State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction and Purpose of the Brief

The Affordable Care Act (ACA) was designed in part to help bring stability to the individual health insurance market. But faced with a fluid federal regulatory environment, many states continue to encounter challenges including large premium increases and declining insurer participation. One solution to continued market instability is a state-based reinsurance program similar to the federal program that reduced premiums by more than 10 percent per year from 2014 through 2016.

Table 1. Four Reasons to Consider a State Reinsurance Program

Four Reasons to Consider a State Reinsurance Program	
Reason	**Rationale and Support**
Reduce Premiums	> Reinsurance reduces insurer claims' costs by covering a portion of the most expensive claims with financing provided through a state-based funding source and a federal match. > States can use actuarial modeling to predict how much financing it will take to reduce premiums by 10% or 20%.
Attract Insurers	> Insurers are concerned that a small number of large claims can dramatically impact their overall costs in the individual market where there may not be a large enough pool of healthy participants to balance out their risk pools. > Insurer participation was higher before federal reinsurance was phased out in 2016, and insurers often cite federal or state-based reinsurance as the best way to make market participation more attractive.
Limit Volatility	> The individual market is small and vulnerable to the "5/50 rule": 5% of enrollees account for 50% of costs. > Reinsurance reduces market volatility by covering most claims' costs for the highest-cost enrollees with the least predictable claims.
Leverage Federal-State Partnership	> State reinsurance programs are eligible for federal matching funds through Section 1332 waivers.

The Department of Health and Human Services (HHS) and the Department of the Treasury ("the Departments") have strongly encouraged states to establish their own reinsurance programs. The Departments approved three 1332 "state innovation" waivers for reinsurance programs in 2017 and another four in 2018. These waivers offset state program financing with federal "pass-through" funding equal to the federal savings generated by reducing premiums. This means that to fund their reinsurance programs, states only have to cover the net cost after the federal pass-through funding (offset) is applied.

Table 2. Overview of Approved 1332 Reinsurance Waiver Funding

Overview of Approved 1332 Reinsurance Waiver Funding, 2019 (in millions)							
	Alaska	**Maine**	**Maryland**	**Minnesota**	**New Jersey**	**Oregon**	**Wisconsin**
Total Reinsurance Program Funding[1]	$64	$93	$462	$271	$324	$95	$200
Federal Pass-Through Funding	$69	$65	$373	$85	$180	$42	$128
State Funding Required (after pass-through funding)[2]	N/A	$28	$89	$186	$144	$53	$72
Percentage of Program Covered by Federal Dollars[3]	100%	70%	81%	31%	56%	44%	64%

With Congress failing to make any changes to the 1332 process, HHS did issue new 1332 guidance in October 2018 that provided more flexibility to states in how they meet the four statutory guardrails applicable to all 1332 waivers. HHS also issued a discussion paper in December 2018 that highlighted reinsurance and high-risk pools. Neither the guidance, nor the discussion paper, should have much impact on reinsurance waivers since the seven reinsurance waivers approved so far have had no trouble meeting stricter guardrail standards. The most germane guardrail is the one requiring that a 1332 waiver not increase the federal deficit, which acts as a cap on federal pass-through funding, and the new guidance generally left those rules unchanged. The new guidance could be more relevant if a state wanted to combine a reinsurance waiver with other marketplace changes. This topic brief provides a roadmap of policy, program design, and financing considerations for states that are contemplating development of a state-based reinsurance program under 1332 waiver authority.

Understanding the Potential Impact of a Reinsurance Program

Health care markets vary widely among states and within regions of the same state. Understanding how reinsurance might help a specific state market starts with a few questions.

> **What market problem does the state need to solve?** Reinsurance can be a strong tool if the key market problem is affordability of premiums, insurer withdrawals, or excess volatility/uncertainty. However, reinsurance will not help with other problems including network adequacy and affordability for individuals eligible for federal subsidies.

> **What is the average premium?** States with higher average premiums have more to gain from reinsurance, especially for unsubsidized enrollees paying full premiums. While reinsurance will not directly benefit subsidized enrollees, it will save the federal government money and 1332 waivers allow states to recoup those savings.

> **How much premium variation is there across rating areas?** States with large regional variations in premiums may be hard-pressed to retain insurers in high-cost areas; a targeted reinsurance program may be a solution to underserved areas in a state.

> **What does current insurer participation in the market look like?** Insurance regulators will want to consult with current market participants, as well as past and prospective participants, to understand what role reinsurance might play in their future participation.

> **What is the profile of the state's highest cost enrollees?** Disease and accident patterns vary by state, and states may target specific high-cost conditions through a condition-based reinsurance program.

The percentage of enrollees receiving federal subsidies in the individual market (both in and outside the marketplace) is the best predictor of how large a state's federal pass-through funding to offset state funding needs might be under a 1332 waiver. Federal pass-through funding will generally be larger than a state's subsidized percentage. For example, a state with 60 percent of their enrollees getting subsidies would generally have to finance less than 40 percent of its reinsurance program with state funds, though it is important to note that federal pass-through funding is based on calculations that are updated on an annual basis.

Designing a Reinsurance Program

Once a state determines that reinsurance may be beneficial, the next step is to answer questions that help to provide the parameters related to the scale and type of reinsurance program that is the best fit, given the state's unique market characteristics.

Table 3: Comparing the Two Reinsurance Models

	Benefits	Drawbacks
Condition-Based Model	Creates opportunity for better medical and cost management of expensive conditions.	Harder to implement in states with no prior experience with this model.
Attachment Point Model	Used in all states for federal program, 2014-2016, and may be more familiar to legislators and stakeholders.	May not address state-identified cost drivers as well as condition-based model.

- **How large of a reinsurance program?** States typically start with a target for premium reduction of 5 percent to 20 percent, and then use actuarial modeling to determine what level of reinsurance financing is needed to achieve that premium reduction. The next step is to calculate how much of that financing is projected to be offset by federal pass-through funding. The final step is to determine what level of state financing is politically feasible and whether to cap the state's contribution, which means that insurers would receive smaller reinsurance payments if there is a shortfall in the program.
- **What type of reinsurance program?** There are two broad types of reinsurance programs with many permutations.
  - A **condition-based model** identifies specific high-cost conditions to be included in the reinsurance program. Under this model, insurers typically cede some lives and premiums to the reinsurance program. Insurers could still handle claims and patient management (e.g., preauthorization, claim payment or denial, or care coordination), but might not have financial responsibility for the claims.
  - An **attachment point model** focuses on all claims, including accidents, and is based on the claim's cost. This model features an attachment point, a coinsurance corridor, and a cap. The attachment point is the cost at which reinsurance starts to pay. In the coinsurance corridor, insurers pay a specified percentage of the claims cost with reinsurance covering the remaining part of the cost. The cap is the amount at which the claim is no longer eligible for reinsurance, and full responsibility reverts to the insurer.

Example: Maine's Condition-Based Reinsurance

Under Maine's 1332 reinsurance program, which is similar to a pre-ACA version, insurers are required to enroll people with a list of specific conditions into the reinsurance pool and have the option of enrolling others. The plans must cede 100 percent of the premiums paid for these enrollees to the reinsurance pool.

For those ceded, the reinsurance covers 90 percent of claims between $47,000 and $77,000. This is the same basic structure as the pre-ACA program.

Table 4. Example of Attachment Point Reinsurance

Federal Attachment Point Reinsurance	
Attachment Point	$45,000 (2014—2015) $90,000 (2016)
Coinsurance Rate	80% (2014) 50% (2015—2016)
Cap	$250,000

Sources: Kaiser Family Foundation, Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors, August 2016.

State Financing Considerations

The funding sources for a reinsurance program must be adequate and should include funding sources outside of the individual market. Without outside subsidization, reinsurance may help stabilize the individual market but will not reduce premiums in the individual market overall.

Table 5. Sources of Reinsurance Program Funding

Source	Example
Policy Assessment	The federal reinsurance program assessed all health insurance coverage, including, the large and small group markets, as well as stop-loss and third-party administrators (TPAs) to reach self-insured plans. Maine assessed health insurers and TPAs to reach all forms of health insurance except self-funded and self-administered plans.
State Premium Tax	Alaska's program is financed by a portion of the state's premium tax that applies to all lines of insurance.
State General Funds	Minnesota used general funds as one of several sources, which spreads costs across all taxpayers.
State Provider Assessments	Minnesota's funding includes a portion of the state's 2% provider tax, which applies to hospitals and other providers.

1332 Waiver Authorizing Legislation

Securing legislative authorization is typically the second most challenging step in the 1332 waiver process, though the October 2018 guidance allows that authorization to be general, rather than specific. Developing a strategy for legislative support and determining where this step fits in the timeline should be part of the early planning process. Federal law and guidance require state legislative authorization for both the waiver and the reinsurance program. If there is an existing high-risk pool or reinsurance statute, that may provide a good starting point. The statute should be specific as to the size and funding source, or sources, for the reinsurance program. The legislation should make the financing of the reinsurance program contingent on federal approval of the waiver.

Developing a 1332 Waiver Application

HHS has published a checklist that provides a step-by-step guide for what a state must include in its waiver application.[4] States can review the approved applications from Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin to see how the checklist has been successfully used, and may also consult the standardized application template developed by the State Health and Value Strategies program. Key areas of the waiver application include:

- **Goals for the Waiver:** Description of how the reinsurance program will achieve state goals, such as lowering premiums, increasing enrollment, and encouraging insurers to remain in the market.
- **Authorizing Legislation:** Description of the state's legislation that authorizes both the 1332 waiver and the reinsurance program, and makes the operation of the reinsurance program contingent on federal approval of the waiver.
- **Funding:** Description of the funding sources used for the reinsurance program, the funding amount from each source, and the estimated amount of pass-through funding. Note that final pass-through funding will be determined using actual approved premiums, funding will be provided in quarterly installments starting in April of the covered year, and funding levels will be adjusted each year based on actual enrollments and premiums.

- **Actuarial Analysis:** Actuarial modeling, including a baseline scenario without the reinsurance program, and a year-by-year comparison of premiums and coverage with and without the reinsurance program. States may be able to utilize in-house actuaries, though outside actuarial firms may shorten timelines.
- **Ten-Year Budget:** Economic analysis, including a 10-year budget that considers all costs associated with the program, including administrative costs and demonstrates that the waiver is deficit neutral.
- **Waiver Development Process:** List of public hearing dates and compliance with other public participation requirements. States must observe a 30-day public comment period and hold a minimum of two public hearings. The public comment period can rely on a draft waiver as long as the public has sufficient information to meaningfully give input. The public comment process must include consultation with federally-recognized American Indian tribes.

Planning the Waiver Timeline

State Health and Value Strategies has a to-do list for states considering a Section 1332 reinsurance waiver. The first step listed in the to-do list is to sketch out a calendar for activities. Federal guidance advises states to file waivers by March for the subsequent calendar/plan year, though HHS did markedly shorten the review time for reinsurance waivers that were filed later in 2018 so they could go into effect for 2019. The most important lesson on the timeline is to be in close communication with the Departments, identifying and discussing any trouble spots, as well as understanding what other states may be in the queue. Federal officials may be open to allowing states to pursue various parts of their application simultaneously, with, for example, final legislative approval, public comment, and actuarial modeling taking place under overlapping timelines. While states have been successful in submitting applications in late spring, it is better to plan early for 2020 and submit 1332 waiver applications by March or April. Later filings may necessitate asking insurers to file two sets of rates or taking other actions that add complication to the process.

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Endnotes

1. These amounts are set by the states, which have the flexibility to decide on the size of the reinsurance program, typically based on what percentage of premium reduction they have targeted.
2. Note that the state share of costs after the federal pass-through are calculated by using projected reinsurance losses, which are not actually settled until the following year in most programs (e.g., 2019 losses are filed and settled in 2020). Actual losses could increase or decrease the state share depending on how the state's reinsurance program allocates those losses.
3. If a state uses all of the federal funds to replace state dollars, this is the percentage of the total program covered by federal dollars.
4. Centers for Medicare & Medicaid Services. *Checklist for Section 1332 State Innovation Waiver Applications, including specific items applicable to High-Risk Pool/State-Operated Reinsurance Program Applications*. CMS.gov. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf. May, 2017. Accessed February 26, 2018.