Public Reinsurance

How Have States Like New York and Arizona Used Reinsurance to Help Businesses Control the Cost of Health Insurance?

Randall R. Bovbjerg, J.D.
(Bó - berg)
Principal Research Assoc., Urban Institute, Wash., DC
PI for SCI Reinsurance Institute***** Team

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Roadmap

I. What is reinsurance?

II. How does it work?

III. What are its rationales?

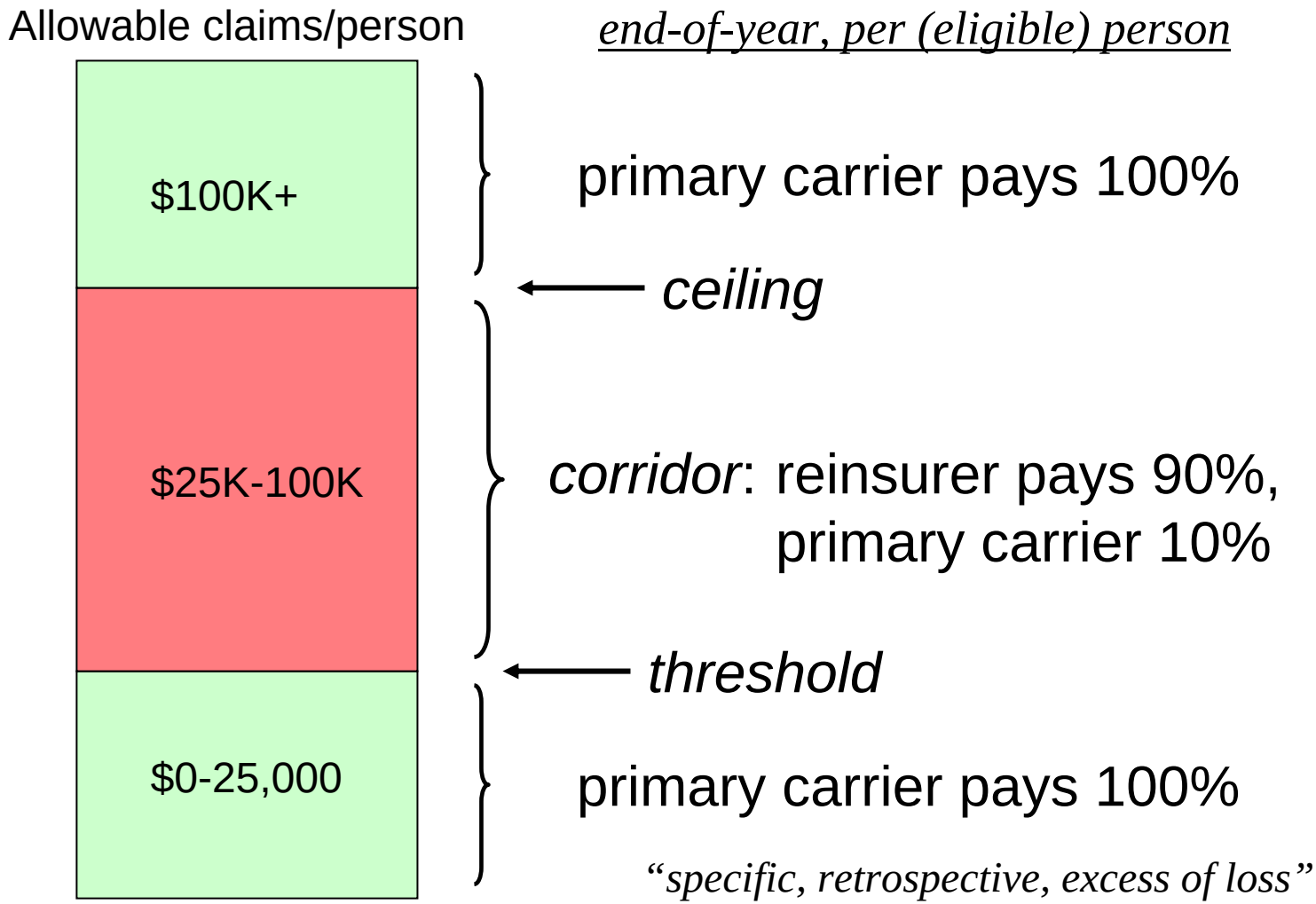
IV. What's the evidence - NY & AZ?

V. How is Reinsurance Inst. helping WI?

What Is Reinsurance?

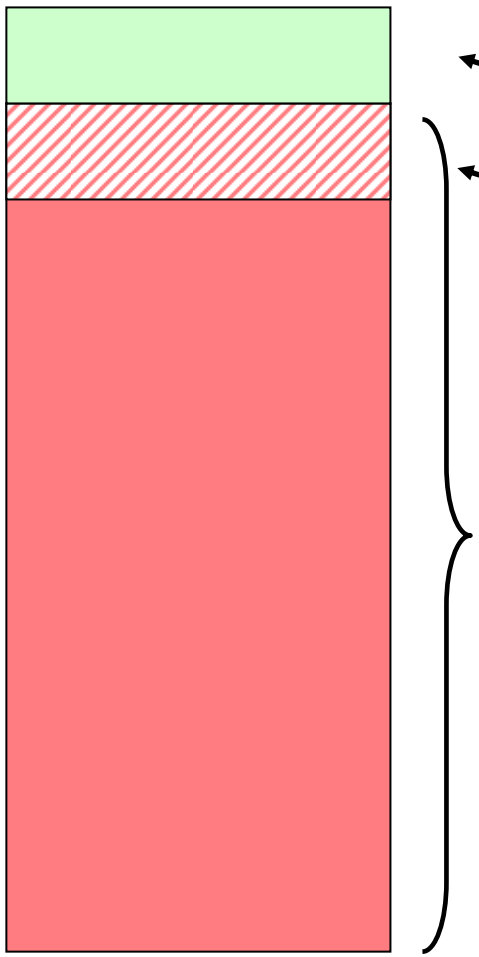
- Insurance for insurers (invisible to insured people)
- Vocabulary:
  - the *primary* risk bearer *cedes* (transfers) the risk
  - the reinsurer *assumes* the risk
  - transfer may be *prospective* or *retrospective*
  - risk sharing may be
    - *proportional*, akin to coinsurance (a.k.a. *pro rata*), or
    - *excess of loss,* akin to deductible (a.k.a. above *threshold)*, or
    - a mix of both
  - risk sharing typically has ceiling, creating risk *corridor*
  - may be *specific* (per person) or *aggregate* (for pop'n)

Simplified Sketch: HealthyNY



Simplified Sketch: HCP, AZ

Allowable claims/MCO



<u>end-of-year, per (targeted) population</u>

Public reinsurance pays above set %age of premium

Private reinsurer covers high per-person losses first

Participating MCOs cover claims up to 80-86% of premium

"aggregate, retrospective, excess of loss"

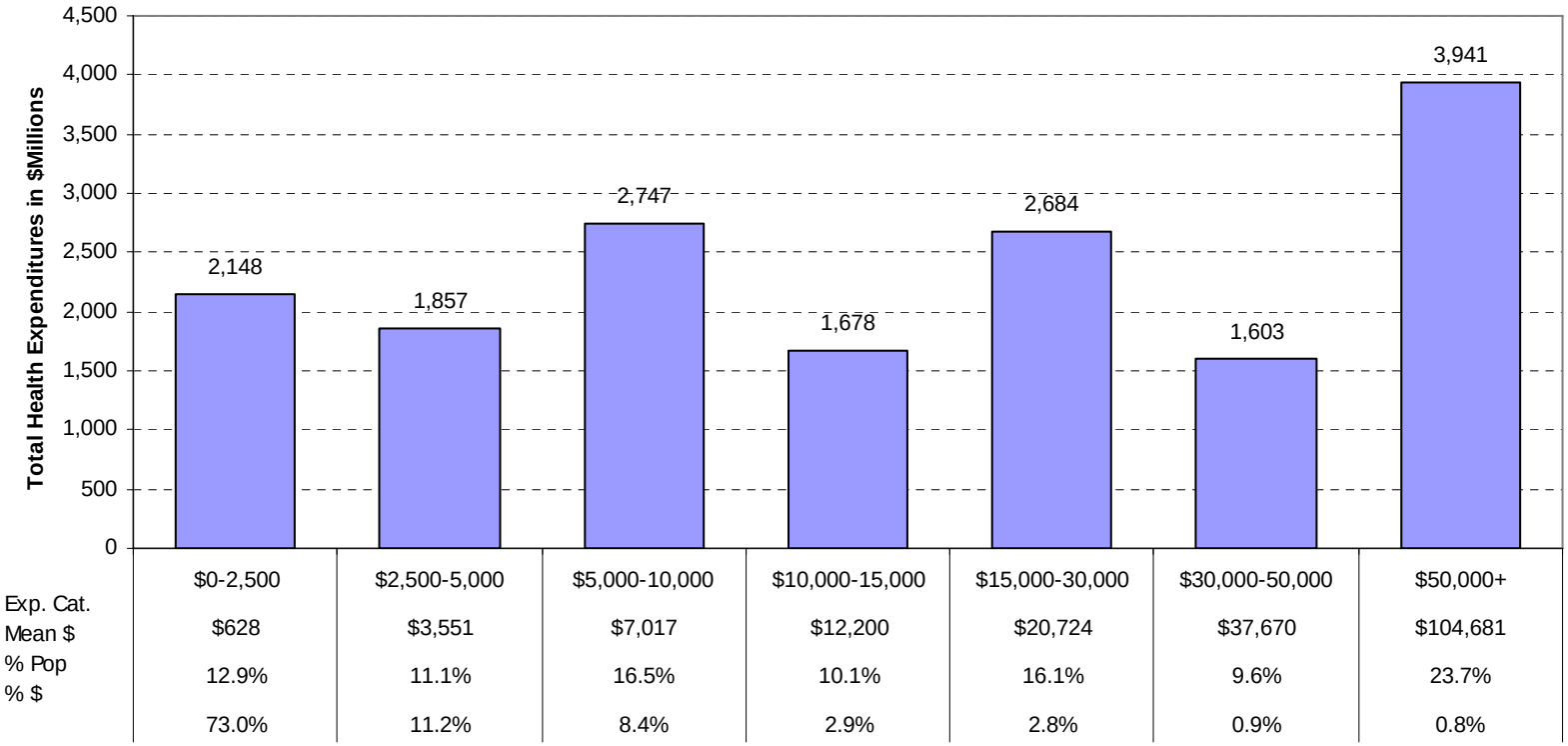
What Are the Rationales for Reinsurance?

Main private goals

- Financial protection, especially for small primary insurers, self-insureds
  - both specific and aggregate protection
- Spread risk of high-cost claims
  - much is spread-over time thru premium adjustments
- Obtain specialized knowledge, services
- Does not lower costs because primary carriers must pay for reinsurance coverage

Rationale, cont'd

High dollars at high end of spending per person year



note: data are preliminary, amounts are total health expenditures by expenditure category, 2001-2003; source: survey-adjusted MEPS Data, Wisconsin population under 65

Rationale, cont'd

Public goals

- Encourage enrollment by subsidizing cost
  - Reduced insurer costs reduce premiums
  - Add'l small impact from lower "risk premium"
  - Insureds/employers still contribute
  - Lower premium attracts more healthy insureds
- Targeted subsidy; *ex post* risk adjustment
- Reduce costs of unfavorable selection, cut benefit of cream-skimming
- Help new market entrants by assuming high, unfamiliar risk

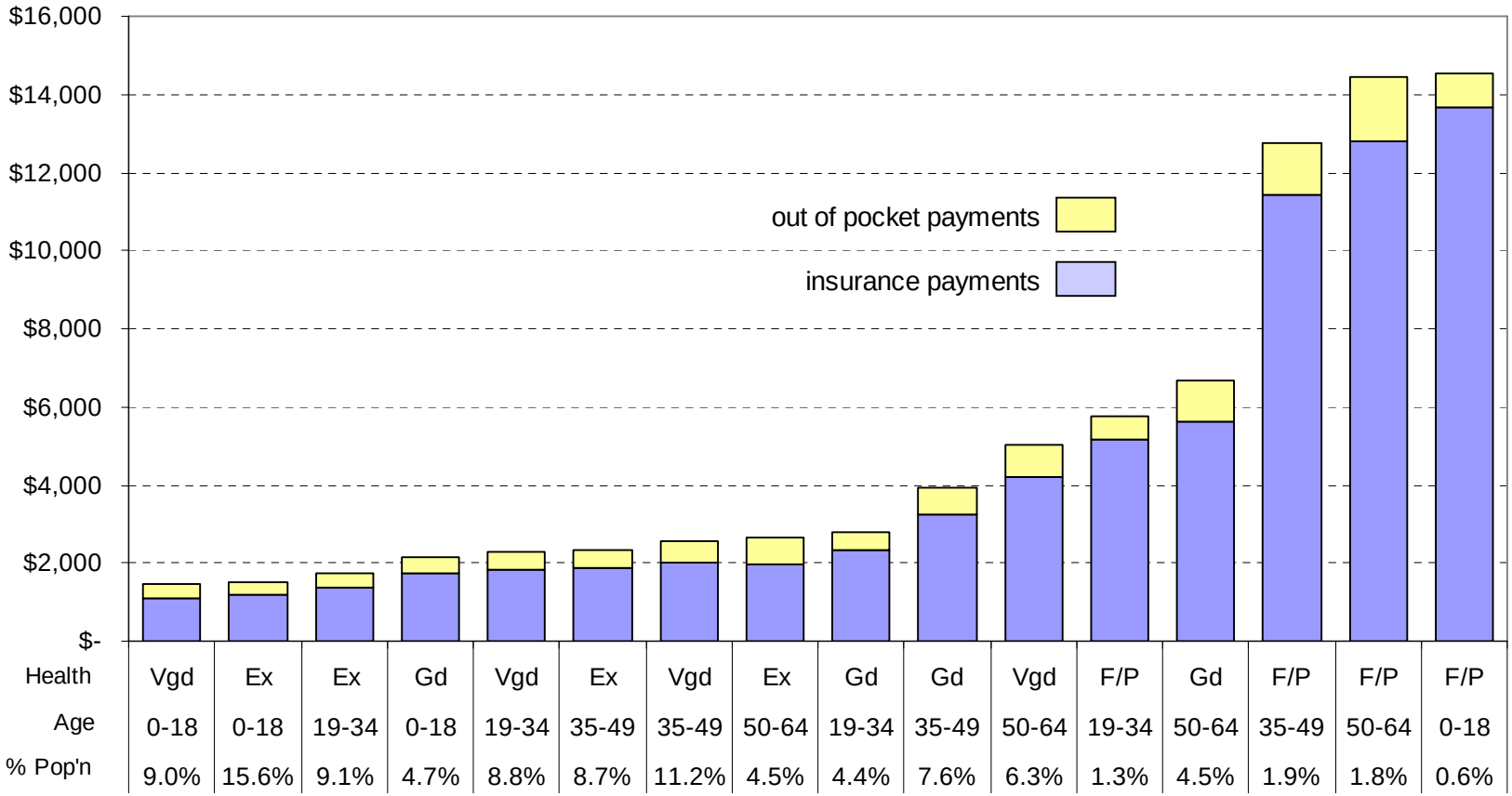
Rationale, cont'd

Rationales & design of reinsurance

- Specific excess-of-loss vs. aggregate
- Individual and small-group markets vs. all
- Previously uninsured vs. already insured
- Costs vary with size of population targeted, generosity of public subsidy
- Financing by surcharges on already insured vs. broad financing base

Rationale, cont'd

Enrollees vary greatly in spending per person year



Health	Vgd	Ex	Ex	Gd	Vgd	Ex	Vgd	Ex	Gd	Gd	Vgd	F/P	Gd	F/P	F/P	F/P
Age	0-18	0-18	19-34	0-18	19-34	35-49	35-49	50-64	19-34	35-49	50-64	19-34	50-64	35-49	50-64	0-18
% Pop'n	9.0%	15.6%	9.1%	4.7%	8.8%	8.7%	11.2%	4.5%	4.4%	7.6%	6.3%	1.3%	4.5%	1.9%	1.8%	0.6%

Note: Total Health Expenditures (in 2007 $s) by age and health, small group employees and dependents; preliminary data
Source: Urban Institute tabulations from statistical models estimated with 2001-2003 Medical Expenditure Panel Survey data, re-weighted to reflect Wisconsin population.

Rationale - last

Private & public compared

- Similarities
  - similar mechanisms of risk assumption
  - similar claims handling
- Big differences
  - public funds provide outside subsidy
  - target subsidy to neediest, the high cost
  - ultimate target is insured, not insurer
  - reinsurance only part of public reform

What's the Evidence on Reinsurance?

- Private
  - widely purchased, which shows it offers value
- Public
  - 1990s small group reform - prospective reinsurance
  - from late 1990s AZ Healthcare Group - aggregate, uninsured small groups
  - NY, Healthy New York - specific, retrospective, excess-of-loss; targets low-income uninsured workers
  - VT has reinsurance in new bill
    - Expect 10-30% cut in premiums, depending on design
  - Others - serious planning

Arizona and New York Experience

- AZ
  - enrollment of about 20K
  - vs. 1.1M uninsured, 0.9M Medicaid
  - ave. subsidy $300+/enrollee, evidently cut off
- NY
  - shifted corridor down to $5K-75K
  - cut premiums 20+%
  - rapid enrollment growth after slow start
  - 100K+ as of mid-2006
  - vs. 2.5M uninsured, 3.1M Medicaid

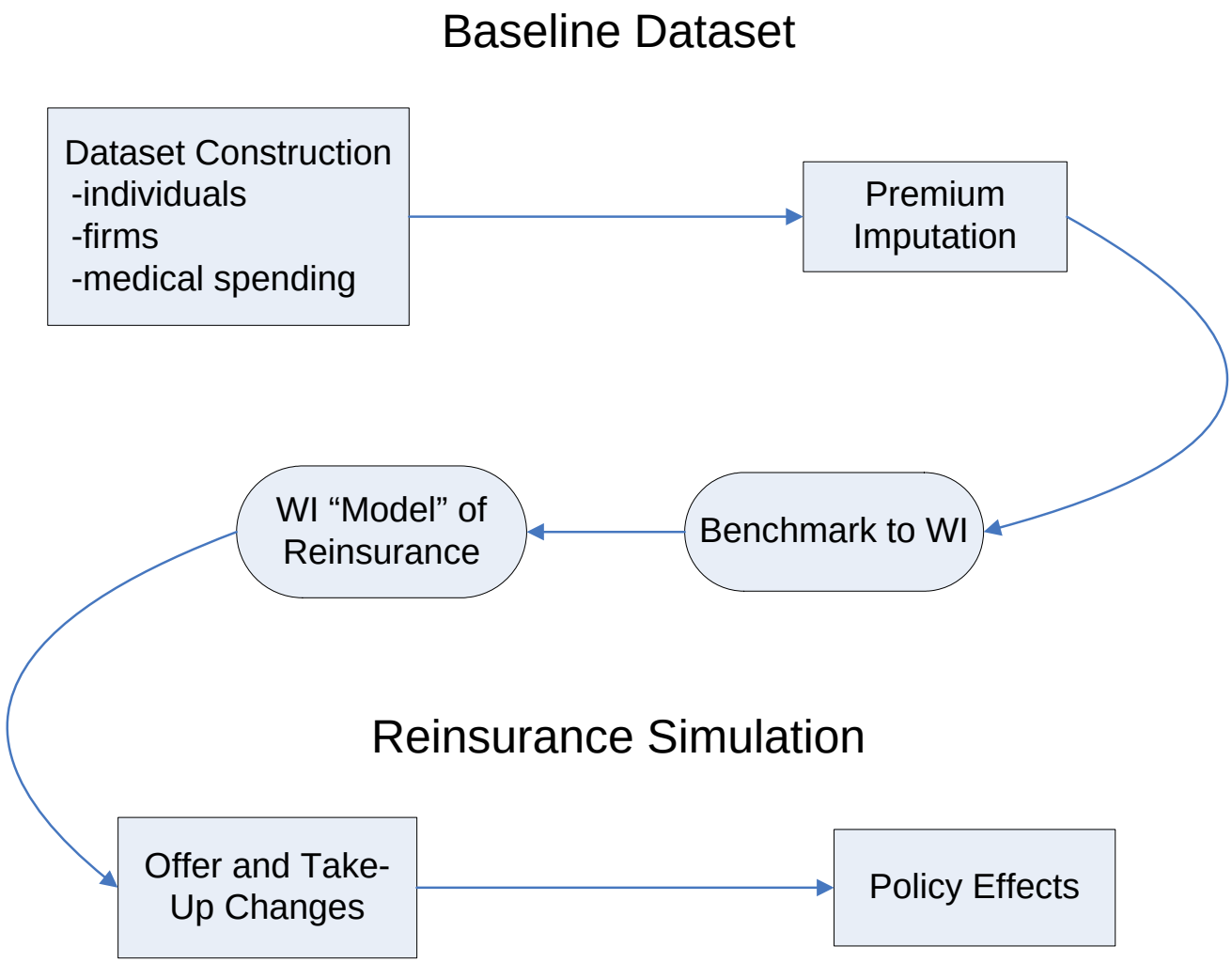
Reinsurance Impacts

- Subsidy cuts premiums
  - for savings, design needs to hold down transaction costs, maintain primary insurers' cost-containment efforts
- Extent of impact could go beyond extent of subsidy if
  - subsidy keeps healthier risks in the market
  - public reinsurance supplants private, reduces "risk premiums" charged by primary carriers
  - reinsurance facilitates competitive entry by MCOs

Reinsurance Impacts

- Can reduce premiums for insureds, impacts of adverse selection on insurers
- Can improve availability of insurance for people now turned down
- Impacts, costs vary with design & current market
- Not panacea, but component of intervention
  - Add'l subsidy needed to attract low-income workers
  - Other components also affect cost, accessibility of coverage to targeted population
  - Add'l regulatory interventions may also be needed

Reinsurance Modeling



How Is Institute Helping?

- Creating model of WI insurance costs
  - by employer size and employee characteristics
- Consult with WI policy makers
  - market & regulatory context, perceived problems
  - funding available, targeting desired
  - design of reinsurance benefits/cost sharing
- Estimate costs and effects of approaches
- Promote focus on problems, solutions

The End

. . . time for questions