Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

NOVEMBER 2018

Assessing the Effectiveness of State-Based Reinsurance: Case Studies of Three States' Efforts to Bolster Their Individual Markets

By Rachel Schwab, Emily Curran, and Sabrina Corlette

Robert Wood Johnson Foundation

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Authors

Rachel Schwab, Emily Curran, and Sabrina Corlette

Georgetown University Health Policy Institute
CENTER ON HEALTH INSURANCE REFORMS

The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

Since the Affordable Care Act (ACA) was signed into law, it has dramatically changed the health insurance landscape and brought about historic coverage gains. The launch of the ACA's marketplaces provided new opportunities for previously uninsured individuals to obtain comprehensive and affordable coverage, regardless of health status. At the same time, implementation of the new market protections and pent-up demand for health care created considerable uncertainty for insurers selling in the individual market, prompting many to increase premiums and, in some cases, exit certain markets completely.

The ACA anticipated some of these fluctuations, and included mechanisms to insulate insurers from losses and keep premiums down. However, after Congress dramatically limited the funds available for one of these mechanisms (the ACA's risk corridors program) and another (the reinsurance program) expired, insurers were left with fewer buffers against a risk pool that was sicker than expected.[1] Moreover, recent federal actions have weakened or eliminated several key components of the law, resulting in greater market disruption and instability.[2] In the midst of these destabilizing forces, some states have taken steps to bolster their insurance markets, implementing policies to protect consumers and mitigate risk for insurers. One policy that has found footing in red and blue states alike is reinsurance.

To date, three states have implemented their own reinsurance programs using the ACA's Section 1332 State Innovation Waivers, while a number of others are in the process of doing so. Alaska, Minnesota and Oregon were the first to gain approval and federal funding to operationalize programs under a 1332 waiver. This issue brief assesses the state reinsurance programs' progress in accomplishing their goals and outlines the lessons they have learned so far.

Background and Approach

The ACA prohibited certain underwriting practices used by health insurers, such as denying coverage to individuals with pre-existing conditions and charging individuals higher premiums based on health status. In doing so, the law helped to expand access to health insurance for millions of Americans who were previously excluded from coverage or priced out of plans, and compelled insurers to offer products to a comparatively sicker population than they had before the law's implementation.[3] To accommodate this risk and to discourage insurers from avoiding sick individuals, the law implemented several mechanisms designed to keep premiums down and encourage ongoing insurer participation. See Table 1.

Table 1. The ACA's Premium Stabilization Programs

Program	Description	Duration
Reinsurance	The government provided payments to insurers that enrolled high-cost individuals by partially reimbursing them for claims above a specified dollar threshold, capped at a certain amount.	2014-2016
Risk Corridors	Limited insurer gains and losses beyond certain thresholds, in order to protect against inaccurate or unstable premiums in the first years of implementation. Insurers with lower than expected claims paid into the program, while insurers with higher than expected claims could receive funding from the program to offset losses.	2014-2016
Risk Adjustment	Insurers that enroll a relatively larger share of high-risk enrollees receive payments from those insurers with a relatively low share of high-risk enrollees.	Permanent

Source: Authors' analysis

One mechanism was reinsurance, a temporary program that reimbursed insurers for eligible high-cost claims, thereby reducing their exposure to a disproportionate share of risk. The ACA's reinsurance program, funded by insurer contributions, was in effect from 2014 to 2016. In that time, insurers who incurred claims between a threshold and a cap were reimbursed for a portion of the claims. Experts have estimated that the ACA's reinsurance program lowered premiums by 10 to 14 percent in its first year.[4] When federal reinsurance ended in January 2017, rate increases were partially attributed to the program's sunset.[5] In 2017, Congress considered, but ultimately did not enact, bipartisan legislation to reinstate federal reinsurance, a policy that the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimated would have lowered premiums by 10 percent in 2019.[6]

While the federal government did not restore the ACA's reinsurance program, a handful of states have worked to develop their own reinsurance programs by applying for Section 1332 State Innovation Waivers, now also called "State Relief and Empowerment Waivers" under recent federal guidance.[7] Section 1332 of the ACA allows states to apply to waive certain provisions of the ACA and try alternative approaches, within certain limits.[8] Among other requirements for a 1332 waiver, the state approach must be budget neutral for the federal government. If the program saves the government money, for example by reducing the amount of federal premium tax credits through a policy that lowers premiums, states can draw down the federal savings (also called federal pass-through funding) to aid in implementing their alternative policy.[9] The Centers for Medicare and Medicaid Services (CMS) and the Treasury Department are responsible for approving and overseeing the five-year, renewable waivers.

The 1332 waiver opportunity became available in 2017. Since then, several states have requested to waive the ACA's single risk pool requirement to allow insurers to vary their market-wide risk assessments for high-cost individuals, an essential predicate to establishing a reinsurance program. The first three states to receive a 1332 waiver for a state reinsurance program – Alaska, Minnesota, and Oregon – have been administering their programs under 1332 waivers since 2018. In 2018, four states – Wisconsin, Maryland, Maine, and New Jersey – received federal approval for 1332 waivers to establish reinsurance programs that will begin in 2019.

After the ACA's federal reinsurance program ended, each of these states suffered substantial market instability, including a number of insurer exits and increasing premiums. Alaska was the first state approved to implement a state-based reinsurance program, which it did to help retain its one remaining insurer providing individual market coverage and mitigate an anticipated significant premium rate hike. Unlike the ACA's reinsurance program, which used a claims-based model to reimburse insurers for a portion of their high-cost claims, Alaska opted to use a condition-based model, which partially reimburses insurers for claims incurred from consumers with one of 33 high-cost health conditions. Following Alaska, Minnesota and Oregon applied and received approval and funding for claims-based reinsurance programs. While all three states were approved to operate their programs for plan years 2018 through 2022, Alaska's program predates the federal waiver, and was in place early enough to influence 2017 rates.[10] See Table 2.

Table 2. State Reinsurance Program Parameters

State	Alaska	Minnesota	Oregon
Waiver Timeline	2018-2022*	2018-2022	2018-2022
Model	Condition-based	Claims-based	Claims-based
Annual Total Cost (2018, Projected)	$60 million	$271 million	$90 million
2018 Federal Pass-Through Funding	$58.5 million	$131 million	$54.5 million
2018 State Funding, Projected	$1.5 million	$140 million	$35.5 million
State Funding Source	State general funds, funded by existing premium tax on all insurers	State Health Care Access Fund, funded by a provider assessment, and state general fund	One-time state fund transfers and a premium assessment on fully insured commercial major medical plans and self-insured public plans
Payment Parameters	Insurers reimbursed for all claims incurred by customers with one of 33 high-cost conditions, such as cystic fibrosis or HIV/AIDS°	Insurers reimbursed for 80 percent of claims between $50,000 and $250,000	Insurers reimbursed for 50 percent of claims between $95,000Δ and $1 million

Source: *Alaska 1332 Waiver Application*. Anchorage: State of Alaska Department of Commerce, Community, and Economic Development, Division of Insurance, 2016. https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033. Accessed July 2018.

Randy Pate (Director, Center for Consumer Information and Insurance Oversight). Letter to: Lori Wing-Heier (Director, Alaska Division of Insurance), February 6, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-AK-2018-letter.pdf. Accessed July 2018.

Minnesota 1332 Waiver Application. Saint Paul: Minnesota Department of Commerce, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf. Accessed July 2018.

Randy Pate (Director, Center for Consumer Information and Insurance Oversight). Letter to: Jessica Looman (Commissioner, Minnesota Department of Insurance), January 26, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-MN-pass-through-Rothman-180126.pdf. Accessed July 2018.

Oregon 1332 Waiver Application. Salem, OR: Department of Consumer and Business Services, 2017. https://healthcare.oregon.gov/DocResources/1332-application.pdf. Accessed July 2018.

Randy Pate (Director, Center for Consumer Information and Insurance Oversight). Letter to: Cameron Smith (Acting Director, Oregon Department of Consumer and Business Services), February 6, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-OR-2018-letter.pdf. Accessed July 2018.

*Alaska implemented a state reinsurance program in 2017 without a 1332 waiver or federal pass-through funding, which was instead funded by a state appropriation of $55 million; the state also received a $25 million reimbursement from Premera due to low claims costs in 2017. "Premera Contributes $25 Million to Alaska Reinsurance." Mountlake Terrace, WA: Premera Blue Cross Blue Shield of Alaska, December 1, 2017. https://www.premera.com/ak/visitor/about-premera/press-releases/2017_12_01/. Accessed August 2018.

°Payments are limited to the total annual program limit

ΔFor 2018. *Second Quarter 2018 Quarterly Report*. Salem, OR: Department of Consumer and Business Services, 2018. https://dfr.oregon.gov/business/reg/health/Documents/reinsurance-quarterly-report-20180826.pdf. Accessed September 2018.

Approach

This brief evaluates the progress of the three state reinsurance programs currently operating by examining the design, implementation, and outcomes of reinsurance in Alaska, Minnesota and Oregon. The information is based on a review of each 1332 waiver application and individual market rate filings in the states from 2017 through 2019. In addition, we conducted nine structured interviews with state regulators and insurer representatives in the three states to better understand the process and subsequent challenges of setting up and administering a reinsurance program at the state level.

Findings

The Reinsurance Programs Have Been Largely Effective in Achieving Their Aims.

The states shared four common goals for their reinsurance programs:

1. Stabilize individual market premiums and mitigate future rate increases;
2. Increase consumer enrollment;
3. Maintain insurer participation and attract future competition; and
4. Generate federal savings to fund state-level innovation, while ensuring a financially sustainable program.

To date, the states report success in achieving most of these outcomes.

Premiums

The reinsurance programs in all three states have directly reduced individual market premiums. For 2018, the states saw average rate changes that met or exceeded their expectations, with several respondents claiming that the programs should be credited for holding down 2019 rates, as well. One insurer noted that the program had a "tremendous immediate impact," allowing them to reduce their proposed rates by over 20 percent. In Alaska, the state's only insurer initially proposed 2017 rate increases of over 40 percent, on average, prior to approval of the 1332 waiver. Following implementation of the reinsurance program, average final rates increased just 7 percent. Several insurers stated that in the absence of a reinsurance program, their rates would have been significantly higher. Despite a number of policy changes that put both upward and downward pressure on 2018 premiums, respondents nevertheless asserted that the reinsurance programs, in particular, have had a "material" impact, calling even a single-percentage point change in rates "a big deal." In fact, in 2018, while the national average premium increase for the lowest-priced silver plan was 32 percent, all three states saw their average premium rates decrease.[11] One insurer cautioned that if a reinsurance program were to go away, it would create a "catch-up market," in which subsequent rate increases would need to account for several years of annual changes.

> "This is one of the most effective tools to stabilize in the short-term…"
>
> – *Insurer*

While we did not review rate filings for the four states receiving 1332 waivers for reinsurance programs that begin in 2019, published reports suggest that their approved programs have prompted reductions in 2019 premiums.[12]

Table 3. Projected and Actual Marketplace Premiums in States with a Reinsurance Program, 2017-2019

State	1332 Reinsurance Program Approval Date	Projected Rate Changes Under the 1332 Waiver (Compared to no waiver)	Year-Over-Year Average Rate Changes*		
			2017	2018	2019
Alaska	7/7/17	Premium increases will be 20% lower in 2018	Initial Rates: +42% Final Rates: +7.3%	-26%	-6.5%
Minnesota	9/22/17	Premium increases will be 20% lower in 2018	+57.8%	-11.30%	-27.7% to -7.4%
Oregon	10/18/17	Premium increases will be 7.1% lower in 2018; 6.5% lower in 2019	+9.8% to +32%	-1.6% to +14.8%	-9.6% to +10.1%

*Data are not available to determine the degree to which the reinsurance programs contributed to year-over-year rate changes, compared to other factors such as claims experience, medical trend, and other federal or state policy changes.

Sources: Authors' analysis of states' 1332 waivers, interview feedback, and state-reported premiums.

AK Rates: "Alaska Individual Health Plan Rates to Decrease in 2018." Mountlake Terrace, WA: Premera Blue Cross Blue Shield of Alaska, September 19, 2017, https://www.premera.com/ak/visitor/about-premera/press-releases/2017_09_19/. Accessed August 2018.

"Health insurance rates down 25 percent since launch of Alaska reinsurance Program." Anchorage: Bill Walker, Office of the Governor, August 1, 2018, https://gov.alaska.gov/newsroom/2018/08/health-insurance-rates-down-25-percent-since-launch-of-alaska-reinsurance-program/. Accessed August 2018.

"2019 Individual Health Plans by Area." Premera Blue Cross Blue Shield of Alaska, https://www.premera.com/ak/visitor/shop-for-plans/individual-and-family-plans/health-plans/plans-by-county/. Accessed October 2018.

MN Rates: "2017 Rate Summary." Saint Paul: Minnesota Department of Commerce, 2016, https://mn.gov/commerce-stat/pdfs/rate-release-packet-2017.pdf. Accessed August 2018.

"2018 Health Insurance Rate Summary." Saint Paul: Minnesota Department of Insurance, 2017, http://mn.gov/commerce-stat/pdfs/rate-release-packet-2018.pdf. Accessed August 2018.

"Final 2019 Health Insurance Rate Changes Individual Market," Minnesota Department of Commerce, http://mn.gov/commerce-stat/pdfs/fact-sheet-individual-rates.pdf. Accessed October 2018.

OR Rates: "Oregon announces final health insurance rate decisions." Salem, OR: Oregon Department of Consumer and Business Services, June 30, 2016, https://www.oregon.gov/newsroom/pages/NewsDetail.aspx?newsid=1193. Accessed August 2018.

"DCBS posts final rate decisions for 2018 health plans." Salem, OR: Oregon Department of Consumer and Business Services, July 20, 2017, https://www.oregon.gov/newsroom/pages/NewsDetail.aspx?newsid=2170. Accessed August 2018.

"Final rate decisions released for 2019 health plans," Oregon Department of Consumer and Business Services, https://dfr.oregon.gov/news/2018/Pages/20180720-2019-final-rate-decisions.aspx. Accessed September 2018.

Enrollment

While all the states saw individual market enrollment growth in 2018, they had mixed success in achieving their enrollment aims. Both Alaska and Oregon surpassed their projected enrollment growth, while Minnesota fell just shy of its goal by a few thousand lives.[13] Despite the growth, some respondents expressed disappointment that 2018 enrollment was not higher, speculating that consumers might be pursuing alternative forms of coverage or continuing to go uninsured. The states reported that it is too early to tell how the reinsurance programs might have shifted member demographics, though one noted that they have seen a marked increase in enrollment among the unsubsidized.

Insurer Participation

For 2018, none of the states saw an increase in the number of insurers participating in their marketplace following implementation of the

> "[W]e have some confidence that with this pool in place, there will be a level of stability and predictability…that hasn't been there for a number of years."
>
> – *Insurer*

reinsurance programs. However, insurers currently participating in the states that we interviewed reported that reinsurance provided them with an incentive to maintain participation at a time when many of their peers in other states were exiting the market. One insurer further explained that reinsurance likely played a role in insurers' participation in more lightly populated counties, where limited provider networks and high-cost claims would have made participation difficult without a reinsurance backstop. Another insurer commented that reinsurance is an important factor in their decision whether to re-enter a state or expand their geographic reach. In fact, one state official attributed the expansion of two insurers into rural counties to the reinsurance program. While a few insurers noted that they were committed to the market, regardless of whether a reinsurance program was enacted, all attested that the programs have provided increased stability and have been effectively managed by their states.

Table 4. Projected and Actual Marketplace Enrollment in States with a Reinsurance Program, 2017-2018

		Year-Over-Year Marketplace Enrollment Changes*		
State	Projected Enrollment Changes Under the 1332 Waiver (Compared to no waiver)	2017 Effectuated Enrollment[o]	2018 Effectuated Enrollment[o]	Change in Enrollment 2017-2018
Alaska	Enrollment will increase by 1,650 in 2018	14,177	17,789	3,612
Minnesota	Enrollment will increase by 20,000 in 2018	90,146	106,492	16,346
Oregon	Enrollment will increase by 1.7% in 2018; 1.6% in 2019	137,305	143,157	5,852

*Data are not available to determine the degree to which the reinsurance programs contributed to year-over-year enrollment changes, compared to other factors such as advertising, outreach, and other changes in federal or state policy.

Sources: Authors' analysis of states' 1332 waivers and interview feedback.

[o]"Marketplace Effectuated Enrollment 2017-2018." Menlo Park, CA: Kaiser Family Foundation. https://www.kff.org/health-reform/state-indicator/marketplace-enrollment-2017-2018/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed August 2018.

Table 5. Insurer Participation in the Marketplaces, 2017-2019

	On-Exchange, Individual Market Insurer Participation		
State	2017 Participation	2018 Participation	2019 Participation
Alaska	1 insurer (Premera)	1 insurer	1 insurer
Minnesota	4 insurers (Blue Plus, HealthPartners, Medica, UCare)	4 insurers	4 insurers
Oregon	6 insurers (ATRIO, BridgeSpan, Kaiser Foundation, Moda, PacificSource, Providence)	5 insurers (ATRIO exits)	5 insurers

Sources: Authors' analysis of state-reported insurer participation and interview feedback.

Federal Savings

States had little to report on the federal savings generated to date, noting that it is too early to tell how membership and claims might develop over the year. However, every state estimated that their savings are tracking in line with expectations and attest that they are working closely with CMS to monitor quarterly savings.

Reinsurance Has Widespread Support, But State Funding Remains an Issue

In light of these outcomes, insurers and state officials in all three states voiced support for the reinsurance programs, with a majority of respondents indicating that reinsurance has played a pivotal role in moderating premiums, encouraging enrollment, and preserving insurer participation amidst great uncertainty over federal ACA policies. One insurer said that the state's reinsurance program is at "the top of our list" in terms of policy priorities, while another called reinsurance the "clearest path forward" to maintain stability in the individual market. State regulators echoed this sentiment.

> "It really did help save our market."
>
> *– Department of Insurance*

Respondents also indicated that state reinsurance programs have garnered bipartisan support. One insurance department noted that there is "an understanding [from both major political parties] that it's been beneficial." An insurance industry stakeholder described how the program's inception involved everyone compromising "to figure out what…would keep everyone in the market." One insurer characterized reinsurance as "really well accepted" and "not controversial," suggesting that this support will allow the program to continue. Respondents expressed confidence that the demonstrated success of reinsurance and the volatility that would result in its absence provides a platform for continuing the state programs. One insurance department argued that "we've shown the impact…so hopefully that logical argument is carried forward [in the next legislative session]."

Despite their success and widespread support, a number of respondents mentioned that maintaining state funding could be an ongoing challenge for these reinsurance programs. Each state reported that the programs were sufficiently funded at their outset, but continued state funding is not guaranteed. Upcoming changes in state government leadership and controversies over the source of funding were cited often as potential roadblocks to the programs' continuation. For example, Alaska and Oregon's programs are funded by an insurer tax, which some insurers argued is not a permanent solution. Minnesota's funding is only guaranteed in 2018, requiring the legislature to appropriate funding for 2019 and beyond. All respondents indicated that the uncertainty over future revenue raises concerns about the future viability of the program.

Lessons Learned: Advice for Other States

Don't Let Design Complexities Stall Progress

In designing their programs, each state leveraged existing infrastructure and institutional expertise to identify program elements that were politically palatable and quick to implement. For example, to some extent, all three states leveraged the remnants of their state high-risk pools – including mechanisms for collecting insurer assessments and claims data – which many states have largely unwound following implementation of the ACA. Similarly, the states noted that internal actuaries and other experts were "critical" to developing the methodology and technical specifications for their programs.

Feeling an urgency to act, state respondents also found that they were able to avoid debates

> "[W]e didn't create much. We used what we knew, what was there and looked at how we could replicate it."
>
> – *Insurer*

over operational details that could have delayed implementation. For example, in deciding between the condition and claims-based models, state officials concluded that neither model was superior to the other, and focused instead on the model with which they were the most familiar. Minnesota and Oregon opted for the claims-based model, given their experience with the ACA reinsurance program's model and their own high-risk pools. Alaska elected the condition-based model based on internal actuarial advice.

In developing a program, the states advised their peers to not let design "perfection" stall progress, noting that there are ongoing opportunities to revisit and modify their models. However, some

> "It's hard for states to do this alone. We had hoped two years would be a bridge until the federal government would do something."
>
> – *Insurer*

cautioned that administering a program might be more difficult in states that lack institutional actuarial support, reinsurance knowledge, or a pre-ACA high-risk pool.

Engagements with CMS Have Been Constructive, but Federal Support for Other Stabilization Measures Is Needed

To facilitate federal oversight of the reinsurance waiver programs, states are required to submit quarterly and annual reports to CMS detailing implementation progress, operational challenges, and data related to compliance metrics.[14] To date, the states have found the reporting to be feasible and "straightforward." Several officials noted that the agency has been a constructive partner in providing valuable risk management feedback, clearly articulating reporting expectations, and assigning states points of contact to facilitate information sharing. Officials in one state reported they were "shocked" with CMS's responsiveness in answering questions, while another encouraged states to frequently engage with the agency throughout program development.

While the states spoke highly of their collaboration with CMS thus far, states and insurers alike expressed frustration with the lack of federal support for broader stabilization efforts. Despite the states' positive outcomes, most respondents reported that state-level reinsurance programs are not a permanent or national solution, particularly given numerous states' funding and infrastructure constraints. Many respondents advocated for a federal reinsurance program, so long as it can be adapted to states' individual circumstances. Others pointed to the need for more comprehensive changes in the individual market to increase the number of individuals participating. Overall, respondents praised the success the state-based programs have had, but noted that broader changes to the individual market will be needed to significantly reduce the number of individuals who continue to be uninsured.

Ongoing Monitoring and Assessment Is Critical

Though the states' programs have been in place for only a short time, officials are laying the groundwork to assess their programs' effectiveness. In addition to collecting claims information, two states reported that they are engaged in regular actuarial analysis and one is in the process of developing outcomes-based performance measures. This state hopes to create a standard operating procedure to test samples of claims to ensure that the program's payment parameters are appropriately set. As other states seek to create their own programs, respondents spoke of the need to develop similar performance measures to ensure that the programs are achieving their initial aims.

Conclusion

In the face of insurer exits and increasing individual market premiums, Alaska, Minnesota and Oregon worked to shore up their markets by implementing state-based reinsurance programs. Facing an urgency to act, the states relied on existing state infrastructure and institutional knowledge to set up their programs. In doing so they took diverging paths, but early results show that they all have been largely effective in achieving their aims. Across the states, the reinsurance programs have helped to reduce premiums, increase consumer enrollment, and maintain insurer participation. While it remains to be seen whether the programs will achieve the federal savings they project, feedback from insurer stakeholders indicates that reinsurance has been efficiently managed and boosted their confidence in the state's commitment to a stable and functioning individual market. Ongoing concerns remain regarding the sustainability of future funding and the role politics might play in support for market stabilization. Though these challenges are ever-present, the experiences of Alaska, Minnesota and Oregon demonstrate the value in pursing state-based solutions in a time of federal policy uncertainty.

Acknowledgments

The authors are grateful to Justin Giovannelli, Jason Levitis, and Joel Ario for their thoughtful review and comments on early drafts of this paper. We also thank the state officials and insurance industry representatives who so generously shared their experience and insights. This work was made possible thanks to the generous support of the Altarum Institute and the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Endnotes

1. In 2014 and 2015, Congressional appropriations bills required HHS to compensate insurers under the risk corridor program solely using funds collected from insurers with high profits. Because more insurers experienced losses than gains in the early years of the ACA, HHS paid insurers only 12.6 percent of the risk corridor payments they were owed. *Risk Corridors Payment Proration Rate for 2014*. Washington: Department of Health & Human Services, 2015.https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf. Accessed September 2018.

2. *See, for example*: Repeal of the individual mandate penalty in the Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081 (2017); Final federal rules to expand insurance that does not have to comply with the ACA's rules: Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38212 (finalized August 3, 2018) and Definition of "Employer" under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018); Cuts to Navigator program funding, "CMS Announces New Funding Opportunity Announcement for the Federally-Facilitated [sic] Exchange Program." Washington: Centers for Medicare and Medicaid Services, July 10, 2018. https://www.cms.gov/newsroom/press-releases/cms-announces-new-funding-opportunity-announcement-federally-facilitated-exchange-navigator-program. Accessed August 2018; withdrawing federal funding for cost-sharing subsidies, "Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments." Washington: Department of Health and Human Services, 2017. https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html. Accessed August 2018.

3. Glied A and Jackson A. *Access to Coverage and Care for People with Preexisting Conditions: How Has It Changed Under the ACA?* New York: Commonwealth Fund, 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/access-coverage-and-care people-preexisting-conditions-how-has. Accessed August 2018.

4. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*. Washington: American Academy of Actuaries, 2017. https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf. Accessed August 2018. Since the

ACA's reinsurance program ended, Congress has also considered other legislation to implement a federal subsidized reinsurance program. *See* Harrington S. *Stabilizing Individual Health Insurance Markets with Subsidized Reinsurance: A Comparison of Approaches*. Philadelphia: University of Pennsylvania Leonard Davis Institute of Health Economics, 21(7), 2017. https://ldi.upenn.edu/brief/stabilizing-individual-health-insurance-markets-subsidized-reinsurance. Accessed November 2018.

5. *Drivers of 2017 Health Insurance Premium Changes*. Washington: American Academy of Actuaries, 2016. http://www.actuary.org/files/publications/IB.Drivers5.15.pdf. Accessed August 2018.

6. *Congressional Budget Office Cost Estimate: Bipartisan Health Care Stabilization Act of 2018*. Washington: Congressional Budget Office, 2018. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/bipartisanhealthcarestabilizationact.pdf. Accessed August 2018.

7. Department of the Treasury and Department of Health & Human Services, "State Relief and Empowerment Waivers," 83 Fed. Reg. 53575, Oct. 24, 2018.

8. The ACA's 1332 provision includes limits (also known as "guardrails") on state waiver plans that would jeopardize the affordability or adequacy of residents' coverage, reduce the number of people with insurance, or increase the federal deficit. However, 2018 federal guidance implementing this provision gives states considerable flexibility in how these guardrails are met. See Department of the Treasury and Department of Health & Human Services, "State Relief and Empowerment Waivers," 83 Fed. Reg. 53575, Oct. 24, 2018.

9. 42 U.S.C. § 18052 (2010).

10. *Alaska 1332 Waiver Application*. Anchorage: State of Alaska Department of Commerce, Community, and Economic Development, Division of Insurance, 2016. https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033. Accessed July 2018; *Minnesota 1332 Waiver Application*. Saint Paul: Minnesota Department of Commerce, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf. Accessed July 2018; *Oregon 1332 Waiver Application*. Salem, OR: Department of Consumer and Business Services, 2017. https://healthcare.oregon.gov/DocResources/1332-application.pdf. Accessed July 2018

11. Holahan J, Blumberg L and Wengle E. *Changes in Marketplace Premiums, 2017 to 2018, March 2018*. Washington: Urban Institute, 2018. https://www.urban.org/sites/default/files/publication/97371/changes_in_marketplace_premiums_2017_to_2018_0.pdf. Accessed September 2018.

12. Maryland's reinsurance program, along with the insurance department's review of rate filings, reduced proposed 2019 individual market premiums by 43.4 percent; New Jersey's reinsurance program, along with the state's individual mandate that also goes into effect in 2019, reduced proposed individual market premiums by 9.3 percent; Wisconsin's reinsurance program reduced individual market premiums by an estimated 11 percent; and after federal approval of their state reinsurance program, Maine reported final average rates ranging from a 4.3 percent decrease to a 2.1 percent increase, down from proposed average rate increases ranging from a 9.2 to 13.8 percent increase. See Maryland: "Governor Larry Hogan Announces Health Insurance Premium Rate Decreases." Baltimore, MD: Maryland Insurance Administration, September 21, 2018, https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2018201 (accessed September 2018); New Jersey: "Governor Murphy Announces Impact of New Jersey's Actions to Stabilize Health Insurance Market." Trenton, NJ: State of New Jersey Governor Phil Murphy, September 21, 2018, https://www.state.nj.us/dobi/pressreleases/pr180907.pdf (accessed September 2018); Wisconsin: "Lowering the Cost of Health Care: Individual Market Premiums Expected to Drop 3.5% on Average Next Year Thanks to Governor Walker's Health Care Stability Plan." Madison, WI: Scott Walker, Office of the Governor, July 29, 2018, https://walker.wi.gov/press-releases/lowering-cost-health-care-individual-market-premiums-expected-drop-35-average-next (accessed September 2018); Maine: Anderson JC, "Rate hikes sought by Maine's ACA insurers come in lower than expected for 2019," *Portland Press Herald*, Tuesday, June 5, 2018, online, https://www.pressherald.com/2018/06/05/maines-aca-insurers-seek-single-digit-rate-increases-for-2019/ (accessed September 2018) and "2019 Individual and Small Group Health Insurance Rate Filings." Gardiner, ME: Maine Bureau of Insurance, 2018. https://www.maine.gov/pfr/insurance/legal/upcoming_hearings/pdf/final_2019_rate_summary.pdf. Accessed September 2018.

13. Minnesota is the only state among the three study states with a Basic Health Program, which covers low-income residents between 138-200 percent of the Federal Poverty Level (FPL) through plans offered outside of the marketplace.

14. Giovannelli J. *State Flexibility in a New Era*. Washington: AcademyHealth, 2018. http://www.academyhealth.org/sites/default/files/1332_Waivers_Issue_Brief_Jan2018.pdf. Accessed August 2018.

Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20007
Telephone (202) 687-0880
http://chir.georgetown.edu/