shadac

STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Modeling State-based Reinsurance: One Option for Stabilization of the Individual Market

Brett Fried, Lynn Blewett, Coleman Drake

AcademyHealth Annual Research Meeting • June 24, 2018 • Seattle, Washington

Acknowledgments

- Funding for this work is supported by the Robert Wood Johnson Foundation

- Coauthors:
  - Lynn Blewett (SHADAC)
  - Coleman Drake (University of Minnesota)

Subsidized Reinsurance
What is it? and why use it?

What is it?

Provides subsidies to insurers to offset the risk of very high health care expenses.

Why use it?

In the context of the individual market the purpose is to:

- Reduce premiums
- Stabilize the market
- Attract and keep insurers

Why should states care about reinsurance?

Some state's individual markets are struggling.

From 2017 to 2018 health insurance marketplaces in **12 states**:

- Lost over 30% of their issuers
- Had premium increases of over 50%

Repeal of the individual mandate penalty will increase instability.

In 2019 the individual mandate penalty will be $0 which will likely:

- Increase premiums
- Decrease stability

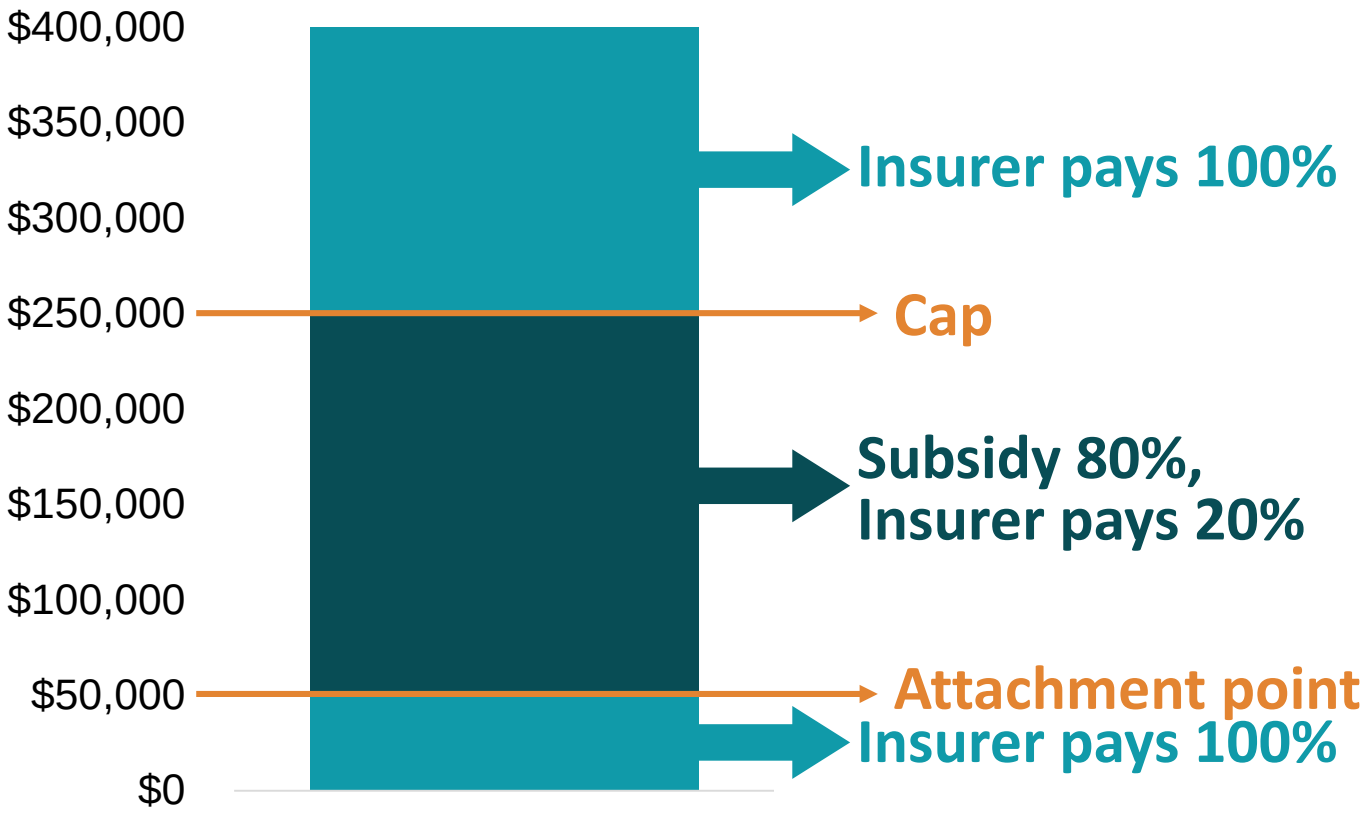
Sources: Kaiser Family Foundation—Note: Percent increase is for average benchmark premiums and issuers are defined as issuer of an individual qualified health plan: https://www.kff.org/state-category/health-reform/health-insurance-marketplaces/

Congressional Budget Office—Repealing the Individual Health Insurance Mandate: An updated estimate. https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf

Hypothetical Example

Expense: $400,000
Attachment point: $50,000

Cap: $250,000
Coinsurance: 80/20%



Potential federal funding sources for reinsurance in states

Pass-through of federal savings in premium tax credits through 1332 waivers

- Approved waivers : AK, MN & OR
- Submitted waivers: WI, ME
- Withdrawn waivers: IA & OK
- Draft applications: ID, LA, MD & NH

Potential funding through federal legislation

- No bills have been signed into law but some include funding for reinsurance in states

Source: SHADAC-Resource-1332-state-innovation-waivers-state-based-reinsurance-http://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

ACA Federal Transitional Reinsurance 2014 to 2016

Reinsurance: Attachment point and cap

- 2014-- $45,000 to $250,000
- 2015-- $45,000 to $250,000
- 2016-- $90,000 to $250,000

Coinsurance Rates

- 2014-- 100/0%
- 2015-- 55/45%
- 2016-- 53/47%

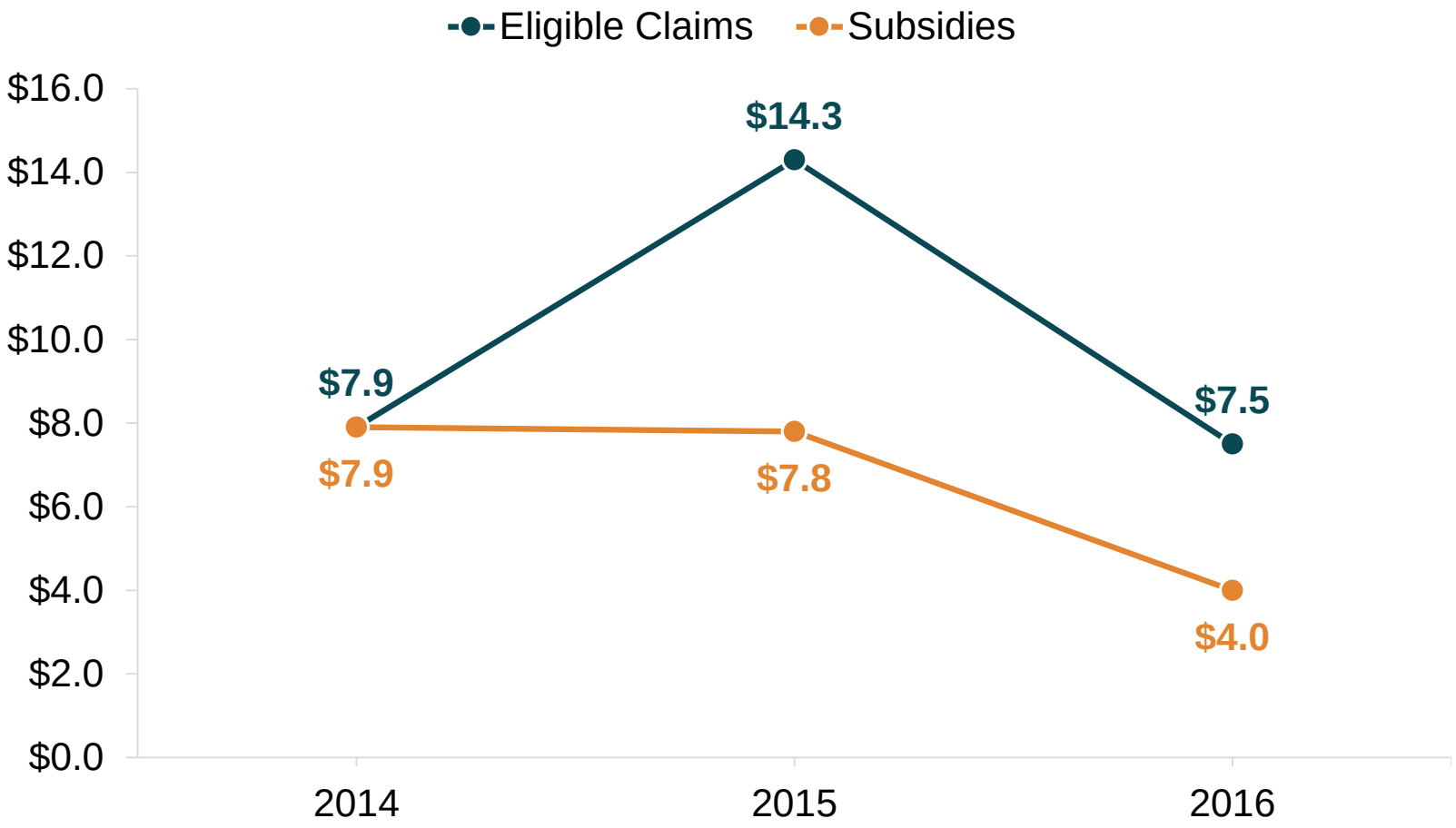
Estimated Range of Premium Reductions

- 2014-- 10%-14%
- 2015-- 6%-11%
- 2016-- 4%-6%

Source: Congressional Research Service—The Patient Protection and Affordable Care Act's Transitional Reinsurance Program https://fas.org/sgp/crs/misc/R44690.pdf

ACA Federal Transitional Reinsurance

Eligible Expenses and Subsidy Paid (in billions)



Source: Congressional Research Service—The Patient Protection and Affordable Care Act's Transitional Reinsurance Program https://fas.org/sgp/crs/misc/R44690.pdf

shadac
STATE HEALTH ACCESS DATA ASSISTANCE CENTER

1332 Waiver State Traditional Reinsurance Program Parameters

Submitted or *Approved* Waivers

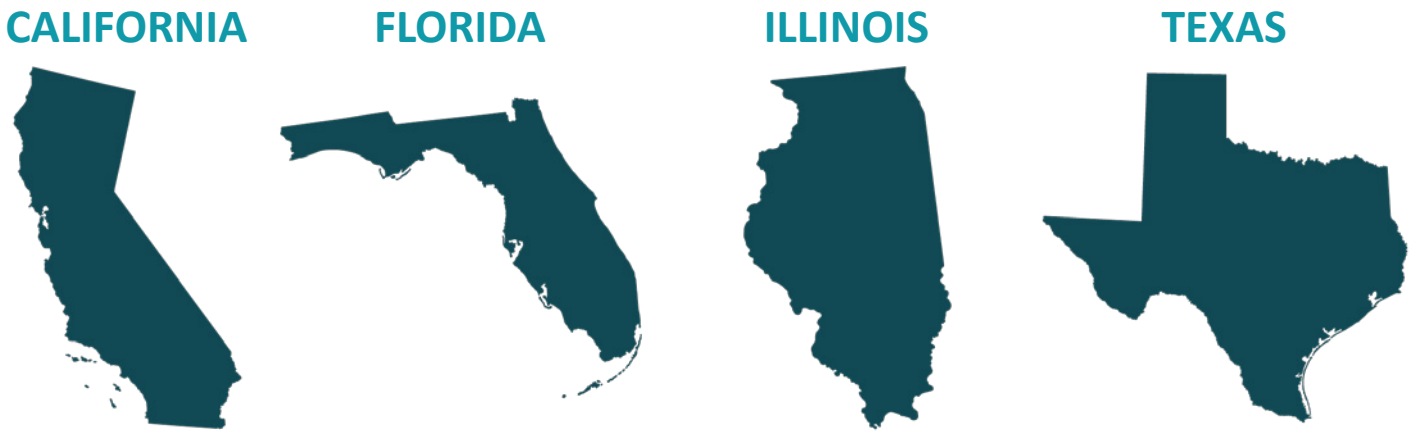
State	Attachment Point and Cap	Coinsurance rate
Iowa	$100,000 to $3,000,000	85/15%
Minnesota	$50,000 to $250,000	80/20%
Oklahoma	$15,000 - $400,000	80/20%
Oregon	TBD to $1,000,000	50/50%
Wisconsin	$50,000 to $250,000	50/50%

*Note: Maine and Alaska have condition-specific reinsurance programs. Whether or not the claim is subsidized depends on the medical condition of the claimant.

Source: SHADAC-Resource-1332-state-innovation-waivers-state-based-reinsurance-
http://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

Research Question

For nonelderly (age 0-64) in the individual market, nationally and in the four states that had sufficient sample:



Given assumptions about the **reinsurance** program parameters:

- **What is the number and size of eligible expenditures?**
- **How large will the subsidy be to insurers?**

shadac
STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Methods

- We used the **2012-2015 pooled Medical Expenditure Panel Survey/ Household Component (MEPS/HC)** data to build a prediction model and then used it to estimate total expenditures in the **pooled 2014-2016 (data years) Current Population Survey (CPS).**
- Multiple imputation using predictive mean matching
- ***Covariates:*** Health status, age, sex, type of insurance coverage, race/ethnicity, educational attainment, poverty level and census region

Results

Estimated enrollment and health care expenditures (in billions) for nonelderly adults in the individual market, 2018

Enrollees	Total Expenses (billions)	Per-Capita ($)
20,000,000	$75.1	$3,700

Notes: Estimates are inflated from 2015 dollars to 2017 dollars using the medical CPI and 2017-2018 healthcare cost growth projections from the National Health Expenditure Accounts.

Source: SHADAC analysis of 2012-2015 MEPS-HC and 2015-2017 CPS-ASEC data.

Results

Estimated health care expenditures by attachment point (no cap), individual market 2018

Attachment Point	Enrollees		Total Expenses	
	Number	% of total	(billions)	% of total
>$20,000	680,000	3.4%	$35.6	47.4%
<=$20,000	19,320,000	96.6%	$39.5	52.6%
None	20,000,000	100.0%	$75.1	100.0%

Notes: Estimates are inflated from 2015 dollars to 2017 dollars using the medical CPI and 2017-2018 healthcare cost growth projections from the National Health Expenditure Accounts.

Source: SHADAC analysis of 2012-2015 MEPS-HC and 2015-2017 CPS-ASEC data.

Results

Estimated reinsurance costs with varying attachment points and coinsurance (in billions), individual market 2018

Attachment Point and Cap	Eligible Expenses (billions)	Coinsurance Rate		
		90/10%	80/20%	70/30%
$20,000 to $250,000	$20.0	$18.0	$16.0	$14.0
$40,000 to $250,000	$11.8	$10.6	$9.4	$8.2
$60,000 to $250,000	$8.0	$7.2	$6.4	$5.6

Notes: Estimates are inflated from 2015 dollars to 2017 dollars using the medical CPI and 2017-2018 healthcare cost growth projections from the National Health Expenditure Accounts.

Source: SHADAC analysis of 2012-2015 MEPS-HC and 2015-2017 CPS-ASEC data.

Results

Estimated reinsurance costs (in billions) for four states (sample size >1,000), individual market 2018

Coinsurance rate: 80/20%

Attachment Point and Cap	Reinsurance Costs (billions)				
	Top 4 States	CA	FL	IL	TX
$20,000 to $250,000	$5.1	$2.0	$1.2	$0.7	$1.2
$40,000 to $250,000	$3.0	$1.2	$0.7	$0.4	$0.7
$60,000 to $250,000	$2.1	$0.8	$0.5	$0.3	$0.5

Notes: Estimates are inflated from 2015 dollars to 2017 dollars using the medical CPI and 2017-2018 healthcare cost growth projections from the National Health Expenditure Accounts.

Source: SHADAC analysis of 2012-2015 MEPS-HC and 2015-2017 CPS-ASEC data.

Summary

1. We estimate total expenditures of about $75 billion in the individual market and that 3.4% of the nonelderly in the individual market spend 47.4% of total expenditures.
2. Our results show that subsidy amounts (using different attachment points and a coinsurance rate of 80/20%) vary from $6.4 billion to $16 billion
3. Estimated reinsurance costs in the 4 states included in the analysis vary from close to $300,000 in Illinois to $2 billion in California using different attachment points and an 80/20% coinsurance rate.

Implications for policy and research

Federal

- Our estimates are in the range of those found for the ACA federal transitional reinsurance program and the $10 billion per year amount included in one of the congressional bills

State

- Key to understanding the potential benefit of reinsurance and choosing the right reinsurance parameters is knowing the spending levels of top spenders in the state

Data

- Using the MEPS/CPS has downsides and upsides
  - Sample size at the state level is still limited
  - Very high spenders not included in the MEPS data
  - Rich set of covariates in the CPS
  - Includes the uninsured

Future Research

- Change the corridor to reflect other potential attachment points, coinsurance rates and caps.
- Examine how the subsidy level would change if we excluded those between 100% and 138% FPL in non-expansion states
- Expand the model to include the uninsured who are eligible for tax credits in the individual market
- Add more years of data to improve sample size

Thank you!

SHADAC Resources for 1332 State Waivers

Up to date waiver descriptions:
http://www.shadac.org/publications/resource-1332-state-innovation-waivers-state-based-reinsurance

Coming soon:
"Use of 1332 Waivers to Stabilize State Individual Markets: Findings from Structured Interviews in Alaska, Minnesota, and Oregon"

shadac
STATE HEALTH ACCESS DATA ASSISTANCE CENTER