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ISSUE BRIEF

DECEMBER 2017

STATE-BASED STRATEGIES TO STABILIZE THE HEALTH INSURANCE MARKETPLACE

Section 1332 of the ACA provides options for states to make coverage more affordable

Introduction

Since March 2017, Congress has debated several bills to repeal and replace the Affordable Care Act (ACA). Almost all the bills have included provisions to create a fund to provide billions of dollars for grants to states to stabilize their individual (non-group) health insurance markets and address cost and coverage issues. All three of the major bills considered by Congress also included amendments to simplify the application and approval process for Section 1332 of the ACA, titled *Waiver for State Innovation*, which allows states to waive certain provisions of the ACA and receive funding to implement new state-based programs and strategies to provide their citizens with access to affordable health care.

Two of the programs frequently suggested to address the cost of providing coverage for high-risk, high-cost individuals are traditional high-risk pools and reinsurance programs. This issue brief examines a small number of reports and limited summary data for 2000 through the first quarter of 2013 from the Kansas high-risk pool, which operated from 1994 through the end of 2013, and provided coverage for some Kansans at premium rates above the average market rate. KHI also has reviewed information about state-based reinsurance programs that have been implemented or proposed by other states, to describe the costs and benefits of these programs and how they impact a state's individual health insurance market. To date, a total of seven states have implemented or proposed reinsurance programs.

Section 1332 of the ACA

While Congress has been considering repeal and replace legislation for the ACA, the Trump administration also has been encouraging states to consider using the existing Section 1332 provisions to address cost and coverage issues in their individual health insurance markets. On March 13, 2017, the U.S. Department of Health and Human Services (HHS) issued a letter to all state governors encouraging them to submit applications for waivers. Under existing Section 1332, states applying for waivers and funding must demonstrate that a proposed waiver will:

- Provide comprehensive coverage that is comparable to the coverage offered through the ACA;

KEY POINTS

- ✓ Claims for high-cost individuals have resulted in increasing premiums for all consumers purchasing individual coverage on the health insurance marketplace created by the Affordable Care Act (ACA).
- ✓ The U.S. Department of Health and Human Services in 2017 encouraged all governors to consider using the ACA's Section 1332 *Waiver for State Innovation* to implement high-risk pools, reinsurance programs or other strategies to lower marketplace premiums.
- ✓ If a state's approved waiver results in savings to the federal government, the state may receive an aggregate amount of the funds saved, which can be used for implementation.
- ✓ Five states have submitted waiver applications to implement reinsurance programs; three have been approved by the federal government.

- Ensure affordability by providing coverage and cost-sharing protection against excessive out-of-pocket spending;
- Provide coverage to at least a comparable number of residents as the ACA; and
- Ensure the waiver plan will not increase the federal deficit.

If a state's approved waiver would make its eligible citizens and small businesses ineligible for the ACA's premium tax credits, cost-sharing subsidies or small business tax credits, the state also may receive an aggregate amount of those unused funds to pay for marketplace coverage to implement the state's waiver plan. The HHS letter specifically encouraged governors to consider implementing a high-risk pool or a state-operated reinsurance program to lower premiums, improve market stability and increase consumer choice in their health insurance markets. One state, Oregon, just received approval of its application in late October.

State-Operated High-Risk Pools

Under the ACA, insurance companies are prohibited from denying coverage to individuals with pre-existing health conditions or setting premium rates based on health status. Prior to implementation of the ACA, individuals applying for coverage in the individual health insurance market with pre-existing health conditions were medically underwritten and subjected to pre-existing condition exclusions, charged higher premiums or denied coverage. Thirty-five states, including Kansas, operated traditional high-risk pools (in which enrollees were kept separate from the standard risk pool) prior to 2014 to provide state-based, subsidized health insurance coverage for individuals who were unable to obtain adequate and affordable coverage in the market.

Kansas' Experience

K.S.A. 40-2117, et seq., the Kansas Uninsurable Health Insurance Plan Act, was passed by the Legislature in 1992 to establish a nonprofit legal entity known as the Kansas Health Insurance Association (KHIA). The Act requires all insurers providing health care benefits in the state to be members of KHIA, which operates under a plan established and exercised by a board of directors, with statutory oversight by the commissioner of insurance. For almost 20 years, until coverage was discontinued on January 1, 2014, KHIA operated a high-risk pool for Kansans who met certain eligibility requirements, including:

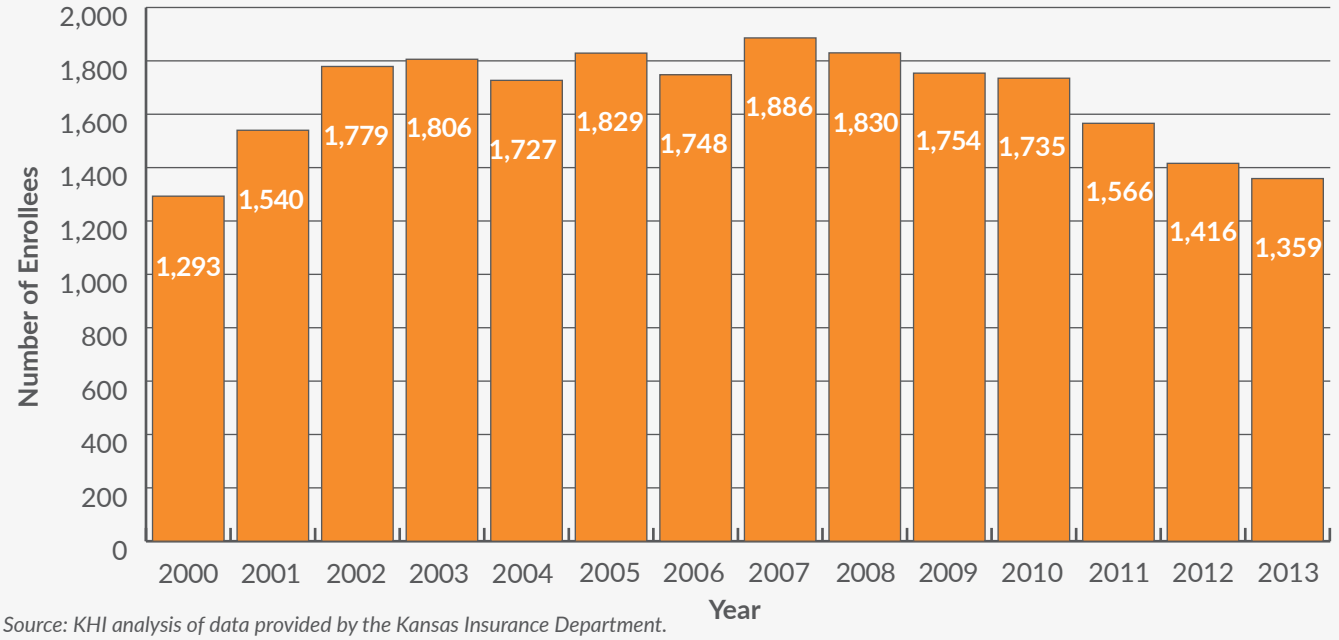
- Residing in Kansas for six months prior to application;
- Having their health insurance coverage involuntarily terminated for any reason other than nonpayment of premium;
- Having applied for health insurance and been rejected by two insurance carriers because of health conditions;
- Being a child under the age of 19 who had been unable to purchase coverage under an individual health insurance policy because such coverage was not available for sale in the county in which they resided;
- Having applied for health insurance and been quoted a premium rate in excess of the KHIA rate;
- Having been accepted for health insurance subject to a permanent exclusion of a pre-existing disease or medical condition; or
- Meeting certain federal law requirements relating to having previous creditable coverage (generally recognized types of public and private insurance) that made them a "federally defined eligible individual."

Resident dependents of persons who were eligible for KHIA coverage also were eligible for coverage.

Individuals who were not eligible for coverage included:

- Persons who were eligible for Medicare or Medicaid;
- Persons whose coverage with KHIA was terminated less than 12 months prior to the date of a current application (did not apply to federally defined eligible individuals);
- Persons who had received accumulated benefits from a KHIA plan equal to or in excess of the lifetime maximum benefits under the plan;
- Persons who had access to coverage through an employer-sponsored group or self-insured plan; or
- Persons who were eligible for any other public or private program that provided health services.

Figure 1. **Number of Enrollees in the Kansas High-Risk Pool by Year, 2000–2013**



Source: KHI analysis of data provided by the Kansas Insurance Department.

A third-party administrator selected by the board was responsible for collecting premiums, processing the payment of claims, and submitting quarterly reports to the board regarding the operation of the pool. The board was responsible for setting premiums and setting and collecting assessments on the KHIA member insurance companies in proportion to their annual respective market shares of total health premiums received in the state to cover the net losses experienced by KHIA.

Enrollment

In 1994, the first year of operation for the Kansas high-risk pool, KHIA had 578 enrollees. Enrollment continued to grow into the mid-2000s (*Figure 1*), peaking at 1,886 in 2007, and then tapering off through 2013, with 1,359 enrolled in the last year of operation.

With full implementation of the health insurance provisions of the ACA in 2014, KHIA enrollees were able to purchase guaranteed-issue insurance coverage on or off the federally facilitated marketplace, and enrollment in the KHIA plan was terminated effective January 1, 2014.

Coverage and Benefits

In 2013, four comprehensive health plans, with annual deductibles ranging from $1,500 to $10,000, were available to KHIA enrollees (*Figure 2*, page 4). The $2,500 deductible policy met the requirements to be used in conjunction with an individual health savings account (HSA) and was the most popular policy among enrollees.

Each plan had a preferred provider network, which offered lower out-of-pocket costs—such as copayments and coinsurance—if enrollees received care from a provider in the network. Plan benefits were comparable to those of private health insurance plans and included access to a nationwide network of pharmacies and negotiated discounts on prescription drugs.

Coverage under the plan was subject to deductibles and coinsurance provisions established by the KHIA board and coverage under the plan was subject to a maximum lifetime benefit per covered individual. That maximum was $1 million until 2011, when it was increased to $3 million by the Kansas Legislature at the request of the board when some enrollees began to exceed the cap, and it was increased again to $4 million in 2013.

Coverage under the plan also was subject to a pre-existing condition exclusion during the first 90 days of coverage, which served to discourage individuals from joining and dropping out of the plan to meet an immediate, one-time need for services. The pre-existing condition exclusion did not apply to federally defined eligible individuals who applied for coverage within 63 days following the termination of their most recent creditable coverage.

Premiums

Premium rates were set annually by the board, but by law could not exceed 150 percent of the average premium rate charged for similar coverage in the private market. The board also could adjust rates for risk factors such as age, sex, tobacco use and geographic location, but could not consider specific health conditions or illnesses as a risk factor. Premium rates for 2013 were 126 percent of the private market rates, and the rate for a 45-year-old male (non-tobacco user) enrolling in the $2,500 deductible plan was $489.82/month, while the premium rate for a female of the same age was $655.95/month. Annual premium rate increases ranged from 2.5 percent to 14 percent from 2003 to 2012. No financial assistance or subsidies were available for enrollees to reduce the cost of premiums.

Costs and Funding

KHIA's total incurred claims ranged from $21,494,834 in 2008 for 1,830 enrollees to $32,304,758 in 2012 for 1,416 enrollees. Average annual costs per enrollee nearly doubled during the last five years of the plan's operation, increasing from $11,746 in 2008 to $22,814 in 2012 (*Figure 3*, page 5). Between April 2012 and March 2013, end-stage renal disease claims made up 15 of the 20 largest claims, including total combined claims of $1.35 million for one enrollee.

Annual revenues for KHIA included premiums paid by enrollees, assessments on insurers, and cost-sharing by enrollees. The plan also received grants from the federal government, averaging about $1.2 million annually from 2006 through 2012. KHIA received no state general funds for its operations.

Premiums paid in 2008 were $11,743,747 and increased each year until 2012. Assessments paid by

Figure 2. **Example KHIA Insurance Policy Benefits (as of 2013)**

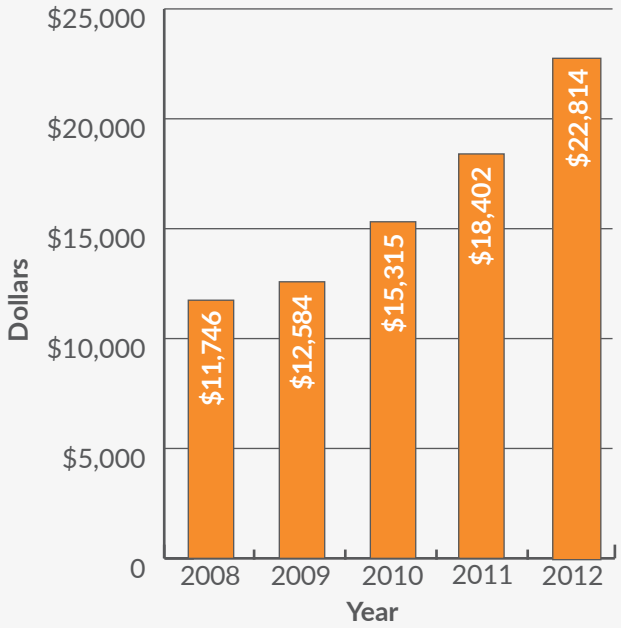
Benefits	Policy Type (by deductible)			
	$1,500	$2,500*	$5,000	$10,000
Coinsurance (in network)	70 percent of next $5,000	70 percent of next $8,333	70 percent of next $5,000	70 percent of next $15,000
Benefit Percentage Payable**	100 percent	100 percent	90 percent	90 percent
Coinsurance (out of network)	50 percent up to lifetime maximum	50 percent up to lifetime maximum	50 percent up to lifetime maximum	50 percent up to lifetime maximum
Individual Lifetime Maximum	$4,000,000	$4,000,000	$4,000,000	$4,000,000
Prevention Services	$25 copay then 100 percent paid	Benefits payable on the same basis as any other sickness	$25 copay then 100 percent paid	$25 copay then 100 percent paid
Outpatient Mental Health/Substance Abuse	First visit reimbursed at 100 percent, deductible waived; visits 2–20 subject to $25 copay, deductible waived; 20 visit maximum limit/year	Benefits payable on the same basis as any other sickness, no limit	First visit reimbursed at 100 percent, deductible waived; visits 2–20 subject to $25 copay, deductible waived; 20 visit maximum limit/year	First visit reimbursed at 100 percent, deductible waived; visits 2–20 subject to $25 copay, deductible waived; 20 visit maximum limit/year
Inpatient Hospital Care	Benefits payable on same basis as any other sickness; prior authorization required, $1,000 penalty for failure to obtain pre-authorization			
Prescriptions	Subject to calendar year deductible then paid at 50 percent until out-of-pocket costs met; thereafter, paid at benefit percentage payable for selected policy up to lifetime maximum			

Note: Out-of-pocket costs include deductibles, coinsurance and copayments for all services plus all costs for services that are not covered. *HSA compliant. **After deductible and coinsurance.

Source: KHI analysis of data provided by the Kansas Insurance Department.

insurers ranged from $10.5 million in 2008 to $14 million in 2012 (*Figure 4*, page 5). In 2012, premiums covered approximately 39 percent of KHIA's total expenses, assessments covered approximately 43 percent, and cost-sharing by enrollees (including deductibles, copayments and coinsurance) covered the balance.

Figure 3. **Average Annual Costs Per Enrollee in the KHIA Plan, 2008–2012**



Source: KHI analysis of data provided by the Kansas Insurance Department.

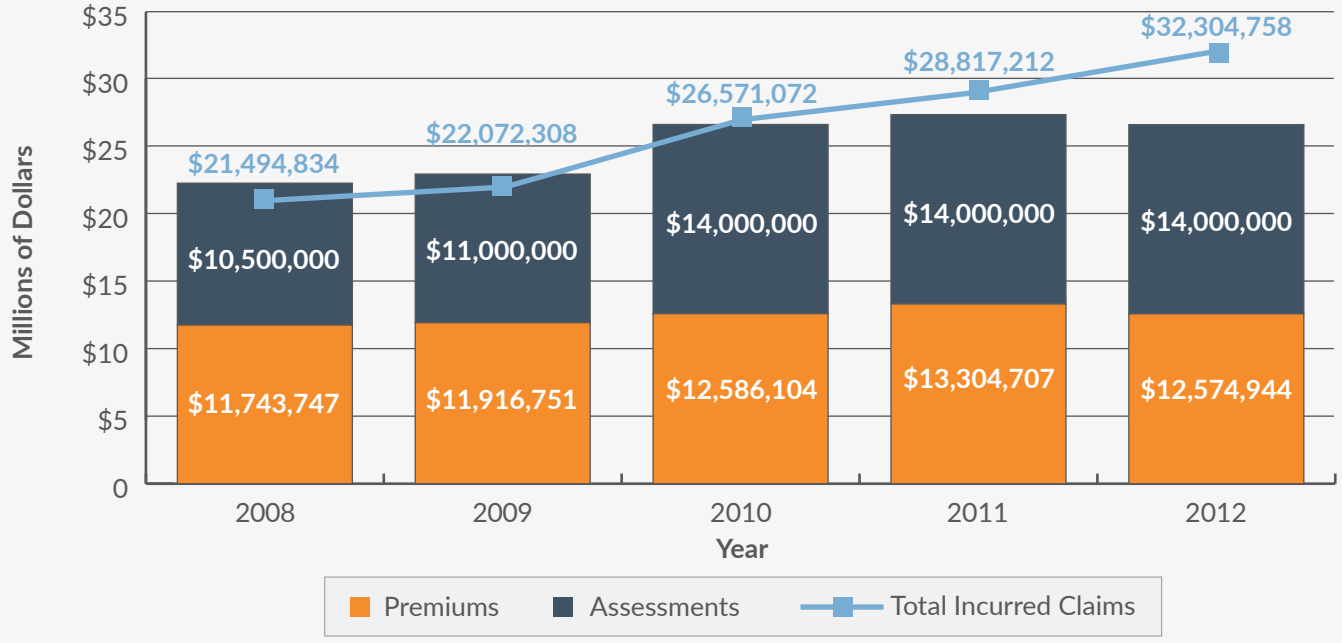
State-Operated Reinsurance Programs

Under the ACA, health insurance companies are required to maintain one risk pool for all enrollees purchasing insurance in the individual market, including on and off the marketplace. Since 2014 insurers have reported that claims experience for high-cost individuals have significantly increased overall claims cost in the pool, resulting in increasing premium rates for all consumers purchasing individual coverage.

Reinsurance programs, an alternative to a traditional high-risk pool, also can stabilize insurance markets and address affordability for high-cost individuals, allowing them to pay health insurance premiums comparable to lower-cost individuals while still providing them with the same comprehensive benefits and access to health care providers.

In general, reinsurance programs reimburse insurers for some portion of their incurred claims when they exceed a certain amount. Some states have implemented what is referred to as an "invisible" (invisible to the enrollee) high-risk pool, which allows high-cost enrollees to participate in the regular private market and pay comparable premiums, but keeps all or a portion of their claims costs separate from the overall risk pool, thereby mitigating the

Figure 4. **Total Incurred Claims, Premiums Paid and Assessments Collected in the KHIA Plan, 2008–2012**



Note: Although the claims costs exceeded the premiums paid and assessments for 2011 and 2012, enrollee cost-sharing and/or surplus funds from previous years covered the remainder of the costs. Data for administrative expenses, surplus funds, federal grants and enrollee cost-sharing were not available to include in this figure. No state general funds were used.

Source: KHI analysis of data provided by the Kansas Insurance Department.

impact of those costs on the pool. For these types of programs, a state may develop a list of high-cost health conditions (e.g., using diagnostic codes) and then identify enrollees with one or more of those conditions (e.g., using a health questionnaire) for participation in the program. Following the end of the plan year, or sometimes quarterly, insurers submit their covered claims costs to the reinsurance program for reimbursement based on an "attachment point" (threshold dollar amount) and cap, and/or a percentage of the claims.

Funding for state-based reinsurance programs typically comes from two sources: contributions—including premiums or assessments—collected from insurers and government funds (federal and/or state). Adequate funding to reduce the overall claims cost paid by insurers is key to keeping premiums affordable for all enrollees.

What are States Doing?

Seven states have implemented or proposed to implement individual market reinsurance programs using Section 1332 waiver applications.

ALASKA. The Alaska Reinsurance Program (ARP), which began in 2017, provides payments to insurers for enrollees who have one or more of 33 identified high-risk conditions. For 2017, the ARP is being funded through state general fund revenues of $55 million. Premiums, pharmacy rebates and other revenue collected by the insurers for these individuals also is passed to the program. Beginning in 2018—as a result of HHS's approval of Alaska's Section 1332 waiver application on July 11, 2017—the savings in ACA premium tax credit payments for Alaska enrollees resulting from the program's impact on reducing premium rates will be passed through to the state. HHS expects the program will cost $59 million for 2018, of which the federal government will pay $48.4 million, with the balance to be paid by the state. For 2017, individual health insurance premiums in Alaska increased 7 percent instead of the projected 42 percent without the ARP. The state projects that with the program in place individual market premium rates for 2018 may decrease by up to four percent relative to 2017 rates.

The Alaska Reinsurance Program is expected to cost $59 million for 2018, of which the federal government will pay $48.4 million.

IOWA. In its Section 1332 waiver application submitted to HHS on August 21, 2017, Iowa proposed establishing the Iowa Stopgap Measure for 2018, which included a reinsurance program. Iowa proposed using the federal dollars that would otherwise be used for ACA premium tax credits and cost-sharing reduction payments—estimated to be $421 million for 2018—to fund the program, which would cover 85 percent of claims between $100,000 and $3 million. The program was projected to reduce claims costs by 15 to 17 percent and significantly reduce premium increases in the state's individual market. When HHS determined it was unable to approve some elements of Iowa's waiver under existing ACA rules and requirements, Iowa withdrew its application on October 23, 2017.

MAINE. In 2011—even before full implementation of the insurance provisions of the ACA—Maine established a state-based reinsurance program (an invisible high-risk pool), which existed from 2012 to 2014. Administered by the Maine Guaranteed Access Reinsurance Association (MGARA), the program required enrollees to fill out a health questionnaire, and if certain costly medical conditions were disclosed, their application was flagged for the program. Enrollees paid regular premiums and received the same coverage as any other enrollee in their health plan, but their claims costs were paid by MGARA. Funding for the program came from two sources: (1) the insurance premiums paid by the high-cost enrollees, and (2) a $4-a-month surcharge on all policyholders in the state.

Although the program was in effect for a very brief period, Anthem—the largest insurer in Maine—estimated that premium rates would have increased more than 20 percent without the program, but instead went up less than 2 percent. The program ended when the ACA marketplace was implemented in 2014. House Republicans studied the Maine program when crafting the American Health Care Act introduced this year. In June 2017, Maine passed legislation to amend MGARA to authorize resumption of operations of the state's reinsurance program "if it is likely to provide significant benefit to the state's health insurance market," and also to develop a proposal for a Section 1332 waiver.

MINNESOTA. Minnesota passed legislation in April 2017 to create the Minnesota Premium Security Plan (MPSP), a reinsurance program that will begin in 2018.

The $271 million reinsurance program, funded from a combination of federal and state dollars, will pay insurers 80 percent of enrollee claims between the attachment point of $50,000 and a cap of $250,000. The MPSP is projected to reduce premiums by an average of 20 percent, and the state anticipates the federal government will be providing $139.2 million in pass-through funding with the program in place. The legislation required the state to apply for a Section 1332 waiver and included language indicating that the program was contingent on approval of the application, which was filed on May 5, 2017, and approved by HHS on September 22, 2017.

> Minnesota's reinsurance program begins in 2018 and is projected to cost $271 million, of which the federal government is expected to pay approximately $139.2 million.

NEW HAMPSHIRE. New Hampshire passed legislation in July 2017 that authorized its state insurance commissioner to develop a plan for a risk adjustment program, high-risk pool, reinsurance program or other program to "support the affordability of health insurance in the individual market." The law also authorized the commissioner to submit a Section 1332 waiver application to HHS if required.

Under Section 1332 requirements, New Hampshire has posted for public comment a draft of its waiver application, which proposes to implement a state-operated reinsurance program for 2018 and subsequent years. The state has projected that the program will limit the amount of ACA premium tax credits to be provided to New Hampshire residents by the federal government, and is requesting $8.2 million from the federal government in pass-through funding from the savings. Additional funding will come from a fee that will be imposed on all the state's insurers, regardless of whether they sell plans in the ACA marketplace. The state has estimated that the program will decrease premium rates by approximately 7.3 percent from what they would have been absent the program.

OKLAHOMA. During the 2016 legislative session, Oklahoma legislators created a task force to investigate and analyze options for a Section 1332 waiver application to be submitted in 2017. The charge of the task force was to bring together a diverse set of stakeholders to develop potential strategies to increase enrollment and stabilize the individual market. The task force recommended implementation of the Oklahoma Individual Health Insurance Market Stabilization Program (OMSP) for 2018, which the legislature authorized in June 2017. In the Section 1332 waiver application submitted to HHS on August 16, 2017, the state proposed to use federal pass-through funding and state-based assessments to create a reinsurance program for 2018 for the insurers operating in the Oklahoma marketplace. The application also stated that the purpose of the program was to provide payments to health insurers for claims for "eligible individuals (high-cost enrollees) in order to lower premiums..." High-cost enrollees were defined as those whose total claim experience in a one-year period reached $15,000, the state's attachment point. The state would then reimburse insurers for 80 percent of the enrollees' costs between the attachment point and a cap of $400,000. Enrollee costs above the cap, and the administration costs, would be the responsibility of the insurers.

Oklahoma engaged actuarial firm Milliman to analyze the state's health care utilization characteristics to determine the attachment point and cap, as well as the amount of funding needed for the program. The firm determined that a $325 million per year (for 10 years) reinsurance program would generate premium savings in excess of 30 percent from the state's 2017 average rates. Of the $325 million needed for 2018, $16 million would come from Oklahoma's assessment on insurers, and the state projected it would receive $309 million in pass-through funding from the federal government.

To implement its reinsurance program for 2018, Oklahoma had requested approval of its application by September 25, 2017. When HHS advised the state that approval would not be provided on that date, Oklahoma withdrew its application on September 29, 2017.

OREGON. Oregon passed legislation in July 2017 to submit a Section 1332 waiver application to develop a state reinsurance program for five years beginning in 2018. In the application submitted to HHS on August 31, 2017, the state projected the program will lower premiums and reduce federal payment of ACA premium tax credits. Oregon proposed to partially fund its program with federal pass-through funds, provided by premium tax credits savings that are estimated to be more than $30 million per year through 2027, and projects that the program will result in a net premium decrease of 7.1 percent

in 2018 and 6.5 percent in 2019. HHS approved Oregon's waiver application on October 19, 2017.

Conclusion

With both Congress and the Trump administration encouraging states to consider applying for a Section 1332 waiver to stabilize their insurance markets and provide affordable coverage for their citizens, it is likely that more state legislatures around the country will be studying the historical results of high-risk pools and the potential benefits and challenges of implementing a state-based reinsurance program. If Kansas, like other states, continues to see a rise in health insurance premiums due to the increasing cost of providing health care services to high-risk, high-cost individuals, Kansas legislators may be interested in taking a closer look at KHIA's history and operational data to gain an understanding of the costs and benefits of a traditional high-risk pool. They also may want to explore the experiences and funding approaches utilized by the handful of states that have already implemented or proposed the establishment of a state-based reinsurance program.

Figure 5. **Proposed Section 1332 Reinsurance Programs**

State	Description	Status
Alaska	The Alaska Reinsurance Program is estimated to cost $59 million for 2018. The federal government will pay $48.4 million, with the balance to be paid by the state.	Section 1332 waiver application submitted to HHS on 12/29/2016; approved 07/11/2017
Iowa	The proposed 2018 reinsurance program would have used a portion of the federal dollars—estimated to be $421 million—that would otherwise be used for advance premium tax credits (APTC) and cost-sharing subsidies for Iowa citizens.	Section 1332 waiver application submitted to HHS on 08/21/2017; withdrawn on 10/23/2017
Maine	Legislation was passed to amend the Maine Guaranteed Access Reinsurance Association Act to authorize resumption of operations of the state's reinsurance program and development of a proposal for a Section 1332 waiver.	Legislation enacted 06/02/2017
Minnesota	The Minnesota Premium Security Plan will begin operation in 2018 and will use funding from a combination of federal dollar savings generated by the APTC that would otherwise be paid to Minnesota citizens without the reinsurance program and state funds. Cost of the plan for 2018 is expected to be $271 million.	Section 1332 waiver application submitted to HHS on 05/05/2017; approved 09/22/2017
New Hampshire	The proposed reinsurance program for 2018 will be funded by fees imposed on all the state's insurers, regardless of whether they sell plans in the ACA marketplace, and federal pass-through funding from savings on reduced APTC of $8.2 million.	Per Section 1332 requirements, the draft waiver application is posted for public comment
Oklahoma	The proposed creation of the Oklahoma Individual Health Insurance Market Stabilization Program for 2018 was to be funded with federal pass-through funding of $309 million and state-based assessments of $16 million.	Section 1332 waiver application submitted to HHS on 08/16/2017; withdrawn 9/29/2017
Oregon	The proposed five-year reinsurance program beginning in 2018 is to be partially funded with federal pass-through funds provided by APTC savings, which are estimated to be more than $30 million per year through 2027.	Section 1332 waiver application submitted to HHS on 08/31/2017; approved on 10/19/2017

Source: KHI analysis of State Roles Using 1332 Health Waivers from the National Conference of State Legislatures.

ABOUT THE ISSUE BRIEF
This brief is based on work done by Linda J. Sheppard, J.D., and Hina B. Shah, M.P.H. It is available online at khi.org/policy/article/17-38.

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