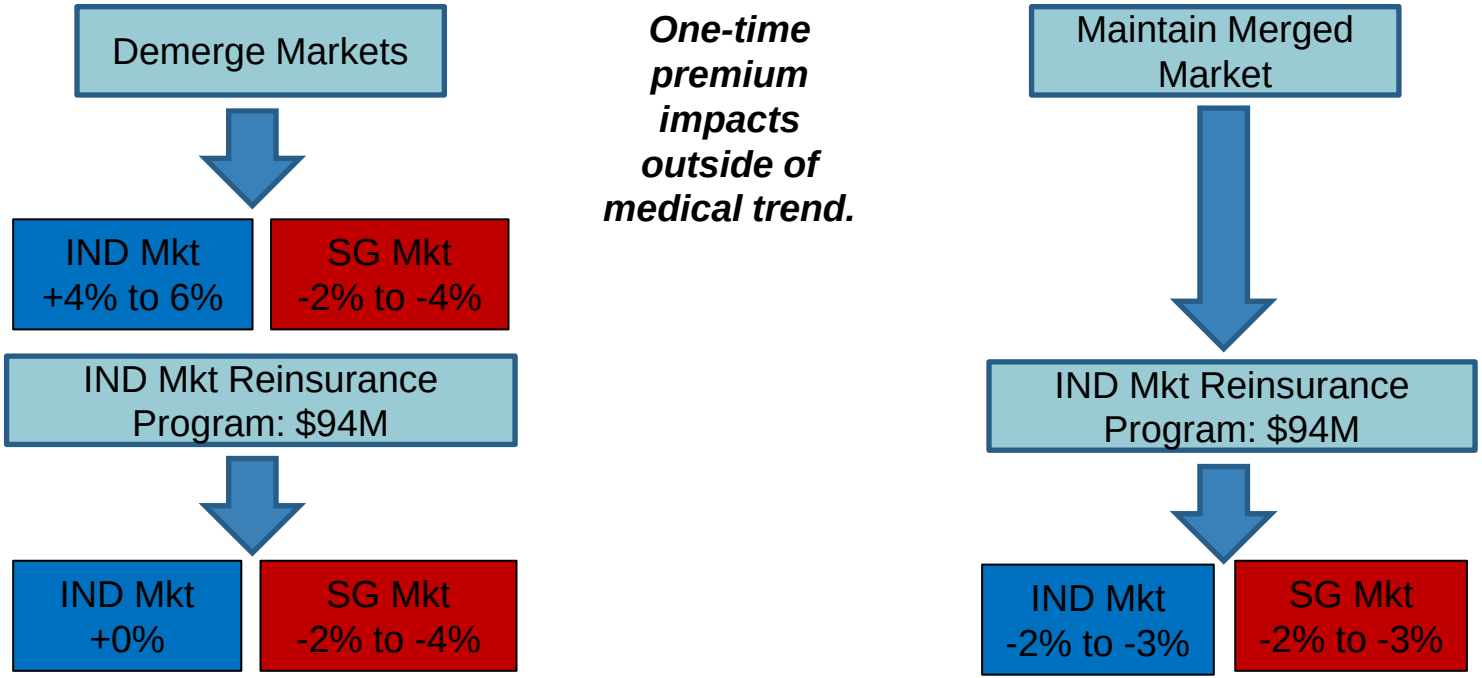
Reinsurance Programs & Funding

Bela Gorman, FSA,MAAA

Policy Comparison: Best Estimate Comparison - Recap



Section 1332 Waiver & Federal Funding

Section 1332 – State Innovation Waiver

- ***What is a 1332 Waiver?*** ***Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a "State Innovation Waiver" to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.***

- ***How does it work?*** ***If the state can demonstrate that a strategy can save the federal government money, the federal "savings" can then be used by the state to implement the health policy.***

- ***Where does the federal savings come from?*** ***The federal government pays premium tax credits for individuals earning less than 400% of the federal poverty level (FPL) to purchase health insurance through the marketplace (i.e., the MA Health Connector). The savings come from a reduction in premium tax credits, which can then be used to support the state's innovative health policy.***

Federal Premium Tax Credits
Step 1: Calculate what the enrollee pays

CY 2021				Enrollee's Share of Monthly Premium	
Federal Poverty Level	Annual Income of Single Household	Annual Income of Family of Four	Premium Contribution (% of Income)	Single Household	Family of Four
133%	$16,970	$34,846	3.1%	$44	$90
150%	$19,139	$39,300	4.1%	$66	$136
200%	$25,519	$52,400	6.5%	$139	$285
250%	$31,898	$65,500	8.3%	$221	$455
300%	$38,278	$78,600	9.8%	$314	$644
400%	$51,038	$104,800	9.8%	$418	$858

- An enrollee's premium contribution is based on a percentage of their household income.
- For a single household earning $25,519 a year, the Affordable Care Act (ACA) requires the monthly maximum health insurance premium to be $139. (6.5% of $25,519/12)

Federal Premium Tax Credits
Step 2: Determine the second lowest costing silver plan (SLCSP)

Boston Region	2021 Silver Plan Premium - Age 40	Rank
BMC HealthNet Plan	$353.84	1
Tufts Health Plan Direct (Tufts Health Public Plan)	$366.08	2
Allways	$549.16	3
Fallon Health	$720.60	4

- The SLCSP determination is among Connector plan offerings only
- SLCSP in Boston is from Tufts Health Public Plan at $366.08

Federal Premium Tax Credits
Step 3: Determine the Advanced Premium Tax Credit (APTC)

- *Single person with annual income of 200% FPL ($25,519), Age 40, living in Boston*

  SLCS Plan's Premium (THPP) = $366.08

  Enrollee's Share of Premium = $139.00

  APTC = $366.08 - $139.00 = $227.08

- *The federal government provides $227.08 a month in subsidies towards enrollee's health insurance.*

- *APTC is determined by subtracting the member's share of the premium, based on household income and family size, from the SLCSP's premium.*

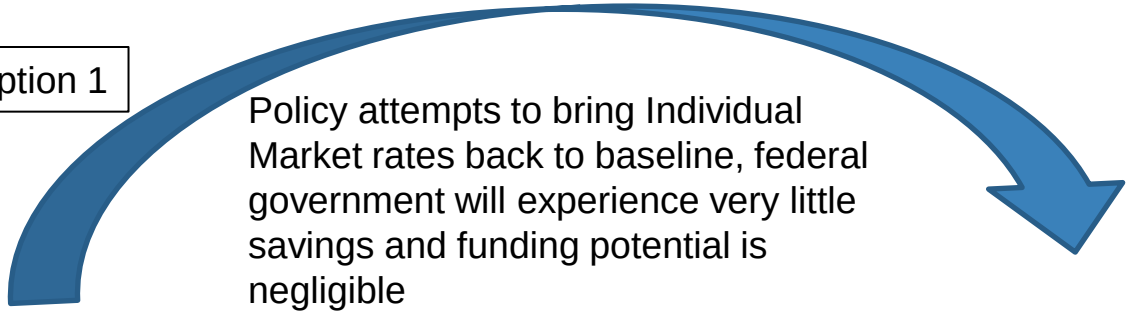
How Section 1332 Waiver Funds are Determined

Premium Tax Credits are driven by the second lowest costing silver plan rate (SLCSP) offered to ConnectorCare market

How Section 1332 Waiver Funds are Determined

Demerge Markets With Reinsurance Program
Unclear how CMS will Interpret the Baseline

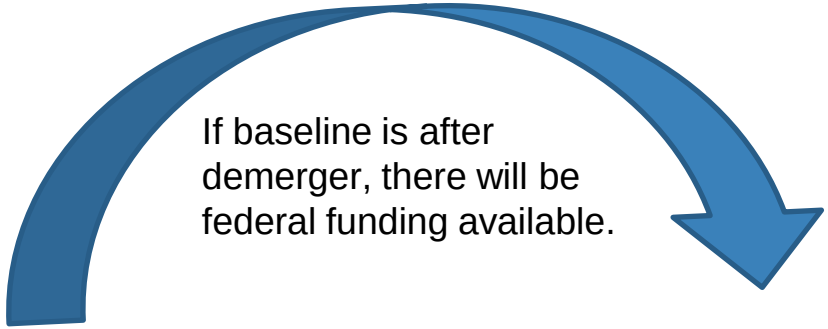
Option 1



How Section 1332 Waiver Funds are Determined

Demerge Markets With Reinsurance Program
Unclear how CMS will Interpret the Baseline

Option 2



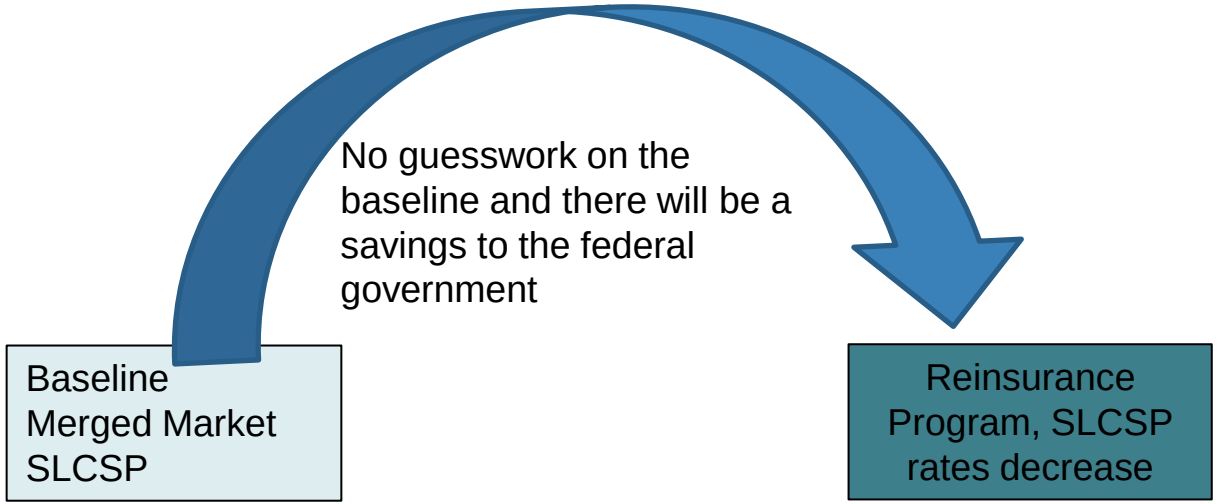
Merged Market SLCSP

Baseline Demerge Market SLCSP Increases

Reinsurance Program SLCSP Decreases

How Section 1332 Waiver Funds are Determined

Merge Markets With Reinsurance Program
Baseline much more clear



Reinsurance Program Design Recap

	Target Population	Distribution of Funds
Program Design 1	High Risk/Cost population but not the highest	More evenly distributed across insurers
Program Design 2	Highest Risk/Highest Cost population	Targeted towards insurers with highest risk

- There are many possible ways to create a reinsurance program --
- The structure of the program can be designed to achieve target policy goals. For example:
  - Is the policy goal to target highest cost individuals?
  - Is the policy goal to maximize federal funding?
  - Is the policy goal to put downward pressure on provider reimbursement?
- Not all policy goals can be met with the same program design.

Reinsurance Program Design – Processes in Other States

- Oversight of the reinsurance program varies by state
  - Creation of separate board or commission: (NJ, ME, DE)
  - Oversight within the Exchange (MD,RI)
  - Oversight within the DOI (NH, PA)

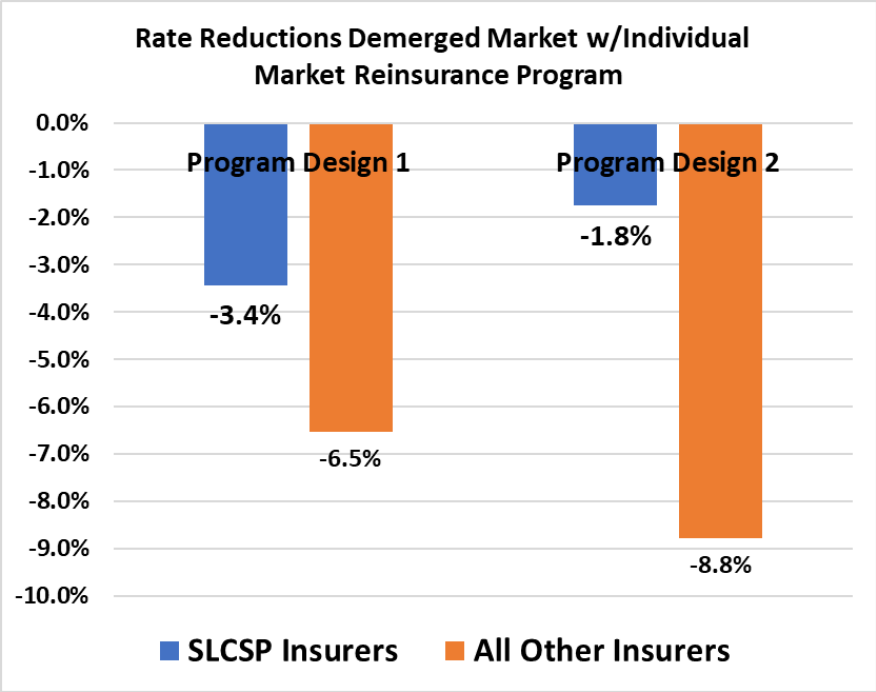
- Each year data is reevaluated, modeling performed, and states assess funding availability. Based on these analyses the reinsurance program design (parameters) are established.

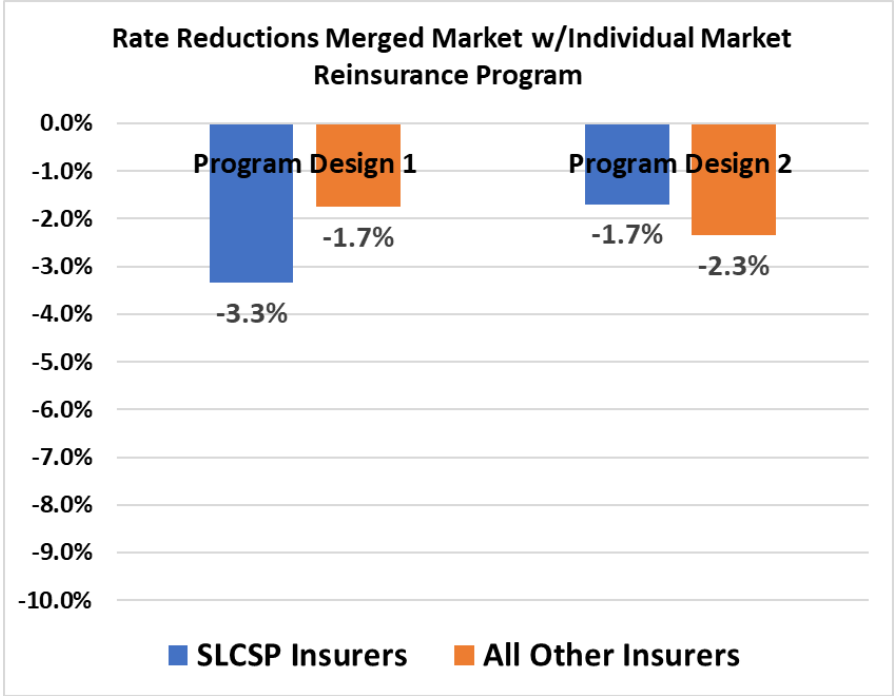
- Parameters: Attachment points, and reinsurance percentage

- The program design can change each year and is usually determined right before rate filings are submitted.

- These parameters can change from year to year.

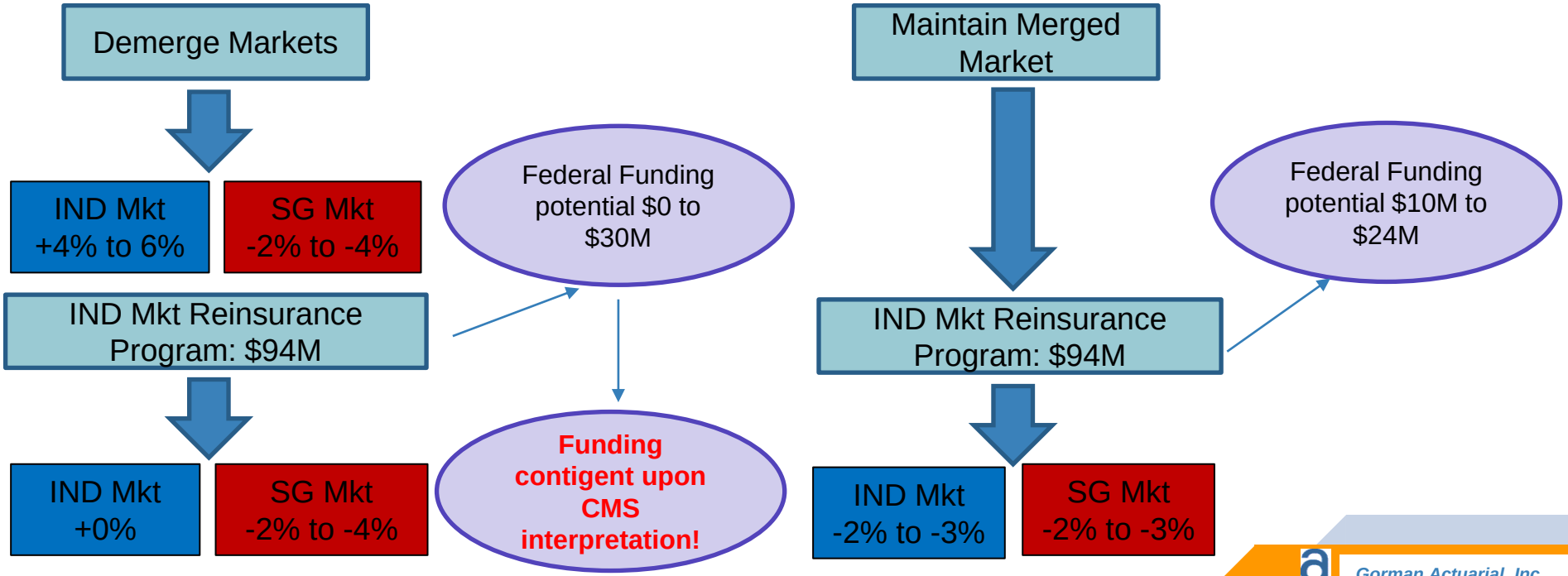
Reinsurance Program Premium Impacts





Policy Comparison: Best Estimate Comparison - Recap

One-time premium impacts outside of medical trend.



Key Takeaways from Federal Funding Analysis

- If the state introduces a health policy (e.g., reinsurance program) that lowers the premiums for the SLCSP, the result will be a savings to the federal government. The state can then apply to use these savings as part of a Section 1332 waiver.

- In Massachusetts, the insurers that have the SLCSP are not the insurers with the highest risk individuals.

- A policy designed to target the insurers with the highest risk individuals may result in smaller federal funding opportunity.

- Also, if we choose to demerge which increases individual market rates - and then apply a reinsurance program, it is unknown at this time whether CMS will consider the baseline as when we were merged or after demerging. If they consider baseline as when we were merged - then there will be no opportunity for federal funding.

- A reinsurance program can't be funded by federal funding alone – there must be state investments as well.

Funding Ideas

- State Assessments:
  - NH, ME,MD,ND,OR,MT
  - All insured markets
- Individual Mandate Penalty
  - RI, NJ
- General Funds
  - Alaska, CO (fees on hospitals), MN

Sources: "*CCIIO Data Brief: State Relief and Empowerment Waivers: State-based Reinsurance Programs,*" Centers for Medicare and Medicaid Services, June 2020; and "*The Benefits and Limitations of State-Run Individual Market Reinsurance Programs*," The Commonwealth Fund, November 2020.

Any assessment will increase rates for applicable population and reduce the impact of the reinsurance program

To Fund $94M

MA Assessed Population Scenarios	Membership	PMPM Assessment	Premium Charge
Fully Insured and Self Insured Membership	3,980,000	$2.00	0.4%
Fully Insured Only	1,690,000	$4.60	0.9%
Exclude Merged Market Fully Insured and Self Insured Large Group Membership	3,230,000	$2.40	0.5%
Fully Insured Large Group Membership	940,000	$8.30	1.6%

Enrollment estimated based on Aug 2020 CHIA reports
All numbers are rounded.

Discussion Topics & Questions

- How to finalize the reinsurance parameters/program design?
  - Need to determine policy goal.
  - Need to determine the amount of funding.
  - Need to determine the underlying provider reimbursement.
  - Will require a refresh of data for the individual market.
- The program design can change each year and is usually determined right before rate filings are submitted.
- Where will the state funding come from? Will the funding be sustainable forever?
- Are there other funding sources the state can explore?
- If the state chooses an assessment – which populations will be assessed. If the merged market is assessed, the reinsurance program impact gets smaller.

Disclosures and Limitations

Limitations and Data Reliance

Gorman Actuarial prepared this presentation for use by the Massachusetts Merged Market Advisory Council. While we understand that this document may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This presentation should only be distributed in its entirety.

Users of this presentation must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented. The presentation addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this presentation was based on data provided by the MA DOI, insurers in the Massachusetts health insurance markets, the MA Health Connector, and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The results presented in this report are estimates based on complex actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. Actual experience will most likely not conform exactly to the assumptions used in this analysis. Actual results will differ from projected results to the extent that actual experience deviates from expected experience. **Given the many unknowns, we have not yet accounted for changes that may occur in these markets due to the impact of COVID-19.**

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 4, 2020. If subsequent changes are made, these statements may not appropriately represent the expected future state.

Qualifications

This study includes results based on actuarial analyses conducted by Bela Gorman and peer reviewed by Jenn Smagula, both of whom are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.