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Using Reinsurance to Lower Premiums for Health Insurance: Could It Work Here in Massachusetts?

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According to the Economic Policy Institute ("EPI"), as of April 30, 2020, 12.7 million workers have likely lost employer-provided health insurance since the coronavirus pandemic hit the United States in full force in early March 2020. The EPI has noted that, inasmuch as the vast majority of health insurance benefits are tied directly to employment in the country, many of these newly unemployed persons will face an unenviable option: either pay for costly healthy insurance on their own or go without any health coverage. Unfortunately, this new reality of large numbers of uninsured people has only added to the recent trend of loss of health insurance nationwide among the formerly insured, the exact opposite of what Affordable Care Act ("ACA") until recently has been trying to achieve.

The Commonwealth Fund ACA Tracking Survey in 2018 reported that about 4 million working-age people have lost insurance coverage since 2016, and the uninsured rates among lower-income adults rose from 20.9 percent in 2016 to 25.7 percent in March 2018. Various actions by Congress and the Trump Administration were likely the cause of at least some of this decline in coverage, including: Congress' termination of financial penalties for failing to obtain health insurance; and the Trump Administration's resistance to paying cost-sharing reductions for low-income purchasers of marketplace coverage, its encouragement of the sale of short-term policies and association health plans, and its defunding of advertising and outreach in federally facilitated marketplaces.

One way to mitigate the adverse effects of these policies and events might be by creating a new reinsurance program to cover the risks being assumed by health insurers. Reinsurance was a critical feature of ACA marketplaces in their first three

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years of their existence. Because the marketplaces were new, insurers faced considerable uncertainty about the health status of a flood of new enrollees, for whom any pre-existing conditions were no longer relevant underwriting features. The availability of reinsurance to cover uncertain risks allowed for less uncertainty.

The ACA's reinsurance program offered insurers some protection against unexpectedly high claims through the mechanism of a federal reinsurance program, which was designed to protect health insurers: by reducing uncertainty and thereby allowing carriers be better able to set rates; and by limiting the carriers' exposure to very high, unpredictable medical expenses incurred by their members by covering some of those expenses when they exceed a certain threshold.

For example, from 2014 through 2016, the ACA stipulated that insurers with claims costs that exceeded a threshold amount for a particular individual — $45,000 in 2014 — qualified for reinsurance payments for 100 percent of the excess up to $250,000 under the federal reinsurance program. The program was financed by fees on both individual and employer plans, including self-insured employers, and was thus deficit neutral. It is estimated that reinsurance reduced average premiums in the marketplaces by as much as 14 percent.

The ACA, however, phased down the reinsurance program over the three year period from 2014 to 2016, ending it by the end of 2016, under the assumption that as insurers gained more familiarity with enrollees under the ACA-mandated coverages, they could price their products with greater certainty. Unfortunately, this assumption was incorrect, and after the program ended in 2016, premiums for health insurance rose in 2017 more sharply than they had in prior years, an increase that was partly attributed to the loss of reinsurance.

Industry stakeholders and health policy experts have suggested that reinsurance could stabilize the health insurance marketplace. Researchers Chrissy Eibner and Jody Liu of RAND have estimated that reinstating the federal reinsurance program could reduce premiums in the marketplaces by 3.9 percent to 19.3 percent in 2020, depending on the generosity of the program. Because lower premiums also reduce what the federal government spends on tax credits, the researchers projected federal deficit savings of $2.9 billion to $13.1 billion. However, the researchers also assume that some of those fees ultimately would be passed on to people enrolled in private plans.

Federal reinsurance programs have appeared in a number of recent Congressional bills. In recent years, ACA repeal-and-replace bills included reinsurance programs for the individual market that would be financed directly by the federal government. Senator Susan Collins, Republican of Maine, and then-Senator Bill Nelson, Democrat of Florida, introduced a bill with a similarly structured reinsurance program at the end of 2017. And in 2018, Senators Jeff Merkley, Democrat of Oregon, and Chris Murphy, Democrat

of Connecticut, introduced a bill proposing that a Medicare plan to be offered through the marketplaces and by employers also include a reinsurance program.

Some of these proposals would fund reinsurance through upfront federal expenditures, rather than charging fees to insurers. Deficit reductions could be lower under this scenario, but might still be possible because the federal expenditures on reinsurance would be offset by savings on lower tax credit expenditures as premiums fall. However, the RAND researchers also found that the cost to taxpayers would be about the same under both.

In the absence of consensus in Congress on how to strengthen the marketplaces, several states have secured, or are seeking, approval from the federal government to establish state-based reinsurance programs through the ACA's state innovation waiver program. Section 1332 of the ACA permits a state to apply for a "State Innovation Waiver" (now also referred to as a "State Relief and Empowerment Waiver" or more commonly, a "Section 1332 waiver") to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA approaches, since insurers would likely pass on fees to their customers in the form of higher premiums.

Section 1332 waivers allow states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit. Section 1332 waivers were made available beginning January 1, 2017. State innovation waivers are approved for five-year periods, and can be renewed. Under the Section 1332 waiver program, states have been able to apply to the federal government to make changes to their health insurance marketplaces as outlined under the ACA. Reinsurance has been the most common innovation pursued by states thus far.

Alaska, Maine, Minnesota, New Hampshire, New Jersey, Maryland, Oregon, and Wisconsin and other states have received federal approval to establish reinsurance programs. There are two basic approaches to the reinsurance programs being proposed: "claim type" and "claim amount." One such "claim type" approach is represented by Alaska.

In Alaska, medical claims for individuals with at least one of 33 high-cost conditions are covered by the Alaska Reinsurance Program. The program is credited with preventing the state's last remaining insurer from leaving the individual market in 2017. On July 11, 2017, the Centers for Medicare and Medicaid Services ("CMS") had announced that the Departments of Health and Human Services ("HHS") and Treasury had approved Alaska's request for a Section 1332 waiver for its reinsurance program.

The program was to be administered by the state and by the Alaska Comprehensive Health Insurance Association ("ACHIA"). Alaska was to reinsure insurers for individuals with one or more of 33 high-cost conditions. Insurers would cede to the Alaska Reinsurance Program ("ARP") both premiums received for individuals with these conditions and claims they would have paid had the individuals remained enrolled with the insurer. Insurers and the ACHIA would then be responsible for truing up any risk adjustment payments received by or owed by covered insurers under the federal risk adjustment program to avoid duplicate federal payments from the two programs.

It was expected that because of the program, premiums would be 20 percent *lower* in 2018 than they would otherwise be, and that 1,460 additional individuals would gain coverage. The program was expected to reduce the cost of the benchmark silver plan, and the federal government would pass through funds to Alaska that it otherwise would have spent on premium tax credits had the benchmark premium not been reduced. The first disbursement from the federal government to help cover Alaska's high-cost individual insurance market pool was announced February 9, 2018 at $58.5 million for 2018, an amount higher than projected.

The ARP was designed to reinsure claims for Alaskans with high-cost medical conditions and isolate the higher costs from the majority of people in the insurance pool. The creation of the ARP is credited with leading to a smaller premium hike in 2017 and a *decrease* in premiums of more than 20 percent in 2018 for about 18,000 Alaskans in the individual market. The Alaska Legislature used $55 million from existing insurance policy taxes to cover the cost of the program in 2017. Under the waiver, the ARP will receive $332 million in federal appropriations over five years.

It was the first time the average rate had *decreased* under the current federal health care law in Alaska, where high health care and premium costs had been an ongoing concern as some of the highest in the nation. Rate increases were nearly 40 percent in 2015 and 2016, but stabilized in 2017 with a 7 percent increase after the ARP was created. Other states, such as Minnesota, have approached the creation of their reinsurance programs differently, focusing instead on "claim amounts."

In Minnesota, the reinsurance program that was created covers 80 percent of all claims for individuals up to $250,000 cap once a $50,000 threshold is passed (once an individual's claims reach $50,000, the state pays 80 percent of those claims, up to $250,000). For the 2018 plan year, insurers submitted two sets of premiums, one assuming reinsurance and one without it. The rates accounting for reinsurance were approximately 20 percent lower.

For 2019, in fact, the final approved rates from four of the five companies selling coverage in the state *dropped* at double-digit rates. Blue Plus plan's average rates decreased the most — 27.7 percent. HealthPartners plans had the smallest average drop at 7.4 percent. Democrats and Republicans in the Minnesota legislature had

disagreed over how to finance the state costs associated with the reinsurance proposal, but the bill that was ultimately passed contained two years of financing from the state's Health Care Access Fund funded by a 2 percent provider tax.

On May 9, 2018, Maine submitted a waiver application to the federal government seeking funding for a state-based reinsurance program. On July 30, 2018, Maine's request was approved. The Maine proposal was a "hybrid model," combining elements of both the "claim type" and "claim amount" models. Maine had proposed to re-establish a reinsurance program – the Maine Guaranteed Access Reinsurance Association ("MGARA"), the state's reinsurance program that operated in 2012 and 2013.

MGARA would reimburse plans 90% of claims paid for enrollees whose claims exceed a threshold (called an attachment point) of $47,000 through a ceiling of $77,000; and fully reimburse claims that exceed $77,000 without a cap for high-risk enrollees diagnosed with certain health conditions. Maine's reinsurance program is funded with a combination of fees, assessments on commercial insurers and on third-party administrators of self-insured plans, premiums paid by insurers who cede claims to the pool, and federal pass through dollars. Maine received over 90 million pass-through dollars for 2019.

In 2018, Maine projected that the reinsurance program would reduce premiums an average of 9% in 2019. In recent prior years in Maine, insurers had requested annual increases of up to 40%. As reported by the Kennebec Journal on August 24, 2019, two of Maine three ACA marketplace insurers filed rates with the Maine Bureau of Insurance in July 2019 that will reduce their average rates for individual insurance plans in 2020, while the other insurer will increase its average rates by less than 1%.

The three Maine insurers – Community Health Options, Harvard Pilgrim Health Plan and Anthem Blue Cross Blue Shield – all have stated that their lower rates were implemented because new evidence had emerged that the ACA health insurance marketplace in Maine had substantially stabilized in 2019. Community Health Options went from a 7.7% increase to a .8% increase. Harvard Pilgrim Health Plan went from a 1.9% increase to a 7% decrease. Anthem Blue Cross Blue Shield went from a 1% increase to a 2% decrease.

In 2019, various other states have implemented state-based reinsurance programs, for the most part following the "claim amount" model. For example, on July 31, 2019, Colorado became one of the latest states to receive a Section 1332 waiver to implement a state-based reinsurance program. Colorado had sought federal "pass-through" funding to partially finance its reinsurance program. The waiver allows federal pass-through funding to partially finance a reinsurance program to be administered by the Colorado Department of Insurance. The reinsurance program will reimburse

insurers 60% of claims paid between $30,000 and an estimated $400,000 cap.

On July 31, 2019, North Dakota's waiver request was allowed, allowing federal pass through funding to partially finance the Reinsurance Association of North Dakota ("RAND"). RAND would reimburse insurers 75% of claims paid between $100,000 and $1,000,000. On August 16, 2019, Montana's 1332 waiver application was approved, allowing for federal pass-through funding to partially finance a reinsurance program to be administered by the Montana Reinsurance Association Board and the Commissioner of Securities and Insurance. The reinsurance program will reimburse insurers 60% of claims paid between $40,000 and an estimated $101,750 cap.

On August 20, 2019, Delaware's Section 1332 waiver request was allowed, which permitted federal pass-through funding to partially finance Delaware Health Insurance Individual Market Stabilization Reinsurance Program. The reinsurance program will reimburse insurers 75% of claims paid between $65,000 and $215,000. On August 28, 2019, Rhode Island's waiver application was approved, permitting federal pass-through funding to partially finance a reinsurance program to be administered by HealthSource RI. The reinsurance program will reimburse insurers 50% of claims paid between $40,000 and an estimated $97,000 cap.

Massachusetts has been exploring a variety of reforms, some under Section 1332, and others under another section of the A - Section 1321(e) - that authorizes Massachusetts, which offered state-subsidized coverage through an exchange marketplace pre-dating the ACA, to continue some of its earlier initiatives. In its Section 1332 waiver application submitted to CMS in the fall of 2017, Massachusetts proposed to use federal pass through money to provide advance payments to insurers operating cost-sharing reduction plans when federal CSR payments disappeared. The expected effect was that individual market premiums would decrease and federal spending on premium tax credits for residents of Massachusetts also would decrease. The state would receive the resulting reductions in federal spending as pass-through funding.

Under the proposed waiver, Massachusetts would use the pass-through funding for advance payments to issuers for an initial period of one year, beginning in CY2018, and the state would request the opportunity to renew the waiver through CY2022. At the time, Massachusetts estimated that Massachusetts estimated it would receive between $143 and $146 million for CY2018 in federal pass-through funding. This proposal was deemed incomplete by CMS – CMS said it was too close to the 2018 enrollment period to be workable. As of August 2019, the application was still deemed to be "incomplete."

Massachusetts has notably *not* sought to create a state-based reinsurance program, although there are good reasons why it should. Massachusetts could create a state-based reinsurance program similar to the approach taken in Minnesota, Maine, and

other states that would partially reimburse plans for enrollees – say 75% of claims – whose claims exceed a certain attachment point – say $75,000 - through a certain ceiling - say $500,000. The state could perhaps also fully reimburse claims that exceed $500,000 without a cap for high-risk enrollees diagnosed with certain health conditions.

The Massachusetts reinsurance program could be funded in a similar way to Maine, with a combination of fees, assessments on commercial health plans and on third-party administrators of self-insured plans, premiums paid by insurers who cede claims to the pool, and federal pass through dollars. In addition, Massachusetts Health Connector currently has a state subsidy program for enrollees in plans sold through the state exchange up to 300% of the federal poverty level – or FPL. By including these subsidy funds, the overall funding of a proposed Massachusetts reinsurance program could be even more robust.

One potential impediment to this approach in Massachusetts is that, like no other state except Vermont, Massachusetts is a "merged market" state, with a merged individual and small group risk pool. Merging the market was an effort to create stability by increasing the size of the health care insurance market and taking advantage of a more robust mix of risk.

A merged market dilutes the impact of reinsurance or other premium reduction efforts because the premium reductions are spread across the *entire* market of both individuals and small businesses, not just the individual market as in other states. In the context of a Section 1332 waiver, this could reduce the potential pass-through funding available because the amount is determined based on the individuals eligible for tax credits. As such, the ratio between premium and premium tax credits in the market dictates the relationship between state investment and federal pass-through funding for reinsurance through a Section 1332 waiver.

The Vermont Agency of Human Services has been looking into this very issue, and issued a study report in September 2018 entitled "State-Based Reinsurance Options for Vermont." In looking at its enrollment and subsidy information, Vermont has determined that a purely merged market limits the amount of federal pass-through funding available to the state. In Vermont, there is about a 5:1 ratio between premiums and premium tax credits. Thus, a reinsurance program would need to be about 80% state funded. For example, in order to target a 5% premium reduction through reinsurance, the state would need to invest approximately $20 million and would receive about $5 million in federal pass-through dollars.

In Vermont, assuming an "unmerged market," the ratio between premiums and premium tax credits would *decrease* because a significantly larger portion of the market would be subsidized. The Vermont report concluded that this would increase the potential federal share of available pass-through dollars from 20% to a range of 40-45%. Based on this analysis, Vermont concluded that any state-based reinsurance

program in its merged market would likely require a significant investment of state funds. Vermont also concluded that such an investment of state funds investment *could* be reduced, and additional federal dollars leveraged, *if* the market were unmerged or treated as unmerged for the purposes of reinsurance.

According to the July 24, 2017 Kaiser Family Foundation Report on "Premiums and Tax Credits under the Affordable Care Act," showing 2017 data, in Massachusetts, under its merged market, there is about a 3.5:1 ratio between premiums and premium tax credits. Thus, here, a reinsurance program would need to be 70% state funded. For example, in order to target a 5% premium reduction through reinsurance, Massachusetts would need to invest approximately $17.5 million and would receive about $7.5 million in federal pass-through dollars.

In Massachusetts, therefore, assuming an "unmerged market," as in Vermont, the ratio between premiums and premium tax credits would also likely *decrease* because a significantly larger portion of the market would be subsidized. Drawing from the Vermont report's analysis, such a "demerger" could perhaps increase the potential federal share from 30% to around 60%.

As previously noted, Vermont concluded in its study report, that any state-based reinsurance program in its existing merged market would likely require a significant investment of state funds. Unlike Vermont, however, Massachusetts already has committed to investing funds on premium reduction efforts – namely, the Connector's existing state subsidy program for enrollees in plans sold through the state exchange up to 300% of the FPL. By investing these already-existing subsidy funds into a proposed Massachusetts reinsurance program, it is likely that a reduction in health insurance premiums could be achieved even in Massachusetts' existing merged market.

Experience with reinsurance programs clearly demonstrates their efficacy in reducing health insurance premiums in the private individual market. This was demonstrated with respect to the federal reinsurance program that was in effect from 2014 – 2016. This has also been shown with respect to the increasing number of state-based reinsurance programs that have come online over the past several years.

An increasing number of states have now implemented Section 1332 waver-based reinsurance programs, and all have accomplished three important goals: the increased stability of the health insurers participating in the state insurance marketplaces; a reduction in uncertainty among carriers as to potential claim exposures; and a reduction in the overall premium cost of health insurance for individuals. If Massachusetts were to also create such a reinsurance program, even with its "merged market" structure, it is very likely that premiums in the state for health plan coverage in the state marketplace could be reduced. Moreover, to the extent that Massachusetts were to decide to "demerge" its healthcare insurance market, it is possible that it would be able

to utilize more federal pass-through dollars to even further reduce premiums in the Commonwealth through such a Massachusetts reinsurance program.