Proposed Amendments to LRB Draft for a WI Health Exchange Authority

Offered by David R. Riemer

Note: All page & line numbers refer to WLC: 0038/1

1. On p. 23, after line 8, insert the following (and renumber Subsections **(3)** and **(4)** as Subsections **(4)** and **(5)**):

(4) "Exchange" means the American Health Benefit Exchange required under Sec. 1311(b)(1) of the federal Patient Protection and Affordable Care Act, the Small Business Health Options Program (SHOP) exchange required under Sec. Sec. 1311 (b)(1) of the federal Patient Protection and Affordable Care Act, and any other health insurance exchange that the authority is authorized to design, establish, and operate under this chapter.

Explanation: Technically, the federal Patient Protection and Affordable Care Act (PPACA) creates two state health insurance exchanges: (1) the "American Health Benefits Exchange" (authorized by Sec. 1311(b)(1) of the PPACA), which is referred to in the draft legislation as "the individual exchange" (p. 28, line 10, proposed Sec. 260.04(3)(10)), and (2) the Small Business Health Options Program (SHOP) exchange (also authorized by Sec. Sec. 1311(b)(1) of the PPACA), which is referred to in the draft legislation as "the small employer health options exchange" (also on p. 28, line 10, proposed Sec. 260.04(3)(10)). The clear intent of the draft legislation, fully consistent with federal law, is to require the Wisconsin Health Exchange Authority (Authority), its board, and its staff, through what is referred to in the draft legislation as simply the "exchange," to

simultaneously and jointly design, establish, and operate both of these two federally-required exchange, i.e., the American Health Benefits Exchange and the SHOP exchange. However, the draft legislation does not include in the definition section of proposed Chapter 260 a formal definition of the "exchange," nor does the proposed legislation make crystal clear that the Chapter 260 "exchange" encompasses both of the two federally-required exchanges. Rather, on p. 26, line 5, in requiring the board to "[e]stablish and administer a health insurance exchange in this state," leaves open the question of whether the board is being made responsible for the American Health Benefits Exchange, the SHOP exchange, or both. Only when we get to a subsequent provision in the draft legislation (i.e., p. 28, lines 8-10, creating proposed Sec. 260.04(3)(10)), does it become clear that the prior reference to establishing and administering a health insurance exchange related only to the American Health Benefits Exchange, for in this subsequent section the board is required to establish "a small employer health options exchange."

To avoid any confusion about what Chapter 260 means when it uses the word "exchange," this amendment provides an early (i.e., in the definition section) and formal definition of what an "exchange" is and means in Chapter 260. It makes explicit that the "exchange" is a combination of the two federally-required exchanges, thus clearly authorizing the authority—through its board and staff—to design, establish, and operate both federally-required exchanges, consistent with federal and state law. (NOTE: The question of whether the two federally-required exchanges should be "merged," i.e., not merely simultaneously and jointly administered, but fully integrated with a single risk pool for the individual and small group insurance products that are offered, is another matter. The

draft legislation raises the merger issue on p. 28, lines 8-10, proposed Sec. 260.04(3)(10); a proposed amendment appears later in this document.)

It is also possible that the Legislature may wish to expand the proposed Chapter 260 "exchange" so that, in addition to encompassing both of the federally-required exchanges, it includes one or more additional exchanges established under state law. The proposed amendment provides that the Chapter 260 "exchange" would incorporate any state-required exchange that state law authorizes the authority to design, establish, or operate.

2. On p. 23, lines 9, amend the draft as follows:

(4) "Fund" means the Wisconsin Health Exchange Authority Fund under s. 260.03(2).

Explanation: This technical amendment clarifies that the "fund" is not the Wisconsin Health Exchange Authority itself, but rather a fund administered by the Authority.

3. On p. 25, lines 10-11, amend the draft (last sentence of the paragraph) as follows

Meetings of the members of the board may be held anywhere within ~~or without~~ the state.

Explanation: This amendment, by deleting the words "or without," requires the Authority's board to meet only within the State of Wisconsin. The board should limit its meetings to venues in Wisconsin to avoid any appearance that it's seeking to conduct its business in secret or trying to avoid scrutiny from the Legislature, press, or public.

4. On p. 25, lines 12-4, amend the draft as follows:

(3) BOARD MEMBER RESPONSIBILITY AS TRUSTEE. Each member of the board shall function as a trustee and be responsible for taking care that the highest level of independence and judgment is exercised at all times in ~~administering~~ designing, establishing, and operating the exchange. All members of the board shall annually complete, and file with the Wisconsin government accountability board, a statement of economist interests as required by the Wisconsin ethics code. No member of the board shall take part in any discussion of, or vote on, any matter in which the member, or any organization that employs the member or provides compensation to the member for services rendered, has a substantial economic interest.

Explanation: The proposed amendment is intended to strengthen both the reality, and the appearance, of the board's integrity and independence by requiring all board members (a) to explicitly function as trustees, (b) submit the same statement of economic interests that other high-level state officials submit to the Wisconsin Government Accountability Board, and (c) recuse themselves from participating in, or voting on, any matter in which they (or their employers) have a substantial economic interest.

5. On p. 25, lines 15-17, amend the draft as follows:

260.03 **Administration of exchange. (1)** AUTHORITY. The authority shall be responsible for the design, establishment and operation of ~~the~~ a health insurance exchange in this state that complies with the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education

Affordability Reconciliation Act of 2010, Public Law 111- 152, and the provisions of this Chapter, shall administer the fund, and may enter into contracts for the exchange's administration.

Explanation: This amendment clarifies that the Authority is responsible for designing and establishing Wisconsin's exchange, as well as operating it. This amendment also clarifies that the exchange that the Authority must operate is the same entity as the federally-required state health insurance exchange. This amendment also explicitly empowers the Authority to administer the Wisconsin Health Exchange Authority Fund, which is defined in Sec. 260.01 (3), and which is identified in Sec. 260.03(2) (the next subsection) as the vehicle for paying the exchange's expenses. Finally, this amendment makes the reference to exchange ("a health insurance exchange in this state") consistent with the reference used in Sec. 260.04 under "Duties" (see p. 26, line 5).

6. On p. 25, lines 18-21, amend the draft as follows:

(2) FUND. (a) (intro) The authority shall pay the ~~operating and administrative~~ expenses of designing, establishing, and operating the exchange from the fund, which shall be outside the state treasury and which shall consist of all of the following:

1. Enrollment fees imposed and collected from all qualified health care plans that sell their products on the exchange, as specified in Sec. 260.05 (7), as well as the ~~Premiums~~ premiums (net of such enrollment fees) paid by ~~eligible persons~~ individuals and employers who use the exchange to purchase health insurance from qualified health care plans if the board

decides that the exchange shall collect and briefly retain such premiums prior to transmitting them (net of enrollment fees) to the health care plans selected by individuals who use the exchange.

Explanation: The proposed amendment fund makes clear that the Authority may use the exchange to pay the expenses of "designing" and "establishing" the exchange, as well as "operating" it. The amendment also replaces an undefined term ("eligible persons") with the group it is intended to refer to ("individuals and employers who use the exchange to purchase health insurance from qualified health plans"). The amendment further clarifies that it is really the enrollment fees that the exchange imposes and collects (under Sec. 260.05(7) that constitute its main source of revenue, because most of any premium revenue it collects from individuals and employers must (after netting out the enrollment fees) be transmitted to the health care plans that individuals who use the exchange have chosen. Finally, the amendment acknowledges that the board may decide not act as such a "pass-through" mechanism for premium revenue, but may decide instead to create a mechanism under the exchange only collects the enrollment fees, while individuals and employers make their premium payments directly to health care plans.

7. On p. 26, line 3, amend the draft as follows:

(c) Moneys in the fund may be expended only for the purposes specified in par. (a), except that all premiums paid into the fund shall, after deducting the fees imposed and collected by the board under Sec. 260.05 (7), shall be transmitted to the qualified health care plans selected by individuals who use the exchange.

Explanation: As drafted, the legislation would require that premiums paid into the fund (in addition to all moneys received from the federal government and the fund's earnings) must be retained by the exchange to pay for the its administrative expenses. However, if the board decides to use the exchange as a "pass-through" for premium payments, only the portion of premiums that consists of per-enrollee administrative fees should be retained to cover the exchange's administrative expenses. The balance of premiums should of course be passed through to the health care plans that individuals have selected. The proposed amendment fixes this problem.

8. On p. 26, lines 4-7, amend the draft as follows:

260.04 **Duties.** The board shall:

(1) Design, ~~Establish~~ establish and administer a health insurance exchange in this state that complies with the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Affordability Reconciliation Act of 2010, Public Law 111- 152, and the provisions of this Act. The exchange shall be available to all qualified individuals as defined in Sec. 1501 of the federal act; to all employers within up to 100 full-time equivalent employees beginning on January 1, 2014; and to all employers beginning on January 1, 2017. In establishing and administering the health ~~care~~ insurance exchange, the board shall seek to attain all of the following goals:

Explanation: This amendment clarifies that the Authority's duties include designing, as well as establishing and operating, Wisconsin's exchange. This amendment also clarifies that the exchange that the Authority must operate is the same entity as the federally-required state health insurance. Further, this amendment authorizes the exchange to serve small employers with up to 100 full-time equivalent employees beginning on January 1, 2014 (rather than wait until January 1, 2016, to include small employers with up to 100 FTE employees), an option that states may exercise under the federal law. The amendment further authorizes the exchange to serve all employers regardless of size beginning on January 1, 2017, an option the state may also exercise under federal law. Finally, this amendment makes consistent the reference to the exchange as a "health insurance" exchange (rather than a "health care" exchange).

9. On p. 28, lines 8-10, amend the draft as follows:

(n) Establishes a small ~~employer~~ business health options program (SHOP) exchange ~~through which~~ to assist qualified employers in the state who are small employers to ~~may access coverage for~~ enroll their employees in qualified health plans offered in the small group market in the state. The authority may determine whether the ~~small employer health options exchange and the individual exchange may be merged~~ exchange, in addition to simultaneously and jointly administering the American Health Benefit Exchange and the small business health options program (SHOP) exchange, shall fully merge the American Health Benefit Exchange and the small business health options program (SHOP) exchange, including consolidating the individual and small group market risk pools of qualified health care plans into a single risk pool.

Explanation: This amendment is largely technical. It brings the precise language of the federal PPACA into the draft legislation. It also clarifies that the main impact of the "merger" option is to replace separate risk pools for individual vs. small group insurance with a single, consolidated risk pool.

10. On p. 28, lines 14-15, amend the draft as follows:

(p) Accounts for expenditures and keeps accurate accounting of all activities, receipts, and expenditures and annually ~~submit~~ submits to the ~~secretary~~ legislative audit bureau and secretary of administration a report of such accountings.

Explanation: This amendment is largely technical. The draft legislation did not clarify (since "secretary" is a undefined term) who would receive the annual "report of such accountings." This amendment provides that this report be submitted to the Legislative Audit Bureau and the Secretary of Administration.

11. On p. 29, after line 23, amend the draft as follows:

(z) Complies with any other requirements for the exchange established under federal or state law.

Explanation: This amendment enables the exchange to comply with any additional federal or state requirements, whether imposed by law or regulation.

12. On p. 29, after line 23, insert the following additional duty of the board, and on p. 30, renumber subsections **(4)** and **(5)** as subsections **(5)** and **(6):**

(4) Strengthen the capacity of the exchange to galvanize competitive private market forces, and thus hold down health insurance costs and improve health care quality, by adopting measures that mitigate adverse selection, improve consumer information, and replace perverse economic incentives with rational economic incentives, including:

(a) Safeguarding the exchange against various types of adverse selection that will otherwise undermine effective market competition in health insurance, including:

(i) Implementing participation rules that provide that, when an employer voluntarily chooses to use the exchange to provide health insurance coverage for its full-time employees, full-time employees' spouses or dependent children, or part-time employees or their spouses or dependent children, the employer must enroll in the exchange at least 90% of the individuals in each category who do not have comparable coverage from another source; and

(ii) Creating an exchange risk reserve trust fund and risk-adjustment payment mechanism, under which the authority collects and deposits in a segregated risk reserve trust fund a fixed percent (not to exceed 10%) of all premium payments made by individuals and employers that use the exchange, and then allocates 100% of the amount collected and deposited in the risk reserve trust fund (less actual and reasonable collection, actuarial, and other administrative costs that have not been absorbed by any interest accrued by the risk reserve trust fund) to the qualified health care plans that participants in the exchange have chosen, in proportion to the

actuarially validated levels of relative risk the qualified health care plans have taken;

(b) Increase the amount and quality of the information that consumers receive about the nature, cost and quality of their health insurance choices, including providing potential and actual participants in the exchange with complete and understandable information about:

(i) Which health care plans listed on the exchange, as well as outside the exchange, have entered into exclusive economic arrangements with at least 75% of their primary care doctors, thus making those doctors primarily dependent on the competitive capacity of those health care plan to lower costs and improve quality;

(ii) Which health care plans listed on the exchange, as well as outside the exchange, are owned and operated primarily by Wisconsin doctors, clinics, or hospitals;

(iii) What additional dollar amount, within the Bronze, Silver, Gold and Platinum actuarial levels, must be paid within the exchange and outside of the exchange to enroll in each more costly health care plan within that actuarial level (compared to the lowest-cost health care plan offered at that level within the exchange or outside of the exchange);

(iv) What portion (expressed in both dollars and percent) of the cost of each qualified health care plan listed on the exchange, as well as what portion of the cost of each health care plan offered outside the exchange, is attributable to medical payments, administrative costs other than payments to agents or brokers, and payments to agents or brokers; and

(v) The quality of all health care plans offered on the exchange, as well as those offered outside the exchange, based on the quality measurement and reporting tools used by the Wisconsin State Employee

Health Plan, the Wisconsin Health Insurance Risk Sharing Program, and other quality measurement and reporting tools that the board determines are credible; and

(vi) The extent to which all health care plans offered on the exchange, as well as those offered outside the exchange, are following the National Voluntary Consensus Standards for the Treatment of Substance Use Conditions;

(c) Give consumers who use the exchange clear economic incentives to select low-cost and high-quality qualified health care plans, thus stimulating qualified health care plans to lower their costs while improving their quality, including:

(i) Encouraging employers who voluntarily select the exchange to provide health insurance to their employees, or their employees' spouses or dependents, to limit their financial contribution, at whichever actuarial level the employer voluntarily selects, to a dollar amount or percentage formula, per person or per family per month, that does not exceed the lowest premium bid by qualified health care plans at the selected actuarial level, thus requiring each employee to pay out-of-pocket the full extra cost of enrolling in any more costly qualified health care at the selected actuarial level; and

(ii) Encouraging employers, if they wish to subsidize their employees' choice of more costly health care plans, to limit their subsidy to no more than 110% of the lowest premium bid within the selected actuarial level, and to offer such a subsidy only to qualified health care plans that have entered into exclusive economic arrangements with at least 75% of their primary care doctors.

Explanation: A central premise of the Patient Protection and Affordable Care Act is that the most acceptable mechanism for lowering the growth of health insurance and health care costs, and for promoting improved health care quality, is to create a market mechanism—an exchange—that more efficiently organizes the relationship between buyers and sellers of health insurance so as to incentivize a slower rate of cost growth and gains in quality. In Wisconsin, several decades of experience with the Wisconsin State Employee Health Plan and other efforts have demonstrated that an exchange will be effective in achieving its twin goals--lower costs and improved quality—<u>only if</u> it has a pool of participants that is average in risk, large in size, and driven by clear economic incentives to select low-cost, high-quality health insurance plans. While the federal law and the proposed draft lay the foundation for an exchange whose pool meets these three tests, the draft needs to be amended in three areas to create an exchange pool whose risk profile, size, and incentive structure give it a fighting chance of actually going into the private health insurance market in a manner that constrains costs and improves quality.

First, the exchange pool must be prevented from turning into an open-ended "dumping ground" for bad risk. To reduce such adverse selection, the amendment provides that employers who wish to use the exchange must bring in virtually <u>all</u> of their employees (or spouses and dependents), both the high-risk and the low-risk. In addition, to offset the possibility that, once the pool is formed, its risk will not be evenly distributed among all qualified health care plans, a risk-adjustment mechanism is necessary to ensure that additional premium dollars follow to those health are plans that inadvertently attract a disproportionate share of bad risk. The amendment

establishes such a risk-adjustment mechanism. With these two mechanisms in place, the exchange pool will not be so frightening to health insurers that they will simply walk away—or bid prices that are extremely high—to protect themselves.

Second, the exchange pool needs to be big enough in size (i.e., in the number of enrollees who participate) to affirmatively attract bids—and competitive bids, in terms of both price and quality--from health insurers. A prior amendment, which opens up the exchange to employers with up to 100 FTE employees as of January 1, 2014, and to employers of all sizes as of January 1, 2017, will help build the size of the exchange pool.

Third, the flow of information and incentives within the exchange must be robust and rational enough—must be enough like other markets—to give competing health insurance plans and the health care providers in their networks a compelling economic reason not only to bid, but to bid low and raise quality…but to do so year after year. To this end, the amendment includes several provisions designed to provide important and understandable information, targeted at both consumers and employers, that is calculated to make market forces work better by alerting consumers and employers about which health care plans have more cost-effective structures, lower total costs, lower overhead, and better quality. The amendment also encourages employers to not spend than the low-cost bid within each actuarial level. To the extent that employers limit their contributions the low-cost qualified health care plans within each actuarial level, and thus require employees to spend out-of-pocket for the full extra cost if those employees wish to enroll in a more costly plan, one of the worst

perverse incentives that drives up inflation in health care—lack of consumer "cost-consciousness"-- will be reversed, thus placing great pressure on health insurance companies and health care provider to lower their costs and improve their quality.

Note that this amendment does not require any employer to buy insurance does not require any individual or employer to use the exchange; does not require any individual or employer (who does use the exchange) to select a particular actuarial level or choose particular health care plans; and does not require individuals or employers to spend any particular amount. The only requirements here are ones that safeguard the exchange against adverse selection, and improve the flow of information to consumers, thus empowering the marketplace to work much better.

13. On p. 30, lines 3-4, amend the draft as follows (NOTE: This amendment assumes that Subsection **(5)** has here been renumbered as Subsection **(6)):**

(6) Contract for annual, independent, program evaluations and financial audits that measure the extent to which the ~~plan~~ board is achieving the goals under sub. (1) (a) to (c).

Explanation: Technical.

14. On p. 30, after line 4, amend the draft by inserting the following additional duty of the board ((NOTE: This amendment assumes that Subsection **(5)** has here been renumbered as Subsection **(6)**):

(7) Coordinate with the Wisconsin Department of Corrections and the Department of Health Services to ensure that Wisconsin residents who:

(a) Are incarcerated and therefore not applicable individuals

under Sec. 1501 of the federal Patient Protection and Affordable Care Act, but who upon their release from incarceration will become applicable individuals, are identified prior to their release from incarceration and enrolled either in BadgerCare Plus, an individual or small group health insurance plan, or another form of health insurance, so that immediately upon their release from incarceration they have minimum essential coverage as required under Sec. 1501 of the federal law; and

(b) Become incarcerated, and therefore lose their status as applicable individuals, are disenrolled from BadgerCare Plus or any other form of health insurance they previously had, for the duration of their incarceration.

Explanation: Today, many prisoners who complete their sentences, or receive a parole, fail upon their release from prison to obtain health insurance, and don't get medically necessary care. As a result, they have a high risk—especially if they have an addiction to alcohol or other drugs, or a mental illness—of both committing new crimes and ending up in hospital emergency rooms. Local and state taxpayers bear the cost if they break the law and return to prison. Meanwhile, the cost of their emergency room care gets shifted to hospitals' insured patients and Wisconsin's insuring employers, in essence imposing a de facto "tax" on them. To reduce this local and state tax burden, and to reduce the imposition of a de facto tax on the state's workers and employers, this amendment requires the board to coordinate with the Departments of Corrections and Health Services to ensure that, when felons leave prison, they immediately get health insurance so that they're less likely to commit new offenses, less likely to receive care

in hospital emergency rooms, and thus less likely to impose both real and de facto taxes on the people and employers of Wisconsin.

15. On p. 30, after line 4 (and the amendment above), amend the draft by inserting the following additional duty of the board:

(7) Coordinate with the Wisconsin Department of Health Services and the counties of the state to ensure that Wisconsin's emerging system of providing health insurance coverage for the treatment of addiction and mental illness is synchronized in a cost-effective manner with the traditional county-administered system of providing outpatient and inpatient addiction and mental health treatment, with the goals of:

(a) Maximizing coverage and improving access through the health insurance system for Wisconsin residents who need outpatient or inpatient treatment for an addiction or mental illness;

(b) Improving the quality of treatment for persons with an addiction or mental illness, in whatever setting such treatment occurs;

(c) Fully integrating the treatment of physical conditions, addiction, and mental illness; and

(d) Reducing costs to Wisconsin's taxpayers, at both the local and state level, by avoiding duplication and gaps between the health insurance system's growing coverage of persons with an addiction or mental illness and the traditional county-administered system for providing treatment.

Explanation: This amendment requires the board to coordinate with the Wisconsin Department of Health Services and the state's counties to reduce the duplication and gaps that arise because both health insurance and county-administered programs provide treatment for persons who have

an addiction to alcohol or other drug, a mental illness, or (often) both. This is already a concern. It will only get more serious as the new insurance structure takes hold more Wisconsinites—in particular, starting in 2014, when BadgerCare begins to cover many more low-income adults without dependent children (whether the income ceiling is set at 133% of the poverty line, the minimum required by federal law, or a higher percentage), and the exchange begins to offer health insurance options to individuals and the employees of small firms, thus resulting in a large increase in the number of state residents who have private insurance plans that provide "essential health benefits" and, thus, "mental health and substance use disorder services, including behavioral health treatment" (Sec. 1302(b) of the federal Patient Protection and Affordable Care Act). Rather than accept the costly confusing, duplication, and gaps that will only worsen as insurance-based coverage of addiction and mental health treatment runs into the traditional county-administered treatment system, this amendment directs the board to address the problem up-front and take a leadership role in harmonizing the two systems, in order to make the make the overall treatment of addiction and mental illness more effective and less costly to Wisconsin's taxpayers.

16. On p. 30, lines 13, amend the draft as follows:

(5) Accept gifts, grants, loans, or other contributions from private or public sources, provided that the board determines in open session and on the record that neither a conflict of interest nor the appearance of a conflict of interest will arise because of its action.

Explanation: The proposed amendment ensures that the board's integrity and independence will not be compromised by its acceptance of any gift, grant, loan, or other contribution from any source.

17. On p. 30, lines 14-15, amend the draft as follows:

(6) Establish the authority's annual budget, ~~and monitor~~ oversee the fiscal management of the authority, and oversee the fund established under Sec. 260.03(2), the receipt of all revenues received by the fund, and the payment of all the expenses of the exchange from the fund.

Explanation: This amendment strengthens the board's oversight of the authority's fiscal operations.

18. On p. 31, lines 1-2, amend the draft as follows:

(7) Impose ~~assessments on health care facilities, providers, services, and insurance products~~ , collect, and deposit in the fund created under Sec. 260.03(2), an enrollment fee, on a per enrollee per month basis as determined by the board, from all qualified health care plans that sell their products on the exchange, which shall be included in the premiums charged by the health care plans.

Explanation: The board will need the power to impose fees to cover its costs. But the draft gives the board the authority to "impose assessments on health care facilities, providers, services, and insurance products" regardless of whether—and to what extent--they use or benefit from the exchange. This is too broad a power to collect revenue. It is also not compatible with the federal Patient Protection and Affordable Care Act, which did not contemplate giving state exchange authorities such sweeping powers to impose assessments. The proposed amendment narrowly limits the board's authority to collect fees from only those qualified health care plans that "list" on the exchange, as an add-on their premiums. The proposed amendment also requires that the fee paid by any particular health care plan

must be proportionate to the number of enrollees it insures. Under Sec. 260.03(2), these fees are deposited in the Authority's fund and used to pay for the exchange's administrative expenses.

19. On p. 31, delete lines 10-11 of the draft (i.e., delete the current Subsection **(13)),** and renumber Subsections **(14)** as Subsection **(13).**

Explanation: Proposed Sec. 260.05(13)—the power of the board that would be eliminated—would permit the board to "[c]ompel witnesses to attend meetings and to testify upon any matter concerning the plan." While this may be an appropriate power for the HIRSP Board of Directors, it seems like an excessive power to give to the Wisconsin Health Exchange Authority's board. (Also, the reference in Sec. 260.05(13) to "the plan" refers to the HIRSP plan, and needs to be removed in any case.)

20. On p. 31, lines 12-14, amend the draft as follows (NOTE: This amendment assumes that Subsection **(14)** has been renumbered as Subsection **(13)**):

(13) Allow all qualified health plans to ~~participate in the health exchange~~ offer their health insurance products on the exchange.

Explanation: This amendment accepts the 1st alternative presented by the Legislative Council draft legislation to allow all qualified health plans to list their products on the exchange. It also replaces the more general notion of "participating" in the exchange with a more specific reference to "offering their health insurance products" on the exchange.

21. On p. 31, delete lines 15-16 (i.e, delete the current Subsection **(15)**.

Explanation: The draft legislation would give the board the power to require qualified health plans to offer "benefits in addition to the essential health benefits." This is extremely broad discretion. What other benefits? It is too great a delegation of power.

22. On p. 31, line 17, renumber Subsection **(16)** as Subsection **(14)**, and amend the legislation as follows: has been renumbered as Subsection **(13)**):

(14) ~~Extend some [or all] exchange-specific regulations to the outside insurance market~~. If the board determines, after consulting with the commissioner of insurance, that it will reduce adverse selection against the exchange or create a more effective health insurance market to apply the same requirement both to qualified health plans that offer their health insurance products within the exchange and to health care plans that offer their health insurance products outside the exchange but within the individual and small group markets, and the board further determines that the federal Patient Protection and Affordable Care Act does not already require or authorize the board to level the playing field in this manner, the board may, after notice and the opportunity for a hearing, adopt regulations that apply the same requirements to health care plans both inside and ouside of the exchange.

Explanation: Protecting the exchange against adverse selection is essential to its success, and in particular to its capacity to trigger competitive private market forces that operate to lower health insurance (and health care) costs and improve quality. The federal Patient Protection and Affordable Care Act already contains some provisions that "level the playing field" between the qualified health care plans that are listed on the

exchange and health care plans offered outside the exchange (but within the individual and small group market). The draft legislation gives the board very broad power, without consultation with OCI or a specified decision-making process, to apply the same rules both within and "without" the exchange. The proposed amendment substitutes a narrower provision that (1) requires the board to consult with OCI before taking any action, (2) limits the board to those areas of "inside vs. outside" that are not already addressed by the federal law, and (3) requires the board to give notice, and hold a hearing, before making a decision that the same rules should apply both inside and outside the exchange.

23. On p. 31, lines 19, through p. 33, line 4, amend the draft as follows:

SECTION 42. 260.06 of the statutes is created to read:

260.06 **Contracting for products or professional services. (1)** Whenever contracting for products or professional services, the authority shall solicit competitive sealed bids or competitive sealed proposals, whichever is appropriate. Each request for competitive sealed proposals shall state the relative importance of price and other evaluation factors.

(2) (a) When the estimated cost exceeds $50,000, the authority may invite competitive sealed bids or proposals by publishing a class 2 notice under ch. 985 or by posting notice on the internet at a site determined or approved by the authority. The notice shall describe the products or contractual services to be purchased, the intent to make the procurement by solicitation of bids or proposals, any requirement for surety, and the date the bids or proposals will be opened, which shall be at least 7 days after the date of the last insertion of the notice or at least 7 days after the date of posting on the internet.

(b) When the estimated cost is $50,000 or less, the authority may award the contract in accordance with simplified procedures established by the authority for such transactions.

(c) For purposes of clarification, the authority may discuss the requirements of the proposed contract with any person who submits a bid or proposal and shall permit any offerer to revise his or her bid or proposal to ensure its responsiveness to those requirements.

(3) (a) The authority shall determine which bids or proposals are reasonably likely to be awarded the contract and shall provide each offerer of such a bid or proposal a fair and equal opportunity to discuss the bid or proposal. The authority may negotiate with each offerer in order to obtain terms that are advantageous to the authority. Prior to the

award of the contract, any offerer may revise his or her bid or proposal. The authority shall keep a written record of all meetings, conferences, oral presentations, discussions, negotiations, and evaluations of bids or proposals under this section.

(b) In opening, discussing, and negotiating bids or proposals, the authority may not disclose any information that would reveal the terms of a competing bid or proposal.

(4) (a) After receiving each offerer's best and final offer, the authority shall determine which proposal is most advantageous and shall award the contract to the person who offered it. The authority's determination shall be based only on price and the other evaluation factors specified in the request for bids or proposals. The authority shall state in writing the reason for the award and shall place the statement in the contract file.

(b) Following the award of the contract, the authority shall prepare a register of all bids or proposals.

Explanation: This amendment modifies the draft legislation in two ways. First, it applies the transparent and competitive process spelled out in the legislation to products as well as professional services. Second, it establishes $50,000 as the dividing line between informal procurement and the formal procurement procedures spelled out here.

24. On p. 33, lines 6-14, amend the draft as follows:

260.07 **Political activities. (1)** No <u>member of the board or</u> employee of the authority ay directly or indirectly solicit or receive subscriptions or contributions for any partisan political party or any political purpose while engaged in his or her official duties as <u>a member of the board or</u> an employee. No <u>member of the board</u> or employee of the authority may engage in any form of political activity calculated to favor or improve the chances of any political party or any person seeking or attempting to hold partisan political office while engaged in his or her official duties as <u>a member of the board or</u> an employee<u>. No employee of the authority may</u> engage in any political <u>or non-political</u> activity while not engaged in his or her official duties as an employee to such an extent that the person's efficiency during working hours will be impaired or that he or she will be

tardy or absent from work. Any violation of this section by a member of the board of the authority is an adequate grounds for removal from the board, and any violation of this section by an employee of the authority is an adequate grounds for dismissal.

Explanation: The proposed amendment ensures that members of the board of the authority, as well as its employees, refrain from inappropriate political activity while engaged in their roles as trustees carrying out the board's work.

25. On p. 34, after line 10, amend the draft by inserting the following new **SECTION 45** and by renumbering the current **SECTION 45** as **SECTION 46:**

SECTION 45. 260.9 of the statutes is created to read:

260.09 **Open meetings and records. (1)** The board, in conducting all meetings, shall comply with Wisconsin's Open Meetings Law. If the board creates any committees or subcommittees, those committees or subcommittees, in conducting all of their meetings, shall comply with Wisconsin's Open Meetings Law.

(2) The board, and all of its officers, agents, and employees, shall maintain records and make them available in a manner that complies with Wisconsin's Open Records Law.

Explanation: The proposed amendment ensures that the board complies with Wisconsin's Open Meetings and Open Records laws.