



**HOW REINSURANCE
SAVED MINNESOTA'S
INDIVIDUAL HEALTH
INSURANCE MARKET**

The program is a model for other states and Congress to help fix the ACA's broken premium subsidy structure

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How Reinsurance Saved Minnesota’s Individual Health Insurance Market

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Executive Summary

- Minnesota implemented a reinsurance program in 2018 to lower premiums in the individual health insurance market after premiums skyrocketed by 119 percent from 2014 to 2017.
- The reinsurance program—called the Minnesota Premium Security Plan—successfully lowered premiums by up to 36 percent.
- A federal evaluation shows that reinsurance saved the market as an affordable coverage option for people who do not qualify for federal subsidies.
- This federal evaluation suggests that reinsurance adds incentives to control costs which the federal government does not acknowledge.
- These cost controls help mitigate the inflationary nature of the Affordable Care Act's current approach to subsidizing premiums.
- Based on the success of reinsurance in Minnesota, other states and Congress should adopt reinsurance to lower premiums and improve the ACA's premium subsidy structure.

Introduction

The full implementation of the Affordable Care Act (ACA) and the launch of MNsure in 2014 quickly created a crisis in Minnesota's individual health insurance market. From 2014 to 2017, average monthly individual health insurance premiums in Minnesota rocketed from \$256 to \$560—a 119 percent increase. At these prices, the unsubsidized who earned too much to qualify for ACA premium subsidies could no longer afford individual health insurance and began fleeing the market.

To address this affordability crisis, the Minnesota legislature established a reinsurance program in

“By successfully lowering premiums, the Minnesota Premium Security Plan (MPSP) saved Minnesota’s individual health insurance market for the unsubsidized.”

2017 called the Minnesota Premium Security Plan (MPSP). The program uses state and federal funding to reinsure a portion of high-cost claims in the individual market. This reduces the claims that insurers must pay for the entire risk pool, which results in lower premiums for everyone in the market. By successfully lowering premiums, the MPSP saved Minnesota's individual health insurance market for the unsubsidized. This report details that success and offers recommendations on how other states and Congress can use reinsurance to improve the ACA's premium subsidy structure. ■





Minnesota's Problem: ACA plunges insurance market into a death spiral

The ACA's main programs and regulations, which passed in 2010, did not begin until 2014. In that first year, premiums were kept relatively low in Minnesota and, in fact, ended up being the lowest in the country. Low premiums were, in part, due to pressure from the Minnesota Department of Commerce. After receiving insurers' initial premium rate filings, Commerce "asked" insurers to change their actuarial assumptions to justify lower premiums.¹ Every insurer complied which lowered premiums between four and 37 percent from their initial rate filings.²

Setting rates too low led Minnesota insurers to sustain the second highest per member per month loss in the country next to Alaska in 2014.³ Due to these losses, PreferredOne—the insurer that agreed to lower rates by 37 percent from their initial rate filing—decided to pull out of MNsure after only eight months.⁴ Eventually Blue Cross also pulled out, citing losses of over \$500 million in the first three years of the ACA.⁵

Mounting financial losses and the departure of the

state's dominant insurer forced the remaining insurers to hike premiums. From 2014 to 2017, average monthly individual health insurance premiums in Minnesota rocketed from \$256 to \$560—a 119

percent increase. This 119 percent increase was the largest in the nation and pushed premiums well above the national average in 2017.

At these prices, the unsubsidized who earned too much to qualify for ACA premium subsidies could no longer afford individual health insurance and began to abandon the market in 2016. Unsubsidized enrollment dropped by 54,000 (22 percent) when premiums increased by 29 percent in 2016 and dropped another 104,000 (53 percent) when premiums jumped another 45 percent in 2017 (see Figure 2). For perspective, the combined loss of 158,000 unsubsidized people from the market over these two years represented 2.8 percent of the

state's population.

These sharp enrollment drops strongly suggest the unsubsidized portion of the market had plunged into what's called a death spiral. Healthier people

“From 2014 to 2017, average monthly individual health insurance premiums in Minnesota rocketed from \$256 to \$560—a 119 percent increase... the largest in the nation and pushed premiums well above the national average in 2017.”

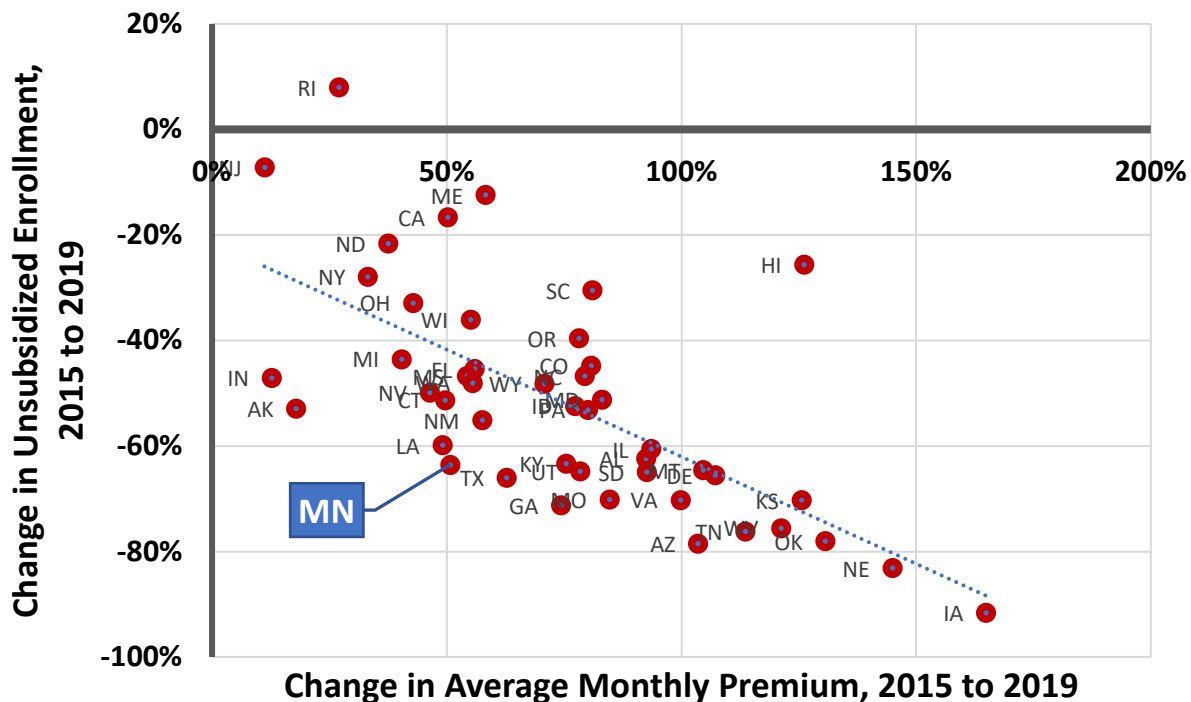
left the market which left a sicker, more expensive pool of people behind. This required insurers to raise rates even more. Federal taxpayers protected the subsidized portion of the market from this death spiral, but cycles of higher premiums pushing healthier people out was killing the market for the unsubsidized.

Though the ACA may have damaged Minnesota's individual insurance market more than most—Minnesota experienced the third largest percentage drop in unsubsidized enrollment next to Arizona and Oklahoma in 2017—nearly every state faced

similar problems.⁶ Several reports from the Centers for Medicare & Medicaid Services (CMS) document how rising premiums were correlated with declining enrollment across the country.⁷ Similar to figures CMS published, Figure 1 clearly shows that rising premiums were strongly correlated with declining unsubsidized enrollment across the country from 2015 to 2019. This figure offers possibly the best depiction of how a vulnerable segment of America—working people who do not have access to employer-sponsored coverage—lost access to affordable health coverage after the implementation of the ACA. ■

FIGURE 1

Change in State Average Monthly Premium versus Change in Unsubsidized Enrollment, 2015 to 2019



Sources: Authors calculations from Centers for Medicare & Medicaid Services Medical Loss Ratio, Risk Adjustment, and Effectuated Enrollment data. Analysis excludes Massachusetts and Vermont because their individual and small group markets are merged in the risk adjustment data.



As thousands of Minnesotans lost access to affordable coverage in 2017, state lawmakers scrambled to find a solution to the ACA's affordability problem. As a stopgap, the state quickly passed a temporary premium assistance program in January 2017 before open enrollment closed in February.⁸ By March, lawmakers adopted the MPSP as a more long-term solution.

The MPSP is a reinsurance program that funds a portion of high-cost claims in the individual market. Funding these claims results in lower premiums for everyone in the market. The MPSP operates as a partnership with the federal government under a State Innovation Waiver. Section 1332 of the Affordable Care Act allows states to waive certain ACA requirements to develop innovative state health programs. Using this authority, CMS and the Department of the Treasury approved the MPSP in 2017 for the 2018 plan year.

The MPSP operates under a claims cost-based reinsurance model. It pays 80 percent of an enrollee's claims costs that exceed a \$50,000 attachment point up to a \$250,000 cap. These reinsurance payments reduce the claims cost for the health insurer and these savings are passed through to consumers in lower premiums. These

lower premiums also reduce the premium tax credits the federal government pays because the amount of the tax credit is directly tied to the premium amount. Under the waiver, the federal government provides the state "pass-through funding" to support the program in place of the forgone tax credits. For plan year 2020, the state contributed \$74 million and the federal government contributed \$86 million to fund the MPSP.⁹

The MPSP was one of three reinsurance waivers approved by the Trump administration in 2017. By the end of the Trump administration, CMS had approved a total of 15 reinsurance waivers. Most of these waivers aligned with the Minnesota model. However, Alaska uses a conditions-based model which pays claims for people with one or more of 33 specific high-cost conditions. Maine follows a hybrid approach.

The ACA allows waivers to be approved for five-year periods and Minnesota's reinsurance waiver was set to expire at the end of 2022. Based on the success of the program discussed next, the Minnesota legislature and Commerce took the necessary steps to extend the MPSP for another 5 years. ■



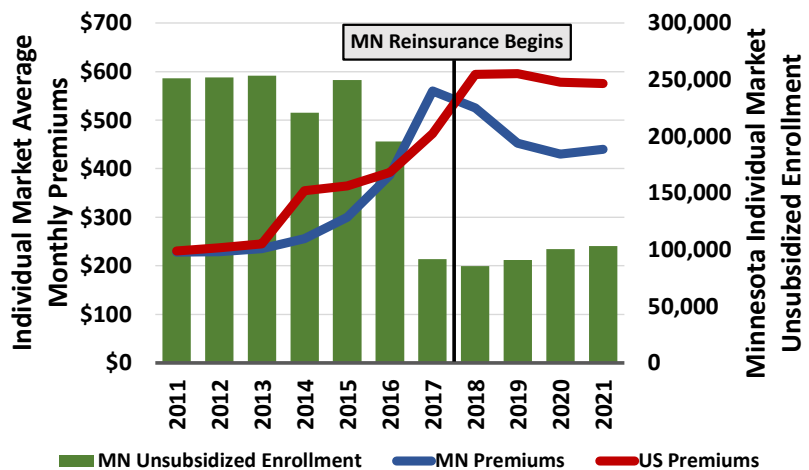
In its first year, the MPSP delivered immediate results. CMS reports that the program successfully lowered premiums by nearly 17 percent in 2018 which rose to over 21 percent in 2021.¹⁰ This dropped the state’s average monthly premiums to the lowest in the country in 2019.¹¹ This represents a dramatic shift from 2017—the year before implementing reinsurance—when the state ranked 37th in affordability. While Minnesota gave up the top affordability spot, the state still ranked 2nd in 2020, 3rd in 2021 and remains among the most affordable in the country.

These lower premiums pulled the state’s individual market out of a death spiral. Figure 2 shows trends in unsubsidized enrollment alongside premium trends in Minnesota. At the same time Minnesota premiums declined in response to the MPSP, unsubsidized enrollment stabilized at 85,000 in 2018, just a 7 percent drop compared to the 53 percent drop in 2017. Since 2018

unsubsidized enrollment increased each year, reaching 103,000 in 2021—a 21 percent increase.

While a 21 percent enrollment increase is good, it underrepresents the success of the MPSP. Without the MPSP, unsubsidized enrollment in

FIGURE 2
Unsubsidized Enrollment Drops in Minnesota as Premiums Rise



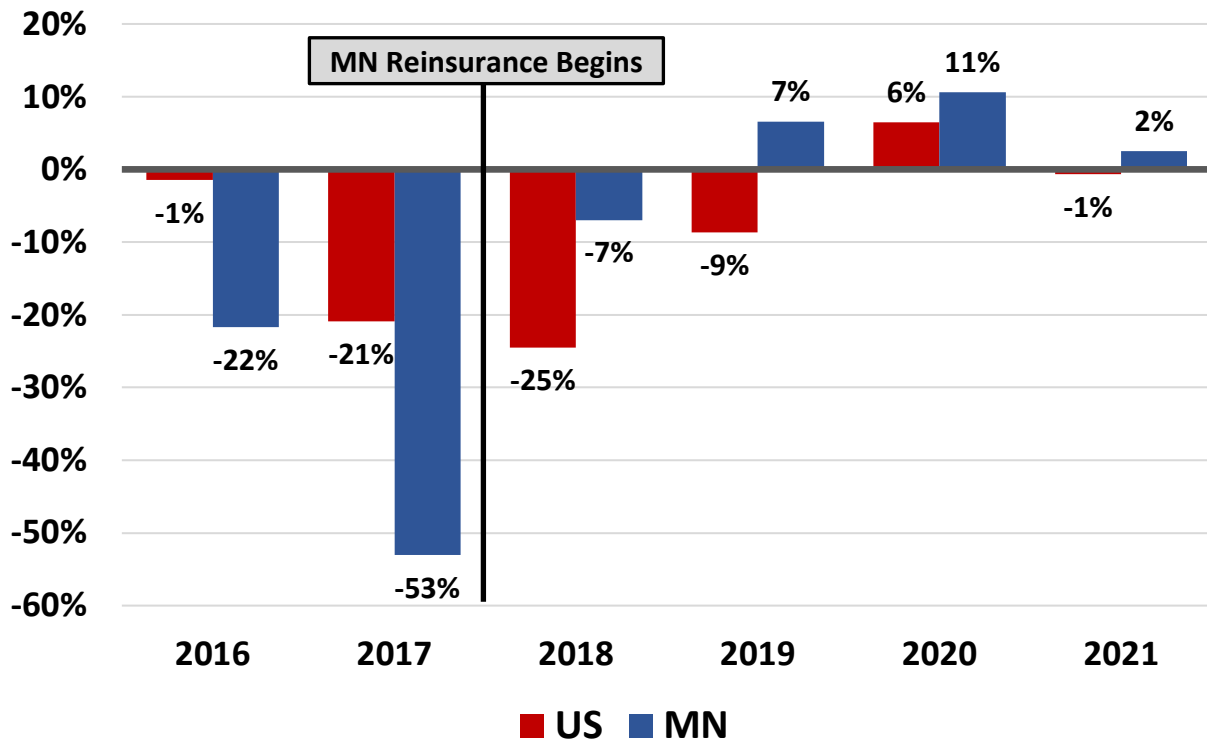
Sources: Authors calculations from Centers for Medicare & Medicaid Services Medical Loss Ratio, Risk Adjustment, and Effectuated Enrollment data. Analysis excludes Massachusetts and Vermont because their individual and small group markets are merged in the risk adjustment data.

Minnesota would likely have continued to drop in step with enrollment losses across the country. Figure 3 shows that the annual percent change in unsubsidized enrollment in Minnesota beat these

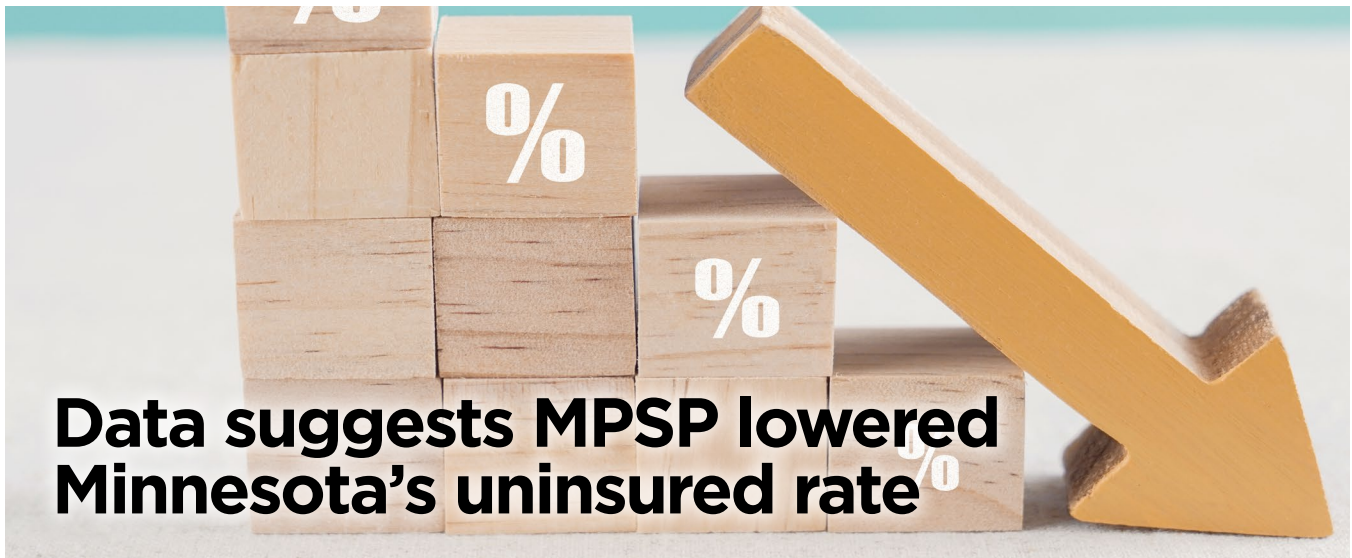
national trends each year since the MPSP was established. Since 2017, unsubsidized enrollment declined by 27 percent nationally while enrollment increased by 12 percent in Minnesota. ■

FIGURE 3

Percent Change in Unsubsidized Enrollment



Sources: Authors calculations from Centers for Medicare & Medicaid Services Medical Loss Ratio, Risk Adjustment, and Effectuated Enrollment data. Analysis excludes Massachusetts and Vermont because their individual and small group markets are merged in the risk adjustment data.



Data suggests MPSP lowered Minnesota's uninsured rate

The purpose behind making coverage more affordable and stabilizing the individual market is to keep more Minnesotans insured. Changes in the Minnesota uninsured rate between 2015 and 2021 suggest the MPSP successfully kept more Minnesotans from going uninsured. Some of the unsubsidized people who left the individual market in 2016 and 2017 likely moved to employer coverage through a spouse or found some other way to obtain more affordable coverage. However, some people likely opted to drop health coverage entirely when premiums spiked. Figure 4 suggests this is exactly what happened.

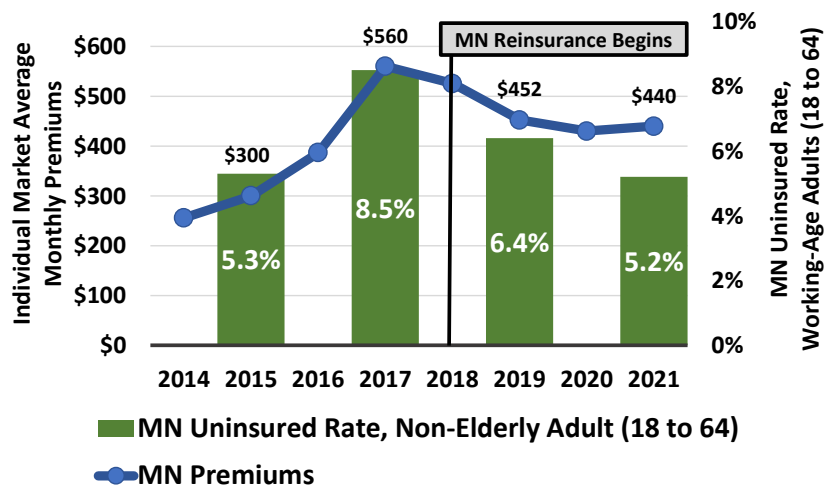
Working-age adults (aged 18 to 64) who rely the most on private coverage are the most exposed to higher individual market premiums. As shown in Figure 4, from 2015 to 2017, the uninsured rate for working-age adults in Minnesota sharply increased from 5.3 to 8.5 percent when individual market premiums spiked by 87 percent. The uninsured rate then dropped nearly as quickly as it rose after the implementation of the

MPSP reduced premiums.

Notably, the implementation of the MPSP is the only major change within Minnesota's health care financing structure between 2017 and 2019. Therefore, it's reasonable to conclude the MPSP played an important role in reversing the sharp increase in the uninsured rate for working-age adults over this time. ■

FIGURE 4

Minnesota's Uninsured Rate Increases as Individual Insurance Premiums Spike



Source: Centers for Medicare & Medicaid Services Risk Adjustment data; and Minnesota Department of Health, Minnesota Health Access Survey.



CMS commissioned the RAND corporation to evaluate Minnesota's reinsurance waiver program and answer two research questions.¹² First, what is the waiver's impact on enrollee premium spending by representative individuals (by age and income)? Second, what is the waiver's impact on individual market enrollment by income and for unsubsidized individuals? To answer these questions, the evaluation compared Minnesota's pre-waiver and post-waiver period to a "synthetic comparison group" of 24 states.

The evaluation concluded with two clear findings. On the first question, it concluded that "Minnesota's waiver was associated with lower premiums across all plans offered in the marketplace." As a result of these lower premiums, RAND further concluded that the waiver "appears to have stabilized enrollment trends among unsubsidized individuals more rapidly than would have occurred in the absence of the waiver." In other words, the MPSP worked.

While the evaluation presents its conclusions with characteristic academic modesty, a closer look at RAND's findings reveals dramatic results which show how MPSP stopped a death spiral and saved Minnesota's individual health insurance market for the unsubsidized.

Premium Impact

Not only was the MPSP associated with lower premiums, but the premium reduction during this

time was substantially higher than the estimates the state reports to the federal government each year. Based on data from Minnesota's insurance carriers, the state gives the federal government an estimate of the MPSP's premium impact to help establish the amount of pass-through funding the Treasury contributes to the program. According to these estimates, the MPSP reduced premiums by approximately 20 percent.¹³ In contrast, RAND estimates Minnesota premiums for a benchmark plan are 36 percent "lower than would be expected in the absence of the waiver."¹⁴

RAND notes their estimate of a larger premium reduction suggests other factors beyond reinsurance may have contributed to lower premiums. However, as discussed in more detail later, this also suggests other aspects of the reinsurance program may contribute to lower premiums which the state and federal government do not consider. If true, then the federal government has been shortchanging Minnesota's pass-through funding amount.

Enrollment Impact

The most dramatic finding from the RAND evaluation shows how the MPSP saved the individual market for unsubsidized enrollees. Over the three-year evaluation period, RAND estimates "that 66,000 more individuals, on average, enrolled in plans than would have done so absent the waiver."

RAND emphasizes how this enrollment impact is a “large effect” considering the entire unsubsidized market was just over 90,000 people the year before the waiver began.

While this represents a large impact, highlighting the average over the evaluation period underrepresents the full impact. If allowed to go on, the death spiral would have resulted in a cumulative enrollment loss over the three-year period as enrollment would have continued to decline from year to year. By stopping this cumulative loss, the enrollment impact from reinsurance should be expected to accumulate annually until reaching an equilibrium much higher than the average. This is precisely what the RAND evaluation shows.

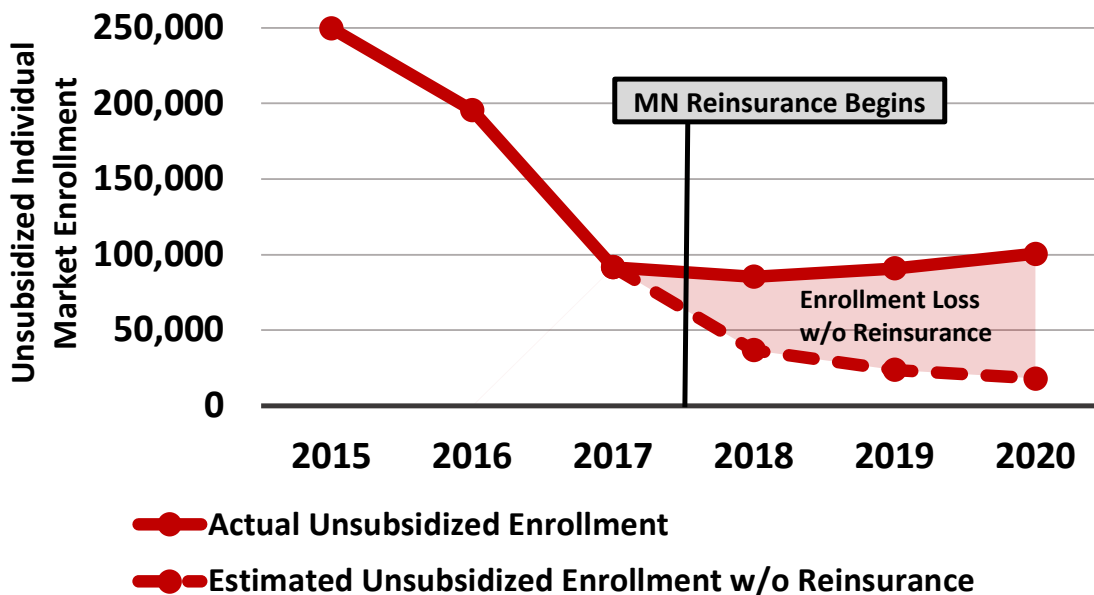
As expected, the annual impact shows the

enrollment gain increases each year from 2018 to 2020. Reinsurance enrolled 48,498 more unsubsidized people in 2018. This enrollment impact increased to 67,183 in 2019 and then to 82,455 in 2020. Considering unsubsidized enrollment had declined from 250,000 in 2015 to 92,000 in 2017, the potential loss of another 82,000 by 2020 would have effectively completed the death spiral and killed the market for unsubsidized people.

Figure 5 illustrates what the enrollment losses would have looked like without the MPSP (dashed red line) compared to the actual unsubsidized enrollment with the MPSP (solid red line). Without reinsurance, unsubsidized enrollment would have continued to spiral down to just 18,000 by 2020. This didn’t happen. Instead, after implementation

FIGURE 5

Federal Study Estimates Unsubsidized Individual Market Enrollment Would Have Plunged by 82,455 in Minnesota Without Reinsurance



Source: Author’s calculations from calculations from Centers for Medicare & Medicaid Services Medical Loss Ratio, Risk Adjustment, and Effectuated Enrollment data; and Justin W. Timbie, et al., Section 1332 Waiver Evaluation Report: Evaluating the Minnesota Reinsurance Program, RAND Corporation prepared for Centers for Medicare & Medicaid Services and Office of the Assistant Secretary for Planning and Evaluation (September 2021).

TABLE 1

Enrollment and Costs for Key Minnesota Insurance Affordability Programs, 2020

Insurance Affordability Program	Income Eligibility Thresholds	Enrollment Impact	Annual Public Cost	Annual Public Cost per Enrollee
Medicaid Adult Expansion	Up to 133% of FPL	196,967	\$2,124,773,646	\$10,787
MinnesotaCare Basic Health Program	133% to 200% of FPL	72,936	\$395,645,356	\$5,425
ACA Premium Tax Credits	200% to 400% of FPL	57,664	\$284,419,453	\$4,932
MN Premium Security Plan	Over 400% of FPL	82,455	\$74,284,140	\$901

Note: The annual public cost for ACA premium tax credits includes the cost of both the advance premium tax credit (\$198,355,632) and the federal pass-through funding for the MPSP (\$86,063,821). This reflects the full public cost to cover this population as federal pass-through funding equals the amount the federal government would pay in premium tax credits absent the 1332 reinsurance waiver. The annual public cost per enrollee may somewhat overestimate the cost of premium tax credits and underestimate the cost of the MPSP because it does not factor in the shift in enrollment between the two programs that happens when lower premiums under the MPSP reduces the number of people who qualify for premium tax credits. As noted in the appendix, this enrollment shift is difficult to estimate due to the lack of individual market enrollment data by income level.

Sources: Medicaid and CHIP Payment and Access Commission, MACStats, Exhibits 15 and 22 (2022); Minnesota Department of Human Services, November 2022 Forecast Tables (December 2022); Centers for Medicare & Medicaid Services, Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average (June 5, 2021); Minnesota Department of Commerce, Reinsurance Waiver Annual Report (July 21, 2022); and Justin W. Timbie, et al., Section 1332 Waiver Evaluation Report: Evaluating the Minnesota Reinsurance Program, RAND Corporation prepared for Centers for Medicare & Medicaid Services and Office of the Assistant Secretary for Planning and Evaluation (September 2021).

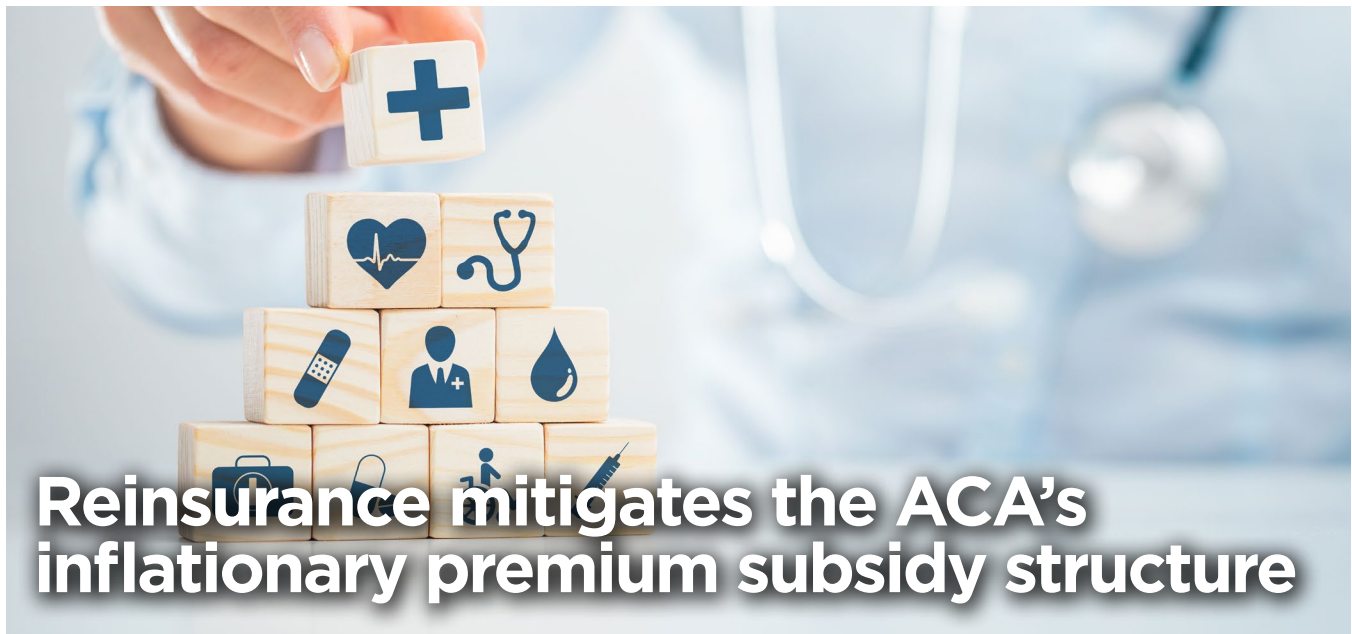
of the MPSP, enrollment stabilized and then grew to over 100,000 by 2020.

Recent growth in unsubsidized enrollment strongly suggests the Minnesota individual market regained its footing and now offers at least the minimum level of affordability to keep middle- to higher-income people covered if they can't access coverage elsewhere. Considering 82,000 people represent 2.4 percent of the Minnesota working-age population in 2020, it's reasonable to conclude that keeping this percentage covered in the individual market played an important role in lowering the uninsured rate for this age group as previously shown in Figure 4.

Relative to other state and federal insurance affordability programs, the \$74 million state cost for the MPSP represents a remarkably cost-effective approach to keeping another 2.4 percent of Minnesota's working-age population covered. The annual cost in 2020 came to approximately \$900 per person to keep 82,455 unsubsidized people covered in the individual market. By contrast, Table 1 shows the annual per person

cost in 2020 came to nearly \$11,000 for the Medicaid adult expansion population, \$5,400 for MinnesotaCare, and \$4,900 for federal premium tax credit subsidies. Naturally, it costs far more to cover lower-income people who need a larger portion of their coverage subsidized. But on a purely cost per person covered, the federal evaluation shows that reinsurance has proven to be the cheapest way to lower Minnesota's uninsured rate.

Overall, the results from the RAND evaluation demonstrate the remarkable success of the MPSP. By averting a death spiral for the unsubsidized, the MPSP protected access to the only viable health coverage option for thousands of working-age Minnesotans who earn too much to qualify for federal subsidies and do not have access to employer-sponsored coverage. ■



Reinsurance mitigates the ACA's inflationary premium subsidy structure

The RAND findings also suggest that reinsurance may keep premiums lower than current estimates report. As noted previously, RAND estimates premiums for a benchmark plan are 36 percent lower from what they would have been without reinsurance. This is substantially higher than the approximately 20 percent premium reduction insurance carriers estimate. To account for this large disparity, RAND suggests some other factors that might contribute to the difference beyond reinsurance. They posit Minnesota might have been experiencing substantially different market conditions than the comparison states before the waiver was implemented. According to RAND, Minnesota and the comparison states may have also implemented different policies after implementation which influenced premiums differently. These are both plausible explanations.

RAND, however, ignored an important feature of reinsurance that may have also contributed to a larger premium reduction. Specifically, reinsurance helps mitigate the inflationary impact of the ACA's premium subsidy structure. It does this by replacing a portion the ACA's inflationary premium subsidy that generally pays the full cost of a premium increase with a

reinsurance subsidy to fund high-cost claims that keeps insurers responsible for a portion of any increase in claims costs.

The ACA's inflationary subsidy structure

The ACA's premium subsidy structure creates inflationary pressure because the value of the ACA's premium tax credit is tightly linked to the price of insurance premiums. This is because the subsidy is set to cover the portion of the benchmark plan premium—the second lowest-cost silver plan—that exceeds a certain percentage of income. As premiums rise above this percentage of income, the subsidy rises in lockstep. This means the government generally pays the full cost of any premium increase. As a result, there's little pressure on insurance companies to keep premiums down for subsidized people.

Research using pre-ACA data from the 2011 Massachusetts health insurance market estimates this inflationary subsidy design increases premiums by 6 percent in Massachusetts.¹⁵ The impact is likely much larger in other states due to differences in market dynamics that keep premiums lower in Massachusetts versus other states.¹⁶

Reinsurance design adds pressure to control cost

By design a reinsurance waiver replaces a portion of the ACA's premium tax credit subsidy with a reinsurance subsidy. Reinsurance subsidizes a portion of high-cost claims across the entire market, which, in turn, lowers premiums across the entire market. By lowering premiums, reinsurance lowers the amount of federal premium subsidies the federal government must pay. Just as federal premium subsidies increase in lockstep with premium increases, they decrease with premium reductions. Thus, by subsidizing broad-based premium reductions, reinsurance replaces a portion of federal premium tax credit subsidies that would otherwise go to individuals.

Naturally, replacing a premium subsidy that matches premium increases dollar-for-dollar with a reinsurance subsidy that matches 80 percent of high-cost claims will increase incentives to control costs. While 80 percent might be a generous match, insurers still have some skin in the game.

Reinsurance adds another, maybe more important type of pressure on insurers to control costs and keep premiums lower. By lowering premiums market wide, reinsurance increases the number of unsubsidized people in the market. As a result, a larger portion of the market is fully price sensitive to any premium increase an insurer tries to charge consumers. The need to be responsive to more price sensitive consumers likely adds substantial pressure on insurers to control premium growth.

Lower premiums increase the number of unsubsidized people via two mechanisms. First, lower premiums by themselves will attract more unsubsidized enrollees just the same as lower prices attract more buyers in any market. Second, reinsurance also reduces the number of people who qualify for premium subsidies. This happens because

the subsidy amount is calculated by how much a benchmark premium exceeds a certain percentage of income that increases on a sliding scale as income increases. This percentage of income is referred to as the required contribution. If the benchmark premium is less than the required contribution, then the premium subsidy technically equals zero dollars. By lowering the benchmark premium, reinsurance increases the number of people with a benchmark premium that's less than their required contribution. Thus, more people pay full freight. The appendix provides a more detailed discussion of how this works. ■

“By lowering premiums market wide, reinsurance increases the number of unsubsidized people in the market. So, a larger portion of the market is fully price sensitive to any premium increase an insurer tries to charge consumers.”



Reliance on insurer data likely understates the reinsurance premium impact

States depend on insurers to provide information on how much reinsurance impacts premiums. This reliance likely leads states to underestimate the impact of reinsurance on premiums because insurers generally ignore how competitive pressure impacts their rates. Insurers submit actuarial memos to justify their rates each year. Despite the fact that numerous studies show how the addition of an insurer to a market leads to lower rates, no insurer would acknowledge that an added competitor led them to lower rates in these actuarial memos. Likewise, no insurer will build in the cost pressure from higher unsubsidized enrollment to the reinsurance data they submit to states.

Instead, insurer's actuaries likely estimate the premium impact from reinsurance using some very basic math and assume reinsurance payments simply reduce premiums dollar for dollar. That appears to be true based on the premiums Minnesota's individual market insurers collected in 2020 compared to the reinsurance payments they

received. Reinsurance payments spent on claims totaled \$160,210,351 in 2020.¹⁷ Adding this to the \$792,684,450 in premiums Minnesota insurers collected in 2020 would increase premiums by 20.2 percent.¹⁸ That's only one percentage point lower than what CMS reports.¹⁹

“Keeping 101,000 unsubsidized people who are fully price sensitive in the market exerts substantial pressure to discipline insurers to keep premiums low.”

While the difference between a 20 percent premium impact and RAND's estimate of a 36 percent impact might be large, it's not unreasonable to think premiums would be 36 percent higher without reinsurance if the unsubsidized enrollment in the market had plummeted to just 18,000 people as RAND estimates. Keeping 101,000 unsubsidized people who are fully price sensitive in the market exerts substantial

pressure to discipline insurers to keep premiums low. What is unreasonable is ignoring the premium impact that results from retaining this level of unsubsidized enrollment. Not accounting for this premium impact has likely resulted in Minnesota receiving less federal pass-through funding than it



Since Minnesota, Alaska, and Oregon implemented reinsurance programs in 2018, another 12 states have followed. With a strong record of success, other states should consider adopting a similar reinsurance waiver to increase the stability and affordability of their individual market. At this time, however, reinsurance is even more important for Congress to consider.

To address insurance affordability problems during the pandemic, Congress temporarily expanded premium tax credit subsidies through 2022 in the American Rescue Plan Act. This subsidy expansion made subsidies more generous for people currently eligible and extended eligibility to people above 400 percent of FPL. In August 2022, Congress extended this temporary premium subsidy expansion to the end of 2024 in the Inflation Reduction Act. The expiration of this temporary subsidy expansion will force Congress to decide between 1) letting it expire, 2) adopting another extension, 3) making the extension permanent, or 4) implementing an alternative solution.

Among these options, Congress should focus on putting an alternative solution in place that fixes fundamental flaws with the ACA's premium subsidy structure and establishes a more functional,

competitive and affordable individual health insurance market. While reinsurance does not offer a complete solution, Congress should adopt it as part of a comprehensive ACA reform package.

As explained previously, the structure of the ACA's premium tax credit subsidy inflates premiums because it eliminates incentives for insurers to control costs for subsidized people. That's because any annual increase in premium is fully funded by an increase in the premium subsidy. Reinsurance counters these perverse inflationary incentives by requiring insurers to match a portion of the reinsurance subsidy and increasing the size of the unsubsidized market.

Ideally, the individual market would not need reinsurance. However, due to the ACA's regulatory framework—in particular the law's guaranteed availability and community rating regulations—the individual market now attracts people with relatively higher health risks than the group market and, as a result, costs more than it otherwise would. To address this inequity and at the same time improve the ACA's subsidy structure, Congress should implement a nationwide reinsurance program structured to help equalize the cost of the claims experience between the individual and group market segments. ■



Conclusion

This report focuses on Minnesota’s reinsurance program. A new reinsurance program established by Congress or in another state may not experience the same level of success as Minnesota because each state’s market characteristics and policy framework are different.²⁰ However, any new reinsurance program will ultimately succeed if implemented to modify or replace the ACA’s current premium subsidy approach. That’s because, within the framework of the ACA, reinsurance introduces incentives to contain costs where none exist. In other words, reinsurance can only help matters.

Reinsurance addresses just a portion of the problem with the ACA’s approach to regulating and subsidizing the individual market. Congress should adopt reinsurance as one part of a comprehensive package to replace the ACA’s inflationary approach to subsidizing premiums. Another key part of that comprehensive package should adopt a fixed premium subsidy to replace the ACA’s inflationary subsidy that now rises lockstep with

the rise in premiums.

There is broad agreement in Congress that health care costs are too high. There’s also broad agreement that lower-income people need financial support to afford health coverage. The ACA provides that financial support to some people but worsened affordability for unsubsidized people. Moreover, the ACA ignored the broader problem with the high and rising cost of care in America. Congress can continue to help lower-income people afford health coverage while, at the same time, implement a package of reforms to improve affordability in the individual market and reduce the overall cost of care. Reinsurance is one policy tool that can help. ■

“Congress should adopt reinsurance as one part of a comprehensive package to replace the ACA’s inflationary approach to subsidizing premiums.”



The Affordable Care Act (ACA) began providing premium tax credit subsidies to people with incomes between 100 percent and 400 percent of the federal poverty level (FPL) in 2014. However, not everyone who meets this income eligibility requirement qualifies for a premium subsidy even if they meet every other eligibility requirement. This can happen when the premium subsidy calculation determines the cost of the premium is already affordable without a subsidy. Thus, though eligible, they are technically qualified for a premium subsidy of zero dollars. Reinsurance expands the portion of the individual market in this position, which expands the number of people who are fully price sensitive to the cost of their insurance premium. This appendix provides a more detailed description of this important cost-control feature of reinsurance.

One of the main criticisms of the ACA from both supporters and opponents of the law is the fact that it creates a “subsidy cliff.” People who qualify for premium subsidies and earn close to 400 percent of FPL can experience a sharp increase in premiums if their income rises and they lose eligibility for subsidies. However, not everyone is exposed to a subsidy cliff. As just explained, the subsidy calculates to zero dollars for some people who earn 400

percent of FPL or less if they already have access to affordable premiums. ACA premiums can vary quite substantially by geography and age. Thus, there’s always been a portion of younger people living in more affordable areas of the country where subsidies phase out gradually.

Here’s how the subsidy amount can equal zero dollars. The subsidy amount is calculated by how much a benchmark premium exceeds a certain percentage of income that increases on a sliding scale as income increases. This is referred to as the required contribution amount. If the benchmark premium is less than the required contribution amount, then the premium subsidy technically equals zero dollars. Because the benchmark premium varies by age under the ACA’s age rating ratio, the ACA’s subsidy eligibility for people with the same income varies by age under this calculation. As a result, a 60-year-old at 400 percent of FPL may qualify for a subsidy when a 30-year-old at the same income level but with a lower benchmark premium would not qualify.

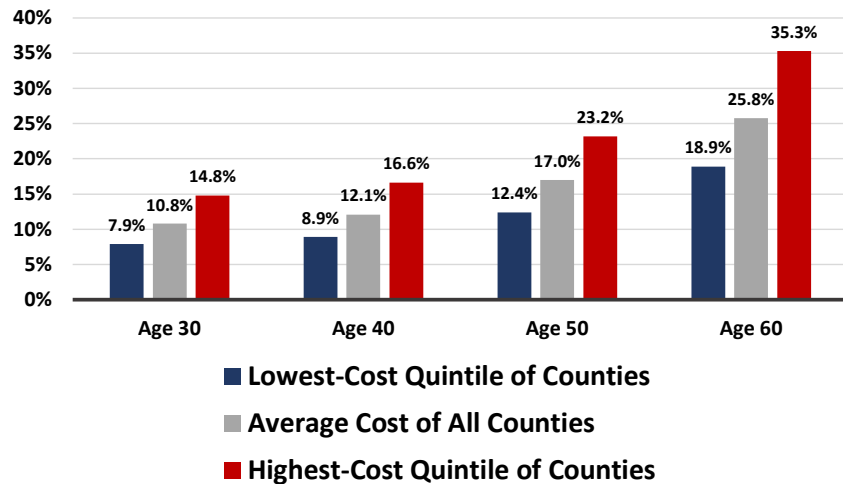
A CMS report documents how this subsidy cliff varied substantially by age and geography in 2020.²¹ On average, a subsidized premium for the lowest-cost silver plan for a 60-year-old earning \$45,000 cost 7.9 percent of income. However, if their income

rose to \$50,000—just a hair over the 400 percent of FPL eligibility threshold—the average cost of an unsubsidized premium jumped to 25.8 percent of income. As Figure A-1 shows, if this 60-year-old lived in the highest-cost quintile of counties, the average unsubsidized premium rose to 35.3 percent of income. That amounts to \$17,652 in premium for someone earning \$50,000. At the opposite end of the affordability spectrum, Figure A-1 shows that the unsubsidized premium for the lowest-cost silver plan for a 30-year-old earning \$50,000 who lived in the lowest quintile of counties added up to just 7.9 percent of income, or \$3,950. In this case, the benchmark premium was less than the required contribution amount and so there was no subsidy cliff.

By lowering premiums for the entire individual market risk pool, reinsurance increases the portion of the individual market who are not subject to the subsidy cliff. Instead, their subsidy phases down to zero dollars at some point before they earn more than 400 percent of FPL and technically lose eligibility. Here it is important to remember that “losing” access to a premium subsidy under reinsurance is a good thing. Losing access to a premium subsidy means the individual is gaining access to more affordable coverage as a percent of their income without a direct premium subsidy.

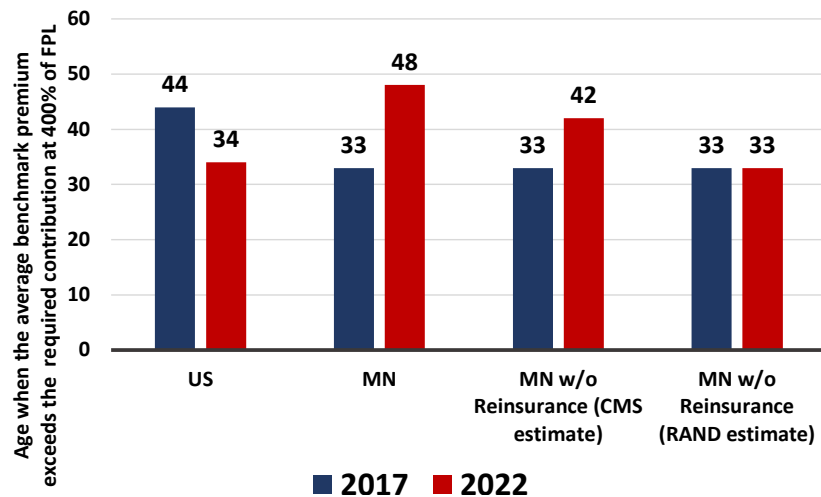
To understand the impact of

FIGURE A-1
Lowest-Cost Silver Plan Average Premium as a Percentage of Income at \$50,000 by Age, 2020



Source: Centers for Medicare & Medicaid Services, Affordability in the Marketplaces remains an issue for Moderate Income Americans, CCIIO Data Brief Series (January 2021).

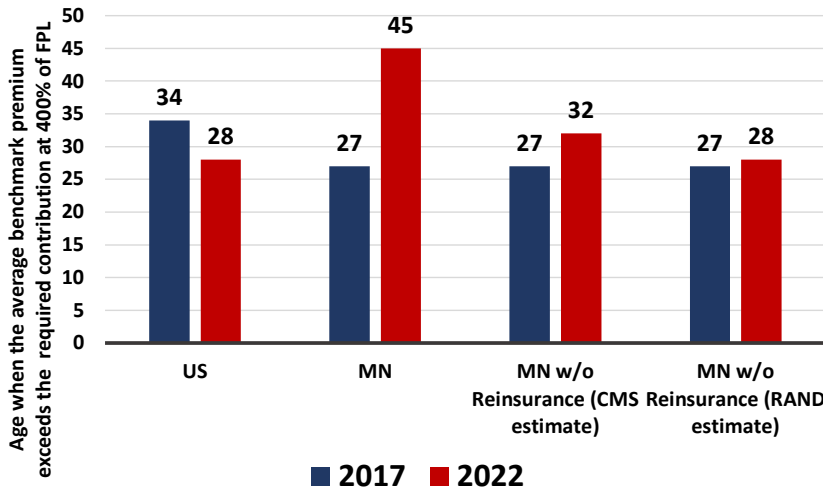
FIGURE A-2
Average age when people begin to qualify for subsidies at 400% of FPL (2017 Law)



Source: Author’s calculations from 2017 and 2022 benchmark plan premium data available from Kaiser Family Foundation website, “Marketplace Average Benchmark Premiums,” at <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/> (accessed on December 15, 2022); Centers for Medicare & Medicaid Services, State Specific Age Curve Variations (May 31, 2017); Centers for Medicare & Medicaid Services, State Innovation Waivers: State-Based Reinsurance Programs, CCIIO Data Brief Series (August 2021); and Justin W. Timbie, et al., Section 1332 Waiver Evaluation Report: Evaluating the Minnesota Reinsurance Program, RAND Corporation prepared for Centers for Medicare & Medicaid Services and Office of the Assistant Secretary for Planning and Evaluation (September 2021).

FIGURE A-3

Average age when people at 400% of FPL qualify for a premium subsidy under ARPA



Source: Author's calculations from 2017 and 2022 benchmark plan premium data available from Kaiser Family Foundation website, "Marketplace Average Benchmark Premiums," at <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/> (accessed on December 15, 2022); Centers for Medicare & Medicaid Services, State Specific Age Curve Variations (May 31, 2017); Centers for Medicare & Medicaid Services, State Innovation Waivers: State-Based Reinsurance Programs, CCIIO Data Brief Series (August 2021); and Justin W. Timbie, et al., Section 1332 Waiver Evaluation Report: Evaluating the Minnesota Reinsurance Program, RAND Corporation prepared for Centers for Medicare & Medicaid Services and Office of the Assistant Secretary for Planning and Evaluation (September 2021).

reinsurance on the size of the unsubsidized market, there would ideally be a way to segment the people enrolled in the individual market who would newly gain access to more affordable premiums than the current subsidy provides. Unfortunately, estimating the number of people who newly gain this access is constrained by the lack of individual market enrollment data by income level. The only publicly available data are the number of plan selections made during the annual open enrollment period by income level that CMS reports. However, the income levels they report are not always comparable from year to year and they do not reflect actual enrollment of people who followed through and paid their first month's premium.

An alternative way to visualize how reinsurance increases the number of price sensitive people in the market is to compare the age when someone at the highest income eligibility limit—400 percent of FPL—gains access to premium subsidies.

This is the point when the age-based benchmark premium rises above the individual's required contribution. Where premiums are more affordable, the premium subsidies kick in at a later age. When reinsurance lowers premiums even more, the age when subsidies start increases more. As a result, this narrows the age band of people who qualify for subsidies at this income level which reflects the broader number of price sensitive people in the market.

As shown in Figure A-2, in 2017 the average person at 400 percent of FPL begins to qualify for premium subsidies at age 44 in the U.S. and at age 33 in Minnesota. The fact that Minnesotans begin qualifying at an earlier age reflects the state's higher average benchmark premium in 2017. Figure A-2 also calculates how this age would change in 2022 using the 2017 eligibility rules. After Minnesota

implemented reinsurance and lowered premiums, the age when people at 400 percent of FPL qualify for subsidies would have increased to 48 in 2022. Because average premiums increased in the U.S., the average U.S. age dropped to 34.

The fact that the American Rescue Plan Act temporarily amended premium subsidy eligibility rules adds a further dimension to the analysis. For the purpose of this exercise, the analysis under the new eligibility rules is essentially the same because it still uses 400 percent of FPL as the income benchmark to compare the age when subsidies begin. The difference is that affordability is now based on a lower 8.5 percent of income. That means people will qualify for subsidies at lower premium levels and, therefore, lower ages. This is shown in Figure A-3.

Both Figures A-2 and A-3 also report ages when subsidies would kick in if Minnesota had not implemented reinsurance. One uses premium

estimates from CMS and the other uses premium estimates from RAND. Notably, the age under the RAND estimate would remain largely unchanged from 2017 to 2022. Thus, while RAND estimates a much higher premium reduction than CMS, it appears to lead to a more status quo result in 2022. It's also more consistent with the average U.S. experience. This suggests the RAND estimate may be more accurate than the CMS estimate. If true, this helps show how reinsurance results in more premium savings than just the amount of high-cost claims it pays. The most reasonable explanation for this outcome is that reinsurance adds incentives to lower costs.

Therefore, measuring the claims reinsurance pays does not fully reflect the program's premium impact. That suggests the federal government is shortchanging the amount of pass-through funding provided to states. It also suggests reinsurance can add better incentives to control costs to any congressional proposal to reform the ACA's premium subsidy structure. ■

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