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Reinsurance 101:
A Framework for State Advocates and Policymakers

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Across the country, political leaders have proposed state initiatives to restore the Affordable Care Act's (ACA's) temporary reinsurance program, which ended after 2016. This issue brief describes reinsurance and explains why it was originally included in the ACA. It then analyzes why some advocates and policymakers might consider implementing reinsurance in their states but others could hesitate to pursue such a policy. The right answer will vary, but considerations are likely to be similar in most states.

What is Reinsurance?

Reinsurance is insurance for insurance companies. Typically, a public or private reinsurance program pays a percentage of claims that exceed a specified annual threshold but fall below an upper limit. Carriers sometimes use their own resources to buy reinsurance. The ACA instead provided public dollars for this purpose. Those dollars were raised by taxing health insurance carriers, as well as employers that insured their workers and dependents.

Why Did the ACA Create a Temporary Reinsurance Program?

Reinsurance was part of a suite of programs intended to encourage risk-averse insurers to offer coverage at reasonable rates, starting in 2014. At that time, the individual insurance market was slated to begin operating under completely different rules than before the ACA, and carriers did not know what to expect. Scheduled to end after 2016, reinsurance limited the risks insurers would experience if they happened to enroll even a small number of consumers whose costs greatly exceeded projected levels.

The original rationale for the temporary reinsurance program has now lost much of its force. After nearly half a decade operating under the ACA's rule book, carriers have a much better understanding of the individual insurance market, even though Trump administration policy changes continue to pose market risks.[1] Moreover, the danger of individual consumers incurring extraordinarily high, unexpected costs has been mitigated by the Center for Consumer Information and Insurance Oversight (CCIIO), the office within the Department of Health and Human Services that oversees implementation of the ACA's individual market reforms. As part of its risk adjustment program, CCIIO operates a

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nationwide High-Cost Risk Pool Adjustment that pays 60 percent of an enrollee's claims that exceed $1 million in any given year.[2]

Why Would a State Consider Providing Reinsurance Today?

Reinsurance is a familiar and effective method for cutting premiums

Simply by substituting public reinsurance dollars for premiums in covering a portion of paid claims, reinsurance lowers premiums. In recent years, Minnesota's reinsurance program reduced premiums by 20 percent, for example, and Maryland lowered premiums by 30 percent.

Reinsurance achieves these savings without imposing large administrative costs. Carriers are familiar with mechanisms for claiming and paying reinsurance, since the most recent payments under the ACA were made less than two years ago, in June 2017.[3]

Premiums matter

Many consumers buy private insurance using federal premium tax credits (PTCs), which are limited to families with incomes at or below 400 percent of the federal poverty level (FPL). These households do not benefit from reinsurance, as a general rule. Their costs are based primarily on income. If premiums rise or fall, PTCs also rise or fall, and consumer expenses remain largely unchanged.[4]

Nevertheless, premiums matter. Many people with earnings modestly above 400 percent FPL face extraordinary costs. For example, if the income of a 60-year-old buying average-price benchmark coverage rises from 400 percent FPL ($48,560) to 425 percent ($51,595), their monthly premium cost jumps from $399 to $1,016.[5]

Premium reduction is a particular priority in geographic regions with extraordinarily high premiums. These are often rural areas without competing hospital systems and carriers. More broadly, states with markets that are doing badly, with high premiums and few carriers, may need the premium relief offered by reinsurance.

Federal funding helps state reinsurance dollars go farther

States can propose waivers under ACA Section 1332 that modify the ACA's private insurance rules. When a waiver lowers federal PTC costs, the federal government gives the state the resulting savings in the form of pass-through payments. Under both the Obama and Trump administrations, states implementing reinsurance through 1332 waivers received federal pass-through payments that covered a significant share of reinsurance costs.[6]

74 percent of people who benefit from reinsurance because they are financially ineligible for PTCs have incomes above 500 percent FPL, or $129,000 per year for a family of four.

What Else Should States Consider About Reinsurance?

Reinsurance saves money for consumers who are ineligible for PTCs, many of whom need little help

In actual operation, reinsurance is a flat, across-the-board premium subsidy for people who are ineligible for PTCs, mostly because of income above 400 percent FPL.[7] Some of those who benefit need help, as explained above, particularly if their income is just above the latter threshold, or if they live in an unusually expensive geographic area. However, policymakers should understand that many who save money from reinsurance because they are ineligible for PTCs have relatively little need for help:

- Nearly two-thirds (64 percent) of individually insured consumers with incomes too high for PTCs earn at least $100,000 per year.
- More than one in five (21 percent) makes $200,000 or more per year.
- Almost three out of four (74 percent) have incomes above 500 percent FPL, or $129,000 per year for a family of four.

People above 500 percent FPL have nearly universal health coverage; only 3.2 percent are uninsured, or roughly half the 6.0 percent of those between 400 and 500 percent FPL who lack health coverage. Tables 1 and 2 (pages 5 and 7, respectively) provide these numbers for each state and for the country as a whole.

State funding for reinsurance could be spent in far more targeted ways

Policymakers could repurpose state reinsurance dollars to provide more targeted help to people in need. For example:

- A state could supplement federal PTCs and cost-sharing reductions for low-wage workers and moderate-income families, many of whom experience significant challenges paying for insurance and care. Providing them with additional financial help, along with funding public education and consumer assistance, would reduce the number of uninsured and increase enrollment of young and healthy consumers. Those risk pool improvements lower premiums, saving money for people who pay for insurance without help. Precisely such supplemental affordability assistance limited to low- and moderate-income families is the most

important reason Massachusetts has some of the country's lowest individual-market premiums, despite also having one of the country's highest-cost health care systems.[8]

» A state could raise the current 400 percent FPL cap on PTC eligibility. People struggling to pay full premiums with earnings just above the current cap would receive significantly more help than from reinsurance, and help would be targeted to those who need it.[9]

Conclusion

Reinsurance lowers premiums, with federal pass-through dollars that reinforce and amplify state financial commitments. On the other hand, more targeted uses of finite public resources could provide greater help to people in need, potentially lowering premiums across the board by improving the individual market's risk pool. Whether reinsurance makes sense in a particular state depends on policy leaders' goals, the political momentum supporting alternative options, the power and interests of competing stakeholders, and the conditions presented by state markets and state demographics. While the right answer will differ from state to state, the factors identified above are likely to be important considerations for leaders in every state capitol.[10]

Table 1. Income Distribution of Individually-Insured People with Incomes Too High for Premium Tax Credit Eligibility, by State: 2017

	Percentage with Annual Incomes of $100,000 or More	Percentage with Annual Incomes of $200,000 or More	Percentage with Annual Incomes Above 500% of the FPL
Alabama	62%	16%	70%
Alaska	77%	27%	85%
Arizona	59%	17%	73%
Arkansas	57%	15%	67%
California	72%	27%	77%
Colorado	66%	24%	76%
Connecticut	69%	26%	83%
Delaware	61%	18%	65%
District of Columbia	66%	32%	78%
Florida	61%	19%	73%
Georgia	62%	19%	72%
Hawaii	73%	22%	73%
Idaho	60%	19%	68%
Illinois	61%	19%	76%
Indiana	58%	16%	70%
Iowa	55%	15%	70%
Kansas	56%	15%	70%
Kentucky	54%	16%	71%
Louisiana	66%	22%	72%
Maine	60%	15%	73%
Maryland	71%	26%	78%
Massachusetts	67%	26%	78%
Michigan	57%	17%	70%
Minnesota	57%	16%	75%

Mississippi	58%	17%	65%
Missouri	58%	16%	68%
Montana	58%	18%	66%
Nebraska	56%	15%	71%
Nevada	61%	16%	73%
New Hampshire	62%	21%	74%
New Jersey	71%	25%	77%
New Mexico	58%	20%	71%
New York	67%	23%	73%
North Carolina	60%	19%	73%
North Dakota	54%	12%	71%
Ohio	57%	16%	69%
Oklahoma	58%	17%	67%
Oregon	59%	19%	75%
Pennsylvania	58%	19%	73%
Rhode Island	64%	17%	73%
South Carolina	57%	17%	67%
South Dakota	60%	24%	74%
Tennessee	60%	19%	74%
Texas	70%	24%	76%
Utah	70%	23%	69%
Vermont	49%	14%	74%
Virginia	67%	22%	74%
Washington	64%	21%	79%
West Virginia	51%	15%	65%
Wisconsin	54%	14%	70%
Wyoming	58%	18%	72%
United States	**64%**	**21%**	**74%**

Source: National Center for Coverage Innovation (NCCI) at Families USA, analysis of American Community Survey (ACS) data for 2017.
Note: ACS data do not show employer coverage offers or immigration status. We thus could not identify individual-market enrollees with incomes below 400 percent of FPL who were ineligible for PTCs because of group coverage offers or immigration status.

Table 2. Percentage of Uninsured Residents Under Age 65, by Income as a Percentage of FPL and state: 2017

	Under 139% FPL	139%—400% FPL	401%—500% FPL	Over 500% FPL
Alabama	21.8%	10.8%	5.2%	3.5%
Alaska	17.9%	20.3%	18.0%	7.4%
Arizona	19.7%	14.3%	7.9%	4.0%
Arkansas	15.7%	10.5%	5.9%	3.3%
California	13.4%	10.7%	5.9%	2.8%
Colorado	15.3%	12.0%	5.9%	2.8%
Connecticut	10.7%	10.0%	5.2%	2.6%
Delaware	11.7%	9.9%	4.3%	1.7%
District of Columbia	5.1%	7.7%	2.5%	1.9%
Florida	26.3%	17.8%	9.9%	5.6%
Georgia	28.4%	16.9%	8.8%	4.4%
Hawaii	9.0%	5.0%	3.4%	1.9%
Idaho	21.6%	12.9%	8.2%	5.0%
Illinois	13.6%	10.6%	5.1%	1.9%
Indiana	16.8%	11.2%	6.0%	2.9%
Iowa	8.4%	6.8%	2.7%	1.4%
Kansas	21.5%	10.8%	3.1%	2.8%
Kentucky	10.9%	7.3%	3.6%	1.8%
Louisiana	15.4%	11.2%	6.2%	4.0%
Maine	17.9%	11.6%	5.6%	2.6%
Maryland	14.3%	10.8%	4.5%	2.7%
Massachusetts	5.2%	5.1%	2.7%	1.4%
Michigan	10.1%	7.7%	2.9%	2.0%
Minnesota	11.0%	7.5%	2.5%	1.5%
Mississippi	24.3%	14.4%	6.5%	3.9%
Missouri	21.5%	11.5%	4.3%	2.8%

Montana	16.1%	12.9%	6.6%	5.0%
Nebraska	21.0%	10.2%	5.7%	2.4%
Nevada	20.9%	14.2%	8.5%	5.5%
New Hampshire	12.7%	10.7%	4.7%	1.9%
New Jersey	18.7%	13.3%	6.2%	2.8%
New Mexico	14.6%	12.6%	5.8%	4.1%
New York	10.1%	9.0%	5.3%	2.8%
North Carolina	22.2%	13.8%	6.3%	3.3%
North Dakota	20.5%	9.9%	4.8%	2.5%
Ohio	11.8%	8.7%	4.0%	2.2%
Oklahoma	26.5%	16.7%	9.8%	6.3%
Oregon	12.0%	10.6%	5.6%	2.9%
Pennsylvania	12.1%	8.8%	3.7%	2.4%
Rhode Island	9.1%	7.3%	3.6%	1.7%
South Carolina	24.3%	13.6%	5.7%	4.2%
South Dakota	22.7%	11.8%	3.0%	2.1%
Tennessee	20.1%	11.4%	6.4%	4.1%
Texas	32.9%	23.0%	10.7%	6.2%
Utah	21.4%	10.8%	5.3%	3.7%
Vermont	4.1%	6.7%	5.0%	3.3%
Virginia	21.0%	13.5%	6.2%	2.9%
Washington	12.2%	9.3%	5.0%	2.6%
West Virginia	10.7%	8.0%	5.5%	3.1%
Wisconsin	12.1%	8.0%	2.5%	1.8%
Wyoming	27.7%	15.7%	7.6%	5.8%
United States	**18.2%**	**12.5%**	**6.0%**	**3.2%**

Source: NCCI analysis of ACS data for 2017.

Endnotes

[1] An example of the latter is the Trump administration's rules for short-term, limited-duration insurance. Cheryl Fish-Parcham. "Seven Reasons the Trump Administration's Short-Term Health Plans Are Harmful to Families," August 2, 2018. https://familiesusa.org/product/seven-reasons-trump-administrations-short-term-health-plans-are-harmful-families.

[2] Medicare's coverage of prescription drugs through Part D includes publicly funded reinsurance. Some observers suggest that this has contributed to the success of Part D and provides a precedent for a permanent reinsurance program for the individual market. Timothy Stoltzfus Jost. "Stabilizing Forces: The Difference Premium Stabilization Programs Make in the Affordable Care Act Marketplaces and Medicare Part D." *The Actuary*, 2016. On the other hand, the Medicare Payment Advisory Commission and the Department of Health and Human Services Office of Inspector General have criticized reinsurance for Part D, suggesting that it has generated far higher spending than originally anticipated, due to insurers' reduced incentive to control claims and high prescription drug prices. "Report to the Congress: Medicare Payment Policy." Medicare Payment Advisory Commission, March 2018; Office of Inspector General. High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage (OEI-02-16-00270) (2017).

[3] As noted later, Massachusetts has supplemented federal affordability aid to great effect. Vermont has done so as well, as did New York before implementing the ACA's Basic Health Program. All three states operate their own health insurance marketplaces. In a state that relies on the federal healthcare.gov platform, state-funded supplemental assistance could create administrative challenges. Many of those challenges involve carriers' need to revise their administrative systems to account for three payment streams for a single consumer—not just the federal PTC and the consumer payment but also the state supplemental payment. To avoid this problem, state supplementation in healthcare.gov states could focus on two discrete populations. The first group consists of very low-income consumers, whose entire premium share would be paid by the state, borrowing a page from Ryan White programs and income-based premium supplement programs. Stan Dorn. "Assessing the Promise and Risks of Income-Based Third-Party Payment Programs." *Assessing the Promise and Risks of Income-Based Third-Party Payment Programs.* New York, N.Y.: The Commonwealth Fund, 2018. The second group includes people with incomes slightly above 400 percent FPL, for whom carriers would have two rather than three payment streams, since only the state and not the federal government would provide premium assistance.

[4] A consumer's PTC amount is the difference between the benchmark premium—that is, the second–lowest-cost silver plan available to the consumer on the exchange—and the consumer's income-based payment. Those who buy benchmark plans are thus unaffected by premium changes, since such changes only affect the consumer's PTC amount. However, many PTC beneficiaries enroll in less expensive bronze plans, including 24 percent of those in the healthcare.gov marketplace for 2018. Whether they pay more or less depends on how reinsurance changes the gap between benchmark and bronze premiums. These consumers pay their income-based charges for benchmark coverage minus the difference between benchmark premiums and the lower premiums for their actual bronze plans.

[5] Kaiser Family Foundation. (2018). Health insurance marketplace calculator. Retrieved January 14, 2019, from https://www.kff.org/interactive/subsidy-calculator/.

[6] In several states, actual federal payments have differed from expected amounts. Even so, reinsurance still augments state fiscal commitments with far more federal resources than are currently available for most alternative methods of improving the affordability of individual market coverage.

[7] Some financially eligible consumers do not qualify for PTCs. The most important non-financial barriers that preclude eligibility are employer coverage offers that the ACA classifies as affordable and immigration status that does not confer lawful presence in the U.S.

[8] Stan Dorn. "Affordability Together: How Congress Can Cut Health Costs for People Who Buy Their Own Insurance." Washington, D.C.: Families USA, 2019.

[9] Let's illustrate by returning to our earlier example of a 60-year-old who moves from 400 to 425 percent FPL while buying average-cost benchmark coverage. Even if robust reinsurance cut premiums by 20 percent, that 60-year-old would still experience severe rate shock by moving from 400 to 425 percent FPL, with monthly premiums more than doubling from $399 to $813. By contrast, if the 400 percent FPL cap were lifted, their costs would rise from $399 to just $424.

[10] One option for states to consider would build in a requirement to study the outcome of reinsurance after a specified period. Such a study could examine alternative methods of improving affordability.

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NCCI022119