

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

Before the Affordable Care Act (ACA) took effect in 2010, with its requirement that insurers cover people with preexisting conditions, many people were uninsured. Millions of Americans with a preexisting medical condition sought coverage but were unable to purchase it, either because they applied and were rejected or were offered coverage at rates they could not afford. Due to their complex or costly health conditions, these uninsured individuals are a segment of the larger uninsured population that needs health insurance coverage the most.

Too many customers with high risks or costs can push an insurance company toward insolvency or even bankruptcy. Before the ACA, insurers could mitigate these costs by charging consumers different premiums based on several factors, including gender, age and health status, which usually included preexisting health conditions. They could also offer coverage that excluded benefits for preexisting conditions altogether. This practice is part of [risk selection](#), a broad set of practices that insurers use to avoid excess risk.

Between 1976 and 2010, [35 states](#) took action to provide coverage for people with preexisting conditions and established some form of a high-risk health insurance pool.¹ Typically, such a pool is created so health insurance providers can pool clients into premium rating categories to spread the risk. When an enrolled customer is diagnosed with a condition that is expensive to treat, such as cancer or hemophilia, or even common conditions such as diabetes or severe asthma, the insurance carrier must cover these costly claims. Pooling risk allows the higher costs of less healthy individuals to be offset by lower costs of healthier people. Across the states that established these high-risk pools, national enrollment in them reached approximately 226,615 by the end of 2011.² Although a few states still operate some form of high-risk pool, after the ACA was implemented, many of these programs were phased out and are no longer operational.³

Denying coverage or charging higher premiums based on health status is now prohibited under the ACA, and all individual market enrollees must be classified into a single risk pool. Now, if too many people with high-cost medical needs seek coverage, but not enough healthy people are in the risk pool to counter the costs, insurers charge higher premiums to all enrollees to offset the expenses of the high-need individuals.

During the first three years of the ACA, a temporary federal reinsurance program was established to discourage insurers from setting higher premiums. The program aimed to alleviate uncertain-



ty about who would enroll in the exchanges and marketplaces and what their medical costs would be.⁴ As described by the [Commonwealth Fund](#), the threshold specified in the ACA, often called an “attachment point,” was \$45,000. It allowed insurers with claimants who surpassed \$45,000 in medical expenses annually to qualify for reinsurance reimbursements of 100 percent of the cost, capped at \$250,000.⁵ The program was financed by assessing fees on both individual and employer plans, including large-group, self-insured employers.⁶

Assuming carriers would gain familiarity with the market and would be able to price their products accordingly, the program was phased out by the end of 2016, as required by the federal law. By the end of 2014, it is estimated that it reduced average premiums in the marketplaces and exchanges by as much as 14 percent.⁷ In 2017, the year following the program’s dissolution, the marketplaces saw the most severe jump in [premiums](#) they had since the ACA’s inception. This has led to states to once again implement creative solutions to help ease these steep increases.

Policy Options

Resurfacing as a new solution to mitigating risk selection and rising premiums, reinsurance has generated considerable attention

from states. Often referred to as insurance for insurers, reinsurance works by cushioning insurers' obligation to pay expensive medical claims incurred by their members. It does so by covering some of those expenses when they exceed a certain threshold or attachment point. Similarly, insurers can pay premiums coupled with federal funds to cover the claims of specific high-cost enrollees that they group into a high-risk pool.⁸ Although states are not required to use federal funds for reinsurance programs, states that do want to receive federal funds must first receive approval from the Centers for Medicare & Medicaid Services (CMS).

To initiate a reinsurance program or invisible high-risk pool using federal funds, states must meet certain criteria. First, they must apply to the CMS for a section 1332 State Innovation Waiver, or what the Trump administration now refers to as a State Relief and Empowerment Waiver. The waiver process originated during the Obama administration, and the Trump administration has further encouraged states to use it as a way to expand coverage options and stabilize their health insurance marketplaces.

Section 1332 waivers give states an opportunity to fashion a new coverage system customized for local context and preferences while still fulfilling the aims of the ACA. To help fund these efforts, states can receive "pass-through" money that the federal government would have otherwise spent on premium tax credits, cost-sharing reductions and small employer tax credits.

According to [Health Affairs](#), "For state-based reinsurance programs, states receive pass-through funding based on the amount of premium tax credits that the federal government would have otherwise provided to eligible individuals absent the waiver."⁹

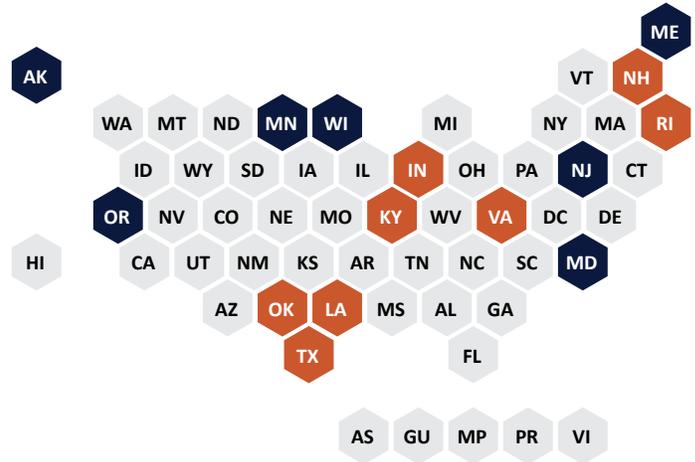
Under the ACA, states were required to enact legislation to authorize the state to apply for a 1332 waiver. The Trump administration has since reinterpreted the statute. Now states can fulfill the requirement with existing general statutory authority to implement or enforce the ACA in combination with executive action specific to the 1332 waiver. Prior to the proposed regulation, more than a dozen states passed legislation authorizing use of waivers for varying purposes. To date, [seven states](#) have enacted laws to initiate reinsurance programs and all seven have received federal approval.^{10 11}

There are four statutory [guardrails](#) that states must meet before they gain CMS approval:

- Provide coverage that is at least as comprehensive as would be provided without the waiver.
- Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent a waiver.
- Provide coverage to a comparable number of state residents.
- The proposal will not increase the federal deficit.

Although not intending to replace them, the Trump administration recently relaxed these guardrails and announced [five prin-](#)

Status of Section 1332 Reinsurance Waivers



- Waiver filed, approved by U.S. Department of Health and Human Services
- Enacted legislation to initiate waiver; waiver not yet filed or approved

Source: NCSL, 2019

principles to help further guide federal regulators in approving or denying a state's waiver or not. The Department of Health and Human Services (HHS) and the Department of the Treasury are responsible for reviewing waiver applications. Regulators will look more favorably upon a proposal if it advances one or more of the following:¹²

- Provide increased access to affordable private-market coverage over public programs, including association health plans and short-term limited duration plans, and increase insurer participation and promote competition.
- Encourage sustainable spending growth by promoting more cost-effective coverage, restraining growth in federal spending, and eliminating state regulations that limit market choice and competition.
- Foster state innovation.
- Support and empower those in need, such as low-income earners or those with high health costs.
- Promote consumer-driven health care.

Although gaining in popularity, critics of state-based reinsurance programs cite several challenges in the implementation process. The most common critique is that, since a state must put up the initial funds for a reinsurance program, it would be difficult for some states with significant budget constraints to adopt this policy. However, once the program is fully implemented, pass-through funding from the federal government can help support the program in future years. In the case of state reinsurance programs, the amount of pass-through funding the state receives is based on what the federal government saves in premium tax credits.

Reinsurance Programs and High-Risk Pools: State Policy Options and Considerations

- States can implement a reinsurance program through a Section 1332 State Relief and Empowerment waiver.
- States can establish a high-risk pool to offset the costs of insuring the most expensive, high-need individuals.

State Examples

REINSURANCE

The first state to implement a reinsurance program with a 1332 waiver was **Alaska**. Enacted in 2016, the Alaska Legislature established the **Alaska Reinsurance Program (ARP)** to reinsure 100 percent of claims from policyholders that live with 33 high-cost medical conditions.¹³ Originally funded by the state general fund and an assessment on insurers, the program is now supported with pass-through funding. So far, the ARP has generated \$58 million dollars in savings.¹⁴ The latest rate filings showed a 25 percent decrease in premiums since the program began and many customers will see a significant price drop—from \$1,043 in 2017 to \$770 for 2019.¹⁵

Newly approved for 2018, **Maine's** waiver uses a similar structure and reinsures claims for **eight** specific categories of high-cost medical conditions. The Maine Guaranteed Access Reinsurance Association (MGARA) is funded through a \$4 per-member, per-month assessment on insurers and third-party administrators.¹⁶ MGARA implements a risk corridor, where reinsurance pays 90 percent of claims above \$47,000 and 100 percent after the claimant surpasses \$77,000.¹⁷ The state estimates it will receive over \$33 million in pass-through funding from the federal government in 2019.¹⁸

Whereas Alaska and Maine created reinsurance programs based on certain high-cost health conditions, the remaining five states with approved reinsurance programs chose options that work more like traditional reinsurance. For instance, the **Minnesota Premium Security Plan (MPSP)** covers 80 percent of claims for individuals up to \$250,000 once a \$50,000 threshold is passed.¹⁹ The program was initially financed using the state general fund and by leveraging funds from the Minnesota Health Care Access Fund (HCAF). The HCAF, which also funds the states' Medicaid plan, is financed by a 1 percent premium tax and a 2 percent assessment on providers.²⁰

After initial implementation, the state expected to receive federal pass-through funding on saved premium tax credits. For 2018, Minnesota received more than \$130 million in pass-through funding from the federal government.²¹ Even more, 2019 premiums in the individual market are projected to be, on average, 13 percent lower than they would have been without the reinsurance program.²²

Maryland was one of the more recent states to receive approval from CMS. The Maryland Reinsurance Program (MRP) is financed

through a 2.75 percent tax on carriers and Medicaid managed care organizations (MCOs).²³ The MRP will reimburse insurers 80 percent of claims up to \$250,000, although the attachment point has yet to be determined.²⁴ It is estimated that premiums for the 2019 plan year will be 30 percent lower than they would have been without the waiver and will increase enrollment by 5.8 percent.²⁵ Furthermore, the pass-through savings provided by the federal government are estimated to be over \$373 million in 2019 alone.²⁶ The program will run through 2020, with the potential to be extended through 2023.

HIGH-RISK POOLS

North Dakota still operates a high-risk pool program. The **Comprehensive Health Association of North Dakota (CHAND)** offers health insurance to residents with high-cost preexisting conditions who are unable to find adequate or affordable health insurance in the private market or who have lost their employer-sponsored group health insurance. CHAND covers major medical and prescription drug expenses, subject to certain limitations and exclusions.

A person is eligible to receive \$1 million in benefits from CHAND during his or her lifetime. An individual who has received \$1 million in CHAND benefits from any combination of benefit plans is not eligible to obtain new coverage through the association. Premiums fund approximately one-half to two-thirds of the program, not to exceed 135 percent of premiums charged in the state for similar coverage.²⁷ The balance is covered by assessments to companies that write \$100,000 in annual premiums on behalf of residents of North Dakota.²⁸

North Dakota is currently exploring, through the 1332 waiver process, how to leverage CHAND to gain additional dollars through the federal government. During the 2018 session, lawmakers commissioned a study on the feasibility and desirability of a North Dakota 1332 waiver by exploring the following options:

- Modify North Dakota's current high-risk pool, the CHAND, to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND. Analyze the corresponding insurance company assessments necessary for CHAND to successfully operate with increased high-risk membership.
- Modify CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
- Create a reinsurance program independent of CHAND.

The conclusion of the study found that, ultimately, the creation of a reinsurance program would be a more viable option.²⁹

Conclusion

Reinsurance programs using 1332 waivers may not be a silver bullet to rein in the problem of escalating premiums, but the latest programs do appear to be viable options for states to explore. With enhanced guidelines and looser restrictions under the Trump administration, it is even easier for states to be creative in how plans are developed and marketed within their own boundaries.

Notes

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