WISCONSIN OFFICE of HEALTH CARE REFORM

Wisconsin Office of Health Care Reform

Wisconsin Health Insurance Exchange: A 2010 Report – A Starting Point

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Table of Contents

1 Introduction: Wisconsin's Vision for a Health Insurance Exchange

The Patient Protection and Affordable Care Act (ACA) creates an opportunity to reform the health insurance marketplace in order to provide all Americans with quality, affordable health insurance coverage. A primary feature of the new law is the requirement that all states establish health insurance exchanges. The exchange will be a marketplace where individuals and small businesses can purchase health insurance or access public benefits. Exchanges are intended to be a tool that will allow consumers to easily compare health plan options, act as a conduit for using premium subsidies provided by the federal government and employers and facilitate the purchase of and enrollment in private and public health insurance. The exchange is envisioned to be a consumer-friendly tool as well as a competitive marketplace for transparent and affordable health insurance options.

The creation of health insurance exchanges is a historic opportunity for states. States will play a critical role in planning for and establishing exchanges and, due to the existence of vastly different insurance markets that exist across the country, states will be in the best position to administer a successful exchange, provided they are given the ability to tailor the exchange to meet their specific needs. Health care reform's success hinges largely on states and their ability to implement exchanges swiftly and effectively. While the new legislation sets forth minimum standards[1] that must be met, significant flexibility is left for states to implement exchanges in a manner that best fits the unique needs of their residents. States must demonstrate their readiness for exchange development by January 2013 and must establish an exchange by January 1, 2014. If a state does not establish an exchange, the United States Department of Health and Human Services (HHS) will establish one in place of a state-based exchange, which will be administered directly by the federal government or by a not-for-profit contracted entity.

Wisconsin taxpayers are expected to directly benefit from national health care reform implementation. National health care reform is good for Wisconsin because it will mean lower taxes for Wisconsin citizens. State taxpayer contributions to public health care programs are expected to decline substantially. Specifically, Wisconsin is expected to save as much as $850 million over a five year period beginning in FY2014. Furthermore, it is estimated that as many as two million[2] Wisconsin residents may be eligible to purchase health insurance through the exchange and that between $500 million and $1.0 billion in federal tax credits[3] will be available to Wisconsin residents to purchase high quality, affordable health insurance through the exchange. These tax credits will

[1] See appendix F for minimum requirements

[2] This figure is an estimate comprised of approximately 160,000 people in the non-group market, 1 million individuals employed by small businesses and 770,000 individuals enrolled in BadgerCare Plus.

substantially reduce health insurance premiums for low and moderate income families. For example, it is estimated that a family of four at 200 percent of the federal poverty level would receive a tax credit of approximately $7,000, or 72 percent of the overall premium. Given the large amount of money that will be available to our state, much of which is dependent on consumers purchasing health insurance through the exchange, it is of great importance that Wisconsin creates a health insurance exchange that provides a value-add to consumers and is effective and easy to use.

The purpose of this document is twofold. First, to put forth a vision and roadmap for the development and implementation of a state-based health insurance exchange, and second, to solicit feedback from a diverse set of stakeholders on the overall direction contained herein. Over the past six months, the Wisconsin Office of Health Care Reform has engaged in many discussions related to health care reform and the development of a state-based exchange with stakeholders and health care leaders. The Office of Health Care Reform (OHCR) looks forward to continued feedback and future discussions with Wisconsin's broader health care community, outside experts, federal officials and other interested parties.

Wisconsin is recognized as a national leader in health care reform. Thanks to Governor Jim Doyle's leadership, Wisconsin has the second lowest uninsured rate in the U.S.[4] and ranks first in quality[5]. The Office of Health Care Reform views the passage of national health care reform and the development of a state-based health insurance exchange as an opportunity to continue to build on its past efforts. Prior to the passage of national health care reform, Wisconsin had made it a priority to provide access to affordable health care for all residents. Wisconsin's expansion efforts include the launch of the BadgerCare Plus program for children, pregnant women, and families; the BadgerCare Plus Core Plan for low-income childless adults; and most recently, the creation of the self-funded, health care coverage program for low-income adults without dependent children, the BadgerCare Plus Basic Plan.

Beyond the minimum ACA requirements, states will need to decide whether the exchange is a neutral source of information that plays a passive role of a market organizer and distribution channel or seeks to play an active role as a purchasing agent to leverage the exchange's collective purchasing power, drive competition, and transform the health care delivery system to reduce health care costs and improve the quality of care.

The Office of Health Care Reform's vision for an exchange moves beyond a mere aggregator of health insurance options, to a mechanism that influences how health care is delivered in our state. The Office proposes to utilize the exchange as a tool to realize

[4] 2008 U.S Census
[5] Agency for Health Care Research and Quality (AHRQ)

greater value in health care by improving quality and reducing health care costs. In short, The Office sees the health insurance exchange as a transformative force.

The remainder of this document lays out, in detail, information on Wisconsin's small group and non-group insurance markets and the Office of Health Care Reform's vision for successful implementation of a health insurance exchange that adheres to the federal guidelines and best meets the needs of the residents of our state.

2 Guiding Principles

To achieve the vision outlined above, the Office of Health Care Reform recommends that the following guiding principles be maintained to help define the structure, power and function of Wisconsin's health insurance exchange.

Develop a State-Based Health Insurance Exchange	Develop a state exchange through an open, deliberative process that will involve a broad range of stakeholders and prepare to implement an exchange that will be operational by January 1, 2014
Create Environment of Choice and Promote Competition Among Health Insurers	The exchange will be committed to strengthening Wisconsin's pluralistic private sector based coverage options. The exchange will maintain an insurance marketplace that maximizes choice for all participants, is accessible and attractive to private insurers, ensures fair competition among insurers, prevents dominancy by a single or small number of payers and preserves and strengthens Wisconsin's tradition of employer sponsored health insurance.
Simple and Easy to Use with Focus on Consumers	The exchange will keep the process of purchasing health insurance simple, with the focus on the consumer and consumer experience and provide accurate, useful information to make informed decisions regarding health plan choices and the purchase of health care.
Non-Partisan and Publicly Accountable	The exchange will maintain a governance model that is non-partisan, insulated from political decision making and publicly accountable.
Maintain Separate Private and Public Insurance Markets	The exchange will maintain an environment under which public insurance programs will remain separate from non-public products offered through the exchange.
Encourage Greater Personal Responsibility	The exchange will make personal responsibility and prudent use of health care services a priority.
Act as a Transformative Force	The exchange will offer broad access and seek to improve quality and reduce health care costs by measuring and rewarding value.

Build Off Regional Strengths

The exchange will operate statewide, while welcoming health insurers to participate regionally. Regional health plans will not be required to expand geographically as a condition of participation in the exchange.

3 Wisconsin's Accomplishments

To date, the Office of Health Care Reform has made significant headway in implementing health care reform at the state level. Wisconsin is among the few states that have made progress in completing deep analysis and addressing key decisions related to health care reform and, more specifically, the development of a health insurance exchange, such as staffing models, governance structure, IT platforms, data sharing processes and alignment of key stakeholders.

This section highlights the Office's most significant accomplishments since the Affordable Care Act (ACA) was signed into law on March 23, 2010, that relate to health care reform.

1. Upon the passage of the ACA, Governor Jim Doyle created the Wisconsin Office of Health Care Reform through executive order #312. The Office was charged with:

    - Developing of a plan that uses national health care reform to build on Wisconsin's successful reform efforts and existing programs;

    - Ensuring that Wisconsin's residents and businesses realize the benefit of national health care reform by doing all of the following:
        - Providing transparent access to information so individuals and businesses can make informed decisions on their health care coverage;
        - Assessing insurance market reforms needed to prepare Wisconsin for final implementation of national health care reform in 2014;
        - Developing a plan to pursue federal funds for a temporary high risk pool to maximize affordable coverage for uninsured persons with pre-existing conditions.

    - Creating a health insurance exchange that will:
        - Create an easy-to-use, consumer-friendly Web site where small business owners and individuals can find an apples-to-apples comparison of insurance policies, including benefits offered and how much they cost;
        - Provide a single point of access for all eligible residents and businesses to choose their insurance;
        - Promote consumer choice by providing easy comparability of health plans and lower health care premium costs by creating a large pool of employees to increase consumer purchasing and bargaining power;

        - Ensure that the health insurance purchasing exchange is structured to reward the highest quality and most cost-effective health care providers and insurers.

    - Pursuing federal grants to assist in developing the exchange and implementing any other aspects of health care reform.

    - Directing that the Department of Health Services, on behalf of the Office, to launch and regularly update a new Web site — www.healthcarereform.wisconsin.gov — that will provide Wisconsin residents with information about national health care reform, implementation, and how changes may benefit them.

2. Launched the Wisconsin Office of Health Care Reform Web site.

   The Office of Health Care Reform Web site provides the public with information about the ACA, as well as upcoming grant opportunities. The Web site also provides a Lyris list-serve update to keep interested parties informed on a regular basis and includes a vehicle for the public to submit questions directly to the Office.

3. Established a new Federal High Risk Pool.

   Within 90 days of becoming law, federal funds were made available to states to establish or expand state programs for individuals with pre-existing medical conditions. Wisconsin received $73 million in federal grant funds for the new high risk pool program. As of November 2010, Wisconsin has received 422 applications and 249 individuals have been enrolled in the new federal high risk pool, with 68 additional applications pending.

4. Submitted a response to a Request for Information issued by the Department of Health and Human Services regarding exchange development.

5. Applied for and was awarded a $1 million federal planning grant for the design of state-based health insurance exchanges.

   Among other things, the planning grant is funding a Wisconsin-specific insurance market analysis, to be completed by Gorman Actuarial, LLC, which will include a survey of Wisconsin's non-group, small group and large group markets. Dr. Jonathan Gruber, an economist from MIT, will use the data from the Gorman analysis in order to model the impact the new insurance market reforms will have on Wisconsin. Once completed, this modeling will help guide policy and inform key decisions related to health care reform. The insurance market reports are included in the appendix of this document.

6. Issued the first request for proposal (RFP) in the nation for the maintenance and enhancement of Wisconsin's Medicaid eligibility determination system and development of the exchange. The contract has been awarded and design work on the exchange has begun.

   Having secured a vendor for the development of an exchange will allow the Office to proceed immediately with the development and implementation of a health insurance exchange. This is important given the limited resources available for building an exchange and that it is expected that most states and the federal government will all likely need to procure these same resources in order to develop their respective exchanges.

7. Developed the first working exchange prototype in the country. The prototype can be located at the following URL: https://exchange.wisconsin.gov/.

8. Applied for and received awards for many federal grants included in the ACA, including, but not limited to:

   - Rate Review Grant in the amount of $1 million.
   - Consumer Assistance Grant in the amount of $637,114.
   - Medicare Outreach and Assistance in Low Income Programs Grant in the amount of $1.27 million.
   - Maternal, Infant and Early Childhood Home Visiting programs in the amount of $1.18 million.
   - Public Health Infrastructure for purposes of Responding to Emerging Infections in the amount of $2.2 million.
   - ADRC Options Counseling Grant in the amount of $472,000.
   - Money Follows the Person Grant in the amount of $395,000.

9. Actively engaged and solicited feedback from Wisconsin's health insurance sector leaders and stakeholders for the planning of a state-based exchange.

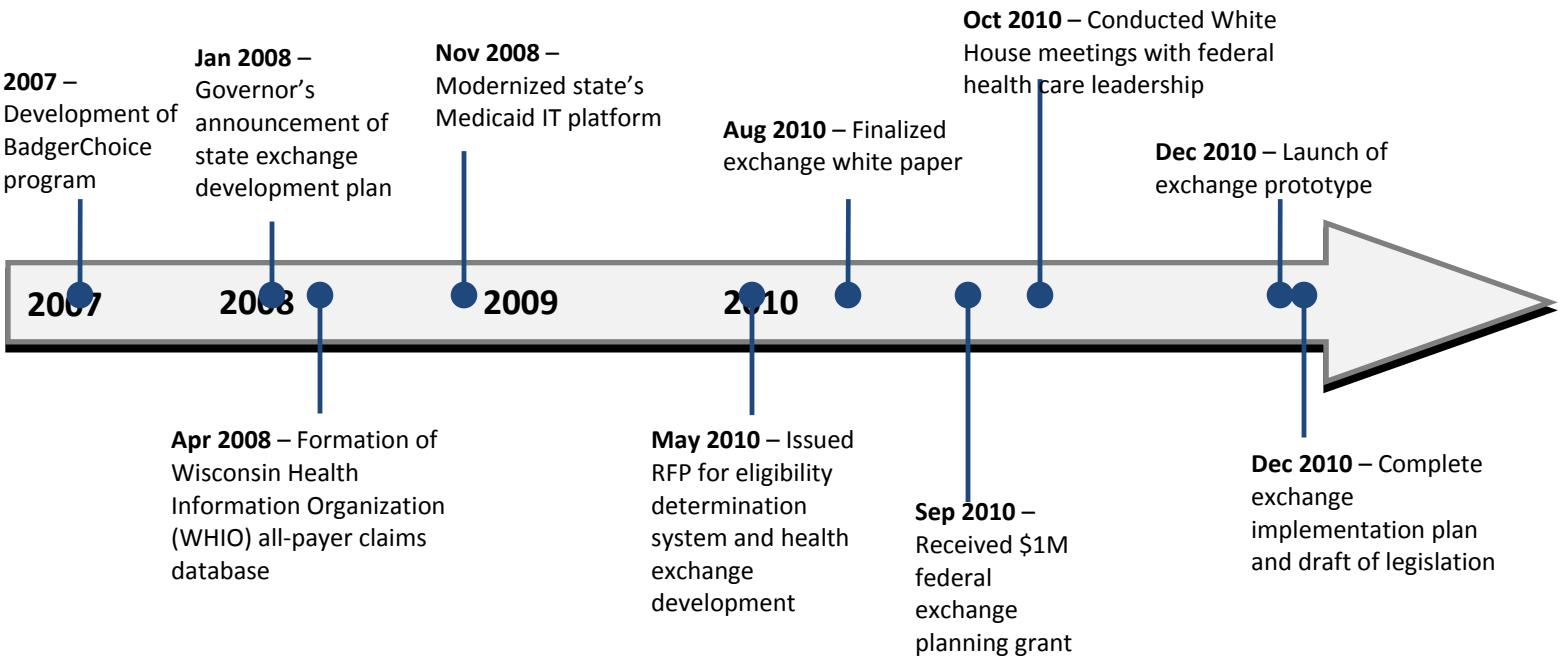
   The Office of Health Care Reform has engaged over 40 health systems, insurers, and provider groups.

   The Office of Health Care Reform has also met with nearly 20 stakeholder groups including rural health providers, consumer advocacy groups, Co-op representatives, broker groups, and business representatives.

10. Met with lead White House and HHS staff to discuss exchange planning and implementation.

11. Applied for an Early Innovators grant, which if awarded, is expected to provide Wisconsin with over $50 million in federal funds in order to assist in the implementation of IT systems that will support the exchange. Awards will be made to up to five states or consortiums.

    The timeline below depicts some of the Office of Health Care Reform's exchange planning related efforts and the date which they occurred.



4 Planning and Implementation Timeline

Rather than a full launch on January 1, 2014, the Office will look to implement a phase in of the exchange, consisting of a series of sequential releases, to ensure exchange designs minimize the risk of systems failures and can course correct over time, but prior to 2014. Areas that have been identified as most benefiting from a phased-in approach include the adoption of the MAGI income calculation methodology, the launch of a Web-portal and implementation of new data sharing arrangements. Each of these items is discussed in greater detail throughout this document.

States like Wisconsin that are prepared to move quickly can provide other states and the federal government with key lessons learned from early activities and best practices for design and implementation and the means for addressing unforeseen challenges and avoiding unintended consequences.

5 Current State of Health Insurance in Wisconsin

5.1 Non-Group Insurance Market

As of December 31, 2009, Wisconsin's non-group insurance market was comprised of approximately 160,000 individuals. Wisconsin has a competitive individual health insurance market with limited regulatory oversight and an estimated 11 carriers offering individual insurance coverage. According to a 2010 study produced by Gorman Actuarial, LLC, there is no dominant carrier in the individual market. Five of the 11 carriers serve just over 75 percent of market membership. Over 70 percent of policies in the non-group market are for single individuals, with an average estimated annual deductible of $2,900. The average estimated annual deductible for a family policy in the non-group market is $7,500. Of those members enrolled in a policy in the non-group market, 41 percent did not incur any medical claims in 2009, while approximately 1 percent of the population accounted for 36 percent of total costs. It is also important to note that for the individual market, the average age of individuals with non-group insurance increases as the deductible amount increases. It is suggested that this paradox may be attributable to individuals purchasing high deductible plans as they get older because of the higher surcharges that accompany age.

While over 77 percent of the individual market is enrolled in a preferred provider network option, the benefits offered by each plan vary by carrier and plan type. Currently, there is no standard definition of preventive services covered by a health plan; however, all 11 carriers cover 100 percent of childhood immunizations. Maternity, pharmacy, and behavioral health benefits are often not included as standard in health plans offered in Wisconsin's non-group insurance market. As a result of the high additional cost of these benefits, 21 percent of individual market members did not purchase pharmacy coverage and only 2 percent of the overall market purchased the maternity rider.

5.2 Non-Group Rating Rules

Individual health insurance policies are subject to rate regulation under ch. 625, Wis. Stats. This chapter specifies that rates are presumed not excessive if a competitive market exists. Specifically, this chapter includes the following provisions: (a) rates cannot be excessive, inadequate, or unfairly discriminatory, nor shall insurers charge any rate, which if continued, will have the effect of destroying competition; (b) the Commissioner has the authority to promulgate a rule delaying an insurer's effective date of for filed rates for a particular line of business to 15 days after filing if the commissioner determines that competition does not effectively regulate the rates charged; (c) the Commissioner can hold a hearing to determine if a rate is excessive, inadequate, or unfairly discriminatory

and order that the rate be discontinued. Chapter 625, Wis. Stats., requires that the Commissioner must demonstrate that the class of business does not have a reasonable degree of price competition in order to establish that a rate is excessive.

Wisconsin Administrative Code requires the following with regard to rate filing requirements in the individual market:

- A schedule of rates including policy fees or rate changes at renewal;
- Variations based on age, sex, occupation, or any other classification;
- Anticipated loss ratio on an earned-incurred basis; and
- For revisions, a statement of the experience on the policy form and the anticipated loss ratio on an earned-incurred basis.

The Office of the Commissioner of Insurance (OCI) reviews all rate filings to verify that sufficient documentation is submitted, including an actuarial certification. The department contracts with an actuary to review rate filings in order to ensure that filings are complete.

The analysis completed by Gorman Actuarial, LLC, indicates that the health plan rating processes for the non-group market currently vary significantly. In addition to age, gender, and tobacco use of the policyholder, most carriers also adjust for geography and an individual's health status. In 2009, all 11 carriers in the individual market adjusted for the gender of the policyholder, with a current overall age band for the market of 5.1:1. Ten of the 11 carriers adjusted for tobacco use, with an average adjustment of 1.3:1. Most carriers also adjusted rates based on the location of the individual, with the lowest discount for members who reside in the Northeastern region of Wisconsin and the highest surcharge for those members in Milwaukee. Six carriers also applied a spousal discount for married policyholders, and four carriers included exclusionary riders as a form of health underwriting in their policies.

The medical loss ratio (MLR) of a health insurer is most simply described as the amount of premium dollars that go towards the participants' medical care. The total MLR for Wisconsin's non-group market in 2009, using the ratio of incurred claims to billed premium, was 81.4 percent. The methodology used to calculate this percentage is slightly different from that which will be used by the federal Department of Health and Human Services (HHS) to determine a plan's medical loss ratio. Generally, it is anticipated that plan MLRs will likely increase by between 2 percent and 5 percent under the new calculation.[6] Milwaukee had the lowest MLR of 67 percent, while the Northern region of the State had an MLR of 93 percent, suggesting that the Milwaukee region may be cross-

[6] Market Summary for Wisconsin's Individual Health Insurance Market, Gorman Actuarial, LLC.

subsidizing the North. Beginning on January 1, 2011, health plans offering non-group health insurance coverage will be required to have an MLR of at least 80 percent.

It should be noted that the OCI was recently awarded a $1 million grant (provided through the Affordable Care Act [ACA]) to develop a process designed to increase the number and the scope of rate reviews for the individual, small group, and large group market segments. Grant funds will be used to enhance transparency and understanding of rate filings through the development of a public hearing process and to invest in creating readable rate information for review by the public. Additionally, the funding will be used to develop a premium database designed to better monitor, assess, and analyze the health insurance market, including individual issuer rate activity. It is expected that the development of this database will provide OCI with the ability to conduct robust data analysis and data exchange capabilities both within the state as well as with the federal government in preparation for enhanced data requirements that will be part of future HHS regulatory requirements.

5.3 Small Group Insurance Market

Wisconsin Statutes define a small group employer as one with two to 50 permanent employees working at least 30 hours a week. The data from the U.S. HHS Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Survey (MEPS) indicates that in 2009 there were approximately 685,278 individuals employed by one of the 96,068 private-sector small businesses in Wisconsin. According to the survey representing 73 percent of Wisconsin's small group insurance market, conducted by Gorman Actuarial, LLC, approximately 25,000 small employers offered employer-sponsored health insurance in 2009. Based on the information from MEPS and the Gorman Actuarial, LLC, survey, it is estimated that approximately 26 percent of small group employers in Wisconsin offered health insurance to their employees in 2009. The Gorman Actuarial, LLC, survey estimates that in 2009, 170,000 employees and 332,000 individuals were covered under a small group insurance policy. Again, by combining the above mentioned data sources, it is estimated that approximately 24 percent of employees employed by small businesses were enrolled in a health insurance policy through their employer. In contrast, according to the MEPS survey, 95 percent of large businesses in Wisconsin offered insurance to their employees, with 78 percent of their employees choosing to enroll in a health plan. Membership in the small group insurance market has declined by about 14 percent since 2007; however, this number is on trend with previous analyses of the market.

About 40 insurers wrote in Wisconsin's small group market in 2009. Of these insurers, 11 of those carriers wrote for 73 percent of the market share.

Furthermore, one carrier had over 30 percent of the market share and three carriers have over 50 percent of the market. The average group size for small employers offering health insurance was seven employees. Approximately 55 percent of small group employees are single policy-holders — 20 percent less than those in the individual market. Sixty percent of small group members are enrolled in a point of service (POS) health plan.

Many of the plans offered in the small group market have similar benefit packages but vary in required cost sharing, deductibles, and preventive service coverage. According to the Gorman Actuarial, LLC, study, the average single policy deductible in the small group was estimated at $1,522, while the average family deductible was estimated at $3,200. Twenty three percent of the small group membership did not incur any claims in 2009, compared to 41 percent in the individual market. Additionally, 1 percent of the membership accounted for 28 percent of total costs, with the average cost per member amounting to $3,431.

5.4 Small Group Rating Rules

Wisconsin statutes do not contemplate significant regulatory involvement by the insurance department over the rates insurers use to calculate the premiums charged to small employers and their employees. However, pursuant to state law, rating factors based on health status (including occupation and claims history) are limited to a 15 percent annual increase, and premiums can vary by no more than more than +/- 30 percent of the midpoint for similar policies. Wisconsin law does not limit the factors used based on case characteristics (e.g., age, sex, geography, group size) and as a result, premiums charged to small employers can vary significantly, depending on the location of the small employer and the composition of the small business employees' medical status and case characteristics. All insurers surveyed in the small group market adjust rates for age, gender, health status, and group size; ten of the 11 carriers adjust for geography. Based on all rating factors combined, Milwaukee region premiums were surcharged 8 percent, while the Northern region was discounted by 5 percent.

The MLR is the proportion of an insurer's incurred claims to earned premiums over a reporting period, or more simply described as the amount of premium dollars that go towards the participants' medical care. The total MLR for Wisconsin's small group market in 2009, using the current methodology for calculating MLR which may or may not include expenses for quality improvement, was 82 percent. Of all 11 carriers surveyed, only one carrier had an MLR below 80 percent. Seventy two percent of members were enrolled in a health plan with an MLR between 80 percent and 85 percent. Twenty eight percent of the membership belonged to a plan with an MLR between 86 percent

and 90 percent. It is important to note, however, that the Milwaukee area had the lowest MLR (74 percent), but the highest average premium per member ($378.36), while the Northern and Western regions had the highest MLRs (92 percent and 91 percent, respectively), but lower average premiums per member. It is suggested that the variances in MLR can be attributed to the type of insurer providing the coverage (HMO versus PPO and POS), the ownership structure of the insurer (provider owned versus non-provider owned), the distribution system utilized by the insurer (independent brokers versus captive agents) and the health care costs in a particular region, among other things.

Similar to the requirement for the non-group market, beginning January 1, 2011, the ACA will require an 80 percent MLR for small group coverage. If a health plan spends less than 80 cents of one premium dollar on medical care and quality, it must provide a rebate to each enrollee that is proportional to the premium amount paid by each enrollee. The definition of an MLR described above does not correspond exactly to the MLR definition that HHS will be using for rebate purposes. Quality improvement measures and federal and state taxes applicable to health insurance coverage are considered to be part of this 80 percent, while administrative costs, profits, and marketing are not. The rebate will go to each group policyholder with the expectation that they will pass it on to the enrollee. Additional insurance market reforms are discussed in Section 13.1 of this document.

5.5 Large Group Insurance Market

In the state of Wisconsin, a large employer is defined as an employer with more than 50 full-time equivalent employees who work at least 30 hours per week. Under the ACA, a large employer is defined as an employer with at least 101 employees during the preceding calendar year, and at least one employee on the first day of the current plan year. However, states may elect to define large employers as those with 51 or more employees during the preceding calendar year and at least one employee on the first day of the current plan year. Currently, 95 percent of large employers in Wisconsin offer health care coverage to their employees. According to the OCI Health Insurance Coverage in Wisconsin Report of 2009, 1,324,571 individuals (including employees and their dependents) were enrolled in a health plan offered in the large group market as of December 31, 2009. Of all members enrolled in this market, 80 percent of enrollees are employed by 20 companies, with the top 10 companies in the market comprising 60.5 percent of the market membership.

The Gorman Actuarial, LLC, survey on the large group market was limited to employers with 51-100 employees. The survey indicates that in 2009, there were approximately 221,000 members and 105,000 subscribers enrolled in employer

sponsored health insurance who were employed by 2,000 large businesses. The Gorman Actuarial, LLC, study surveyed 14 carriers, which make up approximately 79 percent of the market that covers individuals employed by business of this size. Of those members enrolled in a large group 51-100 health plan, 50 percent of the policies were for single individuals, while, 26 percent of the membership was children ages 17 and under. In 2009, approximately 1.2 percent of the market membership accounted for nearly 32 percent of total costs, while 23 percent of members did not incur any claims. The average cost per member for the large group 51-100 market was $4,018. The average in-network deductible for a single policyholder was $1,531, and a family policy had an average deductible of $2,778.

5.6 Large Group Rating Rules

Unlike the small and individual health insurance markets, Wisconsin Statutes do not set forth rating rules for the large group insurance market. Rather, premium rates for this market are largely based on the claims experience of the group seeking coverage. In 2014, small group and individual group health plans participating in a state exchange will only be allowed to vary rates based on age, tobacco use, geographic location, and whether the policy is for an individual or a family. If a state permits a large group employer to purchase health insurance through their exchange in 2017 — an authority granted under Section 1312 of the ACA — the aforementioned rating rules will apply to health plans for any large group employer who goes through the exchange.

The Gorman Actuarial, LLC, survey indicates that between 60 and 70 percent of insurance carriers in the large group 51-100 market combined claims experience ratings with manual adjustments for factors such as age/gender, industry, region, health status, duration, SIC, and other predictive modeling factors. These two rating factors were then further weighted based on credibility, meaning, the greater the group size, the greater the credibility and the greater the weight. The report indicates that variability in premium rates was smoothed out using various techniques adopted by carriers and an administrative charge was generally added to reflect group size. The greater the group size, the lower the administrative charge. The other 30 to 40 percent of insurers manually adjusted their rates for the predictive factors previously mentioned.

The MLR for health plans in the 51-100 large group market was 0.893, a three point increase from 2008; however, the MLR for the entire large group market (including the market above 100) in 2009 was 0.891. Four carriers had an MLR of less than 0.85, with a range from 0.69 to 1.02. Similar to the small group and individual markets, Milwaukee had the lowest MLR by employer location (0.82) and subsidized the MLR for health plans in the Northern, Western, and

Southeastern regions (all with an MLR of 0.94). Beginning on January 1, 2011, large group insurers are required to have a medical loss ratio of at least 85 percent. If a health plan spends less than 85 cents of one premium dollar on medical care and quality, it must provide a rebate to each enrollee that is proportional to the premium amount paid by each enrollee. Quality improvement measures and federal and state taxes applicable to health insurance coverage are considered to be part of this 85 percent, while administrative costs, profits, and marketing are not. The rebate will go to each group policyholder with the expectation that they will pass it on to the enrollee.

5.7 Wisconsin High Risk Pool (HIRSP)

Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP) was established in 1979 as a way to provide an affordable health insurance option for those individuals who cannot obtain affordable insurance due to a pre-existing medical condition. Subsequently, with changes in federal law, HIRSP also serves as the Health Insurance Portability and Accountability Act of 1996 mechanism to provide continuous coverage for Wisconsinites who lose their employer-sponsored coverage. For the past three years, HIRSP has operated under a quasi-governmental authority called the HIRSP Authority that is funded through premiums, federal grants, and subsidies from both providers and insurers. The Authority is currently administered by a small staff under the direction of a 14 person governor- appointed board. The board has also established a consumer advisory council to provide additional feedback to the board and staff.

In 2011, HIRSP will continue to offer five health insurance options. Three plans are traditional options and two are health savings account (HSA) qualified plans. HIRSP will also continue to offer its Medicare Supplement Plan. HIRSP offers three traditional plans with varying deductibles: HIRSP 1000, HIRSP 2500, and HIRSP 5000. While these plans have differing deductibles and medical out-of-pocket maximums, each plan has the same drug copay and lifetime maximum. HIRSP also offers two HSA-qualified plans: HIRSP HSA 2500 and HIRSP HSA 3500. Beginning in 2011, preventive services will be available to HIRSP members with no cost-sharing. Premium rates for all five HIRSP plans vary by plan type, gender, and age.

In order to be eligible for HIRSP, an applicant cannot be eligible for employer-sponsored group health insurance or for Wisconsin Medicaid or the BadgerCare Plus Standard Plan. Each of the plans has a six-month waiting period for medical treatment of pre-existing conditions. However, this waiting period does not apply to prescription drug coverage or to individuals who have lost employer-offered coverage, Medicaid, BadgerCare Plus, Medicare, or other state-risk pool coverage.

According to the HIRSP 2009 Annual Report, 16,381 individuals were enrolled in a HIRSP health insurance option as of December 2009. Only 26 percent of HIRSP members met their medical deductible, while just over 3 percent of individuals enrolled in a HIRSP plan accounted for 33 percent of paid medical claims. The HIRSP 2500 plan, which has the highest enrollment with 54 percent of all HIRSP members enrolled, has premiums ranging from $151 to $656 per month. The HIRSP 5000 plan, which has been growing rapidly, offers premiums ranging from $95 to $416 per month.

The average age of all HIRSP members over the age of 19 is 53.1 years. Based on this information, the monthly premium for a 53 year old male enrolled in a HIRSP 2500 plan in 2009 was $416, while a 53 year old female in the same plan paid $429 per month. The comparable premiums in the HIRSP 5000 plan are $258 and $266 per month. Premium rates for 2011 HIRSP plans are similar to or lower than the 2009 rates for four of the five major medical plans. As of December 6, 2010, HIRSP enrollment has grown to 18,853 members.

To help offset the cost of health insurance coverage under HIRSP plans, subsidies are offered for those members who make less than $34,000 annually. These subsidies can be applied to the cost of premiums, deductibles, drug copays, and medical coinsurance. The premium subsidy discounts range from 15 percent to 43 percent and the deductible subsidy can be as much as $750. In 2009, 27 percent of HIRSP members received a subsidy to help offset their health care costs.

5.8 Temporary Federal High Risk Pool

With the passage of the ACA in March 2010, federal funding was made available to all states to establish or expand state programs for uninsured individuals with pre-existing conditions. In July 2010, Wisconsin received $73 million for the expansion of the state's high risk pool through the creation of the HIRSP Federal Plan program. These plans were first offered with an August 1, 2010, effective date for coverage. To qualify for coverage under a HIRSP Federal Plan, an individual must have been uninsured for six months prior to applying for coverage, must have a pre-existing medical condition, must not be eligible for Medicaid, BadgerCare Plus Standard Plan, or Medicare, and must be a U.S. citizen or in the country legally. Unlike HIRSP plans, the HIRSP Federal Plans does not have a six-month waiting period for the treatment of pre-existing conditions.

In 2011, HIRSP will offer four HIRSP Federal Plans with varying deductibles and annual out-of-pocket maximums: Federal 500, Federal 1000, Federal 2500, and Federal 3500. Each of these HIRSP Federal Plans has the same drug copay and

maximum lifetime benefit limit. Preventive services are available with no member cost sharing. Premiums, however, are determined by plan type and age. Gender of the enrollee is not a rating factor. Wisconsin's Federal High Risk Pool premium rates are lower than both HIRSP plan premiums and federal PCIP premiums in most other states. For example, premiums for Federal 2500 range from $127 to $474 per month.

As of November 2010, Wisconsin has received 477 applications and 328 individuals have been enrolled in the new federal high risk pool, with 71 additional applications pending.

6 Wisconsin Health Insurance Exchange: Structure

Under the ACA, health insurance exchanges must be established to facilitate the purchase of qualified health plans in the individual market and to assist small businesses in facilitating the enrollment of their employees in qualified health plans offered in the small group market (known as the Small Business Health Options Program of SHOP). While the Office of Health Care Reform feels strongly that the state should operate a state-based exchange, states may choose to defer to the federal government to set up an exchange in place of a state-based exchange.

States are provided with three options under the ACA regarding the exchange and insurance market structure:

(1) States may develop two separate exchanges that serve two separate markets: an individual exchange and a SHOP exchange.
(2) States may develop one exchange that operates two separate programs for the individual and small group markets.
(3) States may develop one exchange that operates one program for a combined individual and small group market.

Merging the non-group and small group markets generally means that a carrier is required to price its insurance plans for expected claims and administrative costs as if the aggregation of its non-group and small group enrollees are one large, community-rated block of insurance. By contrast, if the markets are not merged, then a carrier can set premiums separately for its expected claims costs and retention (administration plus margin) in the non-group block of business and in the small-group block of business. It should be noted that when this paper refers to the merging of two markets, it is referring only to the non-group and small group markets. Wisconsin does not intend to merge the Medicaid program with either the non-group or small group insurance markets.

If a state chooses to operate a single exchange, two sets of rating rules, prices, and enrollment processes for non-group and small-group can remain. Moreover, rating rules could still differ between the two segments, even if the two market segments are merged for risk and pricing purposes. Carriers could be required to rate their small-group and non-group books of business as one unified risk pool but they would be allowed to use occupation as a rating factor in small-group, but not in non-group.

Furthermore, consideration should be given as to whether the exchange will be the only market to purchase health insurance. If the exchange is determined to be the only market to purchase insurance for any of the markets, no insurance

could be sold or purchased outside the exchange. This could be the case for either the non-group insurance market, the small group insurance market, or both markets. There are advantages and disadvantages to this decision that should be considered. Possible advantages of having no market outside the exchange include: (a) increased purchasing power of the exchange and (b) reduced threat of adverse selection against the exchange and its participating health plans. However, potential disadvantages of limiting the exchange to the only market for the purchase of health insurance includes reduced choice of heath plans, and the possibility of missing out on innovations in the health insurance marketplace, as insurers will be required to meet standards and benefit designs identified by the exchange, among others.

These decisions surrounding the insurance market structure are complex. At this time, no decisions have been made regarding the insurance market structure of the exchange. Most of these issues are discussed further under Section 12 of this document. The Office of Health Care Reform will complete an analysis of potential benefits and challenges of the development of a single exchange and use the results to determine whether a single exchange or two separate exchanges meets the needs of our state. Analysis will be completed on the rate effects associated with combining the non-group and the small group insurance markets and whether or not the exchange should become the only market to purchase health insurance. There is a range of options that will need to be considered prior to making these decisions. The OHCR looks forward to feedback on: (a) Whether two separate exchanges should serve the non-group and small group markets; and (b) Whether an insurance market should continue to function outside the exchange. If a market outside the exchange continues to exist, the same market rules would apply to both the markets inside and outside the exchange.

Regardless of its structure, an exchange must, at a minimum, meet the following requirements:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;
- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standard comparative information on such plans;
- Assign a rating to each qualified health plan offered through such exchange;
- Utilize a standardized format for presenting health benefits plan options in the exchange;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and if through the screening of the application by the exchange, the exchange determines someone eligible for any such program, enroll him/her in the appropriate program;
- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and cost-sharing reduction;
- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed by such requirement;
- Transfer to the Secretary of Treasury a list of individuals who are issued a certificate of exemption, per the bullet above, and the individuals who are an employee of an employer but who was determined to be eligible for the premium tax credit;
- Provide to each employer the name of each employee of the employer described in the bullet above, who ceases coverage under a qualified health plan during a plan year; and
- Establish a navigator program.

7 Wisconsin Health Insurance Exchange: Governance

7.1 Governance Model

It is important that Wisconsin establish a governance structure that, among other things, is non-partisan and can function independently of political turnover; is comprised of individuals with the necessary expertise to operate a complex exchange; is committed to public accountability and transparency in operations; and has the necessary flexibility to evolve and change as circumstances require. Generally, there are three commonly considered governance models that could be considered for the operation of the exchange. These models include: (1) an independent public authority model, (2) state agency governmental model, and (3) a public/private nonprofit organizational model.

Given the desired characteristics of a governing board that have been identified above, it is recommended that Wisconsin establish a governing board that is an independent public authority. This governing board model will allow the Board to function in cooperation with, but independent of, state government and is expected to provide insulation from political influence and maintain public accountability. An independent public authority model will set the framework necessary for the exchange to succeed in both the public and private insurance marketplace.

7.2 Board of Directors

It is recommended that the Exchange Board of Directors be comprised of the following voting members, who will be nominated by the governor, with the advice and consent of the senate, and appointed for staggered three-year terms:

a) Two members who represent insurers participating in the exchange.
b) Two members who represent health care providers, including one nominated by the Wisconsin Medical Society and one nominated by the Wisconsin Hospital Association, Inc.
c) Five public members, two of whom represent small businesses that purchase health insurance through the exchange, one of whom is a professional consumer advocate who is familiar with the exchange, and two of whom are persons with health insurance coverage through the exchange.
d) The Secretary of the Department of Health Services (DHS), or his or her designee, and the Commissioner of Insurance, or his or her designee.

For the first five years of operation, the Board of Directors should contract with DHS to operate the exchange. Contracting with DHS for operation of the exchange will help ensure that the exchange is fully integrated with the Medicaid program and maximize the cost-effectiveness of the exchange by leveraging existing eligibility determination resources. Thereafter, the Board may transfer administration to another entity but must submit a comprehensive plan to the Governor and Legislature detailing how the Board will maintain integration with the Medicaid program under the new administration.

The Board of Directors should maintain oversight of all DHS activities associated with operation of the exchange. Among other things, the Board must determine and approve all exemptions for the individual mandate filed through the exchange, set the criteria for "qualified health plans," and determine the essential health benefits package in accordance with the minimum requirements set forth in the Affordable Care Act (ACA). Prior to 2017, the Board must also make a recommendation to the Governor and Legislature as to whether Wisconsin should apply for a federal waiver to opt-out of certain requirements of the law, as allowed under the ACA.

8 Wisconsin Health Insurance Exchange: Individual Exchange Front Door Functions

8.1 Participants

Wisconsin's health insurance exchange should offer a single front door for multiple groups, each with varying purposes for using the exchange. Users of the exchange portal will include individuals and families, small employers, navigators, brokers and health plans. The role of each of these users is described in more detail below.

(1) Individuals and Families

Individuals and families will use the exchange to compare, enroll and purchase health insurance in the individual and small group markets and Medicaid. The exchange will determine eligibility for individuals and families who do not have access to affordable health insurance through an employer, as determined by the Affordable Care Act (ACA), for BadgerCare Plus, the Children's Health Insurance Program (CHIP), or other public programs. Inclusion of BadgerCare Plus and CHIP populations in the exchange means that individuals and families eligible for these programs may use the exchange to compare, choose, and enroll in Medicaid certified health plans. Medicaid will remain a separate market from the non-group and small group insurance markets, or if the state chooses, the combined non-group and small group market.

The exchange will also facilitate enrollment for individuals and families that have coverage options through a small employer that has registered with the exchange to provide employer-sponsored health insurance. Employees of small businesses will be guided through the appropriate process of choosing a health plan that best meets their needs, within a tier identified by their employer.

It is important to note that individuals filing for an exemption to the individual mandate will also do so through the exchange. The criteria for the individual mandate exemptions are included within the ACA. The exchange will need to set guidelines and identify a process for granting such exemptions.

(2) Small Employers

Small employers will come to the exchange to provide employer sponsored health insurance to their employees. Upon registration, the

exchange will determine whether the small business meets the required small employer definition, which must be met in order to participate in the exchange. Employers will be guided through a series of steps that will allow their employees to purchase health insurance through the exchange.

Through 2016, small businesses may include employers with up to 100 employees; however, at the state option, small businesses may be limited to those with 50 employees until January 2016. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to participate. At this time, Wisconsin intends to initially limit participation in the SHOP exchange to small businesses with between two to 50 employees, consistent with current Wisconsin law. Limiting the SHOP exchange to small businesses with only two to 50 employees will help to minimize adverse selection by larger, self-insured employers. The exchange should consider expanding eligibility to large employers once the SHOP exchange is operational.

(3) Navigators

Navigators will help individuals and families compare, select, and enroll in a health plan using the exchange. The exchange should have the capacity to provide reports and other useful data to navigators and will allow navigators to act as an authorized representative for individuals and families for purposes of human services programs. Additional information about the role of navigators can be found in Section 10.2.

(4) Brokers

Brokers will work with small employers and their employees in the small group market, as well as individuals and families in the non-group market to choose a health plan. Additional information about the brokers' roles can be found in Section 10.1.

(5) Health Insurers

Health insurers will use the exchange to register their qualified health plans with the exchange and provide information on premiums, cost sharing, additional benefits, actuarial value of plan options, contact information, payment options information, and provider networks, among other things.

8.2 Exchange Portal

The guiding principles behind Wisconsin's exchange portal are to provide a simple, intuitive interface between the user and system, which relies on graphics, simplified language, and easy-to-follow navigation for people to select and enroll in a health plan. The State is committed to creating one virtual access point to health insurance for consumers purchasing in the individual market, for small employers and for members of the Wisconsin Medicaid program.[7] A single exchange portal will allow all exchange eligible participants to use a single, simple-to-use Web site for purposes of comparing, selecting and enrolling in the health plan of their choice, regardless as to whether that individual or family is eligible for non-group insurance, small group insurance or Medicaid and CHIP. This portal will make it easy to communicate with the public, small employers and health plans that participate in the Exchange.

In designing the enrollment process for the exchange, the exchange could build on the State's recent success in enrolling nearly 60,000 childless adults into the BadgerCare Plus program. Childless adults enrollment was completed through an Internet application tool with additional assistance available from a call center with a toll-free telephone number. Over the three months in which the 60,000 individuals were enrolled in the Childless Adults program, 82 percent of consumers enrolled using the Web-based application and the remaining 18 percent enrolled over the telephone. Wisconsin should leverage this enrollment process for the exchange, where individuals and families will be able to select and enroll in a health plan through the exchange portal, using a Web-based tool, or will be able to access a customer service representative who can answer questions about use of the Web site and assist customers experiencing difficulty with the enrollment process. If needed, the customer service representatives can assist the applicant in completing the entire enrollment process over the telephone. Additional assistance will also be available to consumers through community partners, counties, and brokers, as discussed later in this paper.

8.3 Exchange Call Center

As noted above, users of the exchange will be able to speak to customer service representatives through a toll-free call center. To assist consumers, customer service representatives will use a modified version of the health benefits exchange Web site consisting of a conversational version of the exchange, to

[7] As indicated in Section 6, the final decisions about whether the exchange is the exclusive marketplace for individual and small group insurance will need to be made prior to January 1, 2013. This document does not resolve this issue but rather illustrates the potential functionality of the exchange regardless of whether it is the exclusive marketplace.

assist consumers in enrolling in health insurance. Using this modified version of the exchange Web site, customer service representatives will be able to guide consumers through the exchange over the telephone and/or by using other technological tools, such as remote navigator functionality. When needed, consumers will fax or scan necessary verification directly to the exchange. Signatures can be obtained using Wisconsin's existing telephonic signature technology. Customer service representatives will also be available to assist consumers with questions regarding the exchange through e-mail and online chat.

8.4 Current Medicaid and BadgerCare Plus Eligibility Systems as Framework for Individual Exchange

Wisconsin maintains a sophisticated, leading-edge, Web-based application and case management tool (ACCESS) and automated eligibility system (CARES). The OHCR intends to leverage existing state infrastructure, including both the ACCESS and CARES systems to act as the backbone of the exchange. Leveraging these systems will help the exchange to adopt a streamlined eligibility determination and enrollment process in a timely and cost-effective manner. Leveraging these systems will benefit Wisconsin's taxpayers by helping the exchange achieve low administrative costs, maximize affordability and ensure long term sustainability. The Department of Health Services (DHS) currently maintains these programs for the State, and therefore, DHS is well-positioned to continue to run these functions for the exchange.

It should be noted that the eligibility determination process that will be necessary under the exchange does differ from the process currently used by CARES. For example, the enrollment process into health plans through the exchange will include the determination of whether the individual and family is eligible for premium tax credits or reduced cost sharing, as well as determining if the individual and/or family is entitled to be enrolled in Medicaid. The exchange will work to keep this process as simple and streamlined as possible, where eligibility for tax credits is determined automatically by the exchange using available trusted third-party information. Cases that require additional information from the applicant will be handled by specialists located in a central or regional support center. The eligibility determination process is discussed in more detail below.

8.5 Individual Exchange: Modified Adjusted Gross Income and the Exchange

The ACA requires the adoption of modified adjusted gross income (MAGI) for purposes of determining eligibility for and the amount of premium tax credits and reduced cost-sharing and eligibility for Medicaid and CHIP, beginning

January 1, 2014. The MAGI methodology is composed of two distinct components:

1. Who is included in the household for purposes of determining the group size, whose income will be included and who will qualify together to receive the premium tax credit, reduced cost-sharing, and/or BadgerCare Plus.
2. What types of income are counted and what deductions are allowed from that income.

MAGI defines a household, per tax law, as those individuals who live together for more than half of the year, including:

- The individual who does, or would, file taxes (designated as the head of household);
- His or her spouse;
- His or her children under age 19, and
- Other qualifying relatives, including a son, daughter, stepchild, brother, sister, stepbrother, stepsister, or a descendent of any of them who was either under age 19 or under age 24 (if a student) and:
  - Is younger than either the head of household or his/her spouse and
  - Did not provide over half of his or her own support.

In addition, the ACA indicates that Medicaid should continue its policies concerning 'sources of countable income,' which means that some income sources that are exempt under Medicaid and CHIP will continue to be exempt under the new MAGI methodology. A representative list of these income types includes:

- Adoption assistance and foster care payments;
- Combat pay;
- Crime victim restitution program;
- Disaster and emergency assistance;
- Earned income of minors (under age 18);
- Jury duty;
- Kinship care, W-2, and other Temporary Assistance for Needy Families (TANF) program payments;
- Supplemental Security Income (SSI) payments;
- Life insurance policy dividends; and
- EITC and income tax refunds.

It is also important to note that there are some changes to the allowable 'sources of countable income' that BadgerCare Plus will need to adopt as a result of the adoption of MAGI. These changes include, but are not limited to:

- Child support income will continue to count in the income calculation under MAGI for BadgerCare Plus. However, it will not be included for eligibility determination for the premium tax credits and reduced cost-sharing.
- MAGI will require that net self-employment income be used when determining income for BadgerCare Plus. Currently, BadgerCare Plus has a two-step approach with regard to testing eligibility against self-earned income. First, BadgerCare Plus tests the net self-employed income plus depreciation against the 200 percent Federal Poverty Level (FPL) threshold. Only if the person is not eligible using the first test does BadgerCare Plus test by including the depreciation deductible.

Because the MAGI methodology requires that certain deductions are taken from the Gross Income calculated by the exchange, the exchange should:

- Use the most recent tax record available to calculate the self-employment expenses and income to be counted in determining eligibility;
- Analyze the types of income found and determine whether these should be exempted or altered based on information available to the system;
- Check the most recent tax record to determine if any of these deductions were provided and then ask questions specific to those deductions;
- Allow interested individuals to review the list of deductions allowed and claim those deductions and specify the amount. For those who appear to qualify for BadgerCare Plus, these deductions will need to be documented.

The adoption of MAGI, relating to both the new definition of household and the new 'countable income sources' is expected to complicate the Medicaid eligibility determination process. For example, if there has been a significant change in a household's financial circumstances, the exchange will need to gather additional information relating to deductions from the gross income and the composition of the applicant's household. Most of the information regarding gross income deductions can be gathered by asking simple gatepost questions that ask for fairly high-level information and only require greater detail when the answer to the gatepost question is "yes." For instance, consider the question

"Are you self-employed?" If the answer to this question were "yes," a series of detailed questions that relate to additional deductions will be asked. However, if the answer is "no," the consumer will be asked only the next gatepost question and continue to move through the process. In addition, the use of MAGI may distance Medicaid from FoodShare and Wisconsin Shares.

As noted above, the ACA requires the adoption of MAGI for purposes of determining eligibility for and the amount of premium tax credits and reduced cost-sharing, and for Medicaid and CHIP. However, a gap exists between the income definition used for federal subsidies and Medicaid and CHIP. The legislation requires that states use the most recent tax year's income for purposes of calculating MAGI for the federal subsidy programs, except when there has been a change in circumstances. The advancable premium tax credits will then be reconciled with current income at the end of the year. For purposes of determining eligibility for Medicaid and CHIP, the ACA requires states to use current sources and point-in-time income.

Given this inconsistency, and considering that premium tax credits and reduced cost-sharing subsidies will be reconciled at the end of the tax year, Wisconsin will seek to use current income for purposes of calculating premium tax credits and reduced cost-sharing, consistent with the MAGI methodology, rather than using the most recent tax year's information. Using current income will limit the individual's or family's potential liability for payback of advancable federal dollars, should a significant change in circumstance occur, and will allow for a consistent income determination to be used for BadgerCare Plus, CHIP, and premium tax credits and reduced cost-sharing.

In the past, Wisconsin has worked very hard to align its public programs to make the eligibility determination easier on both the member and the worker involved. Wisconsin should work closely with Centers for Medicare and Medicaid Services, the Internal Revenue Service (IRS), and other states, in order to identify a solution that makes the process less labor intensive for states and less cumbersome for members.

The Office of Health Care Reform is very interested in identifying ways to smooth the transition to exchange implementation in 2014. One way Wisconsin has identified in doing so is by adopting the MAGI income calculation methodology and household composition definition prior to 2014, and potentially as early as January 1, 2012. Early adoption of MAGI will benefit Wisconsin in a number of ways: (1) Allow the identification and correction of any potential problems prior to full implementation in January 2014; (2) Minimize the risk of systems failures associated with the roll-out of the entire exchange on January 1, 2014; and (3) Provide lessons learned and best practices for other states and the federal government.

8.6 Individual Exchange: Eligibility Determination

Based on our current understanding of the ACA and related guidance, as well as discussions with Department of Health and Human Services (HHS) staff and other experts, most of the information that will be needed to determine eligibility for the premium tax credit will be provided online, in real-time, using an automated interface with HHS. The HHS will maintain a similar interface with the IRS. The enrollment process for individuals looking to purchase insurance through the individual exchange could follow the process that is detailed below.

(1) The consumer will provide necessary personal identifiable information, including but not limited to, name, Social Security number (SSN), and date of birth. This data will be used to both set up an account with the exchange and to validate the consumer's identity.

The exchange will complete the validation process through a data match with trusted third-party sources. The exchange will ask a series of questions that the consumer will answer in order to validate his/her identity. This validation process is modeled after the validation process currently used in the credit and banking industries.

Additionally, the exchange will conduct third-party data exchanges with the IRS, CARES, and Vital Statistics to generate a list of the household members who make up a household, as defined by MAGI. Once this information is gathered, the consumer will confirm his/her household, or will have the option to make changes, if the information presented is not correct.

At the same time, the consumer is verifying his identity, he will create a secure account for himself. The exchange will be fully compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA), ACA, and other federal program law and regulation requirements related to privacy and the safeguarding of personal identifiable information (PII) and will follow all necessary processes and adhere to required standards to protect all consumer PII.

(2) Only individuals who do not have access to affordable health insurance may purchase health insurance through the exchange. The exchange will check the exchange's employer database, the Employer Verification of Health Insurance (EVHI) system and the insurance disclosure system to identify who is covered by employer insurance. It

should be noted that use of the insurance disclosure system will require a change to Wisconsin Statutes.

For those individuals who do have access to employer-sponsored health insurance, the exchange will determine whether the employer-sponsored health insurance meets minimum benefit and affordability requirements[8], as defined by the ACA. Individuals who are eligible for employer-sponsored health insurance but do not meet the established requirements may be eligible for premium tax credits under the individual exchange.

Individuals determined to have access to affordable employer-sponsored health insurance will be directed through a modified route within the exchange.

(3) Individuals will be asked if they would like help paying for their health care. If yes, the exchange will establish secure data exchanges with HHS and other trusted entities in order to determine eligibility for premium tax credits and reduced cost sharing and Medicaid. The list below includes some of the trusted third-party data sources with which the exchange will communicate:

- State Wage Data, collected by the Department of Workforce Development (DWD);
- OASDI payments, SSI payments, Medicare status, disability status, and citizenship status from the Social Security Administration;
- Unemployment Insurance payment information available through the DWD;
- Child Support income and payment information available through the Department of Children and Families;
- Employment Data, available through WORK Number, which includes 35 percent of employers in Wisconsin;
- Incarceration Data, available through the Department of Corrections;
- Self-employment and deduction information, available through the IRS;
- Driver's License and Personal Identity information from the Department of Transportation to verify identity when suspect.

[8] ACA requires that in order for employer sponsored health insurance to be affordable, the employer's premium contribution must not exceed 9.5 percent of their income and the plan must meet a minimum actuarial value of 60 percent.

The DHS currently has access to all of these data sources for purposes of conducting similar verifications under the BadgerCare Plus program. The state has determined that for the BadgerCare Plus population, which includes families with income up to 300 percent of the FPL and adults without dependent children with income up to 200 percent of the FPL, that nearly 61 percent have income. Of those with income, 89.14 percent have an income source that can be verified through existing trusted third-party data sources.

If the consumer does not want help paying for health insurance, the exchange will not need to collect any information regarding their household income. The exchange will collect their health care preferences and direct them to their available health insurance options.

(4) The exchange will reconcile and aggregate the information. The individual will confirm whether the information provided accurately represents his/her financial situation.

If the information presented is accurate, the exchange will make a real-time eligibility determination for premium tax credits and Medicaid eligibility. If the information is not accurate, the individual may make further changes to more accurately reflect his/her current financial situation. It is important to note that there are some "change-in-life circumstances," as defined by the bill, that may require additional documentation before an eligibility determination for either tax credits or Medicaid can be made. Wisconsin expects that most eligibility determinations will be made without delay at the time of application. Under this real-time eligibility determination model, eligibility workers will focus on exception cases that are error-prone or have been identified as complicated to the extent that human intervention is needed in order to complete the eligibility determination.

It is also important to note that premium tax credits may be advancable to the taxpayer. Meaning, if eligible, the applicant can elect to receive the tax credit immediately, which will have the effect of reducing his/her upfront premium costs. The applicant must agree to the advancable tax credit. If the applicant chooses for the credit not to be advancable, he/she must pay the full monthly premium, and will instead claim the tax credit on his/her tax filings and receive the tax credit with his/her tax return.

In an effort to minimize confusion among consumers regarding the reconciliation of premium tax credits, it is recommended that the exchange conduct regular third-party data matches with trusted third-party data sources in order to see if there are any significant changes to income and household circumstances. If the information received through third-party data exchanges indicates that the amount of a tax credit should be increased or reduced, the exchange would contact that individual or family indicating the potential consequences and available options. The process of conducting ongoing communication with consumers throughout the year will help Wisconsin residents avoid increased tax liability at the end of the year, when they file federal income tax returns.

(5) Prior to making a plan selection, the exchange will provide consumers clear information regarding the full monthly premium and, if applicable, the amount of the qualifying tax credit and the remaining amount that must be paid by the individual.

(6) Individuals eligible for Medicaid will receive only health plan options for those health plans that participate in Medicaid.

(7) It is important to mention that Wisconsin runs an integrated public assistance program system that includes FoodShare (SNAP), Medicaid, CHIP, TANF cash (W-2), TANF for children of disabled parents (SSI Caretaker Supplement), and TANF subsidized childcare (Wisconsin Shares) and we intend to continue to administer an integrated system with the development of the exchange. The exchange should be integrated with these other programs in a manner that continues to allow for high participation rates of Wisconsin residents in all public programs. Given the complexity of the eligibility determination and enrollment process, the exchange will continue to support the priority that the eligibility process remain 'behind the scenes' in order to ensure a simple, streamlined eligibility and enrollment process for exchange customers, regardless as to whether they are enrolling in Medicaid, a private qualifying health plan or any other public assistance program.

8.7 Premium Tax Credits, Reduced Cost Sharing and Affordability

Tax credits will be made available to individuals and families between 133 and 400 percent of the Federal Poverty Level (FPL) to purchase qualified health plans through the exchange.

Tax credits for a given individual will reduce the individual's (or family's) net cost for a "benchmark" plan (the second lowest cost silver plan) to the following share of income:

Poverty Level	Premium Contribution as Percent of Income
Below 133% FPL	2%
133% to 150% FPL	3.0% – 4.0%
150% to 200% FPL	4.0% – 6.3%
200% to 250% FPL	6.3% – 8.05%
250% to 300% FPL	8.05% – 9.5%
300% to 400% FPL	9.5%

Note: a person would realize the cost difference for his/her choice of a more or less expensive plan. For purposes of premium tax credits, an individual may enroll at any level of coverage, with the exception of a catastrophic plan.

Consumers will have the ability to specify their preference to receive the tax credit either as a monthly deduction from their premium or annually at the end of the year. Upon selecting their preferred methodology for receipt of their qualifying tax credit, they will be directed to more information about their plan choice and the premium amount due.

Initial estimates indicate that approximately $500 million to $1 billion in federal subsidy payments could be made to Wisconsin taxpayers to help facilitate the purchase of affordable health insurance.

The ACA also places limits on the amount of cost-sharing for families with low and moderate incomes. Per the ACA, cost sharing includes deductibles, coinsurance, copayments and other expenditures that might be required to pay for a qualified medical expense with respect to essential health benefits covered under the plan. Cost sharing does not include premiums or spending for noncovered services.

Effective for plan year 2014, cost sharing incurred for coverage may not exceed $5,950 annually for individual coverage, or $11,900 annually for family coverage. Effective for plan years beginning 2015 and later, the annual cost sharing limitation will be increased annually. The limits differ based on poverty level and individual or family coverage. The chart below provides additional information on the cost sharing limits.

Household Income	Annual Cost Sharing Limit for Individual Coverage	Annual Cost Sharing Limit for Family Coverage
100-200 percent FPL	A two-thirds reduction in the annual cost sharing limit is required: $5,950*.666 = $3963 $5950 - $3,963 = $1,987	A two-thirds reduction in the annual cost sharing limit is required: $11,900*.666 = $7,925 $11,900 - $7,925 = $3,975
200-300 percent FPL	A one-half reduction in the annual cost sharing limit is required: $5,950*.5 = $2,975 $5,950 - $2,975 = $2,975	A one-half reduction in the annual cost sharing limit is required: $11,900*.5 = $5,950 $11,900 - $5,950 = $5,950
300-400 percent FPL	A one-third reduction in the annual cost sharing limit is required: $5,950*.333 = $1,981 $5,950 - $1,981 = $3,969	A one-third reduction in the annual cost sharing limit is required: $11,900*.333 = $3,963 $11,900 – 3,963 = $7,937

Limits are also placed on cost sharing related to employer-sponsored health plans under the ACA. Effective for plan year 2014, for plans offered in the small group market, the annual deductible is limited to $2,000 for individual coverage and $4,000 for family coverage. Effective for plan years beginning in 2015, the above deductible limits will be increased annually.

The ACA also makes available "reduced cost sharing" to certain individuals and families. "Reduced cost sharing" refers to reductions in a beneficiary's cost sharing obligations that are identified by the exchange and applied by the health plan, in addition to the annual cost sharing limitations discussed above. The HHS Secretary is required to coordinate cost sharing with the actuarial value of the qualified health plan. This means that the Secretary is responsible for providing cost sharing tax credits that limit cost sharing such that costs covered by the silver plan (70 percent of costs covered) will increase to the following:

Poverty Level	Cost-Sharing Limits
100% to 150% FPL	94% of total allowed costs of health plan benefits
150% to 200% FPL	87% of total allowed costs of health plan benefits
200% to 250% FPL	73% of total allowed costs of health plan benefits
250% to 400% FPL	70% of total allowed costs of health plan benefits

The exchange will determine eligibility for reduced cost sharing. Only individuals who are enrolled in a qualified health plan at the silver level of coverage, with income that does not exceed 400 percent of the FPL for their household size, may qualify for reduced cost-sharing.

Initial analysis suggests that the determination of the amount of reduced cost sharing for which an individual or family qualifies will require a multi-step process:

> (1) The exchange will determine the amount by which the cost sharing limitation will be reduced by determining the cost sharing limit, based on household size and poverty level.
>
> (2) The exchange will compare the reduction in step one to the resulting increase in the plan's share of the actuarial value of the plan to ensure that it does not exceed the limited described in the law. If the plan's share of the actuarial value of the plan exceeds the maximums set forth, no additional reduction is applied.
>
> (3) If the cost sharing reduction does not increase the plan's share of the total allowed cost of benefits to the maximum allowed by law, the exchange must calculate an additional reduction in the eligible insured individual's cost sharing, sufficient to meet those maximums.
>
> (4) The exchange must communicate the maximum cost sharing amount allowed to the health plan, as determined in the reduced cost sharing calculation. The health plan must ensure that the cost sharing maximums are not exceeded.
>
> (5) Health plans must notify the HHS of the amount of cost sharing reductions. The federal HHS must make timely payments to the issuer equal to the value of the cost sharing reductions.

If individuals choose to purchase health insurance outside the exchange, they will not qualify for federal tax credits or reduced cost sharing. The segment of the population that has income greater than 400 percent of the FPL is responsible for the full cost of insurance coverage, since there are no tax credits available for this group through the exchange.

When discussing the available benefit options and tax credits that will be made available to individuals purchasing health insurance through the exchange, it is important to point out an element of reform that is unique to Wisconsin. As a result of the maintenance of effort requirements included in the new legislation, there will be families in Wisconsin whose children will maintain insurance

through the BadgerCare Plus program, but whose parent(s) will transition out of Medicaid into the exchange, where they will purchase health insurance with the help of federal tax credits. It is possible that the benefit package offered through the exchange will be less generous than the benefit package that these adults may have had access to under BadgerCare Plus. At the time this paper was written, the essential benefit package mandated under the exchange had not yet been defined, but this will be important to identify in order to ensure that those individuals who are no longer eligible for Medicaid and who purchase health insurance through the exchange are not worse off with the implementation of health care reform.

In order to ensure a smooth transition for low-income families who may transition into the exchange, Wisconsin should look to create hybrid health plan options that will offer the same provider network to both parents and children, in a single family, regardless of which program they are enrolled in (i.e., Medicaid or the exchange). This will help ensure easy navigation of the health care system for these families, by allowing all family members to access the same health care providers and facilities. Covered benefits, cost-sharing and provider payments for the Medicaid program and the private plans operating in the exchange will remain different in order to comply with the requirements of the legislation.

The exchange should continue to consider other initiatives to help increase affordability for individuals and families purchasing health insurance through the individual exchange. One example of a policy that may be considered would be to allow employers who do not offer small employer-sponsored health insurance to make tax exempt, fixed dollar contributions to premium reimbursement accounts that can be used for the purchase of health insurance for their employees in the individual health insurance exchange. This policy would help increase affordability for individuals and families and may provide added incentive for the purchase of health insurance through the exchange.

8.8 Individual Exchange: Basic Health Plan Option

Beginning January 1, 2014, states have several options to provide coverage to adults whose incomes are over 138 percent of the FPL. States may do any one of the following: (1) transition them into the exchange where they may purchase affordable health insurance with premium tax credits; (2) continue to cover them under the Medicaid state plan; or (3) create the “Basic Health” plan.

The Basic Health plan would be available to individuals between 138 and 200 percent of the FPL who are no longer eligible for Medicaid or other available coverage, who would otherwise be eligible for premium tax credits through the exchange. States that choose this option will receive federal funding equal to 95

percent of the tax credits and cost-sharing reductions that would have been provided to individuals to purchase health insurance through the exchange.

The ACA requires that a state basic health program establish a competitive process for entering into contracts with standard health plans including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. The competitive process must consider the following:

- Innovative features including, but not limited to, care coordination and care management (emphasizing chronic conditions);
- Incentives for use of preventive services and establishment of patient/doctor relationships that maximize patient involvement in health care decision making;
- Contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market; and
- Specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Participating states will be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans whenever possible. States will also be able to negotiate a regional compact with other states in order to include coverage of eligible individuals in all such states. State Medicaid Administrators will be encouraged to find ways to integrate their negotiations with any Medicaid or other state administered health care programs in order to maximize efficiency and improve the continuity of care between all state administered health programs.

This new Basic Health Plan option may be important to Wisconsin in ensuring that no one is found to be worse off with the implementation of health care reform. Individuals eligible to participate in this plan are not eligible to purchase coverage through the exchange and premiums may not exceed what the individual would have paid in the exchange. Cost sharing may not exceed that of a platinum plan in the exchange for individuals below 150 percent of the FPL or that of a gold plan for all others. In Wisconsin, it is estimated that there are approximately 75,000 adults currently enrolled in BadgerCare Plus who may be eligible for the Basic Health plan program. This estimate does not include any other individuals, such as those who are currently uninsured. The chart below shows the estimated enrollment for each eligibility group and the benefit plan they currently receive under BadgerCare Plus.

Eligibility Group	Enrollees +133% FPL	Benefit Plan[9]
Parents/Caretakers	59,828	Standard
Pregnant Women	3,206	Standard/Benchmark
Childless Adults	13,500	Core

In determining whether to offer the Basic Health Plan, the state should take into consideration the effect of splitting off this risk pool from the remaining individual market. Upon initial analysis, the Office of Health Care Reform believes the federal funding available under the Basic Health Plan option may be sufficient to offer a more robust benefit plan than would be available to low-income individuals in the exchange. Additional information necessary in making an informed decision regarding the creation of the Basic Health Plan will be available upon completion of Jonathan Gruber's analysis of the new insurance market reforms.

8.9 Individual Exchange: Health Plan Selection

Health insurance needs of individuals vary widely depending on existing health conditions and health status and anticipated use of health care services. Given this variability among consumers, the Office of Health Care Reform would like to direct users of the exchange through a health plan selection process that consists of a health needs assessment (HNA) and questions related to their personal preferences when selecting a health plan. Completion of the health plan selection process will help the exchange organize health plan options based on the consumer stated health status and preferences.

In its current form, Wisconsin's ACCESS Web tool incorporates a confidential HNA into the application and renewal tool and also has recently added functionality for HMO selection for select populations. The exchange would use the HNA similar to that currently used by Wisconsin Department of Health Service for its BadgerCare Plus program, which was developed with assistance from outside experts.

An HNA is a self-reported health questionnaire that will be completed by all individuals seeking to enroll in health insurance through the exchange. Results of the HNA will help develop profiles of individuals based on the anticipated health needs. Individual responses also highlight health risk areas and enable projection of out–of-pocket health care costs. Matching the individual profile with

[9] Individuals and families enrolled in the BadgerCare Plus program qualify for varying benefit packages, depending on their income. The standard plan covers the most comprehensive benefit package available under the BadgerCare Plus program with very minimal cost sharing. The Benchmark plan covers a benefit package similar to that of employer sponsored health plan with slightly higher cost sharing. The Core plan covers a more restricted benefit package with greater cost sharing for members.

appropriate insurance options will enable individuals to identify health insurance options that are most suitable for them and their families. Results of HNAs will not be used for underwriting within the exchange.

It is anticipated that consumers will largely be interested in both premium costs and the amount of out-of-pocket expenses they can expect to pay in any given month for each health plan. Premium information will be provided to the exchange directly from participating health plans. However, the exchange will need to build a calculator for the purpose of estimating annual out-of-pocket expenses.

A survey of available out-of-pocket calculators that are currently available on the Internet suggests that existing tools are not adequate to provide the consumer an accurate understanding of what to expect from each plan. Two methodologies have been identified to calculate estimated out-of-pocket expenses.

> (1) A calculator that uses the health condition(s) of the individuals applying for health insurance, including specific chronic conditions, the individual's estimation of his/her health status and an actuarial estimate of the number of physician visits, prescription drugs, emergency room visits, and hospital stays associated with that person's age, health status, and health conditions.
>
> (2) A calculator that uses medical databases, currently available to health plans to evaluate each household member's health status and health system contacts over time. These values would be applied to each of the health plan options available to consumers.
>
> At this time, the current exchange prototype does not utilize either of these methodologies, but the Office of Health Care Reform recommends that the exchange conduct further research in order to determine the feasibility of adopting either of these methodologies.

The exchange should work with actuaries, health plans and consumers to identify the best out-of-pocket expense calculator and how this information should be provided to consumers. The information that the calculator will use for purposes of calculating estimated out-of-pocket expenses will come from information that consumers provide when filling out the health needs assessment. This philosophy of integrating the out-of-pocket expense calculator with the health needs assessment stays consistent with the goal of a simple, easy-to-use Web site. Individuals can use the estimated out-of-pocket expenses to better compare and select a health plan. The exchange will make it clear to individuals that the information they report, particularly related to health

conditions, will not adversely impact their health plan options or out-of-pocket expenses.

Along with having access to information about cost and quality of various health plans, a prime concern of many consumers will be to identify the health plans that are affiliated with their current health care providers. The exchange should make provider network information accessible to consumers in order to assist them in the selection of a health plan, and to more accurately rank health plans based on consumer needs. To do this successfully, the exchange will need to maintain accurate, up-to-date provider network information with user-friendly search functions. The ranking feature will also require accurate matching of providers with health plans. Both of these functions are crucial to successful implementation of the exchange.

Wisconsin currently utilizes a provider search tool for BadgerCare Plus HMO selection that can be leveraged and expanded to meet the needs of the exchange. Lessons learned from this provider search tool have provided Wisconsin with a good understanding of what will be needed to create a viable provider search tool for the exchange. Some of the lessons learned from the development and maintenance of the BadgerCare Plus provider search engine include:

- Standardization of data is critical in order to avoid duplication and confusion.

  The Wisconsin Office of Health Care Reform recommends that the exchange work with the Department of Regulation and Licensing, health insurance companies, health care providers and the state Medical Society and Hospital Association on the most effective way to develop a provider database with standardized data that allows for uniquely identifying providers that participate in multiple provider networks. The state's listing of Medicaid-certified providers is another existing resource that can be leveraged for purposes of establishing this new database.

- Health plans must be responsible for the accuracy of their provider network data.

  In order to hold health plans accountable, the exchange should allow health plans to upload their provider network information directly to the exchange. This will allow for optimal efficiency and ensure that the most up-to-date information is available.

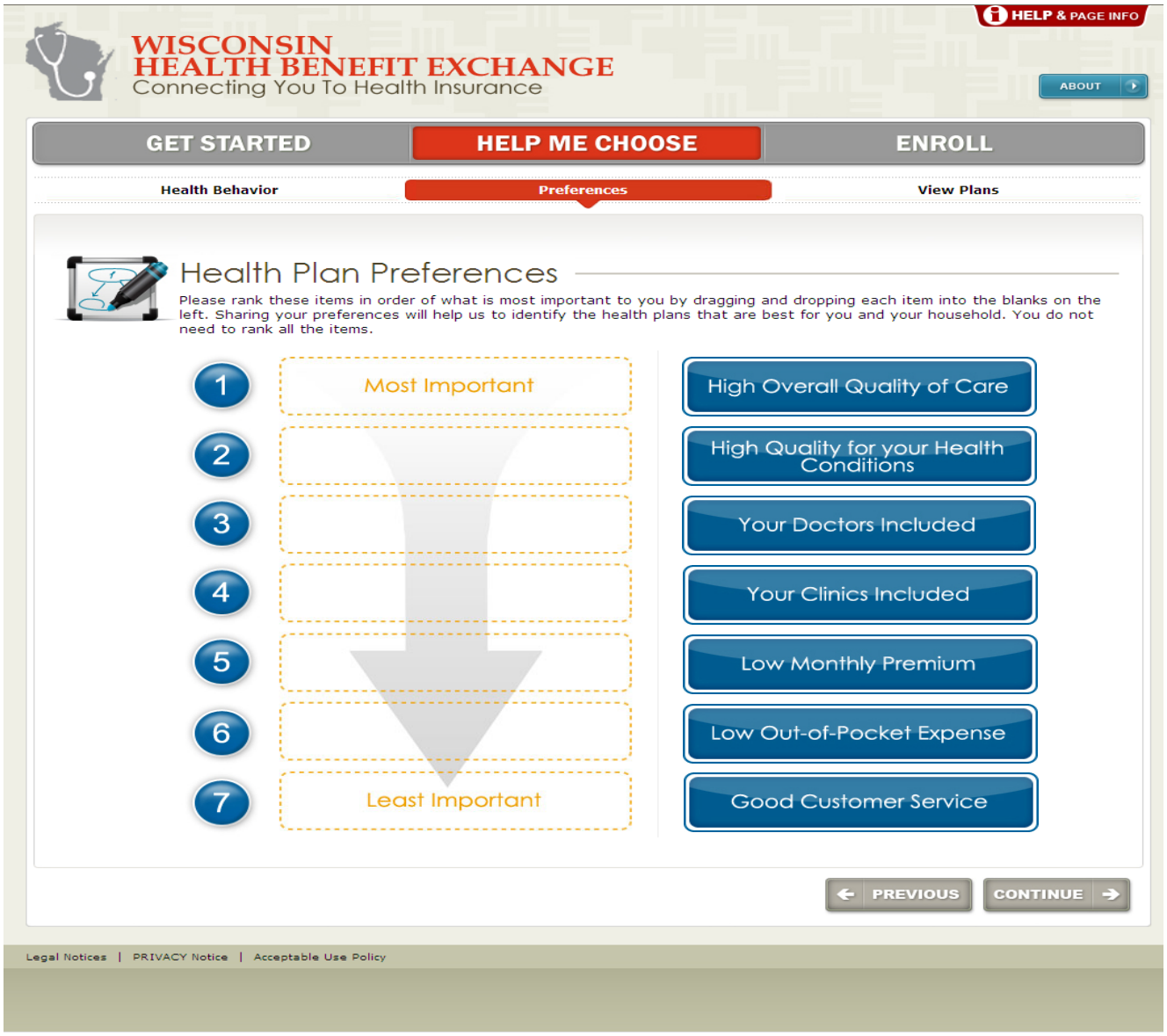
At a minimum, the exchange should maintain primary care provider information. The exchange should aim to also make available information about specialists, pharmacies, and other auxiliary provider types. Wisconsin's past experience with provider network databases has indicated that identifying specialists is difficult, as oftentimes, these providers are not contracted with health plans as affiliated providers and instead are readily accessible through referral.

- Provider networks need to be specific to each plan for each market of the exchange: BadgerCare Plus, non-group, and small group. If the consumer is eligible for BadgerCare Plus, the tool will display only the providers affiliated with plan options that are available under BadgerCare Plus.

Part of the transformative nature of the exchange will be to provide information that will empower consumers to select health plans that meet their specific needs. To further assist consumers in selecting a health plan, the exchange should rank health plans based on his or her preferences. The available health plans will be displayed to consumers in a specified order, based on the information provided.

Using a list of predetermined characteristics, individuals will have the ability to rank the characteristics from most important to least important. Although the criteria to be ranked can be further refined, the following six criteria have been identified: (1) Overall Quality of Care; (2) Quality of Care for Member-Specific Conditions; (3) Preferred Doctor/ Clinic/Hospital In-Network; (4) Low Monthly Premium; (5) Low Out-of-Pocket Expenses; (6) Good Customer Service.

In its current form, the prototype displays the criteria available for ranking in the following manner. Consumers may then drag and drop the criteria on the left into the boxes on the right in the order that is most important to least important to them. The Office of Health Care Reform looks forward to feedback as to whether or not this process for ranking health plans is appropriate, or if consumers feel there is a better way for them to identify their preferences.



The process of ranking health plans will create an opportunity for the exchange to reward high-value health plans. By integrating consumer health status and preferences into the ranking process, the exchange will be able to organize health plan options in a manner that influences people's decisions and results in individuals making choices that best meet their unique health care needs and preferences.

8.10 Individual Exchange: Health Plan Ranking System

The HHS Secretary will develop minimum standards for purposes of rating qualified health plans offered through the exchange in each benefit level on the basis of relative quality and price. The exchange will include the quality rating in

the information provided to individuals and employers. With regard to quality measurement and ratings, the exchange should look to begin to measure participating health plans based on existing Healthcare Effectiveness Data and Information Set (HEDIS) measures and look to adopt additional or different outcomes-based quality measurements in the future.

In developing a rating system, it will be important for the exchange to look to Wisconsin's Employee Trust Funds (ETF) as a successful model of a value-driven health plan selection tool. Among other successful initiatives, ETF designed a premium contribution tiering program, developed to motivate employees to select health plans based on cost and quality. Each health plan is assigned to one of three tiers. Tier designation is based on employee contribution as well as health plan quality and efficiency.

ETF's tiering structure creates the following incentives:

(1) Plans have a strong incentive to be placed in Tier 1 (top tier) to attract enrollees.
(2) Enrollees have a strong incentive to choose Tier 1 plans due to lower premiums.
(3) Benefit levels have been maintained and high quality and safety is encouraged and rewarded.

As a result of the tiering structure, by 2007 nearly all 19 participating health plans were in Tier 1. Furthermore, implementation of the tiering structure has helped to slow the growth of premium increases. Post-tiering, the six-year average premium increase was 7.4 percent, compared to pre-tiering, where the six-year average premium increase was 11 percent.

The exchange should also include a 'dashboard' of administrative performance measures such as customer service and claims processing accuracy, which serves as valuable information that can influence the plan selection process. Finally, the exchange should provide health plans with summary data that reflects preferred physician and hospitals as well as reported health status information. This information can be used by plans to better ensure continuity of care and identify high cost and chronically ill members, whom insurance companies will be required to contact shortly after enrollment. This form of data sharing is currently being implemented in Wisconsin's BadgerCare Plus program.

8.11 Individual Exchange: Premium Payments

Individuals and their families must make premium payments to enroll in the health plan and, if a small employer is providing insurance to its employees through the exchange, small employers are required to make premium

contributions to the heath plan as well. The ACA does not require the exchange to collect premiums. However, collection of premium payments will help make the exchange easier to use for individuals, families, and small businesses.

Currently, in Wisconsin's individual and small group market, premiums are processed by health plans or a contracted third-party administrator. Health plans have a variety of different premium billing and payment schedules, effective coverage date policies and different amounts of time needed to process enrollments. Typically, the minimum amount of time needed for processing between the receipt of payment and the coverage effective date is 15 days; for group health insurance, the minimum is a full month. This gap in time between the deadline for payment and the beginning of coverage is used by plans to validate payment.

With regard to the collection, aggregation and payment of premiums, the exchange could be structured to have the functionality to perform any of the following:

- Allow for all premiums to be paid directly through the exchange. The exchange will then route all payments, singly or combined, to appropriate health plans. This would allow the exchange to accurately track who was enrolled in each health plan and the amount that small employers were contributing to their employees' health insurance on an ongoing basis.

- Allow for payment of the first premium payment through the exchange. The exchange will route the initial payments, singly or combined, to the health plan. This would allow the exchange to know who initially enrolled in each health plan. On-going premiums would be made directly to the health plan. This option would be burdensome for small employers who would be required to make multiple payments to multiple plans. Under this option, special arrangements would need to be made with health plans in order to maintain ongoing information on enrollment and premiums, or

- Allow for all payments to be made directly to the health plan, removing the exchange from the financial transaction. This option poses the same concerns for small employers as identified above.

The ACA requires that individuals have the option to make premium payments directly to the health plan. As is discussed in Section 7.4, this arrangement is not required under the SHOP exchange.

States should be given flexibility in designing payment policies that best meet the needs of enrollees, employers, and qualifying health plans. For purposes of premium collection and payment, the exchange should establish an arrangement under which the exchange and health plans would both contract with the same third-party administrator, and all premium payments would be made through the exchange. Under this arrangement, the requirement that individuals be provided with the option to pay the plan directly is met to the extent that the plan's third-party administrator is also the exchange's third-party administrator. Additionally, it is recommended that Medicaid also contract with the third-party administrator used by the exchange to collect Medicaid premium payments. This will have the effect of consolidating premium collection activities for the exchange and for Medicaid, eliminating the need for redundant systems and other infrastructure.

Facilitating premium payments to flow through the exchange will allow valuable data collection, analysis and reporting, including the tracking of enrollment of individuals and families into health plans and the amount of federal tax credits distributed to health plans. It is important to note, however, that if the exchange processes premium payments, the supporting system will either need to handle the multiple ways that health plans currently do business, or impose standardized billing, payment, and coverage practices on participating health plans. It will be important that the contracts between the exchange and participating health plans address these, and other, enrollment issues.

8.12 Individual Exchange: Secure Exchange User Account

Section 8.6 describes the process by which customers would create a secure user account with the exchange. These secure accounts should be created by all individuals using the exchange, including those that have employer-sponsored health insurance. Below is a list of possible items that the user could access through his/her account:

- Enrollment information and the next open enrollment period for his/her selected health plan.
- Health plan summary information, which was also available to the consumer as he/she completed the enrollment process.
- Premium summary and premium payment management. This payment management page would allow viewing of past plan payments, pending payments, due dates, the scheduling of reoccurring payments and making payments (for single or multiple months).
- Access to the provider, hospital, and clinic search tool.

Additionally, an individual will be able to conduct the following business through his/her secure user account:

- Renew their eligibility and re-enroll during open enrollment periods.
- Report changes to his/her circumstances, including income, deductions, household members, address, etc.
- Receive notifications regarding possible changes to the amount of advancable tax credits, if appropriate.

9 Wisconsin Health Insurance Exchange: SHOP Exchange Front Door Functions

9.1 SHOP Exchange: Employer Participation

As stated previously, the exchange should serve as a single point of entry for both the non-group market of individuals and families looking for health insurance as well as small employers and their employees. The Office of Health Care Reform suggests that small businesses interested in purchasing health insurance for their employees should follow a process similar to what is outlined below:

1) The employer will register for the exchange with a secure login and password. Included in this process is the collection of the employer's federal employer identification number (FEIN), so that the exchange can validate that they are an employer and that they meet the applicable definition of a small employer.

   It is envisioned that the employer verification process would operate similar to the individual verification process discussed in Section 8.9. An employer will provide initial information about his/her business and the exchange will pull necessary and available data from trusted third-party data sources for purposes of verifying the small employer's identity. If the information received through data exchanges is not correct, the employer will have the opportunity to make changes.

2) The employer will provide information about his or her business, including, but not limited to, address, contact information, and the number of employees eligible to be enrolled as part of the employer's plan. For each employee, the employer will need to provide their name, Social Security number (SSN), date of birth, gender, and whether the employer will offer individual or family coverage. This information will be used to identify each employee when he/she comes to the exchange to select and enroll in a health plan of their choice.

   The exchange will need to develop a verification process to ensure that the individuals registered to receive coverage under each employer are in fact employees of the business. The exchange will work with health plans and brokers to clearly understand how employer verification is completed in the current market and assesses

whether changes should be made under the exchange employer verification process.

3) The employer will indicate the health plan tier from which employees may choose a health plan.[10] The employer must also indicate the premium amount that each employee will be required to contribute, based on a benchmark plan, either for an individual or family. The employer will also select how she/he will make payments to the health plan (monthly check, electronic funds transfer, etc.).

   It should be noted that the Affordable Care Act (ACA) does not identify a minimum employer contribution for purposes of participating in the exchange. As is discussed in Section 9.2, employers must contribute a minimum of 50 percent of premium costs in order to qualify for the small business tax credit, however, there is no requirement related to participation in the exchange. Minimum employer contributions are in place for both the Massachusetts and Utah exchanges.

   The Massachusetts Connector requires small employers to contribute a minimum of 33 percent of premiums, or assure that at last 25 percent of full-time employees are enrolled in a plan where the employer is making a financial contribution. The Utah small business exchange requires employers to contribute at least 40 percent of premiums.

   A standard and substantive employer contribution will help to mitigate adverse selection and to make health insurance more affordable for employees. Therefore, it is recommended that a minimum employer contribution requirement be adopted. However, further analysis should be done in order to identify exactly what the minimum contribution should be. Furthermore, any minimum employer contribution requirement should apply to employer sponsored health insurance both inside and outside the exchange.

4) The employer will electronically sign an agreement with the exchange authority that requires the employer to meet certain conditions (compliance with all state and federal laws regarding equal treatment of employees, etc.).

[10] HHS is expected to issue guidance regarding whether employers must select a tier, or whether employers will have the option of selecting a single health plan for employees.

5) The employer will list the name, date of birth, and SSN for each employee who is eligible for coverage by an employer-sponsored health plan.

9.2 SHOP Exchange: Small Business Tax Credits

Certain small businesses are eligible for a tax credit toward their cost of employer-sponsored health insurance coverage. In order to qualify for a tax credit, small businesses must meet all of the following criteria:

(1) Have no more than 25 full-time equivalent (FTE) employees.
(2) Have annual wages that do not exceed $50,000.
(3) Pay at least 50 percent of qualified health plan premium costs.

The chart below identifies the maximum amount a small business can qualify for in a given year.

Year	For Profit Maximum Tax Credit	Non-Profit Maximum Tax Credit
2010	35% of employer's premium contributions	25% of employer's premium contributions
2011	35% of employer's premium contributions	25% of employer's premium contributions
2012	35% of employer's premium contributions	25% of employer's premium contributions
2013	35% of employer's premium contributions	25% of employer's premium contributions
2014	50% of employer's premium contributions	35% of employer's premium contributions
2015	50% of employer's premium contributions	35% of employer's premium contributions

* Beginning in 2014, employer must purchase health insurance through the exchange to qualify for tax credit.
* The tax credit that is available to employers beginning in 2014 is only available for two consecutive tax years.

The methodology used to calculate the tax credit consists of two parts. First, a preliminary amount is determined based on employer premium contributions. This amount will be adjusted based on the number of employees and average wages. Beginning in 2014, the preliminary amount will be equal to 50 percent of the lesser of the following amounts (35 percent during 2010 and 2011):

- Non-elective premium contributions the employer actually made during the tax year on behalf of employees for qualified health plans offered through the exchange, or
- Non-elective premium contributions the employer would have made during the tax year if each employee had enrolled in a qualified health plan with a premium equal to the average premium for the small group market in the identified rating area.

Second, the preliminary amount is then reduced by the sum of the following amounts:

- The preliminary amount multiplied by (total FTEs in excess of 10 divided by 15).

  Plus

- The preliminary amount multiplied by (average annual wages in excess of $25,000 divided by $25,000).

Given that tax credits are only available to small businesses that purchase health insurance through the exchange, beginning in 2014, qualifying small employers will have a strong incentive to purchase health insurance through the exchange, as opposed to purchasing health insurance in the small group market outside the exchange. The Office of Health Care Reform recommends that Wisconsin's state-based exchange include a calculator tool that will estimate the tax credit small businesses may qualify for if they purchase employer-sponsored health insurance through the exchange. This tool will serve as a value-added to employers and further the goal of maximizing utilization of the SHOP exchange by Wisconsin's small business employers. Additionally, it will be important that the exchange work with tax preparers and insurance brokers to educate small businesses on the tax advantage of purchasing health insurance through the SHOP exchange.

The Office of Health Care Reform proposes that the federal Department of Health and Human Services (HHS) create a Web-based small business tax credit calculator in consultation with the Internal Revenue Service (IRS). This calculator tool will allow the employer to maximize his/her tax credit, if he/she chooses, by modifying the employer contribution. The creation of a single tool will create greater efficiency and will allow for greater consistency in the estimation of the tax credit by ensuring that all states are accurately reflecting the Department of Treasury's interpretation of the tax credit law.

9.3 SHOP Exchange: Health Plan Selection

Employees of the small employer will be able to access the exchange via the Internet or over the telephone with our call center. The exchange should also work with insurance brokers to ensure that small businesses can continue their longstanding and trusted relationship with the broker community for human resource needs, including the purchase of health insurance through the exchange. The process that the employees would follow is very similar to the process suggested for individuals and families in the non-group market, with a few notable differences:

1) Employees will provide the exchange with personal identifiable information that will allow the exchange to match the employee with the correct employer. With this basic personal information, the exchange will be able to confirm that this employee is covered by an employer that is registered with the exchange.

2) Employees receiving health insurance through the SHOP exchange are not eligible for the premium tax credits. No determination of eligibility for tax credits will be completed.

   However, the exchange will provide employees with the option of an affordability test, which will ensure the employer sponsored health insurance meets the affordability requirements of the ACA. If the employee would like to test for affordability, the exchange will complete two tests:

   (1) Is the employee's required contribution to the premium greater than 9.5 percent of their household income?

   If yes, the employer sponsored health insurance is determined to be not affordable and the employee may choose to purchase health insurance in the individual market with the help of a federal premium tax credit.

   (2) Is the employee's required contribution between 8 and 9.8 percent of their household income? And, is the employee's household income at or below 400 percent of the Federal Poverty Level?

   If yes, the employee qualifies for a free choice voucher. A free choice voucher allows the employee to take what would have been the employer's contribution in the small group market and use that contribution in the individual market, where he or she may have different health plan choices. Employees can not qualify for both the free choice voucher and premium tax credits.

3) The exchange will inform employees of the tier selected by their employer and the level of premium contribution that he/she will be responsible for, based on a benchmark plan.

4) Employees may elect to enroll in any health plan available under the tier selected by the employer. If the employee selects the benchmark

plan, he/she will be responsible for the premium amount identified by the employer. However, if the employee selects a plan other than the benchmark plan, the employee must pay the full premium cost difference.

5) Employees in the small group market will not be presented with options for payment. The employer will be responsible for making a single payment on behalf of the employer and employee and the employer will deduct the employee share of the premium cost from wages. Therefore, the employer will select his/her preferred method of payment at the time he/she registers with the exchange.

The OHCR recommends considering whether individuals eligible for employer-sponsored health insurance through the SHOP exchange will undergo screening for Medicaid. Similar to the ranking process identified in Section 8.10 for the individual exchange, employees will complete an HNA and identify their provider and hospital preference and will be presented with a ranked listing of available health plans within the specified tier from which they may choose a plan.

9.4 SHOP Exchange: Premium Payments

As noted above, in Section 8.11, the ACA requires that individuals have the option to make premium payments directly to the health plan. This arrangement is not required under the SHOP exchange.

In order to ensure that worker choice of competing plans is manageable for employers, the SHOP exchange should offer one-stop enrollment and premium collection. The administration of these functions for group coverage is significantly different than for individuals. It is also important to note that in order for the employee's premium contribution to be tax sheltered, the employer must collect the employee's contribution by withholding it from compensation. These factors have implications for the structure, operation and administration services of the SHOP exchange. Working under these assumptions, the exchange should explore a premium payment system where small employers would make premium payments that would reflect the employer's contributions and workers' payroll withheld contributions for their respective choice of health plans. Employers would deduct employee contributions from their paycheck and the exchange would provide the employer a worker-by-worker list of selected plans and their respective premiums.

10 Wisconsin Health Insurance Exchange: Customer Assistance

10.1 The Role of Brokers

Insurance brokers will be of great assistance to small employers and their employees. With years of experience working with small businesses in the small group market, brokers maintain a solid understanding of health plans and are able to develop a spectrum of insurance packages that extend beyond just health insurance, including property and liability. It is expected that small businesses will rely on their trusted relationships with brokers in navigating options offered inside the health insurance exchange. While much is still unknown concerning the functions of the small business exchange, there are many administrative services that the exchange can provide that may serve as value-added services for small businesses.

Examples of these administrative services include:

1) Fiscal Agent Functions
   - Collect premium payments from employers for eligible employees.
   - Consolidate premium payments and make appropriate monthly payments to carriers.
   - Bill employers.
   - Assist brokers and employers with estimating tax credits.
   - Calculate, dispense, and track payments to brokers who work for the exchange.
2) Application Processing
   - Process online applications.
   - Coordinate employee information with individual exchange — for purposes of affordability tests and other verifications.
   - Provide administrative support to brokers on marketing and outreach to small employers.
3) Provide Information on Health Plan Options
   - Provide comparative information to employers about available health plan options.
   - Keep track of plan choices and changes.
   - Coordinate coverage for employees with Medicare, dependents, and retirees for the employee or members of their family.
4) Other Customer Service Functions
   - Provide a staffed call center with toll-free number.
   - Staff call center with workers who have expertise in working with small businesses.
   - Assist employers with registering with the exchange.
   - Single point of contact for enrollment changes.

When determining which administrative services the exchange should provide, the exchange should consider which of those services could be best provided by brokers. Furthermore, the exchange could consider training and providing technical assistance to insurance brokers in order to become effective in this modified role and should consider dedicating a call center and Web-portal tailored specifically for use by brokers.

In order for the SHOP exchange to be successful and attract significant market share, it will be important to create an incentive for brokers to sell insurance inside the exchange. The compensation for the insurance brokers, community-based organizations and county/tribal health services departments handling these tasks will need to be reasonable and fair. Broker compensation is dependent upon forthcoming federal guidance and will likely require additional discussion and analysis.

10.2 The Role of Community Partners and Exchange Navigators

As noted in prior sections of this document, one of the exchange's primary goals is to design an enrollment process that is streamlined and easy to use for consumers. The creation of an exchange portal with a toll-free call center will help achieve a streamlined enrollment process. That being said, external resources must be available to assist consumers with health plan selection and enrollment and to assist with the dissemination of information. The Affordable Care Act (ACA) requires that exchanges establish programs to award grants to eligible entities to serve as navigators for the exchange.

The Office of Health Care Reform views existing community partners as being eligible to serve as formal "navigators." In order to ensure that individuals, families, small employers and their employees have ample access to resources for assistance in using the exchange, Wisconsin should expand its network of non-governmental enrollment partners. The State should look to establish new relationships with entities that have strong, established relationships with small businesses and self-employed individuals, including regional chambers of commerce, unions and trade associations. Wisconsin currently uses 200 community-based organizations to assist low-income individuals in applying for BadgerCare Plus, Medicaid, and FoodShare. This effort would further expand the network of non-governmental organizations to train as many different groups around the state as possible in order to assist individuals in completing enrollment and to help explain the process and policies. This will require a large effort on behalf of the exchange to recruit willing organizations, provide training to them, answer their day-to-day questions, resolve problems and monitor their success.

Duties that navigators must perform are:

- Conduct public education activities to raise awareness about qualified health plans;
- Distribute fair and impartial information about subsidies, enrollment, and cost-sharing reductions through the exchange;
- Facilitate enrollment into qualified health plans;
- Provide referrals to the consumer assistance program implemented through the exchange; and
- Provide information in a manner that is culturally and linguistically appropriate.

Entities that are awarded navigator grants under the exchange may include trade industry and professional associations, community and consumer-focused nonprofit groups, unions, chambers of commerce, small business development centers, licensed insurance agents and brokers and other entities that meet the standards that will be issued by HHS. The ACA precludes any health insurance issuer and/or entity that receives consideration directly or indirectly from any health insurance issuer from serving as a navigator.

The Office of Health Care Reform has identified that navigators be used for the following activities:

- Help individual consumers use the online selection tool to locate providers and plans;
- Assist individuals who apply for Medicaid and BadgerCare Plus;
- Educate consumers about health care reform, available health care options, and how to access medical care;
- Direct consumers to appropriate contacts for help on appealing health care decisions or those requesting advice on choosing a health plan, including the Consumer Assistance program and licensed brokers.

In Wisconsin, navigators would be precluded from advising consumers on their health plan choices. Brokers, as licensed agents, will maintain the role of advising consumers on their health plan choices.

10.3 The Role of Counties and Tribal Agencies

Counties and tribal agencies will also be integral in assisting low-income individuals in navigating the new health insurance marketplace. The exchange should seek input from community partners, counties and tribal agencies on how to best accomplish these goals.

10.4 Other Consumer Assistance

The ACA provides for federal grants to states for purposes of expanding or establishing health insurance consumer assistance programs. In October, Wisconsin was awarded $637,114 to operate a consumer assistance program.

As a condition of accepting funds, consumer assistance programs must:

- Assist consumers with filling complaints and appeals;
- Assist consumers with enrollment in health care coverage;
- Educate consumers on their rights and responsibilities with respect to health care coverage; and,
- Collect data on consumer inquiries and complaints.

Wisconsin intends to use the awarded grant funds to expand upon the Office of the Commissioner of Insurance's (OCI) current consumer assistance activities. The prominent features of OCI's proposal include:

1) Increasing capacity to address consumer inquiries and complaints;
2) Increasing consumer outreach and education activities;
3) Contracting with ABC for Health, Inc., to assist consumers with advocacy or enrollment needs that are outside OCI's jurisdiction; and,
4) Expanding data collection capacity and activities.

Beginning in 2014, when the exchange is operational, there is the potential for the consumer assistance program to operate in cooperation with the exchange, primarily by (1) helping resolve consumers' problems relating to obtaining premium tax credits; and (2) accepting Navigators' referrals of consumer grievances, complaints, and questions relating to health insurance coverage in the exchange. Data regarding consumers' experiences in the exchange could help inform and drive decisions regarding plan inclusion and quality rating as well as identifying market trends and problems to be addressed by the exchange.

At this time, the grant is funded for one year, but the White House has requested an additional round of funding for 2011-2012. That being said, assuming the program is funded in the future, it is recommended that the consumer assistance program report certain data components to the exchange. Receipt of certain data will allow the exchange to identify and follow trends that may be relevant and useful to the exchange.

11 Wisconsin Health Insurance Exchange: Back Door Functions

11.1 Regional Strengths

Wisconsin has a strong tradition of high quality, efficient, health insurance issuers. It is a priority of the Office of Health Care Reform that the exchange encourages participation by all qualified health plans that meet the standard requirements set for health plan participation. Among Wisconsin's issuers are regional insurers, many of which include "home-grown" integrated delivery systems. An integrated delivery system is a health care delivery system with its own hospitals and/or a multi-specialty physician group practice and a health plan. The integrated delivery system model holds the organization financially at risk to provide health care services for a defined population and is held clinically accountable for the outcomes and health status of the population served. This insurance model provides flexibility, aligned incentives, and expertise in organizing delivery of high value care. Integrated delivery system models may be "closed," serving only patients within their health plan; "open," serving patients both within and outside their health plan; or a mixed model, including both an integrated medical group and independent physicians in private practice.

The integration of health care services is an important factor in delivering high-quality, cost-effective, accessible and patient-focused care. The exchange should continue to recognize these local delivery systems and allow them to effectively compete against statewide and national insurers in the exchange marketplace. Furthermore, in order to maintain and continue to improve upon Wisconsin's high quality level of care, the exchange should encourage continued development of integrated delivery systems and the overall integration of health care services. The exchange should consider putting incentives in place to encourage the adoption of integrated delivery systems, such as more heavily weighting health plans whose provider networks include integrated delivery systems when ranking health plans or requiring the inclusion of integrated delivery systems in a provider network in order to be certified as a qualified health plan. Ranking health plans in such a manner would strengthen the demand for those health plans that offer only or predominantly integrated delivery systems.

The state implemented a similar system that rewarded integrated delivery systems when awarding the Southeast Wisconsin BadgerCare Plus HMO Contracts. Under that system, integrated delivery systems were eligible to receive up to five percent additional points based on the extent to which their organizational structure met the requirements of an integrated delivery system.

Participation in the exchange by both state-wide, for-profit insurance companies, in addition to participation by local, integrated delivery systems will be important in ensuring sufficient health plan choice for consumers and will contribute to the success of Wisconsin's health insurance exchange.

11.2 Health Plan Bid Process

States can implement exchange functions related to health plan selection and participation with varying degrees of involvement in the market. For example, a state can limit the exchange to the role of market organizer, serving as an impartial information source that merely lists and compares all qualified health plans. Alternatively, a state can make the exchange an active purchaser by adopting a bidding process that applies restrictive certification and reporting requirements and/or by negotiating with plans to identify and select high performers. Additionally, any one of these active purchaser options can be implemented in a manner that actually limits the number of plans participating in the exchange to a pre-determined number. It is expected that higher levels of purchasing power will correlate with greater potential for advancing payment reform initiatives and curbing health care cost growth and may help to simplify the decision-making process for consumers.

Consistent with the Office of Health Care Reform's exchange guiding principles, two primary goals of the health plan bidding process should be to achieve greater transparency among health plans for consumers and increased competition among health plans in order to achieve greater value for health care services. Given these goals, the exchange should explore a competitive bid process that seeks to maximize health plan participation. Under this model, all health plans that meet the minimum certification requirements, as determined by the exchange, will be certified to participate in the exchange. The minimum requirements that must be met for certification should include the requirements from the Affordable Care Act (ACA) and any additional requirements identified by the exchange, including those in Section 11.3 of this paper. This option does not seek to limit the number of health plans that participate in the exchange based on their premium bids. That being said, the ACA does require health plans seeking certification with the exchange to submit a justification for any premium increase prior to implementation of such increase and the exchange may consider this information when determining whether to make a health plan available through the exchange.

This competitive bidding process should include a requirement that health plans submit bids on an annual basis, by rate cell, based on age, group size, and geographic region. Additionally, bids must reflect the actuarial value of each tier allowed (platinum, gold, silver, and bronze). The submission of insurance rates

on an annual basis will help create managed competition and, for the individual exchange, will align well with an annual enrollment period.

Other policies that the exchange could consider relating to the competitive bidding process include:

- Not committing to whether or not the exchange will limit the number of participating health plans. It is thought that this will create even greater competition among health plans looking to participate in the exchange.

- Featuring the three lowest priced health plans in each rating region as "Top Tier" health plans. These plans could always be displayed first in instances where consumers do not rank their preferences, or consumers could have the option to view only the "Top Tier" health plans. If health plans know in advance that the exchange will steer shoppers toward the lowest cost health plans, health plans may bid more aggressively. Another area by which health plans could compete to be in the top tier is based on medical loss ratio (MLR). Under this example, health plans with the highest MLR would qualify as "Top Tier" health plans.

- Identify some way to feature integrated delivery systems to consumers. While not always the lowest cost, integrated delivery systems are oftentimes rated highest in quality performance and value.

11.3 Health Plan Certification

One of the essential functions of the health insurance exchange is to certify qualifying health plans. Only health plans that have been certified by the exchange may offer health insurance in the non-group and small group market through the exchange. The Department of Health and Human Services (HHS) Secretary is charged with establishing minimum criteria for the certification of qualified health plans. The Secretary's criteria will include minimum marketing requirements, minimum provider network requirements, minimum level of performance on clinical quality measures and guidelines for quality improvement strategies. That being said, significant flexibility is afforded to states to adopt certification requirements that move beyond the minimum requirements established by the Secretary and create an environment that generates greater price competition among participating health plans.

It will be important that the exchange set standards that extend beyond the minimum requirements in order to encourage managed competition, bend the

cost curve, improve health care quality and patient outcomes, and increase consumer choice in Wisconsin. It should be noted, however, that increased standards and requirements may call for increased financial commitment on behalf of health plans and has the potential to discourage health plan participation in the exchange, therefore limiting consumer choice.

Wisconsin has a strong tradition of high quality, efficient health insurers. It is a priority of the Office of Health Care Reform that the exchange encourages participation in the exchange by all qualified health plans that meet the standards set for health plan participation. That being said, failure to move beyond the minimum requirements may limit the transformative nature of the exchange. Participation in the exchange by both state-wide, for profit insurance companies, in addition to participation by local, integrated delivery systems will be important in ensuring sufficient health plan choice for consumers and will contribute to the success of Wisconsin's health insurance exchange.

The exchange will develop and implement standards and review criteria that health plans need to meet in order to participate in the exchange. It will be responsible for enforcing both the standards set by HHS and any additional standards implemented by the exchange, and for taking any appropriate action should a participating health plan fail to meet such standards. It should be noted, however, that the overall regulatory authority of the Office of the Commissioner of Insurance (OCI) will not be pre-empted by the insurers' participation in the exchange.

As noted in Section 11.1, the exchange should encourage the expansion of managed care, integrated delivery systems, and other innovative health care financing and delivery models. That being said, it may be necessary or desirable for fee-for-service structured health plans to continue in certain areas of the state, such as rural counties that either do not have managed care or where there is limited provider choice. When certifying health plans, the exchange should consider where traditional fee-for-service options must be made available.

The Office of Health Care Reform has identified the following requirements that health plans should meet, in addition to those identified by the Secretary, in order to participate in the exchange. Additional requirements may be identified at a later date.

(1) Health plans must meet one of the following:

I. Health plans must become nationally accredited, or
II. Health plans must meet minimum quality standards, as determined by the exchange.

(2) Health plans must meet provider network standards that will be set by the exchange. Provider network standards will be based off the network standards in place for Wisconsin's Employee Trust Funds.

(3) Health plans must offer products on a ZIP code basis. To the extent possible, the exchange will welcome health plan participation on a county, regional, and statewide basis.

(4) Health plans must submit to the exchange information on participating doctors, hospitals, and clinics. This information will be used to facilitate consumer choice of health plans based on established provider relationships.

(5) All participating health plans must provide the exchange with encounter data. Encounter data will be necessary in order to perform risk adjustment. Additionally, receipt of encounter data will provide the exchange with the greatest flexibility to use health plan claims and encounter data to monitor health plan performance and set ongoing performance standards.

It is recommended that all health plans submit encounter data directly to the Wisconsin Health Information Organization (WHIO), and through an agreement or memorandum of understanding, the exchange will have access to the encounter data of certified health plans. It should be noted that Medicaid participating health plans will continue to submit Medicaid encounter data to Medicaid.

(6) Health plans must submit nationally validated quality performance scores to the exchange. Nationally validated quality performance scores consist primarily of Healthcare Effectiveness Data and Information Set (HEDIS) measures. The exchange will consider adoption of additional outcomes-based measures, and if the exchange chooses to require certain outcomes-based measures, it will explore partnering with another organization such as Wisconsin Collaborative for Healthcare Quality (WCHQ) or WHIO for purposes of calculating these scores. In advance of the bid process, the exchange will provide insurers with an overview of the non-group and small group markets based on data from the previous year to assist insurers in evaluating market risk. The exchange can build off of the state's experience with plan certification for Employee Trust Funds (ETF) and Medicaid in order to develop an effective certification process for the exchange.

The Office makes additional recommendations relating to ensuring vertical integration for individuals and families in the exchange. There are two primary reasons why vertical integration is important. First, an individual or family's eligibility for Medicaid or federal premium tax credits and cost-sharing reductions may be based on current income and household make-up. Therefore, should a significant change in circumstance occur, an individual or family may gain or lose eligibility for a particular program or may shift across insurance markets. When this occurs, it will be important that consumers are able to stay with their current health insurer and, to the extent possible, maintain their current health care providers. By ensuring this type of vertical integration, continuity of care will be better ensured, resulting in less disruption to the consumer and possible savings in health care costs through the elimination of duplicative services that often occur when changing health plans.

Second, as a result of the maintenance of effort requirements included in the new legislation, there will be families in Wisconsin whose children will maintain insurance through BadgerCare Plus, but whose parent(s) will transition out of Medicaid into the exchange, where they will purchase health insurance with the help of federal tax credits and cost-sharing reductions. In this case, vertical integration would help ensure easy navigation of the health care system for these families, by allowing parents and children of the same family to have health plan options that cover their entire household. Under this situation, covered benefits, cost-sharing requirements, and provider payments for BadgerCare Plus and the private health plan options would remain different in order to comply with the requirements of the legislation.

Recommendations related to vertical integration include:

(1) Solicit proposals for integrated products through insurance carrier partnerships.

(2) Solicit proposals from individual insurance carriers to offer unified products that would be available in multiple markets.

(3) Explore incentives for carriers that participate in both Medicaid and the commercial exchange market. Examples of incentives include:

A. Providing a bonus payment to carriers that are in both Medicaid and the commercial market, and
B. Implementing passive enrollment policies that would auto enroll individuals into the same health plan, if available, when their circumstances change and they move from one market into another. These individuals would be given the opportunity to opt-out of the auto assignment.

(4) Establish policies to address continuity of care concerns when an individual or family shifts out of Medicaid and into the individual market, or vice versa.
Examples of such policies include:

A. Requiring that health plans honor a member's provider for the lesser of either 60 days, or in the case of pregnancy, until the end of the pregnancy, or until the member transitions to a new health care provider.
B. Honoring authorizations and referrals for a limited period of time.
C. Honoring any active course of treatment until the member is stable.

11.4 Benefit Design

The exchange will offer standardized benefit packages that will be available in four benefit tiers, differing only in the amount of cost sharing required. The benefit tiers include:

(1) Bronze (60 percent actuarial value).
(2) Silver (70 percent actuarial value).
(3) Gold (80 percent actuarial value).
(4) Platinum (90 percent actuarial value).

Among other qualified health plans, the exchange will include multi-state plans that will be overseen by the federal Office of Personnel Management and a CO-OP option. A catastrophic plan will also be available for those who are younger than age 30, lack access to affordable insurance, or may be exempt from the individual mandate based on hardship.

The Affordable Care Act (ACA) requires exchanges to offer health plans that cover certain established percentages of the expected claims costs for a defined set of benefits. It does not require standardization of cost-sharing beyond this actuarial value. Under this arrangement, an exchange could allow one carrier to offer a Bronze level plan with a $2,000 annual deductible and relatively little cost-sharing at the point of service and allow a second carrier, also at the Bronze level, with no deductible and relatively high point of service copayments. These two plans have similar actuarial values but are difficult to compare. A consumer could easily assume that the difference in price reflects a difference in benefits.

Allowing such variation can make it easier for carriers to offer existing products in the exchange, rather than creating new products, which they would also have

to offer outside the exchange. However, variations in health plans can confuse consumers and make it difficult to comparison shop based on price, provider network, and other differences in value, in the same actuarial tier.

In order to determine the appropriate level of standardization, it is important that the exchange clearly understand customers' preferences. Over time, the exchange will gain insight into customer preferences and the exchange can standardize around customers' preferred plan designs. The exchange may consider a phase-in of standardized cost-sharing in each tier. Alternatively, the exchange may decide to implement full standardization from inception. This approach avoids the need to transition over time but risks making inaccurate assumptions regarding consumer preferences.

It is important to note that standardization, regardless of the implementation timeline, will likely result in some health plans becoming no longer available.

Qualified health plans operating within the exchange must offer a standardized minimum level of benefits. The minimum benefits include, but are not limited to, the following service categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision. Standardized benefit levels will create an environment of greater transparency among health plans and allow for more informed decision making on behalf of consumers.

States have the option to add additional benefits to the minimum set by HHS. If a state chooses to require additional benefits, beyond those required by HHS, as part of the essential benefit package, the additional cost of the tax credit for these benefits must be borne by the state. The state should evaluate whether it will require additional benefits and, if so, which benefits will be required.

11.5 Enrollment Reporting

The exchange should send enrollment records to interChange where they will be stored as a new client record or will be updated to an existing record. interChange is Wisconsin's Medicaid Management Information System. Through the interChange Web-portal, providers, managed care organizations, partners and trading partners can electronically and securely submit, manage, and maintain health records for members. Once the information is stored, interChange is able to transfer the enrollment request to the plans via the ForwardHealth Portal on a regular basis. The transfer of enrollment data could

occur daily, weekly, biweekly, or monthly. The exchange should work with health plans to determine the best frequency for the transfer of enrollment data.

Upon initial analysis, it is recommended that the effective date for enrollment is as follows:

- For all enrollments received in interChange on or before the 15th of each month, the effective date will be the first of the following month (month +1).
- For all enrollments received after the 15th, through the end of the calendar month, the effective date will be the first of the month following the next month (month +2).

This recommended enrollment schedule is consistent with commercial insurance enrollment policies today.

Additionally, the exchange should leverage the existing interChange system processes and resources that are currently used for Medicaid and BadgerCare Plus to handle federal reporting.

12 Wisconsin Health Insurance Exchange: Mitigating Adverse Selection

The exchange presents an unprecedented opportunity to expand health insurance coverage to individuals and small employers in Wisconsin. That said, the presence of an exchange also creates the opportunity for adverse selection and skewed insurance markets. Generally speaking, adverse selection occurs when certain insurance benefits or premium levels attract a larger than expected number of high risk participants, which can lead to higher costs and premiums.

A skewed market will be unsustainable over time, as those with lower than average risk will seek out insurance plans and premiums that reflect their level of risk, while those with a poorer risk status will elect a higher cost health plan. As health care costs are reflected in premium rates, over time, the difference in premiums will be substantial and low risk individuals/groups will likely gravitate to lower cost plans.

Risk adjustment is a tool anticipated by the Affordable Care Act (ACA) to mitigate risk differences both within health plans participating in the exchange, and between plans operating in and out of the exchange. Unanticipated high cost claims can lead to significant financial loss for health insurers. It will be important that insurers are provided with some assurance that significant anti-selection due to guarantee issue of coverage, modified community rating and other insurance market reforms will be mitigated. Additionally, a risk adjustment mechanism may help to encourage insurer participation and, as a result, increase price competition. If the proper implementation of such a risk adjustment mechanism is not achieved, insurer participation in the exchange could be negatively affected.

The federal government is working to develop basic guidelines for risk adjustment, but it is likely that many of the operational decisions regarding how risk adjustment will be done will be left to the states. Wisconsin has significant experience with risk adjustment in Medicaid, and health plans that offer Medicare Advantage plans are also familiar with risk adjustment models. Currently, Wisconsin Medicaid applies the Chronic Illness and Disability Payment System (CDPS) risk adjustment to participating Medicaid HMOs on an annual basis.

Comprehensive risk adjustment in the Wisconsin individual and small group health insurance exchange will be imperative for achieving a substantial, competitive exchange. Risk selection within the exchange or between the exchange and the outside market can be neutralized by existing actuarial risk adjustment methods. Furthermore, providers of health care services can be

appropriately compensated when available monies are divided on a risk adjusted basis. Adequate and effective risk adjustment is a critical element in the transformation of the insurance market from one that rewards risk selection to a market that rewards the quality and efficiency of the products and services of the insurer, including the underlying health care delivered by the insurer's network of health care providers.

12.1 Risk Adjustment – The Basics

The ACA includes risk adjustment mechanisms that are designed to respond to the concerns identified above. Specifically, the ACA requires the administration of three reinsurance and risk adjustment programs in order to account for variation of insurance risk among plan enrollees and across health plans. One program will be administered by the federal government, while two programs will be administered by each state, in accordance with federally established guidelines.

The three components of risk adjustment called for by the ACA include: (1) risk adjusters, (2) reinsurance, and (3) risk corridors.

A. Risk Adjusters

Each state must adopt a risk-adjustment model, as prescribed by the federal Department of Health and Human Services (HHS) Secretary, to apply risk adjustment to health plans and issuers in the individual and small group markets. Plans with enrollment of lower than average risk will pay an assessment to the state. States will provide payments to plans with higher than average risk.

Risk adjusters refer to the statistical process of estimating the expected medical care resource needs of individuals. These estimations are based on demographic and clinical information. The results for each individual are accumulated to determine a risk score for comparing populations. Risk scores can be translated into dollar amount adjustments. A sustainable risk-adjustment model will be an important element in eliminating insurers' incentives to compete on positive risk selection and risk aversion rather than risk management. It should be noted that the risk adjustment methodology described in this paper and recommended by the Office of Health Care Reform was suggested by a Wisconsin licensed health insurer and was discussed with many of Wisconsin's other participating carriers.

The Office of Health Care Reform recommends a three-tiered approach to risk adjusters. Initially, adjusting for the demographic information of age, gender, and location can occur immediately upon enrollment. Secondly, pharmaceutical information, which is often more complete, standardized, and quickly accessible, can provide for ongoing measurement. Thirdly, medical encounter data measured at the end of a period and taken into consideration with the first two measures can be used to stratify enrollees further into risk classes, treatment groups and estimated resource needs. Further, co-efficients and co-morbidities should be evaluated and adjusted specifically for the commercial population and benefit levels that will be part of the exchange.

It is critical to use a concurrent risk adjuster rather than prospective. Concurrent adjustment more appropriately adjusts for the current enrolled risks rather than estimating future potential risk costs. A concurrent model also better accounts for turnover within a health plan's membership that can be caused by enrollees entering and exiting the exchange. The statistical correlation coefficient of concurrent factors is much higher than prospective factors. This higher correlation will give the market increased confidence that risk differences will be fully adjusted as part of final compensation.

As an example of the compensation adjustment, if the full population equates to a 1.0 factor, a sub-set of the population (one health plan) may incur a 1.10 factor. After risk adjustment, that health plan would ultimately receive a 10 percent subsidy to the premiums collected from the enrollees. This subsidy would be accounted for or funded on an ongoing basis (such as quarterly). A final adjustment would be determined retrospectively to all risk-bearing entities, once all claims are complete, following the experience period.

The ACA requires that risk adjustment be applied to all plans in the individual and small group market, regardless of whether they are sold through the exchange or outside the exchange to provide funds to equalize risk and the revenue for all market participants. This adjustment will enable competitive prospective premiums to be charged in and out of the exchange even if the two populations enroll different risks and will promote a level playing field for exchange participation.

B. Reinsurance

Each state must establish a nonprofit reinsurance program for the individual market by no later than January 1, 2014, lasting through 2016. All health insurance issuers and third-party administrators (TPAs) of group health plans will contribute to a temporary reinsurance program for individual policies that will be administered by a nonprofit reinsurance entity. The total contribution amounts will equal $25 billion nationally over the three-year period. At the time this document was written, HHS had not issued guidance regarding how these funds would be distributed across states. Wisconsin has the option to collect additional amounts from issuers if it determines that the federal funds will not be sufficient for an adequate reinsurance program in our state.

Reinsurance of health care expenses for individuals with large claim expenses will be an essential component of meeting the goals of preventing the negative consequences of adverse selection.

Reinsurance is necessary because risk adjusters generally do not adequately adjust for individuals with very large individual expenses. We recommend that the risk score as calculated in section (A) be limited to the amount that equates to the reinsurance threshold or individual stop-loss level.

Reinsurance should be set at an insurer's adjusted cost level and to reimburse identified individuals for reprised 'cost' above this level.

The insurer would identify the individuals based on the insurer's actual expense. However, the claim would be reprised to reflect an adjusted cost basis using such approaches as prospective payment rates and RBRVS conversion units. They would also reflect a fixed market-based reimbursement rate for all insurers. This approach would mitigate the incentive to not manage costs for claims once they reached the reinsurance level. Further, the fixed reimbursement would enable those with more effective case management or lower cost to benefit from those advantages.

It is expected that this basis for reimbursement would be simple and effective in the short term. In addition, subsequent iterations of the determination of the allowable reprised costs could enable

improvements to reflect best practices for quality care and cost management. This could also further enable the full reflection of adjustment for enrolling individuals with higher medical care needs and reward potential for delivering care by the most competent provider of care to these individuals in a cost-effective manner.

C. Risk Corridors

The HHS Secretary will administer temporary risk corridors from 2014 through 2016, under which payments to qualified health plans in the individual and small group markets will be made according to applicable risk corridor rules, based on the program for regional participating provider organizations under Medicare Part D. If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, the Secretary makes payments to the plan to defray the excess. If a plan's costs (other than administrative costs) are less than 97 percent of total premiums, the plan makes payments to the Secretary.

Risk corridors offer a protection for insurers by serving as an overlay to the financial result of the insurer after the other risk adjustments have occurred. It is anticipated that this protection would be provided for any result beyond a narrow band in the initial year(s) of the exchange and subsequently be broadened as the other risk adjusters are proven and the amount of risk can be better defined by the early exchange experience.

The objective of risk adjustment should be to provide appropriate monies for the medical care needs of the population enrolled by an insurer. This compensation should further be based on the efficiency and the quality of patient care and health management the population receives from the health care providers utilized by that insurer's enrolled members. The compensation should specifically adjust so as to exclude for any financial benefit or reward resulting from favorable risk selection.

The payment mechanism in the exchange needs to be systematically adjusted in order to balance the appropriate delivery of care with the compensation for that care. Generally, risk adjustment mechanisms have previously only partially compensated for the risk differences in enrolled populations. In doing so, favorable risk selection has always remained a viable path to profitable compensation for an insurer, even where risk adjustment mechanisms have been utilized. Similarly, unfavorable risk selection combined with partial risk adjustment equates to inadequate

compensation for the medical expenses of a population. Caring for medical need and economic benefit should not be at odds.

The compensation system in the individual and small group markets must compensate for adverse selection to allow insurers to enroll those individuals most in need of health care and health management. In short, the risk adjustment system must be designed so insurers and providers are compensated appropriately and fairly for caring for either sick or healthy populations.

The risk adjustment methodology recommended by the Office of Health Care Reform, with support from Wisconsin health plans, is designed to achieve the objectives of: (1) adequately adjusting for risk of populations, (2) rewarding health care quality improvement and promoting the best medical care, and (3) transforming the basis of competition.

It should be noted that comprehensive discussions, debate, and communication of risk adjustment with health insurers will enable exchange insurers to rely on this knowledge in designing products without the concern of positive or negative selection. It is important for market participants expecting higher risk enrollment to be able to set prices equivalent to what they would set if they had average market risk enrollment. This advance knowledge will enable these insurers to set prospective prices that are competitive and not excessive. Similarly, participants expecting lower risk enrollment based on past experiences need to be aware of the risk adjustment reductions to revenue, so these insurers price products adequately and not at a level that would result in financial losses after risk adjustment.

It is critical that states are provided with flexibility in establishing their own risk adjustment methodology. A national solution has the potential to be based on a 'weakest link' (other state) approach and therefore fall short of the goal of a vibrant exchange in Wisconsin.

12.2 Additional Policies to Mitigate Adverse Selection

While the ACA envisions effective risk adjustment as the primary mechanism to mitigate adverse selection, it will be important that the exchange consider deploying other policies to actually prevent this problem from occurring in the first place.

The ACA provides for a set of market rules and obligations that apply both inside the exchange and in the broader insurance market, while also imposing some rules only on plans participating in the exchange that may help mitigate adverse

selection. States have the authority to operate their insurance market and exchange as they deem most appropriate to meet their own policy goals, and may choose to impose the same rules and obligations both inside and outside the exchange. States will still need to make conscious decisions on key design elements to protect the exchange from traditional insurance market risks.

There are several characteristics of the exchange that have the potential to create adverse selection. Each of these elements is described below.

(1) Location of subsidies and requirement of silver plan to receive subsidy

The subsidies available to individuals and families below 400 percent of the Federal Poverty Level are available only through the exchange, and are benchmarked to the second lowest cost silver level benefit plan offered. Depending on the pricing of insurance premiums, and whether the premiums for individuals and small groups are linked, it is possible that the availability of premium subsidies only through the exchange could affect the risk mix of exchange enrollees. To the extent those needing a subsidy have a somewhat higher than average risk, the availability of subsidies only though the exchange presents the opportunity for selection against the exchange.

(2) Initial entry from Health Insurance Risk-Sharing Plan (HIRSP) and the Temporary Federal High Risk Pool

In 2014, both HIRSP and the Temporary Federal High Risk Pool will cease operation, and enrollees in the pool will transition to the individual insurance market. As was discussed in Section 5, Wisconsin's HIRSP was established in 1979 as a way to provide an affordable health insurance option for those individuals who cannot obtain affordable insurance due to a pre-existing medical condition. The Temporary Federal High Risk Pool was created under the ACA to create a temporary program under which people who have been denied entry into the insurance market due to pre-existing health conditions may obtain health insurance coverage at premium rates offered to healthy individuals. Although not a requirement of the ACA, it is possible that many of these high risk individuals will choose to enter the exchange. Two risk mitigating components are included in the ACA to address this issue: (1) individual reinsurance, and (2) aggregate stop loss. These components are in place for the first three years of the exchange as the markets settle out and then are expected to no longer be needed.

(3) Availability of grandfathered health plans outside of the exchange

Health plans sold before the passage of the ACA on March 23, 2010, may choose to remain under grandfathered status. Plans making this choice will likely do so to avoid the cost of additional benefits required to participate in the exchange, resulting in lower premium costs. However, in the individual and small group markets, it is unlikely that a critical mass of plans will remain grandfathered, due to the restrictions that action imposes.

(4) Opportunity to offer less rich benefit plans outside the exchange

Under the ACA, health plans will be designated as Bronze, Silver, Gold, and Platinum, indicating their actuarial value. Any health plan participating in the exchange must offer both a silver and gold level of coverage. A silver plan provides coverage at an actuarial value of 70 percent of the total estimated cost of covered services, while the gold plan provides coverage at an actuarial value of 80 percent. In contrast, bronze plans provide coverage at 60 percent of the actuarial value of the benefits, inherently reducing the premium cost. Individuals who prefer a bronze plan are expected to have a lower risk profile than those enrolling in higher benefit levels, other than the population receiving a subsidy, since they are willing to trade a lower premium for higher point of service cost sharing requirements. Unless restricted by the state's insurance regulations, health plans operating outside the exchange may choose to offer only bronze coverage, essentially removing themselves from competition with exchange-based plans, since there will be no need to pool their bronze level experience with the experience of individuals enrolled in richer benefits plans. These plans may be expected to experience favorable selection (i.e., enrollment with lower than average risk).

While there are many characteristics of the new market that present the opportunity for adverse selection both within the exchange and between the exchange and any outside market, there are also a number of critical characteristics that reduce the opportunity for selection or are designed to mitigate the effects of selection.

The key characteristics included in the ACA that are designed to minimize adverse selection are:

(1) A common benefit design within a broad range of actuarial values is required both in and out of the exchange. Specifically, the bronze, silver, gold and platinum actuarial value designations must be used both inside and outside the exchange, providing consumers the ability to comparison shop, at least within categories of covered benefits. Similarly, all health

plans offered in the market must cover the same minimum range of "essential benefits," as defined by the Secretary, and all plans will be required to adhere to the same restrictions on annual and lifetime benefit limits. These limits have, in the past, been used as a means to reduce premium costs while simultaneously severely limiting the level of covered benefits, making the plans attractive to low-risk enrollees and very unattractive to individuals and small groups with adverse risk mix.

(2) Common pricing for the same benefit design is required inside and outside the exchange for each health plan, and the insurance pools for each coverage type (individual v. small group) must be treated as a single pool for rating purposes. In other words, a health plan is required to offer the same silver and gold benefit designs both inside and outside the exchange and to offer those plans for the same premium rate for a demographically similar population. Consequently, an enrollee wishing to purchase a given level of coverage from a particular health plan should not face a premium price difference regardless of where the policy is purchased.

(3) Underwriting and limits on coverage for people with pre-existing conditions are prohibited in both markets. These provisions have been used by insurers to limit their risk and to exclude people with high expected health care costs. Since the same limits on underwriting exist in both markets, there will be no advantage to either the exchange or plans operating in the outside market with regard to risk selection within each coverage tier. Similarly, plans will not be able to explicitly rate for differences in health status (other than smoking and participation in wellness programs) in either market, further reducing the opportunity for premium rating differences.

(4) Beyond underwriting, the same basic market rules and allowable variations in premiums apply inside and outside the exchange. This is a critical protection, as any differences in the premium structure, such as a broader range of rating factors, would favor the system that most discretely differentiates premium rates. The federal rules limit premium rates to a range of 1:3. In other words, the most expensive premium for a product can be no more than three times higher than the lowest premium within a rating tier (single, family, etc). Typically, this will mean that the rate for the youngest adult age group and the premium for the oldest adult group will vary by no more than this amount. Actuarial experience shows that costs for the oldest age group are often as much as five times that of the youngest age group. Consequently, if one part of the system were able to have a wider variation, low-risk younger people would tend to choose that option.

(5) All subsidies are available only inside the exchange. Anyone eligible for a subsidy of their premium costs and/or cost sharing will have access to these subsidies only through the exchange. Consequently, healthy but lower income enrollees will have incentive to purchase their insurance coverage through the exchange. However, unhealthy, lower income individuals may have even more incentive to enroll in the exchange, as they can be expected to have more cost sharing responsibilities than healthier individuals.

(6) The ACA calls for risk assessment and risk adjustment across all health plans operating in and out of the exchange.

Even with the inclusion of these policies to mitigate risk selection, there are a number of design characteristics that states should consider in order to address the problem of selection and its effect on insurance premiums and the stability of the insurance market.

In order to mitigate the risk of adverse selection, the Office recommends that the exchange adopt the following policies:

(1) Limit opportunities for enrolling in health insurance for individuals and small employers to an open enrollment period of approximately four to six weeks per year, with exceptions for life events similar to those allowed for employees of large employers. Broadly publicize the importance of enrolling during the open enrollment period.

(2) Require an initial minimum participation period of one year and consider extending that minimum period to two years or longer, as enrollment in the exchange grows and if allowable group size increases.

(3) Consider financial mechanisms for discouraging exchange enrollees from “shopping” for lower premiums on a frequent basis.

(4) Require employers to enroll all eligible enrollees in the exchange if any non-subsidized employees enroll. Require a minimum contribution level equal to that required by insurers in the small group market.

(5) Allow movement from a lower tier to a higher tier of coverage of only one tier per year in the exchange to encourage purchase of more comprehensive coverage in the early years and to protect against adverse selection. Allow insurers selling coverage outside the exchange to impose the same restrictions on tier movement.

(6) Allow variation in benefit plan design within tiers, but require actuarial certification that the value of benefits is consistent with the tier definitions.

(7) Limit enrollees in the early years of the exchange to individuals and employers with no more than 50 employees. Establish insurance licensure rules that encourage the purchase of insurance (rather than self-insurance) for employers with 51 or more employees.

(8) Model the size of the insurance market for individual and small group coverage in and out of the exchange. In the early years of the exchange, continue to allow an outside market if there is sufficient critical mass of participants to provide choice to consumers.

(9) If a separate insurance market is available outside the exchange, require identical market participation rules, including reporting, data collection, network adequacy, and consumer protections. To the extent these rules result in higher costs to insurers, the costs will be equalized between the exchange and the outside market, and to the extent the rules are considered necessary to provide protections to consumers, all consumers in the market will have an equal level of protection.

(10) Establish insurance licensure rules that require all insurers that offer bronze plans to offer silver and gold plans regardless of whether they participate in the exchange.

13 Wisconsin Health Insurance Exchange: Insurance Market Reforms

13.1 Insurance Market Reforms

The Affordable Care Act (ACA) establishes new federal standards applicable to private health insurance coverage. These changes will impact private health insurance in the individual, small group, and large group markets, depending on the specific requirement. These changes will also significantly influence the structure of BadgerCare Plus. Existing plans will be able to continue to offer coverage as grandfathered plans and will not be subject to all changes, unless they enact a change that results in them losing their grandfathered status, as defined by the Department of Health and Human Services (HHS). Significant changes will be made to Wisconsin's insurance markets for plan years beginning on or after January 1, 2014, including a requirement that states adopt new federal rating rules. Under the new federal rating rules, age (limited to a ratio of 3:1), family composition, tobacco use (ratio of 1.5:1), and location are the main factors that can be considered when making adjustments to the premium rate. Insurers will be prohibited from setting premiums based on health status. A complete list of insurance market reforms effective January 1, 2014, includes:

- Group health plans and issuers in the individual and group markets will be prohibited from basing eligibility for coverage on health status-related factors.
- Requires issuers in the individual and small group markets to determine premiums for such coverage using modified community rating rules. Premiums may vary based only on the following risk factors: family composition, geographic region, age (by no more than 3:1) and tobacco use (by no more than 1.5:1).
- Group health plans and issuers in the individual and group markets will be prohibited from excluding coverage for pre-existing health conditions.
- Prohibits group health plans and issuers in the group market (new and grandfathered) from imposing a waiting period greater than 90 days.
- Requires individual and group health insurance issuers to offer coverage on a guaranteed issue and guaranteed renewal basis.
- Requires qualified health plans in the individual and small group markets to offer coverage that includes the "essential health benefits package."
- Prohibit health plans that provide the essential health benefit package from imposing annual cost-sharing requirements that exceed the out-of-pocket limits applicable to high-deductible

health plans as defined under the health savings account section of the internal revenue code.

- Plans may not discriminate against any provider operating within their scope of practice (this does not require that a plan contract with any willing provider).
- Plans may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial and may not discriminate against participation in a clinical trial.

Given that there is currently limited oversight of premiums in Wisconsin's non-group and small group market (as described in Section 5 of this document), there is concern that implementation of modified community rating may cause significant premium increases in these markets. That being said, it is important to also note that many Wisconsin residents are expected to benefit from the adoption of modified community rating.

The Office of Health Care Reform is currently engaged with Dr. Jonathan Gruber, a professor of economics at the Massachusetts Institute of Technology, to develop a predictive model in order to measure the impact of insurance market reforms on Wisconsin, coupled with other requirements of the ACA. The Office should use the results of Dr. Gruber's analysis to determine what steps can be taken to mitigate any negative impacts, such as placing limitations on insurers' ability to set premiums based on tobacco use and participation in wellness programs, or phasing in the adoption of insurance market reforms. Additionally, Dr. Gruber's analysis will provide information that will help determine whether the individual and SHOP exchanges should be two separate exchanges and whether the non-group and small group insurance markets should be merged. It is important to note that the early adoption of insurance market reforms may require amending Wisconsin Statute.

13.2 Grandfathered Health Plans

The ACA balances the objective of preserving the ability of individuals to maintain their existing coverage with the goals of ensuring access to affordable essential coverage and improving the quality of coverage available. In order to ensure that people would be allowed to keep the insurance coverage they have, the ACA exempts certain existing health insurance plans from many requirements. The ACA "grandfathers" health plans that were in effect on March 23, 2010, and exempts them from many required changes. However, to ensure access to coverage with certain new protections, grandfathered health plans will be required to comply with a subset of the ACA's reform provisions.

The following people may enroll in a grandfathered plan:

- Current enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after date of enactment.
- Family members are allowed to enroll in the grandfathered plan, if such enrollment is permitted under the terms of the plan in effect on the date of enactment.
- For grandfathered group plans, new employees (and their families) may enroll in such plans.

Grandfathered plans must meet the following insurance reforms:

(1) For plan years on and after March 23, 2010:

- Development of uniform explanation of coverage documents.
- Reporting of medical loss ratio and other financial information to the Secretary of HHS, and offering of premium rebates to enrollees if the plan did not meet specified medical loss ratios (rebate offers begin no later than January 1, 2011).

(2) For plan years beginning on and after September 23, 2010:

- Prohibition on lifetime limits on essential health benefits.
- Prohibition on health plan rescissions.
- Requirement to extend dependent coverage to children until the individual is 26 years old. Prior to 2014, a child may enroll for dependent coverage on a grandfathered plan only if such individual is not eligible for employment-based health benefits.

(3) For plan years beginning on and after January 1, 2014:

- Prohibition on waiting periods greater than 90 days.

(4) Grandfathered plans providing *group* coverage must comply with the following reforms:

- Prohibition on restricted annual limits on essential health benefits provided by group health plans, for plan years beginning six months on and after the date of enactment (September 23, 2010).
- Prohibition on coverage exclusions for pre-existing health conditions. For most enrollees, this provision will become effective for plan years beginning on and after January 1,

2014. However, for children under age 19, this provision became effective September 23, 2010.

- Requirement to extend dependent coverage to children until the individual is 26 years old.

The ACA does not address at what point changes to a group health plan or health insurance coverage in which an individual was enrolled on March 23, 2010, are significant enough to cause the plan to cease to be a grandfathered health plan. An Interim Final Rule has been issued that specifies how much an existing health plan can change over time without losing its grandfathered status. Noncompliance with any one of the following standards will cause a health plan to lose its grandfathered status.

The Interim Final Rule provides standards with respect to six main categories of plan design changes:

(1) Elimination of Benefits

If a group health plan eliminates all or substantially all benefits to diagnose or treat a particular condition, it will lose its status. It does not matter how many individuals are affected by this change.

In an example under the Interim Final Rule, a plan that provides counseling and prescription drugs as treatment for a particular mental health condition is treated as eliminating all or substantially all benefits for that condition if the plan eliminates counseling as a treatment for that condition.

(2) Increase in Percentage Cost-Sharing Requirements

If a group health plan increases the percentage cost-sharing requirements on participants above the percentage in effect on March 23, 2010, for any benefits under the plan, it will lose its grandfathered status. This includes any changes to the percent of coinsurance imposed on plan participants.

(3) Significant Increase in Fixed-Amount Cost-Sharing Requirements

If a group health plan makes a significant increase in fixed-amount cost-sharing requirements above the amount in effect on March 23, 2010, it will lose its grandfathered status. A grandfathered plan is still permitted to make some increases, provided that any such increases fall under a certain maximum threshold.

- With respect to fixed-amount cost-sharing requirements other than copayments, the maximum increase permitted without losing grandfathered status is medical inflation plus 15 percent (the "maximum percentage increase").
- With respect to fixed-amount copayments, the maximum increase permitted without losing grandfathered status is the greater of the "maximum percentage increase" or $5.00 increased by medical inflation.

(4) Decrease in Contribution Rate by Employers and Employee Organizations

If an employer or employee organization decreases its contribution rate for any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate in effect on March 23, 2010, the group health plan will lose its grandfathered status.

In an example under the Interim Final Rule, a decrease in employer contributions with respect to family coverage causes the plan to lose grandfathered status even though the contribution rate for self-only coverage remains the same. The "contribution rate" is determined by the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as COBRA premiums are calculated. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost of coverage minus the employee contributions toward the total cost of coverage.

(5) Changes in Annual Limits

Changes related to annual limits can cause a loss of grandfathered status in three circumstances:

- If a group health plan did not impose an overall annual or lifetime limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it imposes an overall annual limit on the dollar value of benefits.
- If a group health plan imposed an overall lifetime limit but not an overall annual limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it imposes an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

- If a group health plan imposed an overall annual limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it decreases the dollar value of the annual limit. This rule applies regardless of whether the plan also imposed an overall lifetime limit on the dollar value of benefits as of March 23, 2010.

(6) Other Changes

A group health plan will lose its grandfathered status if the employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010, which is not a renewal of an existing policy. This means that if a plan changes insurance companies — even if it still meets all of the coverage and cost standards described above — it will lose grandfathered status. A self-funded plan may change its third-party administrator without losing its grandfathered status.

Plan changes that do not exceed the standards described will not cause a group health plan to lose grandfathered status. For example, the Interim Final Rule permits a grandfathered health plan to make voluntary changes to the plan to increase benefits, to conform to required legal changes, to adopt voluntarily other coverage mandates in the ACA and to change third-party administrators without losing grandfathered status. In addition, changes in premiums do not impact a group health plan's grandfathered status.

More information on grandfathered health plans will be available upon completion of the Wisconsin insurance market analysis in late December.

14 Wisconsin Health Insurance Exchange: Interaction with Public Programs

14.1 Medicaid Expansion

The Affordable Care Act (ACA) calls for an expansion of state Medicaid programs. States will be required to expand Medicaid eligibility to all children, parents and childless adults up to 138 percent of Federal Poverty Level (FPL).[11] Current BadgerCare Plus eligibility levels exceed the new eligibility levels mandated in both versions of health care reform. Therefore, while it is likely that Wisconsin will experience some enrollment growth from individuals currently eligible and enrolling in the program in order to comply with the individual mandate, Wisconsin will not experience the large influxes of enrollment that many other states are expected to experience, as a result of having to increase Medicaid coverage levels and expand coverage to new populations. Given that Medicaid will become an entitlement for all children, adults, and pregnant women at or below 138 percent of the FPL, it is expected that childless adults will be the primary eligibility group for which there will be significant increased enrollment. In Wisconsin, childless adults are covered under the BadgerCare Plus Core Plan or the BadgerCare Plus Basic Plan. Currently, Wisconsin's Core Plan is operated under a capped waiver that limits the number of individuals that may enroll in the program. At the time the paper was written, there were 89,017 individuals on the wait list for the Core Plan and an additional 4,010 who have enrolled in the Basic Plan. It should be noted that these enrollment estimates include individuals up to 200 percent of the FPL; therefore, they will not all be eligible for Medicaid beginning in 2014.

The ACA also holds states to maintenance of effort requirements under which states must maintain eligibility for all adults until 2014 and all children and CHIP enrollees through September 30, 2019. If a state does not adhere to these requirements, they risk forfeiting all federal monies for their entire Medicaid program.

In an effort to assist states in financing the Medicaid expansion, the ACA provides states with an increased federal matching rate for certain populations. The matching rate may vary for each state depending on their normal rate, whether or not they have newly eligible populations and whether they qualify as an expansion state, defined by the law. Wisconsin will receive enhanced federal funding of 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent

[11] The ACA expands Medicaid to a national floor of 133 percent of the federal poverty level with a special adjustment of five percentage points to bring effective income eligibility to 138 percent federal poverty level.

in 2018; 93 percent in 2019; and 90 percent in 2020 and thereafter for all childless adults below 138 percent of the FPL.

14.2 Consolidation of Public Programs

The introduction of new insurance market reforms coupled with the exchange presents states with an opportunity to evaluate many of the current public health insurance programs and identify whether there is an opportunity for greater efficiency, consolidation, or sun setting of programs. The identification of greater efficiencies or sun setting of public programs could generate significant savings to state taxpayers.

Some of the programs that could potentially sunset, or shrink in size, beginning in 2014 when numerous insurance market reforms go into place include:

- The Core Plan.
- The Basic Plan[12].
- Some county mental health programs[13].
- Health Insurance Premium Assistance Program (HIPP)[14].
- The state Health Insurance Risk Sharing Plan (HIRSP)[15].

Many newly effective insurance market reforms, such as guaranteed issue and modified community rating, will allow certain enrollees to receive commercial health insurance through the exchange. The Office of Health Care Reform has conducted an analysis of public programs in order to identify any programs that may be consolidated, whose functions and responsibilities may change or may no longer be necessary upon full implementation of health care reform.

The Office of Health Care Reform makes the following recommendations related to the consolidation of public programs:

(1) Transition full-benefit HIRSP enrollees into the exchange where they will be able to purchase health insurance and may qualify for federal

[12] The BadgerCare Plus Basic plan was authorized by the legislature as a temporary health insurance program until the exchange became operational in 2014.

[13] The ACA requires that mental health and substance use disorder services are part of the essential benefits package that all qualified health plans provide through state health benefits exchanges. Such plans will have to provide mental health and substance use benefits at parity with medical/surgical benefits. The important role that county mental health delivery systems currently play in delivering needed mental health benefits may need to change in the future.

[14] Premium tax credits and cost-sharing reductions will be available beginning January 1, 2014. Therefore, an additional premium assistance program may no longer be needed.

[15] Beginning in 2014, health plans will be prohibited from basing eligibility for coverage on health status-related factors and can not charge higher premiums based on pre-existing conditions. Therefore, the state will need to re-evaluate the role for this program which targets persons with pre-existing conditions.

tax credits and reduced cost sharing. Additional analysis is needed regarding the future of HIRSP Medicare Supplemental enrollees, who are not eligible to purchase health insurance through the exchange.

(2) Sunset the BadgerCare Plus HIPP, beginning in 2014. The HIPP program primarily is available to employed adults with income below 150 percent of the FPL. Most enrollees are, and will remain, covered under Medicaid. States have the discretion to participate in HIPP as it is deemed cost-effective. Historically, Wisconsin's HIPP enrollment has been low and administration of the program is labor intensive. Analysis suggests that elimination of HIPP will simplify the administration of BadgerCare Plus and, given low enrollment, will impact a small number of people.

(3) As is discussed in Section 8.8 of this document, further analysis is needed in order to determine the best course of action for adults above 138 percent of the FPL. That being said, beginning January 1, 2014, Core and Basic plan enrollees below 138 percent of the FPL will be eligible (entitled) for Medicaid benchmark coverage. These enrollees will receive richer benefit coverage under BadgerCare Plus Benchmark Plan than currently available under the Core Plan and the Basic Plan.

The Office of Health Care Reform completed additional analysis on the Medicaid Assistance Purchase Plan (MAPP) program and the Wisconsin Chronic Disease Program (WCDP). At the time, the Office of Health Care Reform recommends that no changes be made to either the MAPP program or WCDP.

The MAPP program allows individuals with disabilities who are working and have income in excess of Supplemental Security Income-related eligibility limits to retain Medicaid coverage if household income is less than 250 percent FPL and countable assets do not exceed $15,000. The MAPP program was created to remove disincentives to work or to increase work earnings for individuals with disabilities. Without the Medicare wraparound coverage and long term care services provided by Medicaid, individuals with disabilities would have difficulty maintaining employment and may have to quit their jobs in order to meet the lower income limits for Medicaid.

The WCDP provides assistance to Wisconsin residents with chronic renal disease, hemophilia, and adult cystic fibrosis, once all sources of payment have been exhausted. Members of WCDP must apply for all available public programs and enroll in Medicare, if eligible, to reduce WCDP costs. Given that WCDP is a payer of last resort for specific chronic conditions, it is recommended that WCDP remain available.

15 Wisconsin Health Insurance Exchange: Payment Reform and Health System Redesign

In order for national health care reform to be truly successful, it must slow the growth rate of health care costs. To achieve this lofty goal, the health care system must be redesigned to foster greater accountability for quality and the overall cost of care for patients. Payers must transition away from today's predominantly fee-for-service reimbursement methodology toward a system that ties payments to high-quality, tightly coordinated, cost-effective care. Strategies for achieving this goal include resource redistribution toward early diagnosis and prevention, using evidence as the driver for treatment, chronic care management, avoidance of duplicative or unnecessary tests and procedures and transparency of results to support clinical process improvement. The successful implementation of these efforts rests on the introduction of a new payment system that rewards outcomes rather than activities. In short, "the more you do, the more you get paid" payment structure must end.

Beginning in 2014, the exchange will become the vehicle by which a critical mass of individuals and families will purchase health insurance in our state and, therefore, the exchange will be in a good position to advance payment reform strategies statewide. It is expected that the exchange will achieve significant purchasing power, as there may be as many as 2 million individuals (approximately 35 percent of Wisconsin's total population) eligible to purchase health insurance through the exchange, comprised of approximately 1 million people employed by small businesses, as many as 160,000 individuals who purchase health insurance in the non-group market and about 770,000 individuals enrolled in the state's BadgerCare Plus program. The ability for BadgerCare Plus individuals to use the exchange web-portal for purposes of comparing, selecting and enrolling in a health plan does not mean the Medicaid market will be merged with the non-group or small group insurance markets. It should be noted that the number of individuals purchasing health insurance through the exchange will depend on whether the exchange is determined to be the only marketplace for the purchase of small group and non-group insurance, among other things.

While the exchange may be well positioned to implement delivery and health system redesign on a statewide level, it is important that the exchange not underestimate the heavy lift that will be involved with successful implementation of meaningful reform. As discussed later in this section, the implementation of payment reform will not happen overnight, and will require a phased-in approach, which should evolve over a number of years. Furthermore, it will be of great importance that the exchange work closely with the health care community and other stakeholders to develop a payment reform strategy that is agreed upon and understood by all relevant parties.

15.1 Coordination with Existing Payment Reform Efforts

Wisconsin has a strong tradition of innovation, led by both the private and public sectors, with the goal of achieving greater quality and efficiency in the delivery of health care in this state. These past and present efforts provide a strong foundation upon which to build a health insurance exchange that seeks to strengthen incentives for quality and value in health care.

These initiatives include, but are not limited to, the following:

- Wisconsin Health Information Organization (WHIO) — A partnership that has developed a statewide data mart of health care information that spans payers, providers and systems. The data will be used to improve the quality, affordability, safety, and efficiency of health care delivered to patients in Wisconsin. Section 15.2 of this document provides additional information on WHIO's current reform efforts.
- Wisconsin Relay of Electronic Data for Health (WIRED for Health) — Building the capacity for the exchange of health information statewide to support providers' meaningful use of electronic health records and enable efficient, appropriate and secure flow of information to optimize decisions for health care.
- Wisconsin Collaborative for Health Care Quality (WCHQ) — A consortium of individuals and organizations working to improve the quality and cost-effectiveness of health care for the people of Wisconsin through the development of performance measures, the collection and analysis of data, public reporting of measurement results and identification of best practices, among other things.
- Wisconsin Hospital Association (WHA) and Wisconsin Medical Society (WMS) initiatives to promote value based purchasing and quality reporting.

In recent years, Wisconsin has worked to transform its Medicaid program to become an active purchaser of quality health care. Recent efforts include holding Medicaid and BadgerCare Plus managed care organizations accountable for health care outcomes through the implementation of pay-for-performance programs, a new quality measurement system (HEDIS) and innovative benefit/program designs, such as the BadgerCare Plus Core Plan and the BadgerCare Plus Basic Plan for low-income childless adults.

Wisconsin should look to pursue innovative payment reform efforts that best align with the current initiatives discussed above, and any future goals, as identified.

15.2 Payment Reform and Health Care System Redesign Strategy

As a large employer and large purchaser of health care, the State is in a position to serve as a leader in organizing efforts and moving Wisconsin in a direction that aims to increase quality and control health care spending. In recent years, the State has increasingly made health care purchasing decisions based on quality and cost effectiveness for its Medicaid and public employee programs. Wisconsin's Employee Trust Funds (ETF), the largest purchaser of employer coverage in the state, has served as a national leader in value-based purchasing for state and local government employees and their families. ETF has been successful in gaining and using market power, creating managed competition and establishing strong collaboration with stakeholders. ETF efforts include: public reporting of health plan performance, tiered premiums used to encourage members to purchase more efficient plans, financial rewards to health plans that meet cost and quality benchmarks and participation in a statewide public-private sector health data repository, the WHIO.

Wisconsin's BadgerCare Plus program has increased its efforts to become a more active purchaser of health care, focusing on cost and quality. Wisconsin's efforts began many years ago, as one of the first states to transition away from the traditional fee-for-service payment model and aggressively adopt managed care. Today, while nearly all BadgerCare Plus members are served under the managed care model, Wisconsin should continue its efforts to increase the percent of its population served by high-quality managed care arrangements. BadgerCare Plus' most notable efforts include new statewide pay-for-performance incentives and the issuing of new performance-based Medicaid managed care contracts for the southeast part of the state. The Department of Health Services has implemented a pay-for-performance program under which financial incentives are provided to Medicaid HMOs based on the quality of services delivered by their contracted providers. Results of each HMO's performance are publicly reported in an annual HMO report card. The HMO report cards are based on process and outcome measures, such as HEDIS and Prevention Quality Indicators (PQI). Under the new managed care contracts, HMOs must meet annual benchmarks in a variety of health service areas including diabetes testing, blood lead testing, childhood immunization, asthma management, tobacco cessation, reduced emergency room use, and increased dental utilization.

Significant reform efforts to redesign the health care marketplace have also been made by Wisconsin's greater health care community, many of which were discussed in Section 15.1. The WHIO, a public-private, voluntary, non-profit organization, with involvement by nearly all health care stakeholders in the state, has moved forward with efforts to reduce cost and increase health care outcomes by way of two main initiatives. Both of these leading edge initiatives

align well with the goals of the numerous payment reform initiatives outlined in the Affordable Care Act (ACA).

1) A statewide data repository of health care information that allows the State to analyze and disseminate health data that provides comparative information of cost and quality of Wisconsin health care providers. This data repository can serve as a tool for comparing outcomes and efficiency of the delivery of health care services. Specifically, WHIO data can be used to determine variation in services, costs, and quality by region, provider type and payer type. For example, data can then be analyzed to assist in identifying best practices related to the provision of health care services and establishing "centers of excellence" for certain highly complex and expensive health care services.

2) The Wisconsin Payment Reform Initiative (WPRI) is a statewide, multi-stakeholder, transparent initiative that is dedicated to reforming provider reimbursement by rewarding cost-efficient, high quality providers and those who invest in preventive care and chronic illness management. The WPRI effort was undertaken by the WHIO Board of Directors and includes participation by nearly all health care provider organizations and systems in the state. The WPRI is currently exploring three multi-payer payment reform pilots, which include: (1) Acute Care Pilot, (2) Chronic Care Pilot, and (3) Preventive Care Pilot. While these pilots are still in the development process, all of the necessary stakeholders are engaged and will be involved in the development and design process moving forward. Significant progress has been made toward the implementation goal of July 2011.

Similar initiatives have been attempted in other states; however, to date, Wisconsin is the only state to build an All Payer Claims Database (APDC) through a voluntary, multi-stakeholder private-public initiative. The data mart includes information on 58 percent of the state's population, including both commercially insured and Medicaid enrollees. It is expected that by fall 2011, the data repository will include data for over 65 percent of the state's population, and Medicare data planned for inclusion in 2012. As the number of health care organizations that contribute data to the WHIO data repository increases, it will represent an increasingly powerful analytical tool for the exchange, and the State as a whole, when measuring health care efficiency and effectiveness and when implementing payment reform projects.

The collection of this data will also lead to increased opportunities to better manage population health. Greater collection and analysis of claims data, if

combined with clinical data, will help and the exchange to identify gaps in preventive care and best practices, leading to reduced costs and increased outcomes. This data could be even further enhanced by the inclusion of Medicare claims data. Once fully developed, the WHIO data repository and payment reform pilots will have direct applicability to the delivery of Medicaid and Medicare services and health outcomes of enrollees in Wisconsin.

One of the Office of Health Care Reform's primary objectives is successful adoption of statewide provider and payer reforms that will reduce health care costs and improve the quality of health care delivered to Wisconsin residents. The Office of Health Care Reform feels strongly that in order to achieve comprehensive payment reform and quality improvement in Wisconsin, the state must continue to work to advance the reform efforts that have gained significant momentum and stakeholder consensus in our state. These efforts could include WPRI or any other payment reform initiatives identified as being effective.

Based on meetings with health care leaders, there appears to be consensus that the first step towards the creation of a transformative exchange needs to be the development of a strategic framework for achieving a value-driven exchange. This strategy needs to identify clear outcomes and goals related to payment reform and the health care delivery system, without being overly prescriptive. The strategy should facilitate the advancement of payment reform but should not go so far as to dictate how health plans must achieve such reform. The strategy should clearly identify and define quality measures and desired outcomes that encourage reduced cost and increased quality. Achieving solely lower costs will not equate to better outcomes or better value.

It is expected that some level of payment reform may be achieved indirectly by fundamentally changing how plans compete. The level of competition among participating health plans will inherently change in 2014 with the implementation of strong risk adjustment mechanisms and the adoption of other policies that are successful in mitigating adverse selection. The adoption of a strong risk adjustment methodology coupled with other policies to mitigate adverse selection can serve as a solid starting point from which the exchange can seek to build in future years.

It should be noted that there is less consensus among the health care community as to whether health care providers would prefer a more prescriptive payment reform strategy — one that actually drives payment reform across multiple, if not all, payers and prescribes the specific payment reform strategies. Some believe that if insurers are left to identify their own strategy, allowing each insurer to possibly adopt different strategies, providers will have difficulty meeting the expectations of each insurer and will have difficulty in actually

reducing waste from the delivery system. Others insist that insurers must be afforded the flexibility to identify strategies within their respective health care practices that effectively achieve the goals outlined by the exchange, within parameters set by the exchange.

Other possible payment reform strategies for the exchange to consider, assuming strong risk adjustment and adverse selection policies have already been adopted, include:

(1) Measure the success of the WPRI payment reform initiatives. The exchange could look to expand implementation of any successful WHIO pilots statewide. That being said, the exchange must operate independently of WHIO and be able to move forward independently of the WHIO project.

(2) Identify a handful of strategies that meet the exchange's desired payment reform outcomes and have proven effective in reducing health care costs in other areas of the state or regions of the nation. In order to participate in the exchange, health plans would choose among the available strategies and adopt those that best fit their respective delivery models. Under this option, health plans would be limited to the pool of reform strategies identified as meeting the goals of the exchange but would still maintain some flexibility.

(3) Develop purchasing partnerships. Under the purchasing partnership model, the exchange would require the common adoption of specific purchasing strategies or performance measurement methods that are designed to reward health care providers that lower health care costs and improve quality. These strategies would also be aligned with other government payers (e.g., Medicaid, Medicare, ETF). Strategies that could be considered for adoption across all participating health plans include: bundled payments, patient-centered medical homes, contracting with "accountable care organizations," and/or common use of performance measurement/pay-for-performance systems and other successful payment reform strategies that come, for example, out of the WHIO pilots. Purchasing partnerships can facilitate the adoption of commonly accepted care and case management strategies, which can be implemented across public and private health care sectors and can help to extend new reimbursement methodologies across payers. Purchasing power can also be applied to the purchase of drugs and durable medical equipment, which together can represent over 30 percent of total spending. Such practices will reduce inefficient use of health care resources, improve quality of services delivered, and improve health care outcomes.

Forming a partnership between public programs and the health insurance exchange will also allow for the state to realize greater efficiencies, potentially through a single procurement process and more streamlined contracting. This could be achieved through a single request for proposal process and single plan certification process. Furthermore, the exchange could consider requiring that health insurers wishing to participate in any one of the programs (Medicaid, small group and non-group insurance, and possibly other state funded programs) become certified and participate in all specified programs and use the commonly agreed upon purchasing strategies. Standardized data can be collected across all participating programs allowing for consistent quality measurement and quality improvement programs that must be met by all participating plans. This will help ensure that a single, high-quality level of health care is provided to all individuals, regardless of whether they are enrolled in a public or a private program.

As the exchange moves forward with the development of a payment reform and health care delivery system redesign, it should continue to engage participating health plans and their affiliated providers. Additionally, to further enhance the transformative power of the exchange, the state should work with the Centers of Medicare and Medicaid Services to realign incentives in ways that will reward greater value and discourage waste and errors across all payers, significantly transforming the Wisconsin health care system.

15.3 Multi-State Collaboration

The exchange should explore collaborating with other states, particularly bordering states and other states in the Midwest, to identify and share strategies relating to the development of health insurance exchanges and health care reform as a whole. In particular, Wisconsin should work with neighboring states to ensure that all residents of our state have access to a choice of health care providers. This is of particular importance for residents who live in metropolitan areas that may be on the border of or cross over state lines. It will be important that health plans contract with regional delivery systems and that provider networks extend across state borders in order to provide adequate access to health care providers within reasonable distances of enrollees.

16 Wisconsin Health Insurance Exchange: Funding and Administrative Operations

16.1 Funding

Other than requiring that exchanges are self-sustaining by no later than January 1, 2015, the Affordable Care Act (ACA) provides no further guidance on funding arrangements for the exchange. The ACA assumes that states will establish the funding mechanism(s) for sustainability of the exchange through enabling legislation.

The ACA does provide a series of planning and establishment grants that will fund initial development and first year operational costs for the exchange. Wisconsin was awarded the first planning grant ($1 million) issued by the Office of Consumer Information and Insurance Oversight (OCIIO) and is in the process of applying for the Cooperative Agreements (Early Innovators) grant that, if awarded, will fund the core IT exchange functions. The federal Department of Health and Human Services (HHS) has indicated a third grant will be announced in early 2011.

Given Wisconsin's current fiscal environment, federal funding will be critical in ensuring adequate resources and successful implementation of the exchange. Wisconsin should continue to position itself to receive federal funds immediately upon becoming available. Additionally, Wisconsin should look to pursue other grant opportunities available through private stakeholders, such as the Robert Wood Johnson Foundation and State Coverage Initiatives, in order to secure additional funding for the development of an exchange.

The absence of guidance regarding a funding mechanism for the exchange provides states with significant flexibility in determining how they will fund the operations of the exchange, including, but not limited to, implementation of an assessment on participating insurers. Prior to 2014, Wisconsin will need to explore different revenue streams for long-term operations of the exchange.

Given the decisions that are outstanding regarding the establishment and operations of the exchange, such as whether the non-group and small group markets will remain separate or be merged, the number of individuals and small employers that will purchase health insurance through the exchange, the number of participating insurers and the estimated annual exchange administrative and ongoing costs, this paper does not make a recommendation as to how the exchange should be financed. The Office of Health Care Reform feels strongly that this decision should not be made until further analysis is done, and the outstanding questions identified above are answered. However, the

Office recommends that the exchange not adopt a financing model that would fund the exchange administrative and operational costs through an ongoing annual appropriation. This model would require an ongoing state revenue stream and would make funding of the exchange contingent on the passing of the state budget. Instead, the Office recommends that further analysis be completed on the following two funding options:

(1) A premium surcharge to be paid by consumers purchasing qualified health plans in the non-group and small group markets.

(2) An assessment on carriers providing qualified health plans in the non-group and small group market.

The Office of Health Care Reform recommends that a separate fund be established for purposes of ongoing funding of Wisconsin's exchange. This funding model is similar to that of Wisconsin's Health Insurance Risk Sharing Plan and the California and Massachusetts models. Furthermore, it is recommended that statutory language be established that accomplishes the following:

(1) Prohibits monies assessed and collected by the exchange from being loaned to or borrowed by any other special fund, the general fund, a county general fund, or any other county fund;

(2) Specifies that all interest earned on the monies that have been collected by the exchange will be retained by the exchange and used for purposes consistent with the effective operations of the exchange;

(3) Any monies that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year;

(4) The Board of the Wisconsin Health Insurance Exchange will establish and maintain a prudent reserve;

(5) The Board or staff of the exchange will not utilize any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative or regulatory modifications;

(6) Effective January 1, 2016, if at the end of any fiscal year, the exchange has unencumbered funds in an amount that equals or is more than the Board-approved operating budget of the exchange for the next fiscal year, the Board will reduce the charges imposed (if applicable to consumers/insurers) during the following fiscal year in an amount that will reduce any surplus funds of the exchange to an amount that is equal

to the agency's operating budget including a prudent reserve for the next fiscal year;

(7) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency;

(8) The Board will ensure that the cost to establish, operate, and administer the functions of the exchange do not exceed the total of federal funds, private donations, and other non-general fund monies available for such purposes. No state general fund monies will be used for any purpose under this title without a subsequent appropriation. No liability incurred by the exchange or any of its officers or employees may be satisfied using monies from the general fund.

16.2 Administration of SHOP Exchange

Certain administrative functions, specifically those related to the purchase of insurance with small employers, are specific to functions of the SHOP. These functions include, but may not be limited to, the following:

- Accepting and processing of online applications from employers for participation in the SHOP exchange;
- Verification of employers' Federal Employee Identification Number, employer size, and average wage of employees;
- Entry and tracking of employee demographic and health status information (e.g., age, address, family composition and dependents, tobacco use);
- Facilitate employer selection of tier for employees (platinum, gold, silver, bronze);
- Facilitate employers' choice of premium contribution and method for premium contribution payment; and
- Communication to employers regarding employees who qualify for free choice vouchers or who did not meet the affordability test.

Furthermore, states have flexibility in identifying other services to be performed by the SHOP exchange that extend beyond the minimum requirements identified above. The research that has been done on other states that operate exchanges for small businesses (Massachusetts, Utah, Washington, and Connecticut) suggests that a crucial component to attracting small businesses to an exchange is the presence of a simple registration process and the availability of additional

services that streamlines the administrative process and makes the offering of employer sponsored insurance easy and efficient.

- Provide all necessary information for employers and employees to make informed decisions regarding coverage options;
- Provide a single application;
- Allow employers to make premium payments on behalf of their employees to the exchange. The exchange will allocate the correct premium payments to the appropriate insurers, based on enrollment of employees;
- Provide a single point of contact for all enrollment changes;
- Provide information to employers regarding small business tax credits and estimated tax credit amounts, based on the information they provide;
- Coordinate coverage of Medicare eligible employees, dependents, and retirees;
- Coordinate with exchanges in bordering states to ensure coverage for employees who live out-of-state;
- Assist employers in communicating with and obtaining information from the exchange; and
- Provide additional human resource services to small employers.

Analysis also suggests that that some of the administrative functions of the SHOP exchange differ vastly from the functions necessary under the individual exchange. Therefore, it is recommended that Wisconsin's SHOP exchange provide a more complete range of value-added services to employers than those required by the ACA, to include the additional administrative services identified above.

Furthermore, given the complexity and the level of expertise necessary to assist small businesses with the purchase of health insurance, it is also recommended that Wisconsin's exchange contract with a separate entity for purposes of administering SHOP functions and to work directly with small businesses. To achieve this, the exchange should issue a request for information (RFI) to obtain information from small employers and potential vendors. It is expected that an RFI will help the exchange make an informed decision regarding the specific services the SHOP should offer. Following the receipt of an RFI, the exchange should issue a request for proposals (RFP) for purposes of contracting with a vendor to carry out the administrative functions of the SHOP.

17 Wisconsin Health Insurance Exchange: Community Input

The OHCR should develop a detailed plan that will be used to gain stakeholder support and feedback regarding the implementation and design of a state-based health insurance exchange.

As part of the design process, the OHCR should meet with small group employers, self-employed individuals and other individuals and families seeking to purchase health insurance in the individual insurance market, health insurers, insurance brokers, and other stakeholders to learn about their experiences with the small group and non-group insurance markets and to solicit feedback on Wisconsin's exchange vision and policy ideas.

Additionally, OHCR has created an exchange prototype that will undergo testing by individual consumers, small businesses, and provider and broker communities. The prototype can be located at the following URL: https://exchange.wisconsin.gov/. Feedback on the prototype will be used to better design the exchange to meet stakeholder needs.

18 Wisconsin Health Insurance Exchange: Marketing and Outreach

The exchange should implement a marketing and outreach campaign in order to:

(1) Provide information about the new law and raise awareness about the new mandate to have health insurance.

(2) Promote the availability of new health plans, all of which will be certified by the exchange for quality and value.

(3) Promote the exchange's ability to offer unprecedented affordable health care options.

A meaningful marketing campaign that is effective in disseminating the above messages will require partnerships with a diverse set of stakeholders throughout the state. It will be important that the Office of Health Care Reform continue to foster relationships with the following entities:

Advocates and Community Partners, including all current community partners, advocacy groups, churches and other religious organizations, community centers, and other community organizations.

Small Business Representatives and Partners, including Chambers of Commerce, lobbyists with small business clients, Rotaries, and Jaycees.

Labor Organizations, including unions that are involved with large employer organizations and that will likely bargain for employer-covered health care, such as Service Employees International Union (SEIU) and American Federation of State, County and Municipal Employees (AFSCME).

Insurance Carrier Representatives

Internal Partners and State Agencies, including Department of Health Services (DHS) staff. The DHS staff can help link the Office to local public health departments, aging and disability resource centers, county staff, etc., Department of Revenue, Department of Workforce Development, and Department of Transportation.

The marketing campaign should include, but must not be limited to, the following components:

- Release of a request for information for initial input on an exchange marketing campaign.
- Release of a request for proposal in July 2012 to contract with a marketing firm for purposes of marketing, education, and outreach for the exchange.
- A research effort for purposes of branding Wisconsin's Health Insurance Exchange.
- Press releases from the Office of Health Care Reform and consideration of other earned media demonstrations.
- Prototype demonstrations.
- Outreach to existing partners.
- Educational forums and focus groups.

The Office of Health Care Reform recognizes that inclusion of a social marketing component will be important in the marketing campaign. Young, healthy, uninsured individuals are one demographic that will be vital to target in order to successfully implement the law. Partnerships with the Green Bay Packers, the Milwaukee Brewers, and the Milwaukee Bucks are possible avenues for marketing and outreach. The exchange, in collaboration with other state agencies and designated ombudsman or a new Office of Health Insurance Consumer Assistance, will work closely to address consumer issues and complaints. Other elements of the exchange marketing campaign may include media outreach, seminars and forums, grassroots efforts, paid advertising, and grants to community organizations.

Other groups to consider for possible discussions include the Milwaukee Enrollment Task Force, the Employer Health Care Alliance Cooperative, AFSCME, SEIU, Wisconsin Primary Health Care Association, Citizen Action, business groups, National Federationo f Independent Businesses (NFIB) and brokers, among others.

19 Wisconsin Health Insurance Exchange: Trade-Offs in Strategic Objectives

This document identifies numerous goals for a state-based health insurance exchange. When making far-reaching policy decisions that oftentimes have competing objectives, it will be important to identify potential advantages and disadvantages associated with each goal. There will likely be trade-offs among goals, whereby pursuit of one will impede others. This section serves to identify some of the competing goals and the issues that are associated with each of them.

(1) Keeping Pressure on Health Plan Premiums

This document proposes that the exchange will serve as a mechanism to keep health plan premiums contained by leveraging the purchasing power of individuals and small employers and using their combined market leverage to secure competitive premiums from qualified health plans. Given that the exchange is the exclusive distribution channel for a significant amount of subsidized insurance, it will have some leverage to improve the competitiveness of the individual and small group insurance marketplace. However, its leverage may be limited by a number of factors, such as a strong countervailing market appeal of popular health plans, the requirement that pricing be the same inside and outside the exchange, the ability of plans to change their prices on a monthly basis outside the exchange and the ability of providers with strong market positions to dictate costs to health insurers. It is important to recognize that the exchange may only be able to prioritize this objective at the expense of other goals.

(2) Making it Easy for Consumers to Shop for Insurance and Enroll

Generally, the less information and time required of customers in order to find a reasonably broad choice of health plans, to price them in an easy-to-compare fashion and to enroll and pay their premium, the more satisfied they will be with their shopping experience. Simplifying the process is an important potential source of customer satisfaction and public support for health reform and exchanges. It contrasts sharply with the confusion, anxiety and difficulty that many buyers currently experience. While transparency should help consumers make informed choices, too much data may overwhelm.

For example, such tools as provider-search engines, out-of-pocket spending calculators and collecting and displaying a wealth of data relating to performance issues may interfere with the consumer's shopping experience. However, the exchange can adopt strategies to minimize customer confusion by

holding focus groups and conducting surveys in order to determine the best way to present information to prospective customers.

(3) Transition Safety-Net Providers to a Private Insurance Model

Health care reform will result in changes for certain types of providers, such as community health centers, critical access hospitals and other types of providers that serve a disproportionate share of the indigent population. Many of these providers may face increased pressures from health plans as a result of increased competition. In competitive provider markets, safety-net providers often have the least market clout, and therefore, can easily be “squeezed” by health plans under premium pressure. Additionally, safety-net providers may lose many patients to other providers in broad-network qualified health plans if the safety net providers are not able to develop and sell in the exchange, their own health plans for subsidized (formerly unsubsidized) patients.

Providing a path for safety-net providers to retain their traditional patient populations may require restricting health plan competition or putting a floor under payment levels from plans to such providers on a temporary basis.

20 Wisconsin Health Insurance Exchange: Risks

There is the potential for unexpected problems to impede or delay successful implementation and operation of state-based health insurance exchanges. Wisconsin should look to the experiences of Massachusetts, Utah, and the other states that have already developed exchanges to learn from their identified success and the past failure of many exchanges in other regions of the country to identify some lessons learned and major risks associated with the development of state-based exchanges. The following is a list of potential risks that Wisconsin should seek to avoid.

(1) Adverse Selection

Many states have tried to build state-based health insurance exchanges over the past years. One of the reasons many exchanges have been unsuccessful is due to adverse selection, i.e., the exchange attracts sick enrollees, in turn, making the exchange a distribution channel that carriers wish to avoid, or resulting in the exchange disadvantaging some health plans, forcing them to withdraw from participation in the exchange. The ACA offers several important safeguards against adverse selection, including subsidies for low-income individuals and families, the individual mandate to have health insurance and the application of risk adjustment. However, this combination of protections included in the ACA has not been proven to successfully mitigate adverse selection, and the fear or perception of adverse selection may work against the success of the exchange. For these reasons it is important that new exchange policies recognize and actively counter the possibility of adverse selection against the exchange.

(2) Carrier Disinterest

The exchange will not have the ability to force health plans to participate. Therefore, its influence or leverage depends on the ability to offer a robust distribution channel. If the exchange is small, is onerous and expensive to use, imposes high costs or negative margins, offers adverse selection, or puts the carriers in conflict with their other distribution channels (large employers and their consultants, brokers, general agents, and intermediaries), then carriers may choose not to participate. The exclusive access to subsidies for low-income individuals and small employers gives exchanges a large draw, but does not create unlimited appeal.

(3) Relationships with Brokers

As a distribution channel for health insurance, exchanges have the potential to either compete with or complement the interests and functions of brokers,

general agents, and other intermediaries. In turn, brokers have significant influence over segments of the market, especially small employer groups. It will be important that positive, productive, and efficient arrangements with agents and intermediaries are established early on in order to achieve market success.

(4) Customer Service

Fundamentally, the exchange will function as an electronic marketplace for health insurance. While some low-income, subsidized households have to use the exchange, some small employers will be subsidized for their first two years in the exchange but will then lose this subsidy. Additionally, unsubsidized enrollees can access qualified health plans outside the exchange. Since the purchase of insurance is a commercial enterprise, which is often complex and confusing, good customer service is vital to grow the exchange and win political support. Public perception is that customer service is not a function of which government outperforms the private sector. Good customer service is difficult and important to the exchange's success. Therefore, maintaining good customer service from the exchange's inception is critical. Poor customer service will drive employers and consumers away from the exchange and jeopardize its overall effectiveness.

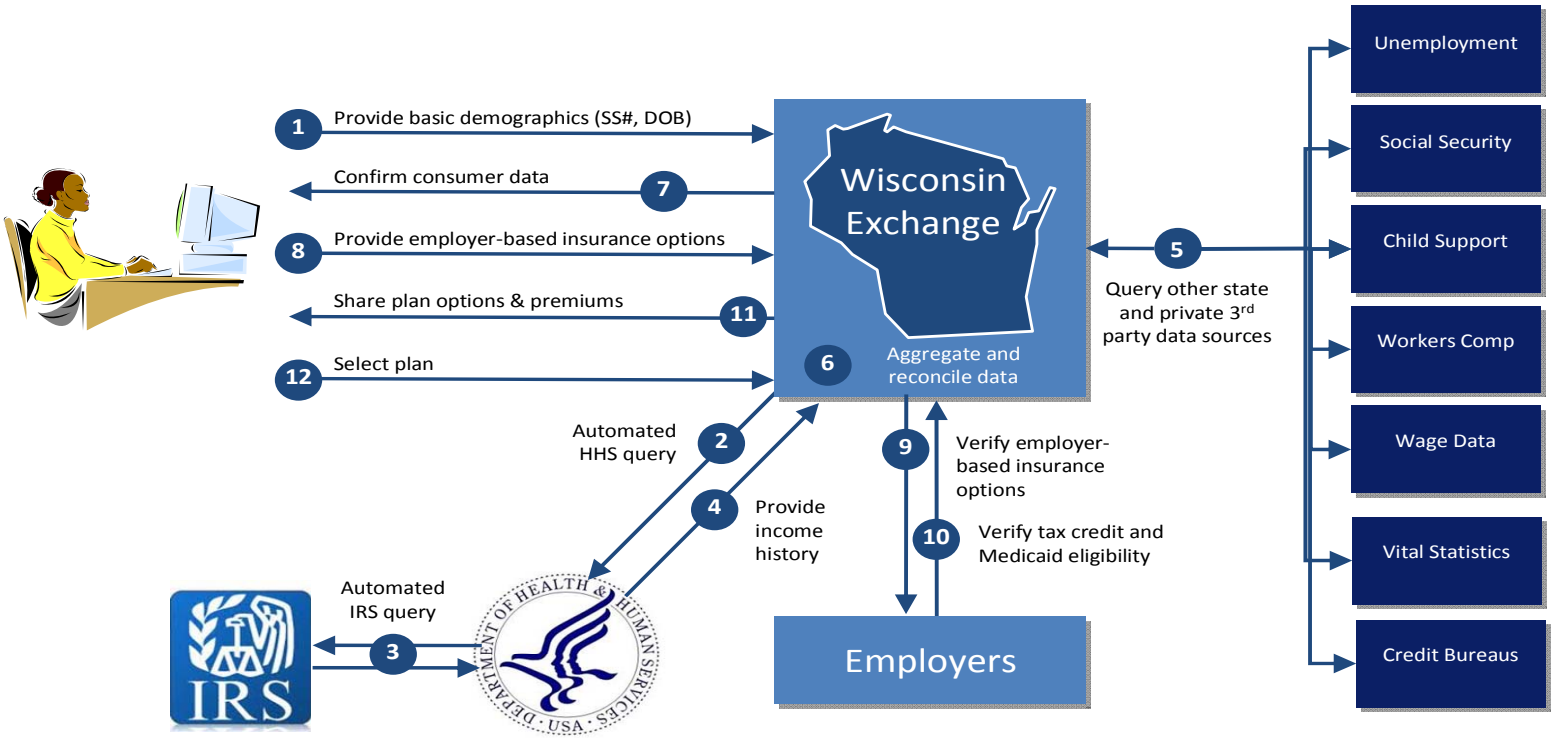
(4) Eligibility Determination

The ACA imposes on states a new and complex process for determining eligibility for tax credits and Medicaid, which constitutes a very high element of customer service. Moreover, higher income, unsubsidized individuals must meet a threshold eligibility determination, that they are not undocumented immigrants. Given that outside the exchange, unsubsidized individuals will not bear this burden of proof, it is important that the requirements for proving legal residence are not an obstacle to accessing health insurance through the exchange. The burden must be on the exchange to proving residency. This will be one of the many critical components to serving the unsubsidized market.

21 Conclusion

Wisconsin's past health care reform efforts have demonstrated the State's ongoing commitment to creating a health care delivery system that lends itself to improved access, higher quality and reduced costs. The recently passed health care reform legislation has created additional opportunities for Wisconsin to accelerate its health care reform agenda through the implementation of a health care exchange, which Wisconsin should utilize to bring greater transparency, managed competition and delivery reforms to the Wisconsin health care marketplace. Wisconsin has always maintained a dialogue with the greater health care provider and consumer communities when developing major policy changes. Similarly, the sweeping changes that health care reform brings will also require the involvement and commitment of all stakeholders to be a success and move the State towards the goal of universal coverage for all our citizens

Appendix A Complex Data Environment of Exchange



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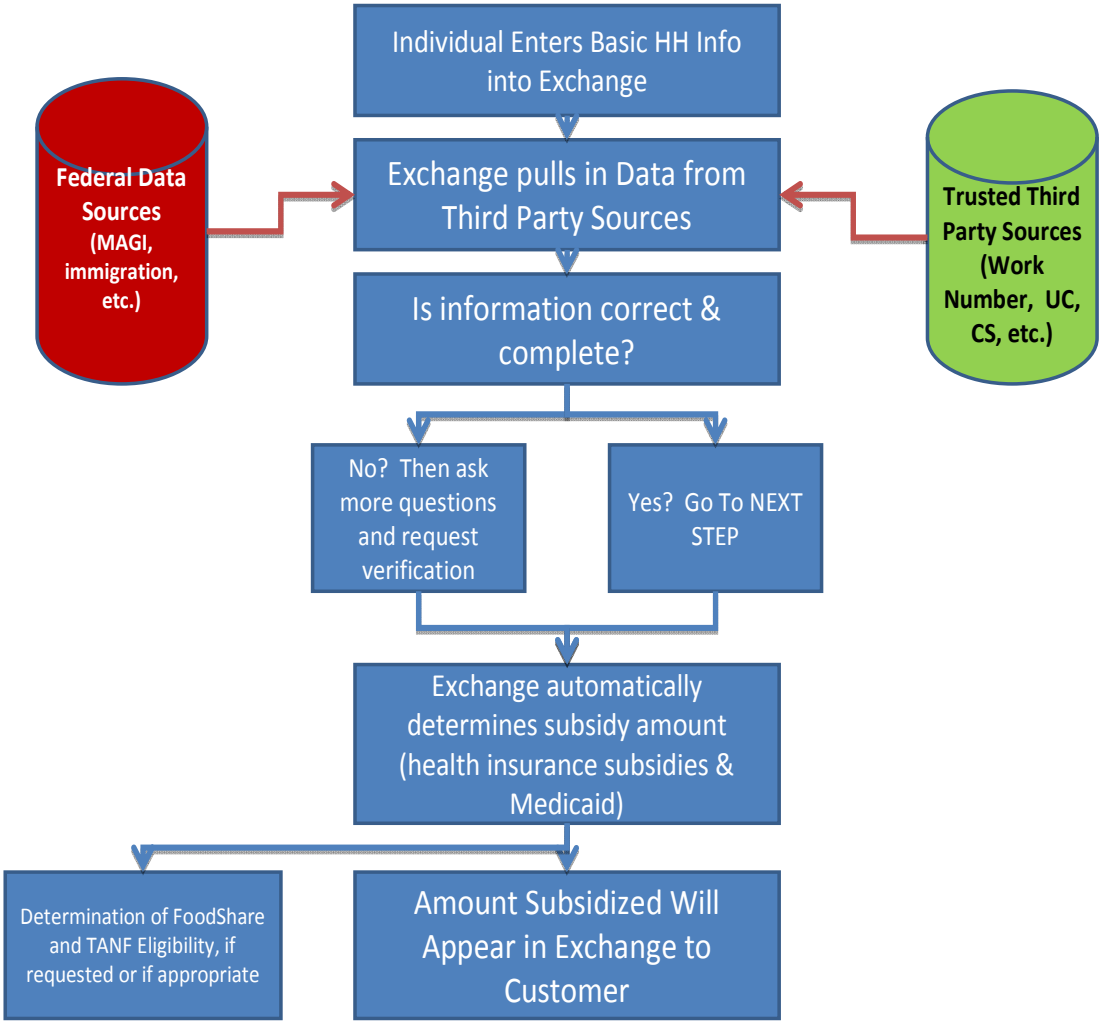
Appendix B Eligibility Determination Flow Chart

The flow chart below provides an overview of the eligibility determination process that could be conducted by the health insurance exchange.



Appendix C Payment Reform Initiatives Included in the ACA

The Patient Protection and Affordable Care Act (PPACA) includes several new programs and demonstration projects to promote quality, primary care delivery in a medical home setting, with the potential to significantly impact the structure and function of the health care delivery system. There is widespread agreement that current methods of paying for health care contribute to both high costs and poor quality. While some of these initiatives simply address cost issues through changes to reimbursement rates for providers, hospitals, etc., there are many that address true payment reform through the implementation of innovative approaches to health care delivery that address not only cost of care but also the quality.

Medicaid Payment Reform and Quality Improvement Initiatives

(1) State Option to Provide Health Homes for enrollees with Chronic Conditions (Sec. 2703)

Through a state plan option amendment, states may provide an option for eligible individuals with chronic conditions to enroll into a health home. The Secretary of the federal Department of Health and Human Services (HHS) will establish standards of who is an eligible provider to be in a health home and the state will specify the methodology to be used in determining the payment for the provision of health home services within a set of guidelines as noted in the legislation. States can submit waiver requests starting January 1, 2011. The waiver would grant 90 percent FMAP for two years for home health-related services, including care management, care coordination, and health promotion.

(2) Medicaid Demonstration Project to Evaluate Integrated Care Around a Hospitalization (Sec. 2704)

Allows for the establishment of a demonstration project to evaluate the use of bundled payments for the provision of integrated care for Medicaid beneficiaries, including hospitalizations. The demonstration will be performed in up to eight states based on the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. The program may be targeted to particular diagnoses, geographic regions, or categories of beneficiary. This project is to begin on January 1, 2012.

(3) Medicaid Global Payments Demonstration Project (Sec. 2705)

Establishes a Medicaid global payments demonstration to fund large safety net hospitals in five states to adjust their current payment structure from a fee-for-service model to a global capitated structure. A global payment structure generally refers to paying a single amount to cover all of the services needed to manage a patient's conditions during a fixed period of time, regardless of how many separate episodes of care occur. This gives the providers involved in the patient's care the flexibility to try innovative approaches and tailor services based on the patient's needs, and it gives them an incentive to avoid

hospitalizations and unnecessary or overly expensive services. The current legislation does not include details as to how this program will be administered. This program is to operate between FY2010-2012, with five states selected to participate.

(4) Medicaid Pediatric Accountable Care Organization Demonstration Project (Sec. 2706)
Similar to Section 3022, this provision specifically focuses on the development of Accountable Care Organizations (ACOs) from pediatric medical providers (under Medicaid). Pediatric ACOs would be required to meet certain performance guidelines as determined by HHS as well as an annual minimum level of savings. If the ACO meets the performance guidelines and a greater level of savings than the minimum established — they will share in a portion of the excess savings. States must apply to participate in this program. This program is to be established by January 1, 2012.

(5) Medicaid Emergency Psychiatric Demonstration Project (Sec. 2707)
Establishes a three-year Medicaid demonstration project in up to eight states and requires participating states to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. The project is authorized from October 2011 through December 2015 with $75 million appropriated for FY2011. The demonstration will be conducted for three consecutive years and the Secretary will ensure a balanced geographic distribution of participating states.

(6) Incentives for Prevention of Chronic Disease in Medicaid (Sec. 4108)
Awards grants to states to provide incentives to Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. Programs must have a demonstrated success in helping individuals achieve one ore more of the following: ceasing use of tobacco products, controlling or reducing their weight, lowering cholesterol, lowering blood pressure, avoiding the onset of or improving the management of diabetes. The purpose of the initiative is to test approaches that may encourage behavior modification and determine solutions. $100 million is appropriated for the five-year period, beginning on January 1, 2011.

(7) Medicaid Payment Adjustment for Hospital Acquired Conditions (Sec. 2702)
Effective July 1, 2011, payments to states for hospital acquired conditions will be prohibited. The Secretary will develop a list of health care acquired conditions for Medicaid based on those defined under Medicare as well as current state practices.

(8) Medicaid Payments to Primary Care Physicians (Sec. 1202 of Reconciliation Act)
Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100 percent of Medicare payment rates for 2013 and 2014. One hundred percent federal funding will be provided to states for the additional costs of meeting this requirement. For purposes of this provision, payment will be increased for services furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. Primary care services means

evaluation and management services in the Evaluation and Management category of the Healthcare Common Procedure Coding System and services related to immunization administration for certain vaccines and toxoids.

(9) Incentive to Reduce Cost Sharing for Adults in Medicaid (Sec. 4106)
Expands the current state option to provide other diagnostic, screening, preventive, and rehabilitation services to include additional specified services. States that elect to cover these additional services and vaccines and also prohibit cost-sharing for such services would receive an increased FMAP of one percentage point for each of these services. This provision is effective January 1, 2013.

(10) MACPAC Review of Policies Affecting Medicaid Beneficiaries (Sec. 2801)
Beginning in 2010, the Medicaid and CHIP Payment and Access Commission (MACPAC) will clarify topics to be reviewed, including federal Medicaid and CHIP regulations, additional reports of state-specific data, and an assessment of adult services in Medicaid.

Medicare Payment Reform and Quality Initiatives

(11) Medicare Value Based Purchasing Demonstration Programs (Sec. 3001)
Establishes a value-based purchasing program for hospitals, where a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. This program will apply to discharges on or after October 1, 2012. At least the five following conditions: acute myocardial infarction (AMI), heart failure, pneumonia, surgeries (as measured by the Surgical Care Improvement Project), and health care-associated infections.

(12) Medicare Pay-for-Performance Pilot Program (Sec. 10326)
Provides HHS with the authority to test value-based purchasing programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long-term care hospitals, certain cancer hospitals, and hospice providers. Pilot programs may not create additional expenditures and may be expanded if they are found to reduce spending and either improve or not reduce quality. Pilot programs are to be begin no later than January 1, 2016.

(13) National Pilot Program on Medicare Payment Bundling (Sec. 3023)
This provision establishes a pilot program focused on integrative care during an episode of hospitalization (essentially an expansion of the Acute Care Episodes Demonstration project of the Centers for Medicare and Medicaid Services [CMS]). The goal is to improve coordination, quality, and efficiency of health care services. This bundled payment arrangement removes the need for providing separate payments for services provided and provides an incentive for providers to coordinate activities and eliminate unnecessary procedures. The initial pilot program is voluntary, and HHS has the

authority to expand the pilot if payment bundling is found to reduce costs and improve (or not reduce) quality. To be established no later than January 1, 2013.

(14) Medicare Hospital Readmissions Reductions Program (Sec. 3025)
Beginning October 1, 2012, payments may be reduced for hospitals that have excess readmissions of patients. Specifically, payments for hospitals paid under the inpatient prospective payment system will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for three specified conditions. The legislation allows the Secretary of HHS to expand to additional conditions in future years.

(15) Medicare Community Based Care Transitions Program (Sec. 3026)
Provides funding to hospitals with high admission rates and certain community-based organizations that improve care transition services for "high-risk Medicare beneficiaries." The legislation defines "high-risk Medicare beneficiaries" as an individual with diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care. The program will be conducted for five years, beginning on January 1, 2011 (up to $500M available).

(16) Medicare Accountable Care Organizations (Sec. 3022)
Establishes a Medicare shared-savings program that promotes accountability for a patient population, coordinates items and services, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Encourages the formation of ACOs (serving at least 5000 Medicare beneficiaries) to gain efficiencies and improve quality of care. Accountable Care Organizations that meet quality of care targets and reduce costs relative to a spending benchmark will share in the savings generated for Medicare. This program is to be established no later than January 1, 2012.

(17) Medication Management Services in Treatment of Chronic Diseases (Sec. 3503)
Effective May 1, 2010, the Secretary will create a program to provide grants or contracts to eligible entities to support and implement medication therapy management (MTM) services provided by licensed pharmacists. Medication therapy management services are intended to help manage members with chronic diseases, reduce medical errors, and improve patient adherence while reducing acute care costs and reducing hospital readmissions. To be eligible to receive a grant, entities must provide a setting appropriate for MTM services as recommended by experts, submit a plan to the Secretary for achieving long-term financial sustainability, and where applicable, submit a plan for coordinating MTM services through local community health teams or in collaboration with primary care extension programs, among other things.

(18) Reduction of Geographic Variation in Medicare (Sec. 3102)
Extends the floor on geographic adjustments to the work portion of the maximum allowable fee schedule through the end of 2010, with the effect of increasing practitioner fees in rural areas and also provides immediate relief to areas negatively impacted by the geographic adjustment for practice expenses. Requires the Secretary to improve the methodology for calculating practice expense adjustments beginning in 2012.

(19) Increasing Reimbursement for Primary Care in Medicare (Sec. 5501)
Strengthens primary care by providing primary care physicians, as well as general surgeons practicing in health professional shortage areas with a 10 percent Medicare payment bonus for primary care services (available for five years, beginning in 2011). For the purposes of this provision, physicians with a primary specialty designation of family or pediatric medicine or a nurse practitioner, clinical nurse specialist, or physician assistant, and for whom primary care services accounted for at least 60 percent of the allowed charges in a prior period as determined by the Secretary. Primary care services include certain Evaluation and Management Services, including *Current Procedural Terminology* procedure codes 99201-99215, 99304-99340, and 99341-99350.

(20) Medicare Quality Payment Monitoring (Sec. 3007)
Directs the Secretary to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. Measures will be published by 2012 and the new payment system will be phased in over a two-year period beginning in 2015.

(21) Medicare Payment Adjustment for Conditions Acquired in Hospitals (Sec. 3008)
Beginning in FY2015, hospitals in the top 25th percentile of rates or hospital-acquired conditions will be subject to a payment penalty of a 1 percent rate reduction under Medicare. Prior to FY2015, the Secretary must provide reports to applicable hospitals with respect to hospital-acquired conditions of the applicable hospital during the applicable period.

New Institutions Created Under Patient Protection and Affordable Care Act

(22) Establishment of Center of Medicare and Medicaid Innovation within CMS (Sec. 3021)
This provision is currently listed under the Long Term Care Policy bucket — but links directly with some of the aforementioned initiatives. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. This provision specifies 20 models (18 in Sec. 3021, 2 added in Sec. 10306) for the CMI to evaluate. These models are selected from areas where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical

outcomes or potentially avoidable expenditures. Once evaluated, the Secretary of HHS may expand a model (even to a nationwide basis) should the expansion be expected to reduce spending and either improve or not reduce quality of care. The CMI may coordinate activities with other entities such as the Independent Payment Advisory Board (established under Section 3403) and the Global Payment Demonstration Project (created under Section 2705).

(23) Independent Payment Advisory Board (Sec. 3403)
Establishes an independent, 15-member board required to make recommendations on cost-saving measures for Medicare in years where the costs are projected to be unsustainable. These recommendations are automatically adopted unless Congress is able to provide a plan that will produce equal or greater savings. Recommendations of the board are prohibited from rationing care, raising taxes or Part B premiums, or changing Medicare benefits, eligibility, or cost-sharing standards. The board will regularly consult with the MACPAC.

Patient Protection and Affordable Care Act and Health Information Technology

The PPACA emphasizes the use of EHRs and other HIT in provisions pertaining to measuring and enhancing quality and establishing new methods and models for delivering care that may lead to cost-savings and payment reform. Several grants or demonstration programs are also contingent upon the use of EHRs. Some provisions mentioned previously also contain incentives for HIT use including Secs. 3021, 3022, 3023, and 3502).

(24) Integration of Physician Quality Reporting Initiative and Meaningful Use Reporting (Secs. 3002 and 10327)
One of the most significant HIT/EHR-related provisions in the PPACA requires the Secretary of HHS to integrate the respective reporting mechanisms for the Physician Quality Reporting Initiative (PQRI) and the more recent electronic health record "meaningful use" incentives established by the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Not later than January 1, 2012, the Secretary must develop a plan to integrate reporting on quality measures under PQRI with reporting requirements under the HITECH Act provisions pertaining to the meaningful use of EHR. Such integration must consist of the selection of measures, the reporting of which would demonstrate both meaningful use of EHR and quality of care furnished to an individual under PQRI. Meaningful use guidance (final rule by CMS) was issued in July 2010 (http://www.hhs.gov/news/press/2010pres/07/20100713a.html) and has received support from both the public and private sectors (including state licensing boards, payers, and providers). Meaningful use may have the most significant effect on the take-up of EHRs, as doctors can qualify for thousands of dollars in incentives and hospitals may be eligible for millions in incentives.

(25) Quality Reporting by Health Plans (Sec. 1001, Sec. 2717 of PHSA and Sec. 1311)
The Secretary is required to develop reporting requirements for use by health plans addressing plan benefits and health care reimbursement structures that, among other goals, implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and HIT. Plans are required to submit annually to the Secretary, as well as to plan members, a report on whether the benefits under the plan include the specified elements. These mechanisms must be in place not later than two years following enactment (March 23, 2012).

In connection with the establishment of the exchange, the Secretary is required to develop guidelines that require periodic reporting by participating health plans to the applicable exchange of quality-related activities. Such activities include improving patient safety and reducing medical errors through the appropriate use of best clinical practices, evidence-based medicine, and HIT.

(26) Independence at Home Demonstration Project (Sec. 3024)
The Secretary is required to conduct a demonstration program to test payment incentive and service delivery models that use physician- and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes. In approving medical practices for participation in the program, the Secretary is required to give preference to practices that, among other things, have experience in furnishing health care services to beneficiaries at home and that use EHR and other HIT. The demonstration project is to begin by January 1, 2012.

(27) Enhancement of Long-Term Care Services (Sec. 6703, 'Sec. 2041 of SSA — part of Elder Justice Act)
The Secretary is authorized to make grants to long term care facilities for the purpose of assisting them in offsetting the costs related to procuring certified EHR technology. Funds provided under the grants may be used to purchase, lease, and install computer software and hardware, including handheld computer technologies. These funds also can be used to make improvements in existing computer software and hardware, to enable e-prescribing, and to provide education and training to eligible long term care facility staff on the use of such technology. Further, the Secretary is required to adopt electronic standards for the exchange of clinical data by long term care facilities. Funding is authorized for FY2011-2014.

(28) Personalized Prevention Plan (Sec. 4103)
Medicare plan beneficiaries will have access to health risk assessments based on guidelines developed by the Secretary. The assessments will identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephone- or Web-based program during an encounter with a health professional. The Secretary will set standards for the electronic tools that can be used to deliver the assessment. In carrying out the assessment, the Secretary will

encourage the use of, integration with, and coordination of HIT (specifically including EHRs), and may experiment with personalized technology to aid in the development of self-management skills and adherence to provider recommendations. Standards for programs used to furnish health risk assessments are to be established by March 23, 2011. The health risk assessment model is to be available to the public by September 2011.

(29) Centers of Excellence for Depression (Sec. 10410)

The Secretary is required to award grants on a competitive basis to eligible entities to establish national Centers of Excellence for Depression. Each center will collaborate with other centers in the network. The centers shall use EHR and telehealth technology to better coordinate and manage and improve access to care. Not more than 30 Centers are to be established by September 30, 2016.

Opportunities for the Exchange and Payment Reform/Quality Improvement

The health benefits exchange must meet certain requirements or fulfill specific guidelines that relate to quality improvement and payment reform.

Requirements Related to the Payment Reform and Quality Improvement for Which the Exchange Is Responsible

- Assign a rating to each qualified health plan offered through the exchange, in accordance with the criteria developed by the Secretary;
- Require health plans seeking certification as a qualified health plan to submit a justification for any premium increase prior to implementation of the increase. The exchange may take this information into consideration when determining whether to make a health plan available through the exchange.
- Require health plans seeking certification as qualified health plans to submit to the exchange, the Secretary, the State Insurance Commissioner, and make available to the public accurate and timely disclosure of the following information:
    - Claims payment policies and practices;
    - Periodic financial disclosures;
    - Data on enrollment;
    - Data on disenrollment;
    - Data on the number of claims that are denied;
    - Data on rating practices;
    - Information on cost-sharing and payments with respect to any out-of-network coverage;
    - Information on enrollee and participant rights; and
    - Other information as determined by the Secretary.

Guidelines Related to Rewarding Quality Through Market-Based Incentives Inside the Exchange

The Secretary, in consultation with experts in health care quality and stakeholders, will issue guidance regarding the following payment structures that provide for increased reimbursement or other incentives for*:

- Improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model;
- The implementation of activities to prevent hospital readmissions through a comprehensive program for 'hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional;
- The implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology; and
- The implementation of wellness and health promotion activities.

* More specific requirements will be established within the guidance once provided.

Enhancing Patient Safety Inside the Exchange

Beginning January 1, 2015, a qualified health plan may contract with:

- A hospital with greater than 50 beds only if the hospital: (1) utilizes a patient safety evaluation system (as in the Public Health Service Act); and (2) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional;
- A health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary requires.

Appendix D Wisconsin's Exchange Implementation Timeline

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Planning	**Federal funding & regulations -** the following represent the federal tasks that will assist and/or are required for states to complete their planning effort.		* Planning grant funding * RFC solicitation * Implementation grant funding * Standards, criteria, and protocols
Planning	Notice of state planning grants	7/29/2010	
Planning	Notice of request for comment (RFC) solicitation	7/29/2010	
Planning	Award state planning grants	9/30/2010	
Planning	Collect request for comment (RFC) responses	10/4/2010	
Planning	Publish RFC results	10/25/2010	
Planning	Establish interoperable standards and protocols for enrollment; including citizenship, affordability, and individual mandate exemption.	3/23/2011	
Planning	Define essential health benefits package	3/23/2011	
Planning	Establish basic health program	3/23/2011	
Planning	Develop standards for compiling and providing enrollees with summary of benefits coverage explanations	6/30/2011	
Planning	Establish certification criteria for qualified health plans that will be sold through the Exchanges	6/30/2011	
Planning	Develop a rating system for qualified health plans and a model template for an Exchange's internal portal	6/30/2011	
Planning	Establish an initial and open enrollment period as well as special enrollment periods for people under varying circumstances	6/30/2011	
Planning	Establish procedures under by which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies	6/30/2011	
Planning			
Planning	**WI project management tasks** - the following represent the project management startup and planning tasks required to establish the foundation and infrastructure for the project		* Team assignments * Planning budget and schedule * Draft implementation budget and schedule * Planning grant application * RFC response
Planning	Establish workgroups	6/22/2010	
Planning	Develop planning budget	8/31/2010	

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Planning	Develop planning schedule	8/31/2010	
Planning	Draft initial implementation timeline	8/31/2010	
Planning	Apply for state planning grants	9/1/2010	
Planning	Respond to HHS request for solicitation (RFC)	10/4/2010	
Planning	Draft administrative organization structure	12/31/2010	
Planning	Draft implementation budget	3/30/2011	
Planning	Apply for state implementation grants	5/30/2011	
Planning			
Planning	**WI insurance market impact analysis** - analysis to understand current landscape of WI insurance markets and impact given changes from 2010 through 2014. Specific analysis will include: • Estimate range of enrollment take-up for individual/small-group markets • Estimate the number of covered lives for "grandfathered" plans • Scope out Medicaid expansions and changes • Assess impact of new insurance rating rules on premiums • Understand the potential of adverse selection to be experienced by exchange and develop mitigating policies		* Insurer data specification * Aggregated report of "current landscape" within each market * Market impact analysis and modeling of insurance reforms
Planning	Develop and distribute data specification for individual market, small and large group markets, and high risk pool	7/22/2010	
Planning	Receive completed data specifications	9/10/2010	
Planning	Scrub and summarize results and produce current landscape results	10/7/2010	
Planning	Model and analyze impact to respective markets	12/7/2010	
Planning			
Planning	**WI white paper -** the white paper provides the concept and blueprint for establishing the WI state exchange, laying out specific goals and objectives and identifying required policy decisions. Please see supporting tabs for specific goals, objectives, and policy decisions.		* Exchange goals and objectives * Outstanding policy decisions
Planning	Draft exchange white paper	7/16/2010	
Planning	Collect input from national experts	7/27/2010	
Planning	Collect input from OHCR leadership	8/2/2010	
Planning	Collect input from Governor	8/18/2010	
Planning	Collect input from White House/HHS/CMS	8/31/2010	
Planning	Finalize exchange white paper	9/1/2010	
Planning	Offsite meeting with workgroups	9/15/2010	

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Planning	Collect input from leg study council	9/30/2010	
Planning	Collect input from WI stakeholders	9/30/2010	
Planning			
Planning	**WI policy analysis -** using the list of identified outstanding decisions from the white paper, the project team will develop options papers that provide the pros and cons and present a recommendation. Note that some decisions will be dependent on federal regulations and/or guidance. The options papers will be presented to both internal and external stakeholders for review and comment.		* Options Papers * Recommendations * Policy Decisions
Planning	Assign option paper topics to workgroup teams	9/15/2010	
Planning	Develop option papers for outstanding decisions identified in white paper	10/31/2010	
Planning	Present recommendations to OHCR leadership for review and approval (Governor is necessary)	11/15/2010	
Planning			
Planning	**WI draft legislation -** the project team will develop legislation for those policies that require regulatory authority and enforcement.		* Draft legislation
Planning	Draft applicable legislation	11/30/2010	
Planning	Present recommendations to OHCR leadership for review (Governor is necessary)	12/15/2010	
Planning			
Planning	**WI functional planning -** The functional model will describe what each entity will do and will provide the functional interactions and interface requirements for all exchange stakeholders (e.g. consumers, small employers, brokers, insurers, call center, federal agencies, etc.) The functional model will show the role each stakeholder will play, their specific information requirements, and the frequency of each interaction.		* Exchange functional model
Planning	Identify exchange functional stakeholders and their roles	9/30/2010	
Planning	Develop functional process flows, data exchanges, and frequencies	9/30/2010	
Planning	Develop exchange functional model	10/31/2010	
Planning	Review functional model with applicable stakeholders	11/30/2010	
Planning	Finalize and publish functional model	12/15/2010	

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Planning	**WI technical planning -** the technical planning tasks will identify the physical interface requirements between the exchange and insurers, federal agencies, etc. This information will be used to identify required hardware, software, and staff resources and the development of an initial technical implementation plan.		* Exchange technical model * Technical implementation plan
Planning	Issue eligibility determination and exchange (CARES) RFP	5/13/2010	
Planning	Collect and score RFP responses	8/31/2010	
Planning	Select vendor	9/1/2010	
Planning	Create mock exchange web site	9/30/2010	
Planning	Identify technical interface requirements for Medicaid/BadgerCare, insurers, and federal agencies for eligibility determination, enrollment, and subsidies	9/30/2010	
Planning	Initial technical estimate (e.g. order of magnitude)	9/30/2010	
Planning	Draft exchange technical model	10/31/2010	
Planning	Review technical model with applicable stakeholders	11/30/2010	
Planning	Define technical architecture requirements	12/31/2010	
Planning	Identify required software and hardware	1/31/2011	
Planning	Estimate required resources	2/28/2011	
Planning	Draft technical implementation plan	3/30/2011	
Design/Execution	**Federal design & execution -**		
Design/Execution	Contract with health insurers to offer at least two multistate qualified health plans (at least one non-profit) through the Exchanges in each state.	1/1/2013	
Design/Execution	Establish federal standards for the determination of high-risk individuals, a formula for payment amounts and contributions required of insurers to support the transitional reinsurance program.	1/1/2013	
Design/Execution	Federal agencies make required interfaces available for exchange integration testing	12/1/2011	
Design/Execution	**WI project management tasks** - the following represent the project management design and execution tasks.		* Implementation timeline * HHS progress reports * Administrative structure defined
Design/Execution	Finalize implementation budget and timeline	5/31/2011	
Design/Execution	Provide progress reports to HHS	As required	

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Design/Execution	Finalize administrative structure	5/31/2011	
Design/Execution			
Design/Execution	**WI enabling legislation -** the project team will develop legislation for those policies that require regulatory authority and enforcement.		* Legislation enacted
Design/Execution	Present legislation for review by ?	5/31/2011	
Design/Execution	Enact legislation	8/31/2011	
Design/Execution			
Design/Execution	**WI operational design and execution -** using the policy decisions and functional model as input, the operational design and requirements will define how each exchange function will be executed		* Operational guide * Operational budget * Vendor and resource procurement * Training manuals
Design/Execution	Develop operational policy, procedures, and standards for each function	6/30/2011	
Design/Execution	Identify operational resource requirements	9/30/2011	
Design/Execution	Appoint board and executive director	6/30/2011	
Design/Execution	Executive director hires key personnel	9/30/2011	
Design/Execution	Determine if any exchange functions will be outsourced	10/30/2011	
Design/Execution	Prepare applicable Grants/RFPs (e.g. QHPs, Call Center, Navigator, Fiscal Agent) (if necessary)	12/31/2011	
Design/Execution	Collect and score RFP responses (if necessary)	2/28/2012	
Design/Execution	Select vendor(s) and/or award grants (if necessary)	3/1/2012	
Design/Execution	Define operational software and hardware requirements	4/1/2012	
Design/Execution	Develop required internal accounting and financial controls	3/1/2012	
Design/Execution	Develop required disaster recovery and business continuity plans	3/1/2012	
Design/Execution	Develop operational budget	5/31/2012	
Design/Execution	Develop operational training manuals	9/30/2012	
Design/Execution	Draft operational guide	9/30/2012	
Design/Execution	Review operational guide with applicable stakeholders	10/31/2012	
Design/Execution	Publish operational guide	11/30/2012	
Design/Execution	Conduct applicable training	12/31/2012	
Design/Execution	Begin exchange operations	1/1/2013	
Design/Execution			

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Design/Execution	**WI technical design & execution -** using the policy decisions and technical model developed in the planning phase, the technical requirements, design, construction, and testing will be completed during the design and execution phase.		* Technical requirements * Physical design * Construction * Integration, system, and user acceptance testing
Design/Execution	Develop individual and SHOP exchange requirements	3/1/2011	
Design/Execution	Develop exchange web portal physical design	4/30/2011	
Design/Execution	Construct exchange web portal	8/31/2011	
Design/Execution	Test exchange web portal	11/30/2011	
Design/Execution	Develop integration requirements with CARES system	3/1/2011	
Design/Execution	Develop integration physical design	4/30/2011	
Design/Execution	Construct integration from exchange web portal to CARES system	8/31/2011	
Design/Execution	Test integration between exchange web portal and CARES system	11/30/2011	
Design/Execution	Develop financial and accounts system requirements	3/1/2011	
Design/Execution	Develop financial and accounting system physical design	4/30/2011	
Design/Execution	Construct financial and accounting system	8/31/2011	
Design/Execution	Test financial and accounting system	11/30/2011	
Design/Execution	Test integration points between exchange and insurance carriers	2/28/2012	
Design/Execution	Test integration points between exchange and federal agencies	2/28/2012	
Design/Execution	Conduct full system testing between exchange, insurance carriers, and federal agencies	5/31/2012	
Design/Execution	Conduct user acceptance testing of the individual and SHOP exchanges (test all functionality) with brokers, carriers, state and federal agencies, navigators, employers, etc.	12/31/2012	
Design/Execution	Conduct disaster recovery testing	2/28/2013	
Design/Execution			
Design/Execution	**WI outreach, marketing, and advertising campaign** - the following tasks represent the effort to conduct the applicable market research, develop the marketing and outreach strategy,		* Marketing strategy * Vendor selection
Design/Execution	Conduct initial market research, draft strategy, and discuss with stakeholders	3/31/2012	
Design/Execution	Develop RFP requirements	4/30/2012	
Design/Execution	Issue RFP	8/1/2012	

Phase	Task/Activities	Completion Date	Milestone Deliverable(s)
Design/Execution	Collect and score RFP responses	10/31/2012	
Design/Execution	Select vendor(s)	11/1/2012	
Design/Execution	Conduct final market research, analyze, finalize strategy (including media and distribution channels)	12/31/2012	
Design/Execution	Review final strategy with stakeholders	1/31/2013	
Design/Execution	Execute outreach, marketing, and advertising campaign	6/30/2013	
Design/Execution			
Implementation	**Federal implementation**		
Implementation	Certify state exchanges	1/1/2013	
Implementation			
Implementation	**State implementation**		
Implementation	Exchange goes live	9/1/2013	
Implementation	Federal interfaces go live	9/1/2013	
Implementation	Insurance carrier interfaces go live	9/1/2013	
Implementation	Initial enrollment cycle	10/1/2013	
Implementation	Monitor cash flow/funding stream	Monthly	

Appendix E Overview of Wisconsin's BadgerCare Plus and Medicaid Programs

Wisconsin launched an ambitious health care reform agenda in January 2006 with Governor Jim Doyle's announcement of his "Affordability Agenda" to ensure that all Wisconsin residents have access to affordable health care coverage. To ensure that all of Wisconsin's children have access to health care, Wisconsin created a single health care safety net – BadgerCare Plus. BadgerCare Plus merged existing family Medicaid programs, BadgerCare (Wisconsin's SCHIP), and Healthy Start into one comprehensive, dramatically simplified program. The BadgerCare Plus program covers all children, regardless of income; those with incomes above 200 percent of the federal poverty level (FPL) pay premiums on a sliding scale based on income. Those above 300 percent of FPL pay the full cost. BadgerCare Plus also covers parents and caretaker relatives up to 200 percent of FPL, pregnant women with incomes up to 300 percent of FPL and youth aging out of foster care up to 21 regardless of income. In 2009, BadgerCare Plus was expanded to cover childless adults up to 200 percent of FPL.

With the implementation of BadgerCare Plus, Wisconsin's medical assistance program can be viewed as two programs. The first, BadgerCare Plus, provides coverage primarily to low-income children, their families, adults without dependent children (childless adults) and pregnant women. The second, usually referred to simply as "Medicaid" provides coverage for elderly, blind, and disabled individuals under a series of subprograms such as Elderly, Blind and Disabled Medicaid, Family Care, and the home and community based waivers.

BadgerCare Plus applicants must meet the following non-financial criteria to participate in BadgerCare Plus.

- They must be Wisconsin residents.
- Individuals must be U.S. citizens (or U.S. nationals or qualified aliens) and must be able to document their status.
- Individuals must cooperate in establishing medical support and third-party liability for medical expenses[16].
- Individuals must provide a social security number or apply for a number if they do not have one.
- The must cooperate with requests to verify information relevant to their participation in BadgerCare Plus, such as their social security number, citizenship and identity, immigration status, pregnancy, income, and access to other health insurance coverage.

[16] Medical support refers to the obligation a parent has to pay for his or her child's medical care. An example of the member's duty to cooperate in this regard is their obligation to help establish the paternity of any child born out of wedlock for whom coverage under BadgerCare Plus is received.

- BadgerCare Plus does not consider assets for eligibility purposes. However, assets are considered for purposes of eligibility determination for the Medicaid program.

The following chart provides the income limits for the BadgerCare Plus program.

Eligibility Category	WI Current Income Limits
Children	No Income Limit
Parents and Caretakers	200 percent FPL
Pregnant Women	300 percent FPL
Childless Adults	200 percent FPL

Notes:

- Children include individuals under age 19 and youths exiting out of foster care under age 21.
- Pregnant women with income greater than 300 percent of the FPL can qualify for BadgerCare Plus if they meet a deductible equal to the amount by which their income exceeds 300 percent of the FPL.
- Parents and caretakers with self-employment income are income-eligible for BadgerCare Plus if their family income after deducting depreciation does not exceed 200 percent of the FPL.

The following chart provides income and asset limits for the Medicaid program.

Eligibility Category	WI Current Income Limits	WI Current Asset Limits
Medicaid Standard Plan	$533.11 per individual per month plus shelter costs $806.05 per couple per month plus shelter costs *If income exceeds limits, can qualify by meeting a deductible	$2,000 for individual $3,000 for couple
Community Waivers	Income limit is $2,022 *Spousal impoverishment rules apply for cases where one spouse is sill living in the community.	$2,000 for individual *Spousal impoverishment rules apply for cases where one spouse is sill living in the community.
Institutional Medicaid	Income limit is $2,022	$2,000 for individual *Spousal impoverishment rules apply for cases where one spouse is sill living in the community.
Medicaid Purchase Plan	Income limit is $2,256.25 for one person Income limit is $3,035.42 for two people	$15,000 *Assets owned by spouse do not count towards limit
Family Care	Must be able to enroll in one of the above Medicaid plans or the BadgerCare Plus Standard plan if a person meets non nursing home level of care. If a person meets nursing home level of	

	care, he/she can enroll in Family Care (must meet Community Waiver income and asset limits).	
Tuberculosis Related Services Plan (TB)	$1,433 per applicant.	$2,000 per applicant.

The following chart provides an overview of November 2010 BadgerCare Plus enrollment.

BadgerCare Plus Enrollment November 2010	
	Current Enrollment
Total Enrollment	777,467
BadgerCare Plus	724,908
Children	455,674
Parents/Caretakers	250,413
Pregnant Women	18,821
BadgerCare Plus Core Plan	48,549
Childless Adults	48,549
BadgerCare Plus Basic Plan	4,010
Childless Adults on Waitlist	84,311

Medicaid, like Medicare and Social Security, is an entitlement program. This means that the federal government is required to pay its share of state Medicaid costs regardless of the total amount. The federal law outlines categories of people who are eligible for Medicaid. Generally, eligibility groups can be summarized into the following categories: children, parents or caretakers, pregnant women, and elderly, blind and disabled individuals. Occupation or employment status of an individual is not considered as a category for Medicaid eligibility purposes. Once Medicaid is offered to a certain group of people, it has to be offered to all similarly situated individuals.

States have flexibility to waive certain parts of the federal law to expand coverage or gain more flexibility in how the program is administered; however, not all parts of the federal law can be waived. Childless adults, was an example of a group that had to be "waived" to be covered. Without a waiver childless adults were not eligible for Medicaid and, therefore, historically many states did not cover childless adults. The Affordable Care Act allows states to cover childless adults through a state plan amendment without requesting a waiver. Because Wisconsin covered childless adults before the passage of the Affordable Care Act, the State had to stay within the agreed budget neutrality limits, and, therefore, had to limit either the number of enrollees or benefits covered, or both.

Initial coverage of the childless adult population was extended on January 1, 2009, with an automatic transfer of approximately 13,000 low-income adults from current general

medical assistance programs operated by county government. On May 15, 2009, the Department was given approval to begin accepting applications from the general population of low-income childless adults on June 15, 2009 with benefits beginning July 15, 2009. The interest in enrolling in BadgerCare Plus Core Plan has been overwhelming. About 50,000 residents now have access to affordable health care through the Core Plan – many for the first time in years. This tremendous interest, however, has now resulted in the suspension of program enrollment and enactment of a statewide waitlist to comply with Federal waiver budget neutrality requirements.

Under the direction of Governor Doyle, DHS has developed a new program to allow access to health care to address the needs of low-income adults without dependent children who are currently on the BadgerCare Plus Core Plan Waitlist. It is designed to assist those people while they're otherwise waiting to enroll in the Core Plan and offer them some basic primary and preventative services that can help meet their health care needs and help prevent bankruptcy due to excessive medical debt. This new program, the BadgerCare Plus Basic Plan, is only available to those eligible for the Core Plan Waitlist, has higher member cost sharing, and a benefit package that is not greater than the Core Plan benefit package. The legislature has approved the BadgerCare Plus Basic plan. The State is accepting applications and the benefits started on July 1, 2010. Monthly premiums are $130 per month per person. The program is self-funded by monthly premiums; there is no state or federal funding for this program.

Notes:

A detailed description of Wisconsin's BadgerCare Plus and Medicaid programs is available on the Legislative Fiscal Bureau website: http://www.legis.state.wi.us/lfb/Informationalpapers/44_medical%20asssitance,%20badgercare%20plus,%20seniorcare,%20and%20related%20programs.pdf

To screen and/or apply for BadgerCare Plus, visit www.access.wi.gov.

Appendix F ACA Minimum Exchange Standards

The ACA requires that either a governmental agency or a nonprofit entity established by a state run the exchange. Exchanges are required to make qualified health plans available to eligible individuals and employers and must consult with various stakeholders in carrying out their responsibilities. States must submit an annual report to the Secretary on the exchange's activities and on receipts and expenditures, and must publish pertinent information about the average costs of licensing, regulatory fees, administrative costs and moneys lost to waste, fraud, and abuse.

Additionally, the exchange must do all of the following:

- Implement procedures for certification, recertification, and decertification of qualified health plans.

- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

- Maintain an Internet website containing comparative information on qualified health plans.

- Assign ratings to each qualified health plan offered through the exchange on the basis of relative quality and price, in accordance with criteria as defined by the Secretary.

- Present plan options (bronze, silver, gold, platinum, and a catastrophic plan for young adults) in a standard format.

- Inform individuals of eligibility requirements for the Medicaid program and Children's Health Insurance Program (CHIP) or any applicable state or local program and enrollment in these programs, if an individual is determined eligible through screening by the exchange.

- Provide an economic calculator for consumers to determine the actual cost of coverage after application of any premium tax credit or cost-sharing reduction.

- Grant certification to individuals relating to hardship or other exemptions.

- Establish a "navigator" program to facilitate enrollment and refer consumers' questions and complaints to the appropriate agencies.

Appendix G Individual Market Report

Market Summary for Wisconsin's Individual Health Insurance Market

Prepared for the Wisconsin Department of Health Services

November 22, 2010

Gorman Actuarial, LLC
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Table of Contents

List of Tables

1. Introduction

With the passing of the Patient Protection and Affordable Care Act of 2010 (PPACA), states will be assessing the impact of various components of the law on their insured markets. The Wisconsin Department of Health Services has commissioned Gorman Actuarial and Dr. Jon Gruber to assess the impact of PPACA on the Wisconsin (WI) insured markets. The first phase of this analysis, performed by Gorman Actuarial, is to understand the market landscape of the existing privately insured markets. This report focuses on the Individual Market and is the first of a series of reports that will be produced.

2. Key Findings

The WI Individual Market is relatively large with approximately 160,000 members insured as of December 31, 2009. There are an estimated eleven carriers that participate in the market today. Since there is very little regulation in this market, we found considerable variation in rating practices and product offerings. This variability added to the complexity in the data collection and data review process. In addition to the privately insured market, WI also has a high risk pool, the Health Insurance Risk Sharing Plan of Wisconsin (HIRSP) that had approximately 15,500 members as of December 31, 2009. Premiums for the high risk pool population are subsidized through a provider subsidy, reflected through provider reimbursement and an insurer subsidy reflected through insurer assessments. Below, we identify key findings for both the privately insured market and the HIRSP. As we continue to analyze this market, issues will begin to surface that will assist Wisconsin in preparing for CY 2014.

- The Individual Market has a healthy competitive environment and is not dominated by a few carriers.
- The average age of the Individual Market is 35 as compared to the average age of the HIRSP at age 52.
- Approximately 70% of the market is enrolled in Single policies.
- The market appears to be evenly distributed across the state.
- There is significant variability in how carriers price this market.
- The medical loss ratio as defined as incurred claims to billed premium in CY09 is estimated at 0.81 for the Individual Market.
- 41% of the Individual Market did not incur any claims in CY09 as compared to 9% of the HIRSP population.
- The average single policy deductible is estimated at $2,900 and the average family policy deductible is $7,500. We estimate the average actuarial value for the WI Individual Market to be approximately 0.67.
- Approximately 21% of the market does not have the pharmacy benefit.

- The maternity benefit is not part of the standard plan, and only 2% of the market has purchased the maternity benefit.
- Most carriers do not offer the behavioral health benefit to this market.

3. Methodology

After conducting phone calls with all of the carriers, Gorman Actuarial (GA) developed a survey instrument that would capture data for each member in the Individual Market. The carriers were given four to ten weeks to deliver data. A list of carriers that participated in this study is found in Appendix I. Due to the complexity of the market, some carriers had difficulty providing information in the format required. We also found a large amount of variation in how carriers operate and report data, which led to additional time and resources scrubbing the data once it was received. Some common issues included multiple member records within one dataset, incorrect premium reporting and incorrect plan design reporting. There was a considerable amount of communication between GA and the carriers to ensure that GA was interpreting the information received correctly. As a result, some carriers had to supply supplementary data sets. Once the data sets were "scrubbed", a master database was developed which combined all the carrier data sets into a single database for the individual market. This database along with additional information from the carriers (e.g. plan summary descriptions, rating factors and rating methodology) was used to perform this analysis.

We define "carrier" as a separate legal entity. For example, we treated BCBSWI and Compcare as two different carriers. Throughout this report we have obscured each carrier's identity so that data associated with a particular carrier cannot be identified. We use labels such as "Carrier A", "Carrier B", etc. Note that the carrier labels are not consistent throughout the report. This is done intentionally so that a carrier's identity may not be discerned.

4. Market Demographics

For CY 2009, we estimate that there were approximately 189,000 members and 117,000 subscribers in the Individual Market during CY2009. This includes members and subscribers that were active for only part of the year and double counts members that switch from one carrier to another (i.e. members that switch carriers will show up in two carrier datasets.) As of 12/31/09 there were approximately 160,000 active members[1], and 95,000 subscribers.

[1] The estimated number of members as of 12/31/09 is 158,024 and includes all members with termination dates greater than or equal to 12/31/09. One carrier was only able to provide the month for effective date and termination date, so in this case the estimated number of members as of 12/31/09 includes members with term dates of December 2009. In addition, this number does not include short term policies and old blocks of business. We have estimated this to represent an additional 10,000 to 20,000 members.

The membership within the market is spread across the carriers, as shown in Table 1. While there are a few carriers that have higher market share than the others, 5 of the 11 carriers hold just over 75% of the membership and there are six carriers that have at least a 10% share of the market. This indicates a healthy competitive environment.

Carrier	Market Distribution
A	24%
B	17%
C	13%
D	11%
E	10%
F	10%
G	5%
H	5%
I	3%
J	1%
K	1%
Total	100%

Table 1 – WI Individual CY09 Market Member Distribution by Carrier

In addition to analyzing the private individual market, we also analyzed the HIRSP. For CY09, there were 18,800 HIRSP members who were enrolled at some point during the year. We estimate that there were approximately 15,500 members enrolled as of December 2009.

We have analyzed the demographics of these two populations and show the gender demographics by age cohort in Table 2 for the Individual Market and Table 3 for the HIRSP. Table 2 shows that the Individual Market population is almost distributed evenly across males and females. However, there are slightly more younger males than younger females in this population. Also, 19% of this population is children and approximately 15% of this population is between the ages of 18 and 24. The demographics for the HIRSP population are heavily skewed to the ages 50 and over where 70% of the HIRSP population is over age 50 (as compared to 28% of the Individual Market). The average age for HIRSP is 52 years as compared with the WI Individual Market which has an average age of 35 years. There will be some premium disruption as this pool merges into the privately insured pool in CY 2014. We would expect to see premiums increase for the privately insured pool and the revenue requirement decrease for the HIRSP.

	% Distribution		
Age Cohort	F	M	Total
0-17	9.5%	9.8%	19.3%
18-24	6.9%	7.7%	14.7%
25-29	4.0%	5.0%	9.0%
30-34	2.6%	3.3%	5.9%
35-39	2.9%	3.3%	6.2%
40-44	3.7%	4.0%	7.7%
45-49	4.5%	4.9%	9.4%
50-54	4.6%	4.9%	9.5%
55-59	4.6%	4.2%	8.8%
60-64	5.5%	3.6%	9.1%
65+	0.3%	0.2%	0.4%
Total	49.1%	50.9%	100%

Table 2 – WI Individual CY09 Age Gender Distribution

	% Distribution		
Age Cohort	F	M	Total
0-17	None	None	None
18-24	1.6%	1.9%	3.5%
25-29	1.6%	2.1%	3.7%
30-34	1.5%	1.6%	3.1%
35-39	1.8%	1.9%	3.7%
40-44	2.8%	3.1%	5.9%
45-49	4.7%	5.3%	10.0%
50-54	7.7%	7.3%	15.0%
55-59	11.5%	9.8%	21.3%
60-64	19.0%	12.0%	31.0%
65+	1.8%	1.0%	2.8%
Total	53.9%	46.1%	100%

Table 3 – WI High Risk Pool CY09 Age Gender Distribution

As shown in Table 4, as of December 31, 2009, we estimate that 70% of total contracts are Individual Only Policies, and the average family size of Family contracts is 3.06.

Estimated Year End 12/31/2009				
Individual Contracts	Family Contracts	Total Contracts	Total Members	Average Family Size
68,561	29,264	97,825	158,024	3.06

Table 4 – WI Individual Market CY09 Average Family Size

We performed a geography analysis and Table 5 shows a member distribution by region. The regions are defined using the county associations shown in Appendix II. These region definitions are the same as those used by the Wisconsin Department of Health Services, except that we have assigned Milwaukee County to its own region. We have also provided data for each county. This is shown in Appendix III. Note that some of the data by county is not credible, due to the small number of members in that county. As shown, the top two regions are Northeastern at 22.6% and Southeastern at 21.6%. Note that average age of Milwaukee County is 33 years, the youngest of all the regions. The Northern region has the oldest demographic with an average age of 38 years.

Region	% Member Dist	Average Age
Milwaukee	9.0%	33
Northeastern	22.6%	36
Northern	11.3%	38
Southeastern	21.6%	34
Southern	18.5%	34
Western	16.3%	36
Unknown	0.8%	32

Table 5 – WI Individual Market CY09 Geography Distribution

We also analyzed the number of carriers that had greater than a 10% market share in each region. There are six carriers that have greater than 10% market share in the Milwaukee, Northeastern, and Southeastern regions. There are only three carriers in the Southern region with more than 10% market share.

Region	Number of Carriers
Milwaukee	6
Northeastern	6
Northern	4
Southeastern	6
Southern	3
Western	4

Table 6 – Number of Carriers with Greater Than 10% Market Share CY09

5. Market Pricing

Due to the limited regulatory oversight, pricing for this segment varies significantly across carriers. The table below shows the wide variation across carriers on the rating formula used in the individual market.

Carrier ID	Age/Gender	Tobacco	Geography	Health UW	Duration	Spousal	Exclusionary Riders
A	x	x	x	x			x
B	x	x	x	x		x	
C	x	x					
D	x	x		x			
E	x						
F	x	x	x	x	x	x	x
G	x	x	x	x		x	x
H	x	x	x	x			
I	x	x	x	x		x	
J	x	x	x	x		x	
K	x	x	x	x			x

Table 7 – WI Individual Market Rating Methodologies

As shown, out of the eleven carriers surveyed, all use an age/gender adjustment and most use a tobacco, health underwriting and geography adjustment. Only one carrier noted that they use a durational adjustment (adjustment to the policy rate based on policy duration) and about half the carriers use a spousal discount. Finally, four carriers apply exclusionary riders when health underwriting new business. In CY 2014 we believe that carriers will only be able to adjust rates for age, tobacco, and geography.

In addition to the rating adjustments noted above, other practices include block rating. That is, some carriers will choose a target medical loss ratio for certain blocks of business and then adjust each policy's rate to achieve this target. This may be in the form of a minimum floor and a maximum cap of increase. And some carriers may include a surcharge for lifestyle practices such as riding a motorcycle.

Most carriers charge a separate rate for each member within a family. Some carriers cap dependent children premium up to a maximum of 3, while others do not. For example, take a family of 6 with 2 adults: One carrier would charge 6 member rates and another would charge 5. Some carriers age/gender rate the children, others charge a flat child rate. For policies that wish to change their mode of payment (i.e. from monthly to quarterly) some carriers charge a modal charge.

6. Age/Gender Rating

All carriers currently use age and gender rating when setting policy premiums. Some carriers use the same age/gender curve for all the products they offer while others use different age/gender curves by product or deductible level. We have identified at least three carriers representing over 50% of the market that use different age/gender curves by

deductible level. The table below shows age curves for males for a representative carrier in the market. As expected, as age increases, the age adjustment or surcharge increases. However as the deductible increases, the age curve becomes steeper. The age adjustment for the oldest age for a $250 deductible plan is a little above 2.0 whereas the age adjustment for a $10,000 deductible plan is around 2.7. This means an older demographic gets surcharged more in a higher deductible plan as compared to a lower deductible plan.

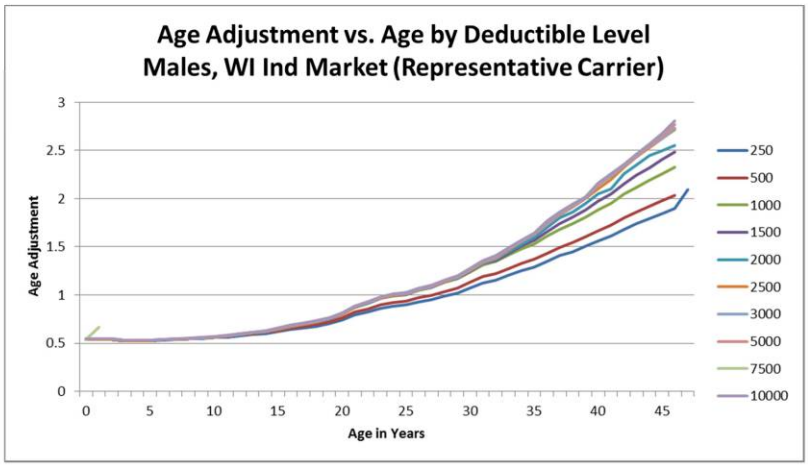

Table 8 – Male Age Curves by Deductible for Representative Carrier

In 2014, for non-grandfathered plans, carriers will no longer be allowed to gender rate and age adjustments will need to be within a 3 to 1 band for adults, meaning that a premium rate cannot be greater than 3 times the lowest rate due to age. All WI carriers gender rate today. Generally, for younger ages, male age adjustments are lower than female age adjustments. For older ages, the opposite holds true where male age adjustments are higher than females. We have observed spreads as wide as 10 to 20% between the male and female factors.

Currently, in the WI Individual Market, the age band varies by carrier and sometimes by product. We have estimated the charged age band in the market using 2009 data by carrier. Table 9 estimates the age band in practice in the Individual Market. The overall age band in practice in the Individual Market is 5.1. That is, due to age, the premium rates charged an adult can be 5.1 times higher than the lowest premium rate. The age band ranges from as low as 3.3 to as high as 6.2. In CY 2014, the age band can be no more than 3.

Carrier	Age Band
A	5.6
B	5.1
C	6.2
D	4.6
E	6.1
F	5.2
G	4.6
H	5.0
I	4.4
J	5.0
K	3.3
Total	5.1

Table 9 – WI Individual Market CY09 Charged Age Bands by Carrier

7. Tobacco Adjustment

Of the eleven carries surveyed in the Individual Market, all but one collects information on member tobacco use. Of the carriers that collect tobacco information, 8% of the market reports using tobacco with an average surcharge of 1.30. Some carriers will only surcharge the member premium while other carriers surcharge the premium for a whole family. Table 10 shows the average tobacco adjustment by carrier. Surcharges range from 20% to 50%. In CY 2014, health plans will be able to charge up to a 50% surcharge for smoking status.

Carrier ID	Avg Tobacco surcharge
A	1.50
B	1.42
C	1.39
D	1.35
E	1.30
F	1.30
G	1.24
H	1.20
I	1.20
J	1.28
Total	1.30

Table 10 – WI Individual Market CY09 Tobacco Adjustment by Carrier

We have observed that four carriers vary their tobacco surcharge based on age. This practice will not be allowed in CY 2014 as the tobacco adjustment cannot also adjust for age. Table 11 shows how the average tobacco adjustment generally increases for older members.

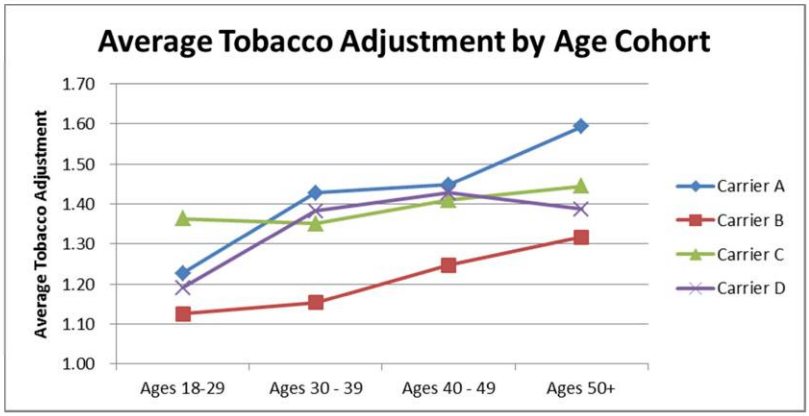

Table 11 – Tobacco Adjustment by Age Cohort

8. Geography

Most carriers apply a geography adjustment when setting premiums for the Individual Market. The table below shows the average rating adjustment by region across all carriers. As shown, Milwaukee and the Southeastern region premiums are surcharged and all other region's premiums are discounted. The highest surcharge is 1.07 or 7% and the lowest discount is 0.96 or -4%, resulting in an average geography rate band of approximately 1.12. We have also provided detailed data by county in Appendix II. Note that due to the small sample size, some of the counties will not show credible data.

Region	% Member Dist	Avg Geo. Adj.
Milwaukee	9.0%	1.07
Northeastern	22.6%	0.96
Northern	11.3%	0.99
Southeastern	21.6%	1.05
Southern	18.5%	0.98
Western	16.3%	0.99
Unknown	0.8%	0.83

Table 12 – WI Individual Market CY09 Geography Adjustment by Region

9. Health Underwriting

In 2014, carriers will not be able to health underwrite non-grandfathered business. Most carriers in the WI Individual Market today apply a health underwriting adjustment. The practice varies from carrier to carrier and takes many forms, such as applying new business discounts or applying durational adjustments. Some carriers classify individuals into risk groups when first applying for insurance using a medical questionnaire. Each risk group is then surcharged or discounted. Individuals at certain carriers stay within their risk class upon renewal, while other carriers may reevaluate the member's risk class each year. Those that do not use a health underwriting adjustment still health underwrite to accept or deny applicants. The table below estimates the health underwriting band that is used in the market today. Note that two carriers did not provide health status adjustments and are therefore not included. Only one carrier uses a Preferred Status adjustment, and this adjustment is included in Table 13. Since there are some outliers in the data approximately 0.5% of the lowest and highest adjustments were not included the health underwriting band. We have estimated that on average the highest rate is 1.77 times the lowest rate due to health underwriting. As shown, the band ranges by carrier from 1.18 to 2.41.

Carrier ID	Health UW Band
A	1.18
B	1.24
C	1.50
D	1.54
E	1.92
F	2.04
G	2.08
H	2.09
I	2.41
Total	1.77

Table 13 – WI Individual Market CY09 Health Underwriting Adjustment by Carrier

10. Spousal Adjustment

We believe that in CY 2014, for non-grandfathered business, carriers will no longer be able to apply a spousal discount. Six of the eleven carriers surveyed in the Individual Market apply a spousal discount. Table 14 shows the spousal discount for carriers that use this adjustment in their rating.

Carrier ID	Spousal Discount
A	-12.0%
B	-10.0%
C	-10.0%
D	-10.0%
E	-9.7%
F	-5.0%
Total	-8.5%

Table 14 – WI Individual Market CY09 Spousal Adjustment by Carrier

11. Exclusionary Riders

Four carriers also use exclusionary riders as a form of health underwriting. This is the practice of excluding certain benefits for a policy upon review of a health questionnaire. This practice will no longer be allowed in CY 2014. Approximately 6.5% of the market has an exclusionary rider attached to their policy. Of the four carriers that use exclusionary riders, approximately 16% of their members have riders associated with their policy. Table 15 shows the top 20 exclusionary riders for each carrier. Some common exclusionary riders across carriers appear to be back disorders, asthma, arthritis, and acne.

Exclusionary Rider Summary (Top 20)			
Carrier A	Carrier B	Carrier C	Carrier D
PSYCHIATRIC/PSYCHOLOGICAL DISORDERS -OP	Musculoskeletal Disorder	Any dysfunction, disorder or injury of the back, neck or spinal	ENTIRE SPINE
BACK DISORDERS	Migraine or Headaches	Asthma, to include exercise induced & seasonal asthma and COPD any	ALLERGY
ASTHMA/ALLERGY (Outpatient)	ACNE	Esophagitis, functional dyspepsia or indigestion, gastroesophageal	Asthma
Cholesterol/Lipids (Outpatient)	Herpes Simplex	Asthma with allergies, allergy shots and any complications,	ACNE, ACNE VULGARIS
Headaches	Arthritis, Osteoarthritis or R	High cholesterol, hypercholesterolemia, hyperlipidemia, elevated	ARTHRITIS, RHEUMATOID ARTHRITI
ACNE	Esophagitis or GERD	Allergies, hayfever, allergic rhinitis, seasonal allergies,	ASTHMA WITH ALLERGIES
CAESAREAN DELIVERY	Osteoporosis	Any disease or disorder of the fallopian tubes, ovaries, uterus	ESOPHAGITIS
Female Disorders	ADD/ADHD	Acne, acne vulgaris and any complications, treatment, medication,	MIGRAINE,CEPHALAGIA,TENSION,HE
Urinary Calculi (Stones)	Colon or Rectal Papiloma or Po	Migraine headaches, cephalgia, tension headaches, headaches and	FEMALE DISORDERS TO INCL ABNOR
ATTENTION DEFICIT DISORDER	Obesity	Any disease, dysfunction, disorder or injury of the left knee and	KNEE PROBLEM, RIGHT
PSYCHIATRIC/PSYCHOLOGICAL DISORDERS	Asthma	Herpes Simplex I, Type II, Herpes genitalis and any complications,	HERPES GENITALIS, HERPES SIMPL
BACK DISORDERS -- Outpatient	Cyst, Tumor or Neoplasm	Cataract of one or both eyes, total or partial loss of sight in	KNEE PROBLEM, LEFT
KNEE, Right	Uterine Fibroids or Leiomyomas	Any disease, dysfunction, disorder or injury of the right knee	CATARACT
KNEE, Left	Kidney or Ureteral Stone or Co	Arthritis, osteoarthritis, degenerative joint disease, or	SHOULDER PROBLEM, RIGHT
Upper Gastrointestinal Disorders	Internal fixation	Glaucoma, total or partial loss of sight of one or both eyes and	HYPERCHOLESTEROLEMIA, HYPERTRI
EARS	Spinal disc complications	Otitis media, infection in one or both ears and any complications,	Osteoporosis
Cervical Dysplasia or HPV	Temporomandibular Joint Syndro	Any residuals of the fracture of <name and location> and any	BREAST DISORDER
Endometriosis	Breast Implants	Any disease, dysfunction or injury of the left shoulder or upper	SHOULDER PROBLEM, LEFT
INFERTILITY - Obsolete	HEMORRHOIDS	Condylomata accuminata, genital warts, venereal warts, and any	GLAUCOMA
ARTHRITIS	Cataracts	Osteoporosis, osteopenia, any fractures related to osteoporosis or	DEAFNESS

Table 15 – Popular Exclusionary Riders by Carrier

Some carriers that do not use exclusionary riders may use a preexisting condition clause which requires a 12 month waiting period before coverage begins on a preexisting condition.

12. Financial Analysis

The MLR for the entire market is 81.4% which has increased from 77.1% in CY 2008. We define MLR as the ratio of incurred claims to billed premium and therefore it does not correspond exactly to the MLR definitions that HHS will be using for rebate purposes. However, it is a good measure to understand directionally the potential rebates that may be paid back to policyholders. (Generally, it is assumed that the MLR for rebate purposes would increase 2% to 5% from the MLR using the ratio of incurred claims to billed premium.) The table below shows an Incurred Claims PMPM (per member per month) for CY 2009 for the Wisconsin Individual Market. We define incurred claims as claims paid for services incurred in CY 2009. In addition, we show an Allowed Claims PMPM which is defined as incurred claims plus member cost sharing. In CY 2009, member cost sharing was $97.71 PMPM or 40% of total benefits offered.

WI Individual Market	CY 2009	CY 2008
Allowed Claims PMPM	$ 245.71	$ 230.74
Member Cost Sharing PMPM	$ 97.71	$ 94.29
Incurred Claims PMPM	$ 148.00	$ 136.45
Premium PMPM	$ 181.75	$ 176.87
MLR	0.814	0.771
Member Months	1,615,195	1,503,312

Table 16 – WI Individual Market MLR for CY09 and CY08

Table 17 shows the MLR by carrier with the carrier name obscured. As shown, MLR's range from 0.54 to 1.09 with the majority of carriers in the 0.70 to 0.90 range. Based on this analysis, we believe that the majority of carriers' MLRs will be greater than the 0.80 threshold defined in PPACA for rebate purposes. We also show the distribution of membership by the carrier's MLR in Table 18. This figure shows that 10.6% of the membership is enrolled in carriers that have MLR's lower than 0.70 and 5.6% of the membership are enrolled in carriers with MLRs greater than 1.00.

Carrier	CY 2009 MLR
A	0.75
B	0.82
C	0.82
D	0.85
E	0.54
F	0.75
G	1.07
H	1.09
I	0.68
J	0.89
K	0.71
Total	0.81

Table 17 – WI Individual Market Carrier CY09 MLR

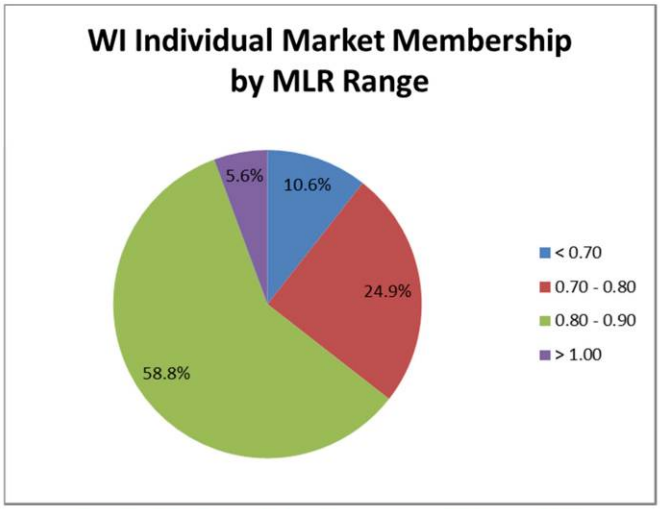

Table 18 – WI Individual Market Membership by MLR Range (CY09)

Table 19 and Table 20 display the MLR by region. Milwaukee has the lowest MLR, and is therefore cross subsidizing the Northern and Western regions, which have the higher MLR. The Northern and Western regions also happen to be the two regions with the higher average age. It is also interesting to note that the member cost sharing is highest for Milwaukee and Southeastern regions, both regions younger in age. In Table 21, we analyzed average deductible by region and show that members in Milwaukee are enrolled in plans with higher deductibles.

MLR and Percent of Individual Market Members by Region, 2009

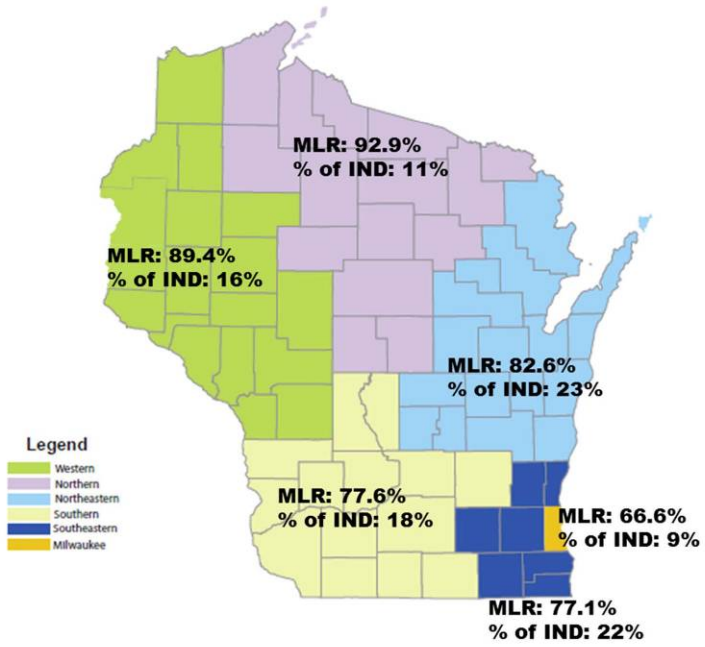

Table 19 – WI Individual Market CY09 MLR by Region

Region	% Member Dist	Incurred Claims PMPM	Allowed Claims PMPM	Member Cost Sharing PMPM	Premium PMPM	MLR
Milwaukee	9.0%	$ 123.15	$ 231.94	$ 108.79	$ 184.78	0.67
Northeastern	22.6%	$ 138.94	$ 237.24	$ 98.30	$ 168.14	0.83
Northern	11.3%	$ 182.61	$ 278.98	$ 96.37	$ 196.62	0.93
Southeastern	21.6%	$ 142.08	$ 254.42	$ 112.33	$ 184.18	0.77
Southern	18.5%	$ 145.70	$ 224.39	$ 78.68	$ 187.70	0.78
Western	16.3%	$ 160.22	$ 256.69	$ 96.48	$ 179.18	0.89
Unknown	0.8%	$ 117.19	$ 167.67	$ 50.48	$ 163.38	0.72
Total		$ 148.00	$ 245.71	$ 97.71	$ 181.75	0.81

Table 20 – WI Individual Market Geography CY09 MLR

Region	Average In-Network Deductible (Individual Policies)	Average In-Network Deductible (Family Policies)
Milwaukee	$ 3,009	$ 8,526
Northeastern	$ 2,898	$ 7,361
Northern	$ 2,753	$ 6,633
Southeastern	$ 2,993	$ 8,549
Southern	$ 2,545	$ 6,328
Western	$ 2,993	$ 7,538
Unknown	$ 2,740	$ 7,337
Total	$ 2,867	$ 7,501

Table 21 – WI Individual Market CY09 Geography Average Deductible

We performed a deeper dive into the distribution of claims by member for the WI Individual Market. Approximately 1% of the population accounts for 36% of total costs and 21% of the population accounts for 94% of total costs. Approximately 41% of the market did not incur any claims in 2009 as compared to 19% in the Maine Individual Market.[2] The Maine Individual Market's product portfolio is similar to Wisconsin's yet it is a guaranteed issue state. We show the distribution of claims for 2009 below. Some caveats need to be placed around this analysis. Most carriers have a calendar year deductible but some carriers have plan year deductibles and therefore the true distribution of claims may be skewed.

Allowable Claims	Cumulative Percent of Members	Cumulative Percent of Dollars	Average Claims per Member
$0	41%	0%	$0
$1 to $999	79%	6%	$345
$1,000 to $4,999	93%	21%	$2,196
$5,000 to $14,999	97%	38%	$8,544
$15,000 to $49,999	99%	64%	$26,426
$50,000+	100%	100%	$113,796
Total			$2,098

Table 22 – WI Individual Market CY09 Allowed Claims Distribution

We performed a similar analysis for the HIRSP population and show the results below. Since there is a provider subsidy, we summarized our data on the Usual & Customary

[2] Gorman Actuarial performed an analysis of the Maine Markets using CY 2005 data. The Maine Individual Market product portfolio is similar to Wisconsin but Maine is a guaranteed issue state with restrictive rating limitations.

field. This field represents what claims would have been paid in the Individual Market[3]. The average costs per member for HIRSP is almost 4.5 times as high as the average costs in the Individual Market. 9% of the population does not incur any claims (as compared to 41% in the Individual Market) and 9% of the population incurs costs greater than $50,000 in a given year (as compared to 1% in the Individual Market). It is interesting to note that while there are significantly more high cost claimants in the HIRSP, the intensity of claims is higher in the Individual Market for claimants with greater than $50,000 in claims.

Allowable Claims	Cumulative Percent of Members	Cumulative Percent of Dollars	Average Claims per Member
$0	9%	0%	$0
$1 to $999	33%	1%	$431
$1,000 to $4,999	65%	10%	$2,562
$5,000 to $14,999	84%	28%	$8,645
$15,000 to $49,999	91%	41%	$19,366
$50,000+	100%	100%	$59,775
Total			$9,324

Table 23 – WI HIRSP CY09 Allowed Claims Distribution

13. Product Analysis

The majority (77%) of the WI Individual Market is enrolled in PPO deductible/coinsurance plans. Cost sharing follows many forms and can include a mixture of deductibles, coinsurance charges, and copayments. Products can generally be grouped into the following four forms:

1. Copay Only Plans
2. Deductible Only Plans
3. Deductible and Coinsurance Only Plans
4. Hybrid Plans – A mixture of Deductibles, Coinsurance and Copays.

In addition, some plans that have deductibles may exclude preventive services from the deductible. These services may be covered at 100% or a copay charge is applied. Other plans exclude copay charges for preventive office visits. Generally, we found that the definition of preventive services from carrier to carrier is not consistent and is also difficult to find in the plan descriptions. Below are four descriptions we found. We did observe that all plans cover childhood immunizations at 100%.

[3] Per Discussions with Amie Goldman, the U&C field is comparable to the allowed claims in the Individual Market.

Preventive definition 1	Preventive definition 2	Preventive definition 3	Preventivie definition 4
Immunizations	Routine OV	child immunizatins birth to age 6	1 eye exam
Mammograms	Childhood immunizations	child immunizations 6 to 18*	1 hearing exam
Pap Smears	Urinalysis	Preventive ov*	immunizations up to age 6
PSA	Bone density screenings	Pap smear*	mammography
Vision and hearing exams	EKGs	Prostrate screening*	
up to $300 Benefit Maximum	Cardiac stress tests	Mammogram	
	Mammography screenings	Preventive lab and x-ray*	
	Cervical smears and pap smears		
	Prostate-specific antigen tests and digital rectal examinations		
		* up to 300 benefit maximum per CY	
		90 day waiting period	

Table 24 – WI Individual Market Preventive Services Benefit

Due to the inconsistency of the definition of preventive services, analyzing the existing preventive services benefit is complex. We did however ask two questions in our survey regarding preventive services. The first question was did the existing deductible apply to preventive services. Approximately, 97% of members have an in-network deductible of which 54% have their deductible apply to preventive services. The second question was if there was a copay applied to office visits, did the copay apply to preventive visits. Approximately 39% of members had an office visit copay of which 63% have their office visit copays apply to preventive visits.

The survey asked additional questions around lifetime maximums and annual maximums. A small percent of the market (0.7%) has an annual total dollar limit on all services that ranges from $100,000 to $250,000. Approximately 34% of the market does not have any lifetime maximum dollar limits and about 66% of the market has a lifetime limit of greater than $2 million.

Lifetime Max	% Distribution
None	34.0%
$100K-$250K	0.1%
$1M	0.4%
$2M	19.9%
$3M - $25M	45.6%

Table 25 – WI Individual Market CY09 Lifetime Maximum Distribution

We also analyzed the product design features. The table below shows average cost sharing amounts for the Individual Market. [4] For single policy contracts the average in-

[4] Generally, carriers have reported what the Single Policy Deductible and Out of pocket maximum is for Family policies. As such for these carriers, we have multiplied what is reported by 2 as our best proxy for family deductibles and family out of pocket maximums.

network deductible is $2,867 and for family policy contracts it is $7,501. The average out of pocket maximum is $4,191 for single policies and $10,149 for family policies. We estimate the average actuarial value for the entire WI to be approximately 0.67.

	Single Contract	Family Contract
In-Network Ded	$ 2,867	$ 7,501
OV Copay	$ 32	$ 33
Coinsurance	22%	22%
OOP Max	$ 4,191	$ 10,149
Generic Copay	$ 15	$ 14
Brand/Formulary Copay	$ 31	$ 30
Non-Formulary Copay	$ 54	$ 53
Specialty Copay	$ 48	$ 43

Table 26 – WI Individual Market CY09 Average Cost Sharing by Single and Family Policies

In CY 2014, we believe that the limit on out of pocket expense will be around $5,950 for single policies and $11,900 for family policies. We believe these limits will be indexed to 2014 however it is unclear by how much. The next few tables show distributions of deductibles and average out of pocket maximums. There are 50 to 60 deductible levels in the market today. We have summarized these levels into ranges. As shown, 39% of single policies have deductibles greater than $2,500. It is interesting to note that the average age seems to be increasing as the deductible increases. This may be due to older demographics "buying down" given the higher surcharges at the older ages. For family policies, we estimate that 53% of the families have deductibles greater than $5,000.

Single Policies				
Deductible	% Distribution	Avg Deductible	Average Age	Avg OOP Max
0	2.3%	$0	37	$0
$1 to $500	8.4%	$444	33	$2,546
$501 to $1000	14.7%	$989	35	$2,759
$1001 to $1500	10.2%	$1,451	37	$2,426
$1501 to $2000	5.0%	$1,967	41	$2,903
$2001 to $2500	20.3%	$2,494	39	$4,279
$2501 to $3000	7.6%	$2,916	44	$3,321
$3001 to $3500	3.2%	$3,500	44	$3,815
$3501 to $5000	22.1%	$4,963	45	$6,169
$5001+	6.3%	$6,964	45	$7,698

Table 27 – WI Individual Market CY09 Single Policy Deductible Analysis

Family Policies				
Deductible	% Distribution	Avg Deductible	Average Age	Avg OOP Max
0	3.1%		26	
$1 to $1000	5.0%	$906	26	$4,990
$1001 to $2000	10.4%	$1,990	29	$5,744
$2001 to $3000	6.7%	$2,892	29	$4,512
$3001 to $4000	5.4%	$3,972	30	$5,918
$4001 to $5000	16.7%	$4,930	32	$8,576
$5001 to $6000	10.5%	$5,376	31	$7,094
$6001 to $7000	2.5%	$7,000	32	$7,933
$7000 to $10000	21.1%	$9,580	33	$12,870
$10000+	18.7%	$14,518	33	$17,660[5]

Table 28 – WI Individual Market CY09 Family Policy Deductible Analysis

Also, many members do not have a pharmacy benefit. Approximately, 21% of the membership does not purchase the pharmacy benefit. The table below shows financial information on members that have the pharmacy benefit as compared to members that do not. Claims differential on an allowed basis is approximately 15%, however, the premium differential is minimal.

	Allowed Claims PMPM	Incurred Claims PMPM	Premium PMPM	MLR	Avg Age	Avg INDed
No RX Benefit	$ 221.64	$ 152.14	$ 179.51	0.85	37.0	$ 3,141
RX Benefit	$ 253.13	$ 146.72	$ 182.45	0.80	34.6	$ 3,311

Table 29 – WI Individual Market CY09 Pharmacy Analysis

We also reviewed the pharmacy benefit in the market and found a lot of variability. Approximately 49% of members have pharmacy copays and approximately 10 to 30% of members (depending on tier) have separate pharmacy deductibles and coinsurance charges. Finally some plans first apply the medical deductible to pharmacy benefits prior to charging a copay.

In the Wisconsin Individual Market, the maternity benefit is a rider and it is not offered with the standard plan. In 2009, approximately 2% of the overall market and 3.5% of the Female age 18-49 market had the maternity rider. A review of the rate filings indicate

[5] Gorman Actuarial estimated deductibles and out of pocket maximums for Family Policies by taking reported information and multiplying by two. Reported information is for corresponding Single policies. Deductibles and OOP Maximums

that the maternity benefit can double the existing premium. We also looked at the premium PMPM for women who did not purchase the maternity rider ages 18 to 49 and compared it to the premium PMPM of those women who had the maternity rider. Those who did not purchase the rider had an average premium PMPM of $140, while those who purchased the rider had an average premium of $244. This represents a 74% increase in cost.

In our review of the summary of benefits, it came to our attention that most plans do not cover behavioral health in the individual market. We did not collect data on this in our survey.

The definition of Essential Benefits has yet to be defined. However, it is likely that pharmacy, maternity and behavioral health benefits will be included. This more comprehensive health coverage may increase premium 10 to 20%.

14. Conclusions

The Wisconsin Individual Market is complex. Rating practices and product portfolios vary widely across the market. This made analyzing the market challenging and several assumptions were made to simplify the analysis process. However it is clear that the changes that will occur in CY 2014 will have implications to the market. Many of the rating practices that are in existence today will no longer be allowed. This increases the cross subsidies across demographics and health status. More importantly, many of the product offerings will no longer be allowed which will increase premiums while providing more comprehensive coverage. Finally, the demographics and cost distribution of the HIRSP population will increase the overall pool costs if they are merged into the Individual Market.

15. Appendices

Appendix I – List of Surveyed Carriers

Gorman Actuarial surveyed 12 entities for the Wisconsin Individual Market Data. They were:

1. **Assurant**
2. **Physicians Plus**
3. **Anthem Blue Cross and Blue Shield (BCBS)**
4. **Security**
5. **Compcare**
6. **Unity**
7. **Dean**
8. **WPS Ins. Corp.**
9. **Golden Rule**
10. **WPS Health Plan Inc**
11. **Humana**
12. **HIRSP**

Appendix II – Region Definition by County

Milwaukee	Northeastern	Northern	Southeastern	Southern	Western
Milwaukee	Brown	Ashland	Jefferson	Adams	Barron
	Calumet	Bayfield	Kenosha	Columbia	Buffalo
	Door	Florence	Ozaukee	Crawford	Burnett
	Fond du Lac	Forest	Racine	Dane	Chippewa
	Green Lake	Iron	Walworth	Dodge	Clark
	Kewaunee	Langlade	Washington	Grant	Douglas
	Manitowoc	Lincoln	Waukesha	Green	Dunn
	Marinette	Marathon		Iowa	Eau Claire
	Marquette	Oneida		Juneau	Jackson
	Menominee	Portage		Lafayette	La Crosse
	Oconto	Price		Richland	Monroe
	Outagamie	Sawyer		Rock	Pepin
	Shawano	Taylor		Sauk	Pierce
	Sheboygan	Vilas		Vernon	Polk
	Waupaca	Wood			Rusk
	Waushara				St. Croix
	Winnebago				Trempealeau
					Washburn

Appendix III – MLR by County

The counties highlighted in red have less than 5,000 member months, and therefore the reported MLR is not credible.

Region	Members	Member Months	Premium	Allowed Claims	Incurred Claims	Avg. Geo Adjustment	MLR
Adams	399	3376	$ 665,387	$ 709,339	$ 413,660	1.00	0.62
Ashland	635	5595	$ 1,051,303	$ 1,380,548	$ 872,049	0.95	0.83
Barron	2192	18772	$ 3,421,401	$ 5,035,246	$ 3,230,481	1.01	0.94
Bayfield	639	5628	$ 1,127,937	$ 1,435,932	$ 869,364	0.95	0.77
Brown	8373	72761	$ 11,693,392	$ 14,965,658	$ 9,151,100	0.96	0.78
Buffalo	824	6785	$ 1,342,548	$ 1,644,623	$ 951,180	1.00	0.71
Burnett	620	5706	$ 1,166,502	$ 1,438,263	$ 784,765	0.98	0.67
Calumet	1345	12069	$ 2,091,882	$ 2,981,375	$ 1,649,697	0.96	0.79
Chippewa	2630	22702	$ 4,203,746	$ 6,067,702	$ 3,734,840	1.00	0.89
Clark	2007	19145	$ 3,869,347	$ 6,986,463	$ 5,478,776	1.00	1.42
Columbia	2135	18470	$ 3,608,348	$ 4,488,419	$ 3,035,847	0.99	0.84
Crawford	658	5702	$ 1,041,392	$ 1,049,718	$ 685,922	0.97	0.66
Dane	14069	119658	$ 22,386,942	$ 23,837,823	$ 15,982,876	1.00	0.71
Dodge	3056	26356	$ 4,755,746	$ 6,564,776	$ 4,160,108	1.00	0.87
Door	2328	21906	$ 4,126,196	$ 5,558,206	$ 3,342,852	0.98	0.81
Douglas	977	8655	$ 1,702,761	$ 2,191,690	$ 1,158,139	0.95	0.68
Dunn	1581	13103	$ 2,259,404	$ 3,484,982	$ 2,316,426	1.00	1.03
Eau Claire	3274	27041	$ 4,602,374	$ 6,382,619	$ 3,838,417	1.01	0.83
Florence	122	1089	$ 238,603	$ 198,713	$ 126,271	0.96	0.53
Fond du Lac	3307	27156	$ 4,708,783	$ 7,541,713	$ 4,401,058	0.95	0.93
FORFST	224	2142	$ 511,035	$ 449,805	$ 250,353	0.95	0.49
Grant	2804	24133	$ 4,476,268	$ 4,825,158	$ 2,649,925	0.96	0.59
Green	1577	14600	$ 2,755,260	$ 3,632,440	$ 2,277,694	0.99	0.83
Green Lake	863	7420	$ 1,440,709	$ 2,352,902	$ 1,332,198	0.96	0.92
Iowa	1078	9762	$ 1,903,043	$ 1,621,223	$ 963,638	0.97	0.51
Iron	275	2484	$ 492,308	$ 533,898	$ 313,568	0.95	0.64
Jackson	736	6345	$ 1,177,924	$ 2,319,178	$ 1,691,444	0.97	1.44
Jefferson	2576	22578	$ 4,048,064	$ 4,888,691	$ 3,141,063	0.99	0.78
Juneau	882	7469	$ 1,460,862	$ 3,164,986	$ 2,355,177	0.97	1.61
Kenosha	3583	29382	$ 5,638,988	$ 9,080,239	$ 4,904,812	1.06	0.87
Kewaunee	1108	9360	$ 1,561,898	$ 2,384,087	$ 1,368,566	0.97	0.88
La Crosse	3044	25206	$ 4,312,904	$ 5,471,738	$ 3,603,148	0.99	0.84
Lafayette	964	8153	$ 1,586,745	$ 1,930,550	$ 1,035,768	0.95	0.65
Langlade	931	8199	$ 1,484,487	$ 2,294,313	$ 1,425,820	0.99	0.96
Lincoln	1007	8798	$ 1,815,197	$ 2,599,979	$ 1,762,868	1.00	0.97
Manitowoc	2920	24562	$ 4,133,528	$ 5,994,337	$ 3,116,377	0.96	0.75
Marathon	4884	42642	$ 8,166,583	$ 10,788,947	$ 6,856,909	1.00	0.84
Marinette	1638	14412	$ 2,593,703	$ 6,859,622	$ 4,871,164	0.96	1.88
Marquette	622	5311	$ 1,114,832	$ 947,614	$ 521,889	0.98	0.47
Menominee	21	238	$ 44,158	$ 314,868	$ 209,568	1.01	5.83
Milwaukee	17045	136872	$ 25,291,241	$ 31,745,785	$ 16,855,464	1.07	0.67
Monroe	1609	13151	$ 2,212,620	$ 2,981,929	$ 1,890,942	0.99	0.85
Oconto	1521	13460	$ 2,363,683	$ 3,102,129	$ 1,815,058	0.95	0.77
Oneida	2143	19618	$ 3,919,747	$ 5,250,709	$ 3,463,744	0.99	0.88
Outagamie	6412	54373	$ 7,693,291	$ 10,726,606	$ 6,009,578	0.93	0.78
Ozaukee	4545	39184	$ 7,523,938	$ 10,167,725	$ 5,490,228	1.04	0.73
Pepin	327	4601	$ 924,854	$ 1,542,401	$ 981,451	1.00	1.06
Pierce	2102	17515	$ 3,022,062	$ 3,457,029	$ 1,831,791	0.97	0.61
Polk	1962	16894	$ 3,010,668	$ 4,392,465	$ 2,361,251	0.99	0.78
Portage	2414	21173	$ 3,898,620	$ 7,369,793	$ 4,875,098	0.99	1.25
Price	593	5781	$ 1,259,375	$ 2,157,385	$ 1,460,101	0.97	1.16
Racine	4679	39887	$ 7,402,381	$ 10,600,232	$ 6,071,903	1.05	0.82
Richland	494	4103	$ 844,665	$ 1,160,953	$ 787,961	0.99	0.93
Rock	3014	25444	$ 4,575,025	$ 6,494,081	$ 4,089,233	0.95	0.89
Rusk	551	4861	$ 1,028,370	$ 1,458,858	$ 937,711	1.01	0.91
Saint Croix	3996	32276	$ 4,923,665	$ 7,068,054	$ 3,818,097	0.96	0.78
Sauk	2606	22401	$ 4,232,727	$ 5,679,701	$ 3,930,845	0.98	0.93
Sawyer	983	8622	$ 1,770,934	$ 3,206,047	$ 2,018,100	0.97	1.14
Shawano	1493	13073	$ 2,344,514	$ 2,730,718	$ 1,662,376	0.95	0.71
Sheboygan	3436	28462	$ 5,052,466	$ 5,844,486	$ 3,130,769	1.02	0.62
Taylor	1279	11638	$ 2,042,330	$ 2,845,249	$ 1,946,792	0.99	0.95
Trempealeau	1436	11877	$ 2,329,331	$ 3,132,248	$ 2,041,648	1.00	0.88
Vernon	1182	9825	$ 1,914,992	$ 2,033,743	$ 1,262,928	0.98	0.66
Vilas	1606	14847	$ 3,173,594	$ 4,271,494	$ 2,765,124	1.00	0.87
Walworth	4010	34831	$ 6,464,821	$ 11,443,200	$ 6,603,595	1.04	1.02
Washburn	809	6933	$ 1,357,969	$ 2,087,225	$ 1,257,296	0.98	0.93
Washington	4977	41769	$ 7,663,995	$ 9,350,364	$ 4,841,197	1.05	0.63
Waukesha	16436	139545	$ 25,200,076	$ 32,796,667	$ 18,275,620	1.06	0.73
Waupaca	2267	19709	$ 3,639,046	$ 4,009,494	$ 2,266,269	0.96	0.62
Waushara	751	6573	$ 1,274,099	$ 1,559,628	$ 809,024	0.96	0.63
Winnebago	4313	36809	$ 5,939,005	$ 9,425,948	$ 5,422,888	0.95	0.91
Wood	3606	33051	$ 6,662,251	$ 8,588,052	$ 5,927,967	1.00	0.89
Total WI	**187,705**	**1,603,949**	**$ 291,728,850**	**$ 394,983,780**	**$ 237,728,824**	**1.00**	**0.81**

Appendix H Small Group Market Report

Market Summary of Wisconsin's Small Group Health Insurance Market

Prepared for the Wisconsin Department of Health Services

November 30, 2010

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Table of Contents

List of Tables

1. Introduction

With the passing of the Patient Protection and Affordable Care Act of 2010 (PPACA), states will be assessing the impact of various components of the law on their insured markets. The Wisconsin Department of Health Services has commissioned Gorman Actuarial and Dr. Jon Gruber to assess the impact of PPACA on the Wisconsin (WI) insured markets. The first phase of this analysis, performed by Gorman Actuarial, is to understand the market landscape of the existing privately insured markets. This report focuses on the Small Group Market and is the second of a series of reports that will be produced.

2. Key Findings

The Wisconsin Small Group Market has an estimated 332,000 members and 170,000 subscribers as of December 31, 2009. There were approximately 25,000 small groups as of December 31, 2009. Membership and group enrollment has declined approximately 14% since CY 2007. However, we also observed this level of membership decline when performing a similar study on the Wisconsin market two years ago. In addition, due to the economy, CY 2008 was a difficult year across the country, with insurance carrier financials deteriorating and membership declining. Most of our findings validated our initial work in CY 2007. We also discovered some interesting relationships between this analysis and our analysis of the WI Individual Market. We have highlighted some of these key findings below.

- The Small Group Market appears slightly more fragmented than the Individual Market with a large number of carriers with smaller amounts of market share and a few dominant players.
- The average age of the Small Group Market is 33, only slightly younger than the Individual Market at age 35.
- Approximately 55% of the market is enrolled in single policies as compared to 70% of the Individual Market.
- As expected, there is variability in pricing for this market. However, the rating formulae among carriers seem to be slightly more consistent as compared to the Individual Market.
- The medical loss ratio (defined as incurred claims divided by billed premium) in CY 09 was 82.0%, an increase of four basis points since CY 07.
- 23% of the Small Group Market did not incur any claims in CY 09 as compared to 41% of the Individual Market.
- Small Group average claims costs per member appear to be higher than the Individual Market.

- The average single policy deductible is estimated at $1,522 and family policy deductible at $3,200, nearly half the average in the Individual Market. We have estimated the average actuarial value to be 0.76.

3. Methodology

After conducting phone calls with all of the carriers, Gorman Actuarial (GA) developed a survey instrument that would capture data for each member in the Small Group Market. The carriers were given four to ten weeks to deliver data. A list of carriers that participated in this study is found in Appendix I. GA has estimated that the carriers surveyed represent approximately 73% of the total Wisconsin Small Group Market. This was estimated using OCI premium and group member surveys. Due to the complexity of the market, some carriers had difficulty providing information in the format required. Some common issues included multiple member records within one dataset, incorrect premium reporting and incorrect plan design reporting. Two carriers did not provide member level data and only provided group level detail. There was a considerable amount of communication between GA and the carriers to ensure that GA was interpreting the information received correctly. As a result, some carriers had to supply supplementary data sets. Once the data sets were "scrubbed", a master database was developed which combined all the carrier data sets into a single database for the Small Group Market. This database along with additional information from the carriers (e.g. plan summary descriptions, rating factors and rating methodology) was used to perform this analysis.

We define "carrier" as a separate legal entity. For example, we treated BCBSWI and Compcare as two different carriers. Throughout this report we have obscured each carrier's identity so that data associated with a particular carrier cannot be identified. We use labels such as "Carrier A", "Carrier B", etc. Note that the carrier labels are not consistent throughout the report. This is done intentionally so that a carrier's identity may not be discerned.

4. Market Demographics

For CY 2009, we estimate that there were approximately 332,000 members and 170,000 subscribers in the Small Group Market. We estimate there were approximately 25,000 employer groups.[1] This has decreased since CY 2007 where GA had estimated member enrollment to be 380,000. However, this membership decline is consistent with GA's understanding of the market. GA had observed declining membership in this market in the 2007 study. As shown in the table below, the Small Group Market appears to be dominated by a few carriers, with one carrier having 30% of the market share.

[1]Based on OCI premium and group enrollment surveys, GA has estimated that it has collected data from approximately 73% of the market. Numbers shown are adjusted to reflect this. In addition, there are inconsistencies in the data submitted by the carriers surveyed. Two carriers provided GA snapshot data as of July 31, 2009, whereas other carrier snapshot data was as of 12/31/2009.

Carrier	Small Group Member Distribution
A	30%
B	11%
C	9%
D	6%
E	4%
F	3%
G	3%
H	3%
I	2%
J	1%
K	1%
Other	27%
Total	100%

Table 1 – WI Small Group Market CY09 Member Distribution by Carrier

We analyzed the age/gender demographics of the Small Group Market. Table 2 shows that the largest adult cohort is between the ages of 45 and 49. Also, 47% of the market is female and the overall average age is 33. We have also compared the age distributions of the Small Group and Individual Markets, as shown in Table 3 and Table 4. Approximately 26% of the population is children as compared to 19% of the Individual Market. Approximately 22% of the Small Group Market is over the age of 50 as compared to 28% for the Individual Market. The Small Group Market is slightly younger (age 33) as compared to the Individual Market (age 35).

	% Distribution		
Age Cohort	F	M	Total
0-17	12.8%	13.1%	25.8%
18-24	3.8%	4.9%	8.8%
25-29	3.4%	4.6%	8.1%
30-34	3.4%	4.3%	7.7%
35-39	3.6%	4.3%	7.9%
40-44	4.3%	4.9%	9.2%
45-49	4.9%	5.5%	10.3%
50-54	4.4%	5.0%	9.4%
55-59	3.4%	3.7%	7.1%
60-64	2.2%	2.3%	4.5%
65+	0.5%	0.7%	1.2%
Total	46.6%	53.4%	100%

Table 2 – WI Small Group CY09 Age Gender Distribution

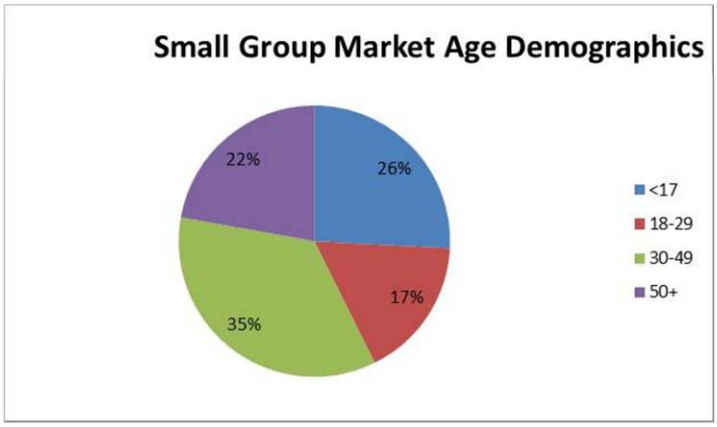

Table 3 – WI Small Group Market CY09 Age Demographics

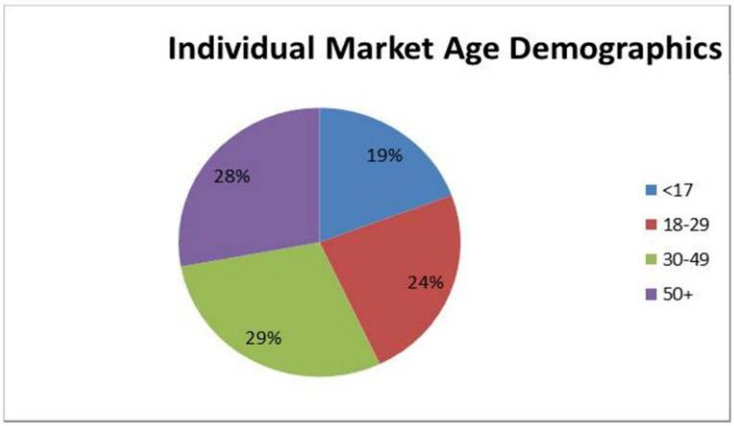

Table 4 – WI Individual Market CY09 Age Demographics

We also analyzed the distribution of contracts by tier type. As shown, 55% of the total Small Group contracts were single policies as compared to 70% of the Individual Market. The average contract size is 1.97 for Small Group as compared to 1.62 for the Individual Market.

Total Contracts	
Single	55.2%
Dual	10.3%
Employee +Child(ren)	11.0%
Family	23.6%

Table 5 – WI Small Group Market CY09 Tier Distribution

We performed a geography analysis using two methodologies, one using the member location and the other using the employer group location. Table 6 is the member distribution by region using member location.

Region	% Member Distribution
Milwaukee	14.4%
Northeastern	21.8%
Northern	8.5%
Southeastern	29.9%
Southern	17.9%
Western	3.8%
Unknown	3.8%
Total	100%

Table 6 – WI Small Group Market CY09 Geography Distribution (Member Location)

Table 7 shows member distribution by region using employer group location[2]. The regions are defined using the county associations shown in Appendix II. These region definitions are the same as those used by the Wisconsin Department of Health Services, except that we have assigned Milwaukee County to its own region. As shown, nearly 30% of members are employed at groups in the Southeastern region. Also interesting to note is that only 3.8% of Small Group Members live in the Western region as compared to 16.3% of the Individual Market.

[2] Included in the Unknown category are those employer groups that are not in Wisconsin, which are approximately 0.3% of both the member and group distribution.

Region	% Member Distribution	% Group Distribution
Milwaukee	17.6%	15.7%
Northeastern	20.7%	19.8%
Northern	8.2%	8.4%
Southeastern	29.9%	26.5%
Southern	16.8%	18.4%
Western	3.1%	4.2%
Unknown	3.7%	7.1%
Grand Total	100%	100%

Table 7 – WI Small Group Market CY09 Geography Distribution (Group Location)

We also analyzed the distribution of groups by Group Size. The average group size is approximately 7 employees per group. Groups with less than 5 employees represent an estimated 54% of all small employers[3].

Group Size	% Distribution of Groups	% of Members	Avg Group Size by EE
<5	53.8%	19.4%	2.9
6 to 9	19.4%	16.7%	7.3
10 to 25	21.2%	39.4%	15.1
26 to 50	2.2%	24.5%	33.9

Table 8 – WI Small Group Market CY09 Group Size Distribution

5. Market Pricing

The current definition of the Small Group Market in Wisconsin is defined as two to fifty employees. Note that PPACA defines the Small Group Market as one to fifty employees. Therefore in CY 2014, sole proprietors or self-employeds will no longer be able to purchase insurance through the Individual Market. In today's market, health plans are allowed to adjust premium rates for health status and other case characteristics such as age, gender, geography, and case size. Rating restrictions exist for the health status adjustment in that rates cannot vary by +/-30% of the midpoint for policies with similar "case characteristics" and benefits. In addition, upon renewal, health status adjustments cannot increase by more than 15%. There are no rate restrictions for adjustments to the rate for other case characteristics. The result is that surcharges and discounts to rates due

[3] Average Group Size was calculated using a subset of our data. One carrier did not supply employee count by employer group. Also, employer groups with greater than 50 employees are reported in the 26 to 50 segment.

to these case characteristics beyond health status adjustments are limitless and therefore there is a wide variation in rates.

Today, premium rates in the Wisconsin Small Group Market are quite variable. This is primarily due to the relaxed rating rules within the state. The rating formula among carriers in the Small Group market is slightly more consistent than the rating formula in the Individual Market. The table below shows a summary of rating variables used by the carriers in the Small Group Market.

Carrier	Age/Sex	Geography	SIC	Health Status	Group Size	Duration	List Bill Part of Market
A	x		x	x	x		
B	x	x	x	x	x		
C	x	x		x	x		x
D	x	x		x	x		
E	x	x		x	x		
F	x	x		x	x		
G	x	x		x	x		x
H	x	x		x	x		x
I	x	x	x	x	x	x	
J	x	x	x	x	x		
K	x	x		x	x		

Table 9 – WI Small Group Market Rating Methodologies

As shown, out of the eleven carriers surveyed, all use an age/gender adjustment, health status adjustment and group size adjustment. All but one carrier uses a geography adjustment. Four carriers use an industry (SIC) adjustment and one carrier noted that they use a duration adjustment (adjustment to the policy rate based on policy duration). The health status, SIC, and duration adjustment are combined to calculate a "total" health status adjustment. This "total" health status adjustment must be within +/-30% of the midpoint of policies with similar case characteristics. Most carriers use a combination of medical underwriting, claims experience, and risk adjustment tools to calculate the health status adjustment.

Most carriers charge different rates by group size. Group size definitions vary across carriers. To capture group size surcharges, we have defined them as:

- Less than or equal to 5
- 6 to 9
- 10 to 25
- 26 to 50[4]

[4] Employer groups with greater than 50 employees are reported in the 26 to 50 segment

All carriers except one charge a geography adjustment, however some carriers calculate an adjustment based on where the employer is located and others calculate an adjustment based on where the member or employee receives care.

Finally, three carriers "list bill" a portion of their small group business. List billing is a method of calculating premiums for each individual subscriber taking all demographic characteristics into consideration. This contrasts to a group composite premium calculation, where the demographic characteristics of all subscribers within an employer group are averaged. Generally, when carriers list bill, premiums will reflect real time enrollment each month. For group composite premiums, premium rates are fixed until the next anniversary of the group. While list billing is more accurate and mitigates rate shocks for an employer, it is also more complex to administer.

6. Age/Gender Rating

All carriers currently use age and gender rating when setting policy premiums.
In 2014, for non-grandfathered plans, carriers will no longer be allowed to gender rate and age adjustments will need to be within a 3 to 1 band for adults. Note that we believe this means that the 3 to 1 age band restriction applies to the member age factors, rather than the composite group age factors. Generally, for younger ages, male age adjustments are lower than female age adjustments. For older ages, the opposite holds true, where male age adjustments are higher than female age adjustments. We have observed spreads to be quite wide between the female and male factors, as much as 30% to 40%.

Currently, in the WI Small Group Market, the age/gender band varies by carrier. We have estimated the charged age/gender band in the market using 2009 data by carrier. We have calculated this charged band by comparing composite group age/gender adjustments. The overall average age/gender band in practice in the Small Group Market is 7.3. That is, due to age and gender, the premium rates charged an employer can be 7.3 times higher than the lowest premium rate. This is consistent with the results from the CY 2007 study where the overall average age/gender band was 7.0. In CY 2009 the age/gender bands by carrier range from as low as 4.9 to as high as 10.5. There is more variation in the bands by carrier and the bands are larger in the WI Small Group Market compared to the experience from the CY 2009 WI Individual Market analysis where the overall age band was 5.1.

Carrier	Age/Sex Band
A	6.8
B	7.9
C	9.1
D	7.6
E	10.5
F	6.0
G	4.9
H	7.2
I	6.0
J	7.6
K	8.1
Overall Average	**7.3**

Table 10 – WI Small Group Market CY09 Charged Age/Gender Bands by Carrier

7. Geography Rating

All carriers except one apply a geography adjustment when setting premiums for the WI Small Group Market. The table below shows the average rating adjustments by region across all carriers. Note that the rating region is defined based on the employer's location. As shown in the table below, the Milwaukee, Southeastern and Western region premiums are surcharged while the Northern and Northeastern region's premiums are discounted. The highest average surcharge of 1.02 occurs in the Western region, but note that this is the smallest region in WI and only six out of the eleven carriers surveyed provide small group coverage in this region. We have also compared the average rating factors in CY 2009 to CY 2007 in the table below. While the regions with surcharges or discounts remain consistent, the magnitude of the surcharges or discounts in CY 2009 is less than the surcharges and discounts in CY 2007. This change is largely driven by one carrier whose geography factors appear to have changed significantly over the time period analyzed.

Region	Average Geographic Factor CY 2009	Average Geographic Factor CY 2007
Milwaukee	1.01	1.09
Northeastern	0.98	0.86
Northern	0.99	0.97
Southeastern	1.01	1.05
Southern	1.00	0.99
Western	1.02	0.99
Unknown	1.01	1.01
Total	**1.00**	**1.00**

Table 11 – WI Small Group Market CY09 Geography Adjustment by Region

The overall average geography rating band is 1.5 which is consistent with the geography rating band from the CY 2007 study of 1.6. Note that unlike the age/gender adjustments, there is less variation in the geography rating in the WI Small Group Market as compared to the WI Individual Market.

Table 12 shows all of the rating factors analyzed by region. The Milwaukee region has the highest age/gender rating factors and highest health underwriting rating factors, not counting the "Unknown" region which has a relatively small portion of the membership. Overall, the Milwaukee region is surcharged 8% on average while the Northern region is discounted 5% on average.

Region	Average Geography Factor	Average Age/Gender Factor	Average Health Status Factor	Average Group Size Factor	Overall Average Rating Factor
Milwaukee	1.01	1.02	1.04	1.00	1.08
Northeastern	0.98	0.99	0.99	1.00	0.96
Northern	0.99	1.00	0.97	1.00	0.95
Southeastern	1.01	0.99	1.00	1.00	1.00
Southern	1.00	1.00	1.00	1.00	1.00
Western	1.02	1.00	0.97	1.00	0.99
Unknown	1.01	0.90	1.07	0.99	0.97
Total	1.00	1.00	1.00	1.00	1.00

Table 12 – WI Small Group Market CY09 Rating Factors by Region

8. Health Underwriting

In 2014, carriers will not be able to health underwrite non-grandfathered business. All carriers in the WI Small Group Market today apply a health underwriting adjustment. The practice varies from carrier to carrier and takes many forms, such as applying new business discounts or applying durational adjustments. Some carriers administer medical health questionnaires for new business and then use claims experience and/or risk adjustment tools to calculate health status adjustments on renewal. After removing some outliers, we found that all carriers rate within the 1.857 band as required by law. The table below shows the distribution of members and groups by different health status ranges. Note that approximately 63% of members and 59% of the groups are currently rated with a health status factor less than 1.0.

Health Status Factor Range	% Member Distribution	% Group Distribution	Average Health Status Factor
Less than 0.85	20.3%	22.7%	0.82
0.85 to 0.94	30.4%	26.0%	0.90
0.95 to 1.04	20.1%	17.7%	0.99
1.05 to 1.14	10.9%	10.9%	1.10
1.15 to 1.24	6.7%	7.1%	1.20
Greater than or equal to 1.25	11.7%	15.6%	1.38
Total	100.0%	100.0%	1.00

Table 13 – WI Small Group Market CY09 Health Status Factors

Four carriers also industry rate, of which two provided industry specific factors by group. The industry rating band for these two carriers is 1.2. The remaining two carriers stated that their industry factors were included within the health underwriting factors.

9. Group Size Adjustment

All carriers charge a group size adjustment. In 2014, carriers will not be able to apply a group size adjustment to premiums of non-grandfathered business. The overall average rating band for group size in CY 2009 is 1.2 which is consistent with the rating band from CY 2007 of 1.3. The average group size adjustment decreases as the group size increases as shown in the table below. These average factors are also consistent with the results from CY 2007.

Group Size	Average Group Size Factor CY 2009	Average Group Size Factor CY 2007
less than or equal to 5	1.04	1.05
6 to 9	1.01	0.99
10 to 25	0.99	0.98
26 to 50	0.98	0.98
Total	1.00	1.00

Table 14 – WI Small Group Market CY09 Group Size Factors

We also found that across carriers, the smaller group sizes have higher age/gender adjustments and higher health status adjustments. The table below shows the various rating factors by group size. Overall, the groups with less than five employees are surcharged 12% on average compared to the groups with 26 to 50 employees[5] that are discounted 7% on average.

[5] Employer groups with greater than 50 employees are reported in the 26 to 50 segment

Group Size	Average Group Size Factor	Average Age/Gender Factor	Average Health Status Factor	Average Geography Factor	Overall Average Rating Factor
less than or equal to 5	1.04	1.06	1.02	1.00	1.12
6 to 9	1.01	0.99	1.01	1.00	1.02
10 to 25	0.99	0.99	1.00	1.00	0.97
26 to 50	0.98	0.98	0.97	1.00	0.93
Total	1.00	1.00	1.00	1.00	1.00

Table 15 – WI Small Group Market CY09 Adjustments

10. Financial Analysis

The MLR for the entire Small Group Market for CY 2009 is 82.0% which has increased from 78.3% in CY 2007. We define MLR as the ratio of incurred claims to billed premium and therefore it does not correspond exactly to the MLR definitions that HHS will be using for rebate purposes. However, it is a good measure to understand directionally the potential rebates that may be paid back to policyholders. (Generally, it is assumed that the MLR for rebate purposes would increase 2% to 5% from the MLR using the ratio of incurred claims to billed premium.) The table below shows financial information from CY 2007 through CY 2009 for the Small Group Market. We define CY 2009 incurred claims as claims paid for services incurred in CY 2009. As shown, the MLR has increased almost four basis points from CY 2007 to CY 2009. The biggest increase in MLR took place from CY 2007 to CY 2008.

	CY 07	CY 08	CY 09
Premium PMPM	$ 307.41	$ 322.56	$ 339.57
Incurred Claims PMPM	$ 240.77	$ 263.90	$ 278.53
MLR	0.783	0.818	0.820
Premium Yield		4.9%	5.3%
Claims Trend		9.6%	5.5%

Table 16 – WI Small Group Market MLR for CY09 and CY08

Table 17 shows the MLR by carrier with the carrier name obscured. As shown, MLR's range from 0.76 to 0.89 with only one carrier having an MLR less than 0.80. Based on this analysis, we believe that most carriers' MLRs will be greater than the 0.80 threshold defined in PPACA for rebate purposes. We also show the distribution of membership by the carrier's MLR in Table 18. This figure shows that 0.9% of the membership is enrolled in carriers that have MLR's lower than 0.80, approximately 72% of the membership have MLRs between 0.80 and 0.85, and about 28% between 0.86 and 0.90.

Carrier	CY 2009 MLR
A	0.80
B	0.86
C	0.80
D	0.81
E	0.85
F	0.89
G	0.80
H	0.76
I	0.80
J	0.88
K	0.84
Total	0.82

Table 17 – WI Small Group Market Carrier CY09 MLR

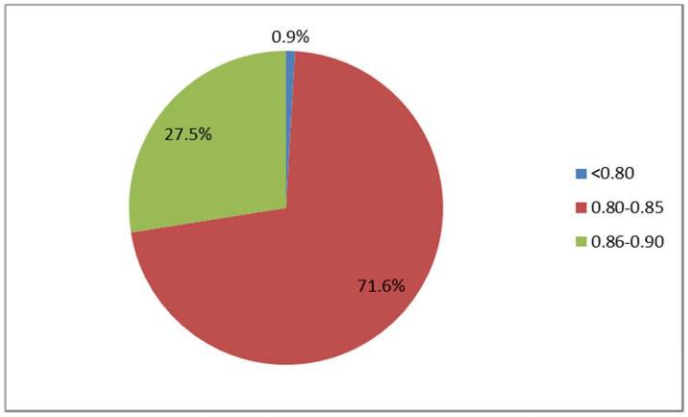

Table 18 – WI Small Group Market Membership by MLR Range (CY09)

Table 19 and Table 20 show the MLR by region. Note that in these tables the rating region is defined based on the employer's location. Milwaukee has the lowest MLR, and is therefore cross subsidizing the Northern and Western regions, which have the higher MLRs. As supported by our rating factor analysis described above, Milwaukee's premiums appear to be the highest while the Northern and Western region claims costs appear to be the highest.

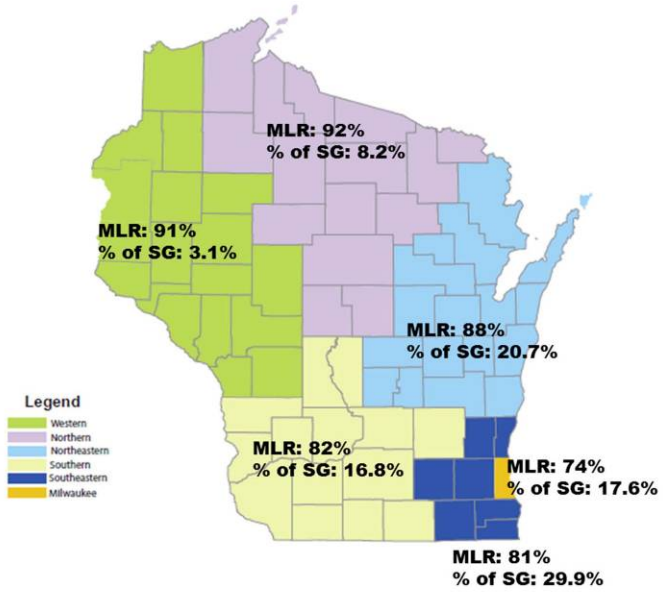

Table 19 – WI Small Group Market CY09 MLR by Region

Region	% Member Distribution	Incurred Claims PMPM	Premium PMPM	MLR
Milwaukee	17.6%	$ 281.86	$ 378.36	0.74
Northeastern	20.7%	$ 257.93	$ 292.26	0.88
Northern	8.2%	$ 316.77	$ 345.35	0.92
Southeastern	29.9%	$ 269.83	$ 333.65	0.81
Southern	16.8%	$ 294.44	$ 358.46	0.82
Western	3.1%	$ 330.42	$ 365.07	0.91
Unknown	3.6%	$ 246.66	$ 348.23	0.71
Grand Total	100%	$ 278.53	$ 339.58	0.82

Table 20 – WI Small Group Market Geography CY09 MLR (Based on Group ZIP)

In Table 21, we analyzed average deductible by region and show that members in Milwaukee and the Southeastern region are enrolled in plans with higher deductibles. Note that the averages in this table are based on the number of groups, rather than the number of members.

Region	Average In-Network Deductible (Single Policies)	Average In-Network Deductible (Family Policies)
Milwaukee	$1,709	$3,418
Northeastern	$1,685	$3,370
Northern	$1,463	$2,927
Southeastern	$1,812	$3,624
Southern	$575	$1,151
Western	$1,379	$2,758
Total	$1,449	$2,899

Table 21 – WI Small Group Market CY09 Group Average Deductible by Region[6]

We also performed a distribution of claims analysis for the WI Small Group Market. Approximately 1% of the population accounts for 28% of total costs. This compares to the Individual Market where 1% of the population accounts for 36% of total costs. Conversely, 23% of Small Group members did not incur claims in CY 2009 as compared to 41% of the Individual Market. It appears from this analysis that the Individual Market has more high cost claimants but also more $0 dollar claimants than the Small Group Market. The end result is that the average cost per member is higher in the Small Group Market ($3,431) as compared to the Individual Market ($2,098).

Allowable Claims	Cumulative Percent of Members	Cumulative Percent of Dollars	Average Claims per Member
$0	23%	0%	$0
$1 to $4,999	86%	22%	$1,185
$5,000 to $14,999	95%	45%	$8,563
$15,000 to $49,999	99%	72%	$25,184
$50,000+	100%	100%	$110,959
Total			$3,431

Table 22 – WI Small Group Market CY09 Allowed Claims Distribution

[6] Family Policies includes polices with tier types Employee+Child(ren), Employee+Spouse and Family. This table excludes some data, since two carriers were unable to provide member level data.

Allowable Claims	Cumulative Percent of Members	Cumulative Percent of Dollars	Average Claims per Member
$0	41%	0%	$0
$1 to $4,999	93%	21%	$867
$5,000 to $14,999	97%	38%	$8,544
$15,000 to $49,999	99%	64%	$26,426
$50,000+	100%	100%	$113,796
Total			$2,098

Table 23 – WI Individual Market CY09 Allowed Claims Distribution

11. Product Analysis

The WI Small Group Market is split among POS, PPO and HMO products. Table 24 shows the distribution of members among these products. Approximately 60% of the Small Group Market members are in POS products.

Product	% Member Distribution
HMO	16%
POS	60%
PPO	21%
Unknown	3%
Total	100%

Table 24 – WI Small Group Market CY09 Product Distribution

Cost sharing follows many forms and can include a mixture of deductibles, coinsurance charges, and copayments. Products can generally be grouped into the following four forms:

1. Copay Only Plans
2. Deductible Only Plans
3. Deductible and Coinsurance Only Plans
4. Hybrid Plans – A mixture of Deductibles, Coinsurance and Copays.

In addition, some plans that have deductibles may exclude preventive services from the deductible. These services may be covered at 100% or a copay charge is applied. Other plans exclude copay charges for preventive office visits. Generally, we found that the definition of preventive services from carrier to carrier is not consistent and is also difficult to find in the plan descriptions. Table 25 shows three of the descriptions we found.

Preventive Definition 1	Preventive Definition 2	Preventive Definition 3
CHILD Exam; to age 18; no $ or visit limit, CHILD Preventive Lab; to age 18, no $ or visit limits, CHILD Preventive Radiology/X-ray; to age 18, no $ or visit limits, Child Preventive Immunizations up to age 18, no $ or visit limits Mandate: • Must provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years for a dependent. Must be covered at 100% in-network. Child Preventive Flu/Pneumonia; limitations = to age 18	Well-baby care	Immunizations for Children from birth to age six
Blood Lead Tests for children under age 6	Blood Lead Tests to Age 5	Primary Physician Office Visit
ADULT Exam; age 18 and over, no $ limits or visit limits, ADULT Preventive Lab; (includes all place of service) age 18 and over, no $ or visit limits, ADULT Preventive Radiology/X-ray; (includes all place of service) age 18 and over, no $ or visit limits	Routine Medical Exams	Specialist Office Visits
Adult Preventive Immunizations, Adult Preventive Flu/Pneumonia, Shingles Vaccination (i.e. Zostavax), age 55 and over	Routine Labs	Lab, X-Ray or other preventive tests.
Preventive endoscopic services Preventive Colonoscopy, Sigmoidoscopy and Proctosigmoidoscopy (no age or limits) includes all places of service	Colonoscopy (screening only, one per 5 years paid at 100%)	Influenza immunizations
HPV Vaccination for prevention of Cervical Cancer (i.e. Gardasil); **no age, $ or visit limits** Note: Plan build reflects no limit. Coverage is indicated for those age 9-26. Although certificates will not clearly delineate the age parameters the listing on the website will.	Immunizations	
Routine Pap no age, $, or visit limits ; Mandate- Must cover gynecological services (Papanicolaou tests, pelvic examinations or associated lab fees) when performed by nurse practitioner	Mammograms & Pap Tests	
Routine Mammogram Note: Plan build reflects no limit. *Certificate will still reflect the following language: Baseline mammogram for a female covered person between 35-40 & an annual mammogram for a female covered person 40 years of age or older.* **Mandate→ Must cover mammograms the same as any other radiological exams that are covered by the policy. The required ages/frequencies are indicated in statute.**		
Routine Prostate Screenings (PSA) Benefit limitation does not reflect certificate language, please see state specific mandate for actual language.		
Routine Vision Screening		
Eye Refractions		
Routine Hearing Screening		
Meningitis Vaccination - up to age 21		

Table 25 – WI Small Group Market Preventive Services Benefit

Due to the inconsistency of the definition of preventive services, analyzing the existing preventive services benefit is complex. We did however ask two questions in our survey regarding preventive services. The first question was "Did the existing deductible apply to preventive services?". Approximately 86% of members have an in-network deductible of which one third have their deductible apply to preventive services. The second question asked was "If there was a copay applied to office visits, did the copay apply to preventive visits?". Approximately 78% of members have an office visit copay. Of these, 83% of members have their office visit copays apply to preventive visits.

The survey asked additional questions regarding lifetime maximums and annual maximums. There are annual limits on certain services and procedures, such as Behavioral Health and Chemical Dependency, Durable Medical Equipment and Transplant Services. However, there are no overarching annual limits in the market. Approximately 8% of the market does not have any lifetime maximum dollar limits and about 79% of the market has a lifetime limit of greater than or equal to $5 million. Less than 0.1% of the market reached their lifetime limit in CY 2009.

Lifetime Maximum	% Distribution
None	8%
$2M	12%
$5M	79%

Table 26 – WI Small Group Market CY09 Lifetime Maximum Distribution

We also analyzed the product design features. The table below shows average cost sharing amounts for the Small Group Market. [7] For single policy contracts the average in-network deductible is $1,523 and for family policy contracts it is $3,200. The average out of pocket maximum is $2,765 for single policies and $5,503 for family policies. We estimate the average actuarial value for the entire WI Small Group Market to be approximately 0.76. Note that the deductibles in the WI Individual Market are approximately twice as much as the Small Group Market and the overall average actuarial value is nine points higher than in the Individual Market.

	Single Contracts	Family Contracts
In-Network Deductible	$1,523	$3,200
PCP Office Visit Copay	$20	$20
Member Coinsurance	9%	9%
In-Network OOP Max	$2,765	$5,503
RX Retail Generic Copay	$10	$10
RX Retail Brand Formulary Copay	$29	$29
RX Retail Non-Brand Formulary Copay	$51	$50

Table 27 – WI Small Group Market CY09 Average Cost Sharing by Single and Family Policies

Table 28 and Table 29 show distributions of deductibles for single policies and family policies, respectively. There are more than 40 deductible levels in the Small Group Market today as compared to 60 deductible levels in the Individual Market. We have summarized these levels into ranges. As shown, 74% of the single polices have deductibles less than $2,000 and 72% of family policies have deductibles less than $4,000. We also show a comparison to the Individual Market. Approximately 88% of the single policies in the Small Group Market have a deductible less than $3,000 which compares to 72% of the Individual Market.

[7] Generally, carriers have reported what the Single Policy Deductible and Out of pocket maximum is for Family policies. As such for these carriers, we have multiplied what is reported by 2 as our best proxy for family deductibles and family out of pocket maximums.

Deductible	% Distribution for Single Policies	Avg Deductible for Single Policies
0	12.0%	$0
$100 to $500	18.8%	$421
$750 to $1000	15.6%	$995
$1050 to $1500	12.9%	$1,464
$1800 to $2000	14.7%	$2,000
$2200 to $2500	7.0%	$2,500
$2600 to $3000	7.1%	$2,960
$3500 to $5000	7.2%	$4,631
$5100+	0.3%	$6,230
Unknown	4.5%	

Table 28 – WI Small Group Market CY09 Deductible Analysis for Single Policies

Deductible	% Distribution for Family Policies	Avg Deductible for Family Policies
0	9.3%	$0
$200 to $1000	18.5%	$848
$1500 to $2000	15.7%	$1,989
$2100 to $3000	13.5%	$2,923
$3600 to $4000	15.2%	$3,999
$4400 to $5000	7.5%	$4,999
$5200 to $6000	7.6%	$5,916
$7000 to $10000	7.7%	$9,276
$10200+	0.3%	$12,510
Unknown	4.6%	

Table 29 – WI Small Group Market CY09 Deductible Analysis for Family Policies

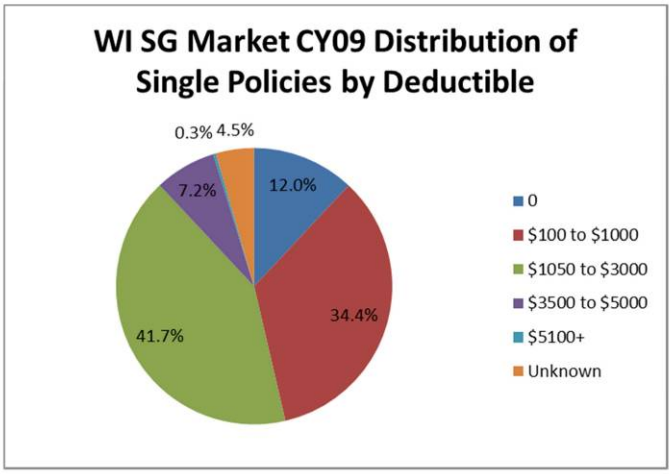

Table 30 – WI Small Group Market CY09 Distribution of Single Policies by Deductible

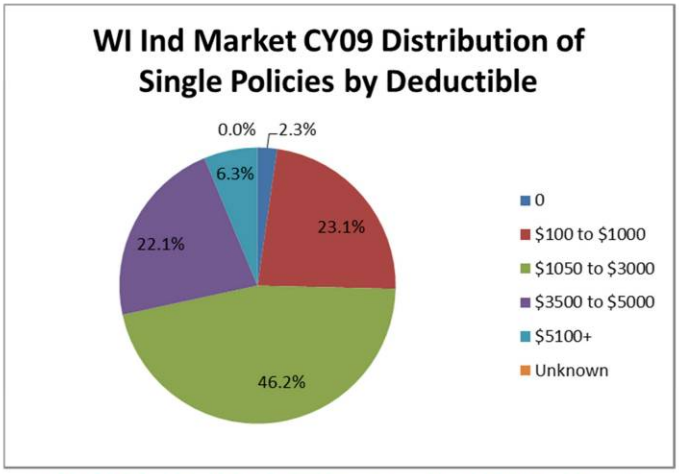

Table 31 – WI Individual Market CY09 Distribution of Single Policies by Deductible

In the Small Group Market virtually all members have a pharmacy benefit (approximately 98.5%). In the Wisconsin Individual Market, less than 80% of members have a pharmacy benefit. Of the groups and members with a pharmacy benefit, approximately 79% of these groups and 75% of the members have a plan design with copays or coinsurance that vary by tier. The retail generic copays range from $3 to $20

and the brand formulary copays vary up to a maximum of $45 while the brand non-formulary copays vary up to a maximum of $85. The coinsurance plans have a member portion that varies between 10% to 30% for generic and brand formulary and 10% to 50% for brand non-formulary. The remaining 21% of groups and 25% of members have pharmacy benefits that include a deductible and/or are integrated with the medical benefit.

12. Conclusions

The Small Group Market rating methodology is fairly consistent with what was analyzed in CY 2007, but it is clear that the MLR for this market segment has deteriorated since it was last analyzed. There are some clear differences between the Small Group Market as compared to the Individual Market, namely that the overall claims experience is worse in the Small Group Market, but the overall benefits are richer. These differences will need to be analyzed further as a merged market is considered. As with the Individual Market segment, the Small Group Market is fairly complex from a rating practice and product portfolio perspective. The changes that will occur under PPACA in CY 2014 will impact this market segment as many of the rating practices and products in existence today will no longer be allowed.

13. Appendices

Appendix I – List of Surveyed Carriers

Gorman Actuarial surveyed 11 entities for the Wisconsin Small Group Market. They were:

1) **Anthem Blue Cross and Blue Shield**
2) **Physicians Plus**
3) **Compcare**
4) **Security**
5) **Dean**
6) **Unity**
7) **UnitedHealthcare Insurance Co.**
8) **United Healthcare of Wisconsin**
9) **Humana**
10) **WPS Health Plan Inc**
11) **WPS Ins. Corp.**

Appendix II – Region Definition by County

Milwaukee	Northeastern	Northern	Southeastern	Southern	Western
Milwaukee	Brown	Ashland	Jefferson	Adams	Barron
	Calumet	Bayfield	Kenosha	Columbia	Buffalo
	Door	Florence	Ozaukee	Crawford	Burnett
	Fond du Lac	Forest	Racine	Dane	Chippewa
	Green Lake	Iron	Walworth	Dodge	Clark
	Kewaunee	Langlade	Washington	Grant	Douglas
	Manitowoc	Lincoln	Waukesha	Green	Dunn
	Marinette	Marathon		Iowa	Eau Claire
	Marquette	Oneida		Juneau	Jackson
	Menominee	Portage		Lafayette	La Crosse
	Oconto	Price		Richland	Monroe
	Outagamie	Sawyer		Rock	Pepin
	Shawano	Taylor		Sauk	Pierce
	Sheboygan	Vilas		Vernon	Polk
	Waupaca	Wood			Rusk
	Waushara				St. Croix
	Winnebago				Trempealeau
					Washburn

Appendix I Large Group Market Report

Market Summary of Wisconsin's Large Group (51-100) Health Insurance Market

Prepared for the Wisconsin Department of Health Services

December 15, 2010

Gorman Actuarial, LLC
210 Robert Road
Marlborough, MA 01752

Table of Contents

List of Tables

1. Introduction

With the passing of the Patient Protection and Affordable Care Act of 2010 (PPACA), states will be assessing the impact of various components of the law on their insured markets. The Wisconsin Department of Health Services has commissioned Gorman Actuarial and Dr. Jon Gruber to assess the impact of PPACA on the Wisconsin (WI) insured markets. The first phase of this analysis, performed by Gorman Actuarial, is to understand the market landscape of the existing privately insured markets. This report focuses on the Large Group Market, specifically those employers with between 51 and 100 eligible employees and is the third of a series of reports produced.

2. Key Findings

The Wisconsin Large Group 51-100 Market has an estimated 221,000 members and 105,000 subscribers as of December 31, 2009. There were approximately 2,000 groups in this segment as of December 31, 2009. We have highlighted some of these key findings below.

- The Large Group 51-100 Market is similar to the Small Group Market with regard to the number of carriers and the products offered in the market.
- Similar to the Small Group Market, the Large Group 51-100 Market appears slightly more fragmented than the Individual Market with a large number of carriers with smaller amounts of market share and a few dominant players.
- The average age of the Large Group 51-100 Market is 34, only slightly younger than the Individual Market at age 35. The average age of the Small Group Market is 33.
- Approximately 50% of the market is enrolled in single policies as compared to 55% of the Small Group Market and 70% of the Individual Market.
- The medical loss ratio (defined as incurred claims divided by billed premium) in CY09 was 89%, an increase of three basis points since CY 08.
- 23% of the Large Group 51-100 Market did not incur any claims in CY09 as compared to 41% of the Individual Market. This is consistent with the Small Group Market.
- Average claims costs per member are higher than the Small Group Market and the Individual Market.
- The average single policy deductible is estimated at $1,531 and family policy deductible at $2,778, nearly half the average in the Individual Market. We have estimated the overall average actuarial value to be 0.76.

3. Methodology

After conducting phone calls with all of the carriers, Gorman Actuarial (GA) developed a survey instrument that would capture data for each member in the Large Group 51-100 Market. The carriers were given four to ten weeks to deliver data. A list of carriers that participated in this study is found in Appendix I. GA has estimated that the carriers surveyed represent approximately 79% of the total Wisconsin Large Group 51-100 Market. This was estimated using OCI premium and group member surveys. Due to the complexity of the market, some carriers had difficulty providing information in the format required. Some common issues included multiple member records within one dataset, incorrect premium reporting and incorrect plan design reporting. Two carriers did not provide member level data and only provided group level detail. There was a considerable amount of communication between GA and the carriers to ensure that GA was interpreting the information received correctly. As a result, some carriers had to supply supplementary data sets. Once the data sets were "scrubbed", a master database was developed which combined all the carrier data sets into a single database for the Large Group 51-100 Market. This database along with additional information from the carriers (e.g. plan summary descriptions, rating factors and rating methodology) was used to perform this analysis.

We define "carrier" as a separate legal entity. For example, we treated BCBSWI and Compcare as two different carriers. Throughout this report we have obscured each carrier's identity so that data associated with a particular carrier cannot be identified. We use labels such as "Carrier A", "Carrier B", etc. Note that the carrier labels are not consistent throughout the report. This is done intentionally so that a carrier's identity may not be discerned.

4. Market Demographics

For CY09, we estimate that there were approximately 221,000 members and 105,000 subscribers in the Large Group 51-100 Market. In our discussions with the carriers, it became evident that carriers do not report the 51 to 100 market consistently. Some carriers report on 51 to 100 enrolled subscribers (contracts) while others report on 51 to 100 eligible employees. Still other carriers report on 51+ eligible employees with less than 100 enrolled subscribers. Carriers that report on enrolled subscribers do not have the ability to identify which of these employers have 51 to 100 eligible employees. Therefore, our data will also reflect larger employers that have a portion of their employees enrolled with another carrier ("slice business"). This issue is not uncommon among insurers. We estimate there were approximately 2,000 employer groups in the Large Group 51-100 Market. The average group size is approximately 50 enrolled

employees per group. For the entire Large Group Market, we estimate that there were approximately 965,000 members, 459,000 subscribers and 4,300 groups in CY09[1].

As shown in Table 1, the Large Group 51-100 Market has three carriers that represent nearly half of the market; with an additional six carriers that each has between 3 and 6% of the market.

Carrier	Large Group (51-100) Member Distribution
A	22%
B	19%
C	8%
D	6%
E	6%
F	4%
G	3%
H	3%
I	3%
J	2%
K	2%
L	1%
M	1%
N	0%
Other	21%
Total	100%

Table 1 – WI Large Group 51-100 Market CY09 Member Distribution by Carrier

We analyzed the age/gender demographics of the Large Group 51-100 Market. Table 2 shows that the largest adult cohort is between the ages of 45 and 49. Also, 48% of the market is female and the overall average age is 34. We have also compared the age distributions of the Large Group 51-100 Market to the Small Group and Individual Markets, as shown in Table 3, Table 4 and Table 5. Approximately 26% of the population is children as compared to 19% of the Individual Market. Approximately 24% of the Large Group 51-100 Market is over the age of 50 as compared to 22% for the Small Group Market and 28% for the Individual Market. The Large Group 51-100 Market is slightly younger (age 34) as compared to the Individual Market (age 35).

[1]Based on OCI premium and group enrollment surveys, GA has estimated that it has collected data from approximately 79% of the Large Group 51-100 Market. Numbers shown are adjusted to reflect this. In addition, there are inconsistencies in the data submitted by the carriers surveyed. Two carriers provided GA snapshot data as of July 31, 2009, whereas other carrier snapshot data was as of 12/31/2009.

	% Distribution		
Age Cohort	F	M	Total
0-17	12.4%	13.1%	25.5%
18-24	4.3%	4.9%	9.2%
25-29	3.4%	3.9%	7.3%
30-34	3.5%	4.0%	7.5%
35-39	3.7%	4.1%	7.8%
40-44	4.2%	4.3%	8.5%
45-49	4.8%	4.9%	9.8%
50-54	4.5%	4.7%	9.2%
55-59	3.8%	3.9%	7.7%
60-64	2.6%	2.7%	5.3%
65+	1.1%	1.2%	2.3%
Total	48.3%	51.7%	100%

Table 2 – WI Large Group 51-100 Market CY09 Age Gender Distribution

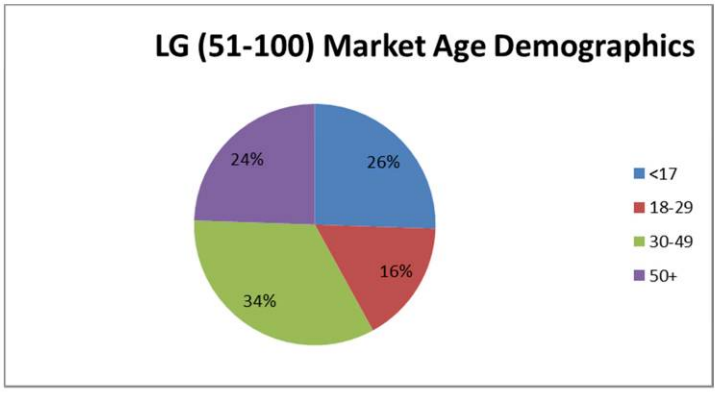

Table 3 – WI Large Group (51-100) Market CY09 Age Demographics

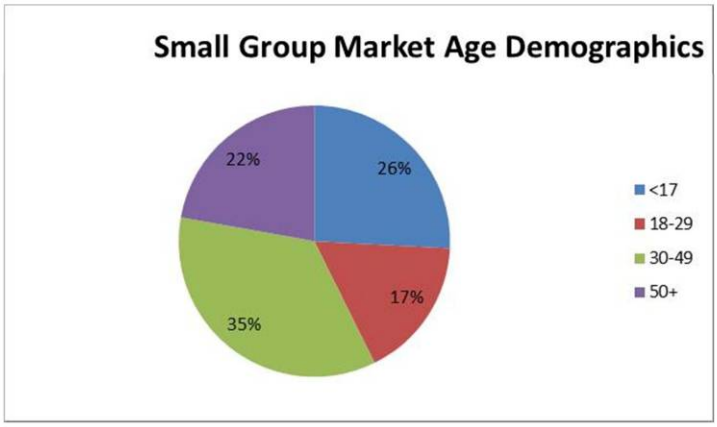

Table 4 – WI Small Group Market CY09 Age Demographics

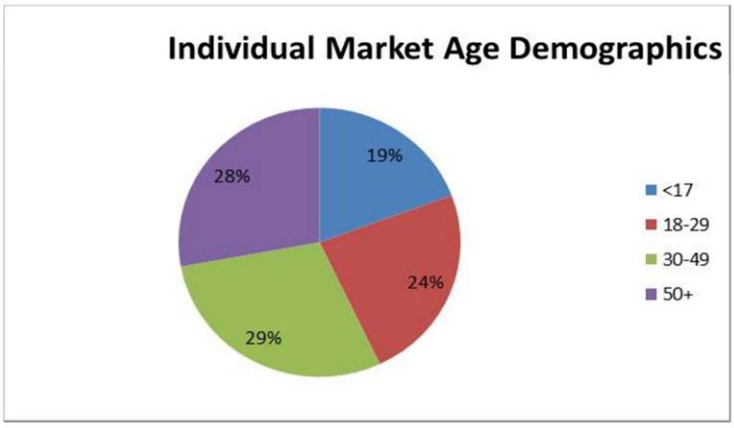

Table 5 – WI Individual Market CY09 Age Demographics

We also analyzed the distribution of contracts by tier type. As shown, 50% of the total Large Group 51-100 Market contracts were single policies as compared to 55% of the Small Group Market and 70% of the Individual Market. The average contract size is 2.09 for the Large Group 51-100 Market as compared to 1.97 and 1.62 for the Small Group and Individual Market, respectively.

Total Contracts	
Single	50%
Dual	14%
Employee +Child(ren)	7%
Family	29%

Table 6 – WI Large Group 51-100 Market CY09 Tier Distribution

We performed a geography analysis using two methodologies, one using the member location and the other using the employer group location. Table 7 is the member distribution by region using member location.

Region	% Member Distribution
Milwaukee	14.0%
Northeastern	17.4%
Northern	9.8%
Southeastern	23.2%
Southern	18.9%
Western	7.8%
Unknown	8.9%
Total	100%

Table 7 – WI Large Group 51-100 Market CY09 Geography Distribution (Member Location)

Table 8 shows member distribution by region using employer group location[2]. The regions are defined using the county associations shown in Appendix II. These region definitions are the same as those used by the Wisconsin Department of Health Services, except that we have assigned Milwaukee County to its own region. Interesting to note is that only 7.8% of Large Group 51-100 Market members live in the Western region as compared to 3.8% and 16.3% of the Small Group and Individual Market, respectively.

[2] Included in the Unknown category are those employer groups that are not in Wisconsin.

Region	% Member Distribution	% Group Distribution
Milwaukee	18.4%	17.9%
Northeastern	17.5%	13.8%
Northern	9.8%	10.1%
Southeastern	24.8%	23.0%
Southern	19.8%	20.7%
Western	8.1%	7.7%
Unknown	1.6%	6.8%
Grand Total	100%	100%

Table 8 – WI Large Group 51-100 Market CY09 Geography Distribution (Group Location)

5. Market Pricing

As expected, the rating formula for the 51-100 Market is much more complex than the Individual and Small Group Markets. In addition, there is very little consistency among carriers, making market analysis on premium rate setting difficult. We estimate that approximately 60% to 70% of the market uses an experience rating formula to set premiums. An experience rating formula uses the actual claims experience of the employer group to establish premium rates. The claims experience is blended with a "manual" rate that is adjusted for various rating factors such as age/gender, industry, region, health status, duration, SIC, and predictive modeling factors. Some carriers use all of these adjustments while others just use a subset. Carriers will blend the rates using credibility weights. The greater the group size, the greater the credibility of the group's experience, and more weight is given to the group's experience. Each carrier uses a different set of credibility tables. Some carriers adjust for large loss claims experience which is the practice of removing large catastrophic claims from the employers' claim experience and replacing it with a pooling charge. This technique decreases the variability in premium rates by smoothing out the claims experience used in setting premium rates. Some carriers use two years of claims experience, which is another approach in smoothing out the variability in premium rates when using claims experience. Final blended rates are further adjusted to reflect group size. This adjustment is usually in the form of an administrative charge. The greater the group size, the lower the administrative charge.

The other 30% to 40% of the market uses a formula that adjusts the manual rate by various rating factors such as age/gender, industry, region, health status, duration SIC, and predictive modeling factors.

If the 51 to 100 market is a part of the small group market, for non-grandfathered business, carriers will no longer be allowed to experience rate in CY 2014. The only adjustments allowed will be age, smoking, and area. Currently, some carriers that experience rate do not capture the portion of a group's premium that is due to the

experience rating formula. Therefore modeling the impact of the rating limitations on this market is difficult to do and is a complex modeling exercise.

6. Financial Analysis

The MLR for the Large Group 51-100 Market for CY09 is 0.893. We define MLR as the ratio of incurred claims to billed premium and therefore it does not correspond exactly to the MLR definitions that HHS will be using for rebate purposes. In addition, this only represents a portion of the Large Group Market. We estimate that the CY09 MLR for the entire Large Group Market is 0.891. Note that the entire Large Group market's MLR requirement for rebate purposes is 0.85.

Table 9 shows financial information from CY08 and CY09 for the Large Group 51-100 Market. We define CY09 incurred claims as claims paid for services incurred in CY09. As shown, the MLR has increased approximately three basis points from CY08 to CY09 for the Large Group 51-100 Market. We also observed a 10% decrease in membership from CY08 to CY09. This is consistent with our observations in the Small Group Market. We estimate that the CY09 MLR for the entire Large Group Market is 0.891.

	Large Group 51-100 Market		Large Group Market
	CY 08	CY 09	CY 09
Premium PMPM	$ 335.24	$ 356.33	$ 397.38
Incurred Claims PMPM	$ 288.15	$ 318.12	$ 354.01
MLR	0.860	0.893	0.891

Table 9 – WI Large Group 51-100 Market MLR for CY09 and CY08

Table 10 shows the MLR by carrier with the carrier name obscured for the Large Group 51-100 Market and the entire Large Group Market. As shown, MLR's for the entire Large Group Market in CY09 range from 0.69 to 1.02 with four carriers having an MLR less than 0.85. Table 11 shows the distribution of membership by the carrier's MLR for the entire Large Group Market in CY09. This figure shows that 35% of the membership is enrolled in carriers that have MLR's lower than 0.85, approximately 34% of the membership is enrolled in carriers that have MLRs between 0.86 and 0.90, and about 29% between 0.91 and 0.95.

	Large Group 51-100 Market	Large Group Market
Carrier	CY 2009 MLR	CY 2009 MLR
A	0.62	0.81
B	0.74	0.69
C	0.76	0.94
D	0.86	0.90
E	0.87	0.90
F	0.88	0.84
G	0.89	0.88
H	0.90	0.89
I	0.90	0.92
J	0.90	0.82
K	0.91	0.95
L	0.92	0.89
M	0.94	0.90
N	1.15	1.02
Total	0.893	0.891

Table 10 – WI Large Group Market Carrier CY09 MLR

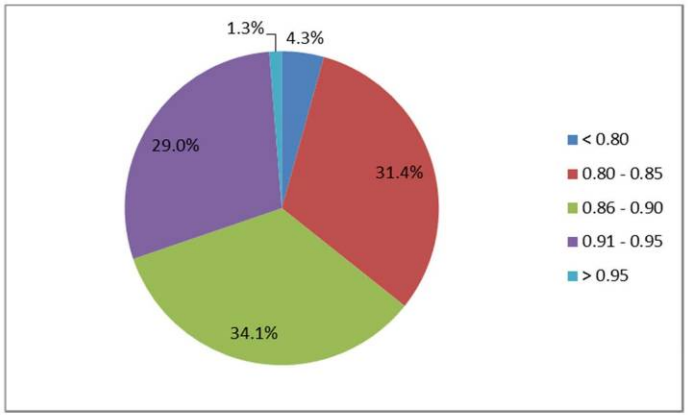

Table 11 – WI Entire Large Group Market Membership by MLR Range (CY09)

Table 12 and Table 13 show the MLR by region for the Large Group 51-100 Market. Note that in these tables the rating region is defined based on the employer's location. Consistent with the Small Group and Individual Markets, Milwaukee has the lowest MLR, and is therefore cross subsidizing the Northern, Western and Southeastern regions, which have the higher MLRs.

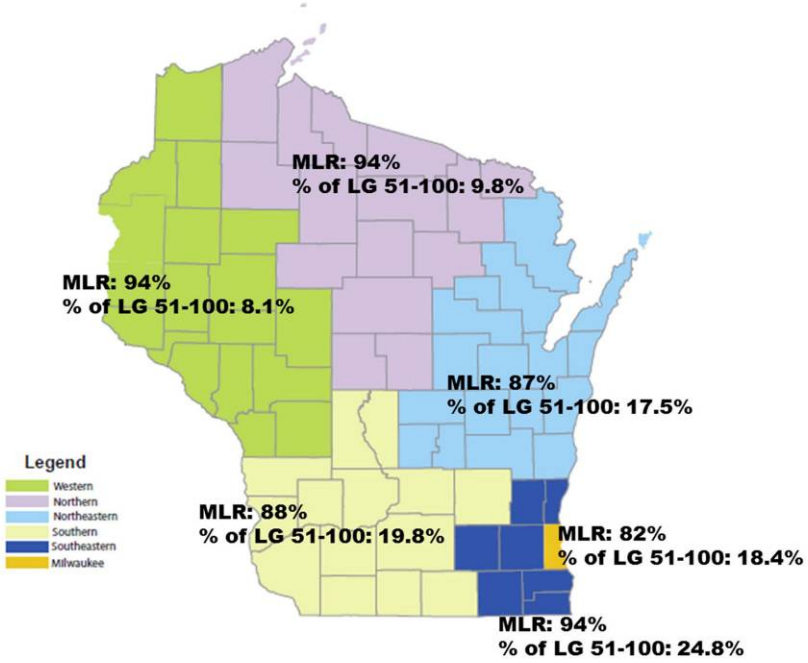

Table 12 – WI Large Group 51-100 Market CY09 MLR by Region

Region	% Member Distribution	Incurred Claims PMPM	Premium PMPM	MLR
Milwaukee	18.4%	$ 281.29	$ 344.05	0.82
Northeastern	17.5%	$ 300.06	$ 344.11	0.87
Northern	9.8%	$ 387.73	$ 413.20	0.94
Southeastern	24.8%	$ 306.35	$ 326.68	0.94
Southern	19.8%	$ 318.57	$ 361.62	0.88
Western	8.1%	$ 396.02	$ 420.13	0.94
Unknown	1.6%	$ 295.03	$ 347.83	0.85
Grand Total	100%	$ 318.12	$ 356.34	0.893

Table 13 – WI Large Group 51-100 Market Geography CY09 MLR (Based on Group ZIP)

We also performed a distribution of claims analysis for the WI Large Group 51-100 Market. Approximately 1.2% of the population has annual allowed claims greater than

$50,000 and account for nearly 32% of total costs. This compares to the approximately 28% and 36% in the Small Group and Individual Market, respectively. Consistent with the Small Group Market, in the Large Group 51-100 Market 23% of members did not incur claims in CY09 as compared to 41% of the Individual Market. It appears from this analysis that the Individual Market has more high cost claimants but also more zero dollar claimants than the Small Group and Large Group 51-100 Market. The average cost per member is higher in the Large Group 51-100 Market ($4,018) compared to the Small Group Market ($3,431) and the Individual Market ($2,098). Some caveats need to be placed around this analysis. Most carriers have a calendar year deductible but some carriers have plan year deductibles and therefore the true distribution of claims may be skewed.

Allowable Claims	Cumulative Percent of Members	Cumulative Percent of Dollars	Average Claims per Member
$0	23%	0%	$0
$1 to $4,999	84%	19%	$1,242
$5,000 to $14,999	94%	40%	$8,581
$15,000 to $49,999	99%	68%	$25,502
$50,000+	100%	100%	$107,655
Total			$4,018

Table 14 – WI Large Group 51-100 Market CY09 Allowed Claims Distribution

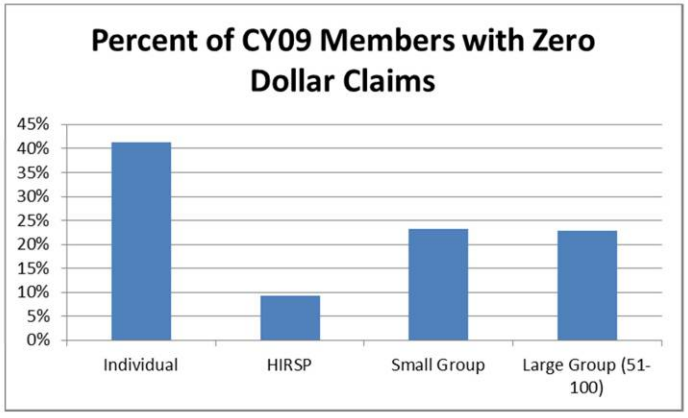

Table 15 –WI Market Zero Dollar Claimants for CY09

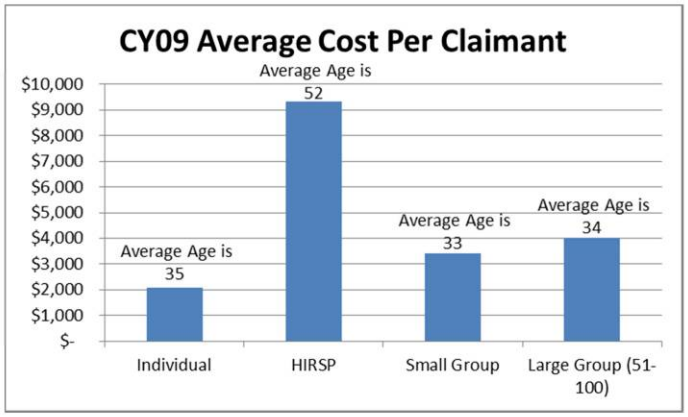

Table 16 –WI Market Average Cost Per Claimant for CY09

7. Product Analysis

The WI Large Group 51-100 Market is split among POS, PPO and HMO products. Table 17 shows the distribution of members among these products. Approximately 60% of the Small Group Market members are in POS products. The distribution is very similar to the distribution in the Small Group Market.

Product	% Member Distribution
HMO	17%
POS	60%
PPO	21%
Other	2%
Total	100%

Table 17 – WI Large Group 51-100 Market CY09 Product Distribution

Cost sharing follows many forms and can include a mixture of deductibles, coinsurance charges, and copayments. Products can generally be grouped into the following four forms:

1. Copay Only Plans
2. Deductible Only Plans
3. Deductible and Coinsurance Only Plans
4. Hybrid Plans – A mixture of Deductibles, Coinsurance and Copays.

In addition, some plans that have deductibles may exclude preventive services from the deductible. These services may be covered at 100% or a copay charge is applied. Other plans exclude copay charges for preventive office visits. Generally, we found that the definition of preventive services from carrier to carrier is not consistent and is also difficult to find in the plan descriptions.

Due to the inconsistency of the definition of preventive services, analyzing the existing preventive services benefit is complex. We did however ask two questions in our survey regarding preventive services. The first question was:

Did the existing deductible apply to preventive services?

Approximately 90% of members have an in-network deductible of which more than half (52%) have their deductible apply to preventive services. The second question asked was:

If there was a copay applied to office visits, did the copay apply to preventive visits?

Approximately 62% of members have an office visit copay. Of these, 81% of members have their office visit copays apply to preventive visits.

The survey asked additional questions regarding annual maximums and lifetime maximums. Some carriers surveyed place annual limits on specific services and procedures, such as Behavioral Health and Chemical Dependency, Durable Medical Equipment and Transplant Services. Approximately 3.2% of the members in the Large Group 51-100 Market have an overall annual benefit limit, and that limit is $2,000,000. Approximately 0.14% of the members in the Large Group 51-100 Market reached their limit in CY09. Approximately 10% of the market does not have a lifetime maximum dollar limit and about 64% of the market has a lifetime limit of greater than or equal to $5 million. No members of the carriers surveyed in the Large Group 51-100 Market reached their lifetime limit in CY09.

Lifetime Maximum	% Distribution
None	10%
$1M	3%
$2M	22%
$5M	64%

Table 18 – WI Large Group 51-100 Market CY09 Lifetime Maximum Distribution

We also analyzed the product design features. Table 19 shows average cost sharing amounts for the Large Group 51-100 Market[3]. For single policy contracts the average in-network deductible is $1,531 and for family policy contracts it is $2,778. The average out of pocket maximum is $2,576 for single policies and $4,506 for family policies. We estimate the average actuarial value for the entire WI Large Group 51-100 Market to be approximately 0.76, which is the same as the Small Group Market. Note that the deductibles in the WI Individual Market are approximately twice as much as the Small Group and Large Group 51-100 Market and the overall average actuarial value for the Large Group 51-100 and Small Group Markets are nine points higher than in the Individual Market.

	Single Contracts	Family Contracts
In-Network Deductible	$1,531	$2,778
PCP Office Visit Copay	$19	$17
Member Coinsurance	10%	9%
In-Network OOP Max	$2,576	$4,506
RX Retail Generic Copay	$8	$8
RX Retail Brand Formulary Copay	$28	$25
RX Retail Non-Brand Formulary Copay	$49	$45

Table 19 – WI Large Group 51-100 Market CY09 Average Cost Sharing by Single and Family Policies

Table 20 and Table 21 show distributions of deductibles for single policies and family policies, respectively. There are approximately 35 deductible levels in the Large Group 51-100 Market as compared to 60 deductible levels in the Individual Market. We have summarized these levels into ranges. As shown, 74% of the single polices have deductibles less than or equal to $2,000 and 77% of family policies have deductibles less than or equal to $4,000.

[3] Generally, carriers have reported what the Single Policy Deductible and Out of pocket maximum is for Family policies. As such for these carriers, we have multiplied what is reported by 2 as our best proxy for family deductibles and family out of pocket maximums.

Deductible	% Distribution for Single Policies	Avg Deductible for Single Policies
0	9.4%	$0
$100 to $500	22.8%	$366
$750 to $1000	15.2%	$982
$1100 to $1500	14.4%	$1,487
$2,000	12.2%	$2,000
$2300 to $2500	7.2%	$2,499
$2550 to $3000	6.1%	$2,955
$3250 to $5000	8.5%	$4,746
$5250+	0.2%	$6,116
Unknown	4.0%	

Table 20 – WI Large Group 51-100 Market CY09 Deductible Analysis for Single Policies

Deductible	% Distribution for Family Policies	Avg Deductible for Family Policies
0	8.8%	$0
$200 to $1000	29.8%	$629
$1500 to $2000	13.5%	$1,967
$2200 to $3000	14.3%	$2,965
$4,000	10.1%	$4,000
$4600 to $5000	7.0%	$4,995
$5100 to $6000	4.9%	$5,889
$6500 to $10000	7.8%	$9,429
$10500+	0.2%	$12,488
Unknown	3.6%	

Table 21 – WI Large Group 51-100 Market CY09 Deductible Analysis for Family Policies

Table 22, Table 23 and Table 24 show a comparison of the distribution of single policy deductibles in the Large Group 51-100 Market to the Small Group and Individual Markets. Approximately 88% of the single policies in the Large Group 51-100 and Small Group Markets have a deductible less than $3,000 which compares to 72% of the Individual Market. In addition, less than 0.5% of single policies in the Group Markets have deductibles greater than $5,100 as compared to 6.3% in the Individual Market.

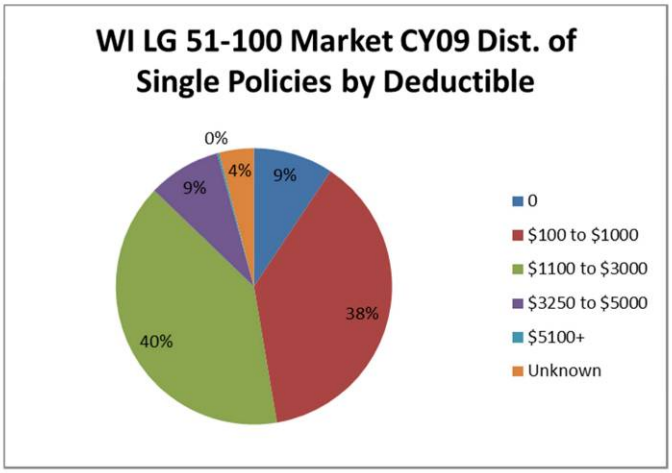

Table 22 – WI Large Group 51-100 Market CY09 Distribution of Single Policies by Deductible

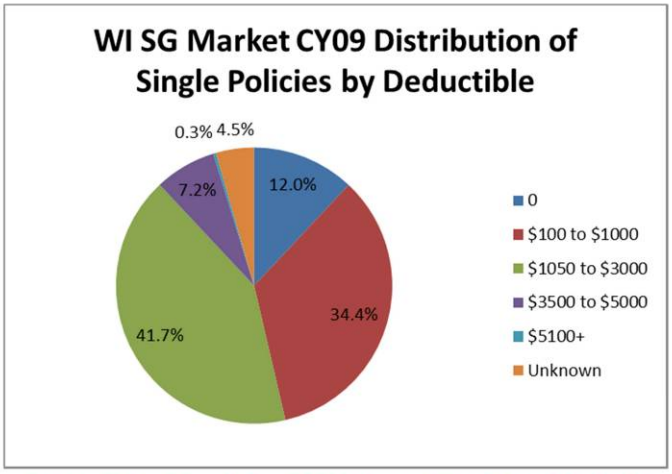

Table 23 – WI Small Group Market CY09 Distribution of Single Policies by Deductible

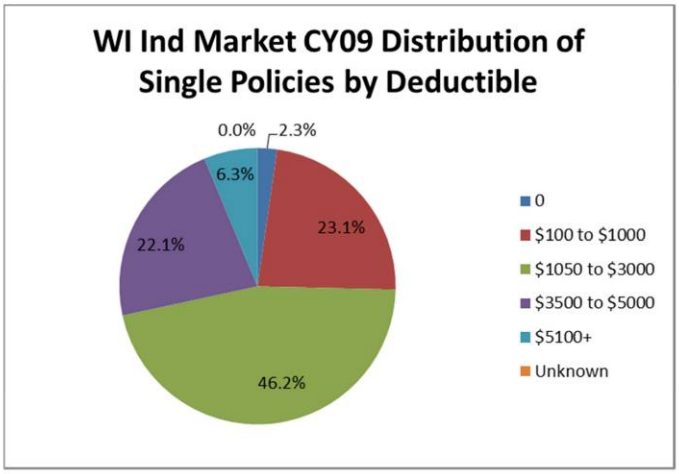

Table 24 – WI Individual Market CY09 Distribution of Single Policies by Deductible

In the Large Group 51-100 Market nearly all members have a pharmacy benefit (approximately 96%). In the Wisconsin Individual Market, less than 80% of members have a pharmacy benefit. The majority of these groups and members with a pharmacy benefit have a plan design with copays or coinsurance that varies by tier. The retail generic copays range from $3 to $20 and the brand formulary copays vary up to a maximum of $40 while the brand non-formulary copays vary up to a maximum of $65. The coinsurance plans have a member portion that varies between 10% to 30% for generic and brand formulary and 10% to 50% for brand non-formulary. The remaining groups and members have pharmacy benefits that include a deductible and/or are integrated with the medical benefit.

8. Conclusions

The product offerings in the Large Group 51-100 Market are consistent with the product offerings in the Small Group Market while the rating methodologies and financial results of the Large Group 51-100 Market are very different as compared to the Small Group Market. These rating and financial differences will add some disruption as this segment is merged into the Small Group Market in CY 2016. The rating formulae for the Large Group 51-100 Market are not simple and modeling the impact to each employer group will be a complex modeling exercise for each carrier. In addition, the claims experience of the Large Group 51-100 market is worse than the Small Group Market, which will cause premium disruptions for the existing Small Group Market when these markets are merged. Since the Large Group 51-100 Market represents approximately 23% of the entire Large Group Market, there may also be some disruption on the existing Large Group Market as a portion of its segment is removed. Many carriers in the market today

do not have the ability to report on the Large Group 51-100 segment as defined in PPACA and will have to update their reporting capabilities as they prepare for CY 2016.

9. Appendices

Appendix I – List of Surveyed Carriers

Gorman Actuarial surveyed 14 entities for the Wisconsin Large Group Market. They were:

1) **Anthem Blue Cross and Blue Shield**
2) **Compcare**
3) **Dean**
4) **Health Tradition Health Plan**
5) **Humana**
6) **Physicians Plus**
7) **Principal**
8) **Security**
9) **UnitedHealthcare Insurance Co.**
10) **United Healthcare of Wisconsin**
11) **Unity**
12) **WEA Trust**
13) **WPS Health Plan Inc**
14) **WPS Ins. Corp.**

Appendix II – Region Definition by County

Milwaukee	Northeastern	Northern	Southeastern	Southern	Western
Milwaukee	Brown	Ashland	Jefferson	Adams	Barron
	Calumet	Bayfield	Kenosha	Columbia	Buffalo
	Door	Florence	Ozaukee	Crawford	Burnett
	Fond du Lac	Forest	Racine	Dane	Chippewa
	Green Lake	Iron	Walworth	Dodge	Clark
	Kewaunee	Langlade	Washington	Grant	Douglas
	Manitowoc	Lincoln	Waukesha	Green	Dunn
	Marinette	Marathon		Iowa	Eau Claire
	Marquette	Oneida		Juneau	Jackson
	Menominee	Portage		Lafayette	La Crosse
	Oconto	Price		Richland	Monroe
	Outagamie	Sawyer		Rock	Pepin
	Shawano	Taylor		Sauk	Pierce
	Sheboygan	Vilas		Vernon	Polk
	Waupaca	Wood			Rusk
	Waushara				St. Croix
	Winnebago				Trempealeau
					Washburn