Chapter Ins 19

WISCONSIN HEALTHCARE STABILITY PLAN

Ins 19.01 Purpose.
Ins 19.02 Definitions.
Ins 19.03 Payment parameters.
Ins 19.07 Eligible claims.
Ins 19.10 Reporting requirements.
Ins 19.11 Quarterly reporting requirements.
Ins 19.12 Final annual report and affirmations.
Ins 19.20 Verification audit.
Ins 19.21 Reinsurance payment calculation.
Ins 19.22 WIHSP payment reconciliation.
Ins 19.24 Compliance audit.

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.

History: CR 19–088: cr. Register November 2021 No. 791, eff. 12–1–21.

Ins 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.

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

(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.

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

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Ins 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.

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Ins 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.

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Ins 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.

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Ins 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.

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Ins 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.

History: CR 19–088: cr. Register November 2021 No. 791, eff. 12–1–21; correction in (1) made under s. 35.17, Stats., Register November 2021 No. 791.

Ins 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.

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Ins 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.

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Ins 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.

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Ins 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.

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