



Implementing Government-Funded Reinsurance in the Context of Universal Coverage



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roadmap
TO COVERAGE

Contents

Introduction 3

Proposed Roadmap Reinsurance 4

Comparisons and Contrasts with Other Forms of Reinsurance 5

Steps in Implementing Reinsurance 7

Sources 22

About the Authors 24

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Introduction

The Roadmap to Coverage would achieve universal coverage in the Commonwealth of Massachusetts by building on four key elements:

1. **MassHealth expansions** to 200% of the federal poverty level for children and parents and to 133% of poverty for childless adults.
2. **A voluntary purchasing pool** open to all that would ease access to an increased choice of plans, especially for small firms and low-income individuals.
3. **Tax credits for individuals** that would pay the difference between market premiums and a specified percentage of income (sliding from 6% to 12% of income) for enrollees up to 400% of poverty. The credits would apply only to those who buy coverage through the pool.
4. **Government funded reinsurance** that would repay insurers for 75% of an insured's allowable costs above \$35,000 per year for enrollees in the nongroup market and in firms with fewer than 100 workers. The reinsurance would apply to all coverage sold, whether through the pool or outside.

These voluntary building blocks would not be sufficient by themselves to achieve universal coverage. Universality requires an individual mandate—a legal requirement that all individuals obtain coverage for themselves and their families. The Roadmap proposes three alternative mandate options: an individual mandate alone; an individual mandate combined with a “play or pay” mandate on employers requiring them to support coverage for their own employees and dependents or pay a payroll tax to support insurance expansion to the extent that they do not; or an individual mandate combined with a mandate on large employers.

This paper discusses the implementation of the fourth building block of the Roadmap—the public reinsurance provided to insurers who cover small employer groups and individuals in Massachusetts. The presentation here

- describes the proposed public reinsurance,
- compares and contrasts it with other forms of reinsurance, and
- details the key steps to be taken in practical implementation.

The numerous actions needed to implement the basic reinsurance design are the main focus of this paper. Certain design decisions inevitably must be taken during implementation, however, and information obtained during implementation planning

may feed back into some changes in anticipated design. The paper thus discusses some design issues as well.

Proposed Roadmap Reinsurance

The Roadmap provides for public reinsurance of insurers selling nongroup or small-employer coverage to Massachusetts residents. These two categories are also often referred to as “individual” and “small-group” coverage. (Self-insured employer groups will also get reinsurance protection, so “insurer” should hereafter be read to include “self-insurer.”) Small employer groups are defined as those with fewer than 100 workers.

The basic design is that a reinsurance fund supported by tax revenues would pay 75% of insurers’ allowable medical claims costs above \$35,000 per person-year, with no upper limit. The key goal of such public reinsurance is to spread the risk of very high claims costs among a broader population. Because the funds come from outside the insurance market, they are a form of external subsidy that is expected to flow through to insurance enrollees and thus help make coverage more affordable. The public reinsurance would also help protect the solvency of insurers operating in the individual and small group markets, as they would no longer face as much risk of losses that are very large in relation to their assets.

The reinsurance will also reduce the impact of any adverse selection against insurers, as at least the largest costs of high-risk enrollees will be borne by taxpayers. Protection for their solvency and against the worst costs of adverse selection should make Massachusetts more attractive to insurers, where participation in the small-group [se](#) markets has been falling in recent years. The public reinsurance would also be provided to insurers in these markets, providing coverage both within and outside the purchasing pool. This provision will help reduce adverse selection against the pool.

Reinsurance does not directly affect insurers’ enrollees or medical providers. All payments to enrollees or their providers continue to be made by the insurer, not the reinsurer, even after the annual reinsurance “threshold” is reached. Reinsurance simply reimburses the insurer for its specified share of covered losses and is not visible to others.

Many more details of the public reinsurance would need to be specified as the Roadmap is finally designed and implemented, and changes may occur even after the program begins operations. Other forms of reinsurance also exist for health plans. These provide some useful precedents for policy makers facing implementing decisions for Roadmap reinsurance, although they differ somewhat in goals and operations.

Comparisons and Contrasts with Other Forms of Reinsurance

Private reinsurance

Many health insurers, including managed care organizations, buy private reinsurance. This reinsurance covers losses above an agreed threshold per person and commonly also covers aggregate losses for a whole category of coverage. Thresholds tend to be larger than the \$35,000 proposed by the Roadmap, and protection is not usually unlimited. Instead, overall ceilings limit total payouts in a year per person and per insurer, and internal limits also often apply on particular categories of insured spending. Some insurers have sufficiently large books of business and surplus that they forgo reinsurance protection altogether, like Blue Cross Blue Shield of Massachusetts.

Private reinsurance differs from public in mechanisms and in nomenclature. Coverage and premiums paid by insurers are set by private contracts, which are much less regulated than insurance sold to the public. The main rationale is that insurers are expert purchasers and have little need of regulatory protection.

Insurers buy private reinsurance mainly to obtain financial protection against the risk of unexpected losses that are very large relative to their uncommitted capital, which must be kept adequate to meet unexpected losses. Such reinsurance protection facilitates market entry by smaller insurers unable to bear high losses on their own. Private reinsurance does not protect against adverse selection, as each insurer pays the cost of all enrollees, including reinsurance costs. Nor does such reinsurance spread risk very broadly. It often serves mainly to spread risk across time. Each insurer must pay its own premiums, and reinsurers consider experience in setting and adjusting premiums over time.

Private insurers each buy somewhat different specifications of reinsurance (or none), depending on their capacity to withstand large losses, tolerance for risk, and other circumstances. Each purchaser of private reinsurance also pays a different premium, depending on its risk and on what other reinsurance-related services it buys. Like insurance for enrollees, reinsurance for insurers raises concerns of moral hazard, which reinsurers are concerned address in several ways. They require early warning of enrollee claims that may reach the threshold during the year, they often cover claims adjustment expense to encourage investigations, they arrange for high cost case management services and centers of excellence, and they have the power to raise premiums over time if an insurer has unusually high claims.

Public or Private Reinsurance for Medicaid Managed Care

Most states instituted reinsurance programs when they implemented at-risk Medicaid managed care (MMC) programs. Here, too, the key goal was solvency protection, and reinsurance protection was important to MMC's success. In the early to mid-1990s, MMC was new and capitation was an unfamiliar risk. Both traditional HMOs and new provider-based plans had some reluctance to participate in MMC

because risk was so unpredictable. Reinsurance was therefore needed to attract and retain managed care organizations (MCOs) and to assure that they would remain in business to serve Medicaid clients. Accordingly, states required participating MMC plans to have reinsurance. States either provided reinsurance protection themselves or approved plans' purchase of private reinsurance. Over time, many states have ceased providing reinsurance coverage themselves. But Massachusetts still provides public reinsurance, while also allowing MCOs to buy comparable private coverage instead.

States that provide MMC reinsurance themselves obtain funding by withholding a share of MCOs' capitation payments. If the coverage is bought privately, the MCO pays a market-set premium. Details vary across states. Most notably, thresholds may be as low as \$5,000 or as high as \$200,000, according to a case study of six states. Arizona allows MCOs to choose among several thresholds for one of its types of reinsurance. Participating plans may thus tailor their retained risk to suit their circumstances and preferences, just as under private coverage.

Quasi-Public Reinsurance Pooling under Market Regulatory Reforms

Massachusetts created forms of reinsurance pooling as part of its reforms of the small-employer and nongroup insurance markets (e.g., Massachusetts Small Employer Health Reinsurance Plan). Many other states did so as well in the 1990s. These reforms sought to protect insurers' enrollees against underwriting and rating practices that could make coverage expensive or unobtainable. In a voluntary market, such restrictions increase the likelihood of adverse selection—that is, enrollment of a larger than expected numbers of high-risk enrollees. Restrictions also reduce insurers' willingness to participate in the regulated markets.

Massachusetts and other states have sought to reduce the impact of potentially adverse selection on any one insurer by providing for reinsurance pooling. Again, details vary. All approaches allow insurers to pay a premium to transfer all or part of a high-risk enrollee's risk to a reinsurance pool at the time of enrollment. The insurer continues to administer the policy, paying claims and the like. To the extent the pool's costs exceed premiums received, the excess is shared among all participants. Such arrangements help shelter insurers from the most adverse fiscal effects of getting a high share of high risks. These reinsurance pools somewhat resemble the assigned risk pools often used for automobile insurance.

Insurers choose in advance which if any risks to transfer and, in many states, also have the option to transfer either an entire group or just selected individual enrollees. Some states provide for the pool to pay all of a transferred enrollee's covered expenses during the year. Others require the transferring insurer to retain a share of risk, a threshold above which reinsurance pooling applies, typically set at about \$5,000.

Public Reinsurance, Notably Healthy New York

The Roadmap reinsurance most closely resembles other public reinsurance programs. These also give insurers an outside public subsidy from a broader source of revenues. Public reinsurance is thus not merely an internal re-arrangement of private risks—unlike like private reinsurance, MMC reinsurance, or market-reform pooling—even though public reinsurance uses similar mechanisms to define and shift risk.

The public precedent most often cited is the reinsurance, or “stop loss,” provided under the state’s Healthy New York program. Begun in 2001, Healthy New York provides for standardized HMO coverage for small employment groups, workers, and self-employed workers who have been without coverage for 18 months or more. The state’s reinsurance subsidy initially covered 90% of spending between \$30,000 and \$100,000 per person in a calendar year.

The initial reinsurance terms only reduced participating HMOs’ medical costs by a few percentage points, and ample funding was available to provide more subsidy. So the state lowered the reinsurance range to between \$5,000 and \$75,000. The lower threshold increased the state subsidy to over a quarter of insurers’ total medical spending. The lower threshold also offset more of the impact on HMOs of adverse selection of high-risk enrollees into the insurance program, which requires accepting them without underwriting restrictions on coverage or higher premiums. Both levels of reinsurance help protect participating HMOs’ solvency, although they retain the risk of the highest layer of claims costs—above the \$100,000 or \$75,000 stop-loss ceiling, which is coverable only by private reinsurance.

New York also operates a similar stop-loss program for individual insurance, termed “direct” coverage. In addition, Arizona and New Mexico provide public reinsurance as part of programs to help small businesses obtain health insurance. Available descriptions of their design and implementation are much less detailed than for Healthy New York.

Steps in Implementing Reinsurance

Implementation needs to address many issues to effectuate the basic design set out in the Roadmap. These are considered here, step by step.

Pass enabling legislation

The first steps toward implementation are the same for reinsurance as for the rest of the Roadmap—to educate policy makers and successfully enact enabling legislation. One early decision will be who is charged with drafting legislative provisions, and also with explaining reinsurance concepts and the Roadmap proposal during legislative consideration.

General vs. specific legislative provisions

It is anticipated that the legislation and even implementing regulations would be quite general in content, much like that establishing the state’s Nongroup Health Reinsurance Plan (M.G.L. ch. 176M). Final legislation should set only the general framework for reinsurance, including its general fiscal parameters, the responsible state agenc(ies), and any new operational powers needed. Indeed, the legislation might leave even the precise threshold to administrative choice, merely setting out general considerations that should be taken into account. This approach leaves substantial leeway for front-line administration to work out operational details in an expeditious and cost-effective fashion.

One can argue that public accountability calls for more detailed specification of rules and procedures, especially given that public revenues would be used for this reinsurance, not private funds as under ch. 176M. However, the degree of knowledge needed to design and implement reinsurance provisions is extensive and better left to administrative implementation. Accountability could be maintained by subsequent review of the reinsurance plan of operations developed by plan administrators.

Reinsurance administrators would need authority to take certain actions, among them personnel decisions, rule making for its own operations and for insurers, entering contracts, opening financial accounts, making payments, compelling compliance with rules, and sanctioning authority. Existing agencies have many of these powers already, but where they are to be conferred on an independent board, legislation would need to specify such powers or to allow the board to propose powers in a plan of operations subject to approval by a state administrator like the Commissioner of Insurance or even by the legislature.

Updating of Threshold over Time

Over time, the reinsurance threshold would 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 to underlying medical cost increases. Alternatively, updates might be left to the discretion of implementing authorities, subject to retrospective review. Similarly, the coinsurance percentage might be made subject to adjustment—not to offset inflation but to offset moral hazard or for other reasons.

Siting of Policymaking Responsibility

An early implementation choice is what entit(ies) within or associated with state government would be charged with making policy decisions affecting reinsurance and taking steps to implement and operate the reinsurance on an ongoing basis. This choice interacts with the decision of how many reinsurance functions should be contracted out for private operations under public oversight.

Either an existing entity or a new one created under the Roadmap could be charged with policymaking and operational responsibility. The responsible agency would need to have substantive expertise in insurance and reinsurance and to be able to coordinate closely with other Roadmap policymaking, especially with regard to decisions on tax subsidies, since these are complementary uses of state resources. It would also need the ability to work well with private insurers, with whom many operational details would need to be arranged. Having an experienced advisory or governance board adds expertise, and is a routine aspect of administering state high-risk pools, market-reform reinsurance, or state reinsurance. Obtaining access to experience and expertise is also a key reason for contracting out some reinsurance functions.

The Division of Insurance would be arguably the most logical site for overseeing this new form of reinsurance. The Division already regulates insurance generally and is specifically tasked with oversight of the state's existing Health Reinsurance Plans

for the markets serving small employers (50 or fewer employees) and individuals (nongroup market). Medicaid officials also have some experience with overseeing the reinsurance required of risk-bearing Medicaid managed care plans.

Another option would be to confer responsibility for reinsurance oversight upon whatever agency is given overall responsibility for implementing the full Roadmap package of reforms. Especially if many reinsurance functions are contracted out, ability to coordinate reinsurance policy with other Roadmap policies might be seen as more important than past insurance experience or expertise. Finally, the agency responsible for administering the new purchasing pool could also oversee reinsurance. The pool would likely be serving mainly smaller employers and individuals, whose insurers would also be the focus of reinsurance support. However, since reinsurance is specifically targeted at small employer and individual coverage outside the pool as well as inside, so as to reduce selection pressures, the argument for making the pool responsible is not extremely persuasive.

It would also be possible to give policy-making responsibility to a quasi-governmental entity. The two reinsurance plans now overseen by the Division of Insurance are both governed by gubernatorially appointed boards dominated by insurance industry participants. Their plans of operations and significant decisions are still subject to review by the Division. This arrangement is also typical for the high-risk pools in many other states. However, these high-risk pools and the two reinsurance pools now operating in Massachusetts receive their revenues from private premiums, topped up with assessments on market participants to the extent needed. They do not allocate public resources as the Roadmap reinsurer would do. Accordingly, stronger public sector oversight seems appropriate for the Roadmap reinsurance.

Timing of Post-Legislative Implementation

A two-year timeframe seems a good target for Massachusetts. New York state was able to start up its Healthy New York program, including reinsurance, in little more than a year. However, New York needed to make significant changes soon thereafter, and the Roadmap anticipates changes well beyond the scale of Healthy New York and other precedents. Moreover, considerable institutional knowledge would need to be generated. Existing insurers have limited experience with the uninsured population, new insurers may enter with limited experience of Massachusetts, and state policy makers and administrators have only limited experience with reinsurance.

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

Funding of implementation

Legislation would need to provide ample funding for start-up of reinsurance. Administrative costs during implementation are likely to be higher than for continuing operations because of the need during planning for expert consultants, investment in data systems, and the like. Reinsurance is retrospective, so its mechanisms would be tested only as claims appear, probably late in the first year when some covered enrollees' expenses would likely surpass the reinsurance threshold. Most other elements of Roadmap implementation would operate prospectively. Enrollment through the pool, for example, must occur before insurers start paying claims and well before insurers submit any reinsurance claims. Moreover, reinsurance would generate far fewer transactions per 1000 enrollees.

For both these reasons, glitches in the reinsurance plan of operations would be discovered relatively slowly, compared with other implementation problems. Fixes would also take longer to develop.

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. One responsibility would be reporting to the top administration official overseeing Roadmap operations and to the appropriate legislative entities. The other responsibilities of the job would vary depending upon how many reinsurance functions are conducted within state agencies versus through a public-private board. At this stage of implementation, the agency/board would need to begin addressing compliance with state hiring processes. The extent of state staff needed would also vary by how reinsurance is finally implemented. Staff needs should get very early attention from the executive director; outside consultants are also likely to be needed.

Constitute the advisory/governing board

Boards have two main functions: First, they provide for public accountability over reinsurance design and operations. Second, they provide expertise not generally available within existing state agencies. If the board is only advisory, with policy making and oversight of ongoing operations concentrated within state agency(ies), board membership should emphasize consumer and insurer interests along with technical experts. If the board is to be 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 well 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 a Medicaid managed care representative. General public members could include, for example, a small business owner, a labor union representative, an operator of a business services firm, a benefits administrator or attorney, and an actuary from an insurer or HMO. Private experts could include a reinsurance broker, a reinsurance actuary, and a third-party administrator. A governmental or academic statistician, especially one with a business orientation,

could usefully add 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.

Define the Reinsured Insurance Market with Precision

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 (the Blues), and HMOs. Also covered should be any other risk-bearing entities allowed to meet the Roadmap requirement that residents obtain coverage, possibly including fraternal benefit societies and multiple employer trusts. Self-insured employers raise major issues in their own right, considered in the next subsection.

New risk-bearing entities might be formed to provide coverage once they are encouraged by the Roadmap’s stimulation of new demand and protected by new reinsurance. New entrants might include provider-based entities willing to accept capitated payments, non-profit associations, and the like. Roadmap implementers would need to decide whether all or only a subset of potential risk bearers are 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.

What constitutes a covered employer group with under 100 employees raises two practical issues of uncertain magnitude. One issue is what workers constitute employees. Boundary issues arise with regard to part-time and seasonal workers as well as independent contractors. As a general matter, it seems preferable for reinsurance administrators to simply rely on the number of people included within an insurance contract, leaving it to the market to determine who those people are. The splitting of employees between an employer policy and purchasing pool insurers is discussed below.

Another issue is what groupings of workers constitute the group of under 100. Firms often have multiple locations of different size, have subordinate franchises, or insure within a multiple-employer arrangement. Today, enterprises seeking insurance are motivated to aggregate to larger sizes to obtain more favorable insurance terms. Under the Roadmap, good coverage would be available to all comers through the purchasing pool, so firms could disaggregate to become smaller and get reinsurance support without harming access to insurance. Other firms might benefit from somehow splitting off higher-risk employees into pool coverage, leaving a smaller, yet more insurable, grouping outside the pool. Deciding how to count employees should be eased by the existing definitions used in regulating the small employer market, which faces the same sorts of issues at a threshold of 50 employees rather than 100. Group regulations formerly applied at 25 employees or below, which was raised to 50. Any differences noted when enforcement shifted up to 50 may also arise at the reinsurance boundary of 100 employees.

Employer-size-related “gaming” is certainly possible, as just described. It might still prove an insignificant problem in practice, however, as the reinsurance benefit is expected to be small relative to overall health insurance premiums, much less to employer labor costs. The possibility of gaming would still bear watching, however, especially if the value of reinsurance subsidy were increased.

Two other practical issues arise because the Roadmap would provide for employment groups to insure workers and dependents through the purchasing pool. Often, the entire workplace group can be expected to seek pool coverage, but some employment groups would have enrollees both in the pool and in a separate insurance plan outside the pool. Reinsurance administrators would need to decide whether a group of 90 employees outside the pool, for example, qualifies for reinsurance if 30 of their low-income (or high-risk) co-workers are in the pool, with or without employer contributions. Administrators or insurers would 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 would be useful whenever multiple insurance plans serve one group, whether through the pool or outside it.

Decide How to Deal with Self-Insurers

Roadmap cost simulations anticipated treating self-insured employer groups (of qualifying size) as insurers covered by reinsurance. Almost all self-insuring smaller employers likely buy private reinsurance today, and the new state reinsurance would save them much of this cost.

Although very large firms are most likely to self-insure, under-100-employee firms not uncommonly do so as well. Some small firms would likely continue to self-insure even after Roadmap implementation, but the advantages of buying through the new purchasing pool may well lead some to shift to buying fully insured coverage there.

Reinsuring self-insurers on the same terms as insurers is the right thing to do on policy grounds. Yet in practical terms, dealing with a large number of self-insured employers—who are not truly expert in the business of insurance—would add administrative complexity to reinsurance operations. Roadmap implementers should seek ways to reduce the transaction costs of such relationships. One way would be to rely as much as possible on intermediaries to help channel information and claims.

Many small firms use brokers or service firms to help obtain benefits. Those firms could facilitate verification of eligibility and tracking of employees in the purchasing pool. In addition, self-insured firms also typically hire a third party administrator (TPA) to validate and pay claims. The TPA is often a health insurance company that is mainly providing administrative services. The public reinsurance program might 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 would need early attention during planning for Roadmap implementation.

Establish the Final Reinsurance Threshold and Coinsurance Level

Another basic implementation decision would be whether to implement the Roadmap’s proposed \$35,000 reinsurance threshold and 25% coinsurance obligation

or instead to select different levels. This calls for weighing several considerations and making some tradeoffs.

Lowering the threshold would increase the extent of subsidy, which is exactly why Healthy New York did so. This would in turn lower premium costs to enrollees and thereby encourage voluntary compliance with the individual mandate to obtain coverage. A lower threshold would also increase risk spreading because more costs would be borne by broader-based revenues. In addition, lowering the threshold would provide more assistance for insurers hit with adverse selection, and forms of reinsurance that address selection tend to have lower thresholds. These greater protections would 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, for private insurers, and probably also for other state implementing agencies. A higher threshold can adequately protect solvency for most insurers, to judge from the private market. Some insurers, however, would likely want more protection than others and would seek out lower thresholds, such as were made available by the state in Arizona. Those or other insurers would also seek additional, aggregate reinsurance against total losses in a year, going beyond the per-enrollee protection discussed here.

Roadmap implementers would likely want to educate themselves somewhat more about all manner of reinsurance issues, tapping into local expertise and data before making final implementing decisions. They might also consider what other mechanisms of Roadmap reform also address subsidy and selection. Reinsurance subsidy might be reduced in favor of increasing tax-credit subsidies, for example. Because significant costs of the chronically ill and others occur below the level of any reinsurance threshold, some incentive for insurers to avoid such cases would remain, however public reinsurance is designed and implemented. Other tools would also need to be used to address adverse selection.

The Roadmap 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 different premiums) to reflect insurers' different circumstances and preferences. Nor can public reinsurance readily provide aggregate protection even handedly, as no single threshold applies equally to insurers of all sizes. If selection effects from specific high-cost conditions seem problematic, it would be possible even-handedly to provide additional, condition-specific reinsurance. Arizona's MMC reinsurance program covers, for example, hemophilia, Gaucher's Disease, and transplants.

Maintain Insurers' Incentives to Economize Appropriately

Reinsurance protection could increase costs if unlimited reinsurance coverage led insurers to reduce cost-control efforts. Private reinsurers are concerned about such moral hazard and use several strategies to reduce it. They require early warning of enrollee cases that may reach the threshold of claims later during the year, they often cover claims adjustment expense to encourage investigations, and they may arrange

for high cost case management services and centers of excellence. MMC reinsurance uses some of these strategies as well. The Roadmap public reinsurance program could adopt some of these mechanisms. One protection against moral hazard that public plans cannot adopt from private, however, is the option to raise reinsurance premiums of any insurer with unexplained and persistently high claims experience.

A reinsurer may also promote economizing by covering only the costs allowable under a benchmark or prototype insurance policy. Then, carriers' costs incurred for additional benefits (or, possibly, higher provider payment rates) would not be reinsured. Having a standard definition of what 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.

For now, the Roadmap assumes that insurers' obligation to pay 25% while reinsurance covers 75% should sufficiently promote economizing. Any upper limits contained in insurers' own policies would also limit reinsurance obligations but would not necessarily limit continued needed services to enrollees that could become provider bad debt. It appears that all coverage sold to individuals in Massachusetts and some sold to small groups contain upper limits. Much HMO coverage, however, appears to lack any upper limit.

Hold Down Transaction Costs

Reinsuring medical services transactions inevitably increases administrative costs, both for the reinsurer and for each insurer reinsured. Any reduction in the threshold level would disproportionately increase the number of enrollees who will surpass it in a year and hence increase the number of claims to be validated and paid.

It would be important under the Roadmap to automate reinsurance claims administration in a way that holds down transaction costs both for the state and for insurers submitting claims. Implementation planners would need to learn what different types of claims software are in use today--and should try to accommodate to existing capabilities to whatever extent is consistent with meeting public needs.

Standardization also holds down administrative costs. The reinsurer's job is easier where insurers are all selling essentially the same policy, as is true for Healthy New York. Insurance market reform has already achieved considerable standardization of nongroup and small employer policies in Massachusetts, up to 50 employees. New rules under the purchasing pool would likely achieve further standardization. Thus, implementation planning for reinsurance should readily 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. Paying reinsurance claims as they occur creates even more. Accepting reinsurance claims only in the aggregate, at the end of a coverage year, might 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, spell of illness, other?

Reinsurance should probably cover only the services included in a standard or benchmark insurance contract, as just noted, up 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.

The Roadmap assumes that enrollee cost sharing would be counted, largely in response to the wide variation in extent of cost sharing outside the purchasing pool. The reasoning is that it is undesirable to reward those “over” purchasing insurance relative to those buying higher cost-sharing, more “efficient” plans. Implementing this policy decision would require tracking enrollees' cost-sharing expenditures. Given that insurers must already track such spending in order to know what their own obligations are, it would seem feasible for the reinsurance program to rely largely on insurers' own tracking.

Timing Issues

Defining “per year” could be complex in practice. One issue is how to operate an annual cycle of reinsurance when insurers may issue policies with different policy years. Consistency with existing practice is desirable to hold down costs of disruption—and potential political backlash. As a practical matter, it may be that most policies today operate on a calendar year or other standard basis. The purchasing pool's requirement of an open enrollment season would also tend to standardize policy coverage years.

A state funded reinsurance entity could in theory tailor each year to the underlying insurer's policy term. For practical purposes of state budgetary planning, however, it seems likely that the state would want the reinsurance fund to operate on the same year for all insurers. Quite possibly, but not necessarily, this would be the state fiscal year. The Healthy New York approach to timing was to make all insurers use the calendar year. Putting all insurance policies on the same calendar year basis seems less feasible for the Roadmap in Massachusetts, given that it would not simply be starting a new insurance-plus-reinsurance program from scratch for previously uninsured populations.

In any event, some way to reconcile different insurer and reinsurer years may well be needed. At this stage, it is not clear whether the New York approach is the best way 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 during only part of the year, or if two different insurers have provided coverage during the year. A threshold issue is whether the reinsurance provisions apply per person-year or per person per insurer in a year. It is easier to apply any threshold per insurer, so that it is not necessary to track expenditures for the same patient under different policies or split any reinsurance reimbursement among multiple policies. But this means less subsidy for those people working part years and changing jobs mid-year.

The Healthy New York approach was to use the same threshold amount for any partial years of coverage, from one or multiple health plans. This may not be perceived as fair in the Roadmap context.

Determine what Functions Should Be Contracted Out

A balance would need to be found between public oversight and accountability on the one hand, as against private expertise and efficient operations, on the other. This balance would be reflected in the extent to which state policy makers decide to contract out some functions of reinsurance. In theory, any functions could either be operated “in house” by state administrators or contracted out to private firms. This is the classic dichotomy of “make versus buy.” But in practice, there is a graduated spectrum of degrees of public and private sharing of responsibilities. Even when agencies “make” certain services, they may benefit from private advice; and even where they “buy” outside services, they may exert control other than through formal purchase contracts.

This section discusses several functions that might be contracted out. The first and most basic function, risk bearing, should probably be public. Beyond this, some extent of contracting out generally seems preferable to doing everything through public agencies and public employees.

Risk bearing

The 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 a Medicaid program overrun. The state could instead fulfill the reinsurance obligations of the Roadmap by purchasing private reinsurance that would bear all fiscal risk. 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 (absent very unlikely 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 would have early warning of unusual shifts in spending trends. Such information would be useful not only for reinsurance decision making but also to inform policy on cost containment, access to care, and other concerns. (The Healthy New York alternative is to save all claims until the end of the year but to 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 the state over time reduced the threshold for public coverage of costs—as New York state recently did under Healthy New York. If keeping insurance fully private is a major political concern and if affordable private reinsurance bids are available, Massachusetts policy makers 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 to and education of insurers should be an important function of reinsurance administration, especially during the implementation phase. For reinsurance operations to run smoothly, the reinsurer would need to understand the various claims payment methods and data processing systems used by carriers. It seems likely to be productive to consult with industry players in making the numerous minor policy decisions needed to create operating systems for reinsurance claims filing, resolution of disputes, etc. Given that many insurers also will have private reinsurance, consultation also seems appropriate to adopt a system of public-reinsurance claims documentation that is consistent with most private approaches, so long as this is also consistent with public goals. Incompatible systems would at a minimum increase the size of new transactions costs, and in the worst case could make public reinsurance nonadministrable. Increased transactions costs directly undercut the intended cost savings on medical spending from reinsurance.

In the late 1990s, the state sought to implement a different form of subsidy to reduce the premiums borne by qualifying small employers. This is now known as the Insurance Partnership program. Implementation was considerably delayed by the failure of state administrators to understand the variety, complexity, and diverse timing of funding flows within the insurance industry. It would be important 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 paucity of institutional knowledge would not affect its ability to implement proposed changes expeditiously.

Relations between the reinsurer, whether public or private, and the state's insurers would be simplified by the relatively small number of insurers still operating in the state's individual and small employer markets. According to the Division of Insurance survey, 10 HMOs and 21 insurers served the small employer market in 2004. Four HMOs plus non-HMO Blue Cross Blue Shield accounted for 85% of total enrollment. (Small now means under 50 employees; the contours of the 50-100 market appear not to be tracked.) Among current commercial carriers, 5 of 20 were not really operational, retaining only 6 or fewer members at the end of calendar 2004 (DOI 2004). According to the Division's listings of available sources of nongroup coverage, 15 plans sell individual coverage. Market participation can be expected to grow, however, both because the insurance mandate and subsidies would create an attractive new target population for insurers and because policymakers might seek to attract market entry so as to promote competition and choice. Self-insurance increases the number of firms to be educated, but reinsurance administrators might be able to work with a smaller number of TPAs, as noted above.

Policy makers might also decide to educate employers and individuals about the reinsurance subsidy, which would otherwise be invisible to them (other than to the self-insured employers). The reinsurance subsidy is meant to reduce premiums for coverage, but in the absence of perfect price competition among the state's largely nonprofit 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 might help promote competition and active re-pricing of policies. Organized purchasing under the pool and state insurance regulation of the reasonableness of premiums in relation to benefits might also help assure that premiums are indeed reduced.

Verification of eligibility

Implementing systems also need to be able to verify the actual status of accounts submitted for reinsurance reimbursement. This reinsurance function could be performed on a 100% real-time verification basis, or by relying on self-disclosure by insurers backed up by retrospective spot-checking targeted by patterns of claims, plus 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. It seems highly likely that private contractors could perform this function more cost-effectively than public administrators, even though size of workforce 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 thoroughgoing protection.

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. Many states that began providing public reinsurance to Medicaid managed care plans ended by allowing plans to buy private coverage instead. Difficulties of claims processing were one reason. Some states do offer public stop-loss coverage, including Massachusetts, which as of 2002 was allowing firms to buy either public or private reinsurance. Public administration is possible, and could benefit from proprietary software systems sold by vendors to help manage reinsurance claims. Case studies of six states' reinsurance for Medicaid managed care 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 like certain organ transplants, and the like. Such provisions may promote quality or otherwise add value, as well as addressing concerns about moral hazard, as already discussed.

Private reinsurance often provides coverage against an insurer's "aggregate" losses (e.g., above 115% of total expected claims for all enrollees in a class) as well as Roadmap-style "specific" reinsurance protection against high costs per enrollee per year. Many or most HMOs and smaller commercial companies seem to have such aggregate coverage, as do self-insured employers. The state should probably leave aggregate risks to private reinsurance, because need varies so greatly and equity calls for pricing protection differently by insurer circumstances. There might, however, be demand for public coverage, so policy makers might need to study this possibility during implementation planning.

For all the functions just discussed, private contractors seem likely to have an advantage over state administrators.

Acquire Appropriate Data Systems

The reinsurance program would need data systems that can automate reinsurance claiming and facilitate retrospective review or audit. Timely implementation suggests that such systems be purchased from existing vendors. The reinsurers' systems need to work well in their own right, of course, but they also need to mesh well with existing insurers' claims-processing mechanisms, for the latter are the source of reinsurance claims. Reinsurance administration would thus need to educate itself not only about the market for its own systems but also about existing insurers' claims administration systems, as noted above. These include data systems needed to automate reinsurance claiming and facilitate retrospective review or audit. This is another implementation task to be accomplished to set up effective reinsurance and another argument for contracting out with an experienced reinsurance administrator.

This stage of implementation would culminate with the creation of a detailed plan of operations. It would need to be reviewed by state authorities and be sufficiently detailed to guide actual start-up.

Estimate budget needs for benefits and administration

Once the final plan of reinsurance operations is complete, a budget must be developed to feed into the state's overall budget process. Both benefit costs and administrative expenses would need to be projected for the initial year of operations—a process that depends on what functions are contracted out for a fixed price knowable in advance. 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 would pass before first year claims are resolved. Prediction of underlying claims patterns would be difficult, especially at first, and reinsurance claims would 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 in many parts of state government.

Beyond the first year, ongoing 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, as noted above. Once the plan of operations and budget are in place, the reinsurance program would need to actually hire a reinsurance administrator. There is Massachusetts experience with such hiring. The two reinsurance pools operated under the state's nongroup and small employer market health reforms are both run by a private vendor. The firm selected was Pool Administrators, a Connecticut corporation, which also performs audits for Health New York. However, multiple candidates should be screened, and, of course, all applicable procurement processes must be adhered to. One administrator would likely be hired to fulfill most operating responsibilities, but duties could be split across multiple vendors if desired.

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

Any administrator needs ways of assuring compliance with its policies and procedures. For reinsurance, concerns range from timely and accurate data reporting to avoiding outright claims fraud. The issues involved in enforcing mandated reinsurance processes resemble those for enforcing employer mandates to pay a payroll tax to support insurance coverage, except that tax authorities are not involved.

Policy makers should investigate during implementation whether any redesign or implementation strategy could increase savings from these sources.

Ongoing monitoring

Policy makers would 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. Are enough insurers being attracted into the state, especially for small employer and nongroup coverage? Are premiums coming down? Are submitted reinsured claims timely and accurate? Are payouts timely and accurate? Is the pattern of payouts what was expected? 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 with outside?

Findings would need to be reported to senior state officials and to legislators as designated in the reinsurance statute or rules. Detrimental findings should lead to prompt adjustments in the fiscal or other terms of reinsurance or to administrative improvements of other kinds.

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