Reinsurance and high-risk pools: Past, present, and future role in the individual health insurance market

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Introduction

While affordability is a challenge across all health insurance markets, the individual market's challenges have historically been more acute. There are a number of reasons for this:

First, it has been (and still is) the "residual market" and the "market of last resort." In other words, individuals who are not eligible for employer-sponsored coverage or a government plan will face the choice of going uninsured or seeking insurance in the individual market. Many will only seek insurance when they have health needs, not when healthy.

Second, because premiums are not paid on a pretax basis as they are under employer-sponsored markets, costs are effectively grossed up by a household's marginal income tax rate for the same coverage, which is simply due to differential tax treatment.

And finally, while there are some exceptions, there is generally no employer contribution in the individual market. While there are meaningful subsidies to increase affordability for those under 400% of the federal poverty level (FPL), many on-exchange and all off-exchange individuals receive no subsidy. Therefore, these individuals are typically responsible for the entire cost of insurance, compared with a much smaller portion in employer-sponsored markets.

Unsurprisingly, policy mechanisms that could subsidize or otherwise reduce premiums in the individual market have been important considerations when policymakers seek solutions to create market stability and access. By subsidizing costs, premiums become more affordable for more individuals, thereby increasing access to coverage and broadening participation, which in turn helps to stabilize prices. This is demonstrated by the high number of low-income households purchasing insurance coverage through the insurance marketplaces with premium subsidies. However, as we note above, premium assistance is not currently available in the insurance marketplaces to households with income above 400% FPL, creating situations where individual market coverage may be considered unaffordable for higher-income households.

While not diminishing the importance of other market stabilization mechanisms such as the individual mandate and government-funded premium subsidies,[1] both high-risk pools (HRPs) and reinsurance[2] are policy mechanisms that have been and likely will continue to be used to address the *market-wide* cost challenges in the individual market. Both mechanisms can play important roles in controlling claims cost volatility as well. In this paper, we examine:

Historical uses of HRPs prior to the implementation of the Patient Protection and Affordable Care Act (ACA)

The role of reinsurance under the ACA, including emerging state-based programs developed using Section 1332 State Innovation Waivers

The proposed usage of reinsurance and HRP under the American Health Care Act (AHCA), as passed by the House on May 4, 2017

Considerations for states that are examining the creation and deployment of these types of mechanisms

High-risk pools dominated the pre-ACA landscape

Prior to the ACA, many states that had underwritten individual markets also employed some form of HRP.[3] In some cases, the HRP pool was completely separate from the standard risk pool and entirely visible to the enrollee: higher rates, distinct benefit plans, unique

networks, etc. In other cases, the HRP was invisible to enrollees. Enrollees were a part of the standard pool in that they had the same product and carrier selection and the same rates. (Please see the Appendix for a summary of different program features). Regardless of the specific structure of an HRP, these programs served several purposes:

HRPs provided safety net coverage for high-risk individuals who could not obtain coverage at all or could not obtain it at an affordable rate because of preexisting conditions. This often included the Health Insurance Portability and Accountability Act (HIPAA) requirement of guaranteed issue for individuals losing group coverage.

HRPs were a method of reducing the cost of coverage in the broader market. High-risk individuals were carved out of the standard underwritten market's risk pool and funded with a variety of external funding sources, including insurer and provider assessments (such as in the form of a tax on premiums or discounted reimbursement) and general revenues, in addition to premiums paid by HRP members.

For example, in Wisconsin's HRP, 20% of funding came from both insurers and participating providers.[4] Effectively, this additional outside funding represented a permanent subsidy to the individual market, helping to hold prices down. Typically, the total enrollment in a state's high-risk pool was a relatively low percentage of the total individual market, averaging around 2%.[5]

Because high-cost conditions are also very volatile, the removal of these risks to a separate risk pool decreased financial volatility, and hence pricing volatility, for carriers offering coverage.

A predictable consequence of carving out high-risk individuals to a separate pool, however, is that HRP costs were often very volatile, which presented a significant budgeting challenge for states that used general revenues to fund HRPs. Additionally, affordability of premium rates in HRPs for low-income individuals was a concern, with state-run HRPs often having premium rates that were as much as 50% higher than standard rates offered in the broader individual market.[6]

The role of reinsurance under the ACA

With the advent of the ACA, the rationale for high-risk pools was largely removed (although some pools remain open with limited enrollment[7]), as all risk in the individual market was intended to be in the "single risk pool" and insurers could not vary premiums by health status or preexisting conditions. However, recognizing the negative price impact that moving high-risk individuals out of high-risk pools and into the single risk pool would have, ACA architects included the transitional reinsurance program (TRP), one of the three risk mitigation components of the ACA's "3R's" programs. The TRP subsidized ACA-compliant individual market coverage for coverage years 2014 through 2016, reducing insurer-paid claims expenses by approximately $8 billion in both 2014 and 2015 and $4 billion in 2016.[8] This represented approximately 22% of ACA-compliant premium in 2014, decreasing to ~5% in 2016.[9] The TRP was funded through an assessment on commercial health insurance coverage, decreasing from $5.25 per member per month (PMPM) in 2014 to $2.25 PMPM in 2016.

Note, the TRP was not intended by the Department of Health and Human Services (HHS) to replace traditional commercial reinsurance, which limits an insurer's exposure to catastrophic losses. Rather, it covered a portion of costs *from an attachment point up to a cap*, effectively subsidizing the market by removing a defined corridor of claims. Moreover, the TRP did not require carriers to cede risk at issue to a defined reinsurance pool as was often done with pre-ACA high-risk pools. Rather, the reinsurance applied to anyone who hit the attachment point regardless of condition or date of onset. This financial construct illustrates how the primary impact of the "reinsurance" as implemented by HHS was not to control volatility (as is the case with typical commercial reinsurance) or even anti-selection (as is the case with traditional high risk pools), but rather was simply an organized way to move money into the individual market in order to reduce prices.

Beginning in 2018, the ACA's risk adjustment program will have a reinsurance component. For claims in excess of $1 million, the risk adjustment mechanism will reimburse insurers 60% of the cost above the $1 million attachment point.[10] The impact of this change can be substantial, particularly in smaller states where severe catastrophic claims could have highly negative impacts on the market as a whole. In Iowa, it has been reported an enrollee in the marketplace incurs $12 million in annual claims expense.[11] This new provision will spread a substantial portion of costs for this individual across a broader national reinsurance pool for the individual and merged markets.[12]

Section 1332 waivers and reinsurance programs

The TRP under the ACA was successful at lowering costs, but it was only temporary and ended with the 2016 benefit year. And while 2014 and 2015 premium rates in the reformed individual market were lower than anticipated,[13] the market has shown signs of pressure on affordability in recent years. In 2017, subsidy-benchmark rate increases have averaged approximately 25% nationwide.[14] Moreover, the earliest indications for 2018 hint that the 2017 increases may not be a "one-time correction"[15] (although regulatory and political instability may be a key contributing factor to a portion of the increases).[16]

With double-digit premium increases and signs of declining enrollment in 2017, some states have taken steps in establishing a state-run reinsurance program for the primary purpose of lowering individual market costs. Further, in a March 13, 2017, letter to governors, HHS Secretary Thomas Price encouraged states to apply for Section 1332 waivers, particularly for proposals related to the introduction of high-risk pool or reinsurance programs.[17] Secretary Price cited the Alaska Reinsurance Program (ARP) as an example of a state using a Section 1332 waiver to stabilize its individual health insurance market. The ARP was established in 2017 through a state appropriation. For 2018 and beyond, the state is seeking pass-through payments from the federal government as a result of the reinsurance program reducing federal expenditures on advanced premium tax credit subsidies.[18] In its waiver application, the state cites the ARP as reducing individual market premium increases in 2017 from 42% to 7%.

While not submitting a 1332 waiver, Minnesota has also introduced a reinsurance program for the individual health insurance market (limited to 2018 and 2019) and provided premium rebates to households not qualifying for federal premium assistance.[19] The state of Maine is also interested in reactivating the Maine Guaranteed Access Reinsurance Association under a 1332 waiver,[20] while Oklahoma is also considering the submission of a 1332 waiver to implement a state-run reinsurance program.[21]

> Section 1332 of the ACA provides states the ability to apply for a "State Innovation Waiver" beginning on or after January 1, 2017, which allows a state to waive several provisions of the ACA, including establishment of qualified health plans, insurance marketplaces, premium, and cost-sharing reductions, as well as the employer and individual mandate.[22] However, for a waiver application to be approved, a state must demonstrate in the application that the waiver will provide coverage that is as comprehensive and affordable as under the ACA, while not increasing the number of uninsured individuals or the federal deficit.[23]
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> States are eligible to receive pass-through funding from the federal government to the extent that the 1332 waiver reduces the cost of the APTC or cost-sharing reduction (CSR) payments that would otherwise be paid by the federal government under the standard provisions of the ACA. *In May 2017, the Centers for Medicare and Medicaid Services (CMS) released a checklist for 1332 waiver applications.[24] The checklist specifies that state applicants must provide an explanation of how a reinsurance program or HRP will reduce federal expenditures on APTC, if the state expects to receive pass-through funding, and how the pass-through funding will be used in the implementation the 1332 waiver.*

Impact to states

How should a state establishing a reinsurance program or HRP evaluate potential federal pass-through funding under a 1332 waiver? If a state introduced either one of these mechanisms under the 1332 waiver that would reduce the premium cost of individual market coverage, it would also reduce federal premium assistance costs for qualifying individuals. Section 1332 indicates that, rather than the federal government spending less as a result of the proposed program, the savings would be provided to the state to help fund the provisions. The amount of savings passed back to the state varies proportionally based on the total amount of advanced premium tax credit (APTC) dollars relative to total ACA premium, but represents a significant matching of funds by the federal government. In 2016, we estimate that over 50% of the individual market was receiving federal premium assistance on a national basis, including nearly 60% of those purchasing ACA-compliant coverage.[25]

Impact to consumers

The financial impacts to consumers from a reinsurance or HRP program will vary significantly by income as a result of the ACA's premium subsidy structure. The example in Figure 1 shows net premium changes for three households receiving varying premium subsidy amounts. Each household purchases the same coverage, with the full premium amount (prior to subsidy application) decreasing from $500 to $450 per month as a result of the introduction of a reinsurance program.

Figure 1: Illustrative example

	Pre-reinsurance program implementation			**Post-reinsurance program implementation**				
Sample household	Full premium	Premium subsidy	Net premium	Full premium	Premium subsidy	Net premium	Consumer premium savings	Federal pass-through amount
A	$500	$300	$200	$450	$250	$200	$0	$50
B	$500	$25	$475	$450	$0	$450	$25	$25
C	$500	$0	$500	$450	$0	$450	$50	$0

Household A. Consumers qualifying for federal premium assistance with greater value than the premium reduction resulting from reinsurance program are unlikely to see a reduction in net premium cost (federal government retains 100% of premium savings).

Household B. For consumers qualifying for limited premium assistance, such as Household B, premium savings will be shared by the consumers and the federal government. Household B does not qualify for premium assistance under the reinsurance program, but experiences a $25 reduction in monthly net premiums (federal government retains 50% of premium savings in this example).

Household C. Higher-income consumers who did not qualify for premium assistance prior to the implementation of the reinsurance program will realize the full premium savings from the reinsurance program (consumer retains 100% of premium savings).

While the percentage of individual market participants purchasing coverage without federal premium assistance varies significantly by state, it is likely that a well-funded reinsurance or high-risk program would reduce premiums materially for nonsubsidized households and could provide a financial incentive to households that would otherwise be uninsured (for perceived unaffordability) to purchase insurance coverage. At the same time, those receiving premium subsidies would not be financially affected.

High-risk pools and reinsurance under the AHCA

On May 4, 2017, the U.S. House of Representatives passed a second version of the AHCA[26] that included several uses of both high-risk pools and reinsurance:

The AHCA establishes the Patient and State Stability Fund (PSSF), which would (if passed by the Senate) appropriate $15 billion to the individual health insurance market in 2018 and 2019, decreasing to $10 billion in 2020 through 2026. The PSSF funds have a number of qualifying uses defined in the law. Additional detail on PSSF funds and considerations for use can be found in the Milliman whitepaper "The Patient and State Stability Fund What Happens Now." However, one of those qualifying uses is to permit a state to create a unique state-run reinsurance program using the allocated funding or default to a federal reinsurance program.[27] The structure of the default program is very similar to the ACA's TRP but with different parameters (i.e., the PSSF default reinsurance program has an attachment point of $50,000, coinsurance of 75%, with a reimbursement cap of $350,000.)

The AHCA also proposes a high-risk pool, the Federal Invisible Risk Sharing Program (FIRSP), funded with a $15 billion appropriation as well as any unused funds from states electing the default reinsurance option under PSSF. Issuers would be *required* to cede new enrollees prospectively who have certain conditions and *allowed* to cede others at the time of enrollment. Costs for ceded individuals would be reimbursed above an attachment point in exchange for a percentage of the member's premium, supplemented by the appropriated funds as necessary. States would be allowed to administer the program starting in 2020, although it is unclear if they would be required to do so.

The MacArthur amendment to AHCA would also allow states to seek a waiver that would grant the right for a state to allow carriers to underwrite individuals based on their health status who do not produce evidence of continuous coverage. States would be required to establish a high-risk pool or a reinsurance pool[28] that could potentially be used to provide coverage for individuals who were rated higher because of health status and find coverage unaffordable. In addition, the legislation provides for $8 billion in funding over five years to at least partially offset the costs of these additional rate-ups.

The details of how these programs will interact is not entirely clear yet. For example, if PSSF funds are used to establish a high-risk pool, how will it interact with the FIRSP? If a state used the default reinsurance program under the PSSF, would that program pay before FIRSP costs are paid, or would the FIRSP pay first? Will participation in the FIRSP be mandatory or will states be allowed to opt out of participation in the FIRSP entirely?

Considerations for policy makers

The outcome of the AHCA is yet to be determined and the Senate, as of this writing, has stated its intention to "start from scratch," though it has indicated it may take good ideas from the AHCA. Moreover, Senate Democrats have signaled their desire to work with Republicans on a "repair" approach to the ACA as opposed to the current "repeal and replace." Thus, the final structure and amounts of any federal dollars available for purposes of price relief in the individual markets are unknown. However, considerations for the use of reinsurance and high-risk pools, regardless of outcome, would include:

Pass-through funding under the ACA versus the AHCA: Under the ACA, Section 1332 notes that any waiver approved will entitle the state to the pre-waiver amount of APTCs and CSR payments. With the AHCA, the potential for pass-through funds under a 1332 waiver exists, but the magnitude of those funds will generally be lower and will vary by state. While Section 1332 remains in place and unchanged by the AHCA, the premium subsidy approach is dramatically different in both form and magnitude. Instead of a structure where subsidies change when a benchmark premium changes, subsidies would instead be a flat dollar amount by age, capped at the cost of coverage. In terms of magnitude, the tax credits under the AHCA, relative to the ACA, are on average less generous. Thus the ability to generate any pass-through savings under the AHCA's Section 1332 requires a greater upfront investment from a state in

order to reduce rates below the flat tax credit amounts. Moreover, the forms of the AHCA tax credits are different from those under the ACA. They are more generous at lower ages and higher income levels and less generous at higher ages and lower income levels.[29] Thus a state's average age and income level of its AHCA market will have an impact on the ability and extent to which it can generate savings. These are important differences between current and proposed law that affect a state's potential options. Actuarial modeling can help frame plausible scenarios, potential costs, and estimated impacts on the individual market.

Funding source: Under an ACA-based 1332 waiver, any state-run HRP or reinsurance program that intended to reduce individual market premium rates will require an upfront investment in order to ultimately reduce federal APTCs and receive pass-through funds. Note that the pass-through funds for all states will not be equal to the state's investment. States will need to implement a mechanism to fund the remaining net program costs after pass-through funds are received. Historical state and federal programs have relied upon premium taxes, provider reimbursement reductions, assessments on employer plans, appropriated general revenues, or a combination of these funding sources. States should also consider the indexing of the ACA's premium tax credits as a change in the methodology for indexing the tax credits may reduce available pass-through funding.

Similarly, under the assumption that the AHCA is passed as is, states will have access to PSSF funds, but will need to assess the structure of a reinsurance program or HRP that can be created with such funds and their needs for any additional funding.

Bending the cost curve: Based on Milliman's Health Cost Guidelines™, individuals representing the upper 95th percentile in costs account for 55% of total market claims expenses in the commercial health insurance market. Stated differently, the most expensive 5% of covered individuals account for over half of the costs of the total market. Policymakers should evaluate the portion of individual market costs that may be included in a HRP and whether the HRP proposal will mitigate the costs associated with the HRP population. For example, a reinsurance program that merely subsidizes the market is unlikely to have any impact on the covered population's healthcare expenses *in total*. Conversely, a HRP that uses the equivalent amount of funding may, because of its structure and authority, be able to reduce costs for the HRP members and the broader market. This is potentially achieved through several means, including:

- Mandating significant and effective care management protocols
- Requiring the use of medical centers of excellence
- Using value-based design specific to HRP members
- Modifying reimbursement rates to providers

As the HRP may cover a material portion of total individual market costs, relatively small improvements in managed care efficiency could result in large dollar savings. In the case of state 1332 waivers, documented savings may also limit the need to create a new state-based funding source.

Consumer experience: When debating the merits of HRP and reinsurance proposals, policymakers should consider how the consumers will enroll or be affected by the program. For example, programs such as the ACA's TRP and Alaska's reinsurance program do not affect consumers' insurance purchasing decisions or the enrollment process. Consumers are unaware of transfer payments that occur between government entities and insurers with these programs. Conversely, pre-ACA HRPs generally would require a consumer to purchase separate HRP coverage. Policymakers should evaluate the trade-offs between complicating the insurance enrollment process relative to the ability to design innovative programs specific to the HRP population.

While there is significant uncertainty with federal healthcare reform legislation, reinsurance and HRP programs are likely to play a role in attempting to stabilize individual market enrollment and premiums. As each state market is unique in terms of size and cost characteristics, state policymakers should consider these features in evaluating the potential impact of these programs.

Appendix: A comparison of high-risk pool and reinsurance program features

The table below compares three different "families" of programs that could be used to reduce costs in the individual market. Note that this is intended to be a high level summary and does not capture all of different program facets of the past or all of the possibilities for future implementations.

Figure 2: High level comparison of high-risk pool & reinsurance programs

	Traditional HRP	Invisible HRP	Reinsurance
Visibility	Visible to enrollee	Invisible to enrollee	Invisible to enrollee
Eligibility	Defined based on clinical condition or other medical underwriting criteria	Defined based on clinical condition or other medical underwriting criteria	Any member of the eligible risk pool that hits the attachment point
Insurance options	Distinct from standard risk pool enrollees	Same as other standard risk pool enrollees	Same as other standard risk pool enrollees
Premiums	May differ from standard risk pool	Same as other standard risk pool enrollees	Same as other standard risk pool enrollees
Ceding	Generally required and done at issue	Generally required and done at issue	No ceding per se. See Eligibility above.

[1]For further discussion of market stabilization mechanisms, please see the Milliman white paper, "Five Key Ways to Help Stabilize the Individual and Small Group Health Insurance Markets in 2018," at: http://www.milliman.com/uploadedFiles/insight/2017/five-ways-stabilize-health-insurance-market.pdf.

[2]Note that we are restricting our definition of reinsurance for this paper to include only market-wide mechanisms that are employed by the states or the federal government, and excluding commercial reinsurance that carriers may purchase.

[3]National Association of State Comprehensive Health Insurance Plans (November 2016). Pool Enrollment Survey. Retrieved May 24, 2017, from http://naschip.org/2016/PoolEnrollmentSurvey2016.pdf.

[4]Wisconsin Joint Legislative Audit Committee (June 2014). Health Insurance Risk-Sharing Plan Authority, p. 5. Report 14-7. Retrieved May 24, 2017, from http://legis.wisconsin.gov/lab/reports/14-7full.pdf.

[5]Wisconsin Joint Legislative Audit Committee, ibid., p. 4.

[6]National Association of State Comprehensive Health Insurance Plans (2011). Quick Checks: Premium Rate Setting Methodology. Retrieved May 24, 2017, from http://naschip.org/2011/Quick%20Checks/25/Premium%20Rate%20Setting%20Methodology%2010.pdf.

[7]For example, Illinois' high risk pool: http://www.chip.state.il.us/downloads/AR2015.pdf.

[8]For additional discussion on the transitional reinsurance program's operation, please see the Milliman Research Report, "2015 Commercial Health Insurance," at: http://www.milliman.com/uploadedFiles/insight/2017/2015-commercial-health-insurance.pdf.

Commercial Health Insurance," at: http://www.milliman.com/uploadedFiles/insight/2017/2015-commercial-health-insurance.pdf.

[9]Based on risk adjusted premiums and TRP insurer payments.

[10]Jost, T. (December 17, 2016). CMS finalizes new marketplace payment rule, effective January 17, 2017. *Health Affairs* blog. Retrieved May 24, 2017, from http://healthaffairs.org/blog/2016/12/17/cms-finalizes-new-marketplace-payment-rule-effective-january-17-2017/.

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[12]Jost, T., ibid.

[13]Commonwealth Fund. The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?, Exhibit 3. Retrieved May 24, 2017, from http://www.commonwealthfund.org/publications/issue-briefs/2015/dec/cbo-crystal-ball-forecast-aca.

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[15]Livingston, S. (May 10, 2017). Health insurers' proposed 2018 rate hikes are early 'warning signs.' Modern Healthcare. Retrieved May 24, 2017, from http://www.modernhealthcare.com/article/20170510/NEWS/170519999?utm_source=modernhealthcare&utm_medium=email&utm_content=20170510-NEWS-170519999&utm_campaign=am

[16]https://www.vox.com/2017/5/30/15701986/blue-cross-north-carolina-obamacare-premiums

[17]The full letter can be read at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

[18]Alaska Governor Bill Walker (December 29, 2016). State of Alaska-Section 1332 State Innovation Waiver. Letter to HHS Secretary Sylvia Mathews Burwell. Retrieved May 24, 2017, from https://www.commerce.alaska.gov/web/Portals/11/Pub/Alaska-1332-Waiver-Application-with-Attachments-Appendices.pdf?ver=2017-01-05-112938-193.

[19]http://www.twincities.com/2017/01/26/mn-just-passed-health-insurance-premium-subsidies-heres-what-you-need-to-know/

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[23]CMS. Frequently Asked Questions About the 1332 State Innovation Waivers, ibid.

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[26]Karcher, J. (May 9, 2017). The American Health Care Act. Milliman Report. Retrieved May 24, 2017, from http://www.milliman.com/insight/2017/The-American-Health-Care-Act/.

[27]http://us.milliman.com/insight/2017/The-Patient-and-State-Stability-Fund-What-happens-now/

[28]Both the FIRSP and the default federal reinsurance program under the PSSF would make a state eligible for a waiver, although the state could also design a separate program that fits the first two allowable uses of funds under the PSSF in order to qualify.

[29]Kaiser Family Foundation (April 27, 2017). Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps. Health Reform. Retrieved May 24, 2017, from http://kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/.