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Reinsurance Basics: Considerations as States Look to Reduce Private Market Premiums

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Several states¹ have implemented reinsurance programs to reduce premiums in their individual health insurance markets and have used the Affordable Care Act's (ACA) "1332 waivers" to help finance their efforts; additional states are considering this approach. This primer provides basic information on how reinsurance programs work, how state approaches differ, potential pitfalls, and the pros and cons of reinsurance compared to other options to help consumers.

The Basics of Reinsurance

What is reinsurance?

Reinsurance programs provide payments to health insurers to help offset the costs of enrollees with large medical claims. In a competitive market, insurers will pass this subsidy on to consumers, so a reinsurance program will reduce premiums (in aggregate) by roughly the amount of the subsidy. For example, in a state where total annual premiums in the individual market amount to \$1 billion, a \$100 million reinsurance program will reduce premiums by about 10 percent. In some cases, a reinsurance program can also make insurers more willing to remain in or enter a state's individual market.

In addition, since the ACA requires insurers in the individual market to accept applicants regardless of health status or pre-existing medical conditions, insurers may try to use tactics such as benefit design or marketing efforts to avoid enrolling people with high-cost medical needs. Along with risk adjustment (discussed below), reinsurance programs can reduce insurers' incentives to do so.

How do reinsurance programs work?

While reinsurance programs can be designed in different ways, many states have modeled their programs on the temporary federal program set up under the ACA, which ran from 2014 through 2016. It provided reinsurance payments to individual-market plans when their annual cost for an enrollee exceeded a specified amount, called the "attachment point." Those payments covered a portion of plan costs (known as the "coinsurance rate") between the attachment point and a limit

¹ As of this writing, seven states have implemented 1332 reinsurance programs: Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin.

called the “reinsurance cap,” above which the insurer stopped being eligible for reinsurance payments.

In 2014, the attachment point was \$45,000, the coinsurance rate was 80 percent, and the reinsurance cap was \$250,000. This meant that, once the 2014 claims for an enrollee reached \$45,000, the insurer was eligible for reinsurance payments covering 80 percent of the costs of that enrollee’s claims from that point until the person reached \$250,000 in total claims.²

The federal reinsurance program was an “attachment point model,” in which all claims within a specified cost range are eligible for reinsurance. An alternative approach is a “condition-based model,” in which reinsurance payments are made only for specific high-cost conditions.³

Is reinsurance the only program that compensates insurers that enroll disproportionately high-cost enrollees?

No. The ACA also set up a permanent federal risk adjustment program, which transfers revenues from insurers that end up enrolling a healthier-than-average group of consumers to those that enroll a sicker-than-average group, compensating the latter for the extra health care costs they incur. This applies in both the individual and small-group markets. Beginning in 2018, the federal government added a feature to the program so that it reimburses insurers for 60 percent of their costs for individuals with annual claims above \$1 million.

Who benefits from the premium reductions that reinsurance programs make possible?

In the individual insurance market, reinsurance programs reduce overall premium costs compared to what they would be without reinsurance. Therefore, consumers who pay the full sticker price of their coverage — that is, people not eligible for ACA subsidies — will see lower premiums if their state implements a reinsurance program.

However, the majority of enrollees in the ACA individual market receive premium tax credits that cap the amount they must pay for coverage at a percentage of their income. For this group, reinsurance *doesn’t* reduce the premium contributions they must pay; instead, by reducing sticker price premiums, it reduces their subsidy provided through the premium tax credit.

Consider, for example, a person at 150 percent of the federal poverty level, or about \$19,000 a year. Under the ACA, they must pay just over 4 percent of their income, or \$63 per month, to buy the silver benchmark plan, with the premium tax credit making up the difference. So, if the sticker price of the silver benchmark plan for a 40-year-old is \$400 per month, they are eligible for a subsidy of \$337 per month. If a reinsurance program reduces the benchmark plan premium by 10 percent, from \$400 to \$360, the amount the person pays stays the same, \$63 per month, and the premium tax credit drops from \$337 to \$297.

² Cynthia Cox *et al.*, “Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors,” Kaiser Family Foundation, August 17, 2016, <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>.

³ “State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States,” Manatt Health and State Health & Value Strategies, March 2018, https://www.manatt.com/Manatt/media/Media/Images/White%20Papers/SHVS_Reinsurance_1332-Waivers-Final.pdf.

Connection With Section 1332 Waivers

How have states used section 1332 waivers to establish reinsurance programs?

Under section 1332 waivers (named for the ACA provision that established them), states can waive certain federal requirements, mainly related to the ACA marketplaces, as long as they meet certain standards, including providing health coverage that is at least as comprehensive and affordable, and covers at least as many people, as they would have without the waiver. Of the states that have implemented 1332 waivers, all but one used them to establish a reinsurance program.

State-funded reinsurance programs reduce federal costs because, as explained above, reinsurance lowers premium tax credits for subsidized consumers. The 1332 waiver is a mechanism for the state to recapture those federal savings and use them to benefit the state's residents: if a state's 1332 waiver plan is projected to reduce federal costs, then the state may be able to receive federal "pass-through" payments equal to the difference. Both the Obama and Trump Administrations encouraged states to take advantage of this pass-through mechanism.

States so far have used the pass-through payments to help fund their reinsurance programs, but that is not required. A state could, for example, use the payments to increase subsidies for low- and moderate-income consumers who don't benefit from the reinsurance program itself.

Does the federal government provide net new funding to states that establish reinsurance programs?

No. As explained above, 1332 waivers just allow the states to recapture the savings that their programs would otherwise provide to the federal government. States need to identify their own funding sources for these programs; a number of states have used fees paid by insurers, for example.

How is pass-through funding calculated?

The amount of a state's pass-through funding represents the amount of premium tax credits the federal government *would have* provided to the state's residents absent the reinsurance program, minus the credits the federal government actually will provide.

The federal government calculates each state's pass-through funding annually, using information such as enrollment by income. Recently, the federal government updated its projections and notified several states they will receive different pass-through amounts in 2019 than they had anticipated. Oregon, New Jersey, Minnesota, and Wisconsin will receive less than expected, while Alaska, Maine, and Maryland will receive more.⁴

⁴ Katie Keith, "CMS Releases New Info on State Reinsurance Funding," Health Affairs Blog, March 4, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190304.112399/full/>.

Reinsurance vs. High-Risk Pools

Is reinsurance different from a high-risk pool?

Yes. High-risk pools segregate patients with serious health needs in separate pools and often provide them with different plan options than those for healthier people. Reinsurance, in contrast, subsidizes the costs associated with sicker people “behind the scenes” and gives all people, regardless of health status, the same set of plan choices for the same premium rates.

States operated high-risk pools for decades prior to the ACA, when insurers in most states’ individual markets could deny coverage to people with pre-existing conditions. High-risk pools were set up as a refuge to help those “uninsurable” people, as well as certain other groups, to bypass the barriers in the regular insurance market and buy health coverage. But the pools were separate from the regular individual insurance market. High-risk pools typically required enrollees to pay premiums far higher than the standard cost of coverage, and people often faced coverage limitations, such as exclusions of their pre-existing conditions from coverage. Also, the plan options for consumers in a high-risk pool often differed from the plans available in the regular insurance market. At their peak, high-risk pools covered more than 200,000 people, but that didn’t come close to providing health coverage to the actual number of people with pre-existing conditions.⁵

Starting in 2014, when the ACA’s market reforms and pre-existing condition protections took full effect, insurers had to allow all consumers to sign up for virtually any of their individual-market plans, regardless of health status or health conditions. Reinsurance programs emerged as a way to subsidize some of insurers’ costs for high-cost people and thereby bring down overall premium costs and promote insurance market stability. A major benefit of reinsurance, compared to old-style high-risk pools, is that, consistent with the ACA, people with high health costs have the same plan options, at the same price, as healthier people. Reinsurance payments may go to an insurer on the sicker person’s behalf, but this happens behind the scenes.

What is an “invisible” high-risk pool?

The term “invisible” high-risk pool comes from a Maine program that operated from July 2012 through December 2013. Under that program, insurers identified people with certain high-cost health conditions and, in advance, ceded those enrollees’ costs to the high-risk pool while also paying a premium. Consumers were required to complete a health risk assessment as part of the program, but otherwise it was invisible to them; they were not placed in separate plans from the rest of the individual insurance market.⁶ The idea attracted attention again in 2017 when an “invisible risk-sharing program” was proposed as an amendment to a House ACA repeal bill.

In 2018, Maine received federal approval for a 1332 waiver to reinstate a version of its invisible high-risk pool, updated to reflect the market rules of the ACA. As with its earlier program, Maine’s

⁵ Karen Pollitz, “High-Risk Pools for Uninsurable Individuals,” Kaiser Family Foundation, February 2017, <http://files.kff.org/attachment/Issue-Brief-High-Risk-Pools-For-Uninsurable-Individuals>.

⁶ Trish Riley, “Should Maine’s Invisible High Risk Pool Law be the Model to Address Market Stability Nationally?” National Academy for State Health Policy,” April 18, 2017, <https://nashp.org/should-maines-invisible-high-risk-pool-law-be-the-model-to-address-market-stability-nationally/>.

pool is prospective, meaning that it identifies ahead of time which policies it will cover. Insurers automatically cede the policies of high-risk enrollees with one of eight specified health conditions (such as HIV and congestive heart failure) to the pool and can voluntarily cede others. When this happens, the insurer pays 90 percent of the individual's premium into Maine's program, and the program pays a part of the insurer's claims if they exceed a certain amount.⁷ Consumers are treated the same whether their claims are ceded to the pool or not. Unlike the earlier program, the new program can't require consumers to complete a health risk assessment before enrolling, and all applicants are protected from exclusions related to any pre-existing conditions, consistent with the ACA.

If "invisible" high-risk pools are truly invisible to consumers, then they function much the same as reinsurance and have the potential to reduce overall premiums without negatively affecting people. But if a high-risk pool treats less healthy consumers differently — for example, by requiring them to fill out a health questionnaire in order to enroll or by offering them only certain plans — then this would amount to illegal discrimination against people based on their health status and pre-existing conditions.

Reinsurance vs. Other Policies to Reduce Premiums

Among policies aimed at reducing consumers' premium costs, how does reinsurance compare to improving subsidies?

Both state and federal policymakers are interested in finding ways to reduce the premium costs of individual-market consumers. In general, improving subsidies holds two important advantages over implementing a reinsurance program. First, subsidy improvements can be structured to benefit people with incomes under 400 percent of the federal poverty level. As explained above, people in this group don't benefit from a reinsurance program, and they are far likelier to be uninsured than the higher-income people who do.⁸ Second, subsidy improvements can also offer more targeted help to people with incomes *above* 400 percent of poverty. While reinsurance reduces premiums by the same percentage for all unsubsidized consumers, expanding eligibility for premium tax credits to people over 400 percent of poverty provides more help to middle-income people and to those who are older, live in high-cost areas, and others with especially high premiums as a share of income.⁹

At the federal level, improving subsidies would clearly be a more effective and better-targeted approach than reinsurance to improving people's ability to afford and access coverage. For states, however, it may be more challenging to supplement marketplace subsidies and coordinate them with existing federal subsidies. While some states with state-based marketplaces are implementing supplemental subsidies or considering doing so, reinsurance may be a more feasible way to bring down premiums in states relying on the federal marketplace.

⁷ Katie Keith, "CMS Approves Maine's 1332 Waiver for State-Based Reinsurance Program," Health Affairs Blog, August 3, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180803.450619/full/>.

⁸ Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," Center on Budget and Policy Priorities, March 21, 2019, <https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing>.

⁹ Aviva Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers," Center on Budget and Policy Priorities, March 21, 2019, <https://www.cbpp.org/research/health/making-health-insurance-more-affordable-for-middle-income-individual-market>.