

1332 STATE INNOVATION WAIVERS

SEARCHING FOR SOLUTIONS TO STABILIZE THE
INDIVIDUAL HEALTH INSURANCE MARKET

WORKING DRAFT

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EXECUTIVE SUMMARY

The State Innovation Waiver, also known as the 1332 waiver, was created as part of the Affordable Care Act and became an option for states to consider on January 1, 2017. States that want to use this option to explore ways to transform health care financing must apply to the U.S. Secretary of Health and Human Services and receive approval to implement a program that would waive certain requirements of the ACA. Only some sections of the ACA are “waivable,” and the state’s proposal must preserve certain consumer protections contained in the ACA, also referred to as “guardrails,” in order to be successful. The waiver proposal must provide for insurance coverage that:

- Is at least as comprehensive as current coverage
- Maintains the same level of affordability, including not increasing consumer cost-sharing
- Covers a comparable number of individuals
- Does not increase the federal deficit

At least 24 states have or are considering legislation to authorize a 1332 waiver. Most of the waivers under consideration are seeking to reduce premiums and provide stability in the individual health insurance market.

The majority of Montanans are covered by employer coverage or other public coverage, such as Medicare or Medicaid. Even though the individual market covers a relatively small percentage of the population in Montana and nationwide, it is an important safety net. Many people will need to use the individual market at some point in their lives, particularly when they are transitioning from one type of coverage to another.

Beginning in 2014, the ACA eliminated all health status discrimination in the individual market so that people can no longer be rejected or rated-up based on their health status, and their pre-existing conditions must be covered with no exceptions. Prior to 2014, many individual health insurance plans did not cover prescription drugs and limited coverage for other important medical services, such as outpatient visits and mental health care. As expected, the changes brought by the ACA caused turbulence in the individual market because it had been medically underwritten for so long. Premium tax credits and cost-sharing reduction benefits made individual health insurance more affordable for individuals who had previously been rejected or priced out of that market. Between 2013 and 2016, Montana’s uninsured rate fell from 20 percent to 7.4 percent, and as the previously uninsured entered the market, it became clear that many of those individuals had unmet health needs, sometimes referred to as “pent-up demand.” The ACA provided several mechanisms to assist the individual market through this transition, including a federal reinsurance program that ended after three years in 2017.

Insurers experienced significant losses in 2014, 2015, and 2016, and as a result, had to raise premiums significantly. Individuals who do not qualify for significant tax credits are now struggling to pay those premiums. In 2017, premiums increased because the federal reinsurance program ended, and in 2018 premiums increased even more because the federal government decided to stop reimbursing insurers for the cost-sharing reduction benefit. Consequently, many states are looking at a 1332 waiver as a way to stabilize the individual market and lower premiums. The most popular proposal is a state-based reinsurance program

that is funded in large part by federal “pass-through” dollars, which will be discussed in more detail in this report. Alaska, Oregon, Minnesota, Wisconsin, Maryland, New Jersey and Maine have already received approval for 1332 waiver reinsurance programs and received significant amounts of federal funding for those programs. This paper discusses the similarities and differences between these approved programs and others that have been proposed.

Publicly subsidized reinsurance is different from commercial reinsurance, which is known as stop-loss in the health insurance market. It is not an optional insurance product that health insurers may purchase, although the reimbursement methodology and terms used are often similar. Unlike risk adjustment, publicly subsidized reinsurance injects additional money into the insurance system to defray the claims costs of high-risk individuals, thereby lowering premiums for all enrollees. Publicly subsidized reinsurance helps to offset the effects of removing health status discrimination in the individual market and may ensure that this insurance product continues to be a safety net for Montanans who need it.

Considerations for Montana in pursuing a 1332 waiver to establish a state-based reinsurance program include:

- The amount of premium rate reduction that could be achieved by state-based reinsurance
- The amount of state and federal funding needed to operate a state-based reinsurance program (The funding formula varies widely from state to state, based on issues that include state demographics, especially the percentage of the individual market that receives premium tax credits.)
- Options for how to fund the state share of the program
- The governance and administration of the program

These considerations need to be evaluated thoroughly by stakeholders and informed by an in-depth analysis conducted by qualified actuaries to determine how a reinsurance program in Montana might benefit consumers and how it would need to be constructed.

INTRODUCTION: BACKGROUND ON THE INDIVIDUAL HEALTH INSURANCE MARKET

The individual health insurance market covers a small percentage of the population in comparison to other types of health care coverage, but it provides a critical safety net. In 2016, the U.S. population was divided into the following health care coverage categories: employer coverage, 49 percent (Montana 43 percent); individual (nongroup) market, 7 percent (Montana 7 percent); Medicare, 14 percent (Montana 18 percent); Medicaid, 19 percent (Montana 22 percent); other public programs, 2 percent (Montana 3 percent); uninsured, 9 percent (Montana 7 percent).¹ People who purchase individual coverage do not have access to employer coverage and are not eligible for Medicaid or Medicare. This population generally consists of early retirees, part-time employees or employees of small employers that do not offer a health plan, the self-employed, and young adults aging-off of their parent’s plan. Many people find themselves needing individual health insurance coverage at some point in their life, but sometimes only for a short period of time when they are transitioning from or to another type of coverage. The size of the individual market in the United States has doubled since 2010.²

Prior to the passage of the Patient Protection and Affordable Care Act in 2010, the majority of states had no protections against health status discrimination for individuals who did not have access to employer coverage or some type of public coverage. In 2009, more than one-third of people who tried to purchase individual market coverage were rejected, charged a higher price, or had a condition excluded from their

Prior to the passage of the ACA, there was no protection from health status discrimination for individuals who did not have access to employer coverage or some type of public coverage.

coverage. One-fourth of Montanans have a pre-existing condition that would make them uninsurable if there were no laws protecting them from health status discrimination.³ Many states operated a high-risk pool as a stop-gap measure, but this coverage was generally very expensive and not always a viable option. Montana's high-risk pool, which existed from 1987 to 2014, charged premiums that were up to 150 percent of average market rates, and it imposed a 12-month pre-existing condition exclusion, unless the individual had prior creditable employer coverage. Known as the Montana Comprehensive Health Association (MCHA), the pool was expensive to operate and frequently faced insolvency, despite the fact that it received considerable assistance from the state. The pool averaged 2,500 – 3,000 enrollees, most of whom had deductibles of at least \$5,000 and often \$10,000 and was funded by very high member premiums and a 1 percent assessment on all health insurance premiums in the state. In addition, \$16 million in federal funds were spent on the federal high-risk pool in Montana to cover 353 individuals between August 1, 2010, and December 31, 2013.⁴ The cost of administering a separate insurance plan for these individuals was significant: up to \$40 per month per individual administrative fee.

Individuals who have access to employer coverage have been protected from health status discrimination for many years. First, employees of small employers in Montana were protected by the Small Employer Health Insurance Availability Act of 1993, and then all employees became protected when the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. HIPAA eliminated most health status discrimination for employees in all group health plans. However, it did little or nothing to protect individuals who were forced to buy in the individual market. The ACA changed that by extending protections to individual market health insurance enrollees that had long been enjoyed by the population with employer coverage or who had some form of public coverage.

The drafters of the ACA correctly predicted that the elimination of all types of health status discrimination would have a significant financial impact on the individual market. Therefore, they included rate stabilization mechanisms to deal with this impact, including permanent risk adjustment, and risk corridors and subsidized reinsurance during the 2014 – 2016 plan years. As a result of ongoing legal disputes, the federal government has never funded the payments that were owed to insurers under the risk corridor program. The risk adjustment program redistributes funds from health insurers with lower-risk enrollees to insurers with higher-risk enrollees. No additional funds beyond premium dollars collected by insurers are injected into this program. The federal transitional reinsurance program injected many millions of dollars into the individual market nationwide, but it was always intended to sunset at the end of 2016. The federal reinsurance program, in particular, helped stabilize the individual market, but it is clear that a three-year program was not long enough.

Because of a myriad of contributing causes, the individual market will need additional public support for longer than three years. In Montana and across the United States, premiums in the individual market rose dramatically in 2016, 2017, and 2018. Experts have identified some of the causes, including 2014 premiums that were set too low; pent-up demand from the previously uninsured; more enrollees with high-cost conditions than originally predicted; and high health care costs, especially rising prescription drug prices. In addition, the end of the federal reinsurance program, the failure to fund the risk corridor payments, and the discontinuation of the federal funding to reimburse insurers for providing the cost-sharing reduction benefit to low-income individuals contributed significantly to rate increases in 2017 and 2018. Incorrect pricing and pent-up demand can be cured within a few years, but the individual market will probably always see a higher percentage of high-risk enrollees than the employer group market, because of early retirees and other individuals who, for health-related reasons, are not fully employed. Consequently, many states believe that a long-term solution, such as a publicly subsidized state-based reinsurance program, in addition to the federal risk adjustment program, is necessary.

ACA 1332 STATE INNOVATION WAIVERS

Section 1332 of the ACA provides that beginning January 1, 2017, a state can apply for a “waiver for state innovation.”⁵ The Centers for Medicare and Medicaid Services (CMS) implemented regulations in 2012 and issued guidance in 2015 that further describes the process that states must follow to obtain such a waiver. In May 2017, the current administration released a checklist that outlines the steps that states must take in order to apply for a 1332 waiver. This checklist outlines what is required in the previously issued regulations and the statute. The statute provides for “pass-through federal funding” to the extent that premium tax credits are not paid or other federal savings occur as a result of a State Innovation Waiver. Section 1332 (a) (3) requires the secretaries of the Department of the Treasury and Department of Health and Human Services (HHS) to reimburse the state for the aggregate amount of tax credits or cost-sharing reductions that the federal government would have paid had the state not received a waiver. That amount is determined annually on a per capita basis by the secretaries.

The statute contains four “guardrails” that the State Innovation Waiver proposal must comply with before a waiver can be granted. Those guardrails require that the state innovation plan will provide coverage that: 1) is at least as comprehensive as the coverage offered through the exchange; 2) has cost-sharing protections against excessive out-of-pocket spending and are at least as affordable; 3) covers a comparable number of residents; and 4) does not increase the federal deficit.

The guidance that was issued by CMS in 2015 further described the requirements of the 1332 regulations. That guidance was recently rescinded and replaced by the Trump administration. However, nothing in the new guidance appears to change the process for obtaining a 1332 waiver and pass-through funding for a reinsurance waiver. Because the primary purpose of this project is to test the feasibility of creating a state-based reinsurance program for Montana, the details of the new guidance will not be discussed here. It appears that 1332 waivers for state-based reinsurance remain viable under the new guidance. The new federal guidance can be found here: <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>.

42 U.S. Code § 18052 – Waiver for State Innovation sets forth the following “guardrails” which must be examined by CMS before a waiver is granted:

“The Secretary may grant a request for waiver under subsection (a)(1) only if the Secretary determines that the State Plan—

- (A) Will provide coverage that is at least as comprehensive as the coverage defined in section 18022 (b) of this title and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare and Medicaid Services [...]
- (B) Will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
- (C) Will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and
- (D) Will not increase the Federal deficit.”

The guidance issued by CMS on October 24, 2018 eliminates the emphasis on protecting low income and vulnerable populations and takes a radically different approach to interpreting the statutory guardrails which apply to 1332. The current administration arrives at different conclusions primarily by analyzing the impact of each guardrail separately. The previous administration considered the four guardrails as a whole, linking them together. The new guidance will likely be tested in the Courts, depending on the outcome of future waiver proposals. You can find further analysis here: <http://chirblog.org/trump-administration-hands-states-another-tool-dismantling-preexisting-condition-protections/> and <https://www.wakely.com/sites/default/files/files/content/new1332guidancewhitepaper102618.pdf>

In addition to these guardrails, the new guidance also states that legislation may not be needed as underlying authority to apply for a 1332 waiver. For instance, if a state has broad authority to enact the ACA into state law, it may be possible to obtain that authority through an executive order or administrative rule. The Montana legislature has never granted that authority. Furthermore, a state reinsurance proposal still requires a sustainable state funding source, as well as a governance structure to administer the program. Therefore, it appears that legislation is necessary to obtain the state funding needed to apply for the waiver.

States that have successfully implemented a 1332 waiver for a state-based subsidized reinsurance program have received federal pass-through funding by using actuarial data that demonstrates how premiums will be reduced, and, therefore, the federal government will save money by paying lower advance premium tax credits (APTC). That is because the formula for determining APTC is based in part on the cost of the second-lowest-cost silver plan. The new guidance states: “The pass-through amount does not include any savings other than the reduction in PPACA financial assistance [APTCs]. The pass-through amount will be reduced by any other increase in spending or decrease in revenue if necessary, to ensure neutrality. In addition, the pass-through amounts will be calculated annually, and may be updated anytime to reflect changes in state or federal law, including sub-regulatory guidance.

States that have implemented a 1332 waiver have received federal funding by using data that demonstrates how premiums will be reduced, and, therefore, the federal government will save money.

The state must include written evidence of its compliance with the **public notice and opportunity to comment** as required by 45 CFR 155.1312. The public notice must include a comprehensive description of the Section 1332 waiver application and where a copy can be obtained. The public must have a minimum of 30 days to submit comments concerning the proposed waiver application. There should be at least one public hearing. Tribal consultation is also required.⁶

STATE INNOVATION WAIVER PROPOSALS SUBMITTED OR DRAFTED AS OF MARCH 2018

At least 31 states have considered legislation for 1332 waivers. Only 17 states have enacted measures related to 1332 waivers, and, of those, eight states have successfully submitted waivers that were approved by HHS. Hawaii was granted a State Innovation Waiver that allowed it to waive certain ACA provisions, including the SHOP requirement, in order to maintain Hawaii’s Prepaid Health Care Act, which requires all private employers to maintain coverage for all their employees. This act covers a large percentage of the people of Hawaii and has since the 1980s when it was first enacted.⁷

The remaining seven approved state waiver applications proposed state-based subsidized reinsurance: Alaska, Minnesota, Oregon, Wisconsin, Maryland, Maine and New Jersey. The reinsurance waiver proposals that received federal pass-through funding submitted extensive data and actuarial projections, which demonstrated that individual market health insurance premiums can be significantly reduced as a result of subsidized reinsurance.

There are numerous other state waiver proposals that are currently in draft form or have already been withdrawn for various reasons. Most of these proposals echo the same themes: 1) individual market premiums have risen at an alarming rate, especially since the federal funding for cost-sharing reductions was withdrawn and the federal reinsurance program ended, and 2) enrollment in the individual market is beginning to decline because of the high premiums, especially among those who do not receive premium tax credits. Individuals whose income level allows them to receive substantial premium tax credits are generally not as affected by premium increases, because their premium is capped at a percentage of their income. Some individuals and families who do not receive premium assistance are being priced out of the market and are the most likely to drop coverage. There is evidence that shows that those who are most likely to drop coverage are younger and healthier. A Massachusetts study found that enrollees who leave the market have costs that are approximately 73 percent of those who remain.⁸ If the risk pool shrinks and the healthier individuals leave the market first, rates will continue to spiral up.

There are two common proposals for subsidized reinsurance programs, although other variations could occur:

1. **Claims-based “corridor type” reinsurance:** Reimburses retrospectively a portion of claims (e.g., 80 percent, while the insurer pays a 20 percent “co-insurance”) between an attachment point (e.g., \$50,000) and a cap (e.g., \$250,000), regardless of the health condition of the member. The insurer does not cede premiums. This type of program provides the most predictable funding levels for both state budgeting purposes and insurer predictability.
2. **Condition-based reinsurance:** Reimburses a percentage of annual claims above a threshold amount for enrollees diagnosed with certain specified conditions. In some cases, all claims of enrollees with specified conditions are reimbursed to the insurer. The insurer may be required to cede all, or a portion of, the premiums for that individual.

This paper focuses primarily on states that have received CMS approval for their waivers or have waiver proposals that are still in draft form, pending, or recently withdrawn. For a more complete listing of states that have attempted legislation and/or waivers, see the report from the National Conference of State Legislatures.⁹

There is a similarity between the waiver proposals that involve state reinsurance. However, every state has unique demographics and issues, and the actuarial data submitted produces different results. The state waiver proposals that only seek some form of state-based subsidized reinsurance generally do not have difficulty meeting the statutory guardrails of scope of coverage: affordability, comprehensiveness, and deficit neutrality. Pass-through federal funding has been granted for state-based reinsurance to three states for 2018: Alaska, Minnesota, and Oregon, and four more states for 2019: Wisconsin, Maryland, Maine and New Jersey.

All seven of those reinsurance proposals sought to waive section 1312 (c) (1) of the ACA, which requires “all enrollees in all health plans ... offered by an issuer in the individual market to be members of a single risk pool.”¹⁰ Waiver of this requirement, to the extent that it would otherwise require excluding total expected state reinsurance payments when establishing the market-wide index rate, will not affect any other provision of the ACA. The success of the seven state proposals seeking a waiver of this provision demonstrates that disregarding the single risk pool requirement does not violate any of the guardrails established in 1332 and, in fact, will achieve federal savings that can be passed on to the states. Waiving this part of section 1312 will not affect the comprehensiveness of the coverage offered. It will have a positive effect on the number of people covered and the affordability of the coverage, and it is deficit neutral for the federal government.

DETAILS OF STATE WAIVERS APPROVED FOR 2018

ALASKA: In 2016, Alaska created its state-based subsidized reinsurance program, the Alaska Risk Pool (ARP), utilizing the governance and funding structure for a pre-existing high-risk pool program. The program was implemented in 2017, before any federal pass-through money had been granted. The Alaska program is administered by the Alaska Comprehensive Health Insurance Association (ACHIA), which is a quasi-governmental entity that previously administered Alaska's high-risk pool. It is a condition-based reinsurance program. Individuals keep the insurance plan they originally purchased, but if they have been diagnosed with one of 33 identified conditions, the insurer can submit those claims to the ACHIA for 100 percent reimbursement. In 2018, the federal government granted \$58.5 million in funding for 2018 (97 percent of the total). The ARP lowered premiums by approximately 20 percent in 2018. The total cost of the program is estimated to be about \$60 million. The state share is funded by an insurer assessment that is structured as follows: health insurers: 6 percent of premium, net of claims; title insurance: 1 percent of premium; other insurance 2.7 percent of premium.

Alaska has a small population (738,432) and a large Alaska Native population (14 percent). The majority of Alaska Natives have health coverage, and the Alaska Native Tribal Health Consortium provides superior health care services. In 2017, there were 24,064 Alaskans with individual health insurance coverage and 17,746 in the small employer group market, and only one health insurer offered individual coverage. Alaska has expanded Medicaid, utilizes the federal exchange, and has an uninsured rate of approximately 13.5 percent. It has the highest health care costs in the United States, in part because many Alaskans have to travel out of state for health care.¹¹

MINNESOTA: In July 2017, Minnesota passed enabling legislation that created a state-based reinsurance program, the Minnesota Premium Security Program (MPSP), and authorized the state to apply for a 1332 waiver to obtain pass-through federal funding for that program. Part of the waiver application included changes that would assist with funding Minnesota's Basic Health Plan (BHP), which covers individuals between 138 percent and 200 percent of Federal Poverty Level (FPL). CMS rejected Minnesota's proposal regarding the BHP. The MPSP repurposes the state's former high-risk pool administrator, the Minnesota Comprehensive Health Association (MCHA), which has a 13-member board, to administer the reinsurance program. The MPSP is a traditional claims-based reinsurance program: all claims in a specified corridor (\$50,000 to \$250,000 for 2018) are paid at an 80/20 coinsurance rate, wherein the insurer pays 20 percent of the claims that fall within the corridor. The payment parameters can be adjusted each year to adapt to the prior years' experience and available funding. The state funding is appropriated from Minnesota's Health Care Access Fund (which is funded by a 2 percent provider tax) and its general fund. In 2018, the funding for this program was projected to be \$271 million, and the state would contribute about 61 percent of the total; the actual federal pass-through funding granted for 2018 was \$130.7 million, about 48 percent of the total. The premium reduction (relative to the same year baseline without a reinsurance program) was approximately 20 percent to 23 percent.

Because Minnesota expanded Medicaid and because it implemented a BHP, the individual market is smaller than it might otherwise be (estimated at 270,000 in 2016). Minnesota's population is much larger than Alaska's, and its uninsured rate is lower than many other states (approximately 4.3 percent). Minnesota runs its own state-based exchange, which has four insurers offering qualified health plans in 2018; however, all but one has enrollment caps in place for 2018. Like Alaska, Minnesota struggles with very high health care costs—the fifth highest in the United States.¹²

OREGON: Oregon's proposal was the last 1332 State Innovation Waiver to be approved in 2017 for the 2018 plan year. The legislation was enacted on July 5, 2017 and the waiver proposal was filed August 31, 2017 and approved October 19, 2017. The legislation established the Oregon Reinsurance Program (ORP), which

is administered by the Department of Consumer and Business Services (DCBS). The state funding will come from a premium assessment levied on major medical premiums in 2018 and from excess fund balances in two state programs. The premium assessment will be phased in: .03 percent in 2018, .06 percent in 2019, and the maximum 1.5 percent in 2020 and each year thereafter that the program continues.

The ORP will operate as a traditional claims-based reinsurance program: all claims in a specified corridor, between \$(TBD) and \$1,000,000, are paid, with 50/50 coinsurance, wherein the insurer pays 50 percent of the claims within the corridor. The DCBS has the authority to adjust the corridor's attachment point and cap and the coinsurance rate according to the funding available and other factors. Oregon received \$54.5 million in federal pass-through funding for 2018 (about 61 percent of the total cost of the program) and the premium increases were lowered by approximately 7 percent. The projected program cost for 2018 was estimated to be \$90 million.

The uninsured rate in Oregon is approximately 6.2 percent. Oregon has expanded Medicaid and has a state-based exchange, which still has seven insurers offering qualified health plans in 2018. There are approximately 217,000 covered lives in the individual market.¹³

WISCONSIN: Wisconsin passed legislation in February 2018 and issued a draft waiver proposal for public comment in March 2018. Wisconsin is proposing a traditional claims-based, corridor type reinsurance program. Total funding for the program is limited to \$200 million annually, and the state received 83 percent of that amount in federal pass-through funding (\$166 million). The state will contribute approximately \$34 million. The state funding is coming from general purpose revenue. The program will be administered by the Wisconsin Office of the Commissioner of Insurance (OCI). The reinsurance program will have an attachment point of \$50,000, a cap of \$250,000, and a coinsurance rate between 50 percent and 80 percent (50 percent in 2019). The OCI estimates that the program will reduce premiums in 2019 by about 10 percent or more and thereby increase projected enrollment.

Wisconsin has not expanded Medicaid and utilizes the federal exchange.

MARYLAND: Maryland passed enabling legislation on April 5, 2018, released a draft waiver application on April 20, 2018, submitted the waiver application on May 31, 2018 and received approval of the waiver from CMS on August 22, 2018. Maryland has imposed an assessment of 2.75 percent on certain types of health plans and Medicaid Managed Care Plans (MCOs) and expects to collect \$365 million in 2019. Maryland proposes a traditional claims-based reinsurance program and seeks to achieve a premium decrease (relative to same-year baseline without a reinsurance program) of 30 percent and a 5.8 percent increase in enrollment. The Maryland Health Benefit Exchange (MHBE) will administer the reinsurance program.

With regard to the assessment on health plans, Maryland proposes that the federal health insurer fees that were suspended for 2019 instead be paid to the state and used to fund this program. Total program costs for 2019 are estimated to be \$462 million. Maryland requests \$97 million in pass-through funding in 2019 (about 21 percent of the total). Maryland has expanded Medicaid and also has a state-based exchange.

NEW JERSEY: New Jersey passed enabling legislation on May 30, 2018, released the draft waiver application for public comment on May 31, 2018, submitted the waiver on July 2, 2018 and received approval from CMS on August 16, 2018. The reinsurance program will be administered by the New Jersey Individual Health Coverage Program Board of Director (IHC Board), which is "in but not of" the Department of Insurance. The New Jersey Insurance Commissioner will be an ex-officio member of the Board. The Board will design and adjust the payment parameters of the reinsurance program. New Jersey seeks to lower rates by 15 percent in 2019. Total funding for the program is estimated to be \$323.7 million. The state also enacted an individual mandate penalty in 2018. Those penalties will partially fund the reinsurance program, along with federal pass-through funding and annual appropriation from the general fund. New Jersey is

requesting \$218 million in federal pass through funds in 2019 (67 percent of the total). New Jersey has expanded Medicaid and utilizes the federal exchange.

MAINE: Maine passed legislation enabling the waiver application on June 2, 2017, released a waiver summary and actuarial analysis in March 2018, submitted their Waiver Application May 9, 2018 and received approval from CMS on July 30, 2018. The program would be administered by the Maine Guaranteed Access Reinsurance Association (MGARA). Maine created this program in 2012, but suspended it when federal reinsurance started in 2014. Maine now seeks to reinstate the same program, funded in part with federal pass-through funds. Maine's program is a type of condition-based reinsurance, which provides for automatic ceding of 8 specified conditions and voluntary ceding of other specified conditions. The reinsurance corridor is 90/10 percent of claims between \$47,000 and 77,000 and 100 percent of claims over \$77,000 for ceded individuals. The state funding for this program comes from a per member per month (PMPM) assessment of \$4 on health insurers and third-party administrators, plus 90 percent of the insurance premium paid by ceded individuals. Maine is seeking \$33.4 million (36 percent of the total) in federal pass through funding for 2019, and predicts a 9 percent premium decrease.

Maine may be expanding Medicaid in 2019 and utilizes the federal exchange.

WAIVERS THAT ARE DRAFTED BUT NOT SUBMITTED 2019

NEW HAMPSHIRE: Enabling legislation was passed in July 2017 and a draft waiver proposal was published for public comment in the same month. However, the proposal has not yet been submitted for formal review by CMS. The New Hampshire draft proposal is a traditional claims-based reinsurance program: all claims between \$45,000 and \$250,000 are paid, with 40/60 coinsurance. The proposal estimates that the state will contribute \$32 million (71.4 percent) and the federal pass-through funding is estimated to be \$12.8 million, or 28.6 percent of the total funding in the first year of the program. The reinsurance program is estimated to lower premiums by 7.2 percent to 7.4 percent. The program will be administered by the New Hampshire Health Plan (NHHP), an existing entity created under New Hampshire law that administered the high-risk pool and other market stabilization programs before the ACA was enacted. The state funding will come from an assessment on the broader health insurance market. The assessment is the same as it was in the past for the high-risk pool. The interest from the assessments will pay for the administrative costs incurred by the NHHP.

New Hampshire has expanded Medicaid and covers that population with commercially insured qualified health plans issued through the federal exchange. This action expanded the individual market significantly. However, New Hampshire is in the process of transitioning the Medicaid expansion population out of the exchange and back to MCOs. In 2018, there are three insurers offering health plans on the exchange. New Hampshire has the third-oldest population in the United States and the fourth-highest medical costs. Only 66 percent of exchange enrollees receive APTC. The uninsured rate in New Hampshire is 6 percent.¹⁴

IDAHO: Idaho published a draft waiver proposal for public comment on November 1, 2017. High risk pool legislation passed in April 2017, but legislation containing authority to apply for a 1332 waiver failed. Idaho was considering a coordinated 1115 and 1332 waiver. The 1115 waiver proposes to cover individuals with complex medical needs up to 400 percent of FPL (estimated to be about 1,000 individuals) in the traditional Medicaid program. It is anticipated that moving these individuals out of the individual market will "substantially decrease" individual market rates.

Idaho recently changed its high-risk pool law so that insurers can cede the claims of individuals who have been diagnosed with certain high-cost medical conditions to the high-risk pool. Those individuals will keep the individual market health plan that they originally chose, but the high-risk pool will reimburse the insurer

for their claims. The Idaho Individual High-Risk Reinsurance Pool, which administers the program, decides which high-cost medical conditions will make an individual eligible for reinsurance through the pool and determines the reinsurance parameters for claims, including the attachment point (cannot be lower than \$25,000), the cap, and the coinsurance that the ceding insurer will pay (cannot be less than 20 percent). The board can adjust these parameters on an annual basis. It determines what premium an insurer will pay when it cedes claims from one of its insureds to the pool and also determines the amount of assessments imposed. This is a form of condition-based state reinsurance.

Idaho has considered a 1332 waiver not related to its reinsurance program. It proposes that individuals under 100 percent of FPL without high-cost needs should be able to buy coverage on the exchange and receive APTC and cost-sharing reductions, the same as if they were above 100 percent of FPL. There are 78,000 individuals in Idaho who are not eligible for traditional Medicaid and do not qualify for APTC because their income is below 100 percent of FPL. Idaho expects that this approach would cover approximately 22,000 of the 78,000 individuals who would otherwise be eligible for Medicaid expansion. Idaho may request that CMS waive the restrictions in 26 USC § 36B(c) (1) (B), which allows individuals under 100 percent of FPL to receive APTC only if they are non-citizens who are lawfully present in the United States. Idaho proposes that *citizens* in Idaho who are under 100 percent of FPL also be allowed to receive APTC.

With regard to the “deficit neutral” guardrail, Idaho sought to calculate federal savings that would occur because Idaho did not expand Medicaid in order to balance out the cost of its proposal to increase the number of individuals eligible to claim APTCs.¹⁵

Idaho has a state-based exchange but did not implement Medicaid expansion. There are 124,589 covered lives in the individual market, and the uninsured rate is 9 percent.

LOUISIANA: Louisiana failed to pass legislation enabling the state to apply for a 1332 waiver and creating a state reinsurance program. The state released a description of the 1332 Waiver application in April 2018, but did not submit a waiver application to CMS for 2019. The proposed legislation description describes a traditional claims-based reinsurance program that would be administered by a board—the Louisiana Health Reinsurance Association. The state funding source would come from a PMPM assessment on all insurance issuers, third party administrators and MEWAs. Louisiana recently expanded Medicaid and utilizes the federal exchange.

WITHDRAWN 1332 WAIVER PROPOSALS

IOWA: Iowa submitted a 1332 waiver proposal in June 2017. The proposal included a traditional, claims-based state reinsurance program, but also proposed to reallocate premium assistance dollars to individuals above 400 percent of FPL and reduce consumer choice to one silver plan. In addition, Iowa proposed to change the premium tax structure to a defined flat dollar amount based on age and income level. There was no authorizing legislation and no state funding contribution amount proposed. Iowa has expanded Medicaid and has a 5 percent uninsured rate.¹⁶ Iowa withdrew its waiver proposal in October 2017.¹⁷

OKLAHOMA: Oklahoma submitted a waiver proposal in August 2017. It has authorizing legislation and proposed a traditional claims-based reinsurance program, similar to those of Oregon and Minnesota. The proposed risk corridor was \$15,000 to \$400,000, with 80/20 coinsurance. Oklahoma was requesting \$309 million in federal pass-through funding (85 percent) and \$16 million in state funding (15 percent). It did not expand Medicaid, and its uninsured rate is 11 percent (500,000 individuals). BCBS of Oklahoma, which is wholly owned by HCSC, was the only insurer in the individual market in 2017 and 2018.

The rate stabilization program in Oklahoma would be run by a board of directors and funded by an assessment on insurers. However, Oklahoma withdrew its waiver proposal in October, stating that CMS was not going to approve its proposal in time to affect the 2018 plan year.¹⁸

OTHER STATE PROPOSALS

Other states had or have waiver proposals that did not or do not involve reinsurance programs. California submitted a proposal that would have allowed its state-based exchange to issue non-subsidized coverage to individuals who were otherwise ineligible because of their immigration status. California withdrew that proposal in January 2017. Massachusetts has a draft waiver that involves several proposals that are unique to the pre-existing insurance regulatory scheme in that state. Several states have considered waivers that would involve some kind of single-payer system, including New Jersey, New York, and Vermont, which is proposing a public option to be sold on the exchange and a plan to expand CHIP to include individuals up to age 26.¹⁹

OVERVIEW OF 1332 STATE INNOVATION WAIVERS FOR STATE-BASED REINSURANCE²⁰
APPROVED STATES

	Alaska	Minnesota	Oregon	Wisconsin
Reinsurance Proposal				
Reinsurance Type	Condition-specific reinsurance	Traditional reinsurance	Traditional reinsurance	Traditional reinsurance
Reinsurance Corridor	All claims from policy holders with one of 33 specific medical conditions	\$50,000 – \$250,000	TBD – \$1,000,000	\$50 to \$250,000
Coinsurance Rate	100percent	80/20	50/50	50 percent to 80percent (50 percent in 2019)
Legislation Enacted	November 7, 2016 HB 374	April 4, 2017 HF 5	July 5, 2017 HB 291	February 27, 2018; SB 770
1332 State Innovation Waivers				
	Alaska	Minnesota	Oregon	Wisconsin
Waiver Status	Submitted December 29, 2016; approved July 7, 2017	Submitted May 5, 2017; approved September 22, 2017; signed October 16, 2017	Submitted August 31, 2017; approved October 19, 2017	Draft waiver released for public comment March 2018; submitted April 18, 2018; approved July 29, 2018.
State Funding	\$55 million annually proposed in 2016	\$271 million annually (61.9percent - 66.3percent of total)	\$90 million in 2018; \$1.1 billion over 10 years (68.5percent of total)	Estimated \$30 million; total cost of program capped at \$200 million
State Funding Source	Insurer assessment Health 6 percent of premium net of claims; Title 1 percent of premium; other 2.7 percent	Healthcare access fund (2 percent provider tax) and general fund	1.5 percent Assessment on fully insured major medical health insurance (phased in over three years)	State general fund
1332 Funding Requested	\$51.6 million in pass-through funding	\$138 million - \$167 million in pass-through funding (33.7percent - 38.1percent of total)	\$35.66 million in 2018; \$356.6 million over 10 years (31.5percent of total)	\$170 million in pass-through funding for 2019 (85 percent of total)
1332 Funding Received	\$58.5 million (2018); \$332 million (2018-2022)	\$130.7 million (2018); \$1.003 billion (2018-2022)	\$54.5 million (2018)	\$166 million for 2019 (86 percent of total)

OVERVIEW OF 1332 STATE INNOVATION WAIVERS FOR STATE-BASED REINSURANCE²¹
APPROVED STATES

	Maryland	New Jersey	Maine	
Reinsurance Proposal				
Reinsurance Type	Traditional reinsurance	Traditional reinsurance	Condition Specific (hybrid); automatic ceding for 8 conditions; voluntary ceding of other specified conditions	
Reinsurance Corridor	\$TBD – \$250,000	\$40,000 – \$215,000	\$47,000–\$77,000	
Coinsurance Rate	80/20	60/40	90/10; over \$77,000—100 percent	
Legislation Enacted	April 5, 2018 HB 1795	May 30, 2018 S. 1878	June 2, 2017 LD 659	
1332 State Innovation Waivers				
	Maryland	New Jersey	Maine	
Waiver Status	Draft Waiver released for comment April 20, 2018; submitted May 31, 2018; Approved August 22, 2018	Draft Waiver Released May 31, 2018; submitted July 2, 2018; Approved 8/16/18	Waiver summary and actuarial analysis March 2018; Waiver submitted May 9, 2018; Approved July 30, 2018	
State Funding	\$365 Million 2019 (79 percent of total)	\$105.8 million 2019, (32.7percent of total)	\$59.6 million (64percent of total)	
Source of State Funding	2.75 percent assessment on Maryland Health Plans and Medicaid MCOs	Penalties from State Individual mandate; general fund	PMPM assessment (\$4) on health insurers and TPAs; 90 percent of premium for ceded members	
1332 Funding Requested	\$97 million in pass-through funding for reinsurance in 2019 (21percent of total)	\$218 million in pass-through funding for 2019 (67.3percent of total)	\$33.4 million pass-through (2019); 36percent of the total	
1332 Funding Received				

OVERVIEW OF 1332 STATE INNOVATION WAIVERS FOR STATE-BASED REINSURANCE²²
 DRAFTED OR WITHDRAWN STATES

	Iowa	New Hampshire	Oklahoma	Louisiana
Reinsurance Proposal				
Reinsurance Type	Traditional reinsurance	Traditional reinsurance	Traditional reinsurance	Traditional reinsurance
Reinsurance Corridor	\$100,000 – \$3,000,000	\$45,000 – \$250,000	\$15,000 – \$400,000	TBD
Coinsurance Rate	85/15 (claims > \$3 million: 100percent)	40/60	80/20	TBD
Legislation Enacted	None	July 10, 2017	June 6, 2017	none
1332 State Innovation Waivers				
	Iowa	New Hampshire	Oklahoma	Louisiana
State Funding	\$0 (0percent of total)	\$32 million annually (71.4percent of total)	\$16 million in 2018; \$230 million over five years (14.2percent of total)	\$24.8 million (17.2percent of total); PMPM assessment (TBD)on all issuers, TPAs; MEWAs
Waiver Status	Amended September 22, 2017; withdrawn October 23, 2017	Draft waiver released for public comment July 19, 2017	Submitted August 16, 2017; withdrawn September 29, 2017	Waiver description released April 2018
1332 Funding Requested	\$70 million in pass-through funding for reinsurance in 2018 (100percent of total); \$396 million total waiver funding in 2018	\$12.8 million in pass-through funding for reinsurance (28.6percent of total)	\$309 million in pass-through funding in 2018; \$1,395 million over five years (85.8percent of total)	\$103.5 million pass-through funding for reinsurance requested (82.8percent of the total)

State 1332 Waiver Reinsurance Proposals: SHADAC: State Health Access Data Assistance Center, *September*, 2018.

POLICY CONSIDERATIONS FOR THE DEVELOPMENT OF A 1332 WAIVER PROPOSAL

The majority of the State Innovation Waiver proposals discussed above involve some form of reimbursement to be paid to individual market health insurers. The purpose of that reimbursement is to partially absorb the cost of individuals with high-cost conditions, thereby lowering premiums and ultimately attracting healthier

Reinsurance proposals have the best chance of winning approval from CMS. They appear to provide the most immediate solution for escalating premium costs.

individuals to the individual market. So far, the experience of the states indicates that reinsurance proposals have the best chance of winning approval from CMS and receiving federal pass-through funding. In addition, reinsurance proposals appear to provide the most immediate partial solution for escalating premium costs in the individual market.

Decisions regarding claims-based vs. condition-based reinsurance should be made only after careful consideration of recommendations from qualified actuaries who have studied the unique demographics of the state. Also, the experiences of states that are already implementing these programs may provide additional information regarding which approach is best for Montana. Many actuaries believe that condition-based reinsurance may create problems for the risk-adjustment mechanism and are less reliable in predicting future losses when setting rates.

Legislation authorizing a waiver application would still be required for a reinsurance proposal from most states because a state funding source is still required. In addition, the legislation should include the basic structure for the governance and administration of the state-based reinsurance program. These programs can be administered through an existing state agency or by a quasi-governmental entity governed by an appointed board. The board may consist of various stakeholders, primarily health insurers, who have easy access to the expertise required to make these types of decisions. The former Montana high-risk pool was governed by an appointed board consisting mostly of health insurer representatives, as well as some consumer representatives and staff from the insurance commissioner's office. Members of the board were often actuaries or lawyers. The decisions made by this program are complex, and insurance professionals are in the best position to make them. A state agency, such as the State Auditor's Office, can collect the assessments and have some oversight authority. The governing body for a state reinsurance program should have the authority to adjust the reinsurance parameters according to changing needs and available funding.

Legislation authorizing a waiver application for reinsurance is still required in order to establish a state funding source. The legislation should also include the structure for governance and administration of the reinsurance program.

Establishing a baseline of the relevant demographics pertaining to Montana, as well as the details concerning the current health care system, is important. Some of that information is required for the waiver application. The amount of premium rate reduction and the amount of funding needed to operate a state-based reinsurance program varies widely from state to state, according to the actuarial projections that were presented with the waiver application. Those variations may be based in part on issues such as whether or not the state has expanded Medicaid, the size of the individual market in comparison to the population of the state, the uninsured rate, the number of insurers still participating in the individual market, the current loss ratios of those insurers, the cost of health care in the state, the average age of the population, the amount of

state funding available to support the program, the average income level of the population, and the number of individuals receiving APTC.

Montana has an aging population and is among the top 10 oldest states in the United States, with an average age of almost 41.²³ The population is small (just above 1,000,000) and the average household income is low (\$45,000 - \$46,000). In 2018, 88 percent of marketplace enrollees receive premium tax credits, which is an increase from 85 percent in 2016 and 2017. In 2016, the individual market had approximately 80,600 covered lives (on and off the exchange). In 2018, enrollment in the individual market declined to about 62,452, in part because of increased premiums. The bulk of the lost enrollment occurred outside the exchange, where individuals do not qualify for APTC. The outside exchange individual market decreased 52.6 percent, from 28,261 in 2016 to 13,372 in 2018.²⁴

Establishing a legislatively approved funding source for this program is critical. Even though Montana may be eligible for federal funding, the state must contribute funding to make the waiver proposal viable.

Establishing a legislatively approved funding source for this program is critical. Even though Montana may be eligible for a significant amount of federal pass-through funding that covers a large percentage of the total cost, the state must contribute funding in order to make the waiver proposal viable. Some states have funds already set aside for these types of programs. Montana does not. The former high-risk pool was funded by member premiums that were up to 150 percent of the average market rate and a 1 percent assessment on all types and categories of health insurance, including non-major medical plans. For-profit insurers were allowed to deduct the assessment from the premium tax they owed. Some states also assess self-funded state government employee health plans. The Employee Retirement Income Security Act (ERISA) would probably preempt states from directly assessing self-funded, private, single-employer plans.

CONCLUSION

A proposal to establish a state-based subsidized reinsurance program appears to be the simplest and most efficient solution for stabilizing the individual market quickly. The individual health insurance market remains a critical safety net for all Montanans and should be preserved to ensure access to health care for a large segment of Montana's population.

¹ Claxton, G., et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, the Henry J. Kaiser Family Foundation, Issue Brief, December 12, 2016; Pianin, E., "52 Million Americans With Pre-Existing Conditions Face Uncertainty Under Obamacare Repeal," *The Fiscal Times*, December 13, 2016. Retrieved from <http://www.thefiscaltimes.com/2016/12/13/52-Million-Americans-Pre-Existing-Conditions-Face-Uncertainty-Under-Obamacare-Repeal>.

² Collins, et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, the Commonwealth Fund, Issue Brief, pub. 1931, vol. 5, February 2017.

³ Claxton, G., et al., and Pianin, E.

⁴ Cauchi, R., *Coverage of Uninsurable Pre-existing Conditions: State and Federal High-Risk Pools*, National Conference of State Legislatures, January 3, 2017. Retrieved from <http://www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx>.

⁵ 42 U.S. Code § 18052.

⁶ *Id.*

⁷ State of Hawai'i Section 1332 Waiver Proposal, August 10, 2016. Retrieved from <https://governor.hawaii.gov/wp-content/uploads/2014/12/REVISED-Hawaii-1332-Waiver-Proposal-August-10-2016.pdf>.

⁸ Finkelstein, A., et al., *Subsidizing Health Insurance for Low-Income Adults: Evidence From Massachusetts*, July 2017. Retrieved from <https://scholar.harvard.edu/files/hendren/files/commcare.pdf>.

⁹ Cauchi, R., *Innovation Waivers: State Options and Legislation Related to the ACA Health Law*, National Conference of State Legislatures, March 13, 2018. Retrieved from <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>.

¹⁰ State of Oregon Section 1332 Waiver Application, August 31, 2017. Retrieved from <http://healthcare.oregon.gov/marketplace/gov/Pages/applications.aspx>.

¹¹ State of Alaska Section 1332 Waiver Application, December 29, 2016. Retrieved from <https://www.commerce.alaska.gov/web/Portals/11/Pub/Alaska-1332-Waiver-Application-with-Attachments-Appendices.pdf?ver=2017-01-05-112938-193>.

¹² State of Minnesota 1332 Waiver, October 16, 2017. Retrieved from http://mn.gov/gov-stat/pdf/2017_10_16_GMD_Signed_1322.pdf.

¹³ State of Oregon Section 1332 Waiver Application, August 31, 2017. Retrieved from <http://healthcare.oregon.gov/marketplace/gov/Pages/applications.aspx>.

¹⁴ State of New Hampshire Section 1332 Draft Waiver Application, July 19, 2017. Retrieved from <https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf>.

¹⁵ State of Idaho Section 1332 Draft Waiver Application, November 22, 2017. Retrieved from <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/1115percent20Waiver/Draft1115WaiverApplication.pdf>.

¹⁶ State of Iowa Section 1332 Amended Waiver Application, September 22, 2017. Retrieved from <https://www.cms.gov/CCHIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Iowa-Stopgap.pdf>.

¹⁷ Jost, T., "Iowa Submits 1332 Waiver Request, Claiming It Is Necessary to Avoid an Individual Insurance Market Collapse," Health Affairs Blog, June 12, 2017. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20170612.060559/full/>.

¹⁸ State of Oklahoma Section 1332 Waiver Application, August 16, 2017. Retrieved from https://www.ok.gov/health2/documents/1332_percent20State_percent20Innovation_percent20Waiver_percent20Final.pdf.

¹⁹ Cauchi, R., *Innovation Waivers: State Options and Legislation Related to the ACA Health Law*, National Conference of State Legislatures, March 13, 2018. Retrieved from <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>.

²⁰ State Health Access Data Assistance Center (SHADAC). Resource: 1332 State Innovation Waivers for State-Based Reinsurance [Internet]. University of Minnesota, Minneapolis (MN) [cited ADD DATE]. Available from: <http://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance>

²¹ *Id.*

²² *Id.*

²³ *Median Age of U.S. Population in 2016, by State*, Statista, the Statistics Portal, September 2017. Retrieved from <https://www.statista.com/statistics/208048/median-age-of-population-in-the-usa-by-state/>.

²⁴ Goe, C., 2018 Uninsured Study. Study funded by the Montana Health Care Foundation.