

How Have States Like New York and Arizona Used Reinsurance to Help Businesses Control the Cost of Health Insurance?

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*P*olicymakers are asking whether publicly funding reinsurance is a useful way to expand primary coverage and reduce the number of uninsured, particularly for small employers. Reinsurance reimburses primary insurers for cumulative claims that exceed established thresholds during a year. The main goal is to reduce premiums and encourage enrollment by subsidizing high-cost claims. Reinsurance may also help spread risk more broadly, protect the solvency of insurers, and reduce variation in premiums from year to year. Arizona and New York have both used reinsurance, although their approaches differ. Relatively modest state subsidies and other changes have helped make health insurance more affordable and have enrolled some people who were previously uninsured. Careful implementation is important to (a) maximize the impact of public dollars and (b) maintain incentives for insurers to control the cost of large medical claims that reinsurance covers.

In many states, keeping health coverage affordable is an urgent priority. The uninsured get less care, live sicker, and die younger than those with insurance. Many of the uninsured work for small employers, who often face uncertain and fluctuating costs for health care. Predicting the claims costs for small firms is harder than for large groups, and a few high-cost claims can sharply raise premiums or encourage employers to drop coverage.

The primary purpose of reinsurance is to bear the risks of large medical claims. High-cost cases account for a substantial amount of health care spending. For example, annual claims of over \$30,000 per person accounted for about 22% of insured health costs in 2004.¹ Policymakers are asking whether a carefully designed and well-executed reinsurance program is a good way to expand coverage and reduce the number of uninsured. This chapter defines reinsurance, explains why policymakers are interested, describes how New York and Arizona have used reinsurance, and raises issues that policymakers might consider.

What is Reinsurance?

Reinsurance serves as insurance for insurers, that is, for insurance companies, HMOs, and self-insured employer groups. Reinsurance protects these “primary” insurers from high-cost medical claims. Insurers, in turn, are expected to lower premiums and reduce variation in the cost of premiums from year to year. There are two main types of reinsurance: retrospective and prospective.²

Randall R. Bovbjerg

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Retrospective reinsurance reimburses a primary insurer for high-cost claims at year's end. A specified threshold operates as a kind of deductible for the primary insurer. For example, reinsurance may pay an insurer for 80% of any individual's cumulative claims that exceed \$50,000 for the entire year. The remaining 20% is then paid by the primary insurer as coinsurance. There is typically a ceiling on reinsurance as well, so that costs are shared within a "corridor" of coverage. Reinsurance is not visible to primary insurance enrollees, as the primary carrier continues to collect their premiums and pay their claims. Retrospective reinsurance is sold by private companies, and many primary insurers purchase its protection. Retrospective reinsurance can also be part of a public reform and funded by public revenues. Both New York and Arizona have used this type of reinsurance. New York covers individuals' claims costs, whereas Arizona has focused more on aggregate levels of cost for participating managed care organizations.

Prospective reinsurance is different. It allows insurers to designate individuals for reinsurance in advance, rather than submit high-cost cases for reimbursement after they have occurred. The primary insurers "cede" or transfer an individual's spending risk to a reinsurance pool at the time of enrollment. The primary insurer continues to cover the individual enrollee's claims, but is reimbursed by the reinsurance pool for some or all costs above a specified threshold. Ceding insurers pay the pool a premium up front, and all participating insurers pay a pro-rata share of any pool deficit at the end of the year, much as for workers' compensation pools.

Prospective reinsurance is a publicly created mechanism and does not exist in the private market because a high-cost individual is not an insurable risk. Prospective insurance has been enacted as part of broader reforms of the small group market that also limit insurers' ability to reject applicants or charge premiums according to health risk.³ Currently, no state is using public funds to subsidize prospective reinsurance.

Public reinsurance, whether prospective or retrospective, is seldom a stand-alone reform. Typically, it is part of a broader strategy to maintain or expand coverage.

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Why are States Interested in Reinsurance?

The principal reason that primary insurers seek **private reinsurance** is solvency protection, that is, protection against losses that are unexpectedly high relative to their net worth or expected annual earnings. Reinsurance especially facilitates participation in the insurance market by new firms unfamiliar with market risks, or by smaller firms unable to bear high losses on their own. For example, many medium-sized firms would not self insure without reinsurance to protect their assets from catastrophic medical losses.

Private reinsurance deals quite well with unpredictable risk, such as accidents. However, it is less effective with identifiable high-risk individuals or groups, such as diabetes patients. For high-cost individuals, the only private options are to (a) pay sharply higher premiums, or (b) agree to reduced coverage. Only public intervention can help them, including through reinsurance subsidies of very high-cost cases.

There are four main reasons that states are interested in public reinsurance as a reform:

- 1) **Help Reduce Risk Selection.** Insurers worry about “adverse selection,” the tendency of enrollees to have higher than average risk of claims where individuals or small groups are choosing whether to buy coverage. Above-average claims experience forces an insurer to raise premiums, which discourages even average-risk individuals from enrolling and forces yet higher premiums, which in the extreme can cause a “death spiral.” Policymakers worry that insurers will combat adverse selection by discouraging or surcharging high-risk enrollment. Public reinsurance serves to reduce the incentive for risk selection by insurers, by assuming most of the burden of high-cost claims.
- 2) **Protect the Solvency of Insurers.** Public reinsurance has also been used to protect new market entrants. The prime example comes from states’ move to Medicaid managed care in the 1990s. No Managed Care Organization (MCO) had much experience pricing this population, and some had no experience with risk bearing at all. States used part of the Medicaid monthly capitation payments to finance public reinsurance, or required the MCOs to purchase private reinsurance to protect their solvency.⁴ Similarly, self-insured health plan groups for small employers also purchase private reinsurance to guard against insolvency.
- 3) **Lower Insurance Costs for Consumers.** Because public reinsurance lowers insurers’ claims costs, it should also cut premiums if either competition or regulation is effective. These lower premiums then encourage people to purchase insurance. Reinsurance is thus a form of premium subsidy, but one that is targeted to high-cost cases. Reinsurance can also complement policies that adjust premium subsidies by risk category; with reinsurance, payments to insurers are adjusted retrospectively, according to the level of high risks actually enrolled.
- 4) **Stabilize the Small Employers Insurance Market.** Small employers and their insurers struggle in the market because their premiums are higher and vary more than the premiums of large employers. High-cost claims can cause sudden rate increases, and insurance enrollment can change quickly as employers seek better terms elsewhere. Reinsurance assistance potentially can help stabilize the market, reducing the need for price increases and changes in carriers.

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Randall R. Bovbjerg

What Approaches to Reinsurance Have States Taken?

To date, no state has chosen to use public funds to subsidize prospective reinsurance. Thus, this section focuses on several states’ proposed and existing retrospective public reinsurance programs.

Kansas is considering two types of retrospective reinsurance. First, *diagnosis-based reinsurance* is one approach that reinsures all claims paid for designated diagnoses, particularly high-cost conditions such as diabetes. Individuals with

these diagnoses are often rejected or face heavy surcharges in the private market. Second, *general small-group retrospective reinsurance* is a broad approach that could reimburse *all* primary health insurance claims above a specific threshold for *all* small-employer businesses.⁵ This mechanism, which is much more expensive to implement, has also been proposed in **Iowa**, where participation would be mandatory for businesses that employ up to 25 people; funding would come, not from businesses, but from fees on tobacco products.⁶

New York. Healthy New York is the most visible national example of using public reinsurance to expand coverage.^{7, 8, 9, 10} The program targets previously uninsured small businesses and working individuals with low incomes. Healthy New York offers coverage only through HMOs, and all such plans are required to participate, more than 20 plans in all. The benefit package is slimmed down somewhat from conventional products, omitting some otherwise state-mandated benefits. There is open-enrollment and premiums are the same for individual and group enrollees.

Participating small businesses must have (a) 50 or fewer employees who pay \$50 or less per month toward their coverage, and (b) at least 30 percent of employees who earn less than \$34,000 (adjusted annually). Individuals and sole proprietors must meet similar income requirements. Employees must pay at least 50% of premiums, and at least half of a firm's employees must participate.

State reinsurance pays 90% of an enrollee's claims between \$5,000 and \$75,000 in a calendar year. On average in 2004, Healthy New York kept medical claims cost at 82% of premiums. Without reinsurance, it would have been 115%. In 2004, the program cost \$38 million (almost 29% of all medical expenses) with costs expected to increase to \$58 million in 2005. The state subsidy of \$400 per person comes from tobacco settlement revenues and is fixed by appropriation.

Enrollment in December 2005 was approximately 107,000 with the majority being individuals. The state subsidy makes the premium lower than with conventional insurance. Despite this, enrollment could be much higher and why it is not remains unclear.

Arizona. The Healthcare Group of Arizona (HCG), a division of the state's managed care-based program for Medicaid, provides health plan choices for the state's small businesses (size 1-50) and political subdivisions.^{11, 12, 13} Groups qualify if they have not offered coverage for at least 180 days. Traditionally, only HMO plans were offered, but in late 2005 a Preferred Provider Organization (PPO) option was made available. Insurers are exempt from conventional insurance regulation, but must meet Medicaid standards, called Arizona's Health Care Cost Containment System or AHCCCS. There is open enrollment, and community-based premiums are set by age, gender, and location. High employee participation rates are required, which reduces adverse selection. As of December 2005, there were more than 17,000 enrollees in almost 6,000 small firms, heavily sole proprietors.

To help assure plan fiscal stability, HCG purchases private reinsurance that covers most annual losses over \$100,000 per enrollee. It also protects participating plans against high aggregate losses by itself making reinsurance or "stop-loss" payments

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to plans that experience annual costs that are high relative to premiums, subject to the availability of funds. The target is to keep plans' medical claims costs between about 80 and 86 percent of premiums. Stop-loss payments go to plans with higher loss ratios and corresponding "stop-gain" payments are due from plans with lower ratios. These reinsurance mechanisms have at times been subsidized by state funds, largely tobacco revenues, but this subsidy was ended, effective fiscal years 2006 and 2007. Other funding comes from withholding a portion of primary premiums.

How New York and Arizona are Similar:¹⁴

- Both subsidy programs targeted limited populations for enrollment.
- Public funds reinsured high-claims losses.
- Only managed care organizations were targeted, and enrollees were given some choice among them.
- Benefits were somewhat reduced from the conventional market.
- Reinsurance funding from the state was limited rather than open-ended.
- Neither plan appears to enroll the bulk of apparent eligibles.

How New York and Arizona are Different:

- New York targeted its subsidy per high-cost enrollee, whereas Arizona protected its carriers from high losses relative to premiums in the aggregate.
- Eligible enrollees included individuals in New York, but only small businesses and political subdivisions in Arizona.
- Available information suggests that the effective public subsidy per enrollee has been higher in New York, and has now ended in Arizona.
- New York targeted previously uninsured people with low incomes, whereas Arizona targeted those poorly served by the private market.
- Arizona offers more benefits options than New York.

Neither Arizona's or New York's reinsurance plan enrolled the bulk of people who were eligible.

What Do Policymakers Interested in Reinsurance Need to Consider?

To design a reinsurance program, policymakers need to consider the experiences of other states as well as several issues pertinent to Wisconsin. In particular, state legislators may want to ask about the following:

What Groups to Target. New York targets those who have been previously uninsured. Another logical target group is small employers, because their employees and dependents constitute a large percentage of the uninsured. Small employers are important to the economy and their insurance market appears to be in flux. Because they can face sudden rate changes in the wake of high-cost claims, small employers are interested in reinsurance, whereas large employers typically are not.

States can create their own target groups, such as:

- what size of small employer group is eligible;
- whether to limit coverage to firms currently not offering coverage;
- whether to cover sole proprietors; and
- what wage, income, or other rules apply. In New York, for example, employers must have 50 or fewer employees, of whom 30% must earn less than \$34,000 annually.

Conceivably, employers or insurers may tailor their employment categories or firm structures to qualify for reinsurance. Given that insurance subsidy is not the main motivator of business decisions, such shifts may not become significant problems; however, they still bear watching, especially if the reinsurance subsidy is substantial.

Where to Focus Reinsurance Benefits. Policymakers must determine what insurers are eligible and whether participation is voluntary or mandatory. States can decide if they want to focus on the entire private market of insurers, a new purchasing pool, or another form of coverage specially created under state authority. Some standardization of covered benefits will help to streamline claims processing and keep administrative costs down.

How Much Public Funding to Provide and From What Sources. Any source of state revenue can be used to fund reinsurance, whether conventional taxes, tobacco settlement monies, or fees on tobacco products. It is possible to fund reinsurance from premiums paid by participants or assessments paid by participating insurers. However, such mechanisms fail to achieve any net subsidy or to lower the cost of insurance as intended by publicly funded reinsurance.

Allocating funds to reinsurance subsidies is an alternative to spending them on premium subsidies. Reinsurance provides subsidies on the back end by covering only high-cost claims; in contrast, premium subsidies provide public support on the front end to any eligible employee who contributes to employer-sponsored coverage.

The impact of reinsurance on premiums needs to be substantial in order to have much influence on purchasing decisions. Higher levels of support for public reinsurance can reduce premiums and encourage enrollment. More support can be implemented by lowering the threshold where reinsurance sets in (i.e., expanding the width of the corridor of claims) or by reducing the coinsurance required of primary carriers. Lower thresholds should further reduce the incentives for adverse risk selection because more claims risk would be broadly shared.

A lower reinsurance threshold could increase health care costs by decreasing insurers' incentives to control costs that reinsurance covers.

Of course, a lower reinsurance threshold would require higher state contributions and would cost more to administer because more claims would need to be processed. A lower threshold could also decrease the incentive for insurers to control costs. For example, if the reinsurance threshold is set at \$25,000 or \$30,000, insurers might not take appropriate steps to reduce costs beyond that threshold because reinsurance will cover them. States can learn from private insurers in this regard. They can require early warning of enrollees whose claims may exceed the threshold during the year, pay for investigations, and arrange for management of high-cost cases.¹⁵

Who Should Assume Responsibility? Accountability in reinsurance operations can be maintained through direct public operations or by a reinsurance board comprised of public and private representatives with insurance expertise and an eye to market response. One reason for favoring an experienced board is that many provisions of reinsurance may not be legislated, but rather decided during the implementation phase. This board can create a plan of operation under public oversight, perhaps from the Office of the Commissioner of Insurance or the Legislature.

One other possibility is contracting out some or all of the reinsurance functions to private reinsurers. A state may purchase its own private reinsurance to avoid overruns and the potential need for additional appropriations mid-year. Other functions the state may contract out include outreach and education, eligibility verification, and claims processing tasks.

Allow Sufficient Start-up Time. About 18 to 24 months seems an appropriate time to start a new reinsurance program. New York was able to start its program in slightly more than a year; however, it required significant changes shortly after it began.^{16, 17}

Provide Funding for Planning and Implementation. Reinsurance requires sufficient start-up funding. Administrative costs are likely to be higher during the planning phase because of the need for expert consultants, investment in data systems, and the like. Retrospective reinsurance will be tested only as claims appear, probably late in the first year. Thus, any glitches will be discovered relatively slowly, and fixes will take time to develop and implement.

Conclusion

In summary, policymakers are interested in reinsurance because of its potential to spread risk more broadly, reduce variability in prices from year to year, and lower premiums for primary insurers' enrollees by subsidizing their high-claim costs with public revenues. Arizona and New York have run public reinsurance programs with modest enrollments relative to the size of their uninsured populations. If Wisconsin is to implement such a program, it will need to consider whom to target, how much public funding to provide, and who should assume responsibility for designing and implementing the program.

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Reinsurance could lower insurance premiums by subsidizing high-claim costs with public revenues.

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Ongoing Reinsurance Project in Wisconsin

Separate from prior work summarized here, Randall Bovbjerg and Bowen Garrett of The Urban Institute are leading a reinsurance project for AcademyHealth under the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program. This Reinsurance Institute project is designed to provide technical assistance to states through insurance-cost simulation modeling and other consultation on various forms of reinsurance subsidy and related reforms. The project team will be working closely with three states selected in November 2006 for intensive consultation and modeling during 2007 legislative sessions—Rhode Island, Washington, and Wisconsin. Databases used to construct the project's model of insured spending, premiums, and impact of reinsurance include MEPS, CPS, Statistics of U.S. Businesses, Society of Actuaries High Cost Claims Studies, and the National Health Accounts. Information on states is gathered through national surveys on regulatory patterns and market structure, as well as state-specific data supplied by participating states. Products will include input into state's decision making processes by memo, in person, and through short reports. Two in-person meetings and additional cyberseminars are being held with a larger group of interested states. The SCI's project webpage is <http://statecoverage.net/reinsuranceinstitute.htm>.

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