Wisconsin 1332 Draft Waiver Application

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Executive Overview

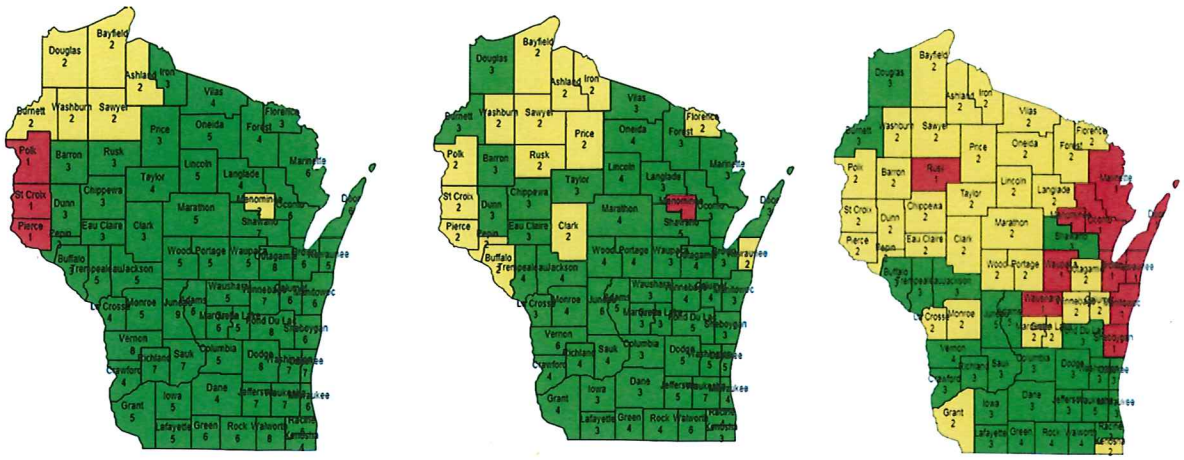
Request

The State of Wisconsin, through its Office of the Commissioner of Insurance (OCI), submits this 1332 State Innovation Waiver request to the United States Department of the Treasury (Treasury) and the Centers for Medicare and Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS). This request seeks waiver of Section 1312(c)(1) under Section 1332 of the Affordable Care Act (ACA) for a period of five years beginning in the 2019 plan year to develop and implement the Wisconsin Healthcare Stability Plan, a state based reinsurance program. This waiver will not affect any other provision of the ACA, but will result in a lower marketwide index rate, thereby lowering premiums and reducing federal payment of advance premium tax credits (APTC).

Basis for Request and Goal of Reinsurance Program

Prior to the ACA, Wisconsin had a thriving individual market. Consumers had over twenty plans to choose from which included national and local insurers, for-profit and non-profit insurers, and HMO's and PPO's. However, the Wisconsin health insurance market is fragile due to a number of unique variables that arose from implementation of the ACA. Over the past few years, Wisconsin has experienced more than $400 million in insurer losses (over the past three years alone); prohibitive rate increases; and insurers consistently leaving the market or reducing service areas. This market volatility has left consumers with unaffordable and dwindling plan options. For example, during the 2018 open enrollment period, approximately 75,000 enrollees were forced to choose a new insurer and thousands of consumers overall had only one or two insurer options on the Exchange in counties previously having three or more. Rate increases averaged 42% across the state and in some areas were as high as 105%. The maps below demonstrate the magnitude of this issue and the impact it has had across Wisconsin.

Figure 1. Number of Exchange Health Plans Available in Wisconsin Counties, 2016-2018



2016 **2017** **2018**

Green: 3 or More Insurers
Yellow: 2 Insurers
Red: 1 Insurer
Source: Wisconsin Office of the Commissioner of Insurance (OCI)

Establishing a state reinsurance plan through a 1332 waiver to cover a portion of claims falling within a defined dollar range is a step toward bringing certainty and stability back into the individual market.

Wisconsin's state-based reinsurance plan will:

Action	Benefit
Assist insurers in managing high risk enrollees and create a broader pool of people to absorb all other risk	Prevent more insurer exits and improve consumer access
Lower rates to keep consumers in the market and attract new entrants	Provide financial relief for those not eligible for subsidies and a step toward a healthier risk pool
Retain federal subsidies for individuals with incomes between 100% and 400% of the federal poverty level (FPL)	Ensure those with access to affordable coverage due to federal subsidies can keep it

Operation, Funding, and Impact of the Wisconsin Healthcare Stability Plan

Senate Bill 770, signed into law as 2017 WI Act 138 on February 27, 2018, establishes the Wisconsin Healthcare Stability Plan (WIHSP), to be administered by the Wisconsin Office of the Commissioner of Insurance (OCI), contingent upon approval of a 1332 Waiver. Total funding for the plan cannot exceed $200 million. The plan will be funded with a combination of state general purpose revenue (GPR) and federal pass through dollars. OCI is estimating an 85% federal pass through rate and therefore anticipates state GPR funding of approximately $30

million annually. However, funding language in the bill is structured as a sum sufficient appropriation, granting the state the needed flexibility to fund the $200 million program if the federal pass through funds differ from the anticipated amount. WIHSP will operate like a traditional reinsurance program by reimbursing qualifying individual health insurers for a percentage of an enrollee's claims between an attachment point and a cap. Act 138 establishes an attachment point of $50,000 and a reinsurance cap of $250,000 for plan year 2019. The Act allows for a coinsurance rate of between 50 and 80 percent. Based on actuarial modeling being performed by Wakely, WIHSP intends to establish a preliminary coinsurance rate of X for plan year 2019[1]. For future plan years, Act 138 requires OCI, after consulting with an actuarial firm, to design and adjust payment parameters with the goal of such things as stabilizing the individual market, increasing participation of insurers in the market, and considering federal funding available to the plan.

OCI estimates the WIHSP will reduce premiums in 2019 by 10.1%, from the projected baseline level if WIHSP was not in place.

Compliance with Section 1332

Waiver of Section 1312(c)(1) will not impact the comprehensiveness of coverage of the Wisconsin insurance markets. As noted above, the waiver will reduce premiums and increase affordability.

OCI and Wakely estimates that average total enrollment in the non-group market for ACA-qualified plans will fall from 227,000 in 2017 to 201,000 in 2018. Average premiums are estimated to increase by nearly 42 percent, from $517 per member per month (PMPM) in 2017 to $731 PMPM in 2018.

Wakely's actuarial analysis indicates that Wisconsin's non-group ACA-qualified enrollment would stabilize under the waiver at about 200,000 enrollees. Exchange enrollment would stabilize at about 182,000, and APTC enrollment at about 164,000. Wakely estimates that the proposed reinsurance program would reduce premiums by approximately 10 percent in 2019 and non-group enrollment would increase by about 0.8 percent relative to the baseline projection.

Due to the resulting reduction in individual health insurance premiums, including premiums for the second-lowest cost silver plan, the federal government will see a net reduction in spending of approximately $170 million in 2019 and approximately $168 million for each year through the first the five-years the waiver is in place.

Table 1: 2019 High-Level Guard Rail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2019)	Relative Premium Decrease of 8.5% to 12.4%
Comprehensiveness	No change to EHBs

[1] A preliminary reinsurance rate will be established in coming weeks, prior to the deadlines for insurers' 2019 rate filings. It is anticipated the coinsurance rate will fall between 50-60%, however, additional analysis is necessary.

Deficit Neutrality (2019)	Federal savings between $160 million and $184 million
Deficit Neutrality (10-year)	Federal savings each year of 10-year window

I. Wisconsin 1332 Waiver Request

The Wisconsin health insurance market is fragile. Operationalizing the ACA has resulted in: approximately $400 million in insurer losses over the past three years; prohibitive rate increases; and insurers consistently leaving the market or reducing service areas. This market volatility has left consumers with unaffordable and dwindling plan options. For example, during the 2018 open enrollment period, approximately 75,000 enrollees were forced to choose a new insurer and thousands of consumers overall had only one or two insurer options in counties previously having three or more. Rate increases averaged over 40 percent across the state and in some areas were as high as 105 percent.

Wisconsin seeks waiver of Section 1312(c)(1) under Section 1332 of the ACA for a five-year period beginning in the 2019 plan year to develop and implement a state reinsurance program. WIHSP is intended to further stabilize the individual market, reduce rates, and to encourage insurance companies to offer plans in more parts of the state.

Section 1312(c)(1) requires "all enrollees in all health plans ... offered by [an] issuer in the individual market ... to be members of a single risk pool." Waiver of the single risk pool requirement, to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate, will not affect any other provision of the ACA. Consideration of these payments will lower the marketwide index rate. A lower index rate will lower premiums for Wisconsin's second lowest-cost silver plan, which will reduce the overall APTC that the federal government is obligated to pay for Wisconsin subsidy-eligible consumers.

As fewer healthy people purchase coverage, the pool of people becomes sicker, older and higher risk, and, therefore, more costly to insure. Healthy lives are needed to balance risk so that consumers can regain access to affordable coverage. Without a reinsurance program, individual health insurance premiums in Wisconsin will continue to rise at an unsustainable rate and more healthy lives will be left out of the pool. Adverse selection will increase and the market will be headed toward a death spiral. Operating a state-based reinsurance plan will help reduce further erosion of this market and is a positive step toward stabilization. The WIHSP will result in decreased premiums and a means for insurers to manage high cost claims in a way that prevents them from leaving the market.

Table 2: 2019 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premiums	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-10.1%	+0.8%	$170 Million

Over the 10 year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in Table 3[2].

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit ($ millions)
Difference in APTCs	$1,768
Difference in Mandate Penalty	$0
Difference in User Fees	-$64
Difference in HIT	-$21
Estimated Net Federal Savings	$1,683

To establish the state's reinsurance program, Wisconsin seeks federal pass through funds in the amount the federal government would have otherwise paid in APTC absent consideration of the reinsurance payments in the marketwide index rate. By mitigating high-cost individual health insurance claims, the WIHSP will help to stabilize Wisconsin's individual market and make premiums more affordable. With the waiver and reinsurance program, Wisconsin anticipates that individual premiums, including premiums for second lowest cost silver plans, will be lower than they would have been without the waiver and reinsurance program by 10.1 percent in 2019, 9.6 percent in 2020, 9.1 percent in 2021, and 6.5 to 8.7 percent in the years between 2020 and 2028 if the waiver were extended for 10 years.

II. Compliance with Section 1332 Guardrails

A. Comprehensive Coverage Requirement (1332(b)(1)(A)):

Neither a waiver of Section 1312(C)(1) nor the WIHSP will affect covered benefits for Wisconsinites. Regardless of whether the waiver is granted, all Wisconsin-compliant plans will be required to provide coverage of essential health benefits. Similarly, the scope of benefits provided by other types of coverage such as Medicaid, Children's Health Insurance Program (CHIP), and grandfathered plans will not be impacted.

B. Affordability Requirement (1332(b)(1)(B)):

As stated in Section I, waiver of Section 1312(c)(1), together with the WIHSP, will make the cost of individual coverage lower each year than it would be without the waiver. The waiver will not affect cost sharing or the affordability of minimum essential coverage obtained through other means, such as Medicaid, CHIP, employer based insurance, or other types of coverage, and the same number of people will have access to such coverage as they would without the waiver. The

[2] Issuers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as a percent of Exchange premium. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. There is a moratorium on the fee in 2019. Individual mandate penalties were set to $0 effective for the 2019 benefit year.

waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower.

C. The Scope of Coverage Requirement (1332(b)(1)(C)):

As previously noted, waiver of Section 1312(c)(1), together with WIHSP, will reduce the cost of coverage in the individual market. In each year of the waiver, the lower cost of coverage will allow more Wisconsinites to purchase or maintain coverage in the individual market than without the waiver. Enrollment in the non-group market is expected to increase by 0.8 percent in 2019. As described in Appendix A, "the decrease in premiums is expected to produce an increase in enrollment relative to what Wisconsin would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function (as discussed previously). APTC enrollment is assumed to stay the same as 2018 since these members are generally unaffected by rate changes.[3] Consequently, the new enrollees are expected to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and/or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.[4]"Those who obtain minimum essential coverage through other means, such as Medicaid, CHIP, employer-based insurance, or other types of coverage, will have the same access to coverage as they would without the waiver. The waiver will have a positive effect on vulnerable people who buy coverage in the individual market since premiums will be lower.

D. The Federal Deficit Requirement (1332(b)(1)(D)):

As stated above, with the waiver and reinsurance program, Wisconsin anticipates that individual premiums, including premiums for second lowest cost silver plans, will be lower, net of the premium assessment, by 10.1 percent in 2019, 9.6 percent in 2020, and 9.1 in 2021. Premium reductions in future years, due to both the reinsurance program and improved morbidity, are shown in annual detail in Table 8 in Appendix A. Because APTC are tied to the second lowest cost silver plan, these lower premiums, the federal government will pay less in APTC. As Table 3, which follows, demonstrates, the federal government will save more than $1,683 million over this 10-year budget cycle.

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[3] This assumption does not preclude normal churn that occurs within the individual market. Normal churn, enrollees leaving for employer-sponsored insurance or enrollees joining the individual market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2019 as had coverage in 2018.

[4]https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit ($ millions)
Difference in APTCs	$1,768
Difference in Mandate Penalty	$0
Difference in User Fees	-$64
Difference in HIT	-$21
Estimated Net Federal Savings	$1,683

III. Description of the Wisconsin 1332 Waiver Proposal

A. Legislation [Senate Bill 770; Wisconsin Healthcare Stability Plan (WIHSP)]

Senate Bill 770 (SB 770) establishes the Wisconsin Healthcare Stability Plan (WIHSP), a $200 million state based reinsurance plan, contingent upon approval of a federal 1332 Waiver. SB 770 was signed into law by Wisconsin Governor Scott Walker on February 27, 2018 (becoming "Act 138"). One of the goals of Act 138 is to stabilize rates for individual health insurance plans and provide greater financial certainty to health insurers and health insurance consumers.

Act 138 requires the Office of the Commissioner of Insurance (OCI) to operate the WIHSP, including setting the attachment point, reinsurance cap, and coinsurance amounts. OCI must set these parameters after consulting with an actuarial firm, however, Act 138 sets the parameters for the 2019 plan year with a $50,000 attachment point and $250,000 reinsurance cap. OCI is required to set the coinsurance rate between 50 and 80 percent.

While Act 138 establishes key dates by which payment parameters must be set, insurers must be paid, and OCI must communicate specified information to insurers, OCI is given broad rule-making authority to address operational and other WIHSP needs.

B. The Wisconsin Healthcare Stability Plan (WIHSP) and Federal Pass Through Funding

The WIHSP is designed to improve Wisconsinites' access to affordable and comprehensive coverage. The goal of the reinsurance program is to manage the risk of high-cost claimants across the broader health insurance market, thereby lowering premiums for the individual market. In doing so, the reinsurance program should incentivize individual enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to Wisconsin residents, WIHSP will also reduce federal expenditures through lower APTC.

Because the amount of APTC available for eligible consumers is tied to the second-lowest-cost silver plan available through the federal Exchange, the amount the federal government will be required to pay in APTC will be reduced. Through this waiver request, Wisconsin seeks the amount of federal savings from these reduced APTC payments. Wisconsin seeks these funds to offset a majority of the costs associated with the reinsurance program.

The WIHSP will reimburse individual health insurers for a proportion (co-insurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, as mentioned under previous sections, Wisconsin will set the reinsurance cap at $250,000 and the attachment point at $50,000. OCI will establish the final co-insurance rate based on the latest available claims data before insurers' rates for 2019 are filed, so that total estimated reinsurance payments match the funding available. As required by Act 138, if the amount available for expenditure for the WIHSP is not anticipated to be adequate to fully fund the payment parameters set for the upcoming plan year, OCI must allow insurers to adjust their rate filings based on any adjustment made to the final payment parameters for the applicable benefit year. If it is the case that funding is not available to make all reinsurance payments in a benefit year, OCI will make reinsurance payments in proportion to the eligible heath insurer's share of aggregate individual health plan claims costs eligible for reinsurance payments during the applicable benefit year.

IV. Waiver Implementation Timeline

02-27-18:	Legislation authorizing the Wisconsin Healthcare Stability Plan (WIHSP) is signed into law
03-14-18:	Public comment period begins
03-14-18:	Public hearing in LaCrosse
03-15-18:	Public hearings in Chippewa Falls and in Marshfield
03-16-18:	Public hearings in Wausau and Green Bay
03-24-18:	Public hearing in Milwaukee
04-04-18:	Public hearing in Madison
04-06-18:	Tribal consultation held in Green Bay
04-14-18:	Public comment period ends
04-20-18:	1332 Waiver application is submitted to the federal government
06-04-18:	OCI issues a request for proposals (RFP) for actuarial expertise needed to set 2020 payment parameters[5]
06-04-18:	OCI issues RFP for claims administrative services[6]
06-05-18:	Federal government determines the waiver application is complete/federal comment period begins
06-05-18:	Administrative rules introduced
07-02-18	Insurer rate submission; one for the 2019 plan year assuming WIHSP in place using Act 138 parameters [rates that will be filed with the federal government]; and an indication of rates assuming no WIHSP
07-02-18:	Office of the Commissioner of Insurance (OCI) staffs the WIHSP; Director of the WIHSP hired
07-04-18:	Federal comment period ends
08-01-18:	Administrative rules for WIHSP finalized
09-04-18:	Federal government grants 1332 Waiver/ funds for WIHSP[7]

[5] Procurement for such services can take between six and twelve months. Actuarial expertise/work product is needed prior to March 30, 2019; the date OCI must release 2020 payment parameters. Vendor selection will be contingent upon 1332 waiver approval.

[6] Vendor selection will be contingent upon 1332 waiver approval.

[7] Approval date assumes HHS/CMS does not take the full 180 day review period before making a determination.

09-04-18:	OCI/WIHSP confirm payment parameters for the 2019 benefit year[8]
01-01-19:	First plan year WIHSP is in place
01-07-19:	OCI/WIHSP awards actuarial and claims administrator vendor contracts
03-04-19:	OCI holds six-month public forum required by 45 CFR 155.1320(c)
03-31-19:	Insurers submit eligible claims data to OCI for the WIHSP
04-01-19:	OCI/WIHSP will provide each eligible insurer with the calculation of total amounts of reinsurance payment requests.
03-30-19:	No later than this date OCI/WIHSP sets the payment parameters for the 2020 benefit year
08-31-19:	Insurers submit eligible claims data to OCI for WIHSP
07-01-19:	OCI/WIHSP will provide each eligible insurer with the calculation of total amounts of reinsurance payment requests
07-01-19	OCI/WIHSP shall adjust the payment parameters if it is not anticipated that the amount available for the program will be adequate to fully fund the payment parameters set earlier in the year (those set no later than March 30)
07-25-19	Insurer rate submission; one for the 2020 plan year assuming WIHSP in place [rates that will be filed with the federal government] and an indication of rates assuming no WIHSP
09-04-19:	OCI/WIHSP holds annual public forum required by 45 CFR 155.1320(c)
09-30-19:	Insurers submit eligible claims data to OCI for WIHSP
10-01-19:	OCI/WIHSP will provide each eligible insurer with the calculation of total amounts of reinsurance payment requests
12-31-19:	Insurers submit eligible claims data to OCI for WIHSP
01-03-20:	OCI/WIHSP will provide each eligible insurer with the calculation of total amounts of reinsurance payment requests
03-01-20:	Federal government funds WIHSP for 2019 plan year
06-30-20:	No later than this date, OCI/WIHSP Director will notify eligible health insurers of reinsurance payments to be made for the 2019 plan year
07-01-20:	General purpose revenue (GPR) funds appropriated to WIHSP
07-02-20:	Insurer rate submission; one for the 2020 plan year assuming WIHSP in place [rates that will be filed with the federal government]; and an indication of rates assuming no WIHSP
08-15-20:	No later than this date, OCI/WIHSP will disburse all reinsurance payments to eligible insurers
09-15-20:	OCI/WIHSP submit required post award annual report

V. Additional Information and Reporting

A. Administration Burden

Waiver of Section 1312(c) will cause minimal administrative burden and expense for Wisconsin and for the federal government. The waiver will cause no additional administrative burden to

[8] 2019 Payment parameters are detailed in 2017 WI Act 138 and are outlined in this waiver application. After final waiver approval, OCI will either confirm the payment parameters approved in the application as submitted or, if OCI was required to modify the parameters as a condition of waiver approval, OCI will ensure insurers are aware of those modifications.

employers and individual consumers because Section 1312(c) does not relate to the administrative functions or requirements typically undertaken by employers or individuals. Individual health insurers also will see no additional administrative burden.[9]

OCI has the resources and staff necessary to absorb the following administrative tasks that the waiver will require the state to perform:

- Administer the Wisconsin Healthcare Stability Plan
- Distribute federal pass through funds
- Monitor compliance with federal law
- Collect and analyze data related to the waiver
- Perform reviews of the implementation of the waiver
- Hold annual public forums to solicit comments on the progress of the waiver
- Submit annual reports (and quarterly reports, if ultimately required) to the federal government

The waiver will require the federal government to perform the following administrative tasks:

- Review documented complaints, if any, related to the waiver
- Review state reports
- Periodically evaluate the state's 1332 waiver program
- Calculate and facilitate the transfer of pass through funds to the state

OCI believes the above administrative tasks are similar to other administrative functions currently performed by the federal government, so that their effect is insignificant. Waiver of Section 1312(c)(1) does not necessitate any changes to the Federally Facilitated Marketplace and will not affect how APTC or cost-sharing reduction payments are calculated or paid.

B. Impact on Residents Who Need to Obtain Healthcare Services Out-of-State

Wisconsin shares borders with Minnesota, Iowa, Illinois and Michigan. Insurer health plans covering individuals living in border counties generally include providers from the neighboring state in their networks. Granting this waiver request will not affect insurer networks or service areas that provide coverage for services performed by out of state providers.

C. Ensuring Compliance, Waste, Fraud, and Abuse

OCI is responsible for regulating and ensuring regulatory compliance and monitoring the solvency of all insurers. OCI preforms market conduct analysis, financial examinations and investigates consumer complaints. OCI also manages the Injured Patients and Families Compensation Fund and the State Life Insurance Fund. Until this year, OCI operated the Local Government and Property Fund (*Legislature ended the program*). OCI will apply the same expertise used in managing other funds to operating the WIHSP.

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[9] Individual health insurers will experience additional administrative burden and associated expense as a result of the WIHSP; however, the waiver itself will result in no additional administrative burden or cost, and the monetary benefit from the WIHSP will far exceed any resulting administrative expense.

Act 138 sets accounting, reporting, and audit requirements for WIHSP. However, OCI can set forth additional requirements and detail by administrative rule. OCI must keep an accounting for each benefit year of all of the following:

- Funds appropriated for reinsurance payments and administrative and operational expenses
- Requests for reinsurance payments made to eligible health carriers
- Administrative and operational expenses incurred for the WIHSP

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 OCI must make available to the public a report summarizing the WIHSP's operations for each benefit year by posting the summary on the office's Internet site.

The WIHSP is subject to audit by the Legislative Audit Bureau (LAB). OCI must ensure that its contractors, subcontractors, or agents cooperate with any audit of the WIHSP performed by LAB.

D. State Reporting Requirements and Targets

OCI will assume responsibility for the reporting requirements of 45 CFR 155.1324, including the following:

- Quarterly reports [45 CFR 155.1324(a)]: To the extent required, OCI will submit quarterly reports, including reports of ongoing operational challenges, if any, and plans for, and results of, associated corrective actions.
- Annual reports [45 CFR 155.1324(b)]: OCI will submit annual reports documenting the following:
  (1) The progress of the waiver.
  (2) Data, similar to that contained in Attachment 1, on compliance with Section 1332(b)(1)(B) through (D) of the ACA.
  (3) Modifications, if any, to the essential health benefits for compliance with Section 1332(b)(1)(A) of the ACA.
  (4) The premium for the second lowest cost silver plan under the waiver and an estimate of the premium as it would have been without the waiver for a representative consumer in each rating area.
  (5) A summary of the annual post-award public forum required by 45 CFR 155.1320(c) together with a summary of action taken in response to public input.
  (6) Any additional information required by the terms of the waiver.

To the extent that quarterly reporting is required under 45 CFR 155.1324(a), OCI recommends that such reporting starts no sooner than April 1, 2021, in order to provide some experience with

the program about which to report. OCI will submit and publish annual reports by the deadlines established in 45 CFR 155.1324(c) or the deadlines established by the terms of the waiver.

VI. Supporting Information and Miscellaneous

A. 45 CFR 155.1308(f)(4)(i) - (iii)

The supporting information required by 45 CFR 155.1208(4)(i) - (iii), including the actuarial analyses and certifications, the economic analyses, the detailed deficit neutral 10-year budget plan, and the data and assumptions demonstrating that the proposed waiver is in compliance with 1332(b)(1)(A) - (B) are found in Attachment 1.

VII. Public Comment and Tribal Consultation

A. Public Comment

[Description of public comment and tribal consultation process]

[Attach comments received as a separate attachment to the application]

B. Tribal Consultation

[Describe tribal consultation outreach and meeting notes]

Attachments

Attachment 1

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Section 1332 State Innovation Waiver
Actuarial and Economic Analysis

DRAFT

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Introduction

The individual health insurance market in the state of Wisconsin ("Wisconsin") has shown symptoms of destabilization in recent years. Insurers have left the market and reduced service areas, plan designs are limited, insurers have lost approximately $400 million over the last three years, and the state experienced rate increases in excess of 30% in 2018. In order to mitigate further potential destabilization, Wisconsin is submitting a Section 1332 State Innovation Waiver ("1332 waiver" or "waiver"). The Affordable Care Act (ACA) permits states to waive certain provisions of the ACA in order to increase access to affordable coverage. However, in order for both of the Secretaries of Health and Human Services (HHS) and Treasury to approve of the waiver, the state must complete an application in which it demonstrates that it has met the regulatory requirements.

Pursuant to 45 CFR 155.1308(f)(4)(i)-(iii), in order for Wisconsin's 1332 waiver to be approved, the state must demonstrate that the waiver does not interfere with the four "guard rails". The four guard rails are defined as:

1. Coverage (there must be at least a comparable number of individuals with coverage under the waiver);
2. Affordability (waiver must not increase out of pocket spending including premiums and cost sharing);
3. Comprehensiveness (the waiver should not decrease the number of individuals with coverage that meets the essential health benefits (EHB) benchmark); and
4. Deficit neutrality (the waiver should not increase the federal deficit).

The waiver, as proposed, would reduce premiums through the introduction of a state-based reinsurance program starting in 2019. The reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Wisconsin has set the attachment point at $50,000, the reinsurance cap at $250,000, and allows for coinsurance rates between 50 and 80 percent.

The reinsurance program will be funded, contingent on approval of the 1332 waiver, through a sum sufficient state appropriation not to exceed $200 million for the 2019 plan year.

The goals of the reinsurance program are to remove the volatility of high cost claimants from being solely the risk of any one insurer as well as to lower premiums for the individual market in total (as the reinsurance funding will come from sources outside the individual market). In doing

so, the reinsurance program would incentivize enrollees to join or remain in the market, encourage insurer participation, and reduce overall instability. In addition to providing lower premiums to residents of Wisconsin, the reinsurance program would also reduce federal outlays through lower premium tax credits.

As part of its 1332 waiver, Wisconsin is requesting federal funds as a way of offsetting some of the costs incurred by the reinsurance program. Wisconsin's reinsurance program will reduce premiums for those purchasing insurance coverage in the individual market. It will also reduce the amount of Advance Premium Tax Credits (APTCs) Wisconsinites receive over the next ten years. APTCs are subsidies for eligible enrollees that can be used to reduce the cost of premiums for plans purchased through the Exchange. The amount of APTCs available for eligible consumers are benchmarked to the second lowest cost silver plan (SLCSP) available on the Exchange. If premiums are reduced (including the SLCSP), then the amount the Federal Government will be required to pay in APTCs will also be reduced.

This report demonstrates that the savings on aggregate APTC amounts exceed lost federal revenue that may result from the reinsurance program. Furthermore, the reinsurance program will not reduce but rather would improve Wisconsinites' access to affordable and comprehensive coverage. The waiver requests that Wisconsin receive the amount of federal savings from APTCs, net of other costs, as a result of the reinsurance program.

The state of Wisconsin retained Wakely Consulting Group, LLC ("Wakely"), through Horizon Government Affairs, to analyze the potential effects of a state-based reinsurance program on the 2019 individual Affordable Care Act (ACA) market. This document has been prepared for the sole use of Wisconsin. Wakely Consulting Group, LLC (Wakely), understands that the report will be made public and used in the 1332 waiver process. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Using the information in this report for other purposes may not be appropriate.

This actuarial report is a supplement to Wisconsin's 1332 waiver report. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Other sections of the waiver contain the non-actuarial portions of the 1332 waiver requirement. Reliance on this report should include a review of the full report by qualified individuals.

Analysis Results

As described previously, the four guard rails of an approved 1332 waiver application are: 1) Coverage Requirement; 2) Affordability Requirement; 3) Comprehensiveness Requirement; and 4) Deficit Neutrality.

Wakely's analysis estimated that the waiver meets each of the four guard rails not only in 2019 but in each subsequent year over the 10-year window. The high-level 2019 guard rail results are shown in Table 1.

Table 1: 2019 High-Level Guard Rail Results

Guardrail	Effect of Waiver
Coverage	Increase in enrollment
Affordability (2019)	Relative Premium Decrease of 8.5% to 12.4%
Comprehensiveness	No change to EHBs
Deficit Neutrality (2019)	Federal savings between $160 million and $184 million
Deficit Neutrality (10-year)	Federal savings each year of 10-year window

Coverage, Affordability, and Comprehensiveness

The reinsurance program is expected to decrease premiums in the non-group market. The reduction in premiums should increase overall coverage. Existing research from Congressional Budget Office (CBO)[1] as the Council of Economic Advisors[2] has noted that premium decreases should result in enrollment increases. As the reinsurance program has no impact on other cost-sharing, the decreased premiums also improves affordability for consumers. Similarly, the reinsurance program would have no effect on the comprehensiveness of coverage. EHB requirements will not be affected by the reinsurance program. Individuals purchasing coverage in the non-group market would have the same benefits with the reinsurance program as they would without it.

Deficit Impact

The following tables display the impact of the reinsurance program on Wisconsin's individual market both for 2019 and for the 10-year deficit window. Based on the best estimate assumptions, in 2019, the waiver reduces premiums by -10.1%[3], increases non-group enrollment by 0.8%, and creates $170 million in federal savings (which incorporates APTC savings net of other federal

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[1] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf
[2]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[3] The premium impacts shown throughout the report represent how much lower premiums would be due to reinsurance relative to what they otherwise would have been in 2019. They do not show 2019 premium changes relative to 2018.

revenue). These results are shown in Table 2. The results are similar for years 2020 to 2028 as is shown in Appendix C.

Table 2: 2019 Impact of Waiver on Premium, Enrollment, and Federal Deficit

	Premiums	Non-Group Enrollment	Federal Savings
Effect of Reinsurance	-10.1%	+0.8%	$170 Million

Over the 10-year window, the reinsurance program provides savings to the Federal Government due to APTC savings net of other federal revenues. The details of the federal savings over the 10-year window are shown in Table 3[4].

Table 3: 10-Year Deficit Impact of Reinsurance Program

Category of Impact	Impact to Federal Deficit ($ millions)
Difference in APTCs	**$1,768**
Difference in Mandate Penalty	$0
Difference in User Fees	-$64
Difference in HIT	-$21
Estimated Net Federal Savings	**$1,683**

Data and Methodology

The following steps were taken to estimate the impact of a state-based reinsurance program on Wisconsin's individual market both for 2019 and for the 10-year deficit window.

1. Wakely's model incorporates 2016, 2017 and emerging 2018 experience as base data, which was provided by Wisconsin insurers.

   Wakely sent a data call to all Wisconsin insurers that offered individual market ACA-compliant plans in 2017 or 2018. The data call requested full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates. The 2017 premiums and enrollment were summarized to create a baseline

[4] Issuers that utilize the Healthcare.gov platform are assessed a fee by the Federal government. This fee is calculated as percent of Exchange premium. The HIT is a fee imposed on each covered entity that provides health insurance for US health risks. There is a moratorium on the fee in 2019. Individual mandate penalties were set to $0 effective for the 2019 benefit year.

picture of Wisconsin's market. The 2018 enrollment, APTC, and premium data were adjusted to account for expected attrition to estimate average enrollment. The summarized amounts are shown in Table 4.

Table 4: 2017 to 2019 Baseline Average Enrollment and Premium Data / Estimates

Baseline	2017	2018	2019
Average Annual Enrollment			
Total Non-Group Enrollment	227,072	200,946	198,927
Exchange Enrollment	201,344	182,591	181,574
APTC Enrollment	163,988	163,957	163,957
Non-APTC Exchange Enrollment	37,356	18,635	17,618
Off-Exchange Enrollment	25,729	18,355	17,353
Total Non-APTC Enrollment	63,084	36,990	34,970
Per Member Per Month (PMPM) Amounts			
Total Non-Group Premium PMPM	$516.01	$731.06	$840.82
Exchange Premium PMPM	$517.87	$740.06	$851.17
Gross Premiums PMPM for APTC Members	$533.48	$770.09	$885.71
Net Premiums PMPM for APTC Members	$130.67	$121.50	$122.71
APTC PMPM	$402.81	$648.59	$763.00
Total Annual Dollars			
Total Non-Group Premiums	$1,406,063,039	$1,762,851,634	$2,007,150,393
Total APTCs	$792,661,152	$1,276,096,520	$1,501,187,644

2. The 2019 enrollment, premium, and APTC amounts were estimated using 2017 and February 2018 insurer information submitted to Wakely, as well as 2017 data from the Center for Medicaid and Medicare Services (CMS).

    a. The state average premium was based on the 2018 insurer information. The 2018 average premiums were increased by the average estimated 2019 rate increase, which would include increases to account for trend, market morbidity changes, lower premiums due to the delay in the health insurance tax (also known as the health providers fee or the HIT), and an overall uncertainty factor. Further details are included in Appendix A.

b. To estimate the average 2019 APTC amounts, Wakely used the emerging 2018 APTC information from Wisconsin insurers including APTC amounts, gross premiums for those with APTCs, and net premiums (gross premiums – APTCs) for those with APTCs. We then inflated gross premiums for APTC enrollees by the estimated 2019 premium increase. Net premiums were increased by 1% from 2018 to 2019 as an approximation for APTC indexing. The 2019 average gross premium is then reduced by the 2019 average net premium (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts.

c. The 2019 individual market enrollment was calculated using 2017 and 2018 data from CMS and Wisconsin insurers and adjusted to account for changes in enrollment due to net attrition throughout 2018 and expected 2019 premium changes, as discussed in Appendix A. Given the high proportion of individuals with APTCs relative to total ACA non-group market and following discussions with Wisconsin, for our best estimate, we assumed that the effective repeal of the mandate would not impact Wisconsin's enrollment. To the extent that experience deviates from this assumption, the results of this analysis will be impacted.

The estimated 2019 information is shown in Table 5.

3. To estimate the effects of the reinsurance program, Wakely assumed that $200 million dollars would be spent to reduce premiums in 2019. None of the funds were assumed to cover administrative costs for Wisconsin to operate the program. The best estimate assumptions resulted in a reduction in premiums of 10.1% due to the reinsurance program and resulting change in morbidity.

Table 5: Projected 2019 Average Enrollment and Premium Amounts, After Reinsurance

After Reinsurance	
Reinsurance Funding	$200,000,000
Reduction in Premiums (Reinsurance Funding)	-10.0%
Reinsurance Assessment	0.0%
Reduction in Premiums (Improved Morbidity)	-0.2%
Total Non-Group Premium PMPM	$755.54
Exchange Premium PMPM	$764.84
APTC PMPM	$673.16
Change in Total Non-Group Enrollment	0.8%
Total Non-Group Enrollment	200,430

After Reinsurance	
Exchange Enrollment	182,331
APTC Enrollment	163,957
Total Premiums	$1,817,186,170
Total APTCs	$1,324,431,253

4. Enrollment was re-estimated with the lower post-reinsurance premium, using an enrollment function (Appendix A contains additional information regarding the enrollment function), to calculate a final individual market average enrollment per scenario. The results for the best estimate scenario are shown in Table 5.

5. Given the enrollment with the reinsurance program is estimated to be higher than without the reinsurance program, Wakely estimated the impact to the morbidity of the market due to the implementation of the reinsurance program.

    a. A health reform study from Massachusetts[5] indicated that enrollees who leave the market have costs that are approximately 73% compared to those who remain. This relationship was applied to enrollees who remain in the market due to the lower premiums caused by the reinsurance program but would have left without the implementation of the reinsurance program.

    b. The result is an additional 0.2% reduction in average costs due to the improved morbidity of the covered population from the lower premiums under the reinsurance program.

    c. Applying the additional 0.2% reduction to the 10.0% reduction in premiums (from the $200 million in reinsurance funding results in an overall premium reduction estimate of 10.1% (under the best estimate scenario). The results of the best estimate can be seen in Table 5.

    d. After reducing the premium impact by an additional 0.2%, Wakely again applied the enrollment function (described in item 4). It resulted in an additional 0.0% increase in enrollment, causing the total enrollment growth from the baseline to be 0.8%. No further iterations were done based on the relationship between change in enrollment and change in morbidity based on the negligible results of this iteration.

[5]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

6. The following were the assumptions incorporated for the 10-year estimates:

    a. Premiums were trended using National Health Expenditure Data from CMS[6]. In 2020, the end of the HIT moratorium was estimated to increase premiums an additional 1.2% based on 2018 rate filing information.

    b. The individual market enrollment was assumed to have reached steady state in 2019.

    c. In 2020, and future years, total reinsurance funding was set equal to $200 million.

The results of these assumptions, such as enrollment (both in total and various distributions), changes to the SLCSP, and impact on the federal deficit are discussed in Appendix A and Appendix C.

Scenario Testing

Wakely performed scenario testing which primarily involved changing the enrollment and premium assumptions for 2019. These assumptions were chosen for scenario testing as they are significant drivers of the results of the analysis. We tested for a scenario (Scenario 2) in which the effective repeal of the individual mandate had a large impact (which resulted in less enrollment and higher premiums) and a scenario (Scenario 3) in which individual mandate repeal had less of an impact on enrollment and premiums (but still has a significant effect). The high mandate repeal impact scenario corresponds to the impact of the CBO projections and the low mandate repeal impact corresponds to the impact of OACT based projections. Scenario 4 tested for a scenario in which enrollment was flat relative to 2018 and premium growth was low (second lowest cost silver premiums were also increased at a lower rate). Scenario 5 enrollment was equal to Scenario 1 but premiums were much higher. Finally, we tested a scenario (scenario 6) in which enrollment was low (similar to Scenario 2) but premiums increases were larger. Scenarios 5 and 6 also assumed that the morbidity of the members leaving the market is even healthier than that assumed in the other scenarios. Further details regarding the scenario testing can be found in Appendix A and Appendix C.

The high-level results of the scenario testing are shown in Table 6. Although a variety of alternative scenarios were tested, the basic conclusions did not alter significantly from the best estimate scenarios.

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[6] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ - Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 6: High-Level Results of Scenario Testing

Scenario	1 – Best Estimate	2	3	4	5	6
Description	No Mandate Impact	High Mandate Impact	Low Mandate Impact	Scenario 1 with Conservative Assumptions (Overall Low)	Scenario 1 with Aggressive Assumptions	Scenario 2 with Aggressive Assumptions (Overall High)
Enrollment	Small Decrease (formula driven)	Mandate Impact - CBO	Mandate Impact - OACT	Flat	Small Decrease (formula driven)	Mandate Impact - CBO
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Low Increase	High Increase	High Increase
Total Reduction in Premiums	-10.1%	-12.4%	-11.5%	-10.9%	-8.5%	-11.1%
Estimated Net Federal Savings	$170,415,512	$182,095,340	$177,464,670	$160,048,941	$173,848,362	$183,936,996

Appendix A
Data and Methodology

2019 Baseline Enrollment and Premium Estimates

To create the baseline estimates, Wakely completed the following steps:

1. Wakely sent a data call to all Wisconsin carriers that offered individual market ACA-compliant plans in 2017 or 2018. The data call requested full year 2017 and emerging 2018 enrollment, premium, and APTC information, which was used to inform the baseline estimates.

   Wakely then used the 2017 insurer data to calculate average enrollment and average premium. Wakely used the 2018 insurer data to identify the 2018 experience as February 2018 in terms of enrollment, state average premium, average Exchange premium, average APTC amount, gross premiums for individuals with APTC, and net premium for individuals with APTC. The data was compared to CMS reports to confirm consistency.

2. Using the 2017 CMS Open Enrollment PUF and insurer submitted 2017 data, estimates were made to approximate the average 2018 experience.

3. For the best estimate, overall enrollment in 2019 was estimated using a non-linear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function).[7] The function computes expected enrollment change based on premium rate increases and the portion of the market that is not receiving subsidies. The resulted in an enrollment decrease of 1.0% compared to 2018. 2019 APTC enrollment was assumed to be consistent with 2018 enrollment, as these enrollees would not experience a net premium change. The result of these two assumptions is that enrollment changes would occur among the unsubsidized portion of the non-group market. The changes in enrollment were distributed pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented.

4. For 2019, premiums were estimated using the 2018 insurer submitted data. The average 2018 premium was increased by 15% to account for all rating factors such as trend, insurer uncertainty, change in morbidity due to mix changes, and to account for the health insurance tax delay for the 2019 benefit year.

5. To estimate 2019 APTC PMPMs, we used 2018 Wisconsin insurer data to calculate the average net premium among APTC enrollees (that is the actual amount APTC enrollees pay). We increased the 2019 required contribution (i.e., net premium) to conform with the indexing of the contribution rate. We increased it 1% annually from 2018 to 2019. We then

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[7]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

inflated gross premiums for APTC enrollees (the 2018 APTC amounts plus net premiums) by the 2019 estimated premium increase (15%). This new gross premium amount is reduced by the net premium amount (since APTC enrollees share of premiums is capped based on their respective household income) to calculate the 2019 APTC PMPM amounts. These assumptions, in totality, were used to generate the baseline estimates shown in Table 4.

2019 Waiver Effects

The impact of the $200 million in reinsurance funding (as discussed previously) as a reduction to premiums was estimated by dividing the total reinsurance funding amount of $200 million by the total estimated 2019 baseline individual market. This resulted in an approximate 10.0% reduction to premiums. In addition, an adjustment was made to account for younger, healthier members remaining covered due to the implementation of the reinsurance program. This reduced premium another 0.2%. The premium adjustments due to reinsurance were made equally to Gross premiums for individuals with APTC (to calculate APTC), on-Exchange premiums, and off-Exchange premiums.

The decrease in premiums is expected to produce an increase in enrollment relative to what Wisconsin would experience without the reinsurance program. Enrollment changes were estimated using the CEA take-up function (as discussed previously). APTC enrollment is assumed to stay the same as 2018 since these members are generally unaffected by rate changes.[8] Consequently, the new enrollees are expected to be above 400% FPL. These new enrollees were allocated pro rata between on-Exchange and off-Exchange by the share of unsubsidized enrollment that on-Exchange enrollees represented. It is likely that enrollees who stay in the market due to the implementation of reinsurance will be healthier and/or younger than the enrollees who will be in the market regardless of whether there is a reinsurance program.[9] These results were discussed previously and are shown in Table 5.

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[8] This assumption does not preclude normal churn that occurs within the individual market. Normal churn, enrollees leaving for employer-sponsored insurance or enrollees joining the individual market who previously had coverage in Medicaid, would continue. The assumption merely assumes in aggregate that a similar number of APTC enrollees would have coverage in 2019 as had coverage in 2018.

[9]https://www.brookings.edu/blog/up-front/2017/02/08/new-data-on-sign-ups-through-the-acas-marketplaces-should-lay-death-spiral-claims-to-rest/

Alternative Scenarios

Wakely estimated five additional 2019 scenarios to analyze the robustness of the initial 2019 findings. The following were the enrollment scenarios that were modeled:

- Scenario 1: 2019 enrollment was lower than 2018 enrollment, as estimated by the CEA take-up function. Those that left the market were estimated to have a morbidity of 0.73.[10] Average premium rates were estimated to be 15% higher than 2018.

- Scenario 2: In this scenario, we assumed that no mandate is enforced in Wisconsin in 2019 and the effect would be high. The initial baseline was the previous Scenario 1. Additional enrollment losses due to the mandate are estimated using the Center for American Progress' state level estimates of the CBO enrollment losses.[11] These losses were estimated for the 2025 year, so an adjustment, following the CBO's estimates for 2019[12], was made to estimate Wisconsin specific enrollment attrition in 2019 due to the loss of the mandate. The result of the mandate loss and resulting premium increases could cause additional enrollment losses, especially given the potential of alternative non-ACA products if regulations change for short-term limited duration plans and associations plans. While initial premium increases correspond to Scenario 1, the additional premium increases due to the smaller individual market and resulting morbidity increase results in an overall estimated 23% premium increase in 2019.

- Scenario 3: In this scenario, we continue to assume that the effective repeal of the mandate in 2019 will have an effect, but the impact is lower in this scenario. There is considerable uncertainty on the exact effects of the mandate repeal. Consequently, we used a different benchmark than the high scenario. Enrollment losses due to the mandate are estimated using the Center for American Progress' state level estimates but then Wisconsin-specific enrollment attrition in 2019 due to the loss of the mandate was reduced to match the nationwide total enrollment losses as estimated by the CMS Office of the Actuary.[13] While CBO estimated a nationwide loss of 3 million enrollees in 2019, the Office

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[10]https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf

[11] https://www.americanprogress.org/issues/healthcare/news/2017/12/05/443767/estimates-increase-uninsured-congressional-district-senate-gop-tax-bill/

[12] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

[13] Please note the while the updated National Health Expenditure estimated an overall reduction of enrollment in the individual due to the mandate loss at 2 million as of 2021it did not provide point estimates for 2019. As such we rely on an earlier OACT estimate found here for 2019 effects

of the Actuary estimated an ultimate loss of 2 million enrollees due to the mandate repeal. The result of the mandate loss for this scenario and resulting premium increases could cause additional enrollment losses, especially given the potential of alternative non-ACA products if regulations change for short-term limited duration plans and associations plans. While initial premium increases correspond to Scenario 1, the additional premium increases due to the smaller individual market and resulting morbidity increase results in an overall estimated 20% premium increase in 2019.

- Scenario 4: This scenario is the most conservative scenario related to estimated Federal savings and uses Scenario 1 as the starting point. Enrollment was estimated to be flat relative to 2018. Premium growth was set to be around 6%. Finally, the second lowest cost plan (SLCP) was assumed to grow at a slower rate than the state average premium by 5%.

- Scenario 5: This scenario was estimated as a more aggressive scenario assuming a starting enrollment assumption similar to Scenario 1. Average premium rate increases were assumed to be high at 40%. Furthermore, we estimated that the morbidity of those leaving the market was low (0.62 relative cost compared to those who stay) which approximately corresponds to our calculation of CBO's estimates of those leaving the individual market due to the mandate. Enrollment was estimated using the CEA take-up function.

- Scenario 6: This scenario is the most aggressive scenario related to estimated Federal savings and Scenario 2 is the starting point for this scenario. In this scenario the effect of the mandate repeal was assumed to be high, corresponding to the effects of the CBO model. Furthermore, insurer uncertainty and other factors were assumed to be high resulting in a "high" premium increase of 40%. Similar to Scenario 5, we estimated that the morbidity of those leaving the market was low (0.62 relative cost compared to those who stay) which approximately corresponds to our calculation of CBO's estimates of those leaving the individual market due to the mandate.

For each of the scenarios, the same reinsurance methodology was applied as was used in the baseline scenario: $200 million in reinsurance funding was applied to the individual market and enrollment was re-estimated using the CEA take-up function. Each scenario produced a decrease in the state average premiums PMPM in 2019 between 8.5% and 12.4%. In each scenario, the lower premiums resulted in more enrollees in the individual market. Finally, in each scenario, the combined lower premiums (including decreased APTC PMPMs) resulted in fewer Federal dollars

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https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf

being spent in 2019 as a result of the reinsurance program. The detailed results of the scenario testing are shown in Table 7.

Scenario 1 is the best estimate scenario including reactive enrollment and premiums to match Wisconsin's recommended premium increases. This scenario was used for the 10-year economic analysis.

Table 7: Summary of Alternative Scenario Results for 2019

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Small Decrease (formula driven)	Mandate Impact - CBO	Mandate Impact - OACT	Flat	Small Decrease (formula driven)	Mandate Impact - CBO
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Low Increase	High Increase	High Increase
Baseline						
Total Non-Group Enrollment	198,927	150,567	166,687	200,946	196,164	149,158
Exchange Enrollment	181,574	142,010	155,198	182,591	180,182	141,072
APTC Enrollment	163,957	133,322	143,534	163,957	163,957	132,863
Total Non-Group Premium PMPM	$840.82	$899.43	$879.00	$772.85	$1,023.23	$1,023.82
Exchange Premium PMPM	$851.17	$910.50	$889.82	$782.36	$1,035.83	$1,036.43
APTC PMPM	$763.00	$824.73	$803.22	$650.69	$955.15	$955.77
Total Non-Group Premiums	$2,007,150,393	$1,625,086,637	$1,758,224,309	$1,863,616,233	$2,408,656,216	$1,832,533,889
Total APTCs	$1,501,187,644	$1,319,460,293	$1,383,469,591	$1,280,224,229	$1,879,234,461	$1,523,837,477
After Reinsurance						
Reinsurance Funding	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000
Reduction in Premiums (Reinsurance Funding)	-10.0%	-12.3%	-11.4%	-10.7%	-8.3%	-10.9%
Reinsurance Assessment	0.0%	0.00%	0.00%	0.00%	0.00%	0.00%
Reduction in Premiums (Improved Morbidity)	-0.2%	-0.16%	-0.18%	-0.22%	-0.22%	-0.19%
Total Premium Impact	-10.1%	-12.45%	-11.54%	-10.93%	-8.50%	-11.08%
Total Non-Group Premium PMPM	$755.54	$787.46	$777.61	$688.36	$936.25	$910.34
Exchange Premium PMPM	$764.84	$797.15	$787.18	$696.83	$947.77	$921.54
APTC PMPM	$673.16	$706.78	$696.41	$566.14	$863.52	$836.23

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Small Decrease (formula driven)	Mandate Impact - CBO	Mandate Impact - OACT	Flat	Small Decrease (formula driven)	Mandate Impact - CBO
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Low Increase	High Increase	High Increase
Percent Change in Total Enrollment	0.8%	0.6%	0.7%	0.9%	0.6%	0.5%
Total Non-Group Enrollment	200,430	151,487	167,827	202,668	197,313	149,926
Exchange Enrollment	182,331	142,474	155,772	183,459	180,761	141,459
APTC Enrollment	163,957	133,322	143,534	163,957	163,957	132,863
Total Premiums	$1,817,186,170	$1,431,475,819	$1,566,045,723	$1,674,097,804	$2,216,797,631	$1,637,801,046
Total APTCs	$1,324,431,253	$1,130,759,631	$1,199,504,197	$1,113,869,847	$1,698,952,566	$1,333,243,533
Savings						
Estimated APTC Savings	$176,756,390	$188,700,662	$183,965,394	$166,354,381	$180,281,895	$190,593,944
Estimated Net Federal Savings	$170,415,512	$182,095,340	$177,464,670	$160,048,941	$173,848,362	$183,936,996

Beyond 2019

For years beyond 2019, Wakely made the following assumptions:

- Baseline premiums (both total non-group and on-Exchange) as well as Gross Premium Amounts for individuals with APTC were trended by the Office of the Actuaries National Health Expenditure spending for each year of the 10 year window.[14]
- APTC Net Premiums were increase 1% annually to account for indexing.
- Premiums in 2020 were adjusted to account for the ending of the HIT Delay (i.e., an increase of 1.2%).
- Enrollment was assumed to be constant starting in 2019.

For each year, the same methodology of applying reinsurance, calculating the change in premiums and APTC amounts as a result of reinsurance, and calculating the change in enrollment as a result of lower premium was used consistently to that described for 2019. Since the total reinsurance funding remains the same for all years, this decreases the impact to premiums over time. The premium impact of 10.1% in 2019 reduces to an impact of 6.5% by 20128. The detailed results are shown in Table 8.

[14] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ Table 17. Premiums were trended by spending per enrollee for direct purchase.

Table 8: Baseline Data and Detailed Results after Reinsurance, by Year[15]

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927
Exchange Enrollment	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574
APTC Enrollment	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957
Total Non-Group Premium PMPM	$840.82	$890.91	$934.56	$981.29	$1,029.37	$1,079.81	$1,131.64	$1,186.93	$1,244.92	$1,305.74
Exchange Premium PMPM	$122.71	$123.94	$125.18	$126.43	$127.69	$128.97	$130.26	$131.56	$132.88	$134.21
APTC PMPM	$763.00	$814.53	$859.28	$907.25	$956.63	$1,008.49	$1,061.80	$1,118.73	$1,178.50	$1,241.25
Total Premiums	$2,007,150,393	$2,126,704,299	$2,230,912,809	$2,342,458,450	$2,457,238,914	$2,577,643,621	$2,701,370,514	$2,833,351,760	$2,971,781,231	$3,116,973,971
Total APTCs	$1,501,187,644	$1,602,570,721	$1,690,606,694	$1,784,988,421	$1,882,154,012	$1,984,177,729	$2,089,060,664	$2,201,084,700	$2,318,681,496	$2,442,124,316
After Reinsurance										
Reinsurance Funding	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000
Reduction in Premiums (Reinsurance Funding)	-9.96%	-9.40%	-8.96%	-8.54%	-8.14%	-7.76%	-7.40%	-7.06%	-6.73%	-6.42%
Reinsurance Assessment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Reduction in Premiums (Improved Morbidity)	-0.20%	-0.19%	-0.18%	-0.17%	-0.16%	-0.15%	-0.15%	-0.14%	-0.13%	-0.13%
Total Non- Group Premium PMPM	$755.54	$805.62	$849.27	$895.99	$944.07	$994.51	$1,046.33	$1,101.62	$1,159.61	$1,220.43
Exchange Premium PMPM	$764.84	$815.53	$859.72	$907.02	$955.69	$1,006.75	$1,059.21	$1,115.18	$1,173.88	$1,235.45
APTC PMPM	$673.16	$724.69	$769.43	$817.39	$866.78	$918.63	$971.93	$1,028.87	$1,088.63	$1,151.37

[15] Please Appendix C for total federal savings net of federal losses under the reinsurance program.

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Change in Total Non-Group Enrollment	0.76%	0.71%	0.68%	0.64%	0.61%	0.58%	0.55%	0.53%	0.50%	0.48%
Total Non-Group Enrollment	200,430	200,341	200,271	200,204	200,141	200,082	200,027	199,974	199,923	199,875
Exchange Enrollment	182,331	182,250	182,187	182,126	182,069	182,015	181,965	181,916	181,870	181,826
APTC Enrollment	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957
Total Premiums	$1,817,186,170	$1,936,769,076	$2,041,000,239	$2,152,567,819	$2,267,368,713	$2,387,792,836	$2,511,537,827	$2,643,536,587	$2,781,982,715	$2,927,191,295
Total APTCs	$1,324,431,253	$1,425,803,810	$1,513,831,560	$1,608,205,319	$1,705,363,486	$1,807,380,144	$1,912,256,498	$2,024,274,162	$2,141,864,896	$2,265,301,948

Appendix B
Reinsurance Parameters

Reinsurance Parameters

As noted previously, the reinsurance program would operate similarly to the Transitional Reinsurance program under the ACA that existed from 2014 to 2016 in that it would reimburse insurers for a proportion (coinsurance amount) of high-cost enrollee claims between a lower bound (attachment point) and an upper bound (cap). For 2019, Wisconsin has set the attachment point at $50,000, the reinsurance cap at $250,000, and allows for coinsurance rates between 50 and 80 percent.

For the final waiver report, Wakely will use continuance tables provided from all insurers for 2016 and 2017 calendar years to estimate the coinsurance amount for the program. The continuance tables will be adjusted to represent 2019 claim levels.

Appendix C
Guard Rail Requirements

Scope of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage to at least a comparable number of residents as would have been provided coverage without the waiver. We expect enrollment to increase between 0.5% and 0.8% each year relative to what would have occurred if the reinsurance program were not in place in each year of the waiver. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least comparable number of enrollees (and most likely a greater number of individuals covered).

Affordability Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that the changes will provide coverage, premiums, and cost-sharing protections that keep care at least as affordable as would be provided absent the waiver coverage to at least a comparable number of residents as would have been provided absent the waiver. Generally, we expect premiums to be approximately 10.1% lower in 2019, and lower than they otherwise would have been each year of the waiver as a direct result of the reinsurance program. Cost sharing for plans will remain within the federal requirements and should therefore not impact affordability. Our analysis estimates that the reinsurance program, and resulting lower premiums, would provide for at least as affordable coverage for residents (and most likely greater affordability for residents).

Comprehensiveness of Coverage Requirement

In order for a 1332 waiver to be accepted, the waiver must demonstrate that it will provide coverage that is at least as comprehensive as would be provided absent the waiver. This waiver will not result in any changes to the EHB benchmark or actuarial value requirements and, as such, will not have any impact on the comprehensive of coverage for residents.

Deficit Neutrality

APTCs

Since APTCs are benchmarked to the SLCSP, the decrease in premiums (specifically the SLCSP) will result in lower per person APTC amounts in 2019. Since enrollees who have APTCs are generally unaffected by changes in gross premiums, due to the subsidies shielding them from premium increases, the introduction of reinsurance is not expected to decrease the number of enrollees with APTCs. Due to the combination of a non-decreasing number of enrollees with APTCs and a decrease in premiums, which is connected to APTC amounts, Wakely's analysis estimates that the overall aggregate amount of APTCs will be lower each year over the 10-year

window. Wakely further estimates that the total federal savings of APTC expenditures will be in excess of $175 million per year. APTC savings net of other Federal losses will be in excess of $168 million per year. These results are shown in Table 9.

Table 9: Detailed Results of Federal Savings, by Year

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Baseline										
Total Non-Group Enrollment	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927	198,927
Exchange Enrollment	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574	181,574
APTC Enrollment	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957
Total Non-Group Premium PMPM	$840.82	$890.91	$934.56	$981.29	$1,029.37	$1,079.81	$1,131.64	$1,186.93	$1,244.92	$1,305.74
Exchange Premium PMPM	$851.17	$901.87	$946.06	$993.37	$1,042.04	$1,093.10	$1,145.57	$1,201.54	$1,260.24	$1,321.82
APTC PMPM	$763.00	$814.53	$859.28	$907.25	$956.63	$1,008.49	$1,061.80	$1,118.73	$1,178.50	$1,241.25
After Reinsurance										
Total Non-Group Enrollment	200,430	200,341	200,271	200,204	200,141	200,082	200,027	199,974	199,923	199,875
Exchange Enrollment	182,331	182,250	182,187	182,126	182,069	182,015	181,965	181,916	181,870	181,826
APTC Enrollment	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957	163,957
Total Non-Group Premium PMPM	$755.54	$805.62	$849.27	$895.99	$944.07	$994.51	$1,046.33	$1,101.62	$1,159.61	$1,220.43
Exchange Premium PMPM	$764.84	$815.53	$859.72	$907.02	$955.69	$1,006.75	$1,059.21	$1,115.18	$1,173.88	$1,235.45
APTC PMPM	$673.16	$724.69	$769.43	$817.39	$866.78	$918.63	$971.93	$1,028.87	$1,088.63	$1,151.37
Federal Savings Calculations										
Exchange User Fees	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
HIT	0.00%	1.20%	1.20%	1.20%	1.20%	1.20%	1.20%	1.20%	1.20%	1.20%
Difference in APTCs	$176,756,390	$176,766,911	$176,775,134	$176,783,102	$176,790,526	$176,797,584	$176,804,166	$176,810,538	$176,816,600	$176,822,367
Difference in Mandate Penalty	$0	$0	$0	$0	$0	HI$0	$0	$0	$0	$0
Difference in User Fees	($6,340,879)	($6,352,932)	($6,363,523)	($6,374,934)	($6,386,745)	($6,399,200)	($6,412,059)	($6,425,832)	($6,440,335)	($6,455,598)
Difference in HIT	$0	($2,279,223)	($2,278,951)	($2,278,688)	($2,278,442)	($2,278,209)	($2,277,992)	($2,277,782)	($2,277,582)	($2,277,392)
Estimated Net Federal Savings	**$170,415,512**	**$168,134,756**	**$168,132,660**	**$168,129,480**	**$168,125,338**	**$168,120,174**	**$168,114,115**	**$168,106,923**	**$168,098,683**	**$168,089,378**

Offsets to APTC Savings

INDIVIDUAL RESPONSIBILITY REQUIREMENT

As part of the ACA, individuals that can afford insurance but forgo insurance are generally required to pay a fee. However, as part of the Tax Cuts and Jobs Act of 2017, the individual responsibility requirement was set to $0 for 2019 and future years. Therefore, it will not directly affect federal savings.

EXCHANGE USER FEE

Wakely acknowledges that there may be a loss of revenue to the Federal government for Exchange user fees (also known as user fees) due to the reduction in premium amounts. To calculate an estimate of this loss, Wakely estimated the baseline Exchange user fees to be 3.5% (per the 2019 proposed HHS Payment Notice) multiplied by total Exchange premiums (using the baseline Exchange enrollment and baseline Exchange premiums). This was then compared to post-reinsurance scenarios in which enrollment and premiums were re-estimated using the lower premiums and higher enrollment as a result of the reinsurance payments. In future years, Wakely assumed that the user fee rate would stay at 3.5%.

HEALTH INSURANCE PROVIDERS FEE

The reinsurance program would also impact the health insurance providers fee, or HIT. Section 9010 of the ACA requires that a tax on health insurance providers be set at an amount totaling $14.3 billion in 2018 and increasing thereafter generally at the rate of premium increase. As part of the Tax Cuts and Jobs Act of 2017 the HIT was suspended for the 2019 benefit year. We estimate that Wisconsin's reinsurance program will have minimal impact on national premium growth rate. To estimate the decrease in collected fees, Wakely first estimated the baseline collection for 2020 using the 2018 rate filing information. Information from Wisconsin's Office of the Commissioner of Insurance (OCI) weighted by enrollment yielded an estimated 1.2% HIT on premiums. This amount was held constant over the 10-year window to align the fee with overall premium growth. To calculate the impact of the waiver, Wakely estimated the total HIT (defined as total premiums multiplied by 1.2%) for the baseline and the waiver scenario to arrive at the federal costs due to the health insurance providers fee for the implementation of the waiver. These estimates are conservative as the losses on Wisconsin's insurers may be partially or fully captured by taxes on non-Wisconsin health insurance providers given that statutory construction of the fee.

OTHER FEDERAL IMPACTS

Wakely did not directly estimate the impact of the proposed waiver on the collections related to the Cadillac or Excise tax, small business tax credit or income taxes. It is unlikely that any of these would have a significant impact on the overall savings.[16]

EMPLOYER MARKETS

A detailed analysis of the group markets was not completed. It is not expected that the reinsurance program will have an impact on the small group, large group, federal employee health benefits program, and other health programs in the state. In particular, we do not expect enrollment migration from the group market to the non-group market as a result of the reinsurance program.

DEFICIT NEUTRALITY IN ALTERNATIVE SCENARIOS

In addition, Wakely calculated the impact of the federal savings under the alternative 2019 scenarios discussed previously. As can be seen in table 10, there was no 2019 scenario in which net federal savings, as a result of the reinsurance program, was less than $160 million.

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[16] http://mn.gov/commerce-stat/pdfs/mn-1332-actuarial-analysis.pdf

Table 10: Estimated 2019 Federal Savings in Alternative Scenarios

Scenario	1-Best Estimate	2	3	4	5	6
Enrollment	Small Decrease (formula driven)	Mandate Impact - CBO	Mandate Impact - OACT	Flat	Small Decrease (formula driven)	Mandate Impact - CBO
Premiums	Moderate Increase	Moderate Increase	Moderate Increase	Low Increase	High Increase	High Increase
Difference in APTCs	$176,756,390	$188,700,662	$183,965,394	$166,354,381	$180,281,895	$190,593,944
Difference in Mandate Penalty	$0	$0	$0	$0	$0	$0
Difference in User Fees	($6,340,879)	($6,605,321)	($6,500,724)	($6,305,441)	($6,433,534)	($6,656,948)
Difference in HIT	$0	$0	$0	$0	$0	$0
Estimated Net Federal Savings	**$170,415,512**	**$182,095,340**	**$177,464,670**	**$160,048,941**	**$173,848,362**	**$183,936,996**

Appendix D
Reliances and Caveats

The following is a list of the data Wakely relied on for the analysis:

- Insurer submitted premium and enrollment information for 2017 and for January/February 2018
- APTC information on enrollment and premiums for January/February 2018
- The June 30th Risk Adjustment and Reinsurance Report for the 2016 benefit year produced by CMS[17]
- The 2016 and 2017 Open Enrollment Report PUF produced by HHS[18] [19]
- Effectuated Enrollment Reports released by CMS[20]
- CBO Analysis on Impact of Repeal of the Mandate[21]
- OACT Analysis on Impact of Repeal of the Mandate[22] [23]
- Information from the Wisconsin Office of the Commissioner of Insurance for estimates of HIT from the 2018 rate filings

Wakely made some assumptions in working with the available data. These assumptions may impact the results of the analyses and were reviewed by Wisconsin for reasonability.

Any impact due to private commercial reinsurance was not reflected in the analyses.

The following are additional reliances and caveats that could have an impact on results:

- Data Limitations. Wakely received data submissions for full year 2017 and emerging 2018 experience from insurers offering individual market ACA-compliant plans. The majority of

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[17] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf
[18] https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report

[19] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html
[20] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[21] https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf
[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf
[23] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

the insurers submitted all the requested information; however, two insurers with smaller market share did not supply some portion of the information requested. This data limitation will not have a significant impact on these results. Wakely relied on the data submitted from all insurers for significant portions of this analysis. We reviewed the data for reasonability, but we did not audit the data. To the extent that the data is not correct, the results of this analysis will be impacted.

- Political Uncertainty. There is significant policy uncertainty. Future federal actions in regards to association health plans, short-term duration plans, reinsurance funds, and/or CSR payments could dramatically change premiums and enrollment in 2019 or future years. In particular, CSR funding could dramatically decrease the pass-through percentage relative to what was estimated in this report.

- Enrollment Uncertainty. Additionally, there is enrollment uncertainty. Beyond changes to potential rates and policy, individual enrollee responses to these changes also has uncertainty. All of these uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Premium Uncertainty. Given that several regulations (association plans, short-term duration plans, etc.) have not been finalized, there is uncertainty in how insurers may respond in their 2019 premiums. These uncertainties result in limitations in providing point estimates on reinsurance parameters and impacts of a 1332 waiver.

- Pass-Through Uncertainty. Ultimately the Department of Health and Human Services and the Department of Treasury model the pass-through amounts. The extent to which the exact assumptions and micro-simulation modeling differs from Wakely's models, differences in the pass-through amounts are possible.

- Reinsurance Operations. If actual operations of the reinsurance program differ from the data configurations used in this analysis, Wakely's analysis would need to be adjusted to match actual reinsurance data requirements. Changes to assumed data requirements, actual data requirements, and data submission quality for reinsurance operations may impact the results. Furthermore, if less than $200 million in spent, for example because some funds are used for reinsurance operations, then effects may be different.

Appendix E
Disclosures and Limitations

Responsible Actuary. Julie Peper and Danielle Hilson are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of the management of Wisconsin. Wakely understands that the report will be made public and used in the 1332 waiver process. Distribution to such parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results. This information is proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Wakely used conservative pass-through assumptions. The extent to which the enrollment experience for 2018 or 2019 is different than expected could affect results. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Wisconsin will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying these analyses. In addition, Wakely is organizationally and financially independent of Wisconsin.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly. The information included in the 'Data and Methodology' and 'Reliances and Caveats' sections identifies the key data and assumptions.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in state or federal laws regarding health benefit plans may have a material impact on the results included in this report. In addition, many of the assumptions are based on the initial 2018 experiences. Change in emerging 2018 enrollment and experience could impact the results. Additional changes in regulations (e.g., association health plans, short term limited duration plans) could impact findings. For example, since neither of the proposed regulations on these topics have been finalized, they were not included in the analysis.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

State of Wisconsin
2017 - 2018 LEGISLATURE

LRBs0320/1
TJD:all

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

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.

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

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

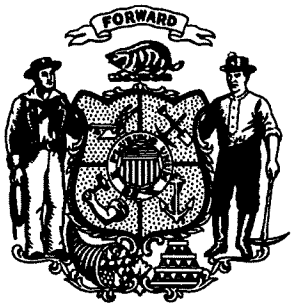
FIRE DEPARTMENT DUES

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

SECTION 11. Nonstatutory provisions.

1 (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.

[Insert public comment announcement – attachment 3]

[Insert public comments received – each as a separate attachment]

[Insert tribal consultation outreach and meeting notes as separate attachments]