MISSOURI FOUNDATION FOR HEALTH

FACT SHEET

April 2006

Cover Missouri Project: Report 11

Implementing Reinsurance: Health Insurance Reform in Missouri

This fact sheet presents excerpts from a research study by the same name that describes the goals, as well as the mechanisms, of reinsurance. The report also highlights other states' experiences with public reinsurance and describes ways that Missouri could apply these efforts in the creation of its own reinsurance program. Finally, it offers a guide to reinsurance implementation, which includes pertinent questions that policymakers must address in establishing a reinsurance program in Missouri as a way to expand coverage and reduce the number of uninsured.

Reinsurance

Reinsurance serves as insurance for insurers. It allows primary insurers to share risk with other entities. Primary risk bearers include insurance companies, health maintenance organizations (HMOs), and self-insured employer groups. Many primary insurers already purchase their own private reinsurance to protect themselves against the risk of unexpectedly high medical expenses of enrollees. Public reinsurance pooling has also been enacted as part of regulating private insurance, notably in the 1990s through reforms such as Missouri's Small Employer Health Insurance Availability Act.

Interest has recently grown in using new forms of publicly funded reinsurance as one way to help maintain or expand private health insurance. Iowa's current governor, Thomas J. Vilsack, has proposed such an initiative, and advanced planning is under way in Kansas to implement one of several forms of reinsurance as part of a broader initiative to expand insurance coverage. Both of these states, in turn, cite current public reinsurance programs in Arizona and New York, which seek to encourage both sellers and buyers of insurance to maintain or expand their provision of health coverage. Sellers receive some protection against incurring more than their expected share of very high-cost medical claims, while buyers receive an indirect premium subsidy and the prospect of reduced variation in premiums from year to year.

Key Findings

Whether to create a reinsurance program for Missouri poses a complex set of issues. Reinsurance supplements other primary mechanisms for bearing health insurance risk. Private reinsurance serves to protect the solvency of private risk bearers. Most private reinsurance does less to spread risk broadly across entities or society than it does to spread a reinsured entity's risk across time, smoothing out unexpected variances from predicted health-related spending.

Public reinsurance can be either prospective or retrospective. Prospective coverage allows primary insurers to share the risk of individuals identified in advance as high-risk enrollees. It resembles the assigned-risk plans seen in automobile and other lines of insurance coverage. Such spreading of risk can encourage market participation despite public rules that limit insurers' traditional prerogatives to reject or charge more to higher risk individuals as a part of underwriting for coverage in individual and small group markets.

Retrospective reinsurance reimburses primary risk bearers for the costs of single enrollees or classes of enrollees whose annual claims exceed pre-specified levels, or thresholds, e.g., $25,000 per enrollee year (specific reinsurance) or 120 percent of expected medical losses on coverage or 85 percent of premium (aggregate reinsurance). Retrospective reinsurance, paid for with public funds, has been used to subsidize primary insurance by reimbursing primary insurers for unusually high medical losses. Usually the primary carrier retains a coinsurance obligation as a way of encouraging appropriate economizing on claims handling.

Public Reinsurance in Arizona and New York

Arizona and New York have retrospective reinsurance programs that subsidize certain individual or small group purchasers of insurance by reinsuring their insurers' high-cost claims with public funds. The first is the Healthcare Group of Arizona (HCG), a division of the state's managed care approach to Medicaid. HCG was authorized in the early 1980s and began operating in 1988. In the late 1990s, the participating plans suffered severe adverse selection, premiums rose rapidly, and one plan dropped out, cutting total enrollment almost in half.

Ensuing reforms put HCG under more direct state control, including terms of coverage and premium rates. Three HMOs now participate; and in late 2005, a Preferred Provider Organization (PPO) option was made available. Reinsurance is provided in several ways. The state withholds a per-member per-month amount from the premiums of all participating HMOs to fund private reinsurance for annual losses over $100,000 per enrollee. HCG itself uses state appropriations to share in losses between $20,000 and $100,000 and also reimburses plan losses. The target is to keep medical claims costs at about 86 percent of premiums. The three participating HMOs are exempt from conventional insurance regulation, but must meet the program's own standards. There is open enrollment

and community-based premiums are set by age, gender, and location. High employee participation rates were required as a way of reducing individual adverse selection. State reinsurance funding was initially set at $7 million for 2001 but reduced over time to $4 million annually. As of mid-2005, there were more than 17,000 enrollees in more than 6,000 small firms and a few units of local government.

Healthy New York (HealthyNY), established in 2001, is the most visible example of supporting coverage expansion through the use of reinsurance. The program targets previously uninsured small businesses and working individuals with low incomes. HealthyNY contracts only with HMOs, and more than 20 plans participate. The benefit package is somewhat slimmed down from conventional products, omitting some otherwise state-mandated benefits. For both individuals and firms, there is open enrollment; and premiums are fully community rated. Enrollment is available to small businesses with 50 or fewer employees, the firm must not have offered to contribute more than $50 a month toward coverage during the prior 12 months, and at least 30 percent of employees must earn less than $34,000 (the 2005 ceiling, although the amount is adjusted annually). Employers must pay at least 50 percent of the premium, and at least half of the firm's employees must participate in order to reduce individual adverse selection. Sole proprietors and individuals working in firms that do not subsidize coverage may also join HealthyNY. Enrollment as of December 2005 was about 107,000, the majority of whom were individuals.

State reinsurance pays 90 percent of an enrollee's claims between $5,000 and $75,000 within a calendar year. This rate corridor was $30,000 to $100,000 in the program's first two years. It was lowered to provide more subsidy, and premiums dropped by about 17 percent. The lower rate corridor resulted in much greater demand on the fund and a larger subsidy to the program by the state. In 2004, reinsurance kept medical claims cost at 82 percent of premiums; without reinsurance, it would have been 115 percent. HealthyNY reinsurance totaled $38 million in 2004 (28.6 percent of medical expenses) and is expected to total $58 million for 2005. The state subsidy comes from tobacco settlement revenues and is fixed by appropriation. If claims exceed the amount available, reinsurance payouts to HMOs may be reduced pro rata, but due to current enrollment levels the program has been underspending and is carrying monies forward from year to year.

Recommendations

Public reinsurance is worthy of serious consideration in Missouri because it would spread risk more broadly, would lower volatility in prices from year to year, and would effectively lower premiums for primary coverage when subsidized by public revenues. The first major item policymakers must consider is what sphere of health coverage to target for intervention. It is logical to focus on small employers because their employees and dependents constitute a large share of the uninsured. Small employers are important to the

economy and their insurance market appears to be in considerable flux. In addition, worries about access to and affordability of health insurance distract from small employers' central role of entrepreneurship and job creation. Small firms lack the large natural risk pools of larger entities, and they cannot afford to maintain specialized benefits expertise within their firms.

Another major issue is whether to focus help on the entire private market, only on a new purchasing pool, or on another form of coverage created under state authority. Broader reinsurance subsidies for all private insurance might achieve more but would be much more costly. Reinsurance tied to enrollment through a state administered purchasing framework or pool could help hold the pool together and help avoid insurer exits from the pool because of adverse selection.

A third discussion for policymakers centers on how much public support to provide and to what extent such support should be prospective or retrospective. Relevant here would be Missouri-specific findings on how much volatility exists among primary insurance premiums and how high the extra "risk premium" currently is that primary insurers require to accept small group enrollees.

If Missouri policymakers decide to create a reinsurance program, detailed discussions with New York and Arizona program managers and health plans about the relative importance of reinsurance to other features of the states' programs would be useful. Discussions with insurance agents and brokers, small business owners, and others with knowledge of current accomplishments and problems in Missouri would also assist in the creation of an effective public reinsurance program in the state.

About This Fact Sheet

The information presented here is taken from *Cover Missouri Project: Report 11: Implementing Reinsurance: Health Insurance Reform in Missouri,* written by Randall R. Bovbjerg, JD, Principal Research Associate, of The Urban Institute's Health Policy Center in Washington, D.C. Report 11 is part of a series of research papers about the uninsured in Missouri prepared by The Urban Institute and published by the Missouri Foundation for Health.

The complete report is available online at www.mffh.org. Printed copies of this Fact Sheet are available upon request while supplies last. Please contact the MFH Health Policy staff at info@mffh.org or toll-free at 1-800-655-5560.

FMFH0306CMP11FS - 6M

MISSOURI FOUNDATION FOR HEALTH
Grand Central Building, Suite 400 • 1000 St. Louis Union Station • St. Louis, MO 63103
314-345-5500 Voice • 314-345-5599 Fax • 1-800-655-5560 Toll-Free • www.mffh.org