Vermont Agency of Human Services

State-Based Reinsurance Options for Vermont

September 28, 2018

Contents

Executive Summary

Reinsurance is a mechanism to reduce health insurance premium increases by reimbursing health insurance issuers for certain high-cost claims. Some states have used the Affordable Care Act's (ACA) section 1332 state innovation waiver program (1332 waivers) to receive federal funding to establish a state-based reinsurance program. The Department of Vermont Health Access (DVHA) convened a team to explore this possibility for the Vermont marketplace. The study group found that a reinsurance program would require a significant state investment, but it may be a useful option, especially on a temporary basis as individual and small group marketplace premiums become less stable due to federal changes. The purpose of this document is to outline the considerations involved in establishing a reinsurance program in Vermont.

Background

Reinsurance

Reinsurance programs provide payments to insurers to help offset the expenses associated with high-cost enrollees. Because insurers do not have to cover the full cost of high-cost claims, they are able to keep premiums at lower rates for all enrollees. It is important to note that reinsurance does not eliminate or stop the drivers behind health care insurance premium rate increases. Rather, it mitigates premium increases by providing funding for high-cost health insurance claims.

The ACA established a federal transitional reinsurance program for plan years 2014 through 2016. While the parameters and levels of funding changed from year to year, the federal reinsurance program resulted in 2.5-5.0% savings in Vermont qualified health plan (QHP) premiums for the years it was in place.[1]

When the federal program sunset, states began exploring state-based programs. The Centers for Medicare & Medicaid Services (CMS) encouraged this activity and suggested that 1332 waivers could provide a portion of the funding.

ACA Section 1332 State Innovation Waiver Program

Section 1332 of the Affordable Care Act allows states to apply to waive certain provisions of the ACA. In a 1332 waiver, a state must show that their proposal will meet four "guardrails:" that coverage will be provided to a comparable number of individuals as would receive coverage absent the waiver; coverage will be as affordable for individuals as it would be absent the waiver; the scope of benefits will be at least as comprehensive as benefits required absent the waiver; and the waiver will not increase the federal deficit.[2] States can receive a "pass-through" of federal funds that would have otherwise been applied to premium tax credits had the state not received the waiver.[3] Reinsurance is one example of a strategy that may be proposed in a 1332 waiver and is the focus of this report.

---

[1] See BCBSVT and MVP Rate Filings 2014-2016

[2] 45 CFR Part 155 Subpart N

[3] When the federal government was still making cost-sharing reduction (CSR) payments, CSR savings could have been included in this calculation.

A 1332 waiver also requires an actuarial and economic analysis, a 10-year budget plan, and state legislation to authorize or instruct the state to submit a waiver application.[4] While experiences among states have varied, the 1332 waiver process may take up to 18 months. As of August 2018, seven states had received 1332 waivers for the purpose of establishing reinsurance: Alaska, Maine, Maryland, Minnesota, New Jersey, Wisconsin, and Oregon. There are several other states that are considering 1332 reinsurance waivers as an option.

A 1332 waiver works as follows in the reinsurance context: because reinsurance allows issuers to lower premiums, the federal government will save dollars that otherwise would have been spent on premium tax credits, which will be passed through to states for the reinsurance program. States may only receive pass-through funding equal to the amount of federal tax credit dollars saved as a result of the reinsurance program.

The potential for pass-through funding depends on the structure of the health insurance market that reinsurance would apply to and, specifically, the proportion of that market that receives premium tax credits.

Vermont Market Structure

Vermont has a merged individual and small group market with nearly 80,000 covered lives (34,000 individuals and 45,000 group members).[5] This is also referred to as the qualified health plan (QHP) market. Vermont is one of two states with a "merged" risk pool (the other is Massachusetts). Merging the market was an effort to create stability by increasing the size of the health care insurance market and taking advantage of a more robust mix of risk. Approximately 23,000 individuals receive premium tax credits. Therefore, two-thirds of the individual market, or one quarter of the merged market, is subsidized. Eligible individuals in the Vermont QHP market will receive $85-$90 million in federal premium tax credits for 2018. This is expected to increase to over $100 million with "silver loading" in 2019.[6]

Unlike many states, Vermont QHP enrollment and premiums were relatively stable between 2014 and 2018.

[4] 45 CFR 155.1308(f)

[5] See DVHA Health Coverage Map at http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q1.pdf

[6] Silver loading refers to the concept of including funding for the federal CSR program in the silver plan rates, because silver plans are the only plans that benefit from CSR. This approach also results in increased premium tax credits since those credits are dependent on the premium of the second lowest cost on-exchange silver plan.

Individual and Small Group Enrollment and Average Rate Increases

Plan Year	Individual	Small Group	BCBSVT	MVP
2019	TBD	TBD	5.6% [1]	6.6% [1]
2018	33,373 [2]	44,744 [2]	9.2%	3.5%
2017	32,705	46,854	7.3%	3.7%
2016	31,249	46,396	5.9%	2.4%
2015	30,344	39,920	7.7%	10.9%
2014	25,589	33,935	N/A	N/A

Source: QHP rate filings and carrier data on member months per plan year as reported to DVHA. A person who had coverage the whole year would count as one member year while someone who had coverage for nine months would count as .75.

[1] Includes silver loading. Effective increase is smaller.
[2] June 2018 active enrollment (covered lives as of 6/15/18 for MVP and 6/30/18 for BCBVT). Because this report was written before 2018 data is complete, a snapshot of mid-year enrollment was used as a proxy.

Recent federal actions have destabilized the marketplace, including the defunding of federal cost-sharing reduction (CSR) payments, removal of the individual mandate penalty, and new regulations to expand short-term limited-duration insurance (STLDI) and association health plans (AHPs).[7] While these changes impact all exchanges, AHP development may have a particularly significant impact on Massachusetts and Vermont due to their merged individual and small business marketplaces.[8] Prior to 2014, Vermont had a number of active AHP insurance groups that were subsequently required to purchase health insurance benefits through the exchange. Vermont anticipates some migration from the small group market back to AHPs in 2019. If this migration includes those with lower health care utilization, or "good risk," there is likely to be additional upward pressure on QHP premiums.[9]

A merged market dilutes the impact of reinsurance or other premium reduction efforts because the premium reductions are spread across the entire market of both individuals and small businesses. In the context of a 1332 waiver, this could reduce the potential pass-through funding available because the amount is determined based on the individuals eligible for tax credits. Therefore, it is important to consider how the market structure and impact of reinsurance would be represented in a 1332 waiver application.

Vermont Process

In May 2018, DVHA convened a study group on the possibility of state-based reinsurance in Vermont. DVHA accessed an offer of technical assistance through the National Governors Association (NGA) Bipartisan Health Reform Learning Network, for which Vermont had been selected in 2017.

[7] See Executive Order 13813 Promoting Healthcare Choice and Competition, October 12, 2017. AHP regulation at 29 CFR Part 2510. CMS also temporarily suspended risk adjustment payments in 2018.
[8] See Association Health Plans: A Primer and Key Considerations for Massachusetts, Blue Cross Blue Shield of Massachusetts Association, May 2018
[9] See BCBSVT amended rate filing July 18, 2018 at http://ratereview.vermont.gov/sites/dfr/files/2018/Amendment%20to%20BCBSVT%20VISG%202019%20Filing.pdf

The study group consists of representatives, actuaries and policy staff, from the Agency of Human Services (AHS)/DVHA, Department of Financial Regulation (DFR), Green Mountain Care Board (GMCB), and both QHP issuers: MVP Health Care and Blue Cross and Blue Shield of Vermont. The group established a goal of producing an options paper by the end of the 2018 summer, detailing preliminary budgetary projections, program options, issues and risks.

Between May and August 2018, the group worked with NGA and its technical assistance consultants. It considered Vermont-specific data and received information from other states, including an in-depth meeting with the Minnesota Commerce Department. It also consulted informally with actuarial experts and the federal government (specifically CMS).

Discussion

Preliminary Budget Projections

A complete budget projection requires actuarial analysis beyond the scope of this study project. A comprehensive actuarial analysis should be the next step if there is interest in further discussion of state-based reinsurance. Instead, the study group used public Vermont data to identify basic, preliminary budget considerations.

The ratio between premium and premium tax credits in the market dictates the relationship between state investment and federal pass-through funding for reinsurance through a 1332 waiver. In looking at Vermont's enrollment and subsidy information, it quickly becomes clear that a purely merged market limits the amount of federal pass-through funding available to the state. Therefore, the study group considered three scenarios:[10]

1. the current market structure;
2. an unmerged market;[11] and
3. a compromised merged market having lost much of its good risk.

In the current Vermont QHP market, there is about a 5:1 ratio between premiums and premium tax credits.[12] Thus, under scenario 1, a reinsurance program would need to be 80% state funded.[13] For example, in order to target a 5% premium reduction through reinsurance, the state would need to invest approximately $20 million and would receive about $5 million in federal pass-through dollars.

---

[10] Our assumption is that reinsurance would apply to qualifying claims across the market in question in each scenario, although a program could be structured to apply only to individual market claims (like CMS's administration of the ACA reinsurance program). This does not impact the budget discussion wherein we are examining the portion of the market affected by potential rate mitigation.

[11] There have been suggestions that it would be possible to write a waiver specific to the individual market even without splitting the market in state law, so the group considered that possibility.

[12] Total premium in the merged market is approximately $500 million. DVHA projects a silver-loaded premium tax credit total of just over $100 million annual.

[13] To illustrate further: spread across the market, Vermonters receive 1 dollar of APTC for every 5 dollars of premium paid; and the federal government would save 1 dollar of APTC for every 5 dollars of premium saved. Saving 5 dollars of premium (i.e. through reinsurance) could be funded with 1 dollar in pass-through funding for every 4 dollars in state funds.

Scenario 1: Example Budget - Merged Market

Rate reduction target ($)	Rate reduction target (%)	Federal funds ($)	State funds ($)
25 million	5%	5 million	20 million
50 million	10%	10 million	40 million

In scenario 2, the unmerged market, the ratio between premiums and premium tax credits would decrease because a significantly larger portion of the market would be subsidized. This would increase the federal share from 20% to a range of 40-45%.

Scenario 2: Example Budget - Unmerged Market

Rate reduction target ($)	Rate reduction target (%)	Federal funds	State funds
25 million	5%	11 million	14 million
50 million	10%	22 million	28 million

Scenario 3, where the merged market exists but a number of small groups have joined AHPs thereby removing a portion of the population from the marketplace, is not possible to model without further actuarial analysis. However, it could require a larger state investment to offset to the potential rate increase resulting from a depleted risk pool.

In brief, any state-based reinsurance program would require a significant investment of state funds. That investment could be reduced, and additional federal dollars leveraged, if the market were unmerged or treated as unmerged for the purposes of reinsurance.

Parameters of a Reinsurance Program

There are a number of program design options a state must consider when establishing a reinsurance program, the first of which is what claims to reinsure. There are two options that have been chosen by states: claims-based reinsurance and conditions-based reinsurance. There are advantages and disadvantages to each approach.

Claims-based Reinsurance

A claims-based reinsurance program repays insurers for a portion of all high-cost claims within a specified dollar value range. This has been the most common approach used by states with an existing reinsurance program.

For a claims-based reinsurance program there are several additional operational considerations:

- the “attachment point” or the dollar amount at which reinsurance begins to apply to high-cost claims;

- the reinsurance cap, or a maximum claim level for which an insurer can receive reimbursement; and
- a coinsurance level or the percentage of claims within the identified range (between the attachment point and the cap) for which reinsurance payment is available.

The attachment point for existing state reinsurance programs is typically between $15,000 and $100,000 for an individual claim, and most of the programs apply the reinsurance cap for an individual claim level between $250,000 and $1 million per claim. Carrier stop-loss insurance coverage typically applies to the very highest level of claims, while reinsurance is focused on more frequent, yet costly, claims.

Claims-based reinsurance has a number of financial decision points, including how to set the attachment point, reinsurance cap, and coinsurance level, and how much funding will be available for the program overall. The program must be modeled on typical claims experience, but it is a relatively straightforward program design. The federal program that operated from 2014 through 2016 was a claims-based system.[14]

Conditions-based Reinsurance

A conditions-based reinsurance program identifies high-cost medical conditions and reimburses for 100% of the claims for individuals with the identified medical diagnoses. Once the individual with the condition is identified, all claims, regardless of whether they are associated with the particular condition, are covered by the reinsurance program. The member does not know that the insurer is receiving reinsurance payments for their claims or incur any additional cost or change to benefits.

Of the five states that have implemented 1332 waiver state reinsurance programs, one (Alaska) chose a conditions-based format. Alaska identified 33 high-risk conditions for which an insurer could be eligible for reinsurance. One of the benefits of this program design could be an opportunity for better management of expensive conditions and identification of cost drivers, yet in Vermont this could conflict with existing case management programs operated through Blueprint, the OneCare ACO, or by insurers' case management programs. Conditions-based programs may also be more difficult to administer, because the conditions must be identified and coverage is focused on individuals rather than claims dollar values alone. High-cost claims due to accidents are also excluded in this model.

Program Administration

The administration of section 1332 state reinsurance programs is usually a partnership between the agency running the health insurance exchange and the state's insurance commissioner, who implements the reinsurance program and operates the financial aspects. The program requires significant cooperation between the state and participating issuers.

[14] The ACA's reinsurance program partially reimbursed plans for high-cost claims in the individual market up to $250,000 per year. Note that it did not account for VT's merged market in administration of the program; however, the rate impact was spread across the merged individual and small group market.

Risks and Issues

Leveraging Federal Dollars

As discussed above, the success of a state reinsurance program is largely based on the amount of federal funding that can be leveraged for each state dollar invested. The merged market in Vermont limits the leveraging ratio. In other states, this is not the case. The Minnesota reinsurance program, for example, is roughly 50% federally funded. If a strategy can be identified to maximize the amount of federal funds, such as mimicking a split pool, actually separating the two groups, or if a significant number of small businesses leave QHP to join the AHP marketplace, then a reinsurance program may be more advantageous for Vermont.

Program Funding

One of the most controversial aspects of state reinsurance programs has been the source of state matching funds. There are any number of revenue sources a state may identify in the 1332 waiver application to apply to the reinsurance program. States have used general fund, issuer assessments, and fees from a state-based individual mandate. Most state reinsurance programs to date are designed to be temporary, and this is in part due to the funding limitations.

Perceived Value: First-year Rate Impact versus Ongoing Price Driver Issues

A state reinsurance program may lower the cost of health insurance premiums or reduce the amount of the increase in the first year it is implemented. In order to maintain the rate advantage, the reinsurance program must continue. Reinsurance does not eliminate or stop the drivers behind health care insurance premium rate increases. The ongoing consumer benefit may therefore be disguised or dwarfed by the underlying growth in medical costs. By providing funding for high-cost health insurance claims, reinsurance lowers the premium increases for consumers. A reinsurance program is as effective as the amount of funding dedicated. The more state funds used, and the larger the amount of claims offset, the bigger the initial rate reduction or mitigation of the increase. While there may be other ways to achieve similar outcomes, under the current federal administration, reinsurance programs are the favored method for mitigating consumer rate increases.

Double-counting with Risk Adjustment Payments

Concerns have been raised as to whether a claims-based reinsurance program and the federal risk adjustment payment program could reimburse insurers twice for the same claims. This group reviewed studies and the work of other states and determined that these concerns are not enough to prevent a reinsurance program from going forward.[15] It appears that the level of duplication may be small, and the only identified method of mitigating the impact, by creating a state-operated risk adjustment program, is a substantial burden. No state with a reinsurance program to date has been prevented from moving forward because of this issue.

[15] See State-Based Risk Adjustment System Assessment and Feasibility Study, MN Department of Health, October 2016; and How Changes to Insurance Market Rules Affect Risk Adjustment, American Academy of Actuaries, May 2017.

Interaction with Vermont's All-payer Model

The study group considered the potential interaction of a QHP market reinsurance program with the all-payer model and specifically the OneCare ACO. Because participating payers would account for reinsurance in their ACO projections, there is not a risk of double indemnification.

Timeline

Obtaining a 1332 waiver can take up to 18 months. Expedited review at CMS has shortened the overall time for federal review, but the state-level steps still require up to an 18-month lead for development. For example, in order to have a program in place for the 2020 plan year, a proposal would need to be developed in the fall of 2018, legislation would need to pass in the 2019 session, and the application process would need to be complete in the summer for implementation in the fall of 2019.[16] This would require a tremendous amount of work and collaboration among stakeholders between now and implementation.

Recommendation and Next Steps

Reinsurance is an approach that can be considered for stabilization of the Vermont marketplace against disruption due to federal changes, including AHP proliferation. While it would require a significant state investment, reinsurance should be on the table as a mechanism for temporary relief if funds are available.

If reinsurance is considered, the study group recommends pursuing a claims-based program as opposed to conditions-based. Claims-based reinsurance would be comparatively easy to administer. Parameters including attachment point and which portion of the market to reinsure would follow from more robust actuarial analysis. A policy discussion around which conditions to reinsure could be unpalatable and distract from other initiatives to address high-cost claims.

Implementation of reinsurance would likely be a partnership between DVHA and DFR, with considerable cooperation from the QHP issuers. DVHA would facilitate federal conversations and submission of a 1332 waiver. The state entities would work together on administration of the program itself.

The next step in pursuing reinsurance would be to commission a formal actuarial study. This would inform both program parameters and budget projections. If there is interest in moving forward from there, legislative action is necessary to authorize a 1332 waiver and appropriate funds. Accounting for waiver requirements and the federal review process, the earliest Vermont could obtain pass-through funding to support reinsurance would be 2020.

Conclusion

Vermont is different than other states that have implemented state-based reinsurance through a 1332 waiver. The primary distinction is its merged market structure. Additionally, its low uninsured rate and relative market stability mean that Vermont has not experienced the market crises that have caused other states to seek this type of solution. However, that stability may be compromised as a result of recent federal changes. Therefore, it is important to consider reinsurance as an option.

[16] See timeline in Appendix B.

Other Areas for Exploration

In discussing reinsurance, other ideas have surfaced related to premium reduction and pass-through opportunities that may warrant further exploration outside the context of this study project, depending on policy priorities. For example, while reinsurance would subsidize the market as a whole, there may be other mechanisms to alleviate pressure in certain portions of the market and insured population. These ideas include changing the market structure to divide between individual and small group, age rating, expanded Vermont premium reduction to soften the benefit cliff, or additional targeted subsidies.

Appendix A: Additional Resources

1332 waiver application template (State Health and Value Strategies)
https://www.shvs.org/resource/application-template-for-section-1332-reinsurance-waiver/

State legislation (National Conference of State Legislatures)
http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx#1332_Legislation

Appendix B: Slide Deck Summary (including 1332 waiver timeline) - begins on next page

Appendix B

NATIONAL GOVERNORS ASSOCIATION

Market Stabilization: Reinsurance and Section 1332 Waivers

September 10, 2018

Purpose of Today's Discussion

- Consider reinsurance as a potential strategy to increase stability in the individual insurance market
- Discuss Section 1332 waivers as a vehicle for state flexibility to establish a state-run reinsurance program

The National Governors Association

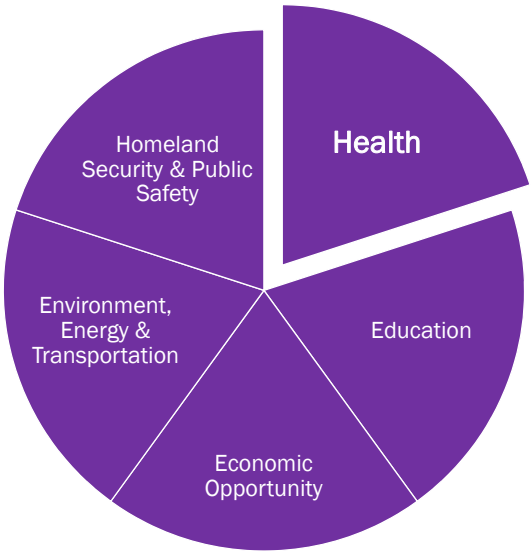
Conference of Governors
The White House, 1908

Who We Are

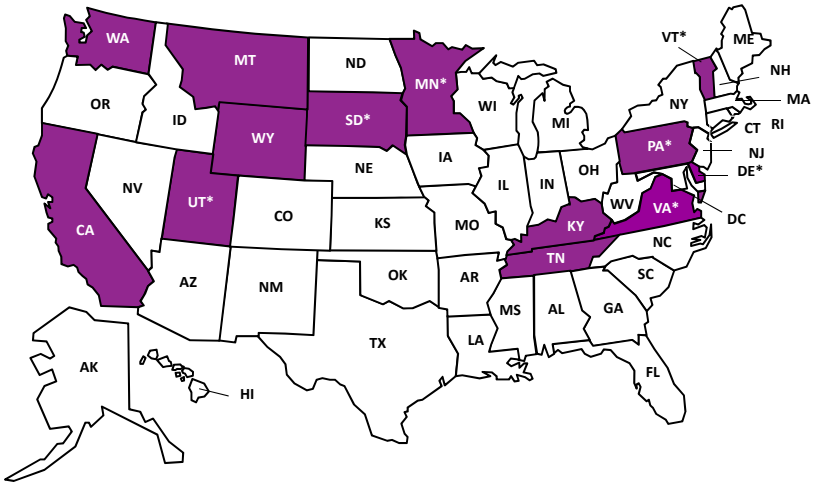
National Governors Association (NGA) is the bipartisan organization of the nation's governors. Through NGA, governors share best practices, speak with a collective voice on national policy and develop innovative solutions that improve state government and support the principles of federalism.

National Governors Association

NGA Center for Best Practices



Governors' Bipartisan Health Reform Learning Network



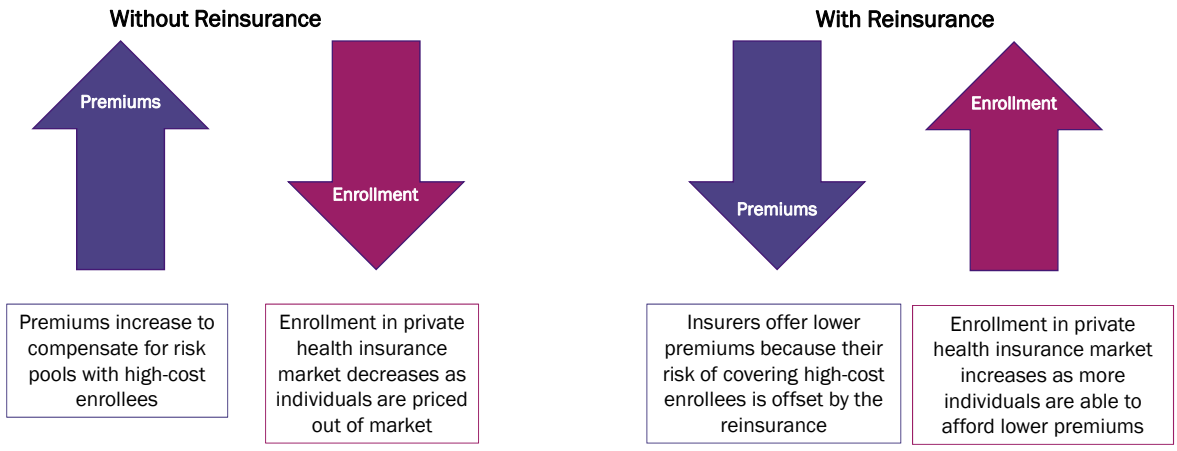
- Provides unbiased information about health reform proposals and the state impact
- Offers a forum for states to engage in dialogue with other state leaders and identify shared priorities for reform
- Released in June, Shared Priorities from the Governors' Bipartisan Health Reform Learning Network highlights priorities for Medicaid, private health insurance and public health

The Affordable Care Act's Federal Transition and Risk Mitigation Programs

Risk Adjustment (ongoing)	• Transfers money from insurers with low expected spending to insurers with high expected spending
Risk Corridors (2014 - 2016)	• Transferred money from insurers with low *unexpected* spending to insurers with high *unexpected* spending
Reinsurance (2014 - 2016)	• Provided subsidies to individual market plans for enrollees incurring high actual spending
Traditional High Risk Pools (2010 - 2014)	• Provided health insurance to those that had been denied coverage by private health insurance companies because of a pre-existing condition

How Reinsurance Programs Work

States are interested in reinsurance programs as one strategy for lowering premiums and increasing enrollment in the individual insurance market



Reinsurance Program Design Options

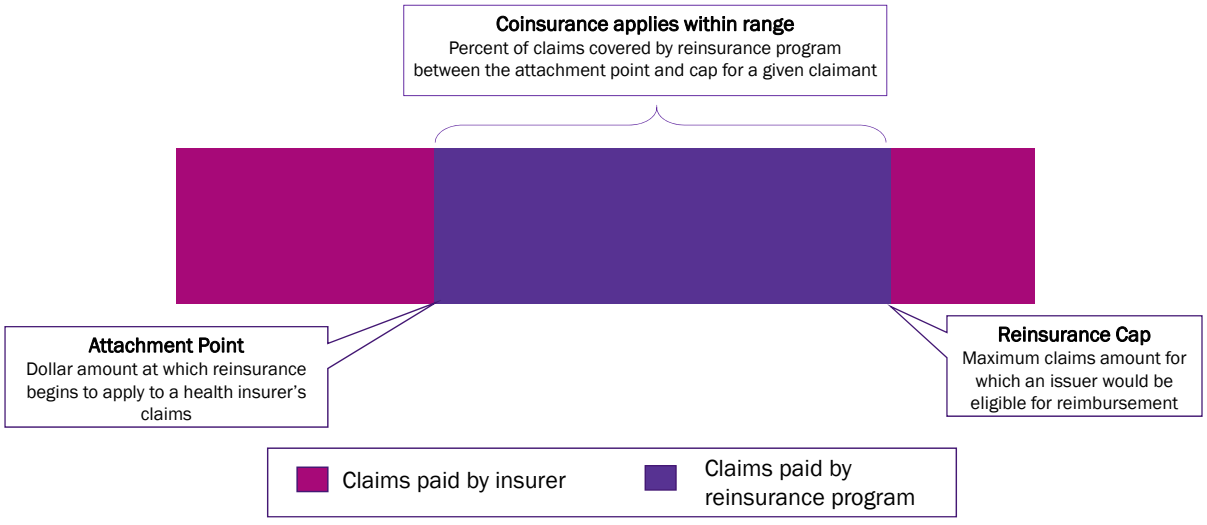
Claims-based

- Insurers are repaid for a portion of all high-cost claims incurred
- Claims do not need to be associated with any particular condition
- Insurers do not cede premiums to receive reinsurance payments
- Increases predictability for insurers regarding financial accountability by helping pay for high cost claims
- Payment is between reinsurance entity and insurer; consumers are not involved regardless of their health status or cost of claims

Conditions-based

- Insurers are paid for all claims associated with individuals diagnosed with certain high-cost conditions in exchange for giving premiums to reinsurance pool
- All claims for individual are paid to insurer regardless of whether they are associated with the high-cost condition
- Members do not know that their premiums have been ceded to the reinsurance pool
- Payment is between reinsurance entity and insurer; consumers are not involved regardless of their health status or cost of claims

Operational Variables of Reinsurance Programs



Section 1332 Waiver Basics

Section 1332 waivers are a vehicle for states to waive certain provisions of the Affordable Care Act, including:

- The establishment of qualified health plans and exchanges
- Individual and employer mandates
- Benefits and subsidies for consumers
- The establishment of a single risk pool

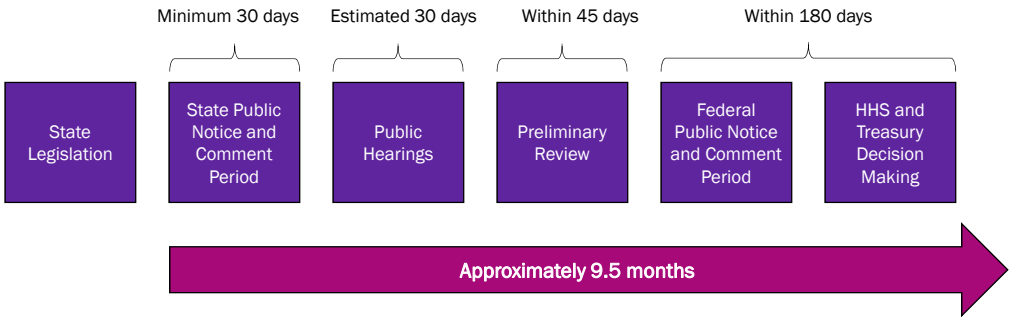
States may receive a "pass-through" of federal funds that would have otherwise been applied to premium tax credits or cost-sharing reductions had the state not received the waiver

Section 1332 Guardrails

All Section 1332 waivers must satisfy the following guardrails:

Coverage Availability	Coverage will be provided to a comparable number of individuals as would receive coverage absent the waiver
Coverage Affordability	Coverage will be as affordable for individuals as it would be absent the waiver
Comprehensiveness of Coverage	The scope of benefits will be at least as comprehensive as benefits required absent the waiver
Deficit Neutral	The waiver will not increase the federal deficit

Section 1332 Waiver Process Timeline



Section 1332 Checklist

Applications must include:

- ☐ List of provisions being waived
- ☐ Proposed waiver implementation plan and timeline
- ☐ Actuarial and economic analysis and 10-year budget plan
- ☐ Data, assumptions, targets and other information related to the impact of the waiver on the four guardrails
- ☐ State legislation authorizing the application that includes language that program is contingent upon federal approval of the waiver
- ☐ Public communications documenting the public hearings and notice of public comment period
- ☐ Communications documenting consultation with Tribal entities in state
- ☐ Written comments received during the notice and comment period
- ☐ Funding strategy for state portion (which may require legislative action)

State Financial Share and Legislative Requirements

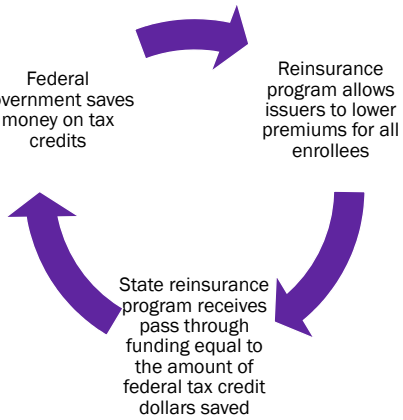
State Financial Share

- States must provide a funding strategy that would cover the cost of the difference between the federal pass-through dollars and the total cost of the reinsurance programs
- Funding needed varies based on range of issues, including demographics and cost of insurance
- In states with 1332 reinsurance programs, the state share has come from several places, including:
  - State General Fund dollars
  - Legislative dollars set aside for health access programs
  - Assessments on insurers

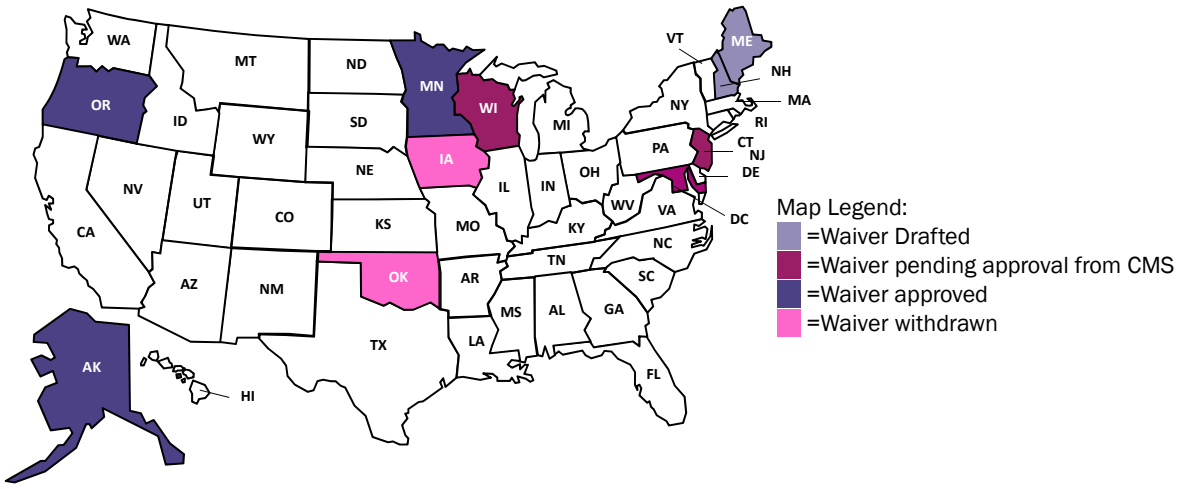
Legislation

- Legislation related to a Section 1332 reinsurance waiver must:
  - Specifically authorize or instruct the state to submit a waiver application
  - Demonstrate legal authority to manage a reinsurance program
  - Provide that the state reinsurance program is contingent upon federal approval of the waiver (or will become effective only if the Section 1332 waiver is approved)

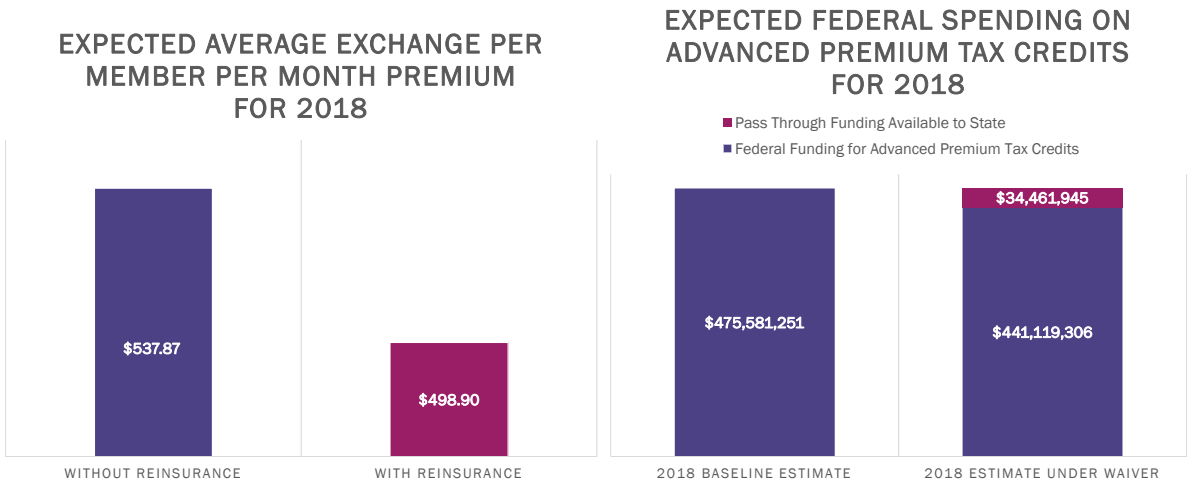
How Reinsurance Works as Part of a Section 1332 Waiver



State Section 1332 Reinsurance Waiver Activity to Date



Example: Oregon Reinsurance Program's Impact on Premiums



Information from Oregon Department of Consumer and Business Services. (August 31, 2017). *Oregon 1332 Draft Waiver Application*, (accessed on 7/10/2018): https://healthcare.oregon.gov/DocResources/1332-application.pdf

Key Decision Points and Considerations

Decision Points:

- **Operational Variables:** Attachment point, cap, coinsurance
- **State funding:** Assessment, general fund dollars, ceded premiums

Key Considerations:

- What will be the impact on premiums and enrollment?
- How much state and federal funding will be needed?
- How will state fund its portion of the program?
- Who will administer the program for the state?

Questions?

Hemi Tewarson
Division Director
NGA Center for Best Practices
htewarson@nga.org
202-624-7803

Lauren Block
Program Director, Health Division
NGA Center for Best Practices
lblock@nga.org
202-624-5395

Appendix

States That Have Existing Reinsurance Programs through 1332 Waivers

State	Attachment Point	Reinsurance Cap	Coinsurance	Estimated reinsurance funding	Source of state funds
Alaska	N/A	N/A	100%	2017: $55M in state dollars from premium tax 2018: $50.5M in federal funding approved $25M contribution from Premara	Premium tax on all health insurers
Minnesota	$50,000	$250,000	80%	$132M in state funding $139M in federal funding approved	State General Fund and Health Care Access Fund
Oregon	Not yet determined	$1,000,000	50%	$90M in state funding $35M in federal funding approved	1.5 % Premium assessment on fully insured commercial major medical plans

States That Are Considering Section 1332 Waiver Reinsurance Programs

State	Attachment Point	Reinsurance Cap	Coinsurance	Estimated reinsurance funding	Source of state funds
New Jersey	$40,000	$215,000	60%	$105.8 million in state funding $218 million in federal funding requested	Revenue from state shared responsibility tax and appropriation from the State General Fund
Wisconsin	$50,000	$250,000	TBD (between 50%-80%)	$30 million in state funding $170 million in federal funding requested	State general fund
Maine	$47,000	N/A	90% for claims between $47,000 100% for claims above $77,000	$60 million in state funding $33 million in federal funding	Organizational and Base market assessments on health insurers and third party administrators and ceded premiums for participating enrollees
Maryland	TBD	$250,000	80%	$365 million in state funding $280 million in federal funding	2.75 percent assessment on health insurance plans and state regulated Medicaid managed care plans