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, meaning it must meet the state's current essential health benefits benchmark
- 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 if 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, and Minnesota 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 and the costs and current structure of the health care system.)
- 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

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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. Annual expenses to cover fewer than 3,000 enrollees, most of whom had deductibles of at least $5,000 and often $10,000, was $24.8 million, funded by premiums and a 1 percent assessment on all health insurance premiums. 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 and the regulations contain 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 describes the requirements of the 1332 regulations:

1. **Comparable Coverage:** A comparable number of state residents must be forecast to have coverage under the waiver as would have had coverage absent the waiver. The term "coverage" means something that would qualify as "minimum essential coverage" (MEC) under the ACA. The impact on all state coverage will be considered—even losses of coverage that may occur outside the insurance market, such as Medicaid or employer health plans. The impact on vulnerable groups, such as low-income individuals, older people, and those with serious health conditions, must also be considered.[6]

   Minimum essential coverage includes, but is not limited to, individual health insurance plans sold inside the exchange and outside the exchange, if they meet the standards for qualified health plans; grandfathered health plans; most employer-based health plans; Medicare Part A or C, but not Part B coverage only; most Medicaid and CHIP coverage; and most student health plans. The coverage must meet "substantially all" of the requirements under Title I of the ACA that apply to non-grandfathered health plans in the individual market, which includes, but is not limited to, the following provisions:

   - Fair health insurance premiums Prohibition on pre-existing condition exclusions
   - Prohibition against discrimination based on health status
   - Provision of essential health benefits
   - Prohibition against lifetime and annual limits
   - Coverage of preventive health services
   - Extension of dependent coverage
   - Mental health parity
   - Actuarial value no less than 60 percent, as determined by the federal minimum value calculator [7]

Spending on health care services that are not covered by a plan may also be taken into account if they are affected by the waiver proposal. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver.

2. **Affordability:** "Health care coverage under the waiver must be forecast to be as affordable overall for state residents as coverage absent the waiver." Affordability will be "measured by comparing the net out-of-pocket spending for health coverage and services to incomes"—this will include both premium contributions and any cost sharing, such as deductibles, copays, and coinsurance. "Spending on health care services that are not covered by a plan may also be taken into account if they are affected by the waiver proposal. The impact on all state residents is considered, regardless of the type of coverage they would have absent the waiver."[8]

   Affordability is also measured by the impact on individuals "with large health care spending burdens relative to their incomes." A significant decrease in affordability for individuals with high-cost medical needs may cause a waiver to fail, even if the waiver would increase affordability for many other state residents. **Vulnerable populations must be considered**, including low-income individuals and those with high-cost health needs. However, a waiver may also fail if it reduces "the number of individuals with insurance coverage that provides a minimal level of protection against excessive cost sharing. In particular, waivers that reduce the number of people with insurance coverage that provides both an actuarial value equal to or greater than 60 percent and an out-of-pocket maximum that complies with" the amount allowed pursuant to federal law. Affordability considerations may also include any changes to employer contributions to health coverage or in wages expected under the waiver.[9]

   A waiver will fail if it decreases the number of residents with coverage.

   If the comprehensiveness of coverage is decreased for any of the vulnerable groups… the waiver will fail.

3. **Comprehensiveness:** This requirement refers to the "scope of benefits provided by the coverage as measured by the extent to which coverage meets the requirements for essential health benefits (EHB)," as defined in the ACA.[10] A waiver will fail the comprehensiveness requirement if it decreases the number of residents with coverage that is 1) at least as comprehensive as the EHB benchmark for that state in all 10 categories and 2) for any of the 10 EHB categories, coverage that is at least as comprehensive as the benchmark in that category.

   This assessment must take into account vulnerable populations. If the comprehensiveness of coverage is decreased for any of the vulnerable groups, even if aggregate comprehensiveness of the population as a whole is met, the waiver will fail.[11]

4. **Deficit neutrality:** Under the proposed waiver, "the projected federal spending net of federal revenues" must be equal to or lower than federal spending without a waiver. The effect on federal revenue "includes all changes in income, payroll, or excise tax revenue," as well as other types of revenue, such as exchange user fees that would result from the waiver.[12] Estimated effects may include changes to premium tax credits, individual shared responsibility payments (to be eliminated in 2019), the excise tax on high-cost employer plans, employer shared responsibility payments, and the tax credit for eligible small employers.

   "The effect on federal spending includes all changes in Exchange financial assistance and other direct spending, such as changes to Medicaid spending (while holding Medicaid policies constant) that result from the changes made through the state's innovation waiver."[13] The effect on federal spending may also include changes in administrative costs to the federal government, including the IRS.

In addition to these guardrails, the guidance also states that the assessment of a state waiver proposal will not consider the impact of state legislation that is proposed but not enacted. The assessment also will not take into account changes to Medicaid and/or CHIP that require separate federal approval, such as the proposed Section 1115 demonstration waiver. "Savings accrued under either proposed or current 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed State Innovation Waiver meets the deficit neutrality requirement."[14]

"The amount of **Federal pass-through funding** equals the Secretaries' annual estimate of the Federal cost (including outlays and forgone revenue) for Exchange financial assistance provided pursuant to the ACA that would be claimed by participants in the Exchange in the state in the calendar year in the absence of the waiver, but will not be claimed as a result of the waiver."[15] 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.

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.

Furthermore, 45 CFR 155.1308 (f) (3) requires that there be **state legislation** that "provides for state actions under the waiver." A copy of the legislation must be included in the waiver proposal. If the state is proposing a state-operated reinsurance program, the legislation must provide that the implementation of the program is contingent on the approval of the 1332 waiver. The proposal must include a list of the provisions of the law that the state is seeking to waive and the reason for that request.[16]

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.[17]

The remainder of the waiver application requirements and the reporting and monitoring requirements are laid out in detail in the regulations and the checklist.[18]

STATE INNOVATION WAIVER PROPOSALS SUBMITED OR DRAFTED AS OF MARCH 2018

At least 28 states have considered legislation for 1332 waivers. Only 14 states have enacted measures related to 1332 waivers, and, of those, only four 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.[19]

The remaining three approved state waiver applications proposed state-based subsidized reinsurance: Alaska, Minnesota, and Oregon. 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.[20] 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.[21]

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.

All three 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."[22] 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 three 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 state estimated contribution is $55 million, funded from premium taxes, and the federal government granted $58.5 million in funding for 2018. The ARP was expected to lower premiums by 20 percent in 2018. The actual rate reduction averaged more than 26 percent.

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.[23]

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 to 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 MPSP expects to achieve a 20 percent reduction in premiums in the individual market. The state funding is appropriated from Minnesota's Health Care Access Fund and its general fund. In 2018, the state funding for this program is projected to be $271 million (about 61 percent of the total) and the federal pass-through funding granted for 2018 was $130.7 million.

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, but 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.[24]

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, and the waiver proposal was filed August 31 and approved October 19, 2017. The legislation established the Oregon Reinsurance Program (ORP), which will be 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 anticipates that this reinsurance will lower the cost of the second-lowest-cost silver plan by 7.5 percent in 2018. The projected state funding for 2018 was estimated to be $90 million and the federal funding granted for 2018 was $54.5 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.[25]

WAIVERS THAT ARE PENDING REVIEW FOR 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. 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.[26]

IDAHO: Idaho published a draft waiver proposal for public comment on November 1, 2017. Legislation has been proposed but has not yet passed. Idaho is proposing 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. It is unclear from the draft whether or not Idaho will also seek pass-through funding for its reinsurance pool.

Idaho is seeking 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 requests 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 is seeking 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.[27]

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.

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 is estimating that 85 percent of that amount will be federal pass-through funding of $170 million, with the state contributing $30 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. The OCI estimates that the program will reduce premiums in 2019 by about 10 percent and thereby increase projected enrollment.

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.[28]

Arguably, the Iowa proposal would have reduced affordability for vulnerable populations and, therefore, may not have met the affordability guardrail. Iowa withdrew its waiver proposal in October 2017.[29]

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.[30]

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.[31]

OVERVIEW OF 1332 STATE INNOVATION WAIVERS FOR STATE-BASED REINSURANCE[32]
APPROVED STATES AND IDAHO

	Alaska	Minnesota	Oregon	Idaho
Reinsurance Proposal				
Reinsurance Type	Condition-specific reinsurance	Traditional reinsurance	Traditional reinsurance	Condition-specific Medicaid eligibility; condition-specific reinsurance
Reinsurance Corridor	All claims from policy holders with specific medical conditions	$50,000 – $250,000	TBD – $1,000,000	$25,000
Coinsurance Rate	100%	80/20	50/50	At least 20%
Legislation Enacted	November 7, 2016	April 4, 2017	July 5, 2017	April 6, 2017; enacting state legislation for waivers expected April 2018
1332 State Innovation Waivers				**1115/1332 Waiver**
	Alaska	**Minnesota**	**Oregon**	**Idaho**
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	1332 waiver released for public comment November 1, 2017; 1115 waiver released for public comment November 22, 2017
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 10 years (68.5% of total)	$16 million in 2019 for state-funded high-risk pool
1332 Funding Requested	$51.6 million in pass-through funding (48.4% of total)	$138 million - $167 million in pass-through funding (33.7% - 38.1% of total)	$35.66 million in 2018; $356.6 million over 10 years (31.5% of total)	$0 for reinsurance; $613 million in 1332/1115 waiver funding
1332 Funding Received	$58.5 million (2018); $332 million (2018-2022)	$130.7 million (2018); $1.003 billion (2018-2020)	$54.5 million (2018)	

State 1332 Waiver Reinsurance Proposals: CMS Sets Pass-Through Funding for 2018 for Minnesota, Alaska, and Oregon, SHADAC: State Health Access Data Assistance Center, February 20, 2018.

OVERVIEW OF 1332 STATE INNOVATION WAIVERS FOR STATE-BASED REINSURANCE[33]
DRAFTED OR WITHDRAWN STATES

	Iowa	New Hampshire	Oklahoma	Wisconsin
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	$50 to $250,000
Coinsurance Rate	85/15 (claims > $3 million: 100%)	40/60	80/20	50% to 80% (undecided)
Legislation Enacted	None	July 10, 2017	June 6, 2017	February 27, 2018
1332 State Innovation Waivers				
	Iowa	**New Hampshire**	**Oklahoma**	**Wisconsin**
State Funding	$0 (0% of total)	$32 million annually (71.4% of total)	$16 million in 2018; $230 million over five years (14.2% of total)	Estimated at $30 million; total funding for the program cannot exceed $200 million
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	Draft waiver released for public comment in March 2018
1332 Funding Requested	$70 million in pass-through funding for reinsurance in 2018 (100% of total); $396 million total waiver funding in 2018	$12.8 million in pass-through funding for reinsurance (28.6% of total)	$309 million in pass-through funding in 2018; $1,395 million over five years (85.8% of total)	$170 million in pass-through funding for 2019 (85% of total)

State 1332 Waiver Reinsurance Proposals: CMS Sets Pass-Through Funding for 2018 for Minnesota, Alaska, and Oregon, SHADAC: State Health Access Data Assistance Center, February 20, 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 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. Some of the other types of State Innovation Waiver proposals discussed above may be unsuccessful because of the statutory guardrails in 1332.

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

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. Some actuaries believe that condition-based reinsurance may create problems for the risk-adjustment mechanism.

Legislation authorizing a waiver application is required by section 1332 of the ACA. If the waiver application is going to include some type of state-based reinsurance proposal, 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 is required. If the application includes a state-based reinsurance proposal, the legislation should 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.[34] 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.[35]

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

Even though some states have considered and even proposed other types of 1332 State Innovation Waivers, 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.

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[11] 45 CFR Part 155, I, Subpart C.

[12] 45 CFR Part 155, I, Subpart D.
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