

Cover Missouri Project: Report 11

Implementing Reinsurance: Health Insurance Reform in Missouri



MISSOURI FOUNDATION FOR HEALTH

About MFH

Established in 2000, the Missouri Foundation for Health is dedicated to its mission of empowering the people of the communities we serve to achieve equal access to quality health services that promote prevention and encourage healthy behaviors. In support of its mission, the Foundation undertakes policy research to educate the public and decision makers on effective health policies that will result in long-term, positive health system change in the state of Missouri. Formulating sound health policies advances the Foundation's efforts to increase access to high quality, cost-effective preventive and curative care, especially for the uninsured, underinsured, and underserved in our service region of 84 Missouri counties and the City of St. Louis.

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Cover Missouri Project

Preface

In an effort to inform the discussion regarding practical policy options to expand health care coverage for the uninsured in Missouri, the Missouri Foundation for Health (MFH) has established the Cover Missouri Project. Under this project, MFH has engaged The Urban Institute to produce a series of papers which considers strengths and weaknesses of the current health care system in Missouri and explores options for decreasing the number of uninsured. MFH offers these studies as a means to further understand and ultimately improve access to health care coverage.

Missouri currently faces considerable challenges related to creating an equitable and comprehensive system of health care for all Missourians. In 2005, between 635,000 and 707,000 Missouri residents were without health insurance. In addition, eligibility cuts and cost-sharing changes to Missouri's Medicaid program made in 2005 increased the number of uninsured. Ultimately, these changes may shift Missouri from being one of the 12 states with the lowest uninsurance rates to being among the 12 states with the highest rates of uninsurance.

Research broadly documents the serious health and financial consequences associated with being uninsured. The uninsured live sicker and die younger than those with insurance. They forego preventive care and seek health care at more advanced stages of disease. Society then bears these costs through lower productivity, increased rates of communicable diseases, and higher insurance premiums. Those without health insurance often must choose between visiting a doctor and paying for other essentials.

This paper, "Implementing Reinsurance: Health Insurance Reform in Missouri," represents the 11th in the series emerging under the Cover Missouri Project. It describes the goals, as well as the mechanisms, of reinsurance. The report also highlights other states' experiences with public reinsurance and articulates 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.

Leslie Reed
Vice President for Health Policy
Missouri Foundation for Health

About the Author

Randall R. Bovbjerg, JD, is a Principal Research Associate at The Urban Institute. He has 30 years experience in public and private insurance, state and local health policy, medical injury, liability, patient safety, safety-net issues, and state regulation. Current research includes a planning grant to help the District of Columbia expand insurance coverage and case studies of state medical boards' performance in physician discipline. He serves on the D.C. Health Care Reform Commission, has been a journal editor and peer reviewer, and has taught for Duke, Johns Hopkins, and the University of Maryland-Baltimore County. The author gratefully acknowledges the comments, advice, and leadership provided by John Holahan and Stephen Zuckerman.

About The Urban Institute

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Implementing Reinsurance: Health Insurance Reform in Missouri

by Randall R. Bovbjerg, JD

Reinsurance serves as insurance for insurers.¹ It allows primary insurers to share risk with other entities. Reinsurance for employer groups and for health maintenance organizations (HMOs) is also termed “stop-loss coverage.” Primary risk bearers include insurance companies, 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 their 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.² 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. Both of these states, in turn, cite prior experiences in Arizona and New York.³ Such public reinsurance seeks 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.

This research paper describes reinsurance mechanisms and their goals. It also highlights prior experience with public reinsurance and describes ways that Missouri could implement reinsurance. Finally, as an aid to further decision making, it provides a roadmap to reinsurance implementation, that is, the steps needed to effectuate public reinsurance.

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Mechanisms of Reinsurance

Reinsurance can be either retrospective or prospective. This useful distinction is one that has been made by the Kansas planners.⁴ Retrospective reinsurance reimburses a primary insurer for claims incurred above certain agreed threshold levels during a policy year. For example, reinsurance may pay the primary insurer for 80 percent of any insured individual's accumulation of claims that exceeds \$50,000 for the entire year.⁵ The threshold operates as a kind of deductible for the primary insurer; and the primary insurer typically retains a co-insurance obligation as well, 20 percent in the example given, just as a health plan enrollee typically does. Reinsurance is not visible to primary insurance enrollees, as the primary carrier continues to collect all enrollee premium contributions and to pay all enrollee claims. The reinsurance is a "side deal" between insurers, and enrollees benefit indirectly and unknowingly.

Reimbursement for very large annual claims is quite valuable, as high-cost cases constitute a substantial fraction of total health spending. For example, amounts over \$30,000 per person per year accounted for about 22 percent of total insured health costs in 2004.⁶ The costs for a particular reinsurance arrangement can be higher or lower than this depending on the thresholds and coinsurance applied, as well as the specific definitions of covered claims, whether claims-adjustment expense is included, and so on.

Private reinsurers charge premiums to primary insurers to pay for such reinsurance coverage. As for primary health coverage, reinsurance premiums vary according to who buys the coverage and are set to include expected claims costs, administrative expen-

ses, plus a "risk premium" to compensate the reinsurer for taking the risk of capital loss if premiums prove insufficient. For public reinsurance, there may be no charge to the primary insurer.

Reinsurance commonly applies to all insured health care costs, but it can cover only a designated sphere of expense. For example, reinsurance can apply only to inpatient hospital expense; many HMOs have bought such coverage. Alternatively, reinsurance can cover only specified catastrophic diseases or diagnoses, as one form of Arizona Medicaid reinsurance has done.⁷

Prospective reinsurance is quite different from its retrospective counterpart. It is a way to share the insurance risk of individuals designated by a primary insurer at the start of the year, not the risk of high claims as tabulated at year's end. Under prospective reinsurance, primary insurers "cede" or transfer an individual enrollee's spending risk to a reinsurance pool at the time of enrollment. The primary insurer continues to cover the enrollee's claims but is reimbursed by the reinsurance pool for some or all costs above a specified threshold.⁸

Prospective reinsurance is a publicly created mechanism. There is no private market because a carrier-designated, high-cost individual is not an insurable risk. Put another way, the risk premium would be enormous for a reinsurer to accept whatever (expensive) individual risk a primary carrier chose to transfer to reinsurance. Prospective reinsurance is created not by private contract but by public rule as part of a larger reform, notably including small-group market insurance reforms that in many states limit insurers' ability to reject an applicant or to

charge premium rates according to their perceptions of health-spending risk. Insurers pay the reinsurance pool a prospective premium that is set by the pool. Insurers also pay a retrospective pro rata share of any annual pool deficit – the amount by which actual pool payouts for reinsured enrollees during the year exceeds the reinsurance premiums paid in. This type of risk-sharing through reinsurance resembles that of assigned-risk pools for automobile insurance or workers' compensation.⁹

It should be remembered that reinsurance is secondary to primary coverage by definition. It can help support that coverage in various ways, but how successful the primary coverage will be in attracting enrollees or achieving other goals depends on far more basic attributes of coverage than the nature of applicable reinsurance provisions. It is therefore no surprise that public reinsurance is seldom seen as a standalone reform, but rather as part of a broader strategy to maintain or expand coverage.

Motivations for Private Reinsurance

What do primary insurers want from private reinsurance? The principal motivation is solvency protection: primary risk bearers, including insurers, HMOs, and self-insured employer groups want to protect their annual earnings and their assets against unexpectedly high losses, especially losses that are high relative to their net worth. Primary risk bearers may also want to obtain specialized expertise or services from reinsurers, such as high-cost case management or access to contracted centers of excellence for known high-cost services such as transplants. Ready availability of reinsurance can thus facilitate market entry by new firms unfamiliar with market risks or by smaller firms unable to bear high losses on their own. With reinsurance, the firms can then underwrite risks that they would not otherwise take on their own. This may be most obvious in the case of small- and medium-sized employers, who would never self-insure their health claims risk without high-end reinsurance to protect their assets from catastrophic medical losses. Very large, experienced insurers and self-insurers have little need for reinsurance as financial protection.¹⁰

Primary insurers do not expect buying reinsurance to reduce their costs for health benefits over the long run because they pay premiums commensurate with the risks being transferred. To the extent that the reinsurer essentially "experience rates" the primary insurer, the primary carrier can expect over time to pay the full cost of benefits under the primary policy, but the year-to-year variation in claims experience will be much less than without reinsurance. To the extent that similar rates are charged to all primary companies in a certain class, that whole class will share risk. Nor does private reinsurance help protect identifiably high-risk individuals or groups; it only protects against the high end of unpredictable risk. For high-risk, would-be insured individuals, the problem is not the unknown risk of high random variability of subsequent claims but rather the prospectively known risk of high spending. For such people, the private market has no answer except making them pay sharply higher premiums or agree to reduced coverage; only public reinsurance can help them.

Motivations for Public Reinsurance

Mitigating Adverse Selection

Different forms of public reinsurance have been used or proposed with different goals in mind. Prospective reinsurance pooling seeks to allow market participants to protect themselves against enrolling an unacceptable number of high-risk enrollees and thus encourages market participation. It has typically accompanied other regulations of the small-group or individual insurance markets that limit participating insurers' ability to underwrite applicants so as to selectively refuse coverage, limit coverage, or charge far higher premiums for higher risks.¹¹ Such reforms sought to make coverage more available and affordable by making insurers accept enrollment on less restrictive terms but then encouraging the carriers to remain in the market by protecting them against the worst adverse selection using reinsurance.¹² Reinsurance and the other regulations are also meant to improve enrollees' access to coverage on less restrictive terms. No direct subsidy of insurance is intended, as financing comes from private premiums and end-of-year pool assessments on participants.¹³

Solvency Protection for Insurers

Solvency protection was the motivation for reinsuring Medicaid managed care (MMC) plans when states sought to implement managed care organization (MCO) enrollment on a capitated basis. Existing MCOs were reluctant to assume the risks of participation in some states because they had no experience in this new market and did not know how to price Medicaid enrollees. Moreover, new MCOs were often formed by medical providers and others who lacked any risk-bearing experience. Accordingly, states typically provided public reinsurance to cover very-high-cost cases or required

participating MCOs to buy similar private reinsurance. Funding came from a share of capitation payments. Not dissimilarly, Missouri requires stop-loss reinsurance for self-insured health plans formed for groups of small employers – not only to protect the employers but to protect their enrollees if the plan fails in mid-year.¹⁴

Subsidy for Insurance

Public funding for retrospective reinsurance is meant to subsidize insurers by reducing their spending for a major element of costs – high-cost claims. Insurers are in turn expected to reduce premiums to enrollees as a result of competition and possibly also regulation. Lower premiums are meant to encourage enrollees to buy coverage. Reinsurance directs support to the neediest people, i.e., those with very high costs. A premium subsidy, in contrast, operates up front, normally without regard to health risk. Either approach lowers the effective cost of health coverage for enrollees and hence should increase purchases.¹⁵ In addition to lowering medical claims costs borne by the primary insurer, public reinsurance would, to some extent, reduce the risk premium charged by the primary insurer or by a private reinsurer in compensation for accepting high-end risk and its threat to profits and even solvency. The effect is similar to the interest savings achieved by borrowers with a higher bond rating; the size of the savings is not known with precision, however, but is likely small.

Promoting Market Stability

Both small employers and the insurers that serve them have problems in the small-group market. Premiums are higher than for large group coverage and quite variable over time. Risks are hard to predict because

group size is small and insurers fear adverse selection. Groups often face sudden rate changes in the wake of bad claims experience. Insurers see much churning of enrollment as groups often change carriers in search of better terms. Administrative costs are high because of individual underwriting and other factors. Reinsurance of very high-cost cases might help stabilize the market by reducing the need for sudden price increases and shifting among carriers. Here too, some small savings from reduction of risk premiums can be anticipated.

In sum, private reinsurance contracts are a way for a private insurer to optimize its own balance of risk assumed and premium retained. In contrast, publicly required or provided reinsurance calls for wider spreading of risk and may involve public subsidy. Public and private goals are different, as is their financing. It is important not to think of the mechanisms as interchangeable even though both have similar features, such as risk transfer, use of thresholds, and the like.¹⁶

Experience with Reinsurance

Private Reinsurance

Primary risk bearers' reinsurance arrangements vary depending on their capacity to withstand large losses, taste for risk, and other circumstances. As already noted, large and experienced insurance companies may not buy reinsurance at all for most of their business. Those that do buy it select according to somewhat idiosyncratic reinsurance terms. Each buyer of reinsurance will also pay different premiums, depending on the underlying risk of their enrollees and on what other reinsurance-related services they buy. Accordingly, policymakers cannot look to any one type of private reinsurance experience to decide how well private reinsurance achieves its objectives. The continued voluntary participation by buyers and sellers in the reinsurance market suggests that performance is satisfactory to them.

Public Reinsurance

This paper describes public reinsurance initiatives that do not seek to regulate or supplant private reinsurance's role in allowing private parties to decide how much risk to

assume. The following outlines the goals of several approaches to public reinsurance.

PROSPECTIVE REINSURANCE

Many states enacted reinsurance pooling as part of small-group market reform. However, only a few states included Blue Cross and Blue Shield plans; and many made the entire program voluntary. Large insurers generally opposed public reinsurance, asserting that they did not need it and that it was not a source of instability in the market. The operational pools in some states attracted very little business, in part because premiums for primary insurers ("ceding" companies) were high. It appears that no state has chosen to use public funds to subsidize these reinsurance pools. Many states, including Missouri, have ceased operating such reinsurance pools.¹⁷

RETROSPECTIVE REINSURANCE FOR MMC PLANS

Many states used public reinsurance to help assure MCO participation in the early transition to capitated managed care. One case study found a more recent trend among

six states studied to rely on plans' purchase of private reinsurance. Arizona continues to support several forms of public reinsurance for its Medicaid plans.¹⁸ States using retrospective reinsurance extensively regulate MMC enrollment, benefits, and other aspects of operations.

RETROSPECTIVE REINSURANCE AS A SUBSIDY

Two states subsidize certain individual or small-group purchasers of insurance by reinsuring their insurers' high-cost claims with public funds.¹⁹ The Healthcare Group of Arizona (HCG) is a division of the state's managed care approach to Medicaid. HCG was authorized in the early 1980s and began operations in 1988 with start-up funding from a private foundation. HCG was an offshoot of the Arizona Health Care Cost Containment System (AHCCCS) in that two of its MMC plans were marketed to small employers under special state rules rather than under conventional insurance regulation. A third MMC plan joined later. In the late 1990s, the participating plans suffered severe adverse selection; premiums rose rapidly; and one plan dropped out, cutting total enrollment by almost half.²⁰

Ensuing reforms put HCG under more direct state control, including its 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 all participating HMOs premiums to fund private reinsurance for annual losses over \$100,000 per enrollee. HCG itself uses state appropriations to share in losses in the \$20,000 to \$100,000 range and also reimburses plan losses, evidently on a judgmental basis rather than through formal aggregate reinsurance. 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. The intent is to phase out public reinsurance support by making plans more efficient and by attracting more favorable risks. As of mid-2005, there were more than 17,000 enrollees in over 6,000 small firms and a few local government units. Most enrollees were sole proprietors.

Begun in 2001, Healthy New York (Healthy NY) is the most visible example nationally of underpinning coverage expansion with reinsurance.²¹ The program targets previously uninsured small businesses and working individuals with low incomes. Healthy NY contracts only with HMOs, and more than 20 plans participate. The benefit package is slimmed down somewhat from conventional products, omitting some otherwise state-mandated benefits. There is open enrollment; and premiums are fully community-rated, the same for individuals and firms. Enrollment is available to small businesses with 50 or fewer employees that have not offered to contribute more than \$50 a month toward coverage during the prior 12 months.²² Also, at least 30 percent of their employees must earn less than \$34,000 (the 2005 ceiling, which is adjusted annually). Employers must pay at least 50 percent of the premium; and at least half of the employees must participate to reduce adverse selection. Sole proprietors and individuals working in a firm not subsidizing coverage may also join Healthy NY if they meet similar income requirements. Enrollment as of December 2005 was about 107,000, the majority of whom joined as individuals.²³

State reinsurance pays 90 percent of an enrollee's claims between \$5,000 and \$75,000 in 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. Healthy NY enrollment has grown rapidly, despite some offsetting disenrollment. Given the extent of subsidy and the plan's low premiums compared with conventional, unsubsidized coverage, enrollment could be much higher; why it is not remains unclear.

On average in 2004, Healthy NY reinsurance kept medical claims cost at 82 percent of premiums; without reinsurance it would have been at 115 percent. The reinsurance totaled \$38 million, or 28.6 percent of medical expenses, in 2004 and is expected to total \$58 million for 2005.²⁴ 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. However, at enrollment levels to date, the program has been underspending and carrying monies forward from year to year.

Reinsurance provisions have clearly been important to current operations in both Arizona and New York. However, in

comparison to Arizona, New York's reinsurance appears to provide somewhat more subsidy per enrollee, about \$400 each in 2004.²⁵ There are other commonalities between these two public reinsurance subsidy programs:

- Reinsurance subsidy applies only within a purchasing framework set by the state.
- Subsidy targets small businesses and sole proprietors.
- Only MCOs are included, and enrollees have some choice among participating MCOs.
- MCO benefits are somewhat reduced from the conventional market.
- Reinsurance funding from the state is strictly limited.
- Neither plan covers the bulk of people conventionally insured within small-group and individual markets.

Differences between the two programs include:

- New York targets the previously uninsured, while Arizona targets those poorly served by the private market.
- New York targets low-income enrollees, and Arizona does not (but may introduce income-related premiums).
- New York offers a limited choice of benefits options, while Arizona offers many more benefits options.
- New York has a low threshold for reinsurance, while Arizona has a higher threshold.

Developing a Reinsurance Approach for Missouri

Developing useful ways to use reinsurance in Missouri is only, in part, a technical issue of what approaches exist or have been tried in some other context, often far from Missouri.

A reinsurance plan also needs to reflect local circumstances in the state, private and public practices, institutions, and capabilities. Finally, designing a social intervention is also

partly a normative matter that gives weight to the values of Missouri businesses, insurance consumers, and taxpaying voters. For these reasons, it is helpful to consider developments in similar nearby states, at least in brief. Developments in Kansas and Iowa are discussed in this section, along with two Missouri institutions: the state employees' purchasing pool, and Missouri's MC+ Managed Care system for Medicaid enrollees. Further consideration of the topic of reinsurance in Missouri should focus on these in much more detail.

Prospective Approaches

Three prospective reinsurance models warrant brief discussion. The Kansas reinsurance project is modeling the costs and likely impacts of two forms of prospective reinsurance.²⁶ Both types call for reinsurance of individuals that the primary insurer cedes to a reinsurance pool but with claims still administered by the primary carrier.

A National Association of Insurance Commissioners (NAIC) approach to small-group reform is one model under consideration. The NAIC model has a \$5,000 annual attachment point, 10 percent retention, and a reinsurance premium paid by the primary carrier. The amount of risk that is shared depends greatly upon the premium provisions.

A number of states have copied a reinsurance mechanism developed in Connecticut. This approach has first dollar reinsurance coverage but with a premium paid by the ceding carrier.

In these prospective models, reinsurance costs that exceeded premiums – the annual deficit – were shared among all insurers in the small-group market. To provide new subsidy, the deficit could instead be met in whole, or in part, from public revenues not raised from insurer assessments. Again,

premium provisions have great practical importance.

Clearly, the practical impacts and political support for these mechanisms will depend on many issues in the final design. Notably important are whether participation in the pool is mandated or voluntary and what share of reinsurance revenues come from primary insurers' premiums, from other insurers' share of annual deficits, and from broad-based tax funding. However, because Missouri has just ended its own small-employer reinsurance pooling of this general type, these prospective reinsurance options are not discussed further in this paper.

Retrospective Approaches

The Kansas project is considering two types of retrospective reinsurance as well. Diagnosis-based reinsurance is one approach that reinsures all claims paid for a designated set of diagnosis codes. Kansas sources note that this idea received consideration in Colorado,²⁷ but a version of it also applies under Arizona's Medicaid reinsurance program.²⁸ The designated conditions, presumably, are the sort highly likely to entail high-cost treatment, such as diabetes. In the individual market, insurers commonly reject or heavily surcharge applicants with such conditions. In the small-group market, employers of such individuals face similar rejection or surcharges.

Missouri's high-risk pool addresses just these types of persons with high-cost chronic conditions. It covers their unusually high costs not through reinsurance but through pooling of year-end deficits on policies sold by the high-risk pool.²⁹ This type of reinsurance targets known high-cost categories of enrollees and would likely cost more per enrollee than general reinsurance with similar provisions. Reinsuring the primary insurer of such people through their workplace coverage allows enrollees to

remain on the job and to benefit from the same insurance with which they are already familiar and which may also be available to the rest of their family. Such reinsurance also removes most of a primary insurer's incentive to exclude such people from coverage.³⁰ A focus on high-cost conditions may also encourage the development of cost-effective, high-cost case management or other approaches of value.

General small-group retrospective reinsurance is the other mechanism under consideration in both Kansas and Iowa.³¹ It could reimburse all paid primary health insurance claims above a specific threshold for all small-employer businesses. Iowa Governor Thomas J. Vilsack spoke in favor of such a broad approach to stabilizing the entire small-group health insurance market through mandatory reinsurance. Governor Vilsack explained that it would “spread the cost and risk of catastrophic illness and injury over a larger group of people with greater resources. . . and it would send a strong signal to small-business owners that they are important and valued in this state.” Funding would come from “increasing the fees and cost of tobacco products.”³² The Iowa proposal would require businesses that employ up to 25 people to participate in a reinsurance pool that would reimburse employers for half the cost of claims between \$25,000 and \$100,000.³³ Making participation mandatory would treat all small groups alike, but without a contribution from them it would not pool risk across all small businesses. The pool would instead spread the costs to the tobacco consumers who fund the reinsurance. Because it is the widest approach, this option is potentially the most expensive to implement.³⁴

Targeted small-group reinsurance is the final retrospective option discussed here. The significant difference from the previous

approach is that targeting reduces the size and cost of the reinsurance. This approach would reinsure only those primary insurers operating within an authorized purchasing framework with attributes desired by state policymakers. These might include open enrollment/guaranteed issue of coverage, streamlined benefits packages and reliance on managed care as a delivery mechanism, or some controls over premium rating structures. Both Arizona and New York offered reinsurance only within a purchasing framework. An alternative way of reinsuring only a smaller group could be not to target all small groups but rather to focus on the previously uninsured, as New York did.

Two existing frameworks in Missouri could serve as the basis for an insurance expansion and possibly facilitate support for new public reinsurance. The first is the state employees' health plan, which could serve as the basis for a health insurance purchasing pool for non-employees, as explained in Cover Missouri Project: Report 7: Expanding Coverage Through the Missouri Consolidated Health Care Plan (MCHCP).³⁵ The second local model is Missouri's MC+ Managed Care system. The same managed care plans or look-alikes could serve private enrollees, in the same way as Arizona adapted its Medicaid plans to serve the small-employer market. In either case, public reinsurance would be an adjunct to the new plans operating under new state rules within the purchasing framework. Reinsurance would serve to reduce the pressures of risk selection on participating plans and thus on relative enrollee premiums within the pool because any plan drawing a large share of very high-cost cases would be relieved of much of its costs. Having reinsurance inside but not outside the pool would be one way to pay for some of the participating insurers' costs of adverse selection versus non-pool plans.³⁶

Massachusetts produced a reinsurance proposal of its own as part of its “Roadmap to Coverage” initiative.³⁷ This proposal took a broader approach and featured stop-loss coverage for all small-group coverage. It proposed mandating coverage but making it easier to obtain by running a purchasing pool that would subsidize coverage with income-related premium support for residents and businesses. Small groups could buy inside or outside the pool, and public

reinsurance support was proposed to apply in either case. The reinsurance was to cover 75 percent of all claims over \$35,000 per enrollee per year, with no upper limit. The goals were to provide additional subsidy, to stabilize small-group claims experience both within and outside of a purchasing pool, and to reduce incentives for risk bearers outside the pool to transfer high-cost enrollees to the pool.

Steps in Final Design and Implementation of Reinsurance

The preceding discussion suggests the menu of reinsurance options available to policymakers. In making final decisions on the nature of any intervention, it is expected that policymakers will further investigate developments elsewhere and will also consider conditions in Missouri. As an aid to working through the choices to be made, this section lays out the steps in the final design and implementation of a reinsurance program. Many of these steps would apply to any reinsurance intervention; others are based on the model of retrospective coverage. Creation of a final program goes through many phases – establishing basic design through legislation, implementation planning and supportive regulation before actual start-up, active implementation at start-up, as well as monitoring and mid-course corrections over time.³⁸

Pass Enabling Legislation

SET THE BASIC FRAMEWORK FOR REINSURANCE
The first step in implementing reinsurance is the same as for any other reform, to develop and enact enabling legislation to set the general framework for reinsurance. Issues to be established include:

- eligibility standards (e.g., for small employers buying coverage through a purchasing pool),³⁹

- general contours of reinsurance benefits to be provided (prospective or retrospective, specific or aggregate, threshold, etc.),
- funding amounts and sources,
- responsible state agencies, and
- any new operational powers needed.

A very basic issue to be discussed involves how much public funding is to be provided through reinsurance. The reinsurance impact on premiums needs to be substantial in order to have any influence on purchasing decisions. In 2004, New York’s reinsurance subsidy was about 28 percent of covered health care expenditures, or nearly \$400 per enrollee per year. Any reinsurance program could be more or less generous than that. Higher support will do more to reduce the impact of adverse selection on plans as well as on enrollee premiums.

Many provisions of reinsurance, however, should not be legislated but rather specified during the implementation phase. Even quite consequential provisions should perhaps not be legislated, including the precise reinsurance thresholds to be implemented. These decisions, as well as many aspects of implementation and financing, need to be made by people with

detailed insurance expertise and with an eye to market response. Front-line administration needs sufficient discretion to work out operational details in an expeditious and cost-effective fashion. Because reinsurance must relate to private risk-bearing arrangements not run by the state, its implementation needs to be granted more flexibility than programs that are wholly under state control.

States have created flexible arrangements in setting up high-risk pools and reinsurance for small-group market reform. Those reforms have typically left operational arrangements to be made by an implementing board of private experts and public representatives. Given that the reinsurance discussed here is funded by public revenues, public accountability needs to be maintained. However, private expertise and knowledge of private business operations are also important for successful implementation, arguing for a large private role. Accountability can be maintained by having a reinsurance board create a plan of operations that is subject to approval by a state administrator, such as the Commissioner of Insurance or even the legislature.

ESTABLISH POLICYMAKING RESPONSIBILITY FOR IMPLEMENTATION

An early implementation choice includes which state entities will oversee implementation and operation of the reinsurance program. The responsible agency needs to have substantive expertise in insurance and reinsurance as well as capacity to maintain good relations with private insurers, with whom many operational details will need to be worked out. Having an experienced advisory or governance board adds expertise and is a routine part of state high-risk pools, market-reform reinsurance, or state reinsurance. Obtaining access to experience and expertise is another key reason for contracting out some reinsurance functions.

The Missouri Department of Insurance (MDI) is arguably the most logical agency to oversee a new health reinsurance program. The department already regulates insurance generally, including reinsurance (e.g., the stop-loss coverage required of self-insured multiple employer trusts). MDI was specifically tasked with oversight of the state's former Small Employer Health Reinsurance Program. If reinsurance is implemented in support of a new purchasing pool, administrative simplicity might be served by giving the pool's oversight agency responsibility for reinsurance as well.⁴⁰

ALLOW SUFFICIENT ADMINISTRATIVE START-UP TIME

It seems desirable to allow between 18 months and two years to start up a new reinsurance program in conjunction with a purchasing pool or other reform for primary insurance in Missouri. The state of New York was able to start up Healthy NY, including reinsurance, in slightly more than a year. However, New York needed to make significant changes soon thereafter.⁴¹ Moreover, considerable institutional knowledge will need to be generated since existing insurers have limited experience with the uninsured population, new insurers may enter with limited experience of Missouri, and state policymakers and administrators have only limited experience with publicly funded reinsurance.

Speed of implementation will also be affected by other factors. One is the extent to which available administrative capacity and managerial talent already exist within Missouri state government. Another is the extent to which implementing policymakers and operational entities will need to work within standard state requirements for hiring, contracting, and procurement.

PROVIDE FUNDING FOR IMPLEMENTATION PLANNING BEFORE OPERATIONAL ROLL-OUT

One key legislative role is to provide sufficient start-up funding for reinsurance. Administrative costs during implementation are likely to be higher than for continuing current operations because of the need during planning for expert consultants, investment in data systems, and the like. Reinsurance is retrospective, so its mechanisms will be tested only as claims appear, probably late in the first year, as some covered enrollees' expenses penetrate the reinsurance threshold. Most other elements of a purchasing pool or other primary insurance reform operate prospectively. Enrollment through a pool, for example, must occur before primary insurers start paying claims and well before insurers submit any reinsurance claims. Moreover, reinsurance will generate far fewer transactions per 1,000 enrollees. For both these reasons, any glitches in a reinsurance plan's operations will be discovered relatively slowly; and fixes during implementation will take longer to develop.

Key Steps in the Implementation of Reinsurance

HIRE OR DESIGNATE THE STATE OFFICIAL WITH LEAD RESPONSIBILITY FOR REINSURANCE

An executive director should be charged with undertaking all implementation activities related to reinsurance. It is possible that this could be a part-time position within MDI if the reinsurance program is small, but more time may be required. The exact nature of the job will also vary depending upon how many reinsurance functions are conducted within state agencies versus through a public-private board. At an early stage of implementation, the executive director and agency/board also need to address compliance with state hiring and procurement processes. The same is true for the extent of state staff needed, which the executive director should determine very

early on. One responsibility will be reporting to the top administrative oversight official, such as the Commissioner of Insurance, and to the appropriate legislative entities.

CONSTITUTE THE REINSURANCE ADVISOR/GOVERNING BOARD

Boards have two main functions: 1) to provide for public accountability over reinsurance design and operations, and 2) to provide expertise not generally available within existing state agencies. If the board is only advisory, with policymaking and oversight of ongoing operations concentrated within state agencies, board membership should emphasize consumer and insurer interests along with technical experts. If the board is an independent or quasi-independent governing entity that makes policy and oversees operations – presumably subject to final approval by a responsible state official – it should also contain state officials from key agencies.

Public members might include the secretary of administration and finance, the insurance commissioner, a commerce or development person, a data expert from the division of health care finance and policy, and an overseer of MMC. General public members could include a small business owner, labor union representative, operator of a business services firm, benefits administrator or attorney, and actuary from an insurer or HMO. Examples of private experts include a reinsurance broker, reinsurance actuary, and third-party administrator. A governmental or academic statistician, especially one with a business orientation, could add useful insight to actuarial recommendations and help translate actuarial concepts into lay terms. Either legislation or implementing regulation should give the board powers appropriate to its function, from hiring staff and reimbursing members for expenses to obligating a state funding account to pay a reinsurance administrator.

DETERMINE SMALL-EMPLOYER ELIGIBILITY

Legislative determination should settle on the size of “small” employers to be targeted for a reinsurance subsidy. The decisions on what size workplaces are included, whether they must have been previously uninsured, and what wage, income, or other rules apply are key determinants of the extent of new state assistance to be provided.

In addition, operationalizing such provisions during implementation raises several practical issues of uncertain magnitude. One issue is which workers constitute “employees.” Boundary issues arise with regard to part-time and seasonal workers, as well as independent contractors. Issues also arise when looking at workers compensation or unemployment provisions. As a general matter, it seems preferable for health reinsurance administrators to simply rely on the number of people included within a health insurance contract, leaving it to the market to determine who those people are. Any splitting of employees between an employer policy and purchasing-pool insurers is discussed below.

Another issue to be discussed includes what groupings of workers constitute the group that fits under the designated ceiling size. Firms often have multiple locations of different size, or subordinate franchises. Today such enterprises are motivated to aggregate to larger sizes to obtain more favorable insurance terms. Under a small-employer purchasing pool or reinsurance, there may be new incentive to disaggregate groups to qualify for new public benefits. Other firms might benefit from somehow splitting off higher risk employees into pool coverage, leaving another grouping more insurable outside the pool. Existing definitions used in regulating the small-employer market, though only applicable to insurers selling to employers of 30 or fewer employees, should provide useful precedent.

Another issue is what entity should validate eligibility and how (with regard to prior lack of coverage, low income, etc.). Participating primary health plans will have the most direct contact with employer groups and could be expected to perform such tasks, subject to oversight and possible verification by state officials.

Some “gaming” of employee definitions or group size by employers or insurers to qualify for reinsurance is certainly possible. But it may be an insignificant problem in practice, as the reinsurance benefit is likely to be small relative to overall health insurance premiums, and much less than employer labor costs. The possibility of gaming still bears watching, especially if the value of reinsurance subsidy is increased.

Two other practical issues arise if employment groups may choose which employees and dependents to insure through the purchasing pool. Often, the entire workplace group will seek pool coverage, but some employment groups will have enrollees in both the pool and a separate insurance plan outside the pool. Reinsurance administrators will need to decide, for example, whether a group of 90 employees outside the pool qualifies for reinsurance if 20 low-income (or high-risk) co-workers are in the pool, with or without employer contributions. Administrators or insurers also need to create reliable mechanisms to track which pool enrollees come from a small enough employment group to qualify their coverage for reinsurance. This will be useful whenever multiple insurance plans serve one group, whether through the pool or outside it.

DETERMINE INSURER OR HEALTH PLAN ELIGIBILITY

What constitutes an insurer that is eligible for reinsurance in the covered markets?

Insurers should include not merely conventional stock and mutual companies regulated as “insurers” under the state code, but also

hospital and medical service plans (e.g., Blue Cross Blue Shield), HMOs, and possibly other entities that are bearing health insurance risk in Missouri without qualifying as members of any of the foregoing categories. Other entities potentially now active and eligible for reinsurance include fraternal benefit societies and multiple employer trusts. Self-insured employers may be a major issue in their own right and will be considered in the next subsection.

New risk-bearing entities might be formed to provide coverage once encouraged by a new purchasing pool or other provisions, and if protected by reinsurance. These might include provider-based entities willing to accept capitated payments, non-profit associations, church-based groups, and even neighborhood organizations. Reinsurance policymakers will need to decide whether all or only a subset of potential risk bearers is to be reinsured. Sufficient capitalization and other solvency protections, including reinsurance, are very important public policy concerns, especially for such new entrants to the health coverage market.

DECIDE HOW TO DEAL WITH SELF-INSURERS

Some employer groups, even relatively small ones, act as self-insurers. The issue arises of whether to treat them as insurers eligible for state funded reinsurance. Although very large firms are the most likely to self-insure, even smaller groups of 100 employees or fewer occasionally self-insure.⁴² Almost all self-insuring smaller employers likely purchase private reinsurance today, and new state reinsurance would save them much of this cost.

Covering self-insurers on the same terms as primary insurers is correct on policy grounds. However, dealing with a large number of self-insured employers, who are not truly experts in the business of insurance, will add administrative

complexity to a reinsurance program.

Implementation should seek ways to reduce transaction costs of such relationships. One way is to rely as much as possible on intermediaries to help channel information and claims. Self-insured firms typically hire a third party administrator (TPA) to validate and pay claims. This TPA is often a health insurance company that mainly provides administrative services. The public reinsurance program may thus be able to work out operational details such as claims and data submission with a smaller number of entities than the full number of self-insured employers. This issue needs early attention during planning for implementation.

ESTABLISH THE FINAL REINSURANCE THRESHOLD AND COINSURANCE LEVEL

Another basic implementation decision includes what level of reinsurance thresholds and coinsurance obligations to implement. This determination calls for weighing several considerations and making some tradeoffs.

A lower threshold provides greater subsidy to the reinsured risk-bearers by reducing their medical spending costs, just as Healthy NY did when it dropped its threshold from \$30,000 to \$5,000 per person per year. This cost cut lowers premium costs to enrollees, ultimately encouraging enrollment. A lower threshold would also increase risk spreading because more costs would be borne by broader-based revenues. Lowering the threshold would also provide more assistance for insurers hit with adverse selection, and forms of reinsurance that address selection tend to have lower thresholds. These greater protections will likely help attract more insurers to sell in these markets as well.

At the same time, a lower threshold would require higher state taxes. It would also decrease incentives for covered insurers to economize on care. In addition, it would

increase transaction costs for the reinsurer, the state program that implements health reform, and for private insurers. A higher threshold is consistent with solvency protection for most insurers, to judge from the private market.⁴³ Some insurers, however, would likely want more protection than others and would seek out lower thresholds, as were made available by the state in Arizona. In addition to per-enrollee protection, these insurers would also aggregate reinsurance against total losses in a year.

Reinsurance implementers would likely want to educate themselves in terms of local expertise and data before making a final decision. They should recall that reinsurance needs to complement any other policy interventions undertaken to promote coverage.⁴⁴ The reinsurance subsidy may be reduced so that tax credit subsidies may be increased. Because significant costs of populations like the chronically ill will fall under any reinsurance threshold, some incentive to avoid such cases will remain even with the public reinsurance. Other tools also need to be used to address adverse selection.

It should be noted that this type of public reinsurance is designed to provide even-handed assistance to all enrollees via their insurers. It cannot provide different terms (much less charge varied premiums) to reflect insurers' differing circumstances and preferences. Nor can public reinsurance readily provide aggregate protection without bias, as no one threshold applies equally to insurers of all sizes.

If selection effects from specific high-cost conditions seem problematic, it would be possible to independently provide additional, condition-specific reinsurance. For example, Arizona's MMC reinsurance program covers hemophilia, Gaucher's disease, and organ transplants.

MAINTAIN INSURERS' INCENTIVES TO ECONOMIZE APPROPRIATELY

Reinsurance protection could increase health care costs if, over time, unlimited reinsurance coverage led insurers to reduce their cost-control efforts. Private reinsurers are concerned about such moral hazard and use several strategies to reduce it.⁴⁵ They require early warning of enrollee claims that may reach the threshold during the year, they often cover claims adjustment expenses to encourage investigations, and they arrange for high-cost case management services and centers of excellence. Private reinsurers also have the power to raise premiums over time if an insurer has unusually high claims. Reinsurance for MMC plans may use some of these same strategies as well.⁴⁶

A reinsurer may also cover only the health care costs allowable under a benchmark or prototype insurance policy. Then, primary carriers' costs incurred for additional benefits (or, possibly, higher provider payment rates) would not be reinsured. Having a standard definition of which services are "medically necessary" (and covered) versus "experimental" (not covered) seems especially important for reinsurance of very high-expenditure enrollees. Standardization also improves horizontal equity across insurers.

The maintenance of a coinsurance obligation for primary insurers will also promote economizing. Any upper limits contained in insurers' own policies would limit reinsurance obligations,⁴⁷ but would not necessarily limit needed services to enrollees that could become provider bad debt. It is likely that all insurance policies sold to individuals and some sold to small groups would contain upper limits. How primary insurers now address high medical spending needs examination as the final reinsurance provisions are crafted.

HOLD DOWN TRANSACTION COSTS

Reinsuring medical services payment transactions inevitably increases administrative costs, both for the reinsurer and for each insurer under a reinsurance program. Any reduction in the threshold level will disproportionately increase the number of enrollees who will “penetrate” the cost range for reinsurance in a given year. Hence, the number of claims to be validated and paid increases as well. Paying claims more frequently than annually also adds to administrative costs.

It will be important to automate claims in a way that holds down transaction costs both for the state and for insurers submitting claims. Implementation planners need to learn what different types of claims software are in use today and try to accommodate public needs to existing capabilities.

Standardization also holds down administrative costs. The reinsurer’s job is easier when insurers are selling essentially the same policy, as seen among the HMOs participating in Healthy NY. Implementers would need to learn how much standardization of non-group and small-employer policies has been achieved by market forces or insurance market reform under Missouri law and the Health Insurance Portability and Accountability Act (HIPAA). New rules under the purchasing pool will likely achieve further standardization. Thus, implementation planning for reinsurance should be able to standardize reinsurance obligations.

Reinsurance claims processes also influence transaction costs. Paying reinsurance claims monthly involves more transactions than waiting until the end of the year, while paying reinsurance claims as they are submitted creates more transactions. Accepting reinsurance claims only in the aggregate, at the end of a coverage year, might also cost less per claims dollar paid

out than accepting them throughout the year, but reimbursement errors and auditing costs might increase.

SPECIFY THE PRECISE RISKS TO BE REINSURED

Covered Costs – Operationally, the reinsurance payor needs very precise definitions of what claims are payable: What covered services may be submitted as part of a claim? What costs are allowable for each element of a claim? What, if any, limitations apply per service, per spell of illness, etc.?

Reinsurance should probably cover only the services included in a standard insurance contract, to specified limits of payment per service. Such a standard might be adapted from today’s regulation of the small-employer market or might be created in conjunction with administering the purchasing pool. Standardizing the claimable elements of insurance costs in this way treats all covered insurers alike.

A secondary issue is whether enrollee cost sharing counts toward attaining the reinsurance threshold. The issue arises when primary coverage differs in the amount of cost sharing required of enrollees. A policy argument in favor of counting both enrollee and primary insurer spending is that this treats all primary policies alike and does not penalize people selecting high-deductible or other coverage that promotes health care cost containment. Having to tally enrollee costs as well as primary insurer costs slightly increases the administrative complexity of reinsurance. The primary insurer already has to verify that enrollees meet their deductibles, and the reinsurer can rely upon those determinations.

Timing Issues – Reinsurance implementation also needs to define what “year” is involved for purposes of covering costs in excess of an annual threshold. One related issue is how to operate an annual cycle of

reinsurance when private insurers issue policies with different policy years. Consistency with existing practice is desirable to hold down costs of disruption – and potential political backlash. It is possible that most policies currently operate on a calendar year or other standard basis, but this must be a known factor in structuring a reinsurance program. Assuming that a purchasing pool will have a single open-enrollment season, this provision would tend to standardize policy coverage years. A state-funded reinsurance entity could tailor each year to the underlying insurer's policy term. For state budgetary planning purposes, however, it seems likely that the state would want all insurers in the reinsurance fund to operate on the same year, and quite possibly, but not necessarily, on the state fiscal year. Some method of reconciling different insurer and reinsurer years may be needed. At this stage, it is not clear how best to accomplish this. An early task of implementation planning should be to determine the extent of any timing problem and what mechanisms are available to ameliorate it.

Another time-related issue is how to calculate and disburse reinsurance payments for an enrollee year if underlying insurance coverage has applied only part of the year or when two different insurers have provided coverage during the year. One issue is whether the reinsurance provisions should apply per person per year or per person per insurer in a year. It is easier to apply any threshold per insurer because this way it is not necessary to track accumulating expenditures for the same patient under different policies or to split any reinsurance reimbursement among multiple policies. But this approach means less subsidy for people who work only parts of a year or who change jobs and insurers in mid-year.

The Healthy NY approach to timing was to make all insurers use the same calendar year.

Putting all insurance policies on the same calendar year is more feasible if the new coverage is sold only to those without existing coverage, as they can all start at the same time. If reinsurance is made available for existing policies, then existing time frames come into play. New York also uses the same threshold amount for any partial years of coverage from one or multiple health plans. This may or may not be perceived as fair in the Missouri context.

Updating of Threshold Over Time – Over time, the reinsurance threshold will need to be adjusted upward to counter the effects of increased medical spending. Without adjustment, reinsurance spending would rise faster than the basic rate of increase in all spending because of the leveraging effect of the threshold itself. The adjustment could be indexed or left to discretionary change. The general nature of the update might be set forth in legislation or left to the discretion of implementing authorities, subject to review. Similarly, the coinsurance percentage might be made subject to adjustment, not to counter inflation but to counter for moral hazard or other reasons. Another possibility is that the state may make available a set amount of funding per year, which the reinsurance board can translate into threshold amounts. Healthy NY allows administrators to reduce reinsurance pay-outs pro rata if the year's claims exceed appropriated amounts plus unspent balances carried forward from prior periods.

DETERMINE WHAT FUNCTIONS SHOULD BE CONTRACTED OUT

A balance needs to be found between public oversight and accountability on the one hand and private expertise and efficiency in operations on the other. This balance will be reflected in the extent to which state policy-makers contract out some functions of reinsurance. Any functions could be operated “in house” by state administrators

or contracted out to private firms. Divisions of functions can be more graduated than the classic dichotomy of “make or buy,” as the buyer can relate closely to the contractor, making adjustments other than through formal re-contracting. Beyond the basic function of risk bearing, which should probably be public, some extent of contracting out generally seems preferable to running everything in house.

Risk Bearing – The first and most fundamental function of a reinsurance program is to bear the specified risks of high medical claims payments. As a large, ongoing fiscal enterprise, the state is easily capable of bearing this risk itself, just as it bears the risk of any variability in program spending.

The state could instead provide reinsurance protection by purchasing private reinsurance that would bear all fiscal risk.⁴⁸ However, the state would have to pay a risk premium to the private reinsurer and would also bear the administrative costs of creating and monitoring the contract. The main argument for contracting out risk bearing is to create fiscal predictability. Paying a reinsurance premium creates a known obligation for the period covered, thus preventing overruns and avoiding any possibility of needing mid-year supplemental appropriations, except in the very unlikely event of reinsurer insolvency. However, private purchase does not protect against future premium increases, and sharp year-to-year increases would be just as disruptive to state budgeting as mid-year shifts. Buying private reinsurance often serves not to pool risk during the coverage year with similarly situated other customers of the reinsurer, but rather to spread out over time any one insured’s unusually high expense in a single year.

Moreover, state risk bearing could minimize the likelihood of supplementals by maintaining the fiscal “cushion” of a trust fund with reserves adequate to cover a number of months of expected reinsurance payments. Setting aside such funds would constitute an opportunity cost to government akin to paying a risk premium; but the interest earned would accrue to the state, and the assets would ultimately belong to the public, not to a private reinsurer. Further, if the state pays reinsurance claims as incurred rather than at the end of the year, state budgeters will have early warning of unusual shifts in spending trends. Such information would be useful not only for reinsurance decision-making but can also help inform policy on cost containment, access to care, and other concerns. (The Healthy NY alternative is to save all claims until the end of the year; however, they also build in a state right to reduce payouts pro rata if appropriated funds are insufficient.)

A second argument for contracting out is to reassure market participants and the public that the state will keep non-Medicaid health coverage fully private. Public reinsurance operations could become quite large and influential in the markets if, over time, the state reduced the threshold for public coverage of costs. New York state recently did this under Healthy NY, although it retained other restrictions on qualifying for reinsured coverage.⁴⁹ If remaining private is a major political concern and affordable private bids are available, Missouri policymakers might want to consider hiring a private reinsurer that would bear risk and presumably perform many or most other reinsurance functions as well.

Outreach, Education, and Other Relations with Insurers – Outreach and education to insurers is an important function of

reinsurance administration, especially during the implementation phase. For reinsurance operations to run smoothly, the reinsurer needs to understand the various claims payment methods and data processing systems used by carriers. It seems likely that it would be productive to consult with industry players in making the numerous minor policy decisions about reinsurance claims filing, resolution of disputes, etc. Given that many, though not all, of the insurers also will have private reinsurance, consultation seems appropriate in order to adopt a system of claims documentation that is consistent with most private approaches, assuming this is also consistent with public goals. Incompatible systems will, at a minimum, increase the size of new transactions costs and in the worst case could make reinsurance very difficult to administer. Increased transaction costs directly undercut the intended cost savings on medical spending from reinsurance.

The experience of state Medicaid and SCHIP programs suggests that it can be quite difficult to provide premium subsidy for workplace private coverage as an alternative to public enrollment. State administrators have found it challenging to understand the variety, complexity, and diverse timing of funding flows within the private insurance industry and have sometimes had to move quite slowly as a result. It is desirable to move much more quickly for the reinsurance program.

The need for expertise and experience with private markets to fulfill this function is an argument for contracting it out. That way, the state's relative lack of institutional knowledge does not affect its ability to implement proposed changes expeditiously.

Relations between the reinsurer (whether

public or private) and the participating primary insurers may be simplified by the relatively small number of insurers that dominate the state's individual and small-employer markets. According to MDI, only six firms accounted for 77 percent of the enrollees under workplace comprehensive coverage within groups between two and 50 people.⁵⁰ Insurers' market participation can be expected to grow, however, if reinsurance and other reforms attract new enrollment. Some unknown number of small-employer groups may be self-insured, but for them reinsurance administrators may be able to work with a smaller number of TPAs, as noted above.

Policymakers may also decide to educate employers and individuals about the reinsurance subsidy, which would otherwise be invisible to them (other than the self-insured employers). The reinsurance subsidy is meant to reduce premiums for coverage. Nevertheless, in the absence of perfect price competition among the state's insurers – and, early on, with no experience about the practical impacts of reinsurance on retained risk – reinsurance savings might be less than completely passed through to consumers. Giving insurance consumers information about the extent of subsidy may help promote competition and active repricing of policies. Organized purchasing under the pool and state insurance regulation of the reasonableness of premiums in relation to benefits may also help assure that premiums are indeed reduced.

Verification of Eligibility – Implementation systems need to be able to verify the actual status of accounts submitted for reinsurance reimbursement. This reinsurance function could be performed on a 100 percent real-time verification basis or by relying on self-disclosure by insurers backed up by

retrospective spot-checking on patterns of claims, along with formal audits. It would be desirable for administrators to inform themselves about standard industry practices during the run-up period to final implementation. In theory, other state agencies should receive regular reporting about the number of workers employed, which is part of the eligibility verification.⁵¹ It seems highly likely that private contractors could perform this function more cost-effectively than public administrators, even though size of work force is not an item normally checked under private reinsurance. A case study of MMC reinsurance in six states found that clients believed private reinsurance to provide better client service and timelier payment, although state reinsurance was perceived to offer more thorough protection.⁵²

Payment Functions – These functions include actual receipt and payment of reinsurance claims, running accounting and other data-processing systems, and auditing claims as deemed necessary. Here, too, private capabilities seem more robust than public. According to case studies of six states' reinsurance for MMC plans, many states that began providing public reinsurance to the plans ended by allowing them to buy private reinsurance instead.⁵³ Difficulty with claims processing in the public sector was one reason. Some states still do offer public stop-loss coverage. Public administration is possible and could benefit from proprietary software systems sold by vendors to help manage reinsurance claims from either an insurer or reinsurer perspective. The case studies just noted found that in the late 1990s, at least, private reinsurers were perceived as providing better service, especially more timely payouts.

Other Functions and Additional Terms of Reinsurance – Private reinsurers offer

additional services, typically as an option for carriers to purchase on top of more basic reinsurance functions. These add-ons include various forms of high-cost case management, access to centers of excellence for high-cost procedures such as organ transplants, and the like. Private reinsurance may also address moral hazard by requiring early notice of cases deemed likely to reach reinsured levels later in the year and by paying for certain claim-adjustment expenses (cost-control measures). The public reinsurance program could adopt some of these mechanisms. One protection against moral hazard that public plans cannot adopt from the private ones is the option to raise reinsurance premiums of any insurer with unexplained and persistently high claims experience.

Private reinsurance provides coverage against “aggregate” losses (e.g., above 115 percent of total expected claims for all enrollees in a class) as well as “specific” reinsurance protection against high costs per enrollee per year. Many or most HMOs and smaller commercial companies seem to have this type of aggregate coverage, as do self-insured employers. The state should probably leave aggregate risks to private reinsurance because the need varies so greatly and equity calls for pricing protection differently by insurer circumstances. There might be, however, demand for public coverage, so policymakers may need to study this possibility during implementation planning. For all of these functions just discussed, private contractors likely have an advantage over state administrators.

ACQUIRE AND TEST APPROPRIATE DATA SYSTEMS
Reinsurance administration will need to educate itself about existing insurers' claims administration systems, including the data systems needed to automate reinsurance claiming and facilitate retrospective review

or audit. Administrators then need to acquire the best system for their purposes, whether by purchase, lease, or hiring of a contractor that has such a system. This task also includes verifying that the reinsurance system can efficiently receive automated claims information and supporting data from primary insurers. This stage will culminate with the creation of a detailed plan of operations. It needs to be reviewed by state authorities and must be sufficiently detailed to guide actual start-up.

ESTIMATE BUDGET NEEDS FOR BENEFITS AND ONGOING ADMINISTRATION

Once the final design is complete, a budget must be developed as part of the state's overall budget process. Both benefit costs and administration need to be projected for the initial year of operations. This process would differ depending on what functions are contracted out at a predictable fixed price. The initial budget would probably need to be based on actuarial projections from existing carriers' claims, estimating likely numbers of transactions and costs.

Benefit costs calculated on the typical state cash-expended basis would presumably be low during the first year, as time will pass before first year claims are resolved. Prediction of underlying claims patterns will be difficult, especially at first, and reinsurance claims will always be more variable than benefits claims as a whole. It seems desirable to build in some budgetary "slack" to deal with the double uncertainty of claims levels and timing, as noted above. A trust fund dedicated to reinsurance is one possible approach. This is a familiar mechanism used in state government.

Beyond the first year, future budgets would need to be projected much as insurance premiums are for private plans. This calls for accurate data to be collected, compiled, and analyzed in a timely fashion.

HIRE A PRIVATE REINSURANCE ADMINISTRATOR

An experienced private administrator can almost certainly operate the various claims verification and payment processes more efficiently than could public administrators. The two reinsurance pools operated under the state's non-group and small-employer market health reforms are both run by a private vendor, Pool Administrators, a Connecticut corporation, which also performs audits for Healthy NY. This administrator could fulfill other functions, in addition, or other vendors could be hired to perform them.

If a decision is reached to operate reinsurance within a public agency, then expert staff and proven claims-management, payment, and audit software would need to be acquired in lieu of hiring a private administrator.

ESTABLISH METHODS OF ASSURING COMPLIANCE AND IMPOSING SANCTIONS

State-funded reinsurance is a significant benefit for primary insurers and, indirectly, for their enrollees. Reinsurance administration should obtain compliance with its policies and procedures mainly by running an effective and insurer-friendly program. Nonetheless, compliance concerns may occasionally arise, ranging from obtaining timely and accurate data reporting to avoiding outright claims fraud. For these, administrators will need to create processes for investigating problems and potentially imposing sanctions, presumably including denial of payment and exclusion from the program. Care must be taken to avoid unduly penalizing enrollees along with insurers.⁵⁴ Policymakers should investigate during implementation whether any redesign or implementation strategy could increase savings from these sources.

ONGOING MONITORING

Policymakers also need to plan for tracking

relevant performance over time once actual reinsurance operations begin. Once public reinsurance is operational, someone needs to carefully track its effects to ensure that it is achieving the desired results. Questions such as the following should be discussed:

- Are enough insurers being attracted into the state, especially for small-employer and non-group coverage?
- Are premiums coming down?
- Are submitted reinsured claims timely and accurate?
- Is the pattern of payouts what was expected?

- Are payouts timely and accurate?
- Are total payouts within budget?
- What is the level of transactions cost being imposed by the new system, inside and outside government?
- Are customers satisfied with reinsurance performance?
- Do any of these matters differ for reinsurance provided inside the purchasing pool compared to outside?

Detrimental findings may need to be addressed through adjustments in the fiscal or other terms of reinsurance or through administrative improvements of various kinds.

Conclusion

Key Findings

Whether to create a reinsurance program for Missouri poses a complex set of decisions. Reinsurance supplements other primary mechanisms for bearing health insurance risk. Private reinsurance serves to protect the solvency of private risk bearers that purchase it, including health insurers, HMOs, and self-insured employer groups. Most private reinsurance often 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 with other market participants 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 risks as a part of

underwriting for coverage in individual and small-group markets. Some larger insurers may not participate voluntarily in such arrangements.

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.

As discussed, two such programs HCG (Arizona) and Healthy NY (New York) are currently operational in the United States. Their approaches have similarities and

differences. Both target limited populations for enrollment in specified primary coverage, provide primary coverage through managed care entities, and use public funds to reinsure high claims losses. New York covers losses on a per enrollee basis only, whereas Arizona also pays for high losses on all reinsured enrollees as a group. It is not clear to what extent reinsurance is central to the programs' successes in encouraging privately purchased insurance in New York and Arizona, which in each state does not completely meet the need of all those potentially eligible to buy coverage. Broader public reinsurance of any primary coverage in the open market has been proposed as a way of subsidizing primary premiums and moderating the volatility of premium changes from year to year. This idea has not yet been implemented, though it is under serious consideration in Iowa and Kansas.

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. A very pragmatic approach is recommended because it is unlikely that one approach would fit all circumstances.

The first major decision for policymakers is what sphere of health coverage to target for intervention. It is logical to focus on small employers because their employees and dependants 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. A secondary issue here is whether to include sole proprietor firms, as do both Arizona and New York.

Another major decision is whether to focus reinsurance on the entire private market, only on a new purchasing pool, or on another form of coverage specially 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 purchasing framework or pool overseen by the state could help hold the pool together and help avoid insurer exits from the pool because of adverse selection. A subsidiary issue here is whether to target even more narrowly by reinsuring only firms without previous significant employer contributions to employee coverage, as New York did.

A third major decision centers on how much public support to provide and to what extent such support should flow through ex post reinsurance of high spending as against ex ante premium subsidy. 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 in order to accept small-group enrollees.

It is to be expected that policymakers would want considerably more detail on the operations of the Arizona and New York reinsurance programs. Decision making in Iowa and Kansas also bears watching. Finally, policymakers will want 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. Discussions with insurance agents and brokers, small business owners, and others with knowledge of current accomplishments and problems in Missouri to assist in the creation of an effective public reinsurance program in the state are also in order.

ENDNOTES

¹ E Vaughan and T Vaughan, *Fundamentals of Risk and Insurance* (New York, NY: John Wiley & Sons, 1999).

² American Academy of Actuaries, “Medical Reinsurance: Considerations for Designing a Government-Sponsored Program” (Issue Brief), American Academy of Actuaries, 2005. Available at www.actuary.org/pdf/health/reinsurance_jan05.pdf; K Swartz, *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers* (New York, NY: Common-wealth Fund 2005). Available at www.cmwf.org/usr_doc/820_swartz_reinsurance.pdf.

³ J Gardyas, “State Reinsurance Program Proposed to Stabilize Health Premiums” Des Moines Business Record, Jan 22, 2006. Available at www.businessrecord.com/Main.asp?SectionID=8&SubSectionID=9&ArticleID=2456; S Praeger [Kansas Insurance Commissioner], Testimony to US Senate Committee on Health, Education, Labor, and Pensions, hearing on “Small Businesses and Health Insurance: Easing Costs and Expanding Access,” (Washington, DC: April 21, 2005). Available at http://help.senate.gov/Hearings/2005_04_21/praeger.pdf.

⁴ Kansas Insurance Department, *HRSA Pilot Planning Grant Interim Annual Report*, Kansas (Insurance Department, Sept 30, 2005). Available at www.statecoverage.net/hrsa/ks_annualreport.pdf.

⁵ In private reinsurance, such individual protection is called “specific” reinsurance, and the annual threshold is called the “attachment point.” The primary carrier is said to “retain” the risk below the attachment point and continuing risk to the extent of coinsurance, while it “cedes” a portion of the insurance risk above that level; the reinsurer “assumes” the ceded risk. Private reinsurance may also cover the risk

that the ceding insurer’s total claims for the year exceed a level of risk it finds acceptable, say 125 percent of the expected annual claims (or premiums) for a group or line of business in a state; such protection is called “aggregate” reinsurance. Private reinsurance always has one or more upper limits on the reinsurer’s obligations; public insurance may not have limits.

⁶ See American Academy of Actuaries, 2005 (Figure A: 22% of total insured spending above \$30,000 a year, according to 2004 actuarial estimate). Compare L Blumberg and J Holahan, “Government as Reinsurer: Potential Impacts on Public and Private Spending,” *Inquiry* 41.2 (2004):130-43 (Table 2: reinsurance of 75% of annual amount over \$30,000 would cover 22.2% of estimated 2004 costs of non-elderly individuals with some employer-sponsored insurance, based on 1998-2000 data).

⁷ Arizona’s Medicaid program is AHCCCS, the Arizona Health Care Cost Containment System; A Lutzky and R Bovbjerg, *The Role of Reinsurance in Medicaid Managed Care* (Princeton, NJ: Center for Health Care Strategies, Inc., Resource Paper under the Robert Wood Johnson Foundation’s Medicaid Managed Care Program, 2003). Available at www.chcs.org/usr_doc/reinsurance.pdf.

⁸ This form of public reinsurance began in Connecticut [R Bovbjerg, “Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?” *Inquiry* 29.2 (1992a):158-75] and became common nationally when made part of an NAIC model reform act. Chollet terms these “conventional reinsurance programs,” as they are the most familiar form of public reinsurance [D Chollet, “The Role of Reinsurance in State Efforts to Expand Coverage” (State Coverage Initiatives, Issue Brief), *AcademyHealth* 5.4 (2004),

available at www.statecoverage.net/pdf/issuebrief1004.pdf].

⁹ See Missouri Department of Insurance, Property and Casualty Section homepage <http://insurance.mo.gov/aboutMDI/mktreg/pc.htm>.

¹⁰ Another textbook reason for a primary insurer to buy reinsurance is to allow them to write a larger volume of premiums with a given amount of surplus capital. Specialized forms of reinsurance can also facilitate exit through shifting of existing liabilities to another party, although the latter is more important for insurance with longer “tails” of claims payout.

¹¹ R Bovbjerg, 1992a; D Chollet, 2004.

¹² L Blumberg and L Nichols, *Health Insurance Market Reforms: What They Can and Cannot Do* (Washington, DC: Urban Institute Press, 1995); M Hall, *An Evaluation of Health Insurance Market Reforms: Summary of Findings* (Winston-Salem, NC: Wake Forest University School of Medicine, 1999), available at www.phs.wfubmc.edu/pub_insurance/PDF/Summary.pdf.

¹³ Retrospective, publicly funded reinsurance will also make primary insurers somewhat less aggressive in underwriting and marketing to avoid high-risk enrollees. The incentive to select risks derives from the extent of difference in predictable risk across potential enrollees. The reinsurance subsidy for high risks reduces the variation across enrollees and thus also reduces the value of efforts to achieve favorable selection. The effect is probably not large, as reinsurance leaves in place substantial variation across enrollees. One National Center analysis found that even a generous reinsurance policy with a threshold of \$25,000 reduced variation by less than 10 percent in primary insurance spending on SCHIP children (National Center, 2005).

¹⁴ Missouri Revised Statutes, Section 376.1010, Aug 28, 2005. Available at www.moga.mo.gov/statutes/C300-399/3760001010.htm.

¹⁵ Premium subsidy increases demand, while reinsurance decreases cost. Competition should lead insurers to compete price down to cost, while it would allow some amount of price increase in response to increased demand. Reinsurance subsidy in New York (see below) did reduce premiums. That level of decrease evidently applied across the board for all enrollees – as New York requires community rating. Where premiums more closely approximate actuarial risk, reinsurance induced subsidy should have a bigger impact for higher-risk classes of enrollees.

¹⁶ Failing to distinguish the purposes of public reinsurance from those of private evidently blocked Maine’s proposed reinsurance reform early in debates over the Dirigo legislation. A preliminary proposal for a statewide public reinsurance mechanism for small-group and individual insurance markets met strong opposition from both insurers and the business community. The opponents asserted that large, especially national primary insurers have “deeper pockets” than the state and can thus better bear large risks and buy their own reinsurance protection than can the state. They successfully argued that the state’s assumption of risk at a low attachment point would merely shift costs from one organization to another, but not lead to any savings. Maine State Planning Grant 2003, Interim Report Available at <http://statecoverage.net/pdf/mereport0703.pdf>). For Missouri, this contention would be mistaken because the primary goal is public subsidy, not a better way to mandate private risk bearing. Although insurers’ risk-premium cost may decline, the key is to reduce claims costs and hence premiums.

¹⁷ D Chollet, 2004; Missouri legislation in 2005 ended new enrollment in the Missouri Small Employer Health Reinsurance Program and provided for transfer of remaining assets to the state high-risk pool for individual insureds, the Missouri Health Insurance Plan. Senate Bill 261, passed July 12, 2005.

¹⁸ A Lutzky and R Bovbjerg, 2003.

¹⁹ Healthcare Group of Arizona homepage at www.hcgaz.com/main/; D Chollet, 2004; S Silow-Carroll and T Alteras, *Stretching State Health Care Dollars: Building on Employer-Based Coverage* (New York, NY: Commonwealth Fund, 2004). Available at www.cmwf.org/usr_doc/781_Silow-Carroll_stretching_employer.pdf.

²⁰ S Silow-Carroll, E Waldman, and J Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (New York, NY: Commonwealth Fund, 2001), available at www.cmwf.org/usr_doc/silow-carroll_6profiles_445.pdf; Healthcare Group of Arizona, 2004; D Chollet, 2004; A Rodgers, "Healthcare Group of Arizona" (presentation to State Coverage Initiatives Summer Workshop), June 28, 2004, available at www.statecoverage.net/0604/rodgers.ppt.

²¹ Healthy NY webpage at www.ins.state.ny.us/website2/hny/english/hny.htm; M Podrazik et al, *Report on the Healthy NY Program*, prepared for the State of New York Insurance Department (Washington, DC: EP&P Consulting, Inc, 2005), available at www.ins.state.ny.us/website2/hny/reports/hny2005.pdf; EP&P Consulting, Inc, Report on the Healthy NY Program 2004 (Washington, DC: EP&P Consulting, 2004), available at www.ins.state.ny.us/website2/hny/reports/hnyepp2004.pdf; D Chollet, 2004; S Silow-Carroll and T Alteras, 2004; K Swartz, *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers* (New

York, NY: Commonwealth Fund, 2005), available at www.cmwf.org/usr_doc/820_swartz_reinsurance.pdf.

²² Starting in 2005, this employer contribution allowance was raised to \$75 for downstate counties. Podrazik et al, 2005.

²³ Podrazik et al, 2005.

²⁴ Podrazik et al, 2005.

²⁵ Per capita support estimated from 2004 total reinsurance payments of \$31,494,756 divided by average of enrollments in July 2004 (55,633) and July 2005 (97,505). Podrazik et al, 2005, Exhibits II-8 and IV-4.

²⁶ Kansas Insurance Department, HRSA *Pilot Planning Grant Interim Annual Report*, Kansas Insurance Department, 2005. Available at www.statecoverage.net/hrsa/ks_annualreport.pdf.

²⁷ S Praeger, 2005.

²⁸ Catastrophic reinsurance covers 85 percent of all annual costs of AHCCCS members diagnosed with hemophilia, von Willebrands' Disease, Gaucher's Disease, needing an organ transplant, and some other cases. The "attachment point" is thus zero. All care is subject to medical review. A Lutzky and R Bovbjerg, 2003.

²⁹ Pool enrollees themselves also pay very high premiums for primary coverage. K Pollitz, *Cover Missouri Project: Report 6: Missouri Health Insurance Pool: Issues for Policymakers* (St. Louis, MO: Missouri Foundation for Health, 2006, web exclusive available at www.mffh.org/CoverMo6.pdf).

³⁰ For these reasons some prior writing also supported reinsurance of persons with HIV/AIDS in place of trying to regulate insurers' underwriting practices. R Bovbjerg, "AIDS and Insurance: How Private Health Coverage Relates to HIV/AIDS Infection

and to Public Programs," Iowa Law Review 77.4(1992b):1561-615.

³¹ Kansas Insurance Department, 2005. Sen. John Kerry in 2004 proposed a national program of reinsurance for all small businesses, which briefly seemed to have some bipartisan support. M Freudenheim and R Pear, "Momentum Builds for U.S. Role in Paying Highest Health Costs," New York Times, Oct 23, 2004, late ed, sec A:1.

³² T Vilsack, "Condition of the State," Governor's address in Iowa House of Representatives, Des Moines, IA, Jan 10, 2006. Available at www.governor.state.ia.us/agenda/2006/cos/COS_2006_Eng_delivered.pdf.

³³ J Gardyasz, 2006.

³⁴ Both Kansas and Iowa sources mention Arizona and New York reinsurance as examples, so they may in final design be more targeted than indicated in summary materials available for review for this issue brief.

³⁵ E Wicks, *Cover Missouri Project: Report 7: Expanding Coverage Through the Missouri Consolidated Health Care Plan (MCHCP)*, (St. Louis, MO: Missouri Foundation for Health, 2006, web exclusive available at www.mffh.org/CoverMo7.pdf).

³⁶ As E Wicks, 2006, notes, one way to address adverse selection against a pool is to pay for it. Reinsurance offers a mechanism for covering unusually high expenses. Aggregate reinsurance (to limit claims costs to a percentage of premium, for example) would do this directly, specific insurance (for per enrollee costs over a threshold) only in part.

³⁷ J Holahan et al, *Executive Summary - Roadmap to Coverage: Synthesis of Findings* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, 2005). Available

at www.roadmaptocoverage.org/pdfs/Roadmap_Synthesis_Summary.pdf.

³⁸ R Bovbjerg and E Wicks, *Implementing Government-Funded Reinsurance in the Context of Universal Coverage* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, 2005). Available at www.roadmaptocoverage.org/pdfs/RoadMap_3_Reinsurance.pdf.

³⁹ MDI now tracks small-group health insurance using two definitions: those with 3 to 25 members, as defined by current Missouri Law, and those with 2 to 50 members as defined by HIPAA, the federal Health Insurance Portability and Accountability Act.

⁴⁰ The Division of Medical Services of DSS is another potential candidate if, as in many states, its officials have experience overseeing the reinsurance for risk-bearing MMC plans. Such experience is tangentially relevant for private health plans. Medicaid reinsurance is publicly funded in some states that withhold a portion of the Medicaid capitation rate otherwise payable in order to pay reinsurance claims as they are made.

⁴¹ EP&P Consulting, 2004.

⁴² According to The U.S. Medical Expenditure Panel Survey of employers, over one-quarter of all Massachusetts employers offer at least one plan that is self-insured. The proportion for firms with less than 100 employees is estimated as about one in six. This estimate is imprecise, and many small-business respondents may not understand what constitutes self-insurance, but many may actually self-insure.

⁴³ R Bovbjerg, 1992a; M Troutman, "The HMO Reinsurance Marketplace: Neither the Best of Times nor the Worst of Times," Contingencies (American Academy of Actuaries), July/Aug 2003: 24-7, available at www.contingencies.org/julaug03/.

HMOReinsurance.pdf; M Troutman, "Aren't You Going to Stop and Ask for Directions? A Roadmap for Reinsurance Deductible Selection," AHIP Coverage (America's Health Insurance Plans), 2004, available at www.summit-re.com/pdfs/DirectionsArticle.pdf.

⁴⁴ E Wicks, 2006.

⁴⁵ American Academy of Actuaries, 2005.

⁴⁶ A Lutzky and R Bovbjerg, 2003.

⁴⁷ Insurance limits affect reinsurance obligations because reinsurance only reimburses insurers, not providers. To reduce moral hazard, it is important to make clear that reinsurance will not reimburse providers where the underlying insurance does not.

⁴⁸ Arizona's HCG does this, funding the private reinsurance through a per-member per-month withhold from premium/capitation payments to participating managed care plans. See discussion.

⁴⁹ Fifteen years ago, in an earlier insurance expansion proposal, Henry Aaron raised just such a possibility in proposing private coverage plus public reinsurance. H Aaron,

Serious and Unstable Condition: Financing America's Health Care (Washington, DC: The Brookings Institution, 1991).

⁵⁰ The six firms were three (3) HMOs and three (3) non-HMOs. In all, 57 firms were listed, but the bottom 43 (three-quarters of the 57) accounted for only 9.4 percent of enrollees. Author's calculation from MDI 2004 data on health plans' insureds for "Accident and Health Group Comprehensive Medical Expense" and on corresponding HMO enrollment, data accessed from <http://insurance.mo.gov>.

⁵¹ Related discussion in L Blumberg, R Bovbjerg, and J Holahan, *Enforcing Health Insurance Mandates* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, 2005a). Available at www.roadmaptocoverage.org/pdfs/RoadMap_ImplementGovtRein.pdf.

⁵² A Lutzky and R Bovbjerg, 2003.

⁵³ A Lutzky and R Bovbjerg, 2003.

⁵⁴ For a detailed discussion of enforcement issues in a related context, see L Blumberg, R Bovbjerg, and J Holahan, 2005a.

Cover Missouri Project Publications

The Cover Missouri Project includes a series of reports and fact sheets produced in early 2006. All materials are available online at www.mffh.org. Printed fact sheets and reports are available while supplies last. For more information about the Cover Missouri Project, contact the MFH Health Policy staff at info@mffh.org or toll-free at 1-800-655-5560.



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Grand Central Building, Suite 400 • 1000 St. Louis Union Station • St. Louis, MO 63103
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