

Leveraging 1332 State Innovation Waivers to Stabilize Individual Health Insurance Markets: Experiences of Alaska, Minnesota, and Oregon

FINAL REPORT

Document Efforts to Stabilize the Individual Market Using State-Based Reinsurance

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INTRODUCTION

In the absence of federal policy to stabilize individual health insurance markets, state policy makers are seeking state solutions to address rising premiums and the exit of health insurers. One strategy being considered by an increasing number of states is state-based reinsurance. Reinsurance is a common tool in the insurance industry that protects insurers by limiting their exposure to very high, unpredictable medical expenses incurred by their members by covering part of those expenses once they exceed a set threshold. In 2014, the Patient Protection and Affordable Care Act's (ACA) federal transitional reinsurance program covered 100% of an individual's claims up to \$250,000 once they exceeded \$45,000. After the federal reinsurance program ended in 2016, however, premiums rose more sharply and many consumers looking to buy individual market coverage experienced not only significant premium increases, but also fewer plan choices as some health insurers exited local markets or entire states. With the subsequent lack of federal action, state policymakers and regulators began to explore state solutions to stabilizing the individual market.

The first state to take action was Alaska. In 2016, in response to projected individual market premium rate increases that exceeded 40%, Alaska implemented a state-based reinsurance program for plan year 2017. The program used \$55 million in state funds generated through an existing tax on insurance plans (health, property, and life insurers) and significantly mitigated rate increases—the actual rate increase in 2017 was only 7%. This program not only saved money for consumers, but also reduced the federal government tax credits used to subsidize individual market plans purchased through marketplace. In order to recoup those federal funds, Alaska became the first state to seek approval to establish a state reinsurance program through Section 1332 of the ACA.

Section 1332 of the ACA authorizes states to waive key requirements under the law in order to experiment with different policies in the individual and small group insurance market within certain guardrails: state waiver applications must demonstrate that the innovation plan will provide coverage that is at least as comprehensive in covered benefits, at least as affordable, cover at least a comparable number of state residents, and not increase the federal deficit.¹ To support their waiver policies, states may request federal funding equal to the amount that residents would have received as premium tax credits and cost-sharing reductions without the waiver, referred to as subsidy pass-through funding.¹ This pass-through funding mechanism available under the 1332 waiver is what states leveraged to support their reinsurance programs. By establishing a reinsurance program via a 1332 State Innovation Waiver, Alaska was able to leverage both federal and state funding to stabilize their individual market.

In a March 13, 2017, communication from the Department of Health and Human Services, Secretary Price encouraged states to consider using the section 1332 State Innovation Waiver opportunity to implement reinsurance programs.² In this letter to governors, Secretary Price cited the success of Alaska's state-based reinsurance program and signaled support for state-based programs that leveraged federal pass-through funding.

By late 2017, Alaska, Minnesota, and Oregon became the first three states to receive federal approval to establish state reinsurance programs with federal funding via section 1332 State Innovation Waivers. The purpose of this study was to document the strategies and rationale used by Alaska, Minnesota, and Oregon to address the volatility of their individual markets via state-based reinsurance mechanisms. We sought to identify the challenges, facilitators, and lessons learned that could be helpful for other states debating policy action, and for federal regulators interested in supporting similar state initiatives. To collect this information, we conducted an in-depth document review and qualitative interviews with 31 individuals across the three study states who were involved in the design and/or implementation of state reinsurance programs and the 1332 waiver application process. Discussions took place between February 2018 and May 2018, and interviewees represented state agency and executive staff, legislators, actuarial analysts, health plan representatives, program administrators, and other stakeholders.

¹ On October 22, 2018, the Department of Health and Human Services and the Department of Treasury released new guidance on Section 1332 waivers that makes significant changes to the Departments' approach to reviewing and approving Section 1332 waivers, and to prior interpretations of the law's guardrails.

Alaska was the first state to establish a state reinsurance program, which pays 100% of claims from policyholders who have one of 33 possible specific medical conditions.³ In July 2017, the Centers for Medicare and Medicaid Services (CMS) awarded \$48.3 million in federal pass-through funding for 2018 (later increased to \$58.5 million) and a total of \$322 million over five years for the program.⁴ Roughly 23,000 individuals (3% of the population) were enrolled in the individual market in 2017.⁵ Approximately 19,145 of these individuals enrolled through the health insurance marketplace.⁶

In 2017, the Minnesota legislature passed the Minnesota Premium Security Plan (MPSP), a traditional reinsurance model with an attachment point of \$50,000 and a cap of \$250,000 with payment of claims at an 80/20 coinsurance rate. CMS approved Minnesota's 1332 waiver application in September 2017, giving the state \$139 million in pass-through funding for reinsurance in 2018, and a total of \$1 billion in funding over five years.⁷ Roughly, 229,000 individuals (4% of the population) were enrolled in the individual market in 2017.⁸ Approximately 116,358 of these individuals enrolled through the health insurance marketplace.⁹

Also in 2017, the Oregon legislature passed the Oregon Reinsurance Program, a traditional reinsurance model with a 50/50 coinsurance rate, as well as an attachment point and cap to be determined at a later date. CMS approved Oregon's waiver in October 2017, awarding the state \$35.7 million (later increased to \$54.5 million) for reinsurance in 2018.¹⁰ Roughly 215,000 individuals (5% of the population) were enrolled in the individual market in 2017.¹¹ Approximately 155,430 of these individuals enrolled through the health insurance marketplace.¹²

Appendix 1 summarizes the key features of the three reinsurance models and provides detail on the components that each state included in its waiver application.

STATES LEAD THE WAY

Each of the three states faced unique local dynamics in their individual health insurance markets that led them to establish state-based reinsurance programs. In addition, while federal reinsurance programs were being discussed by Congress during this time, interviewees in all of our study states noted the pressure they felt to develop a state solution in the absence of clear congressional consensus. Below, we highlight the unique historical context that drove state decisions to establish a state-based reinsurance program as well as some common themes such as cost pressures and a lack of federal action.



ALASKA

Discussants in Alaska all commented that the high cost of health care in the state and small size of the individual market—the smallest in the country at roughly 23,000 covered lives—adversely impacted premiums in their market prior to the reinsurance program. The state's high health care costs (one of the highest in the U.S. per capita)¹³ were attributed to the rural and remote geographic location of the state, a shortage of health care providers, and a sicker-than-expected population.

In addition, some discussants noted that Alaska's "80th percentile rule," which sets a minimum for how much health insurers must pay when enrollees see out-of-network providers, also drives health care costs.ⁱⁱ

Discussants cited these factors as driving the 38% individual market premium increase in 2015, and the 37% increase in 2016. In 2016, the state was projecting a 42% increase for upcoming plan-year 2017 and, faced with growing losses, four of Alaska's original five insurance carriers had left the individual market.¹⁴ The sole remaining carrier indicated that if the market continued status quo, they would have to double their rates for 2017 in order to remain profitable, and there was no commitment that they would even remain in the individual market. Faced with the prospect of no remaining individual market carriers, Alaska's legislature began to consider a reinsurance program in earnest in 2016.

ⁱⁱ A 2018 study conducted by the Institute of Social and Economic Research and Department of Economics and Public Policy University of Alaska Anchorage found that without the rule, which was enacted in 2004, accounted for between 8% and 25% of Alaska's average annual increase in health-care spending between 2005 and 2014. <https://www.commerce.alaska.gov/web/portals/11/pub/headlines/iser%2080th%20percentile%20report.pdf>

One interviewee explained, “It was pretty much at that point in time we just had to do something and it was apparent that relief was not going to come from the federal government. So essentially we knew that if we didn’t...the federal government was not going to come in and fix our problem even if our market completely crashed, that we had to fix it ourselves. And so I think that was the driving force behind the reinsurance plan was just that we had to be sort of architects of our own destiny here because there was no one riding in from Washington, D.C., to save us.”



MINNESOTA

Minnesota’s individual market faced significant premium increases and a partial exit of carriers as a result of a confluence of factors. In 2014, Minnesota had some of the lowest marketplace premiums in the country.¹⁵ One health plan in particular, PreferredOne, priced their premiums significantly lower than the other carriers in the first open enrollment period (plan year 2014).¹⁶ Ultimately, they dominated the market, enrolling 58% of MNsure enrollees by the close of the first open enrollment.¹⁷ While the low premiums were hailed as positive news at the time by Governor Dayton,¹⁸ the Department of Commerce, and MNsure (Minnesota’s state-based marketplace), upon reflection, many interviewees felt that the low rates the first year were a significant contributing factor to the subsequent large increases. Several respondents indicated that insurers initially proposed higher rates for the 2014 enrollment year, but that negotiations with state regulators eventually brought the final rates down much lower. One respondent noted, “I can blame both insurers and regulators in those scenarios. In the end, everyone signed the line. Depending on who you are and where you sit, at that moment in time you can blame one or the other, but the bottom line is, the market was way out of balance and nobody had any interest in calling it out.”

In addition to artificially low premiums, discussants noted that many failed to accurately predict the characteristics of the post-ACA individual market risk pool. For example, there had been an assumption that the roughly 20,000 enrollees in Minnesota’s high-risk pool, a program that pre-dated the ACA, would transition slowly over two years to the individual market. However, because the 2014 marketplace rates were so low most of the high-risk pool enrollees switched immediately to marketplace coverage. Another unique factor that led to uncertainty regarding Minnesota’s individual market risk pool is the state’s Basic Health Program (BHP), MinnesotaCare, which provides coverage for individuals between 133% and 200% Federal Poverty Level (FPL). Interviewees expressed mixed opinions as to the effect Minnesota’s BHP has on the risk profile of the individual market. Some respondents felt it resulted in an individual market pool that was smaller and sicker. Others, however, noted that an analysis commissioned by the local health plans to look at this issue found that individuals in similar lower income categories (between 138% and 200% FPL) in other states had about the same or only slightly higher risk scores compared to the individual market average.¹⁹

The combination of low premiums, uncertainty regarding the risk profile of the post-ACA individual market and a failure of the federal government to fund the risk corridor program led the dominate carrier, PreferredOne, to incur excess losses they couldn’t sustain. PreferredOne abruptly left the market in advance of the second open enrollment, but after other carriers had set their premium rates. Several discussants noted, that had other health insurers known that PreferredOne planned to exit, they would have increased their premium rates for plan year 2015. Ultimately, while rate increases were fairly moderate in 2015 (ranging across carriers from 9% decline to 17% average increase), the market ultimately underwent a correction in 2016, when the average premium rate increases ranged from 14% to almost 50% for Minnesota’s largest individual market carrier.²⁰

When the federal risk corridor program was not funded in 2015—following two years of premium rate increases, increasing public outcry, and insurers’ ongoing concerns about their ability to stay in the market—Minnesota began to explore options to stabilize its individual market. Some respondents indicated they had hoped the federal government

would take action, but realized that due to political dynamics federal action was unlikely. One respondent commented, “I think there’s this hope that the feds would come together around something and they’d do their own reinsurance that would take a bunch of the pressure off the state. Well neither of those things is going to happen.”

In the spring of 2016, Minnesota’s Democratic governor proposed a MinnesotaCare buy-in (a.k.a. public option). Republicans, who controlled the legislature, opposed that strategy. However, in 2017 Democrats and Republicans were able to come together to support a premium subsidy program, which provided a 25% discount to individuals purchasing in the individual market. Due to political debate, the program didn’t pass until three days before the end of open enrollment which limited its impact (the program ultimately paid out less than 50% of its allotted funds).²¹ So, while the premium subsidy program helped insulate some individuals from the large premium increases, the state was still concerned about the possibility of insurers exiting the market. Interviewees reported that during that time they were watching what was happening in Alaska closely. One respondent noted, “Alaska was like a one-year view into our future...It’s a radically different market because it’s so small, but the things that happened to them, happened to us one year later...And so on October 1 [2016], we obviously knew this was coming, and so our staff started calling their counterparts in Alaska and started to talk to them about what were they doing.” These discussions led the state to consider implementing a reinsurance program.



OREGON

Prior to the ACA, Oregon had one of the most competitive insurance markets in the country.²² In 2014, the state had a dozen carriers offering plans in different parts of the state, and some of the lowest rates in the country. Despite the large number of insurers, Oregon’s market is unique in that it is largely dominated by local carriers. One interviewee commented that these local, nonprofit-based insurance carriers, several of which are also directly related to provider networks, helped provide stability to their market, explaining: “Corny as it sounds in the health insurance space, they’ve all got a fairly strong amount of commitment to community and the mission of making sure people have got access to health care. And that also serves to be a real tempering factor in keeping companies being willing to hang with an unstable market longer than an United Healthcare or Aetna.”

Similar to the experience in Minnesota, several Oregon discussants felt that premium prices had been set too low during the first years of open enrollment because carriers didn’t have enough experience with the population. One interviewee explained, “We in fact massively underpriced our market in Oregon. I think we had the lowest individual premiums in the country. A 30-year-old nonsmoker in the Portland area could get a Silver plan before subsidies for under \$200 a month. Everything was great. Second year, we didn’t have enough data to know that everything wasn’t really great, so the prices pretty much stayed about the same. And then we finally had enough claims data to know that everybody was losing money hand over fist. And there was lots of discussion of, ‘Does a low-price provider consciously underbid the market to try to gain market share? Did they just not know what they were doing?’ All that kind of stuff. And who knows ultimately what the answer to all of that is.”

As carriers gained experience with the market, and state regulators saw more data on the experience of the individual market, it was clear that the 2014 rates were not sufficient to cover costs. Premiums began to go up, several CO-OPs left the market, and some carriers decided to reduce their geographic footprint in the state, particularly in rural areas. The threat of losing carriers in certain areas of the state and the continuing escalation of costs were both significant driving forces that led Oregon to pursue reinsurance.

NAVIGATING THE 1332 WAIVER APPLICATION PROCESS

Stakeholders who helped design and/or implement state reinsurance programs via 1332 waivers in Alaska, Minnesota, and Oregon provided important insights as to the challenges and facilitators they faced during their waiver application process, and lessons learned that could be applicable to other states considering similar policy actions.

Challenges

Securing a state funding source

The most commonly cited challenge to establishing a state-based reinsurance program and putting together a successful 1332 waiver was the identification of a funding source for the state share of the program.

Alaska's first draft of a reinsurance bill, which included an assessment on all stop-loss carriers based on a per-person, per-month financing mechanism, faced significant opposition from the legislature and stop-loss carriers for large employers in the state. Only after the state modified the bill to include a premium tax, along with a sunset date, was it able to move forward in a special session and gain passage in the Alaska legislature.

Minnesota's state-portion of the reinsurance program is financed with the state's existing Health Care Access Fund, a fund established in 1992 with a 2% provider tax and a 1% health plan premium assessment, which was originally designated to fund MinnesotaCare before it became a BHP. With MinnesotaCare's transition to a BHP, it is now largely financed by the federal government. Financing the reinsurance program with Health Care Access Fund money was very contentious in the state. Many Democratic legislators objected to use of the Health Care Access Fund for those with incomes above 400% FPL, and felt that Republicans were using the fund for other political purposes. One state policy maker commented, "I think Republicans want to zero out the Health Care Access Fund. They want to eliminate MinnesotaCare and this was one way they could use those funds and accomplish their goal of wanting to also defund MinnesotaCare."

Other respondents disagreed, however. One health plan representative explained, "I think of the Health Care Access Fund as not being all that distinct from the general fund. I think of it as being basically a shared—it's got a little line between it and the general purpose, but hundreds of millions of dollars of obligations were moved from the general fund to the access fund at the same time. So the idea that this is a separate budget or a separate dedicated health care purpose is not borne out by reality. We still talk about it that way, but it isn't. So the legislature had some money in the general fund forecast and it had a whole boatload of money in the Healthcare Access Fund. And they figured they could afford it."

Regardless of the motivations for using the fund, respondents agreed that Minnesota was able to move forward with reinsurance because there was an existing funding source available and the legislature would not have to raise any new funds to support the effort. One interviewee noted, "There were a number of financing options considered...The legislature, let's say the majorities, I think in no small part because they were hearing from their allies in the business community, were not interested in using a tax. And we had just spent \$312 million out of the budget reserves, so that was not an option. And so if you need \$271 million, there aren't that many places you can go find it. We were really fortunate that this happened...[and] the state was in a fiscal situation to be able to put up \$271 million. Most of the other states that are looking at state-based reinsurance programs don't have that kind of cash laying around."

Oregon faced a \$1 billion budget gap in 2017 due to the stepdown in funding of the expansion population through the ACA at the same time that the state was considering reinsurance. The state ultimately tied the funding for the reinsurance program (financed with a premium assessment) to a broader health care financing package for the state, which was approved by a ballot measure in February 2018. Respondents noted benefits and drawbacks to this approach.

Tying the two measures together made the issues more complex to talk about, but it also provided some political cover. One interviewee explained, “Reinsurance was really important and something we could concretely talk about in terms of the benefit to the individual market. But in some conversations, it was kind of dwarfed by Medicaid being kind of the dominant budget need. ...So they were coupled together, I think it really was about telling that whole story of how do we stabilize the market. I think it helped that we could say that there was federal funding, a possibility of federal funding. I think that definitely made it more interesting. And the other piece is that the state funding that was generated to pay for reinsurance, part of that base was also used to fill the Medicaid budget. So they were kind of inextricably linked. I think that that did make it a little bit more complicated, but in some ways it probably helped it to be able to kind of get over the finish line.”

Rapidly shifting political climate made the waiver application process difficult

Several respondents noted that the political climate at the time, including the change in administration that occurred in 2017 and the subsequent efforts to repeal the Affordable Care Act, made the 1332 waiver application process more challenging than they originally anticipated. As one interviewee explained, “It’s easy to forget that with all that was going on with the Affordable Care Act at the federal level during roughly the same period of time. Because so much focus was on that. So I do wonder if, for example, when we’re trying to engage with CMS and there’s administration pushing so hard for this repeal process of the very law that gives us the 1332, I think that perhaps if they were not so focused on their repeal and replace efforts, we could have been more focused on a bipartisan, sensible thing to actually bring down costs.”

Respondents in Minnesota, in particular, felt that politics interfered with solid policy decisions related to Minnesota’s reinsurance program. Minnesota was especially concerned with holding its BHP harmless in any pass-through funding calculations,ⁱⁱⁱ and for several months the state worked closely with attorneys from the Center for Consumer Information and Insurance Oversight (CCIIO) who reviewed and edited Minnesota’s authorizing language and gave assurances that the state would receive a full pass through funds for Basic Health Program funds for MinnesotaCare. After Minnesota submitted its final waiver application, however, respondents recalled that Governor Dayton had difficulty getting a response from Secretary Price or CMS Administrator Seema Verma about the status of their waiver decision. In September, eight days before the state was required to publish its final premium rates for 2018, Minnesota received partial approval for its waiver. The reinsurance program was approved, but funding for the BHP was not—effectively resulting in a net \$169 million loss of federal funding to the state.²³

One interviewee commented on the process, “I feel like it was a real bait and switch from CCIIO and I don’t know that I’ll ever fully understand exactly what transpired. But what we were told was that the general counsel who had originally approved our waiver and our approach and had reviewed the legislative language and all that, that there had been kind of a change of heart within the general counsel’s office...it was hard because it was like we had been told by a staff person ‘This is, you’re good to go, your language is good.’ Then that same staff person told us two months later, ‘Sorry, you’re going to lose millions of dollars.’ So the process was less than transparent.”

Governor Dayton struggled with the decision to accept the waiver once the BHP funding was cut, publicly releasing a letter calling the process “nightmarish.” Ultimately, however, one respondent noted that “the governor felt he did not have the political leverage to go back to the Republican-controlled legislature and renegotiate another solution, such as another premium subsidy program.”

Another Minnesota discussant noted of the process, “Until politics was injected into the process from my personal point of view, was not terribly unusual. It was progressing on the timeframe it was supposed to be progressing on.

ⁱⁱⁱ Minnesota’s BHP is financed with 95 percent of the tax credits and subsidies that enrollees would have received if they had purchased insurance in the individual market. Because the reinsurance program, by design, reduces premiums in the individual market, Minnesota asked to receive the pass through funding for BHP premiums.

And yeah, we would have liked to have heard sooner, but when does government ever move fast enough for people? And it was then only when they weren't going to give us the answer by the timeframe we needed it, and then the answer that they gave, that things really kind of came off the rails and became really I think almost exclusively political. And it also was happening in the context of the repeal and replace conversations were happening in Congress. I don't mean to list the speculation on my part, but if you look at what's happened to some of the other states, like Alaska's 180-day clock ran to 180 days. Because at the end of that 180 days, they were in the middle of the very first attempt to actually send a repeal bill to the president and whose vote [Sen. Murkowski – AK] they [the administration] needed."

Access to timely data

Difficulty accessing timely data was another common challenge cited by respondents involved in the waiver application process. Alaska and Oregon, states that rely on healthcare.gov, reported that they wished they had access to more real-time enrollment data. One respondent noted, "That's a challenge because like I said earlier, we are a federal exchange, we don't have those numbers. And I kept having to remind CMS of that in our meetings. They would keep asking us, 'Okay now you're going to give us your enrollment numbers.' And we'd have to tell them, 'Well no, we can't give those to you, you're going to have to look them up yourself.'"

An analyst in Oregon also commented on the desire for access to more timely data, especially in light of shifting policies that may impact analyses. When analysts in Oregon updated their analyses for 2019 and used more recent numbers provided by the Treasury department, it significantly impacted the results. The analyst explained, "When we're trying to use ancient information and when things are changing as much as they are, and things are going to change a lot again in 2019, it's anybody's guess as to how they change....It's a little bit of a guess in terms of can we really rely on the historical data or is it something different this year?"

Conversely, respondents in Minnesota felt lucky that they had access to data through MNsure, the state's state-based marketplace, such as current premium tax credit enrollments and dollar amounts. One respondent commented, "[MNsure] came through and had the information for us. Otherwise, our award might have been a lot smaller. Because one thing that was happening was that the number of people getting the tax credit has increased steadily over the years. And if we had to rely on 2016 data, they probably would have required us to project that going forward and it would have been a much lower number than the 2017 number. So the fact that we had the higher number, documentation of the higher number, I think led to a higher award."

Identifying a waivable item

A 1332 waiver requires that some requirement of the ACA be waived, but a common challenge states faced in their waiver application process was identifying an appropriate item to waive. This was because the 1332 mechanism did not originally pertain to reinsurance. 1332 waivers do not have a defined application, per se. Instead, applicants have to meet broad specific objectives (i.e., show that their program will provide coverage that is at least as comprehensive in covered benefits, is at least as affordable, cover at least a comparable number of state residents, and not increase the federal deficit). Alaska, who submitted the first state-based reinsurance waiver request, originally thought that the reinsurance program itself qualified as a waivable item. But CMS responded that it did not, and the state tried an additional two times before they were able to identify a waivable item that was satisfactory to CMS. Ultimately, Alaska ended up waiving section 1312(c)(1) of the ACA related to the individual market single-risk pool.

Minnesota experienced a similar difficulty identifying a waivable item. Early drafts of Minnesota's authorizing legislation for its reinsurance program did not include any language indicating that the plan would be contingent on approval of a 1332 waiver. CMS eventually communicated to the state that they would not even consider Minnesota's application valid if the program did not waive some ACA requirement and was not contingent on approval of a 1332 waiver request. Minnesota ultimately waived a provision related to CO-OP plans.

In May 2017, the federal government released a checklist to help states apply for 1332 waivers. The checklist included examples of provisions states could waive, and details on what the state would be required to explain regarding how the waiver would facilitate the operations and/or requirements for participating in a state's reinsurance program.²⁴ Oregon, benefiting from the experiences of Minnesota and Alaska as well as from the federal guidance, included an appropriate waivable item in the first draft of their proposal; specifically, they sought a waiver of section 1312(c)(1), the single-risk pool requirement.

Facilitators

Working hand-in-hand with insurance companies

Discussants in all the study states reported that keeping insurance companies in the market was the primary motivation for many decisions related to program design. Discussants reported reaching out to insurance companies early on to gauge their support for a reinsurance plan. As one interviewee explained, "We made sure that [the insurance companies] were aware that we were considering this and what their appetite was for it as well. Was it something they were interested in or was the market so bad they won't touch it?"

In Alaska, insurance companies provided input on how to structure the program and actuarial resources to help design the plan, including helping to analyze which health conditions would be included and how the reinsurance mechanisms would work. In Minnesota, insurance companies also provided feedback to the state, specifically around the governance of the program. Because of the carriers' previous experience with the state's premium subsidy plan, and the burdensome data exchange that was required in that program, the carriers were apprehensive about the state's role in any reinsurance program. A Minnesota interviewee noted, "In terms of governance...there was certainly a tussle about that because at the end of the day, the insurers wanted to make sure that they were well represented. Because although they were getting the money, they also wanted to make sure that it wasn't knotted up and overly confusing." Ultimately, Minnesota developed a reinsurance program that was governed by the body that ran the state's high-risk pool, in large part because insurance companies were familiar and comfortable with the program and governance structure.

Respondents in Oregon noted that a unique market psychology had developed in their individual market, which ended up shaping their reinsurance plan. As one respondent explained, "This is not a functioning market where you have competitors competing on price and quality to try to gain market share. In fact, what they were trying to do was minimize market share. In general, they wanted to be in the market, but reduce their exposure to unknown risk. And so when we were dealing with carriers trying to do things like make sure we have a carrier in every county and make sure that we had multiple carriers so that there was some amount of competition, what the carriers were most concerned about was: a) were they going to be the only one?, and b) if there were going to be other carriers, were their price points going to be relatively similar so that they wouldn't be the standout low price carrier? It was almost like they wanted a utility marketplace where we set a price and everybody offered that price. And they wanted us to guarantee that there would be multiple players in the market."

For this reason, Oregon's reinsurance program became an important demonstration of the state's commitment to the marketplace during a turbulent political environment. One respondent explained, "Reinsurance became a super important stabilizer way outside the actual economic impact...I think for them [it] demonstrated that the state was willing to use its regulatory power to stabilize the market. And so this now gets into the post-election environment where everyone was kind of panicked. And I think we built up as a regulator a reputation that we would use our regulatory authority to maintain a stable market and keep carriers in the game."

In addition to the state reinsurance program, the Oregon legislature passed a bill that gave the Director of the Regulatory Agency the ability, for a limited period of time and subject legislative oversight, to set aside the state insurance code if it was in the interest of stabilizing the market. As one respondent clarified, "Back to the kind of market psychology, its existence was as important as anything the state would actually do with it."

Leveraging existing infrastructure and experience

Insurance companies' familiarity with reinsurance was key to their support for the state-based programs. Respondents in both Minnesota and Oregon noted that prior experience with the federal reinsurance program gave insurance companies the confidence to proceed with a similar state-based program. As one Minnesota health plan representative explained, "I think that the thing that we were advocating for was let's keep it simple, which is why the program in Minnesota statute largely mimics the ACA program that was in place 2014, 2015, and 2016 because we had a lot of experience with it. Our actuaries had a lot of confidence in using that from a pricing standpoint." Another respondent noted, "So I think there was just again, back to the simplicity, do something that people understand and don't have to reinterpret. I think in the end, the simplicity of just doing it was a key consideration."

Both Minnesota and Alaska utilized existing infrastructure from their respective former high-risk pools in order to administer their reinsurance programs, which made quickly operationalizing the programs possible. As a respondent in Alaska noted, drawing on the experience of their prior high-risk pool and existing relationships were key to making the process work in a short timeframe: "A lot of the infrastructure was already there. We had the board...relationships [were] already there with the Department of Insurance."

Another Alaskan respondent explained, "That's what the state of Alaska, legislators and the people that work in the regulatory side in Alaska, that's what they knew. They were used to that because that's the way it had always been in Alaska before the high-risk pool was repurposed. My advice at the time was, stick with what people know because they're more likely to be comfortable with it, they understand it, it's been in place for years, rather than trying to shift gears to some more traditional way."

Respondents in Oregon noted that although the state had previous experience with a condition-specific high-risk pool, the state decided, like Minnesota, to proceed with the simplest program to administer. One Oregon respondent explained, "We had some lessons learned out of the old reinsurance program as far as the difficulty in managing it and tracking specific individuals under the previous program that just were—there were some structural things that weren't particularly friendly. And then looking at this program being just a little bit more easier to manage and also already having a few models floating around that we just thought this was an effective solution overall, best use of our resources."

Mechanisms in place to get analysis done quickly

Respondents from all three states noted that their ability to complete the required financial and economic analyses within a very short timeline facilitated the successful submission of their waiver applications. Both Alaska and Oregon used outside contractors to complete their analyses. Respondents in those states noted leveraging previously existing relationships and mechanisms, allowing for sole-source contracts in cases where there is sole source of expertise in the field. In Alaska's situation, they knew Oliver Wyman had completed Hawaii's successful 1332 analysis, the only approved waiver at the time, and so they were able to contract with them under a sole-source agreement, bypassing the lengthy state procurement process.

Contractors who worked on the actuarial and economic analyses noted that quick contracting is also facilitated when the state is more relaxed about limitation of liability. One analyst explained, "States don't want to take any risk. They want you to indemnify everything. They don't want a limitation of liability, anything like that. And so when we do rate review work, for example, it's simple policy, it's very low risk work. But as you start moving into modeling and actual numbers that could have financial impact, it becomes riskier." They noted that in the absence of these contract clauses, there is often time consuming back-and-forth between the contractor and state to reach an agreement. In states where limitation of liability language is part of their standard contracts, contracting happens much faster.

Minnesota is the only state thus far to produce all of the waiver application in-house, including the economic and actuarial analyses. Respondents in Minnesota noted that this was only possible because the Commerce Department had staff with the qualifications and expertise to conduct both the actuarial and economic analysis, a situation that may be unique compared to other states and which allowed them to complete the analyses quickly.

Engaging state's congressional delegation

All three states leaned on their congressional delegation in order to help with the waiver application process. Both Alaska and Minnesota reported engaging their delegation early during the drafting process, and then relying on them especially toward the end of the 180 day review time period to communicate with Secretary Price and Administrator Verma about getting the waivers released. As one Alaskan interviewee noted, "I know Senator Murkowski and Senator Stevens were very involved in the last few days in the trying to make sure it was released. Because they had told us it was approved, but getting it out of them was a lot of work."

In Minnesota, several respondents felt it was the bipartisan support of the state's very engaged congressional delegation that helped get their waiver approved. One respondent explained, "Having that engagement with the congressional delegation so it wasn't just the governor's office calling everyday being like 'Where's our waiver?', I think it was enormously helpful."

Respondents in Oregon noted that they also worked to keep their congressional delegation informed and engaged throughout the waiver development and applications process, although they were less certain about the impact of that engagement. One respondent noted, "I think from what I recall from that time, there was—it was really hard to tell whether any political inputs, either from us or from our delegation, were having a meaningful impact on the broader process. But our delegation was definitely interested and engaged. I don't know what back channel sort of inputs they may have provided to CMS or any of those things. But I know by and large they were supportive of this, we didn't have anybody opposed to it."

LESSONS LEARNED

There are both pros and cons to condition-based vs. traditional reinsurance models

As mentioned previously, states generally chose a reinsurance model that would be easy to implement in a short time-frame. Oregon's experience administering a high-risk pool led the state to implement a traditional reinsurance program that was less complex to administer. Alaska implemented a condition-based model that was based on their previous high-risk pool. In Alaska's case, the state settled on the amount of funding needed for the state share by looking at how various amounts would impact the market. When an initial analysis showed that the state would have to spend between \$50 and \$60 million in claims in order to see a 20% change in rates, the legislature settled on a \$55 million. From there, the state began looking at what conditions would add up to that \$55 million total.

One respondent explained, "We really wanted to look at what was the impact in our market, what was driving the costs. We knew that there were some end-stage renal and there were some hemophiliacs and some other high-cost conditions that were really driving up the cost of health care in Alaska. So we did several data calls with our insurers and we went through a lot of the HCPCs^{iv} and tried to figure out how to come up to \$55 million. So we selected 33 conditions that the claims we anticipated would reach the \$55 million. Some of the other states who have done these more traditional reinsurance programs have said to us, 'Well what have you thought about cost overruns on your program?' We were fortunate that we actually looked at the claims cost, we applied some trend to it, and felt like we could forecast with some certainty what the end claim amount would be and then be able to cap the program."

^{iv} Healthcare Common Procedure Coding System: a set of healthcare procedure codes based on the American Medical Association's Current Procedural Terminology, used by CMS for medical billing.

One regret that respondents in Alaska voiced about the condition-based model was the decision to include the list of 33 conditions in state regulation. Now that the state has additional experience with the model there are several conditions that they would like to eliminate from the list and others they would like to add, but the process requires a rule change.

Respondents in Minnesota indicated that they, too, had been interested in exploring a condition-based program. Officials there were concerned that under a traditional reinsurance model there would be a financial incentive for insurance companies to spend to the attachment point and then all the way to cap in order to maximize payments, rather than manage care. Ultimately, however, the insurance companies were not comfortable with the considerably larger role the state would have had to take in order to administer a condition-specific model. As one respondent explained, Minnesota chose the attachment plan model because health insurers had the leverage and that was the structure with which they were familiar. They explained, “This is a legitimate point, I don’t mean to minimize it, from an administering standpoint, they said, look, we’re still set up to do—we did the federal program, if we do the federal program but it’s the state level, like we know how to do it, we’re familiar with how to do it. We’re not opposed necessarily to [the] conditions-based model, but we’ve never done that before. We don’t know how to do it and we don’t know if we can set it up in time. And that I think is what ultimately won the day legislatively.”

Robust communication efforts with multiple stakeholders were needed

Respondents in all states noted the amount of dedicated communication effort necessary to put a successful waiver application together, including communication among state agencies, legislative leaders, health insurers, congressional delegations, CMS officials, and community stakeholders.

In Alaska, those communication efforts were driven by the Director of Insurance, who played a pivotal role in moving the program forward. One Alaskan respondent noted, “I have to give a ton of credit to the Division of Insurance in Alaska. They were the driving force behind all this...the Insurance Director was key to getting that \$55 million approved through the legislature with Governor Walker. I give them a lot of credit to just get this thing up and running and off the ground.”

In Minnesota, the application process was also driven by the state’s Department of Commerce. However because of the role of Minnesota’s BHP, the state’s Department of Human Services was also involved in writing the application. Respondents expressed mixed views as to the effectiveness of the Department’s communication efforts. One respondent noted, “It makes sense that Commerce is in charge of it sort of technically. I wish they could have been more collaborative on the advocacy for it and just pushing it through. There’s always people around the table to help. I wish they would have been more open to it sooner.” Another noted that the process might have benefited from having more involvement from staff at the Department of Human Services, who have extensive experience shepherding CMS waivers through the approval process and who could have potentially noticed “red flags” earlier that might have signaled the final outcome.

Respondents in Minnesota especially felt that the drafting of the enabling legislation was not a transparent process. One interviewee explained, “The drafting of the legislation, which I would agree, was a very, very, very imperfect process that the legislature was in charge of. They were not transparent, they [were] in a basement hearing room basically in the middle of the night, or late at night. And then they would recess the committee and then come over and talk in the governor’s office. And they did not engage the minority in any way that was fair at all either.”

In contrast, Oregon initiated a wide stakeholder engagement effort in order to build support for its reinsurance program. One Oregonian respondent commented, “We don’t do anything without talking to everybody and making sure we’re all friends and holding hands in Oregon.” The state involved their marketplace, the governor’s office, as well as their congressional delegation. They also worked with a consumer advocacy group, the Oregon State Public Interest Research Group (OSPIRG), to build community support. Respondents felt this broad outreach was key to successfully

passing their enabling legislation. One respondent noted, “The things that we were asking for around regulatory flexibility and around reinsurance, are the kinds of things that are extraordinarily difficult to do without broad stakeholder consensus. So you really do need to be able to go in and say that you’ve got the state public interest research group and the insurance companies and the AARP and a variety of other stakeholders consulting, yeah, this makes sense. So we were able to get that pretty readily.”

Overall, respondents found CMS to be responsive to questions during the waiver application process. Interviewees indicated it wasn’t uncommon to talk with representatives from CMS on a weekly basis. As one respondent commented, “I guess I just reiterate, maybe this is more from the state side because I’ve heard this [from CMS]...if you want this to go smooth and fast, engage with us early. If all of the sudden a waiver shows up on their desk from a state that they didn’t even know was working on it, it’s probably going to take longer to get approved.”

Another piece of advice states shared was to document everything regarding discussions with CMS to ensure clarity about what is being discussed on both sides. Respondents also encouraged potential applicants to have contingency plans in place in case the waiver is not approved in time. One respondent explained, “So in terms of [advice] for other states, I think on the one hand be really proactive from the outset. But on the other hand, be sure to have some contingency plans that, just being honest, CMS may not be that responsive or they may be responsive pretty late in the game. Even if the state is pretty prepared...just being very prepared for that I think is super important.”

Microsimulation models allowed states to be responsive to rapidly shifting policies

As part of the waiver application process states had to submit an actuarial and economic analysis that demonstrated how the state’s waiver complied with coverage, comprehensiveness, affordability, and net federal spending requirements. In the midst of the three states’ waiver applications several significant policy changes that impacted the individual market were introduced, including the repeal of the individual mandate tax penalty, the elimination of cost-sharing reduction payments to insurers, and the allowance of association and short-term health plans. Several respondents felt the microsimulation model that Alaska and Oregon used allowed them to incorporate the broad impact of these policies changes easily, which resulted in higher pass-through funding awards. As one analyst commented of microsimulation models, “I think that’s more valuable when you’re trying to do some of these more complex waivers or complex policy changes.”

Minnesota is the only state to date that has completed all of its actuarial analysis in-house, and analysts there used a scenario-based model. Ultimately, respondents wished they had had the resources to utilize a microsimulation model but were limited by resources and a tight timeline. One respondent commented, “For us, a real dynamic microsimulation of analysis would have helped us better understand the appropriate setting of the parameters and sort of who would have been affected.” Respondents in Minnesota also noted that at the time they chose their actuarial methodology they believed the purpose of the report was to demonstrate that the state could save the federal government money. In the end, the state was surprised that the analysis was also used to calculate the pass-through funding amount. An interviewee commented, “Keep in mind, that’s what we thought the purpose of the report was. In the end, we were a little surprised that the purpose of the report was also for the federal government to calculate how much money they’ll give you. So I don’t know if I would have chosen a scenario-modeling approach if I knew the federal government was going to use the report as the basis of their calculation. Because we had already—we had gone into it thinking that they would do a hindsight review of actual data and fine tune that number.”

FUTURE CONCERNS

Difficult to measure the impact of reinsurance programs beyond premium rates

All three study states have seen a reduction in premium costs in their individual market as a result of their reinsurance programs. Alaska saw a 22% rate decrease in 2018 from 2017 levels, Minnesota experienced 15% decline, and Oregon's individual market's saw a 6% decrease.^{25,26,27} Beyond rate reductions, however, discussants felt that it is difficult to measure and articulate the impacts of the program. One health plan representative explained, "You would expect, and there's projections, yeah, it takes money off of the premiums, it should stabilize offerings in areas that are less densely populated. It should do those things. But we already were kind of on the borderline of okay on some of those issues. So how much better did it get? I'm not sure. I think that it's going to be really hard after the fact analysis."

In Minnesota, the primary evaluation measure for the program was to examine premium rates in two scenarios: with reinsurance and without. Insurers were required as part of the enabling legislation to file two sets of rates, preliminary (without reinsurance) and final (with reinsurance), in order to make that calculation. Respondents indicated, however, that it has been difficult to articulate that the goal of the program was not to lower rates 20% overall, but to get rates 20% lower than what they otherwise would have been. One Minnesota respondent commented, "Last week we got an email from someone saying 'My rates were supposed to go down by 20% and they went up.' And we, every opportunity we had, every time we talked to the governor's office, to congressional delegations, stakeholders, we're being very, very clear that the program is not designed to lower rates 20%. It is for 20% lower than they otherwise would be. Which is a nuance that doesn't really translate to the average person, but it's incredibly important."

Respondents also indicated that they currently lack data on which reinsurance model (condition-based vs. traditional) is more effective, and what the impacts are on consumers. Another respondent wanted to see more data on the overall effectiveness of any reinsurance model, explaining "I don't think we should spend another dime on that [reinsurance] model until somebody has proven that it's been an effective use and an efficient use of dollars. I don't actually believe that it will be. And part of that is because nobody has transparency and nobody is being asked to figure out what the health plans are doing. And I don't mean that to say like they're doing something nefarious. I just mean that for example, the difference is, Medicaid is a purchaser and provides oversight on what they're doing for care management and disease management and how they're spending their dollars and what their provider reimbursement rates are and whether or not they're in value based arrangements. Nobody is doing that for people on the individual market. That is a consumer protection that is not in place right now."

Another respondent echoed, "I think where so much, hundreds of millions of dollars are flowing to subsidize a small part of the market, it's probably useful to know what [insurance companies] are funding and what incentives they are setting."

No accountability measures

None of the study states included accountability measures around population health outcomes, care management activities, or commitments from insurers to improve quality or impact premium growth. The reluctance to include such accountability measures was driven by both a lack of time to explore such options, and health insurers' resistance. One respondent explained, "In terms of kind of more of the outcomes and the population health piece, that really wasn't at the forefront of the discussion. And I think there was so much focus on let's just make sure that we can entice the carriers to stay in the market, period." Another respondent noted, "We've been really leery of whether it's that or active purchaser provisions or any of those kinds of things. We've been really leery given the instability and fragility of the market to want to push very hard on anything until we get out of the woods of what's the market going to look like and will it stay that way for any length of time. We were really reluctant to try to go down that path."

Some respondents noted that they hoped policy makers would explore additional accountability measures going forward. One interviewee commented, “I almost feel bad for the consumers in the individual market because nobody is looking out for them. I mean they are from a, ‘Yes, we don’t want the health plans to go under and go out of business, so there’s somebody there to pay your claims.’ But to be honest, could that not be the lowest possible standard ever?”

Health plan representatives, however, were adamant that although there weren’t any formal requirements in the legislation, they continue to provide disease and population health management services to the reinsurance population because of their commitment to their members. One health plan representative explained, “The care management and disease management clinical programs, these are just programs that we run voluntarily for all our members, just because it’s the right thing to do and it really is the best for our members in terms of health outcomes.” Another respondent explained, “People think that insurance companies if given the chance will go out and say, oh, this is a bad risk here, so let’s—if we can reinsure them somewhere, then we don’t have to pay any attention to them anymore because it’s not going to cost us anything. Companies aren’t capable of doing that. Business is handled at a level that you treat every policy the same.”

Reinsurance is only a short-term fix and doesn’t address the underlying problem: health care costs

Respondents indicated that although they viewed state-based reinsurance programs as an important stabilizing mechanism, they questioned the long-term sustainability of such programs. One respondent stated, “In terms of near term stabilization we are in a good spot, but I think what we have right now is a Band-Aid. We need longer term federal solutions now. And people coalescing around that. I don’t think our budget can sustain another half a billion dollars in reinsurance down the road or in the future.”

Alaska, for example, initially only appropriated two years of funding, as they knew their legislature did not want to commit to a long-term funding of a reinsurance program. Minnesota also only appropriated two years’ worth of funding for their reinsurance program, and the current funding source, the provider tax, is scheduled to sunset in 2019. Respondents in Minnesota indicated that they would wait to see who the next governor would be after the fall 2018 elections before having further discussions about whether or not to continue the reinsurance program.

All respondents felt that the states’ reinsurance programs had helped stabilize the markets in terms of insurance carriers’ participation, but that they did not address the core drivers of rising health care costs. One respondent commented, “But when I talk about reinsurance, it’s just that one component... We have not had the conversation about the true cost of care. Let’s talk about prescription drug prices. Let’s talk about where people are [falling] off the cliff and at 400%.^v There’s so much more than just giving money to insurance companies to keep their rates a little lower. That doesn’t fix the problems.”

Another respondent noted, “The one thing I will say about the reinsurance program is I think it’s been fantastic in many ways in terms of providing some downward pressure on health care premiums. It was a market that desperately needed that. But I think if I were to caution somebody, I would caution them to not lean on it too much, because in reality, it’s mostly a Band-Aid. It’s still not addressing the root of the issue.”

Respondents were concerned that all of the energy and resources being spent on one small segment of the market would ultimately not solve the problem. One respondent explained, “I don’t know how you can just isolate it to the individual marketplace and think that you’re going to find a solution, because the problem—two years from now, here’s the deal. Two years from now we’re going to have small group employers saying our premium went up 40%. We can’t afford this. [We’ve] got to do something. So when you take a look at that as being the reality, even though there are a lot of people who are suffering, I think we need to address that problem beyond just the individual marketplace.”

^v Individuals with income above 400% FPL are not eligible for premium subsidies through health insurance exchanges, even though health insurance costs may not be affordable where they live.

APPENDIX

COMPARISON OF STATE REINSURANCE PROGRAMS AND 1332 WAIVER APPLICATION COMPONENTS

State Characteristics	Alaska	Minnesota	Oregon
Governor	Independent – Bill Walker	Democrat – Mark Dayton	Democrat – Kate Brown
Legislative Control	Republican	Republican	Democratic
State Population ²⁸	739,795	5,576,606	4,142,776
Medicaid Expansion	Yes	Yes	Yes
Marketplace Type	Federal – Healthcare.org	State-based – MNsure	State-based exchange on federal platform – Healthcare.org
Size of the Individual Market ²⁹	23,000 (3%)	229,000 (4%)	215,000 (5%)
Number Enrolled Through Marketplace	18,313	116,358	156,105
Number of Insurers in Individual Market Pre-ACA (2014) ³⁰	14	26	25
Number of Insurers in Individual Market when Reinsurance Implemented (2018)	1	4	5
Premium Cost Increase ³¹	The average benchmark-plan premium increased 117% between 2014 and 2017, from \$426 to \$926	The average benchmark-plan premium increased 126% between 2014 and 2017, from \$182 to \$412	The average benchmark-plan premium increased 60% between 2014 and 2017, from \$217 to \$348
Unique Market Characteristics	<ul style="list-style-type: none"> • High health care costs • One carrier • 80th percentile rule³² • Large Alaska Native/American Indian population subject to unique Patient Protection and Affordable Care Act (ACA) rules • Previous high-risk pool structure remained 	<ul style="list-style-type: none"> • Basic Health Plan (133%–200% FPL) • Past policy efforts to stabilize the market • Previous high-risk pool structure remained 	<ul style="list-style-type: none"> • Competitive insurance market • Threat of loss of carriers in geographic areas • Previous experience with a condition-specific, high-risk pool

COMPARISON OF STATE REINSURANCE PROGRAMS AND 1332 WAIVER APPLICATION COMPONENTS CONT.

1332 State Reinsurance Program	Alaska	Minnesota	Oregon
Program Name	Alaska Comprehensive Health Insurance Fund	Minnesota Premium Security Plan (MPSP)	Oregon Reinsurance Program (ORP)
Reinsurance Type	Condition-specific	Traditional	Traditional
Reinsurance Corridor	All claims from policyholders with one of 33 specific medical conditions	\$50,000–\$250,000	\$95,000–\$1,000,000 (2018) \$90,000–\$1,000,000 (2019)
Coinsurance Rate (Percent)	100	80/20	50/50
State Funding	\$55 million annually (51.6% of total)	\$271 million annually (61.9%–66.3% of total)	\$90 million in 2018; \$1.1 billion over ten years (68.5% of total)
State Funding Source	\$55 million in initial funding from General Fund, then funded via assessments on all insurers: • Health: 6% of gross premiums less paid claims • Title: 1% of gross premiums • Other: 2.7% of gross premiums	Assessment on premiums charged by all health insurers and reinsurers	1.5% assessment on fully insured commercial major medical premiums
1332 Funding Request	\$51.6 million in pass-through funding (48.4% of total)	\$138–\$167 million in annual pass-through funding; \$830 million from 2018-2022 (33.7%–38.1% of total)	\$35.66 million in 2018; \$356.6 million over ten years (31.5% 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)
Administrative Body	Alaska Comprehensive Health Insurance Association (ACHIA)	Minnesota Comprehensive Health Association (MCHA)	Oregon Department of Consumer and Business Services (DCBS)
Impact	Premiums decreased 26% in 2018	Premiums decreased 15% in 2018; \$277 million funding cut to Basic Health Plan (BHP) (2018-2020)	Premiums decreased 6% in 2018
1332 Waiver Application	Alaska	Minnesota	Oregon
Timeline	HB 374 November 7, 2016; Submitted December 29, 2016 ; Approved July 7, 2017	HF 5 April 4, 2017; Submitted May 5, 2017 ; Approved September 22, 2017 ; Signed October 16, 2017	HB 2391 July 5, 2017; Submitted August 31, 2017 ; Approved October 19, 2017 ; Signed October 20, 2017
Waived Item	Section 1301 (a)(2) of the ACA: Inclusion of CO-OP plans	Section 1312 (c)(1) of the ACA: Requirement that a health insurance issuer must consider “all enrollees in all health plans...offered by such issuer in the individual market...to be members of a single risk pool.”	Section 1312 (c)(1) of the ACA: Requirement that a health insurance issuer must consider “all enrollees in all health plans...offered by such issuer in the individual market...to be members of a single risk pool.”
Actuarial Analysis	Conducted by Oliver Wyman	Conducted by Minnesota Commerce Department staff	Conducted by Wakely

COMPARISON OF STATE REINSURANCE PROGRAMS AND 1332 WAIVER APPLICATION COMPONENTS CONT.

1332 Waiver Application	Alaska	Minnesota	Oregon
<p>Model Summary 33,34,35</p>	<p>Oliver Wyman’s Healthcare Reform Microsimulation Model (HRM Model)</p> <ul style="list-style-type: none"> • Uses economic utility functions and decision making at Health Insurance Unit (HIU) level • Modeled baseline and waiver scenario • Employer-based economic utility function: will an employer offer, what are costs of not offering (e.g. penalty) compared to benefits for employee (Advanced Premium Tax Credit [APTC]); If an employer offers, it assumes HIU takes up (unless unaffordable or eligible for Medicaid) • Individual market <ul style="list-style-type: none"> • Economic utility: function of premium, cost sharing and risk aversion • Utility of not taking up: function of the penalty, total allowed claim costs for HIU, risk aversion of HIU • Assumes uninsured if the utility of being uninsured is greater • Public: Assumes those eligible for public retain this coverage 	<p>Minnesota’s Scenario Testing Model</p> <ul style="list-style-type: none"> • Scenario-based modeling (L–low but reasonable, M–mid estimate, H–high but reasonable) • State modeled 18 reasonably likely scenarios based on a reasonable range of possibilities regarding the most critical factors • Input factors included: 2018 second-lowest silver premium with/without any waiver or state legislation (\$560 in 2017): \$668 (L), \$688 (M), and \$708 (H) • Individual market premium inflation: 5% (L), 6.5% (M), and 10% (H) • 2018-2027 individual market enrollment with/without the waiver: 160,000/140,000 (L), 170,000/150,000 (M), and 190,000/160,000 (H) • Premium tax credit-eligible enrollee count: 75,000 (L), 77,000 (M), and 85,000 (H) • Risk margin: 10% • It is assumed that only 90% of the aggregate subsidy will be passed on to policyholders due to carriers’ uncertainty related to acute claims in excess of \$50,000 	<p>Wakley’s Scenario Testing Model</p> <ul style="list-style-type: none"> • Scenario testing around enrollment and premium assumptions • Enrollment higher (high scenario), equal (constant scenario), or lower (reactive scenario) than 2017 • Premiums equal to recommended rate filings (rate-filings scenario) or lower than recommended rates (low scenario) • For each of the scenarios, the same reinsurance methodology was applied: \$90 million in reinsurance funding was applied to the individual market, reinsurance assessment was added, and enrollment was re-estimated using a specified take-up function • The best estimate scenario was deemed the scenario that used recommended 2017 rate filings (rate-filing scenario) and lower enrollment than 2017 (reactive scenario) and that was used in the 10-year economic analysis
<p>Unique Assumptions</p>	<ul style="list-style-type: none"> • National health expenditure data adjusted to reflect much higher costs in Alaska • Assumptions took into account the ACA rules related to Alaska Native and American Indians, which make up 14% of the state population • The analysis was conducted before the May 2017 1332 checklist was released and is therefore significantly more robust than required 	<ul style="list-style-type: none"> • Separate analysis related to BHP pass through • Individual market is structurally smaller due to BHP—therefore, assumed Minnesota has a higher relative price elasticity compared to other states • Price elasticity calculated by examining the number of people who left the market between 2015-20156 and the increase in premium (didn’t use publically available because of BHP) 	<ul style="list-style-type: none"> • The individual market enrollment was assumed to have reached steady state in 2018 • In 2019, reinsurance was equal to \$95 million • Enrollment was estimated using a nonlinear enrollment response function estimated by the Council of Economic Advisors (CEA take-up function) • Assumes that reinsurance will reduce the morbidity of the risk pool and reduce average costs by 0.4%
<p>Data</p>	<ul style="list-style-type: none"> • Used 2014 ACS, calibrated to reflect 2015 Alaskan population and projected forward • NAIC 2015 Supplemental Health Care Exhibits for premiums, claims • Data call to insurers (distribution across metal tier, number in non-compliant plans) • CPS: health status • MEPS: distribution of employees, employer health insurance offer rates and employee take-up rates by group size for Alaska • Health Expenditure Data (NHED) projections: projected changes in public program enrollment, trends in spending 	<ul style="list-style-type: none"> • Aggregated from annual issuer survey of individual market experience (Minnesota Department of Commerce): enrollment in individual market (including grandfathered, metal level) • Issuer’s Rate Data Templates: premium • 2016 Millman benchmarks: claims expectations • Economic analysis: CBO estimates, census data 	<ul style="list-style-type: none"> • 2016 EDGE premium, claims, and enrollment data • Member-level CO-OP enrollment data • CMS reports (2016 Final Open Enrollment Report, 2016 March Effectuated Enrollment Report, 2017 Plan and Premium Report, 2017 Final Open Enrollment Report) • Oregon’s quarterly Department of Financial Regulation enrollment reports • Oregon’s CY 2017 effectuated enrollment, April 2017 billing report • 2018 draft carrier rate filings as of July 3, 2017, Unified Rate Review Templates (URRTs), and other related public information

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