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February 12, 2018

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 885/Senate Bill 770: Wisconsin Healthcare Stability Plan and Medical Assistance Lapse

Assembly Bill 885/Senate Bill 770 would authorize the Office of the Commissioner of Insurance (OCI) to seek federal approval, under the waiver authority provided s. 1332 of the federal Affordable Care Act (ACA), to administer a reinsurance program (the Wisconsin Healthcare Stability Plan, or WHSP) to reduce claims costs for health insurers that offer individual health plans to Wisconsin residents. If OCI receives federal approval of the state's waiver request, the agency would be required to implement the program beginning in the 2019 benefit year.

In addition, the bill would require the Secretary of the Department of Health Services (DHS) to ensure that up to $80 million GPR lapses from the appropriation that supports medical assistance (MA) benefits costs to the general fund.

AB 885 was introduced on January 20, 2018, by request of the Governor, and referred to the Joint Committee on Finance. SB 770 was introduced on February 5, 2018, by request of the Governor, and referred to the Joint Committee on Finance.

BACKGROUND

Transitional Reinsurance Program under the Federal Affordable Care Act

The ACA establishes an insurance market exchange for the purchase of health plans by persons who do not receive employer-sponsored coverage (often referred to as the "individual market"). In order to be sold on the exchange, health plans must meet certain standards, including coverage of essential health benefits and limits on the insureds' out-of-pocket costs. The ACA also prohibits insurers from refusing coverage to persons with preexisting medical conditions, or from charging higher premiums based on those conditions.

The sale of insurance plans on the insurance market exchange began in 2014. During the first three years following the ACA changes, the act authorized the U.S. Department of Health and Human Services (DHHS) to administer a transitional reinsurance program. Reinsurance, also called "stop-loss" insurance, protects insurers against the costs associated with very high-cost claims or individuals, by paying a portion of those claims. Since the amount of an insurer's liabilities associated with high-cost claims or individuals can be difficult to predict, reinsurance has the effect of mitigating the financial risk associated with this unpredictability. Insurers can purchase reinsurance coverage by paying a premium to a third-party insurer, and passing along those costs to the covered individual. However, some public programs, including the ACA transitional reinsurance program and the Medicare Part D reinsurance program, are externally-funded, since at least a portion of the funds for paying high-cost claims are derived from sources other than the purchasers of the policy. Although the Medicare Part D reinsurance program is permanent, the ACA's transitional reinsurance program operated in only the first three years that plans were sold on the exchange -- 2014, 2015, and 2016.

The ACA's transitional reinsurance program paid a portion of the medical costs (called the "coinsurance rate") above a certain threshold (an "attachment point") up to a maximum threshold (the "reinsurance cap"). DHHS was required to set the program parameters such that the total amount of estimated reinsurance payments would equal the amount of funding available for that purpose each year. The amount of funding available for reinsurance payments nationwide was set by the ACA at $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. This program was primarily externally funded, since the funding for making the reinsurance payments was collected using per capita assessments of all health coverage plans, including fully-insured and self-insured employer plans in the individual, small group, and large group market.

Based on the funding available for reinsurance, DHHS set the attachment point at $45,000 for 2014 and 2015, and at $90,000 for 2016, while the reinsurance cap was set at $250,000 for all three years. [Note that these are the amounts paid by the insurer, and so do not include any out-of-pocket medical costs paid by the covered individual.] The coinsurance rate was set at 80% for 2014 and at 50% for 2015 and 2016. [1]

The following examples show the calculation of the reinsurance payment paid to the insurer for two individuals with high medical costs, based on the 2014 parameters.

[1] Although these were the initial parameters, DHHS made subsequent adjustments based on actual payments and the amount of funds available. For instance, in 2014, the Department increased the coinsurance rate to 100% to spend surplus funds.

Reinsurance Payment Examples, with $45,000 Attachment Point, $250,000 Reinsurance Cap, and 80% Coinsurance Rate

	Medical Costs Net of Cost Sharing Paid by Individual	Amount Above $45,000 But Below $250,000	Reinsurance Payment at 80% Coinsurance Rate	Net Amount Paid by Insurer
Individual 1	$100,000	$55,000	$44,000	$56,000
Individual 2	$300,000	$205,000	$164,000	$136,000

For Individual 1 in this example, the insurer pays 100% of costs (net of cost sharing) up to $45,000, and pays 20% of the remaining medical costs, up to the $100,000 total. For individual 2, the insurer pays 100% of net costs up to $45,000, 20% of all costs between $45,000 and $250,000, and 100% of costs over $250,000. Because Individual 2 has costs above the reinsurance cap, the insurer receives the maximum reinsurance payment for this individual.

The transitional reinsurance program under the ACA had the effect of reducing a participating insurer's risk exposure associated with high-cost individuals. But the program's externally-funded structure also had the effect of reducing the share of total costs paid by insurers and by individuals covered in the individual market. That is, a portion of the medical costs of high-cost persons in the individual market was, in effect, spread across the entire insurance market. Because the ACA's transitional reinsurance program was temporary, all costs associated with high-cost individuals within the individual market must now be funded internally within that market, through premiums paid by persons in the individual market. Current gross premiums in the individual market have increased in 2017 and 2018 in part because of the end of the external subsidy effect of the transitional reinsurance program.

Affordable Care Act Insurance Exchange and Premium Tax Credits

In order to facilitate the purchase of plans, some individuals can receive assistance to lower the cost of premiums, referred to as premium tax credits (PTC). The amount of the PTC is based on the individual's household income and the cost of a certain index plan sold on the health insurance exchange in the person's region. [2] Relative to the index plan, the PTC lowers the net cost of the premium (actual premium minus PTC) so that it equals a specified percentage of household income, ranging from about 2% for someone with income at 100% of the federal poverty level (FPL) to about 9.7% for someone with income between 300% and 400% of the FPL. Because of the presence of PTC payments, individuals with a household income below 400% of the FPL are generally not affected by changes in premiums available on the insurance market exchange, since the amount that these individuals pay is based on their income level, not the underlying price of the

[2] The index plan is the silver-level plan with the second-lowest premium offered in the rate region. Plans are classified in "metal tiers" based on their actuarial value, which is the average percentage of total medical costs paid by the plan, as opposed to through cost-sharing by the covered individual. Silver plans have an actuarial percentage of 70%.

plan.[3] However, since individuals with an income above 400% of the FPL are not eligible for PTC payments, they must pay the full premium and, therefore, are affected by the underlying price of the premium.

The effect of the underlying premium on individuals above and below the 400% of FPL threshold can be illustrated using an example of 2018 exchange plans sold in different parts of the state. Under the ACA, each state is divided into rate regions for the purpose of establishing and marketing health plans sold on the exchange. Wisconsin has 16 rate regions. The average premium for exchange plans vary widely among the regions, reflecting different insurance and healthcare market conditions. The table below shows the premium paid for the index plan for two individuals, one whose income is above the 400% of FPL threshold and one whose income is below the threshold. To show the impact of the underlying cost of the premium, the table shows what each would pay in two Wisconsin counties in different rate regions (Grant and St. Croix). For the purposes of this example, the plan purchaser is a 45-year old individual in a single-person household.

Monthly Gross and Net Premium Paid for 2018 Healthcare Coverage for Sample Individual in Two Different Counties and at Two Income Levels

		Single-Person Household with Annual Income of:			
	Gross	$40,000 (330% of FPL)		$50,000 (415% of FPL)	
County	Premium	Tax Credit	Net Premium	Tax Credit	Net Premium
Grant County	$531	$212	$319	$0	$531
St. Croix County	$626	$307	$319	$0	$626

As shown in the table, the index plan in St. Croix County has a higher underlying premium than in Grant County. However, the net premium paid by an individual with an income of $40,000, (below the 400% of FPL threshold) is the same because of the impact of the premium tax credit. A person with an annual income of $50,000 is above the PTC eligibility threshold, and so his or her premium varies based on the underlying cost. Although this example shows two counties in different parts of the state in the same year, the same relationship holds for year-to-year changes in premiums. That is, an increase in premiums from 2017 and 2018 will affect individuals above the PTC threshold, but individuals below the threshold will be largely shielded from those changes if they select the index plan.[4]

In 2017, approximately 216,000 individuals in Wisconsin purchased a plan on the insurance market exchange and had effectuated coverage (by paying the premium) for March of that year. Of those, approximately 179,000, or 83%, had an income below 400% of the FPL and so received a premium tax credit to reduce the cost of the premium. Complete 2018 data on effectuated coverage is not yet available.

[3] The gross price of the premium still can affect these individuals' costs to some extent, depending upon the type of plan an individual selects.

[4] Since the poverty guidelines and the PTC formula are changed annually, net premiums for the index plan paid by individuals below the 400% of FPL threshold may change slightly.

2018 Insurer Participation and Premium Levels

In 2018, insurer participation in the health insurance exchange declined in many parts of Wisconsin, relative to 2017. While in 2017 there was just one county in the state that had only one insurer offering plans on the exchange, there are now 11 counties with just one insurer. Several insurers cited prior earning experience or uncertainty regarding the future of ACA provisions as reasons for exiting the exchange. One reason cited by some insurers was the failure of the federal government to pay cost sharing subsidies, which are used by the insurer to lower the out-of-pocket expenses of low income enrollees who purchase a silver-level plan. Since insurers are required by federal law to reduce out-of-pocket costs for such enrollees, the cost of such reductions must be recovered through higher premiums if the federal payments to offset the subsidy are not available.

OCI indicates that the average gross premium (before premium tax credits) for plans offered on the exchange increased by 38% in 2018, compared to 2017. However, premium changes vary widely depending upon the type of plan and the area of the state. Increases were particularly high in the northeast, where insurer participation declined. For instance, using a 40-year old as an example, the unsubsidized premium for the lowest cost silver plan in Brown County increased by 87%. [Silver-level plans generally saw the largest increase, since insurers had to compensate for the loss of federal payments for cost-sharing reductions in these plans.] By contrast, the gross premium for gold-level plans in some northcentral and northwestern counties and in Dane County increased by 5% or less.

State Reinsurance Programs

Section 1332 of the ACA includes a provision allowing states to experiment with alternative methods of providing for healthcare coverage. Under Section 1332, states may request a waiver of various insurance market provisions established by the ACA, and also request pass-through federal funds that would otherwise be spent for premium tax credits. In order to be approved, state proposals must not increase the federal deficit, must provide coverage that is at least as comprehensive and as affordable as plans offered through the exchange, and must provide coverage to at least a comparable number of state residents. States are required to pass a law implementing provisions of a waiver plan.

In addition to the Wisconsin proposal, other states have already or are considering the possibility of establishing a state reinsurance program to lower premiums and encourage insurer participation in the individual market. So far, Alaska, Minnesota, and Oregon have established programs under a Section 1332 waiver. Of these three, Minnesota's program is most similar to the Wisconsin proposal, with parameters that are also similar to the first year of the ACA's transitional reinsurance program. In 2018, the Minnesota reinsurance program uses an attachment point of $50,000, a reinsurance cap of $250,000, and a 80% coinsurance rate. In addition to federal pass-through funds, Minnesota designates state funding sources for the program, including proceeds of a health insurance premium assessment.

SUMMARY OF AB 885/SB 770

Wisconsin Healthcare Stability Plan

Establishment of the Wisconsin Healthcare Stability Plan. AB 885/SB 770 would require Office of the Commissioner of Insurance (OCI) to administer the Wisconsin Healthcare Stability Plan (WHSP), a state-based reinsurance program for health plans sold in the individual market.

OCI would be authorized to seek one or more Section 1332 waivers to implement the WHSP for benefit years beginning January 1, 2019, and would be prohibited from implementing the WHSP if the waiver for the healthcare stability plan or a substantially similar plan is not approved. OCI would also be required to seek, if necessary, any federal moneys for the purpose of the reinsurance program that may become available as the result of the passage of any act of Congress that provides support to states to establish reinsurance programs.

Funding. The bill would create a sum-sufficient GPR appropriation, a federal funds appropriation, and a program revenue appropriation for making reinsurance payments. In the Chapter 20 appropriation schedule, the bill would reflect $50,000,000 GPR and $150,000,000 FED for reinsurance payments in 2018-19, although since the GPR appropriation is sum-sufficient and the FED appropriation authorizes the expenditure of any amounts received, these amounts are estimates, and not limiting. The PR appropriation for reinsurance payments would receive transfers from other agencies equal to any estimated savings to the medical assistance program or to state agencies if the federal health insurance fee established by the Affordable Care Act is no longer applicable. No funding is reflected in the Chapter 20 appropriation for the PR appropriation. The federal appropriation for the healthcare stability plan could be used to spend any pass-through funds received under the Section 1332 waiver or other federal assistance.

Stability Plan Structure and Parameters. The WHSP would have a reinsurance program structure similar to the ACA's transitional reinsurance program, with payments made based on a coinsurance rate multiplied by the amount of a covered individual's claims that fall between an attachment point and a reinsurance cap. OCI would be required to ensure that payments to an insurer could not exceed the total amount that the insurer paid for the claim (the total allowed amount minus any deductible, coinsurance, or copayment paid by another person). OCI would be required to collect data from eligible insurers as necessary to determine reinsurance payments.

For the 2019 plan year, the bill would require OCI to set the reinsurance attachment point at $50,000, the reinsurance cap at $250,000, and the coinsurance rate at between 50% and 80%, although these parameters could be adjusted to the extent necessary to secure federal approval of the Section 1332 waiver request. In subsequent years, OCI would be required to consult with an actuarial firm and adjust payment parameters with the goal of doing the following: (a) stabilize or reduce premium rates in the individual market; (b) increase participation by health carriers in the individual market; (c) improve access to health care providers and services for individuals purchasing coverage in the individual market; (d) mitigate the impact that high-risk individuals have on premium rates in the individual market; (e) take into account any federal funding available for the plan; and (f) take into account the total amount available to fund the plan.

OCI would be required to set the payment parameters no later than March 30 of the calendar year before the applicable benefit year, or by a different date if specified by administrative rule. If the amount of funding available for the healthcare stability plan is not anticipated to be adequate to fully fund the payment parameters as of July 1 of the calendar year before the applicable benefit year, OCI would be required to adjust the parameters in accordance with the moneys available to expend for the healthcare stability plan. Eligible insurers would be allowed to revise their premium rate filings based on the final payment parameters.

Quarterly during the benefit year, OCI would be required to provide each eligible insurer with a calculation of the total amount of reinsurance payment requests. No later than June 30 of the calendar year following the benefit year, OCI would be required to notify each eligible insurer of the reinsurance payments to be made for the applicable benefit year. OCI would then be required to make reinsurance payments by August 15 of the calendar year following the applicable benefit year (by August 15, 2020, for the 2019 benefit year, for instance).

The bill would require OCI to reduce reinsurance payments to each eligible insurer in proportion to the insurer's share of aggregate health benefit plan premiums if it is determined that funding for making payments is not sufficient to make all eligible reinsurance payments in a benefit year. OCI would be required to notify insurers of a funding insufficiency as soon as practicable after it becomes known.

Audits of Reinsurance Payment Requests. The bill would authorize OCI to have any participating insurer audited to assess the insurer's compliance with reinsurance program requirements. The cost of any audits would be paid by the insurer, consistent with current law provisions relating to OCI's insurance company examination costs.

Within 30 days of receiving notice that an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with the program requirements, the insurer would be permitted to provide a response to the proposed finding. In the event that a final audit report includes a finding of material weakness or significant deficiency, the insurer, within 60 days, would be required to do the following: (a) provide a written corrective action plan to OCI for approval; (b) implement the corrective action plan as approved by OCI; and (c) provide OCI with written documentation of the corrective action after implementation. OCI would have the authority to recover from a participating insurer any overpayment of reinsurance as determined under an audit.

Insurer Responsibilities. The bill would establish the following other responsibilities for participating insurers, with respect to the WHSP: (a) make requests for reinsurance payments in accordance with any requirements established by OCI; (b) agree, as a condition of receiving payments, not to bring a lawsuit over any delay in reinsurance payments or any reduction in reinsurance payments due to insufficiency of funds; (c) provide OCI with access, by April 30 of the calendar year following the end of the applicable benefit year, to the data within the dedicated environment established by the insurer under the federal risk adjustment program; (d) submit to OCI a statement attesting to compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines;

(e) maintain for at least six years documents and records, by paper, electronic, or other media, sufficient to substantiate a request for a reinsurance payment, and make such documents and records available to OCI, upon request, for purposes of verification, investigation, audit or other review of a reinsurance payment request; and (f) ensure that its contractors, subcontractors, or agents cooperate with any audit.

The bill would specify that any information submitted by an insurer or obtained by OCI pursuant to administering the program is proprietary and confidential.

Other OCI Duties and Authority under WHSP. Under the bill, OCI would have authority to promulgate any rules necessary to implement the WHSP, including emergency rules, without being required to comply with current law prerequisites for emergency rules.

The bill would include the following additional OCI requirements:

(a) Keep an accounting for each benefit year of the following: (1) funds appropriated for reinsurance payments and administrative and operational expenses; (2) requests for reinsurance payments received from insurers; (3) payments made to eligible insurers; and (4) administrative and operational expenses incurred for the program;

(b) Produce a report summarizing the WHSP operations for each benefit year and make the report available to the public by posting the summary on its website. The report would be produced by November 1 of the calendar year following the applicable benefit year or by 60 days following the final disbursement of reinsurance payments, whichever is later;

(c) Submit to the Governor, by December 31, 2018, recommendations on implementing the Section 1332 waiver, any possible additional waivers to be requested, and any other options to stabilize the individual health care market in the state;

(d) Require each eligible insurer to calculate the rates that the insurer would have charged for a benefit year if the healthcare stability plan had not been established and submit the calculated rates as part of its rate filing. OCI would be required to consider this rate filing as part of the rate filing review; and

(e) Ensure that its contractors, subcontractors, or agents cooperate with any audit of the WHSP by the Legislative Audit Bureau.

Reallocation of Savings Resulting from Nonapplicability of the Health Insurer Fee. The Department of Administration (DOA) would be required to calculate state agency savings related to the avoidance of the ACA's health insurance fee if the fee is no longer applicable to the state medical assistance program or to insurers participating in the state's group health insurance program. Within the fiscal biennium in which the health insurer fee no longer applies, DOA would be required to reduce GPR and PR expenditures (excluding tuition and fee moneys from the UW System) for compensation reserves by an amount equal to the state savings and transfer to the general fund the related available balances in PR appropriation accounts an amount equal to the

calculated program revenue savings. DOA would have the authority to transfer the savings amounts to the PR appropriation for the reinsurance program. In the fiscal biennium following the fiscal biennium in which the savings are calculated, DOA would be required to adjust state agency employer contributions for state agency fringe benefit costs.

Medical Assistance Program Lapse

AB 885/SB 770 would require the Secretary of the Department of Health Services to ensure that there is lapsed to the general fund from the GPR appropriation for the medical assistance program an amount up to $80,000,000, as determined by the Secretary of the Department of Administration.

FISCAL EFFECT OF AB 885/SB 770

The following sections discuss the fiscal impact of the bill's provisions.

Reinsurance Program Expenditures

Fiscal Impact of the Reinsurance Program in the 2017-19 Biennium. AB 885/SB 770 would increase appropriations by $200,000,000 ($50,000,000 GPR and $150,000,000 FED) in 2018-19 to reflect the administration's estimates of the costs of implementing the reinsurance program, beginning in calendar year 2019. However, since reinsurance payments would be made following the completion of the benefit year, no reinsurance payments would be made until state fiscal year 2019-20. [Since the deadline for making 2019 benefit year payments would be August 15, 2020, it is possible that the 2019 payments could be delayed to 2020-21, but OCI indicates that it would intend to make those payments prior to the end of 2019-20.] If the bill were to be enacted, no funding would be included in the GPR sum-sufficient and FED appropriations for the purposes of the Chapter 20 appropriation schedule. Likewise, no GPR spending associated with the program would be included in subsequent estimates of the 2017-19 biennium general fund condition. Any future GPR spending for the program would, therefore, be an increase over the 2018-19 adjusted appropriation base.

Fiscal Impact of Reinsurance Program in Future Years. While the bill reflects a total of $200 million in 2018-19 in the appropriation schedule for the reinsurance program, this amount has no legal effect on the size of the reinsurance program. The actual amount of funding needed for reinsurance payments could be more or less than $200 million, since the total would be driven, instead, by the reinsurance payment parameters and the amount of resulting eligible claims. As the bill is drafted, OCI would generally be obligated to make payments for all eligible claims in accordance with the parameters. [There may be a potential exception to this, discussed further below under "Potential Effect of OCI Payment Adjustments."]

Once the parameters have been established, the amount of eligible claims would depend on the number and morbidity of individuals purchasing coverage in the individual market, which is itself impacted, in part, by the presence and scope of the reinsurance program. That is, insurers will set premiums in the individual market based on their expectations of reduced medical claims costs

associated with reinsurance payments. As premiums go down, participation in the individual market should increase among consumers who are sensitive to price (those not eligible for premium tax credits).

Because of the complex interrelationship between the reinsurance program parameters, premiums, participation in the individual market, and federal premium tax credit expenditures, the U.S. Department of Health and Human Services requires states to submit an actuarial analysis of any proposed Section 1332 waiver application to ensure that the proposal meets the statutory requirements related to the federal budget neutrality and insurance coverage. The actuarial analysis then becomes the basis for determining the amount of federal pass-through funds that the state receives.

OCI has entered into a contract with a vendor, Horizon Government Affairs (hereafter "Horizon"), to assist with the development of a waiver proposal. Horizon has completed a preliminary report, which has been submitted to OCI, but an actuarial analysis has not been completed for the proposal. [Under the vendor contract, Horizon agrees to retain a consulting actuary to perform this work, with a target completion date of March 15, 2018.]

The starting point of Horizon's preliminary analysis is the size of the reinsurance pool, for which it considers three alternatives: $120 million, $200 million, and $360 million. For each alternative, Horizon estimates that federal pass-through funding would cover approximately 75% of the cost, which would result in a state funding commitment of $30 million, $50 million, and $90 million, respectively.

The primary focus of the Horizon analysis is the potential impact of each reinsurance program alternative on premiums and the enrollment in the individual market (these impacts are described further below), rather than the total amount of payments that would result from particular program parameters. A full actuarial analysis would be needed to provide this estimate, as well as an estimate of the share of program costs that could be paid with federal pass-through funds.

However, a general sense of the magnitude of the reinsurance program with the bill's 2019 parameters can be seen by examining the reinsurance payments made under the federal transitional reinsurance program. In 2015, the federal program established an attachment point of $45,000, a maximum cap of $250,000, and a coinsurance rate of 55%. At those levels, the program was similar to the proposed 2019 program, with a coinsurance rate near the bottom of the allowable 2019 range. The total amount of 2015 reinsurance payments made to insurers in the Wisconsin market was $182 million. Inflating this total to 2019 at a 5% annual rate (the underlying trend rate used by Horizon to reflect medical inflation) generates an estimate of approximately $220 million. Although this is higher than the $200 million Horizon scenario, the actual payments could be somewhat lower due to a slightly higher 2019 attachment point ($50,000 as opposed to $45,000) and a somewhat smaller individual market enrollment. [5] Nevertheless, this estimate suggests that to

[5] A decrease in the number of individuals enrolled in individual market plans, relative to 2015, may not significantly impact reinsurance payments, however, if the reduction from 2015 to 2019 is primarily due to relatively healthy individuals electing to forgo coverage, since these individuals would be less likely to have high-cost claims.

have a reinsurance program of approximately $200 million in 2019, OCI would likely need to set the coinsurance rate at the lower end of the 50% to 80% range.

Potential Effect of OCI Payment Adjustments. The bill would allow OCI to apply a proportionate adjustment to payments "if funding is not available to make all reinsurance payments to eligible health carriers in a benefit year." However, since the program is funded, in part, with a sum sufficient GPR appropriation, there would be no legally binding limit on the amount of funding appropriated for making reinsurance payments. OCI indicates that its intent would be to limit the amount of reinsurance payments to $200 million per year, by administrative rule. Such a limit could potentially be used as the basis of reducing payments. However, the bill would not explicitly require or authorize OCI to set a limit by rule.

Administrative Costs. At the time of publication of this memorandum, OCI had not submitted its fiscal estimate for the bill, but indicated that it would absorb the initial administrative costs associated with the program within its current budget. OCI's contract with Horizon is for $350,000.

Reinsurance Program Impacts on Premiums and Enrollment

The Horizon report provides estimates of the impact of a reinsurance program on the 2019 and 2020 individual market premiums and enrollment. The following table shows Horizon's estimates for each scenario (along with 2018 estimates), in comparison with Horizon's baseline estimate, reflecting a scenario with no reinsurance program. Enrollment estimates reflect the anticipated December 31 enrollments, which are lower than initial effectuated coverage due to attrition throughout the year.

Preliminary Estimate of Premium and Enrollment Impacts of $200 Million Reinsurance Program, Horizon Government Affairs

	2018	2019	2020
Average Premium Increase			
Baseline (No Program)	38%	15%	10%
With Reinsurance	--	2%	-2%
Difference	--	-13%	-12%
Individual Market Enrollment			
Baseline (No Program)	194,500	175,100	166,300
With Reinsurance	--	184,700	188,500
Difference	--	+9,600	+22,200

Horizon's estimates take into consideration the impact of the recent repeal of the ACA's individual mandate, which requires individuals, with certain exemptions, to purchase ACA-compliant healthcare coverage. Horizon's baseline estimate assumes that the repeal, which takes effect in 2019, will increase premiums in the individual market by 10% in 2019 and 5% in 2020.

Department of Administration Lapse of State Savings Associated with Federal Insurance Fee Repeal

The ACA imposes various taxes and fees to offset the cost of new federal expenditures, including premium tax credits. Among these is a health insurer fee, imposed on health insurance companies based on respective market share of premium revenues and the size of the company. Congress suspended the health insurer fee on a one-time basis for 2017, and again for 2019.

The bill would require the DOA Secretary to calculate the savings to the medical assistance program and to the state's group health insurance program for employees if the health insurer fee is no longer applicable. In the fiscal biennium in which the savings are calculated, DOA would be required to reduce compensation reserves by an amount equal to the savings.

Impact on Medical Assistance. Certain nonprofit health maintenance organizations whose primary business is to provide coverage for medical assistance beneficiaries are exempted from paying the fee. For those that are required to pay, however, the MA program reimburses the companies for the cost of the fee. MA pays the reimbursement in the fiscal year following the calendar year in which it was imposed. Since the fee was not imposed in 2017, the program will not incur reimbursement costs in 2017-18 and no funding was provided in the MA budget in the 2017-19 budget for that purpose. However, the 2017-19 budget included an estimate of $20.1 million GPR in 2018-19 to reimburse HMOs for the 2018 fee. Since the program will be required to pay this fee, there would be no impact on MA associated with this provision in the 2017-19 biennium. In future biennia, any impact would depend upon whether the biennial budget includes funding for paying the fee, in addition to whether the fee is suspended.

If the MA budget includes funding for reimbursing HMOs for the health insurer fee in future biennia, and the fee is suspended for the applicable year, the proposed adjustment provision would not impact the MA budget. The bill would require only that DOA reduce compensation reserves by the amount of the savings associated with any suspension of the fee. However, the funding for the MA HMO reimbursements is provided through the MA program appropriations, not compensation reserves. Under current law, any reduction in GPR expenditures in MA as the result of a suspension of the health insurer fee would lapse to the general fund at the end of the applicable fiscal biennium.

Impact on Group Health Insurance Plan. The state group health program, which provides health care coverage to state active employees and retirees as well as participating local government active employees and retirees, pays fixed premiums to health insurers for each covered member. The premiums paid to insurers under the program are determined through contract negotiations prior to open enrollment each fall for implementation the following calendar year. State agencies must pay for employee salaries and fringe benefits, including health care coverage, using the appropriations from which the positions are funded. If funding for compensation is not sufficient within an appropriation budget, an agency may request that the Department of Administration recommend a pay plan supplement, subject to Joint Committee on Finance approval, from compensation reserves. The amounts allocated to compensation reserves are determined through the biennial budget process. Under the 2017-19 budget, it was assumed that

amounts associated with the ACA health insurer fee would not be charged to the state group health program by health insurers. Therefore, savings associated with a potential repeal or suspension of the fee have already been accounted for in the 2017-19 budget for compensation reserves.

Further, the Department of Employee Trust Funds and its consulting actuary, Segal, negotiated aggressively with health plans (insurers) for the purpose of realizing cost reductions in amounts established by biennial budget deliberations. Biennial budget savings targets limited the renewal goal to a 3% overall increase in state rates. In comparison, preliminary bids by insurers would have constituted an increase of 7.8%. Additionally, no consideration was given in negotiations to allowing increases specific to ACA health insurer fees projected for 2018.

Given that funding allocated to compensation reserves was based on an assumption that costs associated with the ACA health insurer fee would not be paid by the state for its group health plans in 2017-18 and 2018-19, the elimination of the fee would not result in any additional state employer savings in the 2017-19 biennium. Although a repeal or suspension of the fee could reduce costs for insurers in 2018, premiums paid by the state, which do not include an allowance for the fee, would not be reduced. Therefore, no lapses from compensation reserves should be made in the 2017-19 biennium associated with this bill provision. In the next biennial budget, it is possible that an amount might be estimated for paying the fee in 2020 (a moratorium is in effect for 2019). The amounts allocated to compensation reserves in 2019-21 would be determined by the Legislature through budget deliberations.

Program Revenue Appropriation. The bill would create a PR appropriation for the reinsurance program, with the intent of offsetting GPR costs of the program using any state savings from the suspension of health insurance fee. DOA would be authorized to transfer from the general fund, to the PR appropriation, any amounts taken from compensation reserves under the health insurance fee provision. Since all of the funding in the PR appropriation would be transferred from the general fund, this provision would have no net impact on general fund support for the program.

Medical Assistance Lapse

The bill would require the DHS Secretary to ensure a lapse of up to $80,000,000 from the GPR appropriation in the medical assistance (MA) program. The bill does not specify the year for the lapse, although since the provision was included in a nonstatutory section, it can be assumed that the intent was to lapse the funds in the 2017-19 biennium. The administration indicates that although the bill anticipates state funding of $50,000,000, the bill would allow a lapse of up to $80,000,000 to allow for a margin in the event that additional state funding is needed for the reinsurance program.

It should be noted that since no reinsurance payments would be made in 2018-19 (as explained above), a lapse from MA would not be necessary in the 2017-19 biennium solely for the purpose of funding the reinsurance program. Consequently, any lapse generated under this provision would have the effect of increasing the biennium-ending balance in the general fund.

However, in the event that the MA lapse provision is enacted, DOA has identified several sources of potential MA program savings. In its most recent quarterly report on the status of the MA budget (December, 2017), the Department of Health Services projected that the program will end the 2017-19 biennium with a GPR surplus of $9.6 million. The Department of Administration takes the position that additional program savings are possible, citing two factors. First, DOA indicates that one monthly payment under the state's "clawback" contribution to the federal government (a financing mechanism for Medicare Part D) could be delayed, from fiscal year 2018-19 to fiscal year 2019-20, resulting in one-time GPR savings of approximately $22 million in 2018-19. Second, DOA believes that caseload growth in BadgerCare Plus could be somewhat lower than the December quarterly report projections, resulting in estimated GPR savings of approximately $20 million. When added to the previously-projected biennial surplus, these factors would provide enough GPR savings to generate a lapse of just over $50 million, although still short of the $80 million maximum under the bill. Both of these factors are discussed further below.

Clawback Payment Delay. For the past several biennia, DHS has made clawback payments according to a pattern of 13 monthly clawback payments in the even-numbered fiscal year and 11 payments in the odd-numbered year. The 2017-19 budget for MA was based upon the assumption that this would continue. [The decision to make only 11 payments at the end of the biennium was done at one time to generate one-time savings as the result of a projected deficit.] However, because the program had a budget surplus at the end of the 2015-17 biennium, DHS made the decision to make 12 payments in 2016-17, potentially getting back on a pattern of making 12 monthly payments in each year. The Department's latest quarterly report assumes that 12 payments will be made in each year.

Because DHS currently assumes that 12 payments will be made in 2018-19, it is possible, as DOA suggests, to generate additional one-time savings in MA during the 2017-19 biennium by making only 11 payments in 2018-19, generating GPR savings of approximately $22 million. This would, however, again result in payment delay pattern for the 2019-21 biennium (13 payments in 2019-20 and 11 payments in 2020-21), unless the state budgeted for an additional, twelfth payment in 2020-21.

BadgerCare Plus Enrollment. The 2017-19 budget for MA was developed using relatively cautious assumptions, to provide for a modest budget margin in the event that unanticipated increases in enrollment or spending were to occur. Thus far, there are no clear trends that would suggest that program expenditures will exceed budget projections. Indeed, the Department's December quarterly report, despite using relatively conservative enrollment growth assumptions for 2018-19 (that is, growth at a higher rate than recent trends), projects a small budget surplus. DOA asserts that lower enrollment in BadgerCare Plus, relative to the DHS assumptions, could generate an additional GPR surplus of at least $20 million.

An additional budget surplus is possible, as DOA suggests. However, while there are, seven months into the biennium, no concerning trends in MA enrollment and expenditures, it is also too early in the biennium to rule out the possibility that circumstances would change, resulting in a deficit rather than a surplus. With a biennial budget of $6.1 billion GPR, shifts in expenditures of $20 million or more, in either direction, are not uncommon.

In the event that the MA program does not realize a surplus as the result of lower enrollment, DHS would have limited options for achieving savings in other ways. Under state and federal law, MA pays for medically necessary services for all individuals who meet eligibility criteria. The Department is generally not able to reduce services or enrollment for the sole purpose of reducing expenditures. Consequently, the Department may need to use other measures, such as the clawback payment delay, or provider payment reductions or delays, to generate any necessary savings.

It should again be noted that a lapse from MA would not be necessary for the purpose of funding the reinsurance program, since no payments would be made during the 2017-19 biennium. Even without the bill's lapse requirement, any surplus in the GPR budget for MA would lapse to the general fund at the end of the 2017-19 biennium, since the program is funded with a biennial appropriation.

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