 49.45 (2p), subchapter VII (title) of chapter 601 [precedes 601.80], 601.80, 601.83, 601.85 and subchapter VIII (title) of chapter 601 [precedes 601.93] of the statutes; **relating to:** Wisconsin Healthcare Stability Plan, reinsurance of health carriers, reallocating savings from health insurer fee, providing an exemption from emergency rule procedures, granting rule-making authority, and making appropriations.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

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

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

(2) If the annual fee imposed under section 9010 of the Affordable Care Act is no longer applicable to insurers participating in the state's group health insurance program under s. 40.51 (6) or the Medical Assistance program under subch. IV of ch. 49 and if the state budget allocated an amount to expend on the annual insurer fee, the secretary shall calculate the expected state agency savings related to the avoidance of the fee.

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

(a) In the fiscal biennium in which the savings are calculated, reduce the estimated general purpose revenue and program revenue expenditures, excluding tuition and fee moneys from the University of Wisconsin System, for "Compensation Reserves" shown in the schedule under s. 20.005 (1) by an amount equal to the savings calculated under sub. (2) to the state's group health insurance program; subject to sub. (4), transfer to the general fund the

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

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

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

* Section 991.11, WISCONSIN STATUTES: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication."

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

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

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

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

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

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

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

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

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

CHAPTER 601

SUBCHAPTER VII

HEALTHCARE STABILITY PLAN

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

601.80 Definitions; healthcare stability plan. In this subchapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

601.83 Healthcare stability plan; administration.

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

(b) 1. The commissioner may submit a request to the federal department of health and human services for one or more waivers under [42 USC 18052](#) to implement the healthcare stability plan for benefit years beginning January 1, 2019. The commissioner may adjust the payment parameters under sub. (2) to the extent necessary to

secure federal approval of the waiver request under this paragraph.

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

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

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

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

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

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

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

(g) The commissioner may promulgate any rules necessary to implement the healthcare stability plan under this section, except that any rules promulgated under this paragraph shall seek to maximize federal funding for the healthcare stability plan. The commissioner may promulgate rules necessary to implement this section as emergency rules under s. 227.24. Notwithstanding s. 227.24 (1) (a) and (3), the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph.

(h) In 2019 and in each subsequent year, the commissioner may expend no more than \$200,000,000 from all revenue sources for the healthcare stability plan under this section, unless the joint committee on finance under

s. 13.10 has increased this amount upon request by the commissioner.

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

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

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

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

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

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

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

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

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

(c) If funding is not available to make all reinsurance payments to eligible health carriers in a benefit year, the commissioner shall make reinsurance payments in proportion to the eligible health carrier's share of aggregate individual health plan claims costs eligible for reinsurance payments during the given benefit year, as determined by the commissioner. The commissioner shall notify eligible health carriers if there are insufficient funds available to make reinsurance payments in full and the estimated amount of payment as soon as practicable after the commissioner becomes aware of the insufficiency.

(4) REINSURANCE PAYMENT CALCULATION. (a) The commissioner shall calculate a reinsurance payment with respect to each eligible health carrier's incurred claims costs for an enrolled individual's covered benefits in the applicable benefit year. If the claims costs for an enrolled individual do not exceed the attachment point set under sub. (2), the commissioner may not make a reinsurance payment with respect to that enrollee. If the claims costs for an enrolled individual exceed the attachment point,

subject to par. (b), the commissioner shall make a reinsurance payment that is calculated as the product of the coinsurance rate and whichever of the following is less:

1. The claims costs minus the attachment point.
2. The reinsurance cap minus the attachment point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

601.85 Accounting, reports, and audits. (1)

ACCOUNTING. The commissioner shall keep an accounting for each benefit year of all of the following:

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

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

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

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

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

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

(4) REQUIRED RECOMMENDATION REPORT. By December 31, 2018, the commissioner shall submit to the governor recommendations on implementing a waiver under s. 601.83 (1) (b), any possible additional waivers to be requested, and any other options to stabilize the individual health care market in this state. In developing the recommendations, the commissioner shall consider and include in the report the impacts of creating a high-risk pool or an invisible high-risk pool; funding of consumer

health savings accounts; expanding consumer plan choices, including catastrophic plans or coverage and new low-cost plan options; and implementing any other approach that will lower consumer costs, stabilize the insurance market, or expand the availability of private insurance coverage.

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

CHAPTER 601

SUBCHAPTER VIII

FIRE DEPARTMENT DUES

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

SECTION 11. Nonstatutory provisions.

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