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Issue Brief

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Reinsurance and State Health Reform: *The Role of Reinsurance as a Public Policy Tool in Kansas*

Sheldon Weisgrau, M.H.S.
Sunee Mickle, J.D.
Sarah Carkhuff Fizell

More Information

This *Issue Brief* was jointly produced by the Kansas Health Institute and the Kansas Insurance Department. It is meant to give policymakers a broad understanding of reinsurance and its potential to enhance access to health insurance.

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For more information on this topic, visit www.khi.org.

Key Points

- Reinsurance is a mechanism for distributing risk across a larger pool of people and can lower insurance costs for some consumers, protect the solvency of insurers, and stabilize the small group insurance market.
- By assuming unpredictable high-cost risks, reinsurance can stabilize the volatility of premiums and allow purchasers to more accurately forecast costs.
- There are several models of reinsurance, which can be financed privately with premium surcharges or assessments on insurance carriers or publicly with government funds. A combination of the two can also be used.
- Many states, including New York, Arizona, New Mexico, Idaho and Connecticut have implemented reinsurance programs.
- Reinsurance can be an important component of a broader set of reforms to enhance access to health insurance coverage.

Introduction

Reinsurance, or "insurance for insurance companies," is increasingly viewed as a mechanism to make health insurance coverage more affordable and reduce the number of uninsured. In a traditional insurance relationship, individuals purchase insurance coverage to protect themselves from financial risk and loss due to illness or accident. By doing this, these individuals transfer risk from themselves to an insurance company. Reinsurance takes this transfer a step further, with the "primary" insurer passing risk to another insurance company, or in the case of public reinsurance, to government. By assuming unpredictable high-cost risks, reinsurance can stabilize the volatility of premiums and allow purchasers to more

accurately forecast costs. Reinsurance can also serve as a mechanism for providing public subsidies for high-cost cases and reducing the price of health insurance coverage for some consumers.

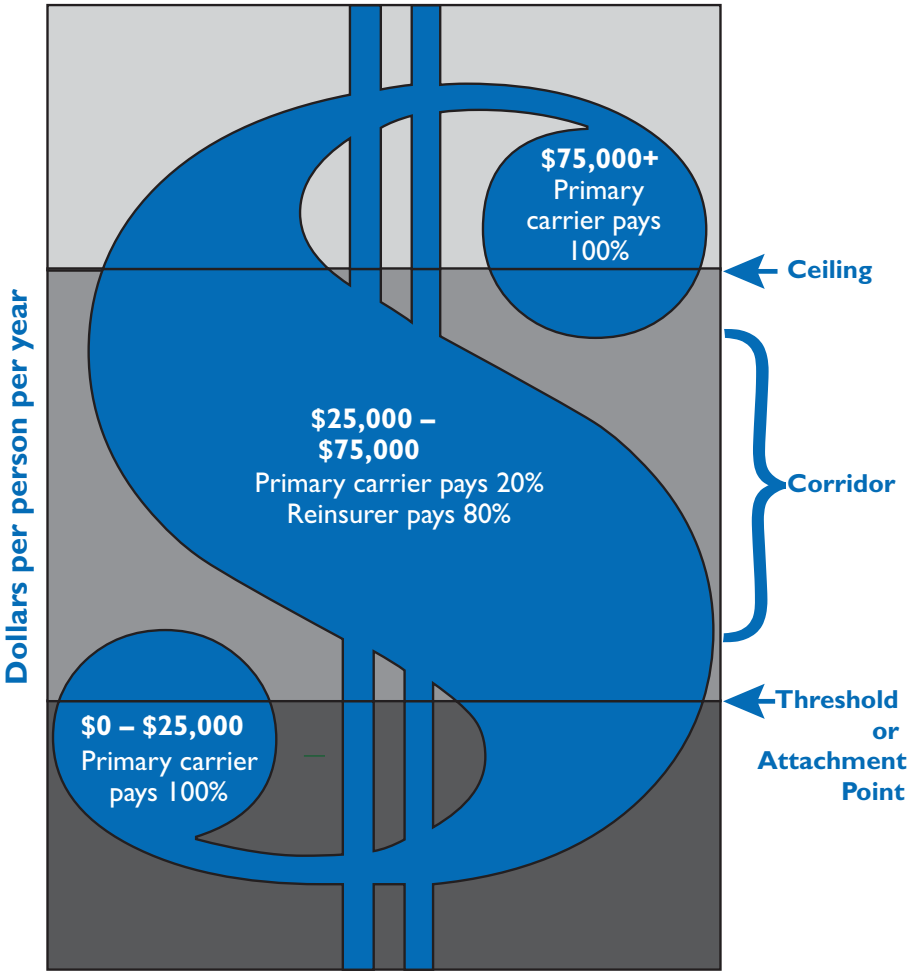
Some states, such as New York and Arizona, use reinsurance programs, particularly for small groups, to stabilize health insurance markets and enroll people who were previously uninsured. This *Issue Brief* provides an overview of reinsurance, including how it works, how it is used in other states and its potential value in Kansas.

What is Reinsurance?

Reinsurance is not a new concept. The first reinsurance contract dates back to 1370, when an Italian insurer contracted with another party to reinsure a ship on part of its voyage from Genoa to the Belgian harbor of Bruges. The original insurer retained risk on the portion of the voyage through the Mediterranean and transferred risk to the reinsurer for the voyage from Cadiz through the Bay of Biscay and along the French coast. To this day, reinsurance is used widely in the private market.

Public reinsurance programs are used by government to reinsure against potentially catastrophic risks that private insurers may not otherwise cover. A well-known example of a publicly financed reinsurance program is the federal government's assumption of the worst risks in disasters such as floods and hurricanes. Without government reinsurance, insurers would be unable to provide these types of coverage.

Figure 1.
Example of a Retrospective Reinsurance Plan



Reinsurance can be either "retrospective" or "prospective." Retrospective reinsurance reimburses a primary insurer, at the end of the policy year, for claims incurred above a specified threshold level. There may be an upper limit on the reinsurer's obligations, creating a "corridor" in which claims costs are shared between the primary insurer and reinsurer. In addition, much like many conventional primary insurance plans, reinsurance has a "deductible," a "ceiling" and a "coinsurance" rate.

For example, a retrospective reinsurance plan could reimburse a primary insurer for 80 percent of a policyholder's cumulative claims between $25,000 and $75,000 for the year. The remaining 20 percent of costs within the corridor continue to be the responsibility of the primary insurer, as do all expenses below $25,000 and above $75,000. In this example, the deductible is the first $25,000 that the primary insurer pays, the ceiling is $75,000, and the coinsurance is the 20 percent that applies to the expenses between the deductible and the ceiling and is the responsibility of the primary insurer. Figure 1 illustrates how this retrospective reinsurance plan works.

In a prospective reinsurance program, rather than sharing the risk of high claims at the end of the year, the primary insurer designates high-risk individuals at the start of the year and shares the risk posed by these people with the reinsurer. Under prospective reinsurance, the

primary insurer transfers or "cedes" a policyholder's claims risk to a reinsurance pool at the time of enrollment. The primary insurer then covers the enrollee's claims, but is reimbursed by the reinsurance pool for some or all costs above a specified threshold. Prospective reinsurance is funded by an upfront premium paid by participating insurers. Any deficits in the pool at the end of the year are also covered by participating insurers, who each pay proportional shares of the shortfall. Prospective reinsurance is generally used with other mechanisms as part of broader reforms of the small group insurance market, such as limiting insurers' ability to reject applicants or charge premiums according to perceived health risks.

Private reinsurance is financed through premiums paid by the primary insurer to the reinsurer and is largely invisible to policyholders. Reinsurance in the private market does not directly lower costs because the primary insurer must pay for the reinsurance coverage, essentially transferring a portion of the premium paid by the policyholder to the reinsurer. In public reinsurance programs, however, the primary insurer transfers risk to the government, often at no charge. With government taking on the risk of paying for the medical expenses of people with the highest costs, the risk and costs for the primary insurer are reduced resulting in lower premiums for some policyholders.

Why Consider Reinsurance?

The cost of health insurance has risen rapidly over the past several years. Since 2000, average health insurance premiums in the United States have increased by 87 percent, more than four times the cumulative growth in general inflation and wages. Over that same period, the percentage of employers that offer health insurance benefits has declined from 69 percent to 61 percent and the proportion of workers who buy health insurance, even when offered, has dropped as well. Due in part to these factors, about 15 percent of the U.S. population is uninsured, a rate that has been steadily rising.

These trends are most pronounced among small employers. In small groups, insurance risk is spread across relatively few people. As a result, older or unhealthy employees have a greater relative impact on group costs. While more than 90 percent of firms with 50 or more employees offer health insurance as a benefit, less than half (48 percent) of firms with 3–9 workers provide health insurance, a decline of 10 percent since 2002.

In addition to rising costs, small employers leave, or avoid, the health insurance market because they face considerable price volatility. It is more difficult for insurers to accurately predict claims costs in small groups than in large groups and a few high-cost claims can lead to considerable premium increases. Businesses need to be able to accurately forecast costs and are often unwilling to provide employee benefits that may change drastically from year to year. Purchasing health insurance is therefore risky and often unaffordable for small firms.[1]

Health insurance in Kansas has followed these same trends. The proportion of large employers (50 or more employees) that provide health insurance coverage has remained relatively steady at 94 percent and above. However, the percentage of small employers (less than 50 employees) that offer health insurance coverage declined from 48 percent to 41 percent between 2000 and 2004. The price of an employer-sponsored family policy rose by about 50 percent over that time for both large and small Kansas employers. Although the Kansas uninsurance rate of 11 percent is relatively low compared to the national rate, some 300,000 Kansans lack coverage and the number covered by public programs such as Medicaid and HealthWave is increasing.

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As costs rise and the number of employers that offer health insurance declines, stabilizing prices and making insurance more readily available and affordable have become increasingly important public policy problems. Many states view reinsurance as a possible mechanism to address these issues, by reducing risk selection, protecting the solvency of insurers, lowering insurance costs for some consumers and stabilizing the small group insurance market.

Reducing risk selection

Insurers are very concerned about "adverse selection." Because enrollment is voluntary, people who expect to use health care services are more likely to purchase insurance than those who are healthier and do not expect to need services. If an insurer is forced to raise premiums due to higher than expected claims costs, healthier people will be discouraged from purchasing insurance policies. The remaining pool of policyholders is then relatively less healthy and more risky for the insurer, causing premiums to rise, which discourages more people from enrolling, and so on.

To combat adverse selection, insurers use a number of mechanisms to screen out applicants whom they believe will generate high claims costs. These selection mechanisms include medical underwriting, the process of evaluating risk to determine whether to provide coverage; risk-based rating, in which premiums are based on a person's likely use of covered services; exclusions for pre-existing conditions, in which illnesses and health problems that were diagnosed before the purchase of a policy are excluded from coverage; and benefit package design, in which some services are covered and others are not.

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Although the use of selection mechanisms by insurers is a rational response to adverse selection, it leads to increased numbers of people who cannot afford health insurance or who are unable to purchase adequate policies. By assuming some of the burden of high-cost claims, reinsurance reduces the incentive for insurers to engage in risk selection.

Protecting insurer solvency

Because of the difficulty in predicting claims costs for individuals and small groups, insurers are reluctant to sell policies to these populations. The same is true for populations with whom insurers have little experience. Reinsurance can be used to mitigate these risks and protect insurers that enter new markets.

There are two prominent examples of reinsurance used in this way. The first dates to the 1990s, when many states began to place Medicaid beneficiaries into managed care programs. Managed care organizations had no experience pricing coverage for this population, so states either required them to purchase private reinsurance or used a portion of their monthly capitation payments to finance public reinsurance programs. Similarly, self-insured health plans typically purchase private reinsurance to protect their assets against unexpectedly high medical claims.[2]

Lowering costs for some consumers

By taking on the responsibility of covering some portion of high-cost claims, public reinsurance lowers the claims costs of primary insurers and may result in lower premiums for some purchasers. Lower premiums should encourage some of those who were previously unable to or chose not to buy insurance to purchase it. Public reinsurance therefore acts as a form of premium subsidy targeted at high-cost cases.

Stabilizing the small group insurance market

As discussed above, small employers often face difficulty purchasing health insurance because of high premiums and price volatility. High claims experience can lead to sharp increases in rates, resulting in frequent turnover in the market as employers seek lower cost products or drop out altogether. Reinsurance that reduces primary insurers' costs and takes on some or all of the responsibility for paying high-cost claims can mitigate price volatility and churning in the small group market.

How Have States Used Reinsurance?

A number of states have implemented various forms of reinsurance programs. A description of the experiences of five of these states follows.

New York

Healthy New York (HNY) is perhaps the best known example of how public reinsurance can be used to expand coverage. Established in 2001, the program targets small employers,

sole proprietors and individuals. It is mostly funded from the state's tobacco settlement fund and thus tax dollars are not required for financing the program.

To cover as many low-income workers as possible, HNY includes a number of eligibility restrictions, most aimed at small employers. Enrollees must work for firms of 50 employees or less and at least 30 percent of these employees must earn $35,500 or less per year. In addition, the firm must not have had a comprehensive group plan available within the last year. This requirement is designed to make certain that enrollees are those who were previously uninsured and prevent "crowd out," in which public insurance replaces policies that were bought in the private market.

Similar to the eligibility restrictions on small groups, sole proprietors or individuals must have income at or below 250 percent of the Federal Poverty Level (FPL)[3] and cannot be eligible for Medicare or have had access to an employer-based health plan within the last year. All health maintenance organizations (HMOs) in the state must participate in HNY and almost everyone covered by the program is enrolled in one of these HMOs.

HNY initially paid 90 percent of claims between $30,000 and $100,000 and primary insurers paid 10 percent. Primary insurers were fully responsible for expenses below the $30,000 threshold and above the $100,000 ceiling. This structure resulted in premiums that were 15 percent to 30 percent lower than premiums in the small group market and about one-half of premium costs in the individual insurance market.

In the first two years of the program there were very few claims above $30,000 because most of the enrollees were relatively healthy. As a result, the reinsurance threshold was lowered to cover 90 percent of expenses between $5,000 and $75,000. This change resulted in an additional 17 percent reduction in premiums and by 2004, HNY premiums were 40 percent lower than average small group HMO premiums and two-thirds lower than premiums in the individual market.

In 2005, HNY was estimated to cost $61.7 million for 107,000 enrollees, a subsidy of about $577 per person. By the end of 2006, close to 133,000 people were enrolled in the program, including more than 10,000 small businesses, about 13,000 sole proprietors, and over 56,000 individuals.

Arizona

The Arizona Healthcare Group (HCG) was created in 1986 to help small employers (50 employees or fewer) and political subdivisions obtain health coverage. Groups qualify for the program if they have not offered health insurance coverage for at least 180 days. HCG is operated by a division of the Arizona Health Care Cost Containment System, the state's managed care-based Medicaid program. For most of its history, only HMO plans were offered to enrollees, but in 2005 a Preferred Provider Organization (PPO) option was added to the program.

HCG takes a different reinsurance approach to the risks faced by insurers than HNY. Rather than protecting insurers from unusually high costs incurred by individuals, as in New York, HCG protects

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insurers from high costs that may be caused by a large number of enrollees that have above average, but not extraordinary, expenses. The HNY approach provides a reservoir of funds that are used as a backup payment source for high-cost cases. As a result, insurers don't have to build such reserves into their premiums and premiums can be set at lower levels. HCG's approach to lower premiums entails subsidizing the higher-than-average expenses of all enrollees collectively.

HCG makes reinsurance or "stop-loss" payments to plans that experience high costs compared to premium revenue. The program is designed to ensure that medical claims costs for each plan are kept between about 80 to 86 percent of premiums. Stop-loss payments are made to plans with higher loss ratios and "stop-gain" payments are made by plans that experience lower loss ratios. At times, the reinsurance plan has been subsidized by the state, but these subsidies were ended in 2006. Other revenue to support the program comes from withholding a portion of the premiums of the primary insurers. HCG also purchases private reinsurance to cover annual losses that exceed $100,000 per enrollee.

As of December 2005, there were 18,000 individuals enrolled in HCG, an increase of more than 40 percent from the previous year. Almost all HCG enrollees are from small businesses and almost 6,000 businesses participate.

New Mexico

The New Mexico Health Insurance Alliance (HIA) was created in 1994 to reinsure small groups and sole proprietors. Enrollees must work for a firm with fewer than 50 employees and at least 50 percent of eligible employees must enroll in the program. Employees must work at least 20 hours per week before they and/or their dependents are eligible.

Like HCG in Arizona, New Mexico's reinsurance program protects insurers through an aggregate loss system, paying out when total claims exceed 75 percent of premium revenues. HIA is funded through enrollee premium surcharges. The program sets a 5 percent premium surcharge during the first year with an increase up to 10 percent in renewal years for small groups. Individuals may have up to a 10 percent premium surcharge in their first year of coverage and up to 15 percent in renewal years. HIA balances funding deficits by having insurance carriers pitch in to cover expenses that exceed collections from premium surcharges. In 2003, New Mexico insurance carriers spent about $4.5 million to cover reinsurance losses. As of 2004, HIA had enrolled approximately 4,000 people, of which 35 percent were sole proprietors.

Idaho

Idaho's reinsurance plan, the Small Employer Health Reinsurance Program (ID-SEHRP), was established in 1994 to cover small groups (2–50 employees). Under ID-SEHRP, small group insurers are given 60 days from issuance of a policy to decide whether to reinsure the entire group, an individual employee or an eligible dependent. Insurers' decisions to reinsure may not be based on actual claims experience within this 60 day period.

Under ID-SEHRP, primary insurers pay premiums for each reinsured person and the state assesses all insurers to fund any losses in the program. Primary insurers are responsible for the first $12,000 of claims and 10 percent of each of the next $13,000 for enrollees in the basic plan, $88,000 for enrollees in the standard plan, and $120,000 for enrollees in the catastrophic plan. As of April 2004, 44 small group plans were reinsured under the program.

In 2001, Idaho created the Individual High-Risk Reinsurance Pool to reinsure four "high-risk pool plans" that all non-group insurers must offer. Under this plan, the primary insurer is responsible for the first $5,000 in claims costs and 10 percent of costs from $5,000–$25,000. The reinsurance pool covers 90 percent of costs in the $5,000–$25,000 corridor and all claims above this amount. This plan is funded with reinsurance premiums from insurers and, if these premiums are not sufficient to cover all claims, with supplemental funding from the state premium tax. As of 2004, the Individual High-Risk Reinsurance Pool had 1,358 enrollees.

Connecticut

Connecticut's Small Employer Health Reinsurance Pool (CT-SEHRP) was established in 1990 and has been used by the National Association of Insurance Commissioners (NAIC) as a model for a state reinsurance program. CT-SEHRP reinsures all insurance carriers in the state that write policies for small groups (less than 50 members). As in Idaho, insurers have 60 days from issuance of a policy to designate individuals or entire groups for reinsurance. Only permanent employees who work more than 30 hours per week and their dependents are eligible for reinsurance.

Primary insurers pay a $5,000 deductible for each reinsured life and the pool pays for all claims above that amount. Funding for the reinsurance pool comes from premiums paid by the insurers who cede risk to the pool and an annual assessment on all carriers in the state, based on market share. Assessments are limited to an annual maximum of 1 percent of an insurers' small group premium base, but have never reached that level. As of October 2004, more than 3,000 individuals were enrolled in the program at an average reinsurance premium of $4,500 per year.

What Issues are Important in Design of a Reinsurance Program?

Policymakers must be aware of a number of issues in designing a reinsurance program. Factors such as who the program will cover, how it is structured and the sources of funding must be carefully considered within the context of the state's regulatory and political environments. Following is a discussion of these issues.

Who will it cover?

The groups and individuals that will be covered by a reinsurance program will to a large degree dictate the design of the program and its cost. States must ask the following questions:

- Who will be reinsured? Possible targets include small groups (e.g., businesses with 2–50 employees), sole proprietors, and/or individuals.
- Will reinsurance be available for all members of the group or only those who meet certain qualifications? The HNY plan in New York, for example, limits employer eligibility to small businesses with a certain proportion of relatively low-wage workers.
- What requirements will be placed on those being reinsured? The program may require certain levels of employee participation and periods of uninsurance. The New Mexico HIA program, for example, requires 50 percent of eligible employees in a group to enroll and only employees who work at least 20 hours per week and/or their dependents are eligible. HCG in Arizona limits eligibility to groups that have not offered health insurance coverage for at least 180 days.
- Will all or only some enrollees be reinsured? In New York, Arizona, and New Mexico, all enrollees are reinsured. In Idaho and Connecticut, on the other hand, the primary insurer selects which enrollees to reinsure.

How will it be structured?

The basic framework of a reinsurance plan will have a direct impact on its cost and effect on the market. Policymakers must first decide whether to reinsure against high aggregate insurer losses (as in Arizona and New Mexico) or high losses from individual enrollees (as in New York).

Aggregate loss programs are more successful at increasing market competition by enabling newer insurers with fewer enrollees to set competitive premiums. There is a risk under an aggregate loss reinsurance program, however, that some insurers will set premiums too low and become dependent on reinsurance to stay financially viable. Plans that reinsure against the high claims costs of individual enrollees, known as "market stabilization" plans, are better at encouraging insurers to control enrollee costs. It is possible, as well, to design a reinsurance plan that shares aspects of both types of programs.

Another fundamental consideration is the design of payment responsibilities — the threshold at which the reinsurer will assume an obligation for covering claims, the ceiling at which the reinsurers' responsibility ends, and the percentage of expenses within the corridor that will be covered by the primary insurer and the reinsurer.

How will it be funded?

Reinsurance programs can be funded with private or public funds or a combination of the two. Health insurers themselves can fund reinsurance by paying per-enrollee premiums or assessments based on their share of the market. Assessments may come only from those plans that reinsure their enrollees or from all insurers in the state. It is important to note that self-insured plans, which cover a large proportion of the insured population, often purchase reinsurance in the private market but do not contribute to such assessments. As previously noted, privately funded reinsurance does not directly lower premium costs. By reducing the level of reserves that an insurer needs to protect against high risks, however, the insurers' costs of doing business may decrease.

Factors such as who the program will cover, how it is structured and the sources of funding must be carefully considered within the context of the state's regulatory and political environments.

Public financing of reinsurance subsidizes insurer risk and can bring down the premium cost for the purchaser. State funding typically comes from general revenues or other sources, such as tobacco settlement dollars. Public financing effectively spreads the burden of high costs to taxpayers, so the per-person impact is relatively small.

Most state-supported reinsurance programs are funded with premiums paid by insurance carriers. In Idaho, New Mexico and Connecticut, for example, reinsurance programs are financed with private premium dollars or insurer assessments. New York and Arizona are the only states that have used public funding for reinsurance

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KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KANSAS HEALTH INSTITUTE
212 SW Eighth Avenue, Suite 300
Topeka, Kansas 66603-3936
Telephone (785) 233-5443
Fax (785) 233-1168
www.khi.org

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programs. Although these programs clearly cover people who otherwise would be uninsured, it is not yet clear to what extent they help to reduce charity care and medical debt.

Is Reinsurance a Viable Option for Kansas?

By redistributing risk across a larger pool, reinsurance can decrease the impact of adverse selection on insurers, stem price volatility in the small group market and improve the availability of insurance for people who are currently unable to buy policies. It is important to understand, as well, what reinsurance cannot do. Reinsurance does not change the fundamental nature of insurance risk. It does not convert an uninsurable risk into an insurable one, make losses either more or less likely to occur, or control the magnitude of losses. However, reinsurance can be tailored to create incentives for carriers to effectively manage portions of their own risks. It is important to understand, as well, that reinsurance does not reduce overall health care costs. Reinsurance redistributes risk and costs, but at the end of the day, the health care bill must be paid, whether by the primary insurer, reinsurer, policyholder and/or government.

Assessing the feasibility of a Kansas reinsurance plan will require the discussion of important issues, such as the roles of the public and private sectors in financing a plan. Given the ever-rising cost of health insurance and the decline in the number of businesses that provide it as a benefit, however, it is appropriate that policymakers assess this option. Reinsurance would not undermine other reforms being considered in Kansas, such as a health insurance connector or a premium assistance program. In fact, it can be designed to complement these efforts. A carefully constructed reinsurance program can be a valuable component of a broader set of interventions to enhance access to health insurance coverage.

References

In preparing this *Issue Brief*, the authors relied extensively on previous reports and research on reinsurance. The work of Randall R. Bovbjerg of the Urban Institute, Katherine Swartz of Harvard University, Deborah Chollet of Mathematica Policy Research, and Joel Cantor and his colleagues at the Rutgers Center for State Health Policy were particularly valuable. For a full list of references, please visit the KHI Web site at www.khi.org.

Endnotes

[1]For more information on how health insurance works, see *Health Insurance in Kansas: A Primer* on the KHI Web site at http://www.khi.org/insurance.

[2]A self-insured health insurance plan is an employer-sponsored health plan in which the employer, rather than an insurance company, is at risk and is responsible for paying for covered services used by policyholders.

[3]The FPL is the minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities, as determined by the U.S. Department of Health and Human Services. FPL varies according to family size and is annually adjusted for inflation. For 2007, 250 percent of FPL is $25,525 for an individual and $42,925 for a family of three.