Issue BRIEF

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Reinsurance: A Primer

Many state policymakers are exploring ways to expand health coverage to the uninsured in their states. Lawmakers have put forth numerous proposals, including reinsurance, to make coverage easier to obtain and more affordable. For example, in just the past year, several states have introduced reinsurance programs as part of their expansion proposals.

In this issue brief, Families USA aims to help policymakers and advocates better understand what reinsurance is and how it operates in the health insurance market. We also identify some of the benefits of reinsurance to aid lawmakers as they design reinsurance programs to meet the needs of their states.

Introduction

Insurance spreads risk among members of a population. Similarly, reinsurance levels the playing field among insurers, offering relief to those that serve a disproportionate share of high-cost enrollees. A small proportion of the population accounts for a significant share of all medical spending. In 2005, for example, 5 percent of the population spent nearly 50 percent of all health care dollars in the United States. Moreover, just 1 percent of the population accounted for 23 percent of all health care expenses.[1]

Clearly, most people with high medical costs cannot pay those costs themselves—that is why they purchase insurance. But who should pay? Figuring out how to distribute costs fairly is a challenge, and states have come up with different answers to this dilemma. Some states require that all insured people in a given health plan be charged equally for premiums. In this way, the expenses of the highest-cost enrollees are distributed among everyone in the plan. But this means that plans have to raise their average premium costs—sometimes significantly—to cover these expensive claims. Furthermore, if one health plan ends up with more high-cost enrollees than other plans, it probably will have to charge higher premiums than other plans, which puts it at a competitive disadvantage.

In other states, insurers are permitted to charge somewhat higher premiums for individuals with higher health risks or for businesses that have more workers with high medical needs. And in some states, individuals with high health risks have a limited choice of health plans, can be charged exorbitant premiums, or can be denied coverage altogether. In these states, consumers who need care the most are the very ones who cannot obtain or afford coverage. And even in

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these states, which do the least to protect sicker people, high health costs can still be problematic for insurers. If they cannot fully predict when enrollees will end up with significant medical costs and if medical claims far exceed expectations, insurers will need to do something to protect their bottom line.

Reinsurance is one tool for addressing these problems. A government-sponsored reinsurance program can equitably spread the highest-cost claims among insurers in a market. If the government contributes additional revenue to subsidize reinsurance (that is, if the government uses dollars from outside the health insurance premium system to pay for high-cost claims), reinsurance can also help reduce premiums for all consumers. For further reading on this topic, see Katherine Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, June 2006).

What Is Reinsurance?

"Reinsurance" is essentially insurance for insurance companies. Typically, the primary insurance company pays a premium and, in exchange, the "reinsurer" agrees to pay part or all of the claims that exceed a certain dollar threshold. Generally, the reinsurer agrees to pay for the most expensive claims.

Reinsurance is not a new concept. For many years, insurance companies privately bought reinsurance policies from other insurance companies. These types of policies are most useful to smaller health insurers that are particularly vulnerable to financial ruin if they have an unexpected volume of high-cost claims in one year.[2] Larger insurance companies are less likely to buy reinsurance. This is because they insure so many people that even an extremely high medical cost would have little impact on the company's average medical costs.[3] But private reinsurance is expensive.[4] Although it helps insurance companies get through bad years, ultimately, they still pay the cost of high claims through their reinsurance premiums.

What is newer is the idea of public reinsurance. In public reinsurance, the government, in this case a state government, organizes and sponsors a reinsurance program. States follow one of two main paths when developing public reinsurance programs:

> **Path A**: The government sponsors the program and may require participating insurers to pay an assessment to finance it, but the state *does not subsidize* it with additional public dollars. Many states have conventionally offered this type of program since the 1990s. Path A is described beginning on page 4.[5]
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> **Path B**: The government sponsors the program and *does subsidize* it with public dollars. Path B is described beginning on page 10.

Why Is Public Reinsurance Important?

Public reinsurance is important for the following reasons:

- Reinsurance, when financed by the state or a broad-based assessment, can help **bring down premium costs for consumers**. This, in turn, boosts rates of health coverage, because the consumer's ability to obtain health care is in large part determined by the affordability of coverage.[6]
- Reinsurance can be used to **spread the risk of high-cost cases** more equitably among insurers. If all insurers know that they will pay equally for the highest-cost cases, then they may be more willing to sell policies to everyone regardless of health condition.
- Reinsurance can **protect insurers from financial losses** if the state or the insurer did not accurately predict the premium charges necessary to cover claims. It can help allay insurers' fears, for example, when a state strengthens its rate regulations.
- Reinsurance helps **foster competition in the small-group and individual markets**. For example, newer insurers are more likely to enter a market if they have some protection from high, unfamiliar risks.

Steps for Policymakers and Advocates

Policymakers and advocates who are considering reinsurance as a tool to make insurance more available or affordable should take the following steps:

1. **Weigh the goals of your reinsurance program.**

   First, review "Why Is Public Reinsurance Important?" above. If your state is trying to stabilize the small-group or individual insurance market, reduce aggressive underwriting of insurance premiums, or minimize the impact of high-cost enrollees on smaller insurance companies, then it may choose to implement a reinsurance program without a government subsidy (Path A). If, however, the goal is also to reduce premium rates (or to prevent increases in premium rates), then the state should consider implementing a government-subsidized reinsurance program (Path B).

2. **Define the target population for the reinsurance program and decide whether reinsurance will be cost-effective.**

   States generally use reinsurance as one tool in a larger reform effort. For example, your state may want to design an affordable insurance program for small businesses or for low-wage workers and may use reinsurance as one component of the program. With a target population in mind, you may seek estimates of how much the state would need to subsidize reinsurance to decrease premiums by a certain amount. The larger the target population and the more you want to decrease premiums, the more dollars will be required to subsidize reinsurance (see Path B). Once you have estimates, you may want to consider whether reinsurance is the best way to accomplish your goals or whether a direct income-based subsidy to individuals or individual businesses is more practical.

As noted earlier, if your goal is not to reduce premium rates but rather to equalize premiums for your target population and/or to equalize the burden of high-cost cases among insurers, public dollars may not be needed. Instead, your state may wish to sponsor a reinsurance program that is financed through premiums and assessments on participating insurers (see Path A).

3. **Determine the political and economic feasibility of developing your reinsurance program.**

In most cases, politics will play a significant role in determining the direction of a reinsurance program. Policymakers and advocates who are designing a program should think about how interest groups and state lawmakers will respond. One key strategy is to gain advance support from relevant community stakeholders, including agents and brokers, agency directors, state associations, medical providers, and area experts.[7] Without the support of these stakeholders, any program is likely to fail.

The level of government funding available for your reinsurance program will also determine which path you choose. Funding can come from new taxes, tobacco settlement funds, or from a state's general fund. If possible, look for sources of funding that will rise with health care inflation—health care costs rise more rapidly than incomes.

Once you've considered all of these factors, choose Path A or B and read the relevant section below.

Path A: Government Reinsurance Programs without Public Subsidies

Goal: Spread risks among insurers, helping make insurance more widely available
Target Population: Small employers and/or individuals

A number of states have operated reinsurance programs for several decades, but most of these programs have been small and have paid few claims. A few states, including Connecticut and Idaho, have larger and more effective programs. This section describes both the conventional model of state reinsurance programs and the features that distinguish the most effective programs that operate without a public subsidy. The programs described in this section rely on participating insurance companies for funding and do not use resources, such as general revenues, that are external to the health insurance system.

The goal of these state-operated reinsurance programs is to spread the risk of high-cost claims among insurers in a given market—generally, among insurers that sell to small employers or to individuals. Reinsurance helps insurers protect themselves so that they can remain solvent and competitive when people with high health risks enroll in their plans.

Reinsurance may be implemented in conjunction with other reforms that make it easier for people with high risks to obtain health insurance. For example, all insurers may be required to issue policies to people regardless of their health ("guaranteed issue"), they may be prohibited from charging higher premiums to people in poor health, or they may be limited in how much they can increase premiums based on health status. Such reforms could cause an insurer to end up with more unhealthy enrollees than its competitors. Reinsurance helps buffer insurers against this risk.

National Association of Insurance Commissioners Model Reinsurance Legislation

The National Association of Insurance Commissioners (NAIC) provides states with model legislation for establishing reinsurance pools,[8] and most states that provide reinsurance programs use a similar structure. States specify which licensed insurers that offer products in the individual or small-group markets will participate in a reinsurance program, also called a reinsurance "pool." In essence, the participating insurers all share in paying for the highest-risk cases. The reinsurance system is financed in two ways: (1) through reinsurance premiums, and (2) through other funding mechanisms.

1. Funding through reinsurance premiums: When a participating insurance company enrolls an individual or small group that seems at risk for particularly high health costs, the insurance company can decide to "cede the risk" to the reinsurance program. In other words, the insurance company can decide whether it wants the reinsurance program to pay some of that risky enrollee's health claims. The participating insurance company pays reinsurance premiums to the reinsurance program for each individual or small group that it "cedes." Reinsurance premiums alone do not redistribute the costs of these claims, however, because the insurers that have high-cost enrollees are the ones that pay the reinsurance premiums.

2. Funding through other mechanisms: Fees collected through an assessment on all individual and/or small-group insurers are part of the reinsurance program. These mechanisms redistribute some of the program's costs among all the participating insurers. This system allows the state-organized reinsurance program to charge lower premiums than a private reinsurance company would charge.

In the NAIC model bill, states have several drafting choices, and analysts believe that these options make a tremendous difference in determining the effectiveness of the pool.

We've developed a series of questions to guide you through key decisions that states will face as they design a reinsurance program without public subsidies.

Should the state mandate participation in the reinsurance program?

Perhaps the most important decision is whether participation in the program will be voluntary or mandatory for insurers in the target market.[9] In a voluntary pool, insurers can decide whether or not they want to be assessed and pay fees for the privilege of participating. If they elect to be assessed and pay fees, they can also decide whether or not to reinsure some of their enrollees by paying additional premiums. In voluntary programs, however, large established insurers that have little financial need for reinsurance themselves generally do not participate. In a mandatory program, by contrast, all insurers in a given market (such as the individual market or the small-group market) are assessed and pay fees, whether or not they ever actually reinsure an

enrollee. Thus, large, well-financed insurers also help to pay the claims of smaller insurers' risky enrollees, and this more evenly distributes the high-cost cases throughout the insurance market. Analysts thus believe that it is best to mandate insurers' participation.[10, 11]

What products can be reinsured?

States decide what benefit packages to reinsure. Some states reinsure only a standard benefit package. If any plan that the insurer offers can be reinsured, there must be some adjustments in the amount that will be covered by reinsurance, because different financial risks are involved depending on the level of benefits covered by the reinsurance. Calculating such differences and adjusting for them may add to the administrative costs of a reinsurance program.[12]

Will insurers have more than one opportunity to reinsure?

Another important policy decision is when an insurer can decide to cede an individual or small group to the reinsurance pool. Some states give the insurer only one opportunity to decide that a new enrollee is too risky to insure without help. For example, states may require insurers to decide whether to reinsure an individual or small group within the first 60 days after they enroll. Other states, however, realize that insurers cannot always accurately predict a high risk at the outset. Providing a second opportunity to reinsure may reduce incentives for insurers to sharply increase premiums for groups that have costly claims. Connecticut, for instance, allows insurers to decide again every three years whether they will maintain full responsibility for a very small group's claims (group of one sole proprietor or group of two) or whether they will reinsure.[13]

How will the state balance financial responsibilities between the original insurer and the reinsurance program?

A third policy decision is how much financial responsibility the original insurer will retain and how much of the costs of claims it can cede to the pool. Financial responsibilities are split in several ways:

- Reinsurance premiums
- Deductibles or "attachment points"
- Co-insurance

We discuss these options below.

Reinsurance Premiums: As noted earlier, under the NAIC model, reinsurance programs are financed by a combination of premiums paid by insurers that want to cede a risk to the pool and assessments on all insurance companies to fund any costs not covered by premiums. States decide what to charge the original insurer in reinsurance premiums and when to dip into pool assessments to pay claims. Commonly, if claims to the reinsurance pool are in excess of the amount of money the pool has collected, the pool is allowed to reassess participating insurers to cover its losses.

States should try to make reinsurance premiums affordable for insurers and not try to fund the entire reinsurance program through reinsurance premium revenue. Assessments levied on all insurers in the program spread costs more equitably.

States calculate insurers' reinsurance premium rates based on the average premium rates that individuals or small groups pay for coverage in the state. The lower states set their reinsurance premium rates, the more the pool will need to tap into assessments for funding. In the NAIC model, if an insurer wants to cede an entire small group to the reinsurance pool—that is, if it wants the reinsurance pool to pay a proportion of the claims for all employees in a given small business—then the insurer must pay the reinsurance pool a reinsurance premium that equals 150 percent of an average small group's premium rate. Whether or not reinsuring that group ends up helping the original insurer depends on the actual costs of the small businesses' health claims. If the actual claims are 1.5 times as high as average claims for a small employer, the original insurer will break even. But if actual claims turn out to be, for example, twice as high as average small employer's claims, the original insurer will receive some help from the reinsurance program. In both the Connecticut law and the NAIC model bill, an insurer can decide to cede a specific person (a particularly high-risk member of a small group) to the reinsurance pool instead of ceding the whole group. In that case, the insurer pays a reinsurance premium for that one individual that is five times as high as an average individual's premiums.

Deductibles or "Attachment Points": This is the amount of money that the insurer must pay on a given claim before the reinsurance program begins to pay any of the costs. For example, in both the NAIC model and Connecticut's law, the original insurer must pay the first $5,000 of claims (the deductible or attachment point), and the reinsurance program will pay all or a portion of any claims beyond that amount. Some states, however, use much higher attachment points; their reinsurance programs have not proven to be very useful.

The lower the attachment point, the more risk is spread. The original insurer, however, should bear some responsibility for providing quality care and managing costs. The attachment point should be high enough that, for people with average medical needs, the original insurer retains full financial responsibility. Typically, the board of a reinsurance program has the power to raise this amount over time to reflect medical inflation. (Note that the decision of where to set an attachment point may be quite different in programs that are publicly funded because, in these programs, the decision will be based on the amount of available state dollars.)

Co-insurance: This requires the original insurer to pay a proportion of claims once reinsurance begins. After claims reach an attachment point, states vary in the proportion of remaining claims that they require the original insurer to pay. For example, in the NAIC model, the original insurer pays 10 percent of claims that are between $5,000 and $50,000 per year. States may also set a maximum amount that the original insurer is liable to pay ($10,000 is the maximum in the NAIC model). Connecticut, however, does not require the original insurer to pay anything beyond the first $5,000 when it has ceded a risk to the pool. Some analysts speculate about whether the original insurer will "manage" the case better, reviewing utilization and pressing its providers to use cost-effective treatments, if it has some financial incentive to do so. Even without a financial incentive, though, a reinsurance program could require that either the original insurer or the reinsurance program provide case management.[14]

Connecticut and Idaho are two of the many states that offer state-sponsored reinsurance programs. Connecticut's program for small employers has been a national model. Idaho's reinsurance program for individuals is unusual in that the state requires all insurers in the individual market to issue a standard health plan to anyone, regardless of health, and then the state provides reinsurance to balance the risks among health plans. This is different than the approach many states have taken, which is to establish a single insurer that will take "high-risk pool" cases.

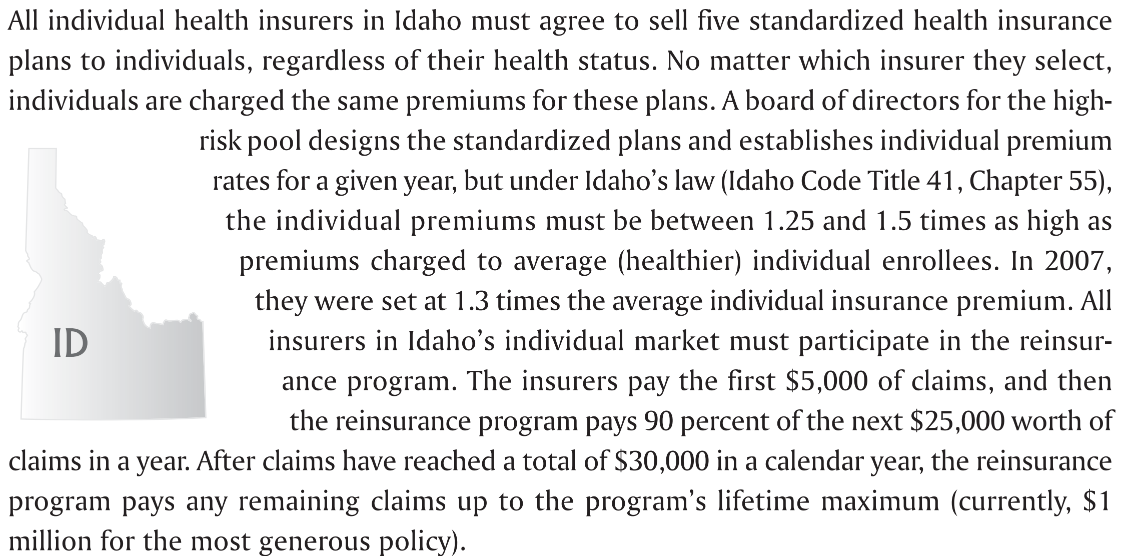
Connecticut's Small Employer Health Reinsurance Program

Connecticut's nonprofit Small Employer Health Reinsurance Pool, the first of its kind, was created by state legislation in 1990. Participation in the pool is mandatory, meaning that all insurers that are licensed to sell health plans in Connecticut must be pool members. Within 60 days of selling coverage to a small employer or enrolling a new employee within the small employer group, the insurer decides whether it (1) will pay all of the claims itself for that person or group or (2) will ask the pool to assume some of the risks. If the insurer wants the pool to assume some of the risks, it pays reinsurance premiums. The reinsurance premiums paid by insurers may not be sufficient to cover the pool's expenses. Sometimes, the people who are reinsured have much higher claims than are covered by the pool's reinsurance premiums. In this case, the pool's "losses" are recouped from all pool participants—that is, all state-licensed health insurers pay the pool's remaining expenses in proportion to the amount of health insurance premiums they earn in the state.

Connecticut's pool has been successful. It has reinsured more than 3,000 employees and dependents annually, paying a portion of their claims. Connecticut has other state laws that aim to make insurance costs equitable. For example, Connecticut does not allow insurers to charge small employers higher premiums based on the health of their employees. The reinsurance pool makes this "community rating" fair for all insurers—that is, all insurers share in the expenses of higher-cost employees. The pool is credited with keeping small insurers in Connecticut that otherwise would be fearful of facing high risks in that market.[15]

Idaho's Individual High-Risk Reinsurance Pool

All individual health insurers in Idaho must agree to sell five standardized health insurance plans to individuals, regardless of their health status. No matter which insurer they select, individuals are charged the same premiums for these plans. A board of directors for the high-risk pool designs the standardized plans and establishes individual premium rates for a given year, but under Idaho's law (Idaho Code Title 41, Chapter 55), the individual premiums must be between 1.25 and 1.5 times as high as premiums charged to average (healthier) individual enrollees. In 2007, they were set at 1.3 times the average individual insurance premium. All insurers in Idaho's individual market must participate in the reinsurance program. The insurers pay the first $5,000 of claims, and then the reinsurance program pays 90 percent of the next $25,000 worth of claims in a year. After claims have reached a total of $30,000 in a calendar year, the reinsurance program pays any remaining claims up to the program's lifetime maximum (currently, $1 million for the most generous policy).



The reinsurance program is financed in several ways. First, all state-licensed insurers pay a premium tax, a portion of which is dedicated to the reinsurance program. Second, insurers pay reinsurance premiums as set by the board, and they are allowed to be changed on a quarterly basis. The state law gives authority to finance the program through an assessment on all participating insurers. However, Joan Krosch, Health Insurance Specialist at the Idaho Department of Insurance, reports that funding from the first two sources has thus far been sufficient to cover the pool's expenses.

The director of the reinsurance pool notes that it has been an easy and straightforward way to spread the cost of guaranteeing individual insurance. It took about a year to get up and running, although state high-risk pools sometimes take longer to start. At one time, insurer participation in the reinsurance system was voluntary. But now, Idaho requires all insurers in the individual market to cede risk to the pool and pay reinsurance premiums. This has developed a consistent flow of premiums, enabling the state to raise the lifetime cap on beneficiaries' coverage.

Although Idaho does not use money external to the insurance industry to finance its program, it does have a broader-based funding mechanism than many other states. All types of insurers, including disability (which includes health insurers), life, property, and casualty and reinsurance carriers, pay premium taxes, a portion of which helps to finance the program.

Path B: Government-Subsidized Reinsurance

Goal: Reduce health insurance premiums and increase rates of coverage
Target Population: Depending on resources, may be targeted to a wide population or targeted to low-income workers and individuals

Government-subsidized reinsurance programs are structured similarly to the more traditional state-sponsored, unsubsidized reinsurance programs described in the previous section. These programs differ in their funding and in the division of financial responsibilities between the original insurer and the reinsurance program. But because they can bring in money from outside the system, subsidized programs are able to decrease premiums and, as a result, increase coverage rates. This section addresses some of the key characteristics of successful government-subsidized reinsurance programs and discusses the New York and Arizona reinsurance programs.

Government-subsidized reinsurance programs can achieve the same benefits as conventional reinsurance programs and many more. Most important, government-subsidized reinsurance programs can directly lower premium rates for consumers and indirectly benefit small businesses and individuals by reducing rate volatility and stabilizing the health insurance market.[16] With lower and more predictable insurance rates, the number of people who are uninsured will go down. This decrease is expected because uninsured individuals and small businesses that are not currently providing coverage to their employees will be more likely to purchase health coverage if it is more affordable.[17] As with other state-sponsored reinsurance programs, subsidized reinsurance may be implemented in conjunction with other reforms that help people with high risk obtain health insurance. For example, if all insurers must issue policies to people regardless of their health (guaranteed issue), or if they are prohibited from charging higher premiums to people in poor health or limited in how much they can increase premiums based on health status, insurers may want protections from the state in case they get more unhealthy enrollees than their competitors.

Just as in conventional reinsurance programs, the design of the program determines how well it stabilizes the market and lowers premium rates. The following are some key structural questions a state must consider when developing a government-subsidized reinsurance program:

What are the target populations for the reinsurance subsidy?

? A state can design its reinsurance program to subsidize coverage for a targeted group of people—for example, low-wage workers—or for everyone in the small-group or individual health insurance markets. Where to target a subsidy depends on the state's goals and available resources. For example, Healthy New York, which is the best-known government-subsidized reinsurance program, targets reinsurance to low-income working individuals and to small businesses with low-wage workers that did not previously offer insurance. These individuals and businesses enroll in health maintenance organizations (HMOs) that contract with the state, and the state subsidizes reinsurance only for these health plans. New York also operates a reinsurance program for individuals who buy coverage directly rather than through Healthy New York, but this program is not as well funded.

A number of states are considering government-subsidized reinsurance programs to make coverage more affordable and easier to obtain throughout the small-group and individual health care markets. Over the past five years, rates in the individual and small-group health insurance markets have escalated nationwide as a result of higher health care costs and loss of employer coverage. In response, Washington State enacted legislation (SB 5930) in 2007 to design a reinsurance program for the entire small-group market (which includes groups smaller than 50) and the individual (nongroup) market.

Will the reinsurance program subsidize individuals or aggregate claims?

Once a state has determined who will receive coverage, it must decide how the coverage will be structured. One key question is whether the state will subsidize the costs for each individual whose costs exceed the attachment point (sometimes referred to as "specific stop-loss" or "excess-of-loss" reinsurance), or if it will subsidize the "aggregate losses" of a health insurance plan beyond a certain "loss ratio." The latter means that, if the health plan's total medical claims exceed the premiums the plan has collected or a certain percentage of the premiums the plan has collected, the state will help pay claims. States use the first type of reinsurance (specific stop-loss or excess-of-loss reinsurance) to reduce premiums. States use the second type (referred to as "aggregate stop-loss" insurance) when they are not sure whether the rates they pay health plans to provide coverage will adequately cover a health plan's medical costs. Some states provide aggregate stop-loss coverage for Medicaid managed care plans, for example, and more states did so when Medicaid managed care was new and they had little experience with managed care enrollees' costs.

New Jersey has proposed a reinsurance program that that would cover 90 percent of claims once an individual's costs exceeded $100,000. Conversely, Arizona contracts with managed care organizations in the state to provide coverage to small businesses (fewer than 50 employees) and, before 2006, reimbursed the participating plans whose aggregate annual medical costs exceeded 86 percent of the total amount of premium revenue collected by the company.

Will reinsurance benefits be automatic?

In the government-subsidized reinsurance programs that exist now, participating insurance companies automatically receive reinsurance benefits when individuals' or small groups' claims exceed a certain dollar threshold. They do not have to make a choice about which individuals or small groups they will cede to a reinsurance pool.

At what dollar amount will the state start subsidizing the highest-cost claims?

A reinsurance program can start subsidizing coverage at any point. In specific stop-loss reinsurance programs, the attachment points are usually a dollar amount, whereas in aggregate stop-loss programs, they are typically a "loss ratio," which is a ratio of costs to premium revenue.

If your state is designing a government-subsidized reinsurance program, one crucial decision is where to set the attachment point. The advantages of setting the attachment point at a lower threshold are as follows:

- reduced premiums for enrollees, which will have the ripple effect of increasing the number of people who purchase coverage;
- increased risk pooling, which helps to stabilize the insurance market and reduce premiums; and
- greater assistance for a larger number of insurance companies that insure sicker people.

New York experienced these benefits by reducing the attachment point for reinsurance in the Healthy New York program in 2003. Previously, the reinsurance program had paid all claims between $30,000 and $100,000 per individual. In 2003, the state invested more funds in the Healthy New York program and reduced the attachment point for reinsurance to $5,000, paying all claims between $5,000 and $75,000. Because many more people had claims at these dollar levels, most of the HMOs offering these plans were able to drop their premiums by 17 percent.

The downside of setting a lower attachment point is that this design is more expensive and requires more state dollars. If a state sets the attachment point at a higher level, then the reinsurance program would cover a smaller number of catastrophic accidents or acute cases. The primary benefit of this design is that it helps smaller insurance companies remain competitive.[18]

If your state is designing an aggregate loss program, the loss ratio should be high enough to maximize the amount of premiums dollars spent on paying for medical services and minimize the amount spent on administrative expenses and profit.[19]

What will insurers pay in a government-subsidized reinsurance program?

In a government-sponsored reinsurance program, the original insurer is responsible for paying a portion of the highest health care costs. As in the Connecticut and Idaho models, the original insurer pays all of the claim costs before the reinsured person or group reaches the attachment point. Once an individual's or group's medical costs exceed the attachment point, the reinsurance program picks up the majority of costs—90 percent in some states—and the original insurer pays the remainder of claims, typically just 10 percent. The reinsurance program, which is subsidized with state dollars, can cover 90 percent of all expenses above the attachment point, or it can set an upper limit on the claims it will reinsure. For example, in Healthy New York, the reinsurance program pays for 90 percent of claims that exceed $5,000, but the program has a "reinsurance cap" of $75,000. This cap ensures that the reinsurance subsidies stop at that point, and the original insurer is responsible for paying all claim costs greater than $75,000.

? How can the state ensure that public dollars are actually used to reduce premiums?

Some states are contemplating using government-subsidized reinsurance for a targeted program in which the state contracts with health plans. In these instances, the contract may set the insurers' payment rates and set forth requirements about what the insurer will charge consumers in premiums. Other states are contemplating government-subsidized reinsurance for the entire small-group or individual market. In these cases, states must use other regulatory tools to ensure that insurers do not use reinsurance to increase their profits. For example, states can review insurance rates and set limits on the amounts that insurers are allowed to retain for administration and profits or directly require that they reduce premiums.

A Final Caution: Evaluate the Costs and Benefits before You Jump In

Although government-subsidized reinsurance programs can reduce volatility in the market, reduce premiums, and increase coverage rates, they do so at a high price. And some wonder whether delivering subsidies this way—as opposed to offering direct premium subsidies—is the most efficient approach to bring down premiums and reduce the numbers of people who are uninsured.

Government-subsidized reinsurance programs use state dollars to reduce premiums. Besides requiring reinsurance premiums or assessments, states can maximize tobacco settlement fund dollars, state general funds, tobacco tax revenue, or other noninsurer sources to fund their reinsurance programs.

Many states that are considering government-subsidized reinsurance models are conducting actuarial analyses to truly understand the costs and benefits of implementing a subsidy program in this way. For example, New Jersey's insurance department recently obtained estimates on the costs of adding publicly financed reinsurance to its individual and small-group markets, which together serve about 1 million people. Its proposed reinsurance system would be combined with another reform (merging the individual and small-group markets). Actuaries estimated that if publicly financed reinsurance automatically paid 90 percent of all claims greater than $100,000, it would cost the state between $150 million and $200 million annually, which is about 1.5 percent of the premiums collected in the state's small-group and individual markets.[20] The program would reduce premiums in the small-group market by 3 to 4 percent. Even though the change in premiums would be slight, New Jersey estimated that 5,000 more people would obtain insurance because of the slightly lowered premiums.[21]

New York:
Individual Insurance and Healthy New York

New York has used state funds to provide reinsurance both for people who purchase comprehensive insurance in the individual insurance market and for low-wage individuals and small businesses who purchase more minimal coverage through Healthy New York. When the reinsurance systems are adequately funded, they have reduced premiums. In recent years, reinsurance has been well funded for one of the state's reinsurance programs, but unfortunately, not for the more comprehensive individual policies. We first discuss Healthy New York, which is the state's most well-known (and better-funded) reinsurance program. On page 15, we discuss the state's "direct payment stop-loss relief program," which has not been sufficiently funded and, as a result, has been less successful.

- **Healthy New York,** which was launched in 2001, is a good example of a functioning government-subsidized reinsurance program. The Healthy New York program was established to provide health coverage to employers with fewer than 50 employees, sole proprietors, and low-wage individuals who were previously uninsured. Since its inception, the Healthy New York program has provided insurance to more than 300,000 people, and, in October 2007, 147,530 people were enrolled in Healthy New York.[22] The program has strict eligibility rules that prevent people from dropping private coverage and enrolling in Healthy New York—a phenomenon known as "crowd-out."

  The Healthy New York program contracts primarily with HMOs, which are required to offer a standard, minimum benefit package[23] to all program participants. The minimum benefit package meets the needs of relatively healthy enrollees, but advocates note that the program does not meet the needs of people with chronic illnesses. The HMOs are required to community-rate their premiums, meaning they can vary their premiums only according to county location and family composition. These HMOs are reinsured through the Healthy New York stop-loss reinsurance pools, which are funded by assessments on insurance premiums (based on the number of people a particular insurer covers) and by other state funds dedicated to insurance initiatives. The program is structured so that all participating insurance HMOs are automatically reinsured and pay no reinsurance premiums. The reinsurance program then reimburses the HMOs for 90 percent of an enrollee's covered health care costs between $5,000 and $75,000 in a year. The HMO pays the remaining 10 percent of costs between $5,000 and $75,000. This level of cost-sharing ensures that the primary insurance company is liable for some of the enrollee's health care costs. The cost-sharing requirement remains low enough, however, that it still reduces health insurance premiums for enrollees.[24] The HMOs that participate in Healthy New York must

spend at least 80 percent of the premium dollars they collect on medical care (as opposed to administration and profit).

Healthy New York has lower premiums than the rest of New York's insurance market,[25] but it is not all because of reinsurance: Healthy New York also has a less generous benefit package and may attract healthier enrollees. However, Healthy New York's experience over several years shows that subsidized reinsurance can reduce premiums. When the state lowered the attachment point from $30,000 to $5,000 in Healthy New York in 2003 and began paying all claims between $5,000 and $75,000, the HMOs that offered Healthy New York were able to drop their premiums by 17 percent.

- **Direct payment stop-loss relief program.** To help people who buy more comprehensive insurance, in 2000, New York began its subsidized reinsurance program, called the "direct payment stop-loss relief program." Under a 1995 law, New York HMOs must provide two different standardized policies to individuals, and they must accept all individuals regardless of their health status. Both policies offer identical comprehensive benefit packages, so they are appropriate for people in poor health as well as for healthier enrollees (one policy includes out-of-network benefits and the other does not). Before enactment of the reinsurance program, premium prices were increasing rapidly. The stop-loss relief program was thus enacted to "provide premium and market stability." Under the stop-loss relief program, a designated fund pays 90 percent of individual claims between $20,000 and $100,000 per year. The fund is financed by assessments on all insurers, hospital and lab surcharges, tobacco settlement and tobacco tax revenues, and proceeds of nonprofit health plan conversions. A clause in the law says that claims will be reimbursed "to the extent that funds are available," and appropriations to the direct payment stop-loss relief fund have been frozen at 2003 levels for the last six years, although appropriations to Healthy New York's stop-loss fund, on the other hand, have continued to grow.

  The direct payment stop-loss program was helpful in paying claims and stabilizing premiums for the first three years, but since about 2003, appropriations to the fund have not been adequate to pay submitted claims. By 2006, only about 40 percent of claims costing between $20,000 and $100,000 were actually paid by the fund. The number of enrollees in New York's individual market has dropped dramatically in recent years, and advocates blame the market's collapse on the freeze of stop-loss funding levels.[26]

  New York's experience illustrates the importance of providing sustainable financing for reinsurance that keeps up with medical inflation and with enrollments. Furthermore, states must plan carefully to ensure that premiums are affordable to people with a full spectrum of health care needs.

The Health Care Group of Arizona

In 1985, the Arizona Health Care Cost Containment System—a division of the state's Medicaid program—created the Health Care Group of Arizona (HCG) to provide guaranteed coverage to self-employed individuals, businesses with fewer than 50 employees, and political subdivisions (such as counties and municipalities). The program has grown since its inception, and in March 2006, it had 26,062 medical plan members. The HCG contracts with HMOs and preferred provider organizations in the state to provide a variety of basic and comprehensive benefit packages.

Premiums for insurance plans offered in the HCG are priced based on a system called "adjusted community rating," which means that participating insurers cannot charge self-employed individuals or small businesses higher rates based on employees' health status. But these insurance companies can vary rates based on age, gender, and location. In contrast, plans offered outside of the HCG can charge higher premium rates to businesses with unhealthy employees. Reinsurance helps guard participating plans from the financial risk associated with enrolling more employees with health problems. Periodically, Arizona has used some public dollars to fund the HCG's reinsurance program to stabilize premiums for enrollees and to protect participating health plans when large and rapid changes occurred in the insurance market.

To participate in the HCG, individuals and especially businesses must meet certain requirements. The Arizona legislature enacted these requirements to prevent the HCG from competing with commercial insurers for the most desirable portion of the small-business market. To qualify for HCG coverage, businesses must meet the following criteria:

- Not have had insurance for the past six months (180 days);
- Enroll 100 percent of their employees in the HCG or provide a waiver for individuals with other forms of coverage (if there are fewer than five employees); or
- Enroll 80 percent of their employees (if there are more than six and fewer than 50 employees).

Businesses participating in the HCG are not required to contribute to their employees' health insurance premiums. However, many employers do choose to contribute. Currently, there are no income requirements for individuals who want to participate in the program. HCG has offered plans with a variety of benefits and provider network options to attract businesses and ensure a mix of employees, not just businesses whose employees have the highest medical risk and health costs.

Before 2006, the HCG ran a hybrid reinsurance system with three main components. First, the reinsurance program used state funds to pay for a proportion of claims between $75,000 and $100,000 per individual. Second, the state used premium dollars collected from participating plans to purchase a private commercial reinsurance policy for all individual claims that exceeded

$100,000. Third, the state itself provided stop-loss coverage to health plans if, after the other reinsurance reimbursement was deducted, total medical claims exceeded 86 percent of the health plan contractor's total annual capitated premium paid by HCG.

In 2006, the state stopped subsidizing the reinsurance program with public dollars in the hopes of making the program self-funded. To achieve this goal, the state restructured the funding for the HCG, relying only on premium revenue collected from participating small businesses and public employers to self-fund the program and provide stop-loss coverage for the participating health plans. However, because of significant medical losses in 2007, the state passed new legislation that again appropriated money to subsidize the HCG for medical losses. HCG used the program subsidies to reduce the participating health plans' medical losses and provide financial relief to the health plans, at least temporarily. The state is again increasing premiums and modifying benefits in HCG health plans, hoping it can reserve enough of the increased premium dollars to end the public subsidy and still protect participating health plans the next time they face high medical losses. [27]

Conclusion

State-sponsored reinsurance can be a useful tool in health reform. When financed only by insurers' premiums and by assessments on health insurers, reinsurance can spread the risk of high-cost claims more equitably among insurers. This helps keep insurers in the market and helps stabilize premiums, for example, when states institute reforms requiring insurers to accept everyone regardless of health status or when they prohibit insurers from charging people higher premiums based on their health status. The design details, however, make a tremendous difference in determining the program's effectiveness. Analysts believe that programs are most effective when states mandate insurers' participation and reasonably divide obligations between the original insurer and the reinsurance program so that the reinsurance program will take on most high-cost claims.

When states add public dollars to a reinsurance system, they can make insurance more affordable—insurers can reduce the premiums that they charge consumers if the state is paying high-cost claims. The consequence of making insurance more affordable is that more people enroll, reducing the ranks of the uninsured. In deciding whether to subsidize a reinsurance system, advocates and policymakers need to determine the target population for a subsidy and the costs required to significantly reduce premiums. Armed with this information, they should weigh the benefits of subsidized reinsurance against other approaches to subsidies (such as income-based subsidies).

Once a state establishes a reinsurance program, consumer advocates should continue to monitor the program. Although the broad parameters of a reinsurance program generally are set forth in legislation, important details may be left to a board of directors for the reinsurance program. The board will likely deal with the details of insurance and therefore will include representatives and experts from the insurance industry. Policymakers should insist that consumer voices are included on the board and that the meetings are open to the public or that specific opportunities are made available for public oversight and comment.

Endnotes

[1] Stephen Cohen and William Yu, *The Persistence in the Level of Health Care Expenditures over Time: Estimates for the U.S. Population 2004-2005* (Rockville, MD: Agency for Healthcare Research and Quality, 2007), available online at www.meps.ahrq.gov/mepsweb/data_files/publications/st191/stat191.pdf.

[2] Employers that self-insure (that is, employers that pay the health claims of their workers instead of passing most risks on to an insurance company) often buy a form of reinsurance known as "stop loss" that protects the employer if claims are much higher than anticipated. Very large companies are less likely to buy or need this protection because they have more resources to absorb unanticipated costs.

[3] Randall Bovbjerg, *Implementing Insurance: Health Insurance Reform in Missouri* (St. Louis: Missouri Foundation for Health, 2006). See also Deborah Chollet, *The Affordability of Coverage for High-Cost Individuals: Options for Washington State* (Olympia: Washington State Office of the Insurance Commissioner, April 30, 2007).

[4] Deborah Chollet, *The Affordability of Coverage for High-Cost Individuals: Options for Washington State*, op. cit.

[5] Deborah Chollet, "The Role of Reinsurance in State Efforts to Expand Coverage," *State Coverage Initiatives* 5, no. 4 (2004): 1–5.

[6] S. Harter, *Expanding Small Business Health Insurance Coverage Using the Private Reinsurance Market*, testimony before the Small Business Committee, U.S. House of Representatives, May 24, 2007.

[7] K. Swartz, K. Ideman, and R. Bovbjerg, *State Specific Conditions and Program Design: Considerations for Successful Implementation*, presentation to Reinsurance Institute's Kick-Off Meeting with States in Albany, New York (Washington: Reinsurance Institute, September 12, 2006).

[8] National Association of Insurance Commissioners, *Small Employer and Individual Health Insurer Availability Model Act, Model No. 35*, section 9–12 (Kansas City, MO: National Association of Insurance Commissioners, 2006).

[9] In the NAIC model bill, states have two drafting options: In option 1, the states allow insurance companies to declare whether they will be "risk-assuming" or "reinsuring" insurers. If they decide to be risk-assuming, they do not pay assessments to the reinsurance pool, and they cannot reinsure their risks. This is a voluntary reinsurance system. Under option 2, all insurers are assessed and contribute financing to the reinsurance system; that is, participation is mandatory.

[10] Comments from Deborah Chollet, Mathematica Policy Research, Inc., Families USA conference call, "What Is Reinsurance?," November 1, 2006, available online at www.familiesusa.org/resources/tools-for-advocates/conference-calls-2006.html.

[11] If the state assesses only state-licensed individual and small-group insurers, it does not get any contributions from employers that self-fund their plans. States can spread the costs of reinsurance even more broadly if they also assess "stop-loss insurers" and "third party administrators," which are commonly used by large, self-insured employers.

[12] Deborah Chollet, *The Affordability of Coverage for High-Cost Individuals: Options for Washington State*, op. cit.

[13] Ibid., and personal communication with Karl Ideman, President, Pool Administrators, Inc., May 1, 2007.

[14] Randall Bovbjerg and Elliot Wicks, *Implementing Government-Funded Reinsurance in the Context of Universal Coverage* (Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2006), p. 14.

[15] Janet Kaminski, *Connecticut Small Employer Reinsurance Pool* (Hartford: Connecticut Office of Legislative Research, January 2005), and personal communication with Karl Ideman, President, Pool Administrators, Inc., 2007.

[16] The Healthy Wisconsin Council, *Reducing Wisconsin's Uninsured Rate and Lowering Health Care Costs for Businesses and Families* (Madison: The Healthy Wisconsin Council, January 2007), available online at http://dhfs.wi.gov/healthywisconsin/pdf/healthy-WICouncilReport2007.pdf.

[17] Ibid.

[18] Randall Bovbjerg and Elliot Wicks, op. cit.

[19] Deborah Chollet, *The Affordability of Coverage for High-Cost Individuals: Options for Washington State*, op. cit.

[20] Without this reinsurance, merging the individual and small-group markets would increase small employer premiums by 1 percent and lower individual premiums by 3 percent. However, New Jersey estimated that the reinsurance program would stabilize and slightly reduce small employer premiums: Premiums charged to small employers would drop by 3 to 4 percent.

[21] New Jersey estimated that its other reform, merging the individual and small-group markets, would have a dramatic effect on individual premiums, lowering them by 30 percent and increasing the number of insured by about 100,000. Because small employer's premiums would rise without it, publicly financed reinsurance would help to make the reform workable.

[22] Rose Chu and Steven Van Tassell, *Report on the Healthy New York Program, 2006* (New York: State of New York Insurance Department, January 2007), available online at www.ins.state.ny.us/website2/hny/reports/hnyepp2006.pdf.

[23] The Healthy New York benefit plan was designed by the state, and because its funding is subject to state budget constraints, it does not cover all services that people need, including prescription drugs, mental health services, rehabilitation, hospice, durable medical equipment and supplies, and private duty and home nursing. Discussed in Deborah Chollet, *The Affordability of Coverage for High-Cost Individuals: Options for Washington State*, op. cit.

[24] Dina Belloff, Joel Cantor, Margaret Koller, and Alan Monheit, *Reinsurance Options for New Jersey's Health Insurance Markets* (New Brunswick: State of New Jersey Department of Human Services and Rutgers Center for State Health Policy, January 2007).

[25] A 2006 annual study found that premiums for Healthy New York were 45 percent lower than premiums offered by other carriers in the small-group market and more than 70 percent lower than the premiums offered in the individual market. New York State Insurance Department, *2006 Annual Report of the Superintendent of Insurance to the New York State Legislature* (New York: State of New York, 2007).

[26] Information from Mark Scherzer, Legislative Counsel of New Yorkers for Accessible Health Coverage, February 27, 2008.

[27] Information from Anthony Rodgers, Director, Arizona Health Care Cost Containment System, January 31, 2008.

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