Purpose of Today’s Discussion

• Consider reinsurance as a potential strategy to increase stability in the individual insurance market
• Discuss Section 1332 waivers as a vehicle for state flexibility to establish a state-run reinsurance program
The National Governors Association

Who We Are
National Governors Association (NGA) is the bipartisan organization of the nation’s governors. Through NGA, governors share best practices, speak with a collective voice on national policy and develop innovative solutions that improve state government and support the principles of federalism.

Conference of Governors
The White House, 1908
NGA Center for Best Practices

Health

Homeland Security & Public Safety

Environment, Energy & Transportation

Economic Opportunity

Education
Governors’ Bipartisan Health Reform Learning Network

- Provides unbiased information about health reform proposals and the state impact
- Offers a forum for states to engage in dialogue with other state leaders and identify shared priorities for reform
- Released in June, Shared Priorities from the Governors’ Bipartisan Health Reform Learning Network highlights priorities for Medicaid, private health insurance and public health
The Affordable Care Act’s Federal Transition and Risk Mitigation Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Risk Adjustment (ongoing)</td>
<td>Transfers money from insurers with low expected spending to insurers with high expected spending</td>
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<tr>
<td>Risk Corridors (2014 - 2016)</td>
<td>Transferred money from insurers with low <em>unexpected</em> spending to insurers with high <em>unexpected</em> spending</td>
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<tr>
<td>Reinsurance (2014 - 2016)</td>
<td>Provided subsidies to individual market plans for enrollees incurring high actual spending</td>
</tr>
<tr>
<td>Traditional High Risk Pools (2010 - 2014)</td>
<td>Provided health insurance to those that had been denied coverage by private health insurance companies because of a pre-existing condition</td>
</tr>
</tbody>
</table>
States are interested in reinsurance programs as one strategy for lowering premiums and increasing enrollment in the individual insurance market.

Without Reinsurance:
- Premiums increase to compensate for risk pools with high-cost enrollees.
- Enrollment in private health insurance market decreases as individuals are priced out of market.

With Reinsurance:
- Insurers offer lower premiums because their risk of covering high-cost enrollees is offset by the reinsurance.
- Enrollment in private health insurance market increases as more individuals are able to afford lower premiums.
## Reinsurance Program Design Options

<table>
<thead>
<tr>
<th></th>
<th>Claims-based</th>
<th>Conditions-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurers are repaid</td>
<td>for a portion of all high-cost claims incurred</td>
<td>Insurers are paid for all claims associated with individuals diagnosed with certain high-cost</td>
</tr>
<tr>
<td></td>
<td>Claims do not need to be associated with any particular condition</td>
<td>conditions in exchange for giving premiums to reinsurance pool</td>
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<td></td>
<td>Insurers do not cede premiums to receive reinsurance payments</td>
<td>All claims for individual are paid to insurer regardless of whether they are associated with the</td>
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<td></td>
<td>Increases predictability for insurers regarding financial accountability by helping pay for</td>
<td>high-cost condition</td>
</tr>
<tr>
<td></td>
<td>high cost claims</td>
<td>Members do not know that their premiums have been ceded to the reinsurance pool</td>
</tr>
<tr>
<td></td>
<td>Payment is between reinsurance entity and insurer; consumers are not involved regardless of</td>
<td>Payment is between reinsurance entity and insurer; consumers are not involved regardless of their</td>
</tr>
<tr>
<td></td>
<td>their health status or cost of claims</td>
<td>health status or cost of claims</td>
</tr>
</tbody>
</table>
Operational Variables of Reinsurance Programs

- **Attachment Point**: Dollar amount at which reinsurance begins to apply to a health insurer’s claims.
- **Reinsurance Cap**: Maximum claims amount for which an issuer would be eligible for reimbursement.
- **Coinsurance applies within range**: Percent of claims covered by reinsurance program between the attachment point and cap for a given claimant.

Legend:
- Claims paid by insurer
- Claims paid by reinsurance program
Section 1332 Waiver Basics

Section 1332 waivers are a vehicle for states to waive certain provisions of the Affordable Care Act, including:

- The establishment of qualified health plans and exchanges
- Individual and employer mandates
- Benefits and subsidies for consumers
- The establishment of a single risk pool

States may receive a “pass-through” of federal funds that would have otherwise been applied to premium tax credits or cost-sharing reductions had the state not received the waiver.
Section 1332 Guardrails

All Section 1332 waivers must satisfy the following guardrails:

- **Coverage Availability**: Coverage will be provided to a comparable number of individuals as would receive coverage absent the waiver.
- **Coverage Affordability**: Coverage will be as affordable for individuals as it would be absent the waiver.
- **Comprehensiveness of Coverage**: The scope of benefits will be at least as comprehensive as benefits required absent the waiver.
- **Deficit Neutral**: The waiver will not increase the federal deficit.
Section 1332 Waiver Process Timeline

- State Legislation
  - Minimum 30 days
  - State Public Notice and Comment Period
- Public Hearings
  - Estimated 30 days
  - Preliminary Review
- Federal Public Notice and Comment Period
  - Within 45 days
- Decision Making
  - Within 180 days
  - HHS and Treasury Decision Making

Approximately 9.5 months
Section 1332 Checklist

Applications must include:

- List of provisions being waived
- Proposed waiver implementation plan and timeline
- Actuarial and economic analysis and 10-year budget plan
- Data, assumptions, targets and other information related to the impact of the waiver on the four guardrails
- State legislation authorizing the application that includes language that program is contingent upon federal approval of the waiver
- Public communications documenting the public hearings and notice of public comment period
- Communications documenting consultation with Tribal entities in state
- Written comments received during the notice and comment period
- Funding strategy for state portion (which may require legislative action)
States must provide a funding strategy that would cover the cost of the difference between the federal pass-through dollars and the total cost of the reinsurance programs. Funding needed varies based on range of issues, including demographics and cost of insurance. In states with 1332 reinsurance programs, the state share has come from several places, including:

- State General Fund dollars
- Legislative dollars set aside for health access programs
- Assessments on insurers

Legislation related to a Section 1332 reinsurance waiver must:

- Specifically authorize or instruct the state to submit a waiver application
- Demonstrate legal authority to manage a reinsurance program
- Provide that the state reinsurance program is contingent upon federal approval of the waiver (or will become effective only if the Section 1332 waiver is approved)
How Reinsurance Works as Part of a Section 1332 Waiver

Federal government saves money on tax credits

Reinsurance program allows issuers to lower premiums for all enrollees

State reinsurance program receives pass through funding equal to the amount of federal tax credit dollars saved
State Section 1332 Reinsurance Waiver Activity to Date

Map Legend:
- =Waiver Drafted
- =Waiver pending approval from CMS
- =Waiver approved
- =Waiver withdrawn
Example: Oregon Reinsurance Program’s Impact on Premiums

**EXPECTED AVERAGE EXCHANGE PER MEMBER PER MONTH PREMIUM FOR 2018**

- **WITHOUT REINSURANCE:** $537.87
- **WITH REINSURANCE:** $498.90

**EXPECTED FEDERAL SPENDING ON ADVANCED PREMIUM TAX CREDITS FOR 2018**

- **2018 BASELINE ESTIMATE:** $475,581,251
- **2018 ESTIMATE UNDER WAIVER:** $441,119,306
- **Pass Through Funding Available to State:** $34,461,945
- **Federal Funding for Advanced Premium Tax Credits:** $441,119,306

Key Decision Points and Considerations

Decision Points:
• **Operational Variables**: Attachment point, cap, coinsurance
• **State funding**: Assessment, general fund dollars, ceded premiums

Key Considerations:
• What will be the impact on premiums and enrollment?
• How much state and federal funding will be needed?
• How will state fund its portion of the program?
• Who will administer the program for the state?
Questions?

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Appendix
<table>
<thead>
<tr>
<th>State</th>
<th>Attachment Point</th>
<th>Reinsurance Cap</th>
<th>Coinsurance</th>
<th>Estimated reinsurance funding</th>
<th>Source of state funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>N/A</td>
<td>N/A</td>
<td>100%</td>
<td>2017: $55M in state dollars from premium tax 2018: $50.5M in federal funding approved $25M contribution from Premara</td>
<td>Premium tax on all health insurers</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$50,000</td>
<td>$250,000</td>
<td>80%</td>
<td>$132M in state funding $139M in federal funding approved</td>
<td>State General Fund and Health Care Access Fund</td>
</tr>
<tr>
<td>Oregon</td>
<td>Not yet determined</td>
<td>$1,000,000</td>
<td>50%</td>
<td>$90M in state funding $35M in federal funding approved</td>
<td>1.5 % Premium assessment on fully insured commercial major medical plans</td>
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<tr>
<td>State</td>
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<td>New Jersey</td>
<td>$40,000</td>
<td>$215,000</td>
<td>60%</td>
<td>$105.8 million in state funding</td>
<td>Revenue from state shared responsibility tax and appropriation from the State General Fund</td>
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<td>$218 million in federal funding requested</td>
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<tr>
<td>Wisconsin</td>
<td>$50,000</td>
<td>$250,000</td>
<td>TBD (between 50%-80%)</td>
<td>$30 million in state funding</td>
<td>State general fund</td>
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<td></td>
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<td></td>
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<td>$170 million in federal funding requested</td>
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<tr>
<td>Maine</td>
<td>$47,000</td>
<td>N/A</td>
<td>90% for claims between $47,000 100% for claims above $77,000</td>
<td>$60 million in state funding</td>
<td>Organizational and Base market assessments on health insurers and third party administrators and ceded premiums for participating enrollees</td>
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<td>$33 million in federal funding</td>
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<tr>
<td>Maryland</td>
<td>TBD</td>
<td>$250,000</td>
<td>80%</td>
<td>$365 million in state funding</td>
<td>2.75 percent assessment on health insurance plans and state regulated Medicaid managed care plans</td>
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<td>$280 million in federal funding</td>
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