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Wisconsin Policy Options for Expanded 1332 Waiver(s) Act 138: Required Recommendation Report

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Notice/Disclaimer

Texas Ruling. *On December 14, 2018, a federal district court in Texas ruled the Affordable Care Act (ACA) unconstitutional. While it is unclear what the impact of the case will ultimately be, the federal Department of Health and Human Services Secretary Azar issued the following statement:*

> *"The recent U.S. District Court decision regarding the Affordable Care Act is not an injunction that halts the enforcement of the law and not a final judgment. Therefore, HHS will continue administering and enforcing all aspects of the ACA as it had before the court issued its decision. This decision does not require that HHS make any changes to any of the ACA programs it administers or its enforcement of any portion of the ACA at this time. As always, the Trump Administration stands ready to work with Congress on policy solutions that will deliver more insurance choices, better healthcare, and lower costs while continuing to protect individuals with pre-existing conditions."*[1]

All assumptions and modeling reflected in this document are presented taking into account current law, with the ACA in effect.

Executive Summary

In recent years, enrollees in Wisconsin's individual market have faced rapidly rising premiums and dwindling choices of health plans. Premiums rose by an average of 17 percent in 2017 and 44 percent in 2018. 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 Health Insurance Marketplace (the "Exchange") in counties previously having three or more.

In response, Wisconsin enacted a state-based waiver of certain provisions of the Patient Protection and Affordable Care Act (ACA) to provide a $200 million annual reinsurance fund to reduce premiums and stabilize the individual market. On July 29, 2018, the Centers for Medicare and Medicaid Services (CMS) approved Wisconsin's ACA "Section 1332" waiver to establish the Wisconsin Healthcare Stability Plan (WIHSP).[2] On November 30, 2018, CMS informed the state that the preliminary federal calculation of the federal "pass-through" funding for 2019 will be $127.7 million. Thus, the federal government will pay for about 64 percent of the WIHSP program.

The fundamental underlying problem in Wisconsin's individual market is an unbalanced risk pool, skewed toward older and sicker enrollees. For example, Wisconsin's individual market had about 82,000 enrollees aged 55-64 selecting plans as of February 2018, with only 36,000 enrollees aged 26-34. However, according to 2017 Census data, there are far more people in the younger 26-34 age range (1.3 million) than the older 55-64 age range (820,000) in Wisconsin's overall population.

[1] https://www.hhs.gov/about/news/2018/12/17/statement-from-the-department-of-health-and-human-services-on-texas-v-azar.html

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Wisconsin-1332-Letter-final-and-signed.pdf.

Wisconsin's response has had an immediate impact: after the enactment and federal approval of the ACA reinsurance waiver creating WIHSP, premiums in the state fell by an average of 4 percent. Premiums for the lowest cost available plan fell by an average of nearly 10 percent.[3]

However, implementing a new reinsurance program may not be enough to hold premiums down permanently for Wisconsin consumers. The law that established WIHSP also requires the state's Office of the Commissioner of Insurance (OCI) to report by the end of 2018 on the following additional or alternative options:

- 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.

Wisconsin's waiver to implement the WIHSP reinsurance program was enacted under section 1332 of the ACA. Section 1332 waivers provide added flexibility for states to explore and implement market stabilization measures, such as those put forth in Act 138. While the ability to waive certain aspects of the ACA promotes innovation and state-driven solutions, the state's authority under these waivers is not limitless.

By law, the federal government requires that ACA 1332 waivers be at least budget neutral for the federal budget, and not reduce coverage, affordability, or the comprehensiveness of benefits in the individual market. These parameters are termed the "guardrails" for ACA 1332 waivers. If waivers save the federal government money – as WIHSP does through reinsurance funding that lowers premiums and federal subsidy costs – that savings is refunded to the states in pass-through funds.

However, the federal government recently changed the regulations defining the ACA guardrail parameters to allow more state flexibility in meeting those requirements. These changes were released on October 24, 2018, and on November 29th, the federal government released an extended conceptual discussion of possible waivers in four main areas: account-based plans, state-defined subsidies, state-defined benefits, and additional reinsurance options.

This report provides an evaluation and modeling of additional options for ACA waivers in the context of the new regulations and the approaches listed in Wisconsin's authorizing law.

[3] https://www.cms.gov/sites/drupal/files/2018-10/10-11-18%20Average%20Monthly%20Premiums%20for%20SLCSP%20and%20LCP%202016-2019_0.pdf

We analyzed four main ideas, which satisfy the requirements of Act 138 and speak to the concepts proposed in the recent guidance:

1. **Account-Based Plans: Providing additional subsidies for young enrollees to improve the risk pool.** Because younger enrollees generally have low health costs, we project that targeting subsidies toward enrollees in the 26-34 age range could lower overall premiums in the individual market. The approach we have modeled assumes the subsidies would apply to all enrollees in that age range; thus, the additional subsidies could be used by existing as well as prospective new enrollees. However, it could be possible to limit the subsidies to new enrollees or limit their duration or amount. The subsidies would be available via personal accounts, regardless of income, and could be used to help pay for premiums, to purchase plans with higher levels of benefits (e.g. gold benefit "tier" instead of silver, or silver instead of bronze), or to pay for out-of-pocket expenses, such as deductibles and copayments. This would help reduce the so-called "cliff"[4] in subsidies for enrollees over 400 percent of poverty (about $48,600 in annual income for a single person, or $100,000 for a family of four) within this age group.

2. **Expanded Reinsurance: Enhancing WIHSP by adding funding for high-cost cases.** Given the initial success of WIHSP in reducing rates, Wisconsin could choose to expand WIHSP with additional coverage for high-cost cases. We estimate that expanded reinsurance funding would yield both lower premiums and federal "pass-through" funding at rates similar to those achieved by WIHSP; that is, a 2-3 percent reduction in premiums for every $50 million invested, and a federal pass-through funding rate of about 64 percent.

3. **Expanding Consumer Choice of Lower-Cost Plans: Incentivizing enrollment in bronze plans by providing state subsidies.** The ACA sets several tiers of coverage, designated by "metals:" Platinum, which has 90 percent coverage, or actuarial value (AV); Gold (80%); Silver (70%) and Bronze (60%). This policy is similar to option 1, except that the subsidies would be provided via accounts to enrollees in Bronze tier plans, regardless of age. However, it would not provide a strong incentive for lower-income enrollees to switch from Silver to the Bronze tier, since lower income enrollees must choose Silver plans in order to receive cost-sharing reduction (CSR) subsidies. Since the account-based subsidies could be used for either premiums or cost-sharing, this option would help provide additional zero-premium or near-zero premium options. The account funding could also create a cushion against the high deductibles usually associated with Bronze-level coverage.

4. **Alternatives to WIHSP: Considering other approaches to high-risk mitigation.** In this section, we summarize the November 29, 2018 discussion paper overview of alternative forms of reinsurance and high-risk pools in the context of Wisconsin's WIHSP program. These options could include condition-

[4]The "cliff" refers to the difference between the premium amount subsidy eligible enrollees pay compared to those individuals with income over 400% FPL (who are not eligible for subsidies). For example, for a single person with income of $49,000 would not qualify for any ACA subsidy in 2018. However, a single person with income of $48,000 (just under the $48,560 income threshold for 400 percent of poverty in 2018) would have his or her premiums limited to a percent of income. This creates a "cliff" where people just above the threshold pay much more than those just below.

based reinsurance, such as that used in Alaska, hybrid programs combining claims based and conditions based approaches, such as that approved for Maine, and modifications of the current claims-based system used by WIHSP and other states (Minnesota, Oregon). In general, risk mitigation programs like reinsurance, whether structured like WIHSP or via condition-based approaches, will generally yield results in lowering premiums that are proportional to the state investment. That is, an alternative approach funded at the same level as WIHSP would likely have similar impacts. This is simply because the same dollar amount of claims is being pulled out of the market, whether those claims are identified through dollar ranges as in WIHSP, or via specified conditions. Alternative mechanisms for high-risk mitigation would also likely yield similar results in proportion to the investment, and would also have similar federal pass-through rates.

The following grid and Summary Table illustrate options for the first three ideas. To make comparisons more straightforward, we targeted approaches that added roughly 5,000 people to the state's individual market enrollment.

In general, the options we analyzed assumed Wisconsin would continue to use the federal Healthcare.gov site for enrollment, and that major changes in the existing federal tax subsidies or the structure of benefits were not made. Our primary emphasis was on ways to potentially improve the state's risk pool and thereby lower premiums and expand enrollment in Wisconsin's individual market.

Proposal	State Investment and Pass Through	Impact on Coverage and Premiums	Guardrails and Considerations
Option 1. Account-Based Subsidies for Young Enrollees (aged 26-34)	Scalable state investment, $76-84 million per year; offset by $14-16 million federal pass-through funding, depending on APTC rate assumption.[5] Base pass-through rate estimate of about 18% (range 8%-22%)	$200 monthly account funding per enrollee increases enrollment by about 5,300, mostly aged 26-34. Premiums overall decline 1.6%; 50-60% for young enrollees. Lower state funding gets proportionately lower results.	Likely acceptable under 2015 or 2018 regulations. Extra subsidy for young enrollees reduces premiums and APTC load depending on APTC rate of new enrollees. Other enrollees not adversely impacted.
Option 2. Enhanced Reinsurance Options	Scalable state investment, $50 million per year is offset by $32 million federal pass-through funding, same rate as WIHSP (about 64%).	Enrollment increase: 2,800 in Year 1 (2020) and 5,300 in Year 2 (2021). Premiums overall decline by about 2.8%.	Acceptable under either 2015 or 2018 regulations; similar to WIHSP.
Option 3. Account-Based Subsidies for Bronze Plan Enrollees	State investment of $67 million, would be offset by minimal (or no) federal pass-through funding, depending on APTC rate of new enrollees.	$200 per month per enrollee account funding increases enrollment about 5,300. Premiums overall decline slightly by 0.4%.	May not be acceptable under 1332 Budget Neutrality guardrail, unless APTC rates are very low (10%) among new enrollees. Other guardrails likely acceptable under 2018 regulations ("access to").
Option 4. Alternative High-Risk Mitigation Options	Similar impacts to WIHSP.		Acceptable under either 2015 or 2018 regulations; similar to WIHSP.

[5]APTC rate assumption is referring to the number of new enrollees eligible for ATPC and the magnitude of their subsidy; the higher that rate, the more the federal government has to pay out in subsides, thereby lowering federal savings and ultimately the pass-through amount.

Summary Table.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding

	2018	2019	2020	2021	2022
Baseline					
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	$744	$711	$747	$784	$823
APTC PMPM	$665	$636	$668	$701	$736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
State Reinsurance Fund (millions)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34					
Enrollees	209,000	200,000	205,280	205,280	205,280
Premium PMPM	$744	$711	$735	$771	$810
APTC PMPM	$665	$636	$655	$688	$722
Market Size Premiums (millions)	1,865	1,706	1,807	1,898	1,993
APTC (millions)	1,190	1,089	1,129	1,186	1,245
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance Fund (millions)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through (millions)	0	0	-14	-15	-15
Net Total State Funding	0	72	135	138	141
Option 2. Enhanced Reinsurance Option -- Medium Funding					
Enrollees	209,000	200,000	202,791	205,315	205,062
Premium PMPM	$744	$711	$726	$763	$802
APTC PMPM	$665	$636	$649	$683	$718
Market Size Premiums (millions)	1,865	1,706	1,766	1,853	1,944
APTC (millions)	1,190	1,089	1,127	1,182	1,241
New State Subsidy (millions)	0	0	50	50	50
State Reinsurance Fund (millions)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through (millions)	0	0	-32	-32	-32
Net Total State Funding	0	72	90	90	90
Option 3. Account-Based Subsidies for Bronze Planholders					
Enrollees	209,000	200,000	205,299	205,299	205,299
Premium PMPM	$744	$711	$743	$781	$820
APTC PMPM	$665	$636	$665	$698	$733
Market Size Premiums (millions)	1,865	1,706	1,832	1,923	2,019
APTC (millions)	1,190	1,089	1,147	1,205	1,265
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance Fund (millions)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through (millions) *	0	0	0	0	0
Net Total State Funding	0	72	139	139	139

Source: Horizon Government Affairs.

Notes: PMPM = per member per month. APTC = advanceable premium tax credit (federal premium subsidy). AV = actuarial value. All options shown are for 25% APTC Rate. Reasonable Rate 10%-50%; worst case 75%. Components may not sum to totals due to rounding.

* = APTC rate must be lower than 25% for new enrollees for federal savings and pass-through funding.

Wisconsin Policy Options for Expanded 1332 Waiver(s)

Act 138: Required Recommendation Report

Background: Wisconsin's Reinsurance Program

Senate Bill 770, signed into law as 2017 Wisconsin Act 138 (Act 138) on February 27, 2018, authorized the Wisconsin Office of the Commissioner of Insurance (OCI) to seek a 1332 Waiver to establish the Wisconsin Healthcare Stability Plan (WIHSP), a state-based reinsurance program. Total annual funding for the plan cannot exceed $200 million. The plan is funded with a combination of state general purpose revenue (GPR) and federal "pass-through" dollars. Funding language in the Act is structured as a sum sufficient appropriation, meaning state funds will equal an amount necessary to fund the program at the $200 million threshold (the difference between the federal contribution and $200 million).

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 performed by Wakely, OCI established a preliminary coinsurance rate of 50 percent for plan year 2019. For future plan years, Act 138 requires OCI, after consulting with an actuarial firm, to design and adjust payment parameters with the goal of stabilizing the individual market, increasing participation of insurers in the market, and considering federal funding available to the plan.

The reinsurance program is already having a significant impact on the forecast for the 2019 plan year (when the reinsurance program takes effect). In 2019, weighted average premiums fell by about 4 percent below 2018 premiums, without any significant reductions in plan offerings or coverage. This is a stark departure from 2018, when average premiums increased by 44 percent over 2017, and several insurance carriers dropped or reduced coverage options. Enrollment in 2019 is also expected to stabilize at about 200,000 covered lives, after having fallen from a peak of nearly 250,000 in 2016 (see Table 1).[6]

[6]Based on cumulative plan selections during the November 1 to December 15 open enrollment, CMS reports that about 207,000 enrollees selected plan in Wisconsin for 2019. There will likely be some attrition as not all people who select plans effectuate their enrollment by paying the premium. Final effectuated enrollment numbers for February 2019 will be published later in 2019. See: https://www.cms.gov/newsroom/fact-sheets/weekly-enrollment-snapshot-week-7

Table 1. Wisconsin's Individual Market

	2014	2015	2016	2017	Estimated 2018	Projected 2019
Average Monthly Enrollment	131,000	212,000	247,000	229,000	209,000	200,000
Total Premium (PMPM)	$390	$410	$442	$518	$744	$711
Annual Growth		5%	8%	17%	44%	-4%
Reinsurance (millions)	211	182	94			200
Market Size (billions)						
Total Premiums				1.4	1.9	1.7
Federal premium tax credits or subsidies (APTCs)				0.8	1.2	1.1

Source: Horizon Government Affairs.

Note: Transitional federal reinsurance 2014-2016; state-based reins. under 1332 waiver in 2019.

The Fundamental Problem: An Unbalanced Risk Pool

While WIHSP is helping to stabilize the market, more efforts are necessary to solve the core underlying problem with Wisconsin's individual market, which is that the risk pool remains substantially overrepresented by older, sicker people. More young and healthy enrollees are needed to restore balance.

Since the implementation of the ACA's single risk pool requirement in 2014, Wisconsin's market for individual health insurance coverage has been very volatile. Enrollment has shifted from plan to plan as companies entered and exited the market. In particular, two multi-state insurers, UnitedHealthcare and Humana, exited the individual market entirely. Other insurers left the Exchange and significantly reduced their service areas. Most Wisconsin enrollees in 2018 were enrolled in locally-based, cooperative, and/or provider-sponsored health plans (associated with a hospital or health system).

For several reasons, enrollment in the ACA's individual market has been much lower than expected, both nationwide and in Wisconsin. Federal cost estimators originally assumed that nearly twice as many people would enroll in the ACA's exchange-based individual health coverage nationwide.[7] Many younger and healthier people instead were enrolled in Medicaid, found employer-based coverage, or remained uninsured.

As a result, risk pools in Wisconsin and most other states have been unexpectedly skewed toward older and sicker enrollees. In 2014 and 2015, insurers set rates based on the assumption of a larger, healthier risk pool than actually materialized. This resulted in large losses. We estimate that Wisconsin individual market premiums increased by 8 percent in 2016 and 17 percent in 2017, as plans tried to raise premiums to match claims costs. It is not uncommon for premium adjustments to lag claims cost experience by two or three years.

[7]CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016 (December 7, 2017), available at: https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53094-acaprojections.pdf.

In 2018, premiums increased by an estimated 44 percent, as health insurers remaining in Wisconsin's individual market finally tried to catch up with the claims costs incurred by an older- and sicker-than-expected risk pool. Also contributing to rate increases for 2018 was the federal government's decision to end funding for Cost Sharing Reduction Subsidies (CSRs). While federal funding for subsidies ended, the ACA still requires CSRs to be available to consumers. Insurers were forced to take on that additional expense, which they ultimately passed along to consumers through rate increases.

Table 2 (below) illustrates the age structure of Wisconsin's 2018 individual market, based on effectuated enrollment data from CMS. Wisconsin's risk pool skews older than the national average ACA risk pool, which, in turn, skewed older than the population at large. For example, 36 percent of enrollees selecting a plan in 2018 in Wisconsin were between ages 55 and 64; only 28 percent of enrollees in other states using Healthcare.gov for enrollment were in that upper age range. Only 15 percent of the overall population in both Wisconsin and the U.S. is in the age range from 55 to 64.

Table 2.
Age Distribution of Affordable Care Act (ACA) Individual Market Enrollment
Persons Under Age 65 making Plan Selections During Open Enrollment

	Total	Age < 18	Age 18-25	Age 26-34	Age 35-44	Age 45-54	Age 55-64
				Effectuated Enrollment (Feb 2018)			
Wisconsin Single Risk Pool	224,273	14,100	18,379	35,876	32,302	41,986	81,630
All Healthcare.gov States	8,648,005	803,649	893,718	1,389,848	1,378,238	1,773,445	2,409,107
				Overall Population Under Age 65			
Wisconsin (2017)	5,476,441	1,282,644	635,465	1,288,573	694,136	760,235	815,388
U.S. (2017)	274,860,499	73,655,378	35,325,323	40,633,818	40,875,370	42,374,952	41,995,658
				Distribution of Enrollees by Age Group			
Wisconsin Single Risk Pool	100%	6%	8%	16%	14%	19%	36%
All Healthcare.gov States	100%	9%	10%	16%	16%	21%	28%
				Distribution of Population Under Age 65			
Wisconsin (2017)	100%	23%	12%	24%	13%	14%	15%
U.S. (2017)	100%	27%	13%	15%	15%	15%	15%
Memorandum:							
Wisconsin Percentage of Population with Individual Market Coverage	4%	1%	3%	3%	5%	6%	10%

Sources: CMS, Health Insurance Exchanges 2018 Open Enrollment Period: State-Level Public Use File, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html and U.S. Census Bureau, American Fact Finder.
Note: Wisconsin effectuated enrollment in Feb. 2018 is estimated to be 200,557. This is less that the number making plan selections during open enrollment because some people do not "effectuate" their coverage by paying the premium. Likewise, average annual enrollment will be less than February effectuated enrollment due to attrition and lapses of premium payment.

Current Law and Regulations for 1332 Waivers

Under the ACA, 1332 waivers allow states to "implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit." While these waivers provide additional flexibility to the states, CMS and the Department of the Treasury are only authorized to waive requirements described in section 1332(a)(2) of the ACA, including but not limited to qualified health plans, essential health benefits, and subsidies for cost-sharing assistance.[8]

[8]Waivable elements of the ACA include "Part I of Subtitle D of Title I of the Affordable Care Act (relating to establishing qualified health plans (QHPs)); Part II of Subtitle D of Title I of the ACA (relating to consumer choices and insurance competition through health insurance marketplaces); Sections 36B of the Internal Revenue Code and 1402 of the ACA (relating to premium tax credits and cost-sharing reductions for plans

Final regulations governing 1332 waivers were issued on February 27, 2012. In the years following, CMS has issued a series of guidance documents. The latest guidance issued by CMS on October 24, 2018 superseded prior guidance issued in 2015, and was further supplemented by a discussion paper published by CMS on November 29, 2018.

For more detailed information on the guardrails and federal guidance, see Appendix A attached.

Basic Estimating Approach

For the estimates below, we used broad assumptions compiled by the Congressional Budget Office (CBO) on the likely impact of subsidies to induce potential enrollees to enroll or current enrollees to retain coverage. We estimate that most people with low incomes who would qualify for a large APTC subsidy are already enrolled.

Thus, we assume that new enrollees, induced to sign up by additional subsidies or lowered premiums in the options below, tend to be both younger and healthier than the average in Wisconsin's current individual market risk pool, and have lower-than-average APTC rates. In general, we use an APTC rate of 25% for new enrollees, but also show a range of possibilities, from 10% (low APTC rate) to 50% (high APTC). As a worst-case scenario, we illustrate the impact with an APTC rate for new enrollees of 75%, which is higher than the estimated rate for current enrollees (64%).

Importantly, for the options below we have not attempted to estimate additional operational or regulatory expenses, such as costs incurred to establish personal accounts, determine eligibility or manage funds. These additional expenses might be small for expanded reinsurance options but could be substantial for other types of subsidies intended to re-balance Wisconsin's individual market risk pool.

For more information on estimating methods, see Appendix B attached.

Option 1 – Account-Based Subsidies for Younger Enrollees

Table 3 illustrates the impact of Option 1, adding account-based subsidies for young enrollees between the ages of 26 and 34. In general, these subsidies would be provided through a personal account that could be used for premium payments and/or deductibles or other cost sharing. The subsidies would apply regardless of income. Therefore, the so-called "cliff" in APTC subsidies for enrollees who exceed 400 percent of the poverty line would be moderated, at least for young enrollees.

In general, this option is scalable; that is, the state could spend more or less and get a proportionate increase in enrollment and reduction in premiums. We believe the best estimate of the pass-through rate for this option would be about 18 percent. However,

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offered within the marketplaces); Section 4980H of the Internal Revenue Code (relating to employer shared responsibility); and Section 5000A of the Internal Revenue Code (relating to individual shared responsibility)." See https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html#Frequently%20Asked%20Questions%20about%201332%20State%20Innovation%20Waivers.

the assumption of the share of new enrollees who would qualify for the APTC is very important. As a general rule, we have assumed that new enrollees induced to purchase coverage would not have high APTC rates – those with high APTC rates would likely have been enrolled previously regardless of the new subsidy. For our base assumption, we used an APTC rate of 25 percent. That is, 25 percent of new enrollees' premiums in the aggregate would be subsidized by the federal government.

Importantly, alternative assumptions about the APTC rate would have a large impact on the projected pass-through rate. Table 4 illustrates alternative assumptions about the APTC rate, from a "low" 10 percent APTC Rate through a "worst case" 75 percent. While it is highly unlikely that APTC rates for new enrollees would be as much as 75 percent, it is important to point out that in that unlikely scenario the federal pass-through rate would be as low as 8 percent.

Tables 4a-4d (detail) illustrate the impact of adding additional, younger enrollees to the Wisconsin individual market risk pool via an account-based subsidy. For this option, we estimate that Wisconsin could add roughly 5,300 new enrollees aged 26-34 by targeting a $2,400 annual subsidy (about $200 per month) for all enrollees in that age group, regardless if they were current or prospective enrollees. Table 4a below shows the results under the assumption of a 25 percent APTC rate. Table 4b shows the results assuming a 50 percent APTC rate, and Table 4c assumes a 10% APTC rate. On the other hand, Table 4d assumes a "worst case" scenario, with the newly induced enrollees aged 26-34 having very high APTC rates (75%) on average.

From these illustrations under Option 1 we can make several broad conclusions:

First, the range of possible federal pass-through outcomes is broad. While we do not believe the worst-case scenario of a 75 percent APTC subsidy rate is a likely outcome, it cannot be ruled out. On the other hand, while we doubt that all potentially eligible APTC enrollees are currently enrolled, it is possible that very few new enrollees would be APTC eligible, leading to a higher federal pass-through rate.

Second, even targeting enrollment to those aged 26-34 leads to plausible outcomes with federal pass-through rates that are less than 25 percent. Thus, the state would almost certainly have to shoulder a much larger share of the cost than under the previously enacted WIHSP reinsurance option, which has a pass-through rate of about 64 percent.

Table 3.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34
Alternative Amounts of State Funding

	2020	2021	2022
High State Investment			
State Investment (millions)	76	80	84
Federal Funding	-14	-15	-15
Net State Funding	62	65	69
Pass-Through Rate (Assumed 25% APTC Rate)	18%	18%	18%
Overall Premium Reduction	-1.6%	-1.6%	-1.6%
Overall Enrollment Increase	5,280	5,280	5,280
Premium Reduction for People Aged 26-34	-55%	-55%	-55%
Medium State Investment			
State Investment (millions)	38	40	42
Federal Funding	-7	-7	-8
Net State Funding	31	33	34
Pass-Through Rate (Assumed 25% APTC Rate)	18%	18%	18%
Overall Premium Reduction	-0.8%	-0.8%	-0.8%
Overall Enrollment Increase	2,640	2,640	2,640
Premium Reduction for People Aged 26-34	-27%	-27%	-27%
Small State Investment			
State Investment (millions)	19	20	21
Federal Funding	-4	-4	-4
Net State Funding	16	16	17
Pass-Through Rate (Assumed 25% APTC Rate)	18%	18%	18%
Overall Premium Reduction	-0.4%	-0.4%	-0.4%
Overall Enrollment Increase	1,320	1,320	1,320
Premium Reduction for People Aged 26-34	-14%	-14%	-14%

Source: Horizon Government Affairs.
Notes: APTC = advanceable premium tax credit (federal premium subsidy). APTC rate assumption for new enrollees = 25%.

Table 4.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34

		2020	2021	2022
Base Assumption: APTC Rate of New Enrollees =	**25%**			
State Investment (millions)		76	80	84
Federal Funding		-14	-15	-15
Net State Funding		62	65	69
Pass-Through Rate		18%	18%	18%
High APTC Assumption: APTC Rate of New Enrollees =	**50%**			
State Investment (millions)		76	80	84
Federal Funding		-10	-10	-11
Net State Funding		66	70	73
Pass-Through Rate		13%	13%	13%
Low APTC Assumption: APTC Rate of New Enrollees =	**10%**			
State Investment (millions)		76	80	84
Federal Funding		-16	-17	-18
Net State Funding		60	63	66
Pass-Through Rate		22%	22%	22%
Worst Case Assumption: APTC Rate of New Enrollees =	**75%**			
State Investment (millions)		76	80	84
Federal Funding		-6	-6	-6
Net State Funding		71	74	78
Pass-Through Rate		8%	8%	8%
Memorandum (applies to all options):				
Percent Increase in Coverage Overall		2.6%	2.6%	2.6%
Percent Decrease (-) in Premiums PMPM Overall		-1.6%	-1.6%	-1.6%

Source: Horizon Government Affairs.
Notes: APTC = advanceable premium tax credit (federal premium subsidy).

Table 4a.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	$744	$711	$747	$784	$823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies to Add About 5,000 Enrollees Aged 26-34 in 2020				
	APTC Eligibility Rate of New Enrollees:			25%	
Enrollees	209,000	200,000	205,280	205,280	205,280
Premium PMPM	$744	$711	$735	$771	$810
APTC PMPM	$665	$636	$655	$688	$722
Market Size Premiums (millions)	1,865	1,706	1,807	1,898	1,993
APTC (millions)	1,190	1,089	1,129	1,186	1,245
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	-14	-15	-15
Net Total State Funding	0	72	135	138	141
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,280	5,280	5,280
Premium PMPM	$0	$0	($12)	($12)	($13)
APTC PMPM	$0	$0	($13)	($14)	($14)
Market Size Premiums (millions)	0	0	16	16	17
APTC (millions)	0	0	-14	-15	-15
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	-14	-15	-15
Total New State Funding	0	0	62	65	69
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-1.6%	-1.6%	-1.6%
Subsidy per Eligible Person Age 26-34 (annual)			$2,400	$2,520	$2,646
Subsidy as a Percent of Premiums Age 26-34			53%	53%	53%
Percent Increase in Enrollment Age 26-34			17%	17%	17%
Percent Decrease (-) in Premiums Age 26-34			-55%	-55%	-55%
Secondary Increase in Enrollment (all ages)			280	280	280

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies. Components may not sum to totals due to rounding.

\a APTC only at this point.

Table 4b.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	$744	$711	$747	$784	$823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies to Add About 5,000 Enrollees Aged 26-34 in 2020				
	APTC Eligibility Rate of New Enrollees:		50%		
Enrollees	209,000	200,000	205,280	205,280	205,280
Premium PMPM	$744	$711	$735	$771	$810
APTC PMPM	$665	$636	$653	$685	$719
Market Size Premiums (millions)	1,865	1,706	1,807	1,898	1,993
APTC (millions)	1,190	1,089	1,133	1,190	1,250
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	-10	-10	-11
Net Total State Funding	0	72	139	142	146
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,280	5,280	5,280
Premium PMPM	$0	$0	($12)	($12)	($13)
APTC PMPM	$0	$0	($15)	($16)	($17)
Market Size Premiums (millions)	0	0	16	16	17
APTC (millions)	0	0	-10	-10	-11
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	-10	-10	-11
Total New State Funding	0	0	66	70	73
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-1.6%	-1.6%	-1.6%
Subsidy per Eligible Person Age 26-34 (annual)			$2,400	$2,520	$2,646
Subsidy as a Percent of Premiums Age 26-34			53%	53%	53%
Percent Increase in Enrollment Age 26-34			17%	17%	17%
Percent Decrease (-) in Premiums Age 26-34			-55%	-55%	-55%
Secondary Increase in Enrollment (all ages)			280	280	280

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies. Components may not sum to totals due to rounding.

\a APTC only at this point.

Table 4c.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	$744	$711	$747	$784	$823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies to Add About 5,000 Enrollees Aged 26-34 in 2020				
	APTC Eligibility Rate of New Enrollees:		10%		
Enrollees	209,000	200,000	205,280	205,280	205,280
Premium PMPM	$744	$711	$735	$771	$810
APTC PMPM	$665	$636	$656	$689	$724
Market Size Premiums (millions)	1,865	1,706	1,807	1,898	1,993
APTC (millions)	1,190	1,089	1,127	1,183	1,242
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	-16	-17	-18
Net Total State Funding	0	72	132	135	138
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,280	5,280	5,280
Premium PMPM	$0	$0	($12)	($12)	($13)
APTC PMPM	$0	$0	($12)	($12)	($13)
Market Size Premiums (millions)	0	0	16	16	17
APTC (millions)	0	0	-16	-17	-18
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	-16	-17	-18
Total New State Funding	0	0	60	63	66
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-1.6%	-1.6%	-1.6%
Subsidy per Eligible Person Age 26-34 (annual)			$2,400	$2,520	$2,646
Subsidy as a Percent of Premiums Age 26-34			53%	53%	53%
Percent Increase in Enrollment Age 26-34			17%	17%	17%
Percent Decrease (-) in Premiums Age 26-34			-55%	-55%	-55%
Secondary Increase in Enrollment (all ages)			280	280	280

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies. Components may not sum to totals due to rounding.

\a APTC only at this point.

Table 4d.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 1. Account-Based $200 Per Month Subsidy for Enrollees Aged 26-34

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	$744	$711	$747	$784	$823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies to Add About 5,000 Enrollees Aged 26-34 in 2020				
	APTC Eligibility Rate of New Enrollees:		75%		
Enrollees	209,000	200,000	205,280	205,280	205,280
Premium PMPM	$744	$711	$735	$771	$810
APTC PMPM	$665	$636	$650	$683	$717
Market Size Premiums (millions)	1,865	1,706	1,807	1,898	1,993
APTC (millions)	1,190	1,089	1,137	1,194	1,254
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	-6	-6	-6
Net Total State Funding	0	72	143	146	150
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,280	5,280	5,280
Premium PMPM	$0	$0	($12)	($12)	($13)
APTC PMPM	$0	$0	($17)	($18)	($19)
Market Size Premiums (millions)	0	0	16	16	17
APTC (millions)	0	0	-6	-6	-6
New State Subsidy (millions)	0	0	76	80	84
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	-6	-6	-6
Total New State Funding	0	0	71	74	78
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-1.6%	-1.6%	-1.6%
Subsidy per Eligible Person Age 26-34 (annual)			$2,400	$2,520	$2,646
Subsidy as a Percent of Premiums Age 26-34			53%	53%	53%
Percent Increase in Enrollment Age 26-34			17%	17%	17%
Percent Decrease (-) in Premiums Age 26-34			-55%	-55%	-55%
Secondary Increase in Enrollment (all ages)			280	280	280

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies. Components may not sum to totals due to rounding.

\a APTC only at this point.

Option 2. Enhanced Reinsurance.

The WIHSP program is bringing down premiums in 2019 after the large increases in 2017 and 2018. In this section, we consider the impact of additional funding to WIHSP or otherwise providing for additional reinsurance in Wisconsin's individual market. In general, these sorts of programs are scalable and predictable. Based on the WIHSP program's initial results, we estimate that as a general rule of thumb, for every $50 million invested in reinsurance, overall premiums will likely fall by an average of 2-3 percent, and the federal pass-through funding would be roughly two-thirds of total reinsurance fund (about 64 percent).

In our estimation, the structure of any additional reinsurance does not matter very much to the overall statewide results, because however the funding is applied, it brings down health plans' claims costs by the amount of the funding, and premiums will fall by a similar amount. However, we did note that Wisconsin had relatively few claims of over $1 million in 2016 and 2017, less than a dozen in each year, according to preliminary aggregated data used in the state's 1332 application. Therefore, a reinsurance threshold set only for claims above $1 million would be less predictable and might not use all of the funds allotted in a given year. Additionally, the federal risk adjustment program has 60 percent reimbursement for claims above $1 million effective since plan year 2018. While the risk adjustment system helps protect health plans against the risk of outlier claims above $1 million by spreading the risk among health plans, it does not lower premiums directly in the same way as a reinsurance program because plans must also pay in to the risk adjustment system.

Table 5 below shows three options for adding reinsurance funding: a "high" option with an additional $100 million in annual funding, partially offset by $64 million in federal pass-through funds; a "medium" option based on a $50 million in annual funding, partially offset by 32 million in federal pass-through funds; and a "low" option" based on $25 million in annual funding, offset by $16 million in federal pass-through.

Table 5.
Option 2. Enhanced Reinsurance
Federal Reins Funding (millions)
Alternative Amounts of State Funding

	2020	2021	2022
High State Investment			
State Investment (millions)	100	100	100
Federal Funding	-64	-64	-64
Net State Funding	36	36	36
Pass-Through Rate	64%	64%	64%
Overall Premium Reduction	-5.6%	-5.3%	-5.1%
Overall Enrollment Increase	5,581	10,631	10,125
Medium State Investment			
State Investment (millions)	50	50	50
Federal Funding	-32	-32	-32
Net State Funding	18	18	18
Pass-Through Rate	64%	64%	64%
Overall Premium Reduction	-2.8%	-2.7%	-2.5%
Overall Enrollment Increase	2,791	5,315	5,062
Small State Investment			
State Investment (millions)	25	25	25
Federal Funding	-16	-16	-16
Net State Funding	9	9	9
Pass-Through Rate	64%	64%	64%
Overall Premium Reduction	-1.4%	-1.3%	-1.3%
Overall Enrollment Increase	1,395	2,658	2,531

Source: Horizon Government Affairs.
Notes: APTC = advanceable premium tax credit (federal premium subsidy). APTC rate assumption for new enrollees = 25%.

Option 3. Consumer Choice. Account-Based Subsidies for Bronze Plans

Act 138 highlights the idea of expanding “catastrophic” or additional “low-cost” plans as possible options for Wisconsin. Likewise, the recent November 29th discussion paper released by CMS to accompany the new October regulations highlights changes in consumers’ benefit choices.

While such approaches would expand choice for non-subsidy eligible enrollees, such options could be difficult for Wisconsin to implement under 1332 waiver guardrails, even considering the less restrictive guidelines introduced in October 2018. For example, we estimate that allowing additional age groups to purchase or switch to catastrophic coverage, which is now limited to individuals under the age of thirty, could worsen the risk pool for the remaining enrollees under some circumstances, since enrollees in the catastrophic plans are part of a separate risk pool. Likewise, the underlying cost of catastrophic plans could increase if older enrollees were allowed to participate.

Moreover, since catastrophic plans are not eligible for federal premium subsidies, we assume that very few subsidized enrollees would switch to catastrophic plans. Therefore, those likely to move from a current ACA plan to a catastrophic plan are individuals who are relatively healthy and unsubsidized. As a result, expanding catastrophic plans under the current ACA rules could actually increase federal premium subsidies, by worsening the health of the risk pool and raising premiums for remaining subsidized enrollees. Thus, that approach could fail the guardrail requiring budget neutrality for the federal government.

Similarly, we estimated the impact of adding a lower-cost "Copper" tier for plans with an actuarial value of 50 percent. In theory, adding subsidized copper plans could substantially increase enrollment without adding state costs directly. Copper plans could improve the risk pool by drawing in more young and healthy enrollees, and many of those enrollees would likely have low APTC rates (or else they already would have enrolled). That effect alone could lower premiums and APTC obligations.

However, copper plans could probably not be created under the current ACA's requirement for an annual out-of-pocket limit. Because Wisconsin's risk pool has become so adverse, even Bronze plans with a 60 percent actuarial value have deductibles that are nearing the out-of-pocket limits, which are $7,350 for individuals and $14,700 for families in 2018.

To illustrate the idea of incentivizing the use of lower-cost plans under 1332 waivers, and also show the difficulty of implementing such waivers without running afoul of the guardrails or non-waivable ACA requirements for benefit design, Table 6 shows our estimates of a state-based subsidy for Bronze plans. Like the subsidies for younger enrollees under Option 1 above, this subsidy would be operationalized through private accounts in the amount of $200 per enrollee, which could be used for premiums or cost-sharing (such as deductibles). We estimate that these subsidies would make Bronze plans more appealing for relatively higher-income enrollees who do not qualify for cost-sharing reduction (CSR) subsidies, and are therefore not incented to choose Silver tier plans. Thus, it is possible that the combination of new and existing Bronze tier enrollees could have quite low federal subsidies. However, if new enrollees had federal subsidies even as high as 25 percent on average, this option could fail the budget neutrality guardrail (because adding new subsidy-eligible enrollees increases federal costs greater than the impact of lower premiums on existing APTC enrollees).

Table 6a-6d show further details for this option, under the assumptions of 25% (base), 50% (high), 10% (low), and 75% (worst-case) APTC rates for new enrollees.

Table 6.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 3. Account-Based Subsidies for Bronze Planholders

	2020	2021	2022
Base Assumption: APTC Rate of New Enrollees =	**25%**		
State Investment (millions)	67	67	67
Federal Funding *	0	0	0
Net State Funding	67	67	67
Pass-Through Rate	0%	0%	0%
High APTC Assumption: APTC Rate of New Enrollees =	**50%**		
State Investment (millions)	67	67	67
Federal Funding *	0	0	0
Net State Funding	67	67	67
Pass-Through Rate	0%	0%	0%
Low APTC Assumption: APTC Rate of New Enrollees =	**10%**		
State Investment (millions)	67	67	67
Federal Funding	-1	-1	-1
Net State Funding	66	65	65
Pass-Through Rate	2%	2%	2%
Worst Case Assumption: APTC Rate of New Enrollees =	**75%**		
State Investment (millions)	67	67	67
Federal Funding *	0	0	0
Net State Funding	67	67	67
Pass-Through Rate	0%	0%	0%
Memorandum (applies to all options):			
Percent Increase in Coverage Overall	2.6%	2.6%	2.6%
Percent Decrease (-) in Premiums PMPM Overall	-0.4%	-0.4%	-0.4%

Source: Horizon Government Affairs.
Notes: APTC = advanceable premium tax credit (federal premium subsidy).
* increases federal subsidies and thus could fail the budget neutrality "guardrail" for 1332 waivers.

Table 6a.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 3. Account-Based Subsidies for Bronze Tier Enrollees

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	744	711	747	784	823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies for Bronze Tier Enrollees				
	APTC Eligibility Rate of New Enrollees:			25%	
Enrollees	209,000	200,000	205,299	205,299	205,299
Premium PMPM	$744	$711	$743	$781	$820
APTC PMPM	$665	$636	$665	$698	$733
Market Size Premiums (millions)	1,865	1,706	1,832	1,923	2,019
APTC (millions)	1,190	1,089	1,147	1,205	1,265
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	0	0	0
Net Total State Funding	0	72	139	139	139
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,299	5,299	5,299
Premium PMPM	$0	$0	($3)	($3)	($3)
APTC PMPM	$0	$0	($3)	($3)	($3)
Market Size Premiums (millions)	0	0	40	42	44
APTC (millions)	0	0	4	4	4
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	0	0	0
Total New State Funding	0	0	67	67	67
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-0.4%	-0.4%	-0.4%
State Subsidy per Eligible Person (annual)			$2,400	$2,400	$2,400
Subsidy as a Percent of Premiums Bronze Enrollees			-27%	-26%	-24%
Percent Increase in Enrollment Age 26-34			3%	3%	3%
Percent Decrease (-) in Premiums Age 26-34			-0.4%	-0.4%	-0.4%
Secondary Increase in Enrollment (all ages)			299	299	299

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies.

\a APTC only at this point.

Table 6b.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 3. Account-Based Subsidies for Bronze Tier Enrollees

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	744	711	747	784	823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies for Bronze Tier Enrollees				
	APTC Eligibility Rate of New Enrollees:			50%	
Enrollees	209,000	200,000	205,299	205,299	205,299
Premium PMPM	$744	$711	$743	$781	$820
APTC PMPM	$665	$636	$665	$698	$733
Market Size Premiums (millions)	1,865	1,706	1,832	1,923	2,019
APTC (millions)	1,190	1,089	1,156	1,214	1,274
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	0	0	0
Net Total State Funding	0	72	139	139	139
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,299	5,299	5,299
Premium PMPM	$0	$0	($3)	($3)	($3)
APTC PMPM	$0	$0	($3)	($3)	($3)
Market Size Premiums (millions)	0	0	40	42	44
APTC (millions)	0	0	13	13	14
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	0	0	0
Total New State Funding	0	0	67	67	67
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-0.4%	-0.4%	-0.4%
State Subsidy per Eligible Person (annual)			$2,400	$2,400	$2,400
Subsidy as a Percent of Premiums Bronze Enrollees			-27%	-26%	-24%
Percent Increase in Enrollment Age 26-34			3%	3%	3%
Percent Decrease (-) in Premiums Age 26-34			-0.4%	-0.4%	-0.4%
Secondary Increase in Enrollment (all ages)			299	299	299

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies.

\a APTC only at this point.

Table 6c.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 3. Account-Based Subsidies for Bronze Tier Enrollees

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	744	711	747	784	823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies for Bronze Tier Enrollees				
	APTC Eligibility Rate of New Enrollees:			10%	
Enrollees	209,000	200,000	205,299	205,299	205,299
Premium PMPM	$744	$711	$743	$781	$820
APTC PMPM	$665	$636	$665	$698	$733
Market Size Premiums (millions)	1,865	1,706	1,832	1,923	2,019
APTC (millions)	1,190	1,089	1,142	1,199	1,259
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	-1	-1	-1
Net Total State Funding	0	72	138	138	138
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,299	5,299	5,299
Premium PMPM	$0	$0	($3)	($3)	($3)
APTC PMPM	$0	$0	($3)	($3)	($3)
Market Size Premiums (millions)	0	0	40	42	44
APTC (millions)	0	0	-1	-1	-1
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	-1	-1	-1
Total New State Funding	0	0	66	65	65
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-0.4%	-0.4%	-0.4%
State Subsidy per Eligible Person (annual)			$2,400	$2,400	$2,400
Subsidy as a Percent of Premiums Bronze Enrollees			-27%	-26%	-24%
Percent Increase in Enrollment Age 26-34			3%	3%	3%
Percent Decrease (-) in Premiums Age 26-34			-0.4%	-0.4%	-0.4%
Secondary Increase in Enrollment (all ages)			299	299	299

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies.

\a APTC only at this point.

Table 6d.
State Options for Re-Balancing ACA Risk Pool and Federal Pass-Through Funding
Option 3. Account-Based Subsidies for Bronze Tier Enrollees

	2018	2019	2020	2021	2022
	Baseline				
Enrollees	209,000	200,000	200,000	200,000	200,000
Premium PMPM	744	711	747	784	823
APTC PMPM	665	636	668	701	736
Market Size Premiums (millions)	1,865	1,706	1,792	1,881	1,975
APTC (millions)	1,190	1,089	1,143	1,200	1,260
New State Subsidy (millions)	0	0	0	0	0
State Reinsurance Fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
Net Total State Funding	0	72	72	72	72
	Subsidies for Bronze Tier Enrollees				
	APTC Eligibility Rate of New Enrollees:			75%	
Enrollees	209,000	200,000	205,299	205,299	205,299
Premium PMPM	$744	$711	$743	$781	$820
APTC PMPM	$665	$636	$665	$698	$733
Market Size Premiums (millions)	1,865	1,706	1,832	1,923	2,019
APTC (millions)	1,190	1,089	1,165	1,223	1,284
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance fund (mill)	0	200	200	200	200
Federal Reins Funding (millions)	0	-128	-128	-128	-128
New Federal Pass-Through \a	0	0	0	0	0
Net Total State Funding	0	72	139	139	139
	Difference from Baseline Note: Savings (-) or Cost (+)				
Enrollees	0	0	5,299	5,299	5,299
Premium PMPM	$0	$0	($3)	($3)	($3)
APTC PMPM	$0	$0	($3)	($3)	($3)
Market Size Premiums (millions)	0	0	40	42	44
APTC (millions)	0	0	21	22	23
New State Subsidy (millions)	0	0	67	67	67
State Reinsurance Fund (mill)	0	0	0	0	0
Federal Reinsurance Funding	0	0	0	0	0
New Federal Pass-Through \a	0	0	0	0	0
Total New State Funding	0	0	67	67	67
Memorandum:					
Percent Increase in Coverage Overall			3%	3%	3%
Percent Decrease (-) in Premiums PMPM Overall			-0.4%	-0.4%	-0.4%
State Subsidy per Eligible Person (annual)			$2,400	$2,400	$2,400
Subsidy as a Percent of Premiums Bronze Enrollees			-27%	-26%	-24%
Percent Increase in Enrollment Age 26-34			3%	3%	3%
Percent Decrease (-) in Premiums Age 26-34			-0.4%	-0.4%	-0.4%
Secondary Increase in Enrollment (all ages)			299	299	299

Source: Horizon Government Affairs DRAFT
Notes: No interactions yet between reinsurance and broader policies.

\a APTC only at this point.

Option 4. Other High-Risk Mitigation Options

While Wisconsin has adopted a traditional attachment point reinsurance program (also known as "claims cost-based" reinsurance) for payments between $50,000 - $250,000, additional reinsurance options are available to the state.
The recently released November 29, 2018 discussion paper on 1332 waivers describes the various reinsurance and other high-risk mitigation options as follows:

1. *Claims cost-based reinsurance program*: One option for states is a claims cost-based reinsurance program where issuers are reimbursed for a portion of the costs of enrollees whose claims exceed a certain threshold (i.e. the attachment point). Typically, issuers are reimbursed for only a portion of costs (i.e., the coinsurance rate) above the attachment point, and in some cases, up to a set cap. High-cost individuals remain in the same risk pool as other enrollees (for both claims cost-based reinsurance programs and conditions-based reinsurance programs) and enroll in the same commercial plans available to the general public. Claims are eligible for payment through a reinsurance program using funds separately raised for that purpose when certain criteria are met.

2. *Condition-based reinsurance program*: Instead of identifying people based on their claims costs, another option is a conditions-based reinsurance program where insurers are reimbursed for costs of individuals with one or more of a list of pre-determined high cost conditions. This program would operate in a very similar fashion as a claims-based reinsurance program as enrollees remain in the individual market risk pool and the funding and structure is invisible to them. However, because claims are only reimbursed for people with a specific set of conditions (determined either in a prior year or current year), insurers must still pay claims for people who run up high claims due to an accident or other health event. The reinsurance program would pay the entire claims of all individuals meeting any of the conditions.

3. *Hybrid Reinsurance Program*: Another option is a hybrid where the state could implement a reinsurance program that is both conditions-based and claims based, where issuers are reimbursed for the costs (or a fraction of costs) of individuals within a specified range with one or more of a list of pre-determined high-cost conditions. For the purposes of a 1332 waiver, the state would need to define the list of conditions as well as the parameters for reimbursement.

Each of these options, whether adopted in whole or in part, represent additional measures that Wisconsin may take to further distribute risk among the individual market and lower costs for individuals.

The list of options does not contemplate a high-risk pool in the traditional, pre- ACA, sense. Prior to enactment of the ACA, Wisconsin had a successful high-risk pool, the Health Insurance Risk Sharing Plan (HIRSP). HIRSP offered health insurance coverage to individuals who could not purchase coverage due to a medical condition and to those who were HIPAA-eligible individuals. HIRSP was financed through premiums paid by plan members; assessments collected from health insurers, and reduced payments to

health care providers for services provided to members. No general purpose revenue supported the plan's operations or administration.

HIRSP offered several plan options with coverage and premiums comparable to those offered in the private health insurance market. Members had access to providers available across the state. Subsidies were available to individuals with an annual household income of less than $34,000. Enrollment ranged through the years from approximately 16,000 members to approximately 22,000 members by the end of 2013.

All HIRSP participants without prior qualifying coverage were subject to a six-month pre-existing condition waiting period. During that period, HIRSP did not cover medical services related to a condition that was diagnosed, or received during the six months preceding the policy's effective date. The goal was to discourage individuals from purchasing the plan only when a known need presented itself. The exclusion period did not apply to HIPAA-eligible individuals or to prescription drugs.

Post-ACA, insurers must adhere to guaranteed issue, no health status rating, and no pre-existing condition exclusions. With the ACA rules in place, individuals with high health care needs have access to the same health plans for the same cost as individuals with low health care needs. Therefore, HIRSP was repealed.

Under the ACA, individuals who are sick can no longer be segmented into a different rating pool. Rather, if there are high cost conditions that a state wants to ensure insurers are managing and wants to help offset those costs for the benefit of the entire risk pool (all the enrollees regardless of their health status), a condition-based reinsurance program is a mechanism for that (also referred to as an invisible high risk pool). In other words, enrollee claims related to specific conditions identified as part of the program would be offset by the state reinsurance program after claims are submitted. There is nothing for the enrollees incurring the claims to do; i.e. it is an invisible process to them.

State Approaches to Reinsurance.

Including Wisconsin, seven states have implemented or are implementing reinsurance programs under 1332 waivers. Table 7 shows the estimated premium reductions from each state's program.[9] The premium reductions are in comparison with what estimated premiums would have been absent the reinsurance program.

[9]See: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/State-Relief-Empowerment.PDF

Table 7.
Premium Reductions Associated with Establishment of Reinsurance Programs

	Year of Implementation	
	2018	2019
Alaska	-20%	
Minnesota	-20%	
Oregon	-8%	
Maine		-9%
Maryland		-30%
New Jersey		-15%
Wisconsin		-11%

Source: Horizon Government Affairs.
Note: Premium reductions are in comparison with estimated premiums absent the reinsurance program.

Alaska

The Alaska Reinsurance Program (ARP) is a condition-based reinsurance program that covers claims for individuals in the individual market with one or more of 33 identified high cost conditions.[10] For individuals with one or more of the 33 identified conditions, 100 percent of claims are paid by the ARP.

Maine

With its 1332 waiver, Maine reinstated the Maine Guaranteed Access Reinsurance Association (MGARA), an independent state agency to operate a hybrid state reinsurance program that combines claims-based, attachment point reinsurance and a conditions-based reinsurance program. The reinsurance program "automatically cedes high-risk enrollees with one of eight conditions, includes voluntary ceding of other high-risk enrollees, and provides 90 percent coinsurance to attach for claims from $47,000 and up to $77,000, and 100 percent coinsurance for claims beyond that up to $1 million. For claims above $1 million, MGARA will cover the net dollar amount of claims not otherwise covered by Federal high-cost risk adjustment program."[11]

Maryland

Maryland used a 1332 waiver to establish the Maryland State Reinsurance Program (MSRP), "a traditional, claims-based, attachment point reinsurance program by reimbursing qualifying non-group health insurers for a percentage of an enrollee's claims costs exceeding a specified threshold (attachment point) and up to a specified ceiling (reinsurance cap). Specifically, the Maryland State Reinsurance Program will be a state

[10] Additional detail available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf
[11] Additional detail available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Maine-fact-sheet.pdf

established reinsurance program with a cap of $250,000 and a coinsurance rate of 80% for 2019."[12]

Minnesota

Minnesota has established Minnesota Premium Security Plan (MPSP), an attachment-point reinsurance program. In its 1332 waiver application, Minnesota explained that "[t]he parameters for 2018, set in state law, are an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000."[13]

New Jersey

New Jersey secured a 1332 waiver to implement the New Jersey Health Insurance Premium Security Plan, a traditional, attachment-point reinsurance program. New Jersey's reinsurance program will reimburse insurers of high-cost enrollees and provide 60 percent coinsurance for claims starting at $40,000 and up to $215,000.[14]

Oregon

Oregon secured a 1332 waiver to develop the Oregon Reinsurance Program (ORP). The ORP is a traditional reinsurance program. As described in the state's 1332 waiver application "the ORP will likely reimburse 50 percent of claims between the attachment point and an estimated $1 million cap."[15]

[12] Additional detail available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/MD-Fact-Sheet.pdf
[13] Additional detail available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf
[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/NJ-Fact-Sheet.pdf
[15] https://healthcare.oregon.gov/DocResources/1332-application.pdf

Appendix A – 1332 Waiver Regulations

To stay within the 1332 waiver authority as defined in statute, there are four key "guardrails" that all 1332 waivers must satisfy:

1. Coverage
2. Affordability
3. Comprehensiveness
4. Deficit Neutrality

Most 1332 waivers that have been approved to date have been reinsurance programs similar to Wisconsin's. While the potential for broader reforms under 1332 waivers exists, the guardrails create unique challenges for states exploring creative options.

However, the original guidance defining how CMS would interpret the guard rails was modified on October 24, 2018. The following sections compare the original rules with the latest guidance:

2015 Guard Rails Guidance.

> **"Coverage** refers to minimum essential coverage (or, if the individual shared responsibility provision is waived under a State Innovation Waiver, to something that would qualify as minimum essential coverage but for the waiver). For this purpose, "comparable" means that the forecast of the number of covered individuals is no less than the forecast of the number of covered individuals absent the waiver. This condition generally must be forecast to be met in each year that the waiver would be in effect.
>
> The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. (For example, while a State Innovation Waiver may not change the terms of a state's Medicaid coverage or change existing Medicaid demonstration authority, changes in Medicaid enrollment that result from a State Innovation Waiver, holding the state's Medicaid policies constant, are considered in evaluating the number of residents with coverage under a waiver.)
>
> Assessment of whether the proposal covers a comparable number of individuals also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. Reducing coverage for these types of vulnerable groups would cause a waiver application to fail this requirement, even if the waiver would provide coverage to a comparable number of residents overall. Finally, analysis under the coverage requirement takes into account whether the proposal sufficiently prevents gaps in or discontinuations of coverage."
>
> **"Affordability** refers to state residents' ability to pay for health care and may generally be measured by comparing residents' net out-of-pocket spending for

health coverage and services to their incomes. Out-of-pocket expenses include both premium contributions (or equivalent costs for enrolling in coverage), and any cost sharing, such as deductibles, co-pays, and co-insurance, associated with the coverage. Spending on health care services that are not covered by a plan may also be taken into account if they are affected by the waiver proposal. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver. This condition generally must be forecast to be met in each year that the waiver would be in effect.

Waivers are evaluated not only based on how they affect affordability on average, but also on how they affect the number of individuals with large health care spending burdens relative to their incomes. Increasing the number of state residents with large health care spending burdens would cause a waiver to fail the affordability requirement, even if the waiver would increase affordability for many other state residents. Assessment of whether the proposal meets the affordability requirement also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. Reducing affordability for these types of vulnerable groups would cause a waiver to fail this requirement, even if the waiver maintained affordability in the aggregate.

In addition, a waiver would fail the affordability requirement if it would reduce the number of individuals with coverage that provides a minimal level of protection against excessive cost sharing. In particular, waivers that reduce the number of people with insurance coverage that provides both an actuarial value equal to or greater than 60 percent and an out-of-pocket maximum that complies with section 1302(c)(1) of the ACA, would fail this requirement. So too would waivers that reduce the number of people with coverage that meets the affordability requirements set forth in sections 1916 and 1916A of the Social Security Act, as codified in 42 CFR part 447, subpart A, while holding the state's Medicaid policies constant."

"Comprehensiveness refers to the scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHBs) as defined in section 1302(b) of the ACA, or, as appropriate, Medicaid and/or CHIP standards. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver.

Comprehensiveness is evaluated by comparing coverage under the waiver to the state's EHB benchmark, selected by the state (or if the state does not select a benchmark, the default base-benchmark plan) pursuant to 45 CFR 156.100, as well as to, in certain cases, the coverage provided under the state's Medicaid and/or CHIP programs. A waiver cannot satisfy the comprehensiveness requirement if the waiver decreases: (1) The number of residents with coverage that is at least as comprehensive as the benchmark in all ten EHB categories; (2) for any of the ten EHB categories, the number of residents with coverage that is at least as comprehensive as the benchmark in that category; or (3) the number of residents whose coverage includes the full set of services that would be covered under the state's Medicaid and/or CHIP programs, holding the state's

Medicaid and CHIP policies constant. That is, the waiver must not decrease the number of individuals with coverage that satisfies EHB requirements, the number of individuals with coverage of any particular category of EHB, or the number of individuals with coverage that includes the services covered under the state's Medicaid and/or CHIP programs.

Assessment of whether the proposal meets the comprehensiveness requirement also takes into account the effects across different groups of state residents, and, in particular, vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues. A waiver would fail the comprehensiveness requirement if it would reduce the comprehensiveness of coverage provided to these types of vulnerable groups, even if the waiver maintained comprehensiveness in the aggregate. This condition generally must be forecast to be met in each year that the waiver would be in effect."

Deficit Neutrality. "Under the deficit neutrality requirement, the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than projected Federal spending net of Federal revenues in the absence of the waiver.

The estimated effect on Federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed waiver. Estimated effects would include, for example, changes in: The premium tax credit and health coverage tax credit, individual shared responsibility payments, employer shared responsibility payments, the excise tax on high-cost employer-sponsored plans, the credit for small businesses offering health insurance, and changes in income and payroll taxes resulting from changes in tax exclusions for employer-sponsored insurance and in deductions for medical expenses.

The effect on Federal spending includes all changes in Exchange financial assistance and other direct spending, such as changes in Medicaid spending (while holding the state's Medicaid policies constant) that result from the changes made through the State Innovation Waiver. Projected Federal spending under the waiver proposal also includes all administrative costs to the Federal government, including any changes in Internal Revenue Service administrative costs, Federal Exchange administrative costs, or other administrative costs associated with the waiver.

Waivers must not increase the Federal deficit over the period of the waiver (which may not exceed 5 years unless renewed) or in total over the ten-year budget plan submitted by the state as part of the State Innovation Waiver application. … A waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement."

October 2018 Regulatory Changes.[16]

October 22, 2018 guidelines from the Administration make the guardrail calculations

[16] Available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf

more flexible and also allow states more leeway to offer lower actuarial value (AV) plans under the comprehensiveness and affordability guardrails, as long as enrollees retain the ability to choose higher benefit plans at actuarially fair rates.

The most significant change made by the recent guidance is that states have to ensure that enrollees have "access to" coverage under 1332 waivers that is just as comprehensive and affordable as that prior to the waiver. But the regulation clarifies that states do not have to guarantee that enrollees will continue to choose those options over lower-cost options.

Specifically, the new guidelines diverge from earlier guidance in four major areas:

1. Total state coverage is the new metric for the Coverage guardrail, including Medicaid, employer coverage, Short-Term, Limited Duration (STLD) plans and Association Health Plans (AHPs). Therefore, a state 1332 waiver that increased STLD coverage but lowered QHP coverage might not necessarily fail the Coverage guardrail, as long as the total number of people covered is not reduced. Likewise, a waiver that increased Medicaid or employer coverage could offset reductions in QHP coverage without necessarily failing the Coverage guardrail. These new definitions would seem to allow more complex 1332 options, possibly in combination with an 1115 Medicaid waiver (including Medicaid expansion).

2. The Comprehensiveness and Affordability guardrails are now based more on aggregate impact, not necessarily on the impact on every subgroup separately. Thus, a 1332 waiver that made coverage a little less affordable for older beneficiaries but more affordable for younger enrollees might not necessarily fail the Affordability guardrail if overall affordability in the state was enhanced. Again, allowing aggregated impact to be considered alongside subgroup impact would allow more complex waivers.

3. The Comprehensiveness and Affordable guardrails are now based on "availability" or "access to" comprehensive and affordable plans, but not necessarily based on which plans consumers choose. Therefore, a 1332 waiver that allows consumers to choose plans with lower actuarial values (AVs) might not necessarily fail the Comprehensiveness and Affordability guardrails if consumers still have "access to" plans with higher AVs. Allowing lower AV plans, possibly in combination with account-based subsidies for target enrollees (young people, young families, etc.) could conceivably improve the single risk pool (SRP) without violating the Comprehensiveness and Affordability guidelines – additional federal pass-through funds would also be possible.

4. The new state legislation requirement for ACA waivers gives permission for a state agency that is authorized to regulate ACA coverage authority to pursue a waiver without additional state legislation, with finer detail filled in through executive orders. It is therefore possible that Wisconsin could authorize OCI to broadly pursue additional waivers during the legislative session in early 2019, with follow-up details on the specifics to be ironed out administratively after the legislative session.

Building on the October 2018 guidance, CMS recently released a discussion paper that presents detailed concepts for states to consider in light of the new guidance.

November 29 Discussion Paper.[17]

The November 29 Discussion Paper presents four unique concepts for the newly revised 1332 "State Relief and Empowerment Waivers," including:

- Waiver Concept A: State-Specific Premium Assistance;
- Waiver Concept B: Adjusted Plan Options;
- Waiver Concept C: Account-Based Subsidies; and
- Waiver Concept D: Risk Stabilization Strategies.

These concepts mirror many of the considerations Wisconsin raised in Act 138 earlier in 2018. The material below provides a snapshot of relevant sections of the November 29 Discussion Paper that could potentially offer greater stability to Wisconsin's individual insurance market, and relief for individual consumers.

The updated guidance interprets the comprehensiveness and affordability guardrails to mean that the waiver must provide access to coverage that is at least as comprehensive and affordable as coverage absent the waiver. The coverage guardrail will be met so long as a comparable number of residents are covered under the waiver as would have been covered absent the waiver. The new guidance expands the definition of coverage for purposes of this guardrail to include more forms of coverage. The guidance also focuses on the aggregate effects of the waiver for the guardrails.

Waiver Concept A: State-Specific Premium Assistance

This new state subsidy structure can redefine the amount of financial assistance provided as a state subsidy, such as a state tax credit, or redefine the populations eligible for such financial assistance, or both. For example, a state might:

- Replace the federal PTC structure with a new per-member per-month, state premium credit based on age.
- Determine eligibility using an affordability percentage and award financial assistance when the costs of health coverage exceed a set percentage of household income.
- Leverage a similar state subsidy or state tax credit structure already in place that could be easily modified for this purpose.

An advanceable subsidy structure based on consumers' projecting their income requires much more complexity than an age-adjusted tax credit. Income-based subsidies could also provide perverse incentives that discourage upward mobility and work, and states may wish to avoid these problems. States considering a subsidy structure based on

[17] Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF

income should also consider how consumers can report changes in income or if the state will perform an income reconciliation. States are encouraged to also consider additional innovations within the subsidy program. Subsidy design will also have an impact on participation.

Waiver Concept B: Adjusted Plan Options

In the Adjusted Plan Options waiver concept, states would have the flexibility to provide state financial assistance for non-QHPs, potentially increasing consumer choice and making coverage more affordable for individuals. States also could choose to expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the PPACA, for example, to make them available to a broader group of individuals. With the Adjusted Plan Options waiver, states may be able to increase consumer choice and affordability by allowing consumers to use a state subsidy towards catastrophic plans, individual market plans that are not QHPs, or plans that do not fully meet PPACA requirements. Under the PPACA, consumers can use PTC only towards non-catastrophic QHPs offered through the Exchanges. Under this waiver concept, states may be able to waive the QHP requirement under section 36B of the Code and allow PTC for a non-QHP if the non-QHP is offered through the Exchanges and if certain other conditions are met.

States may allow state-specific financial assistance to be applied to QHPs and/or non-QHPs such as: all plans approved for sale in the individual market (including non-QHP off-exchange individual market plans); plans that do not meet (or that exceed) a specific AV/metal level; short-term, limited-duration plans; catastrophic plans, employer -based plans, association health plans; plans that do not meet all EHB requirements, but are at least as comprehensive as those that do; value-based insurance design (VBID) plans; or condition-specific benefit plans that might exceed EHB requirements.

Regarding catastrophic plans, states could expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the PPACA, for example, to make them available to a broader group of individuals. Currently, catastrophic plans are available only to individuals under the age of thirty, or to individuals who have qualified for an Exchange affordability or hardship exemption. Catastrophic plans' risk is adjusted separately from other metal level plans. Waiving these limitations would expand plan options to more individuals. However, wider enrollment in catastrophic plans is likely to lead to issuers increasing their cost because it would change the risk profile of their enrollees.

Waiver Concept C: Account-Based Subsidies

In the Waiver Concept C: Account-Based Subsidies waiver option, states would have the flexibility to direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay health insurance premiums or other health care expenses. The account could be primarily funded with pass-through funding made available by waiving the PTC (section 36B of the Code and section 1401 of the PPACA) or the SBTC (section 45R of the Code), along with any additional state funds to implement the 1332 waiver plan. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions.

Similar to Waiver Concept A: State-Specific Premium Assistance, in the Account-Based Subsidies waiver concept, states would have the flexibility to design a new subsidy structure to, for instance, make coverage more affordable for a wider range of individuals and to attract more young and healthy consumers into their market. One option is to use subsidies as a contribution towards funding a defined-contribution, consumer-directed Health Expense Account (HEA). This would be a new type of account a state could create where consumers could use an HEA to pay health insurance premiums and other health care expenses.

The structure of the subsidy could also be tailored to accomplish the same policy goals as Waiver Concept A: State-Specific Premium Assistance, including making coverage more affordable for a wider range of individuals. Like state-specific premium assistance, a state can adjust contributions to redefine eligibility parameters to accomplish specific goals and reach specific populations. For example:

- A state may provide a flat, per-member per-month contribution to the account based on age.
- A state may provide a sliding scale per-member per-month credit based on income and other eligibility factors.
- A state can structure the contribution on a sliding scale to those over 400% of the federal poverty level (FPL) or under 100% FPL to reduce or eliminate the current subsidy cliffs.

In the HEA option, states could request to waive federal laws relating to PTC (section 36B of the Code and section 1402 of the PPACA) to establish a new subsidy program and also fund HEAs.

States could continue using the current Exchange enrollment platform and plan certification, create a new platform, or waive the PPACA's Exchange and QHP provisions and rely entirely on the private market.

Waiver Concept D: Risk Stabilization Strategies

In the risk stabilization strategies waiver component, states can consider ways to address the costs of individuals with expensive medical conditions to mitigate the impact of those expenses on people who purchase coverage in the individual market.

As a reminder to states, the risk adjustment high-cost risk pool has been effective since plan year 2018 and will reimburse 60% of claims above $1 million, with no cap. This risk adjustment high-cost risk pool program will work in conjunction with state reinsurance programs to provide relief from catastrophic claims costs so states should take this into consideration as they establish parameters for their reinsurance program so the state-operated reinsurance program does not duplicate claims covered under the risk adjustment high-cost risk pool.

Appendix B – Estimating Notes

For our estimates of the reaction to premium reductions, we use a price elasticity of about -0.35; that is, a 1 percent reduction in price (compared with baseline) leads to about a 0.35 percent increase in individual health coverage demand.

However, this elasticity of demand does not necessarily translate directly into uptake in health coverage enrollment. CBO has published a chart of "take up" rates for individual coverage in the absence of a mandate, which we have approximated and used in our estimates (see Table 3).[18]

Take up Rates for Non-Group Coverage in Absence of Mandate

Percent of Premium Subsidized	Percent of People Purchasing
10%	20%
20%	23%
30%	25%
40%	28%
50%	30%
60%	35%
70%	40%
80%	50%
90%	65%
100%	80%

Source: HGA based on Congressional Budget Office, CBO's Health Insurance Simulation Model: A Technical Description (October 2007), available at: https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf

In general, we assumed a cost ratio of 5:1 between the oldest group of enrollees (aged 55+) and the youngest (age <35); premium ratios are approximately 3:1, representing the premium rating rules required by the ACA. Cost and premium rates assumed are shown below:

Age Group	Cost Rate (Avg = 1)	Premium Rate
<26	0.4	0.5
26-34	0.4	0.5
35-44	0.5	0.7
45-54	1.0	1.0
55+	1.8	1.5
Ratio 55+/<26	5:1	3:1

HGA's preliminary assessment is that a cost rate for new enrollees of 25-50% of

[18]Congressional Budget Office, CBO's Health Insurance Simulation Model: A Technical Description (October 2007), available at: https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8712/10-31-healthinsurmodel.pdf.

average costs in the pool seems quite reasonable, as long as the new incentives are specifically targeted to younger enrollees, particularly those aged 26-40 and/or families with children. This would be consistent with 5:1 cost experience ratio between the highest cost and lowest cost age groups in the pool.

Likewise, our preliminary conclusion is that most people with low incomes who would qualify for a large APTC subsidy are already enrolled. Thus, new subsidies or inducements to purchase or maintain coverage would most help those at higher income levels, particularly those above 400 percent of poverty (the levels below refer to 2018 incomes):

Household size	2018 Poverty Level	400 Percent of Poverty Level
1	$12,140	$48,560
2	$16,460	$65,840
3	$20,780	$83,120
4	$25,100	$100,400

For example, a single person with income of $49,000 would not qualify for any ACA subsidy in 2018. However, a single person with income of $48,000 (just under the $48,560 income threshold for 400 percent of poverty in 2018) would have his or her premiums limited to a percent of income. This creates a “cliff” where people just above the threshold pay much more than those just below.