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THE ADVOCACY DIVISION OF CONSUMER REPORTS

California State Reinsurance:

A Path to Affordable Health Insurance?

Evaluation of the options and potential for a reinsurance program in California

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Consumers Union is the advocacy division of *Consumer Reports*. We have a long history of advocating for improvements in the consumer marketplace. Since our founding in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a nonprofit, nonpartisan organization with an overarching mission to test, inform, and protect.

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Introduction

Since the enactment of the Affordable Care Act (ACA), California has made great strides in improving access to affordable[i] healthcare and coverage for all Californians. The state's uninsurance rate dropped dramatically, elevating California to one of the highest rates of insured nationwide. With this advancement, millions of Californians have accessed care they could not before and experienced the security of knowing that a trip to the hospital would not mean financial ruin. Yet, the state must not rest on its laurels. In the face of steadily rising health insurance and plan premiums, and federal policy decisions that may undermine key advances, California's policymakers must consider all tools available to them to further the mission of ensuring that all Californians have access to safe, affordable, healthcare and coverage.

This white paper describes one tool for improving health coverage affordability that other states have used: reinsurance. Reinsurance is credited for addressing premium affordability, insurer participation, and health insurance market stability. This paper discusses how reinsurance works and the population in California that could be helped by it, and evaluates whether some form of reinsurance could offer a workable solution in this state in the coming health insurance plan year, 2019.

Consumers Union supports reinsurance as a tool for providing premium relief for those who do not receive premium tax subsidies, but it must be backed by an adequate and reliable funding stream. The paper concludes that, without a stable and long-term avenue for financing a reinsurance program, reinsurance is likely an unworkable solution for California in 2019.

Reinsurance basics

Reinsurance is a common product across many lines of insurance to protect insurers against outsized claims. Essentially, it is insurance for health insurers and health plans against the highest cost policyholders. It allows the costs of the largest claims to not be distributed across all policyholders through rate setting. Unlike high-risk pools – a failed policy approach used prior to the ACA – reinsurance covers high-cost claims without segmenting the risk pool, and operates in the background of the health insurance market, in most cases without consumers knowing. In so doing, it is credited with lowering health insurance premiums across the board. It is especially valuable for consumers who are not eligible for premium tax subsidies and who therefore shoulder the full cost of insurance premiums.

In the health insurance sphere, the federal Transitional Reinsurance Program established in Section 1341 of the Affordable Care Act (ACA)[ii] was fully federally-funded. It was

designed to last only three years, providing stability to carriers during the transitional years of the ACA. It compensated carriers in the individual market for high-cost enrollees, and effectively subsidized individual market premiums. Under the ACA, all insurers and employer plans, including those that self-fund, contributed funds to the reinsurance program. The federal reinsurance program insured carriers for claims that hit set "attachment points," and was capped by preset limits. For the claims that were covered by the program, the carriers were on the hook for a set coinsurance rate, which changed each year. A summary of this program as it operated 2014-16 is shown in Table 1 below.

Table 1: Federal Transitional Reinsurance Program (2014-2016)

Year	2014[iii]	2015[iv]	2016[v]
Attachment point	$60,000	$45,000[vi]	$90,000
Reinsurance cap	$250,000	$250,000	$250,000
Set coinsurance rate	80 percent	50 percent	50 percent
Updated coinsurance rate[vii]	100 percent	55.1 percent	52.9 percent
User fee per enrollee annually	$63	$44	$27
Number of carriers receiving payment	437	497	496
Total payments to carriers	$7.9 billion[viii]	$7.8 billion as of June 2016[ix]	$4 billion as of June, 2017[x]

Evidence shows that the Transitional Reinsurance Program helped hold down premium rates by 10 to 14 percent in 2014 and by 6 to 11 percent in 2015.[xi] The beneficiaries are those paying the full premium price, i.e. consumers in the individual market who do not qualify for a premium tax subsidy generally because they earn more than 400 percent of the federal poverty level (FPL), and the federal government that pays for some or most of the premiums owed by consumers who do qualify for the subsidy. The American Academy of Actuaries credited the Program with stabilizing premiums in the individual market.[xii] The last reinsurance distribution to carriers was applied towards the 2016 plan year, which some actuaries note as part of the reason why premiums increased in 2017.[xiii]

Some policymakers and experts propose reinstating federal reinsurance as either a temporary or permanent program;[xiv] Consumers Union supports permanent reinstatement, both of the reinsurance program and secure long-term financing for the program. Because of its power to decelerate rate increases, a reinsurance program could counteract the

premium impact of Congress's recent elimination of the fee associated with the individual mandate. To wit, the Congressional Budget Office (CBO) forecasts the repeal of the individual mandate will cause a 10% average premium increase[xv] and a properly funded reinsurance program could reduce consumer premiums by 12 percent on average.[xvi] Although some Californians would disenroll due to the higher premiums and lack of penalty, most of the coverage losses projected to occur would be due to the loss of the incentive that the penalty creates to shop and enroll in coverage. Additionally, most of the coverage losses projected to occur due to the elimination of the penalty would be among subsidy-eligible consumers, who would not be affected by the premium reductions under a reinsurance program.[xvii]

Of course, reinsurance comes with a price tag and while the upsides for consumers that would normally pay full freight for their health insurance is all positive, experience shows that the cost would be hefty. If the federal government does establish a reinsurance program, it is most likely to require that the state contribute financially to the program. Thus, the question is whether it is the most effective use of the state dollars required.

The number of consumers that could benefit from a reinsurance program is significant. In California, that portion of the eligible population is substantial: there are 1.1 million Californians enrolled in the individual market who are not eligible for premium tax subsidies and would benefit from the overall reduced premiums attributable to a reinsurance program.[xviii] In addition, reinsurance makes some carriers more comfortable with risk in the individual market,[xix] which translates to reduced market volatility – a good thing for all enrollees.[xx] This may be particularly important in the upcoming plan year, which is predicted to be uncertain and volatile as a result of major policy changes.[xxi]

Finally, reinsurance is an efficient mechanism for removing costly claims from rate setting, but it does not address the underlying healthcare costs that caused large bills in the first place. Nor does reinsurance provide financial relief for lower-income consumers who suffer under the weight of high deductibles and copays they cannot afford. Finally, within the larger conversation about steps to improve health insurance affordability, reinsurance is but one policy option; it is far from the only option to consider and, in fact, the Legislature has several important bills before it this year that are aimed at providing assistance on premiums and cost-sharing.[xxii]

State-Based Reinsurance

Given the evidence that reinsurance works to rein-in health insurance premiums, it makes sense that states are eager to adopt the approach to fill the wake after the culmination of the federal transitional reinsurance program. There is no rule that a reinsurance program must be approved or financed by the federal government. But, operating such a program is costly; only a few states have opted to go it alone, acting as laboratories with their own

reinsurance programs. Most states – even those that operate a wholly independent program for some period of time – eventually require federal waivers and financial support to continue their program over an extended period of years.

- Alaska, a state with historically high premiums, established the Alaska Reinsurance (ARP) program in 2017 and is credited for substantially containing premium increases – dropping the average rate increase from 42 percent to just 7.3 percent in just one year alone. The savings for Alaskans was substantial but the program came with a $55 million price tag.
- Oregon launched the Oregon Supplemental Reinsurance Program, which was designed to last from 2014-2016 and buffer against premium inflation connected to the end of the Oregon Medical Insurance Pool (OMIP), which ended at the end of 2013. It was expected to mitigate premium increases by four percent.[xxiii] Ahead of implementation, a legislative fiscal analysis projected costs of about $104 million for 2013-2015 and approximately $72 million in 2015-17 (including funding for the program as well as administrative costs).
- Maine adopted a variation on reinsurance[xxiv] in 2011, which was estimated to cost $21 million, funded via a $4 per member per month assessment on health insurers, including large groups and self-insured employers.[xxv] At the time the program was adopted, it was estimated to lower premiums by 12-15 percent.[xxvi] At the end of the three-year program, Maine's reinsurance board reported that this program achieved "similar rate impacts" compared to the federal transitional reinsurance program.[xxvii]

Although California could "go it alone," as did the aforementioned states, it is nearly-impossible to imagine a scenario in which California would fully self-fund a reinsurance program, whether funded by insurer fees or another non-federal revenue stream. Because of Section 1332 of the ACA, though, going it alone is not necessary. Indeed, both Alaska and Oregon have secured such waivers and several more are in the pipeline. By receiving a federal 1332 Waiver, states can secure federal funding to operate a reinsurance program but must be mindful that the 1332 Waiver will not fully fund a state-based reinsurance program.

Section 1332 State Innovation Waiver

Whether the federal government will implement its own reinsurance program is uncertain at best and will be for some time. None of the federal legislative proposals on the table proposes a program like the Transitional Reinsurance Program – which was completely federally-funded and administered – and none stands out as likely to be enacted in the near future. In the meantime – and especially given the likelihood that any federal program would require a state contribution – California policymakers may wish to consider launching a state-based reinsurance program. The State Innovation Waiver, designed in

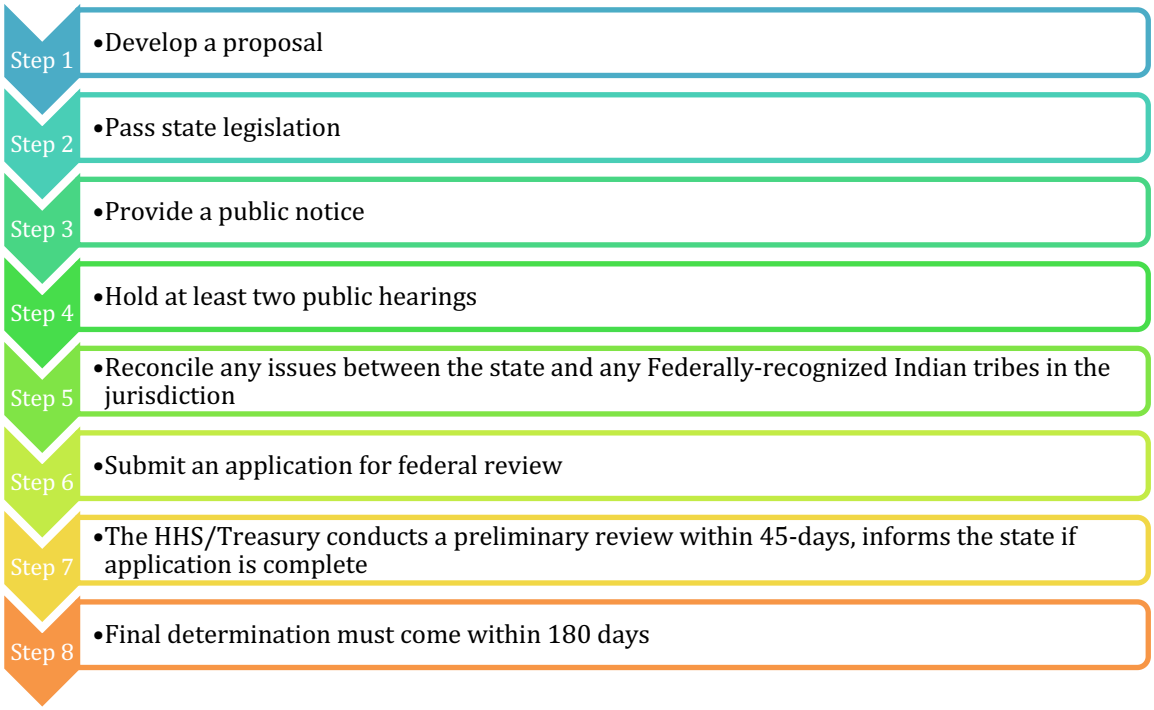
Section 1332 of the ACA, ("1332 Waiver"), offers a path for states to secure partial federal funded for state-based reinsurance programs.

The 1332 Waiver allows states to "pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."[xxviii] There are prerequisites for a state to receive a 1332 Waiver. The program must:

1. provide access to quality healthcare that is at least as comprehensive and affordable as it would be absent of a waiver;
2. provide coverage to a comparable number of residents of the state as would be provided coverage absent of a waiver;
3. provide coverage to a comparable number of residents of the state as would be provided coverage absent a waiver; and
4. not increase the federal deficit.

Federal funding for state-based reinsurance programs using a 1332 Waiver comes from federal pass-through of funding under section 36B of the Internal Revenue Code and 1402 of the Affordable Care Act, relating to Advanced Premium Tax Credits (APTC) and cost sharing reductions for plans offered within the Marketplaces. The extent to which federal pass-throughs finance a state-based reinsurance program varies depending on the percentage of enrollees in that state's individual market who received APTCs.

There is also a mandatory process for states that wish to apply for a 1332 Waiver. This process is long, with eight distinct steps, including a required state legislative process, public review, and two-step HHS review period. For better or for worse, the application process, clearly, was not designed for quick implementation of a 1332 Waiver. This timeline would pose a substantial hurdle if California were to attempt a 1332 Waiver to avoid large premium rate increases in the 2019 plan year.



Three states have already passed state legislation and earned approval for their reinsurance 1332 Waiver:

- Alaska: the state funds the program in part via an assessment on all types of health insurers, including individual, small and large group, and stop-loss.
- Minnesota: the initial two years is financed from the Health Care Access Fund, funded by a 2% provider tax, along with a 1% health plan premium assessment with revenue designated to fund the MinnesotaCare program.[xxix]
- Oregon: the state uses funds left over in the Oregon Temporary Reinsurance Program (which ended in 2016), the Oregon Health Insurance Marketplace assessment, and a 1.5% assessment on hospitals and health insurers.

Approved 1332 Reinsurance Waiver funding for 2018 is shown in Table 2 below.[xxx]

Table 2: Overview of Approved 1332 Reinsurance Waiver Funding for 2018 (in Millions)

	Alaska	Minnesota	Oregon
Total Reinsurance Program Funding	$60	$271	$90
Federal Pass-Through Funding	$58	$131	$54
State Funding required (After pass-through funding)	$2	$140	$36
Percentage of Program Covered by Federal Dollars	97%	48%	61%

For additional examples of 1332 Reinsurance Waivers pending in other states, see Appendix II.

Each of these states designed their reinsurance program differently, but the projected outcome is the same: they will leverage the benefits of reinsurance to contain the rapidly escalating health insurance premiums. Because reinsurance reduces premiums, the federal government will spend less in premium tax credits. That savings could be passed through to the state to subsidize the state-based reinsurance program, which uses it to partially offset the cost of providing reinsurance. Reinsurance in the Golden State

Should California Consider a State Reinsurance Program?

A recent report issued by Manatt Health, under a grant from the Robert Wood Johnson Foundation, offers a four-part test to considering a state reinsurance program. Applying the unique circumstances of the individual market of California to this test, as shown in Table 3, gives a sense of whether this unique financial tool is a ripe solution for the Golden State.

Table 3: Evaluating the Impact of a California Reinsurance Program[xxxi]		
Questions	Why is this important?	California application
What market problem does the state need to solve?	Reinsurance can be a strong tool to address: ● Affordability of premiums ● Insurer withdrawals ● Excess volatility/uncertainty. Reinsurance is not a good tool for other insurance problems, such as network adequacy and cost-sharing burdens.	Expected health insurance premium increases are a pressing concern for Californians that pay the full sticker price for individual health insurance, (primarily those with household income at or above 400 percent of the federal poverty level). Insurer withdrawals and market volatility are relevant as well, though less of a concern in California than in other states.
What is the average premium?	The average premium matters because reinsurance is a tool for combatting higher than average premiums, especially for unsubsidized enrollees who pay full price.	The average Marketplace benchmark premium in California is slightly lower than the national average: $430 in California versus $481 nationally[xxxii].
How much premium variation is there across rating areas?	States that have large regional variations in premiums may use a targeted reinsurance program to both combat rapid premium rate increases as well as to retain insurers in high-cost areas of the state.	Premiums vary widely across California's nineteen health insurance regions. Northern California regions regularly out-price southern regions, and percentage increases are also larger.
What does current insurer participation in the market look like?	Reinsurance is a proven tool to attract and retain insurers in the state, particularly in higher-cost regions.	California's large risk pool counteracts the pressures caused by large claims incurred by a small fraction of the risk pool.[xxxiii] In addition to the substantial size of the market, Covered California's deliberate and collaborative approach has meant the individual market in California is not nearly as volatile as markets in other states. Yet, in a few regions, choice may be more limited than would be ideal.
What is the profile of the state's highest cost enrollees?	Because reinsurance provides a counterweight to high-cost claims, states with higher cost constituents may reap the most benefit from a reinsurance program. Furthermore, depending on their unique demographics, states may elect to target specific high-cost conditions through a condition-based reinsurance program.	The California risk pool is considered to be healthier than the nationwide pool.[xxxiv] However, the cost for care varies widely across the state (see above). This difference is likely linked to variations in provider costs. There may also be regional variations in the type of care patients receive.[xxxv]

Over a Million Californians Would Benefit from Reinsurance

Health coverage generally serves as a gateway to healthcare, and when given the choice, most consumers would not opt to be uninsured.[xxxvi] Excluding those consumers ineligible for Exchange or public coverage, the eligible uninsured rate was approximately 3.4% in 2017.[xxxvii] There are a few reasons why a consumer who is eligible for coverage would opt to go without. While lack of knowledge about subsidies is a possible reason for not applying for coverage,[xxxviii] another is the cost of insurance premiums themselves or the overall cost of coverage – both premiums and out-of-pocket costs – over the course of the plan year. Premium tax subsidies and the cost-sharing reduction plans, (identified as "Enhanced Silver Plans"), bring care and coverage within grasp of many, but not all Californians. Income cut-offs for these valuable programs are shown in Table 4, below.

Table 4: Annual Income as a Percentage of the Federal Poverty Level (FPL) 2017				
FPL	Household Size			
	1	2	3	4
139%	$16,760	$22,570	$28,380	34,190
150%	$18,090	$24,360	$30,630	$36,900
200%	$24,120	$32,480	$40,840	$49,200
250%	$30,150	$40,600	$51,050	$61,500
267%	$32,200	$43,360	$54,520	$65,680
300%	$36,180	$48,720	$61,260	$73,800
400%	$48,240	$64,960	$81,680	$98,400

For Californians who are not eligible for cost-sharing reductions or even premium tax credits, however, escalating premium costs are a pressing concern. In 2016, 495,000 California citizens and lawfully present immigrants who were not eligible for financial assistance went uninsured rather than enrolling and paying full sticker price for their insurance.[xxxix] For many of these Californians, affordability was likely a barrier to coverage. Among Californians earning over 400 percent of the poverty line, the cutoff for premium support, 38% have reported either some or a lot of difficulty paying monthly insurance premiums.[xl] Twenty-eight percent of the same cohort reported some or a lot of difficulty paying out-of-pocket costs when using healthcare.[xli]

To make matters worse, the "subsidy cliff" meant that eligible enrollees who earned just a dollar over $48,240, (or $98,400 for a family of four), lost access to all federal premium support. These Californians do not earn enough to shoulder the full cost of health coverage. The results of this subsidy cliff are striking and shown in Table 5, below, which breaks out the fraction of an individual's earnings, (before taxes), that would be spent on health insurance if that person earned either $1 below or above the subsidy cutoff and enrolled in the lowest-cost Silver product available in his or her region.[xlii] For details on just how much more a 60-year-old would pay for a $2 increase in individual household income, see Appendix I.

Table 5: Percent of Household Income Spent on Premiums Above- and Below-the Subsidy Cliff

	Lowest cost Silver product for an individual 60yo earning $48,239		Lowest cost Silver product for an individual 60yo earning $48,241	
Region	Health plan	% Income spent on premium	% Income spent on premium	Health plan
Shasta	Blue Silver 70 PPO	**8%**	**26%**	BSC Silver 1850 PPO
Sonoma	Kaiser Silver 70 HMO	**9%**	**20%**	Kaiser Silver 70 HDHP HMO
Sacramento	Blue Silver 70 HMO	**8%**	**19%**	Kaiser Silver 70 HDHP HMO
San Francisco	CCHP Silver 70 HMO	**8%**	**21%**	Kaiser Silver 70 HDHP HMO
Monterey	Blue Silver 70 PPO	**10%**	**30%**	BSC Silver 1850 PPO
Fresno	Blue Silver 70 PPO	**8%**	**16%**	Kaiser Silver 70 HDHP HMO
San Diego	Health Net Silver 70 HMO	**10%**	**17%**	Kaiser Silver 70 HDHP HMO

Note: this chart reflects the lowest-cost Silver product option for consumers in the individual market based on income. As a result of the surcharge[xliii] added to Silver-tier products sold on Covered California for the 2018 plan year, the lowest-cost Silver product available to Californians not eligible for a premium tax subsidy is sold off-Exchange, as reflected in this table.

A final compounding issue around affordability of insurance premiums is competing expenses in a high-cost-of-living state such as California. Because premium tax subsidies are based on a national index, which does not take into account regional differences in cost of living, the current cut-off for premium tax credits may be reasonable in some parts of the country but inadequate to support consumers in many areas of California. This troubling truth becomes quite clear when looking at statistics from the Bureau of Labor Statistics, which shows that in a California city such as San Francisco, the average household spends

40.3 percent of its household budget on housing, 11.9 percent on transportation, and 12.6 percent on food.[xliv] It makes sense, then, when the experts behind a recent UC Berkeley report estimated that consumers living in California would need an upper income limit for premium subsidies equivalent to five times the current national cutoff, and six-times that in San Francisco, in order for premiums to be affordable as intended under the ACA.[xlv]

In fact, researchers find that affordability is "the top reason that those eligible for Covered California lack insurance, regardless of income level"[xlvi] and that the trend is likely to get worse for those who shoulder the full cost of insurance. For that population, the statewide weighted average premium rate change for the 2018 plan year was 12.5 percent.[xlvii] Federal Executive branch actions are projected to cause even more premium upheaval in the coming years for those paying full bore. Experts project that new rules drafted to expand the footprint of both association health plans (AHPs) and short-term limited duration plans (STLD plans) will cause non-group health insurance premiums to spike 12 to 32 percent by 2019.[xlviii] Included in that projection is the anticipated impact of the elimination of the tax penalty for failure to enroll in an ACA-compliant insurance product, which is widely expected to escalate the speed at which premiums rise, as well as contribute towards fewer Californians electing to enroll in insurance or a health plan.[xlix] With the elimination of the tax penalty as of 2019, Californians who are not eligible for premium tax subsidies have one more reason not to enroll.[l]

With premiums rising precipitously, consumers who pay full price for their individual health insurance products need a policy solution that keeps comprehensive health coverage affordable. The evidence supports reinsurance as a tool that improves affordability for this cohort. The question is whether it can be established and sufficiently financed within the time and resources currently available.

Establishing Reinsurance in California

Reinsurance is a costly program and it does not lower healthcare costs overall, but rather redistributes them. At the end of the day, someone has to pay for large healthcare bills, either entirely or in part: carriers; patients (through large medical bills and/or higher premiums); providers (through unpaid claims); or an extramural fund. Reinsurance could be that extramural fund, with either state[li] or federal government financing, or both.

Federal funding for a California reinsurance program

As of publication of this paper, there are several federal reinsurance legislative proposals on the table. Consumers Union considers a permanent and federally financed reinsurance program as in the best interest of consumers. Unfortunately, the content of each federal legislative proposal appears to be fluid and none has been put to a vote. Therefore, as it currently stands, there remains only one clear avenue for federal funding of a California reinsurance program: a 1332 Waiver.

Financing Through a 1332 Waiver

If California were to apply for a 1332 Waiver, it would need to satisfy the four prerequisites required by HHS in the waiver application. See Appendix III for a detailed application of the guardrails, which California would meet.

Certainly, a reinsurance program established in California through a 1332 Waiver would require substantial state-based funding. The total price tag for the state depends on a few factors: (1) the premium reduction size targeted by the state and (2) what fraction of the cost of the program will be federally subsidized. For example, the cost to achieve an approximately 7% (on aggregate) reduction in premiums is estimated at about $1 billion in 2019.[lii] A seven-percent reduction may not be enough to make health coverage truly affordable and, for each increase in reductions, the cost to fund grows. A more sizeable premium reduction of 13.8% could increase on-Exchange enrollment by 5,000 to 30,000 enrollees, and off-Exchange enrollment by 25,000 to 175,000 enrollees, but would require a $1.3 billion budget to fully fund. If tax savings are applied to lower the total reinsurance expenditures, the net cost is estimated as 30%-40% of the reinsurance funding, or $390 million to $520 million.[liii]

Already-approved 1332 Waiver reinsurance programs are useful guides for California, but not perfect maps. Because federal funding of such a program is largely based on the share of the individual market enrollment that is subsidized, no two state programs will be financed the same. In California, approximately 52% of individual market enrollees received premium subsidies in 2016, compared to 23% in Minnesota, 39% in Oregon,[liv] and 66% in Alaska.[lv] In the end, the extent to which federal funding would supplant required state reinsurance contributions would depend on an actuarial analysis and negotiations with the U.S. Department of Health and Human Services.[lvi]

Although a 1332 Waiver, if secured, would result in partial federal funding, the state would need to provide some dollars of its own. Questions loom about the practicability of California financing its portion of a state-based reinsurance program. Although bolstered by a large tax base and enjoying a substantial and hard-earned budget surplus, California faces many competing challenges, such as natural disasters and housing shortages, which would compete with a reinsurance program for funding. California also faces the challenge that, unlike most other states, raising revenues requires either a two-thirds vote of the Legislature or a referendum by the people.

Other states have used marketplace assessments and fees on providers and insurers to underwrite the state's share of a reinsurance program. However, in California, those potential reservoirs are likely tapped-out. Insurers and health plans already pay the insurer tax and exchange fee. And California has already implemented Medicaid provider fees on managed care plans (known as the MCO tax) and most providers, with the proceeds from those fees already dedicated to other purposes. There do not seem to be any more

lines of "credit" where these sources are concerned, and trying to draw from this revenue stream could put undue pressure on the other services these assessments already support.

The state could fund the reinsurance program through an individual mandate-type tax assessment, but doing so raises policy questions. At least 76% of Californians who pay the penalty are in tax households with incomes below 400 percent of the federal poverty level.[lvii] Therefore, if a reinsurance program – which primarily benefits individuals earning over 400 percent of the federal poverty level, and the federal government – were funded by the individual mandate penalty, the effect would be that higher-income Californians would benefit from a program financed by their lower-income neighbors. Furthermore, it is unlikely that such a financing scheme would work at all, given that the individual mandate penalty would likely raise several hundred million dollars,[lviii] which would not be enough to make a substantial dent in individual health insurance premiums via reinsurance.

Finally, even with state contributions worked out, federal waiver approval would be required, and obtaining that is not a foregone conclusion in any application but perhaps more so for California and the current Administration.

State-Only Funding

If implementing a reinsurance program in California with federal approvals would be a steep climb, launching a program exclusively funded by the state may be a bridge too far and will certainly not happen in time to help in the 2019 plan year.

Additional Considerations Before Pursuing A Reinsurance Program

Implementing a state-based reinsurance program takes substantial effort for any state. For one such as California, which does not already have an early reinsurance program, the learning curve is precipitous and the time commitment substantial. In addition to passing enabling legislation, the state would have to undergo federal review and negotiate the terms of the waiver with the federal HHS. Those approvals are staff-driven and if a state such as Oklahoma can have its effort to launch a reinsurance program scuttled by HHS,[lix] the likelihood of California receiving a waiver may be all the more tenuous.

Furthermore, implementing a reinsurance program would not happen in a vacuum – funding a program like this could lower premiums for a million Californians, but it would do little to help another million Californians living under the 400 percent of the federal poverty level and still struggling to afford their insurance. In addition, because reinsurance cannot be targeted to those paying the most, it would lower premiums evenly across the board, making premiums affordable for some but not going far enough to meet the needs of many older and low-to-moderate income Californians, for example those highlighted in Table 5. Not only that, a reinsurance program that takes state dollars would divert

resources from that large and needy population. It is a tragedy of the U.S. healthcare system that such a choice has to be made, but it is one that must be made nonetheless. Fortunately for consumers – and especially those above the 400 percent cut-off – there are other policy options[lx] that would improve affordability namely eliminating the subsidy cliff that gives rise to situations like that highlighted in Appendix I.[lxi]

Conclusion

In analyzing reinsurance program options, two things are clear: (1) reinsurance is a program that is proven to lower overall premiums and improve affordability for consumers, and (2) the backbone of an effective reinsurance program is substantial and reliable funding. Having considered whether to recommend this policy tool for the 2019 plan year, we find that although reinsurance is strong when considered in a vacuum, given the high costs and challenging implementation as well as other policy alternatives, a California reinsurance program is not the best path to health insurance affordability for Californians in 2019.

Consumers Union believes that all Americans deserve healthcare and coverage that is accessible and affordable. To meet that ideal, policies must be adopted that ease the burden of premiums on the millions of consumers, one sub-group of whom are those eligible to purchase non-group health insurance but not qualified for a premium tax subsidy. Reinsurance dials down premiums, making insurance more affordable for consumers who pay the full sticker price for their health insurance. Yet, it comes with a price tag that makes it a heavy lift for state policymakers who must balance it with other budget priorities. That is why Consumers Union supports a permanent federally-funded reinsurance program, which could be applied evenly for all consumers regardless of where they live, with adequate and secure financing.

At this time, the absence of substantial and secure federal funding, and the seemingly insurmountable barrier of launching a state-based program in time for rate setting for 2019 and open enrollment in October, mean a state-based reinsurance program is not the clear solution for California in 2019. While not the right choice for California in the very near term, it remains an option to consider in the future or one that could be more viable should a federal reinsurance program re-emerge.

Appendix

Appendix I: The Annual Cost of A $2 Increase in Household Income Over

Region	Difference in Premium Cost for the Consumer
Fresno	$3,916
Monterey	$9,978
Sacramento	$5,326
San Diego	$3,696
San Francisco	$6,146
Shasta	$8,275
Sonoma	$5,532

The table at left shows the increase in premium a 60-year-old consumer would pay in each listed region, with the only change in circumstances being a $2 increase in household earning. This table assumes the consumer purchases the lowest cost Silver product in the region regardless of provider network.

Appendix II: Pending Reinsurance Waivers

- Idaho: this reinsurance plan appears to be a conversion of the state's Individual High-Risk Pool. It would reinsure carriers for specific high-risk medical conditions, at a cost of $16 million. Idaho anticipates that converting these high-risk individuals will lower federal APTC costs.
- Oklahoma: prior to being withdrawn, this waiver program would have partially reimbursed plans for enrollees whose claims exceed an attachment point, up to a cap. Funded partly through a state assessment on fully-funded and self-funded health insurers, partly by federal pass-through based on lowered APTC payments.
- Maryland: the state proposed a reinsurance program for the its health insurance marketplace. This program would be funded by $380 million in taxes on insurers and is expected to reduce premiums by about 21%. The legislation[lxii] behind the reinsurance program mandates submission of a 1332 Waiver application to establish a reinsurance program using federal pass-through funding. Signed into law in April 2018, Maryland is at the early stages of the 1332 Waiver application process.
- New Hampshire: this proposal would be funded by an assessment on the broader health insurance market, using the same assessment base that funded the state's high-risk pool. That pool raised about $32 million per year. The reinsurance arrangement would be based on the federal transitional reinsurance program model. It would also draw federal pass-through dollars from lowered APTC

expenditures. Due to reluctance by the Governor, centered on the assessment on insurers, this application is on hold.

- New Jersey: the state's reinsurance program, the Health Insurance Premium Security Plan, was signed into law by the governor on May 31, 2018. Funding is based on a combination of federal pass-through savings from the 1332 Waiver and the New Jersey Health Insurance Premium Security Fund, which is supported at least in part with taxes imposed via the state's new individual mandate. This program is intended to reduce premium rates between 10% and 20% from what would otherwise be charged. Implementation of the reinsurance program is pending approval of a 1332 Waiver.
- Wisconsin: the state submitted to HHS a 1332 Waiver in April, 2018, to create a reinsurance program. The state expects the program to cost $200 million and to reduce premiums by 5% in 2019. The Wisconsin reinsurance program would cover carriers for 50% of medical claims between $50,000 and $200,000 starting in 2019. The program would be funded by a combination of federal pass-through dollars and appropriations from the general fund.

Appendix III: Satisfaction of the Four 1332 Guardrails – California Analysis

Criteria 1: Provide coverage that is at least as comprehensive in covered benefits

A reinsurance program would not require changes to covered benefits for those purchasing in the individual market under a 1332 Waiver. And it is unlikely that California would unilaterally elect to do so. It is equally unlikely that the California reinsurance program would impact EHBs for the commercial markets, or impact the scope of services required to be covered by the Medicaid or CHIP programs.

Criteria 2: Provide coverage that is at least as affordable

A reinsurance program enacted through a 1332 Waiver is unlikely to affect affordability. Individuals who receive a premium tax subsidy would experience little-to-no change in their insurance premiums because their contributions are based on a percentage of income. Instead, consumers most affected by a reinsurance program are the 1.1 million Californians with incomes in excess of 400 percent of the federal poverty level[lxiii]; those consumers would experience premium reductions. According to an analysis by Milliman, a reinsurance program could provide consumers with premium reductions ranging from 10 to 20 percent, depending on how the program is designed.[lxiv]

Criteria 3: Provide coverage to at least as many state residents

For the same reasons a properly implemented reinsurance program is unlikely to reduce coverage to residents in other states that adopt the program, a California reinsurance program would lead to coverage of more, not fewer, state residents. As premiums go down in direct response to the reinsurance program, enrollment would rise – particularly among

the more than one million unsubsidized Californians who pay the full cost for their insurance. The newly enrolled would also likely be slightly younger and healthier relative to the current individual market (the "baseline market"), because these are the consumers most likely to forgo insurance because of lack of affordability. Although it is foreseeable that the combination of rising individual health insurance premiums and a lack of an individual mandate[lxv] would together reduce the number of additional enrollees covered under the waiver scenario relative to the baseline scenario, that would be a result of factors outside of the reinsurance program.

For Californians under 400 percent of the federal poverty level, the outcome of the reinsurance program would be different. According to an analysis submitted as part of the Alaska 1332 Waiver, the authors anticipated that some consumers in the 300-400 percent federal poverty level would become uninsured.[lxvi] However, they also reported that "the number of subsidized individuals expected to pay higher premiums in the waiver scenario relative to the baseline scenario will be nominal."[lxvii] A similar scenario is foreseeable in California.

Finally, reinsurance programs help maintain a stable market and make continued market participation less risky for carriers. It is generally accepted that more participation means more competition in the marketplace, and more competition benefits consumers by offering choice as well as controlling prices. Each of these further underscores that a reinsurance program in California, as well as any other state, would increase rather than decrease the number of covered state residents.

Criteria 4: Not increase the federal deficit

A primary benefit of launching a reinsurance program through a 1332 Waiver is the opportunity to capture federal financing to subsidize the program. This financing comes in the form of pass-throughs from the total APTCs not spent by the federal government as a result of lower premiums, deducting the small number of subsidy-eligible enrollees who take up insurance after the reinsurance program is introduced.[lxviii] Therefore, so long as the federal contribution does not exceed the estimated savings in APTC, then the waiver would not have a negative impact on the federal deficit.

Consumers, if any, who switch from employer-sponsored insurance to the individual market would reduce excise taxes on high-cost employer sponsored plans, small business tax credits, employer shared responsibility payments, and tax exclusions related to employer-sponsored insurance, which would increase costs or decrease revenues. However, the likelihood of this happening to any measurable extent is extremely slim. Although reinsurance programs are proven to reduce health insurance premiums, individual health insurance premiums start at a price point substantially higher than most employer-sponsored insurance. The likelihood of significant shifts of employees to the individual market is very small.

Finally, lowered premiums in the California individual market theoretically could have a secondary negative effect on the total amount collected through the health insurance provider fee. Rolling moratoriums on this fee – most recently on January 22, 2018 along with the continuing resolution legislation[lxix] – make it difficult to anticipate whether or the extent to which this would affect the federal deficit. If and when fees are collected, the reduction in insurer fee collection will increase over time. Overall though, experts analyzing this issue for the Alaska 1332 waiver found that associated losses would be less than two percent of the size of the savings from the reduced APTC in any given year. "On average, the size of the loss in the insurer tax is about 1.5% of the savings in APTC."[lxx]

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[i] Here and throughout this paper, "affordability" refers to both the ability to pay for premiums as well as out-of-pocket expenses.

[ii] The Center for Consumer Information & Insurance Oversight, *The Transitional Reinsurance Program - Reinsurance Contributions*, available at https://go.cms.gov/106fxlB (last accessed May 17, 2018).

[iii] *Final HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15409 at 15460 (March 11, 2013).

[iv] *Final HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13743 at 13775 (March 11, 2014).

[v] *Final HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10749 at 10777 (Feb. 27, 2015).

[vi] In the *Final HHS Notice of Benefit and Payment Parameters for 2016*, CMS reduced the 2015 attachment point from $70,000 to $45,000 and raised the attachment point for 2016 to $90,000. 80 Fed. Reg. 10749 at 10777 (Feb. 27, 2015).

[vii] Per 45 CFR §153.230(d), HHS had the authority to adjust the reinsurance coinsurance rate if all reinsurance payments requested for a benefit year would not equal the amount of contributions collected. The adjustments detailed on page two of each of the *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers* for each of the benefit years 2015, 2016, 2017 are shown in this row.

[viii] CMS *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for 2014 Benefit Year*, (September 17, 2015), at p.2.

[ix] Per the CMS *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for 2015 Benefit Year*, (June 30, 2016), this amount was subject to change, either upward or downward, depending on the difference between projected and actual reinsurance contribution collections, discrepancies, and appeals.

[x] Per the CMS *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for 2016 Benefit Year*, (June 30, 2017), this amount was subject to change, either upward or downward, depending on the difference between projected and actual reinsurance contribution collections, discrepancies, and appeals.

[xi] American Academy of Actuaries, *Issue Brief: Drivers of 2016 Health Insurance Premium Changes*, (August 2015).

[xii] American Academy of Actuaries*, Issue Brief: Drivers of 2017 Health Insurance Premium Changes, (May 2016).*

[xiii] *Id.*

[xiv] In the first quarter of 2018, for example, at least three federal bills were introduced but never voted on: the Lower Premiums Through Reinsurance Act of 2017 (S. 1835); the Premium Relief Act of 2017 (H.R. 4666); the Bipartisan Health Care Stabilization bill (S. 1771).

[xv] Letter to House and Senate leaders signed by America's Business Benefit Association, Communicating for America, Inc., Council for Affordable Health Coverage, Express Scripts, Healthcare.com, Healthcare Leadership Council, HealthSherpa, HR Policy Association, International Cancer Advocacy Network, National Association for the Self-Employed, National Association of Health Underwriters, NFP, National Retail Federation, and the U.S. Chamber of Commerce, (dated February 26, 2018).

[xvi] Covered California, *Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance*, (January 10, 2018). State-specific premium reductions are estimated to range from 9 to 16 percent, depending on enrollment and risk mix within each state.

[xvii] UC Berkeley Labor Center, *Memo to Covered California Re: Individual Market Effects of Eliminating the Individual Mandate Penalty*, (May 9, 2018).

[xviii] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018) at Exhibit 2, page 9.

[xix] The Urban Institute recently reported: "Some insurers cited the end of the ACA's reinsurance payments in 2016 as an important factor in opting out, especially because they considered risk adjustment insufficient to correct for high-cost patients. Reinsurance payments would have helped to mitigate this concern, if they had not sunset." Urban Institute, *Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018*, (November 2017), at p.7.

[xx] State Health Value Strategies, *State Options for Responding to Federal Changes to the Individual Market*, (January 4, 2018).

[xxi] Covered California, *Executive Director's Report*, (January 18, 2018).

[xxii] For a broader array of tools to address affordability under the ACA, please see UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018).

[xxiii] Oregon Health Authority & Governor's Office, *Implementation of the ACA: Individual & Small Group Markets*, (March 6, 2013).

[xxiv] The program in Maine is a prospective reinsurance program, also known as an "invisible high-risk pool."

[xxv] This assessment excludes the Individual market assessment.

[xxvi] Gorman Actuarial, LLC, *The Impact of PL90 on Maine's Health Insurance Markets*, Prepared for the Maine Bureau of Insurance (December 2011).

[xxvii] *See* memo on the suspension of the MGARA program, *MGARA Suspension FAQs*, available at http://www.mgara.org/FAQs.pdf. (Last accessed May 24, 2018.) In summary, the Maine invisible risk pool was suspended in 2014, upon the start of the federal transitional reinsurance program in Maine, because it served the same function as the federal program and was funded from similar market-based assessments, with the federal program prioritized in receiving those funds.

[xxviii] CMS.gov, *Section 1332: State Innovation Waivers*, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html (accessed March 7, 2018).

[xxix] Julie Sonier, *MinnesotaCare: Key Trends & Challenges*, Vol. 2 Issue 1.

[xxx] Table adopted from Manatt Health, *State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States*, (March 2018). Table 2. Overview of Approved 1332 Reinsurance Waiver Funding for 2018.

[xxxi] These five questions for evaluating the impact of a California reinsurance program are based on a set of questions and explanations offered by Manatt Health in their recent report, *State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States*, (March 2018).

[xxxii] Kaiser Family Foundation, *Marketplace Average Benchmark Premiums*, web site available at https://kaiserf.am/2IiNj2x, (accessed May 14, 2018).

[xxxiii] Known as the "5/50 rule," it is estimated that 5% of enrollees will account for 50% of costs.

[xxxiv] Milliman, *Reinsurance Estimates for 2019-2021*, (February 14, 2018).

[xxxv] For example, according to the California HealthCare Foundation, women living in Paramount are more than twice as likely to undergo a cesarean section as women living in Grass Valley. Also, women living in Gardena are six times more likely to have an an electively induced birth as compared to women living in Napa. California HealthCare Foundation, *All Over the Map: Elective Procedure Rates in California Vary Widely*, (November 2014).

[xxxvi] Kaiser Family Foundation, *Estimates of Eligibility for ACA coverage Among the Uninsured in 2016*, (October 25, 2017). In their analysis of the 2016 National Health Interview Survey, the authors found that "a very small share of the uninsured population – about 2% in 2016 – say that the reason they go without insurance is because they don't want coverage."

[xxxvii] U.S. Center for Disease Control and Prevention National Center for Health Statistics, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2017*, (May 2018). From its 2017 survey results, the CDC reported that the uninsured rate in California was 6.8 percent; half of this number, or roughly 3.4 percent of Californians, were "eligible uninsured."

[xxxviii] Kaiser Family Foundation, *Estimates of Eligibility for ACA coverage Among the Uninsured in 2016*, (October 25, 2017).

[xxxix] UC Berkeley Labor Center, *Taking Stock: Californians' Insurance Take-up Under the Affordable Care Act*, (October 24, 2016).

[xl] California Health Care Foundation, Health Insurance and Health Care Affordability Perceptions Among Individual Insurance Market Enrollees in California in 2017, (May 31, 2018).

[xli] *Id.*

[xlii] For a complementary analysis of the percentage of household income that could be spent when a household income rises just above the premium subsidy threshold, see Covered California, *Older Californians Struggle to Afford Lowest-Cost Plans on Covered California*, (May 14, 2018).

[xliii] For the 2018 plan year, 30 states, including California, instructed health insurance plans and carriers to load all expected CSR costs into their silver marketplace premiums. For more on this surcharge, also known as "silver loading," *see* The Commonwealth Fund, *States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments*, (October 27, 2017).

[xliv] Bureau of Labor Statistics, *Consumer Expenditures for the San Francisco Area: 2015-2016*, (December 5, 2017).

[xlv] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018).

[xlvi] *Id*.

[xlvii] Covered California, *Covered California's Health Insurance Companies and Plan Rates for 2018*, (August 1, 2017). Although this plan book details the preliminary rates, rather than the final rates after the rate review period, the weighted average of the finalized rates remained unchanged.

[xlviii] Covered California, *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With WIde Variation Among States*, (March 8, 2018) at p.2.

[xlix] This assumes California does not implement its own individual mandate.

[l] According to Covered California's analysis, non-enforcement of the penalty is projected to cause premiums to rise by 8-13 percent, depending on the carrier and state local circumstances, with other experts weighing in on premium increases ranging from 5-9 percent to 15-30 percent and possibly even higher for some carriers. Covered California, *Reducing Premiums and Maximizing the Stabilization of Individual Markets for 2019 and Beyond: State Invisible High-Risk Pools/Reinsurance*, (Jan. 10, 2018); Health Affairs, *Eliminating the Individual Mandate Penalty in California: Harmful But Non-Fatal Changes in Enrollment and Premiums*, (March 1, 2018); Covered California, *Executive Director's Report*, (January 18, 2018).

[li] State funding for this program could derive from provider or plans fees, as other states have used. However, other pressures on those potential revenue streams make pursuing that option a challenge in California.

[lii] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018), citing Milliman, *Individual Health Insurance Market Profile: State of California,* (2015). According to the UC Berkeley Labor Center, "Gross reinsurance spending of $1 billion in 2019 would be approximately 7% of estimated aggregate individual market premiums in that year, using 2015 actual aggregate premiums from Milliman adjusted up by 7% annually to estimate premium growth." Notably, the extent to which premiums would be reduced would vary based on the risk mix of each plan.

[liii] PricewaterhouseCoopers, *Impact of Individual Mandate Penalty Elimination and Other Market Factors on Coverage Nationally and in California*, Prepared for Covered California Board Presentation May 17, 2018.

[liv] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018), citing Minnesota Department of Commerce, Division of Insurance, *Minnesota Section 1332 Waiver Application*, (May 20, 2017); Minnesota Department of Commerce, Division of Insurance, *Minnesota Section 1332 Waiver Application*, (May 20, 2017); Oregon Department of Consumer and Business Services, *Oregon 1332 Draft Waiver Application*, (August 31, 2017); Oliver Wyman, *Alaska 1332 Waiver Application*, (undated).

[lv] This percentage is 66% of individual market enrollees including individuals enrolled in grandfathered and transitional plans, receiving premium tax credits during the first nine months of 2016.Oliver Wyman, *Alaska 1332 Waiver Application; Actuarial Analysis and Certification*, (undated, likely 2017), based on an analysis of enrollment information provided by Moda and Premera.

[lvi] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018).

[lvii] *Id*. at p.10 and footnote 30.

[lviii] Californians paid $378 million in penalties in 2015, according to preliminary IRS tax data, which does not include any corrections or adjustments made by the IRS. Internal Revenue Service, *Individual Income Tax Returns: Selected Income and Tax Items by State, County, and Size of Adjusted Gross Income, Tax Year 2015*, available at https://www.irs.gov/pub/ irs-soi/15incyca.xls.

[lix] Oklahoma withdrew its 1332 reinsurance waiver in September, 2017, stating: "lack of timely waiver approval will prevent thousands of Oklahomans from realizing the benefits of significantly lower insurance premiums in 2018." Letter from Terry Cline, PhD, Secretary of Health and Human Services and Commissioner of Health for the Oklahoma State Department of Health, to the Secretary of the United States Department of the Treasury and the Secretary of the United States Department of Health & Human Services, *Re: Oklahoma 1332 Waiver Withdrawal*, (dated September 29, 2017).

[lx] In the 2018 California legislative session, proposed legislation includes: AB 2565 (Chiu), which increases premium assistance; AB 3148 (Arambula), which increases cost sharing assistance; AB 2459 (Friedman), which improves premium assistance and creates a tax credit; SB 1255 (Hernandez), which increases premium assistance..

[lxi] For a deeper dive, see UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018).
[lxii] Maryland state Senate bill No. 1267.
[lxiii] UC Berkeley Labor Center, *Towards Universal Health Coverage: California Policy Options for Improving Individual Market Affordability and Enrollment*, (March 5, 2018).
[lxiv] Milliman memo to John Bertko, Chief Actuary of Covered California, *Re: Reinsurance Program Estimates for 2019-2021*, (dated February 14, 2018).
[lxv] Assumes no state-based individual mandate in California.
[lxvi] Oliver Wyman, *Alaska 1332 Waiver Application; Actuarial Analysis and Certification*, (undated, likely 2017), at p.14. Their explanation is: "Some subsidized individuals are expected to select benefit plans that have a lower premium than the second lowest-cost silver plan. In some instances, the reduction in the [premium tax subsidy] the [individual] receives in the baseline scenario compared to the waiver scenario does not entirely offset the reduction in observed premium for the selected plan. In those cases, the [individual] would pay a higher premium, net of [premium tax subsidy], in the waiver scenario relative to the baseline scenario."
[lxvii] *Id*.
[lxviii] Institute of Social and Economic Research, *Alaska 1332 Waiver - Economic Analysis (prepared for the Alaska Division of Insurance*), (December 5, 2016), stating: "Almost every person induced to take up insurance in the individual market by the waiver is at or above 400 percent of the poverty line, and therefore will not receive an APTC after joining the individual market."
[lxix] H.R. 195, Division D - Suspension of Certain Health-Related Taxes, §403.
[lxx] Institute of Social and Economic Research, *Alaska 1332 Waiver - Economic Analysis (prepared for the Alaska Division of Insurance*), (December 5, 2016) at p.13.