Last summer, as insurers filed their individual health insurance plan rate premiums for 2017, it became clear that something was wrong: Rates in 31 states shot up by double digits (triple digits for Arizona); overall, the average increase in premiums was 25 percent.

In the Midwest, Minnesota was socked with a 59 percent increase that further roiled an already shaky individual health insurance market (or exchange). Legislators there responded earlier this year by first providing help to those not covered by federal subsidies and then creating a state-funded reinsurance program.

An analysis released in October by the Kaiser Family Foundation attributed the premium rate hikes across the country to a combination of factors, including substantial losses experienced by many insurers in the individual market and the phasing out of the federal reinsurance program. Kaiser researchers also found that due to losses in the individual market, the average number of participating insurers dropped to 3.9 per state in 2017, down from 5.4 in 2016 and 5.9 in 2015.

That trend looks to continue. Wellmark Blue Cross/Blue Shield and Aetna both announced in April that they will pull out of Iowa’s exchange in 2018, leaving Medica Insurance Co. as the only available insurer in all but five of the state’s 99 counties.

Wellmark’s president, John Forsyth, told The Des Moines Register that his company has lost $90 million over the last three years, and that the “overall problem is too few healthy, young consumers are buying health insurance,” and that the U.S. Affordable Care Act’s penalty for individuals refusing to buy insurance “hasn’t been enough to goad many young consumers into the pool.”

Iowa Insurance Commissioner Doug Ommen concurred in an April 6 statement: “This is a problem created by the Affordable Care Act and needs to be fixed in Congress.” In early May, Medica said it, too, would withdraw from the Iowa exchange for 2018, possibly making that state the first to have no insurers in most counties.

So with some states’ individual exchanges in flux — and uncertainty over whether the U.S. Congress will repeal and replace the Affordable Care Act — what happened? And what lessons for Iowa (and other states) might there be in how Minnesota dealt earlier this year with the problems in its state exchange?

What happened?

In 2014, as a central part of providing coverage through the U.S. Affordable Care Act of 2010, health insurance exchanges opened up across the country — either run by states themselves, the federal government or a combination of the two.

Because these exchanges created a new way of providing and purchasing health insurance, no one knew what to expect, says Sara Collins, vice president of The Commonwealth Fund’s health care coverage and access program. Hence the federal reinsurance program, which essentially provided insurance for the insurance companies by having the government pay some portion of claims for the first two years of implementation (from 2014 through 2016).

According to Collins, insurance carriers now have a better understanding of how the markets work and, therefore, have a more accurate sense of pricing, so the 2017 premium spikes were basically a pricing correction reflecting both that and the phasing out of federal reinsurance payments.

Gary Claxton, vice president at the Kaiser Family Foundation and director of its Healthcare Marketplace Project, agrees. “There’s reason to believe that rates are in the right place,” so future rate hikes shouldn’t be quite as steep, he says. There’s not a lot states can do about the 2017 rate hikes — “this is what insurance costs” — but some steps do help
stabilize a state exchange for future years, Claxton says. For example, Medicaid expansion helps because it means more chronically ill people are covered through this public health insurance program rather than through private plans offered on the exchanges.

In the Midwest, seven states — Illinois, Indiana, Iowa, Michigan, Minnesota, North Dakota and Ohio — already had adopted Medicaid expansion, agreeing to cover people up to at least 133 percent of the federal poverty level (participating states can opt to cover people above that level). The federal government funded 100 percent of expansion costs from 2014 through 2017, and will gradually reduce that to 90 percent by 2020.

Although Wisconsin did not participate in Medicaid expansion, it does cover adults up to 100 percent of the federal poverty level through its BadgerCare Plus program. Kansas legislators approved a Medicaid expansion earlier this year, but in April, they narrowly failed to override Gov. Sam Brownback’s veto, falling three votes short of the two-thirds majority needed in the House. (This policy issue was scheduled to be revisited in May.)

But even with Medicaid expansion, some individuals who don’t qualify for public health insurance, and don’t get coverage through their employers, rely on the individual exchanges. This becomes a problem in states or counties where the choice of insurers is limited, or where there is only one insurer.

This problem is especially prevalent in rural areas because of small population sizes and a lack of extensive networks of providers (hospitals, clinics, and practitioners). “That’s really difficult to figure out [how to fix],” Claxton says.

Reinsurance, which provides payments to insurers to help offset the costs of enrolling higher-cost individuals, has been one strategy used under the ACA and is now being tried in states such as Minnesota. This may be one policy option for Iowa as well.

If Medica leaves and Iowa is left without a single statewide insurer, people would have to buy insurance outside the exchange, which means they would be forced to do so without subsidies, says University of Iowa professor Keith Mueller, director of the Rural Policy Research Institute Center for Rural Health Policy Analysis.

Finding a solution is “the $64,000 question” for Iowa, says Abigail Barker, a researcher with the center and a professor at Washington University in St. Louis.

Given the time and legislative approval needed to create a reinsurance program, she says, that strategy “might not help much in 2018, but it might be a longer-term solution,” she says. Although some rural areas are doing better than others, Barker says, a fundamental problem is their low population density: There just aren’t enough people to provide a robust individual market, she says.

Tim McBride, another researcher at the Center For Rural Health Policy Analysis and professor at Washington University, says possible ways around the problem of low population density include

- redrawing local rating areas (state-designated geographic areas that are one permissible factor insurance companies can use to set rates),
- creating statewide or nationwide plans open to anyone, or
- recognizing that the exchange markets as currently structured are failing for rural areas and will need better or more-targeted subsidies.

How reinsurance works

For now, some form of reinsurance appears to be one of the more viable options to shore up state health exchanges by better spreading risk. It works, roughly, like this: When a consumer buys a $5 million insurance policy on a house, for example, the insurance company issues the policy, and then has a portion of it reinsured (usually with a company specializing in reinsurance). If the house burns down, the insurance company isn’t on the hook for the entire $5 million.

Under Minnesota’s new reinsurance law, the “attachment point model” will be used; for example, once an insurance provider has paid out $50,000 worth of coverage, reinsurance kicks in and covers 80 percent of costs up to $200,000, at which point the original insurer again bears all costs.

The states of Alaska and Minnesota have funded reinsurance in their health exchanges for different reasons. With a population of only 738,432, Alaska just doesn’t have enough people to sustain much insurer interest. By providing reinsurance for high-cost cases, the state helped reduce the 2017 rate increase sought by its only insurer, Premera, from an estimated 42 percent to 7.3 percent.

Reinsurance programs help stabilize such markets and “gives insurance companies knowledge of what their loss cap will
be,” says Minnesota Sen. Gary Dahms, who is a former owner of an insurance agency. “It’s a model that’s known and has proved to work in many different lines of insurance,” he adds.

Minnesota’s woes began in 2015 when PreferredOne pulled out of the state’s health exchange, which is known as MNsure. PreferredOne had entered the health-insurance market in 2014 with some of the lowest rates in the country, and it soon captured 59 percent of Minnesota’s exchange customers. The company’s low rates, however, proved unsustainable when they didn’t bring in enough people to cover the flood of new MNsure enrollees.

Minnesota is the first Midwestern state to fund a reinsurance program to stabilize its exchange and attract insurers. Passed on March 30, HF 5 establishes a $542 million program for two years; it sets annual appropriations of $200 million from the state’s “health care access fund” and $71 million from the general fund. Money for the state’s health care access fund comes largely from a tax on health care providers and a tax on insurance premiums.

Minnesota legislators had previously passed HF 1 in January, allocating $311.9 million from budget reserves to provide eligible residents a subsidy of 25 percent of the monthly gross premium in the state’s individual market. Those who already get the ACA’s advance premium tax credits or who are enrolled in public program coverage are not eligible.

With HF 1, the Legislature also allocated $15 million to cover transition care for people with new health plans but who are continuing treatment for serious conditions, life-threatening mental or physical illnesses, and pregnancy beyond the first trimester.

Effective through June of next year, HF 1 includes other changes as well, such as permitting for-profit HMOs to join the state-run individual marketplace and allowing hospitals and clinics to use administrative law judges to challenge the way insurance providers select their networks. It also paves the way for agricultural cooperative health plans to provide insurance to farmers and agribusiness employees.

Minnesota Gov. Mark Dayton signed HF 1 (the subsidies for consumers) in January and allowed HF 5 (reinsurance for insurers) to become law without his signature. In a statement, he voiced concerns about the reinsurance legislation, saying it subsidizes insurance companies without assurances from them that they will participate in Minnesota’s market or any indication that rates would be lowered in 2018. But he agreed that state intervention was needed “to try and induce [insurers’] participation in Minnesota’s individual market in 2018 at the lowest possible rates.”

Outside the Midwest, Alaska’s reinsurance program is being funded by a 2.7 percent tax on all insurers. After the bill was passed last June, the only insurer in Alaska’s exchange filed rates for premiums that rose 7.3 percent, as opposed to the 42 percent originally estimated.

Idaho authorized a reinsurance program last month, and in Oklahoma — where premiums jumped 76 percent — a state task force has recommended reinsurance in a 60-page plan to deal with skyrocketing premiums.

“Reinsurance always makes a certain amount of sense if you’re willing to fund it,” Claxton says.

‘Playing catch-up’

Dahms, assistant majority leader in the Minnesota Senate, says reinsurance was necessary because his state’s individual market had essentially collapsed. Reinsurance was the best — and quickest — solution to provide stability and draw insurers back into that market, thus restoring competition and consumer choice, he says.

Lynne Blewett, professor of health policy and management at the University of Minnesota’s School of Public Health, says reinsurance should help stabilize Minnesota’s individual exchange market, which was underpriced and had lots of volatility from the start.

“We had the lowest premium rates and they were all too low,” she says. “We’ve been playing catch-up.” Moreover, Blewett says insurers still can’t get a good grasp of the individual exchange market’s risk profile because it keeps changing; the state’s high-risk pool was folded into it, and now, some large employers in Minnesota are moving their pre-retirement employees into the market (and providing them with money to purchase policies on the exchange).

Having the state act as the reinsurer does cost some money, “but it gives stability to the market and draws insurers back to it,” Blewett adds. If other states want to follow Minnesota’s lead, Sen. Dahms recommends laying the groundwork via close cooperation among legislators, the governor’s office, and state and federal officials to ensure everyone is on the
same page.

Also, he says, know what the Section 1332 waiver [6] process entails, and work with the U.S. Centers for Medicare and Medicaid Services to know what’s possible through that process before crafting a state reinsurance program and waiver application for it.

According to the U.S. Department of Health and Human Services’ website, if a state can demonstrate savings via a reinsurance program, a successful application for a Section 1332 waiver could allow the state to get federal “pass-through” funding to offset part of that program’s costs. Section 1332 authorizes the secretaries of Health and Human Services and Treasury to waive provisions under their respective jurisdictions related to premium tax credits and cost-sharing reductions for plans offered within the marketplaces.

By:
Tuesday, May 30, 2017 at 10:14 AM

Attachments

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