

**Report**  
**on**  
**Reinsurance Options**

**By the Department of Consumer and Business Services  
for the Seventy-sixth Legislative Assembly**

**In accordance with Senate Bill 2755 (2009)**



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# Introduction

In 2009, the Oregon Legislature enacted House Bill 2755 directing the Department of Consumer and Business Services (DCBS) to conduct a study of the options available for utilizing reinsurance in the individual and small employer group health insurance markets. DCBS was directed to submit a report to the Legislature no later than Dec. 1, 2010.

The genesis of the bill was the concern over the inability of many small employers and individuals to purchase or maintain health care coverage given the continued escalation of premiums and health care costs. Testimony before the Legislature stressed that increasing premium rates was not affordable, nor sustainable, given the double-digit increases experienced year after year. Many small employers and individuals either cannot afford to purchase coverage or face the choice between dropping coverage, reducing benefits, or significantly increasing cost-sharing requirements.

The goal of the bill was to recommend strategies using reinsurance that would do the following:

- Facilitate guaranteed issue in the individual market
- Spread risk and stabilize individual and small employer health insurance markets
- Allow carriers to compete based on quality and efficiency instead of risk avoidance
- Reduce the costs to purchasers of health insurance

In addressing these and similar issues, many states have explored or implemented reinsurance programs as a tool to stabilize their individual or small group health insurance markets, expand coverage to the uninsured, or make coverage more affordable. The degree of success of these state initiatives has varied from one state to another depending on how their state insurance market operates, the structure of the reinsurance program, and the availability of public funds.

Reinsurance strategies are important in today's health insurance market, and they can be critical to the success of the market as it changes to reflect the reforms required by the Federal Patient Protection and Affordable Care Act (PPACA), signed into law March 23, 2010. In conjunction with the modifications included in the Health Care and Education Reconciliation Act of 2010, the federal market reforms will significantly change the structure of Oregon's health insurance market while addressing many of the goals outlined in HB 2755.

The purposes of this report are to:

- Explain reinsurance
- Describe how it operates in the health insurance market
- Outline several state public reinsurance programs
- Describe the role of reinsurance in the implementation of the new federal reforms

# Reinsurance

Insurance spreads risk among members of a population. It does that by combining the medical costs of all those enrolled into one pool. This results in premiums based on a group of individuals rather than an individual's specific health risk or costs. The larger the pool, the more stable and predictable the aggregate costs and the premiums for both individuals and businesses.

Reinsurance, generally insurance for insurance companies, provides relief or protection to those insurers that may serve a disproportionate share of individuals with high health care costs, protection from an unexpected high cost claim or claims, or simply bad claims experience beyond what is predictable.

An insurer or health plan may buy *reinsurance* to cover a specific individual's medical costs above some limit over a period of time. For example, reinsurance could cover any claims above \$100,000 dollars in a calendar year for any individual enrolled in a group plan. Alternatively, an insurer may buy *aggregate* reinsurance, providing protection for costs above a certain threshold or within a specific corridor of costs for the entire line of business or a group or individual health benefit plan. For example, reinsurance could cover a portion of claims above \$10 million for a specific group, or could cover 90 percent of claims between two points, such as 90 percent of claims between \$9 million and \$11 million.

In either case, the carrier is seeking to protect itself from unforeseen health care costs, sometimes referred to as outliers, that are above what can be predicted or expected.

The purchase of insurance in almost all states, as in Oregon, is currently voluntary. Individuals or small groups have a choice to either purchase insurance or not, and that decision is generally based on what they perceive as the benefits they may receive versus the potential cost. The young and healthy may forgo or postpone purchasing health insurance until either a specific need arises or later in life when their risk is greater that they will incur medical costs. Likewise, someone who has a chronic health condition is more likely to purchase health insurance than a healthy person because they may see a greater need. Each of these may lead to *adverse selection* and can cause a carrier to attempt to avoid risk in order to remain competitive and keep premiums down.

While historically carriers or self-insured employers purchase reinsurance to protect their risk pool from unexpected or extraordinarily high cost claims, many states have adopted the concept of *public reinsurance*. This represents a broader perspective or strategy toward equalizing risk in a specific market, traditionally the individual or small group markets.

## Public Reinsurance Programs

With *public reinsurance*, the state essentially organizes and administers a *public reinsurance program*. The goal of *public reinsurance* may be to protect carriers in a given market from adverse selection by spreading risk of high-cost medical claims to all insurers in that market. Generally, these programs focus on either the small group or individual market. In addition to spreading risk, *public reinsurance* programs may be used to "infuse" public dollars into a specific market in order to reduce premium costs, in essence subsidizing the premium costs paid by either individuals or small groups that meet certain eligibility requirements.

## **Public Reinsurance Programs**

Many states, including Oregon, have experience with the development and management of public reinsurance programs. Some state programs, such as New York, use public funds to subsidize small group health insurance premiums by reinsuring a corridor of risk of a health benefit plan, while others, such as Connecticut's, provide a methodology for spreading the risk of high-cost groups or individuals to the broader market. In each case, the goal has been to reduce the impact of high-cost individuals or groups, or to reduce premium costs to the individual or group by the state assuming the risk or by directly paying a portion of the claims.

In states that have implemented a health insurance exchange, such as Massachusetts or Utah, public reinsurance and risk adjustment programs are in place to protect the participating insurers from adverse selection within the exchange. For example, a carrier could enroll an unequal share of unhealthy lives putting that carrier at a disadvantage from a premium perspective with the other carriers in the exchange.

Additionally, more than 30 states have high-risk pools, like Oregon's, that function to spread the risk of high-cost individuals to the broader market through an assessment process or by subsidizing the pool with public funds making up a portion of pool losses. By spreading or subsidizing the claims costs of high-risk enrollees, individual market premiums are lower and are more affordable than they would be otherwise.

Idaho has an Individual High-Risk Reinsurance Pool, described below, that unlike the traditional high-risk pool where individuals are enrolled in a single pool, gives people a choice of standardized plans on a guaranteed issue basis that must be offered by all individual market carriers.

While a number of states operate or have operated reinsurance programs in the individual and small group markets, the four highlighted in this report address a non-subsidized model (Connecticut), a state subsidized model (Healthy New York), non-subsidized individual market pool (Idaho) and a non-subsidized exchange model (Massachusetts Connector). The Massachusetts model is important because it combines reinsurance and risk adjustment with the operation of a health insurance exchange to address selection issues between the participating insurers.

### **Non-Subsidized Model: Connecticut Small Employer Reinsurance Pool**

In 1990, Connecticut established the Small Employer Reinsurance Pool, the nation's first such pool, and became the model upon which the Oregon Small Employer Reinsurance Pool was designed in 1993, as well as other states over the past 20 years.

In the Connecticut pool, a licensed insurer must participate in the pool. Those insurers selling coverage in the small group market may decide in the first 60 days, upon enrolling a group or adding a new employee to the group, to either pay all the claims for that group or individual, or cede the risk of the individual or group to the reinsurance pool based on their health status. The pool will pay a portion of the claims to the insurer for those groups or individuals ceded. The insurer must pay a reinsurance premium to the pool for those groups or individuals they choose to cede to the pool.

If the reinsurance premiums collected by the pool do not cover all the losses incurred, all insurers participating in the pool (all state-licensed insurers) make up the difference in proportion to the amount of health insurance premiums they earn in the state.

Like Oregon, Connecticut does not allow insurers to charge small employers higher premiums based on the health status of their employees. Thus, the pool provides a methodology to equitably distribute the expenses of higher-cost employees and dependents among all insurers. It is generally considered successful in keeping small insurers in the state who, because of the smaller size of their risk pool, are more susceptible to adverse selection or unanticipated high cost claims.

The primary difference between the Connecticut and Oregon reinsurance pools was that in Oregon participation was voluntary (and only those insurers that joined the pool were subject to assessment) while in Connecticut participation is mandatory, and all licensed health insurers are subject to the assessment for pool losses.

### **Oregon Small Group Market Reinsurance Pool**

In 1993, Oregon established a reinsurance pool for the small group market (2-25 employees) as directed by Senate Bill 1076 enacted by the Legislature in 1991. The pool was created as part of the guaranteed issue Small Employer Health Insurance Plan (SEHI Plan). At that time, the small group market was underwritten (an insurer could turn down a group because of the health risk of one or more of the employees). The SEHI plan, in contrast, was to be offered on a guaranteed issue basis by all health insurance carriers doing business in the small group market. To protect carriers from adverse selection in the SEHI plan, the reinsurance pool was created.

Participation by a small employer insurer in the reinsurance pool was voluntary. Upon election, the insurer had the opportunity to cede an individual risk or the entire small group to the pool. The insurer would then pay a premium based on the number of lives placed in the pool. Claims in excess of \$5,000 (defined attachment point) would be spread among the participating pool carriers. It was anticipated that an additional assessment above the initial fee would be made depending on the losses of the reinsurance pool in excess of the premiums paid by the participating carriers.

A limited number of foreign carriers, with small Oregon group enrollment, elected to participate. Larger carriers, such as Oregon's domestic carriers, either purchased reinsurance in the commercial market or chose not to reinsure through the small employer pool, assuming the risk of adverse selection or extraordinary claims experience.

The reinsurance pool was disbanded in 1995 with the passage of SB 152. After two years of operation, only about 20 lives were ceded to the pool out of approximately 3,000 covered by the participating carriers, and there is no record of any claims paid out by the pool.

### **Subsidized Model: Healthy New York**

Healthy New York, launched in 2001, is a state-sponsored program designed to provide lower cost health insurance to uninsured workers and their families. The standardized benefit packages are required to be offered by all Health Maintenance Organizations (HMOs) in the state.

The program targets small employers with fewer than 50 employees, sole proprietors, and low wage individuals who were previously uninsured. The program provides subsidized (using state dollars) risk corridor reinsurance through contracted health plans by paying a percentage of claims that an individual incurs between two attachment points. The insurer pays 10 percent and the state pays 90 percent of medical claims incurred during the year for individual medical claims between \$5,000 and \$75,000. The insurer assumes the risk (actual claims) above the upper level.

As a result of the state subsidies, Healthy New York has been successful in lowering premiums for small employers, in some cases by as much as 20 percent to 30 percent. However, the premium savings result from the shift of a portion of the medical costs to the state, not necessarily from a reduction in medical claims. Additionally, benefits in these plans are less than what is generally offered in the regular market and thus the premium costs are lower in general. The program contracts primarily with HMOs, which are required to offer standard benefit plans. The plans provide minimum benefit levels, and some critics maintain they do not meet the needs of people with chronic illnesses. Nonetheless, using significant state dollars to pay for a portion of the medical claims, the program has been successful in providing coverage to more than 200,000 currently enrolled who were previously uninsured.

The participating carriers are also reinsured through a state stop-loss reinsurance pool, which is funded by assessments on insurance premiums and other state funds dedicated to state insurance programs.

### **Non-Subsidized Individual Market Model: Idaho's Individual High-Risk Reinsurance Pool**

In Idaho, all individual market health insurers must offer five standardized health benefit plans to individuals on a guaranteed issue basis. The premiums for the plans are established by a board and are the same regardless of the insurer. Required by the Idaho statutes, insurers must add a surcharge for these standardized health plans that can range from 125 percent to 150 percent of premiums charged to healthier individual market enrollees.

The insurers pay the first \$5,000 of claims and then the reinsurance program pays 90 percent of the next \$25,000. After \$30,000, the reinsurance program pays all remaining claims up to the lifetime limit of the benefit plan.

The program is financed through a portion of the premium taxes paid by all insurers, reinsurance premiums set by the board, and, if additional losses are incurred, through an assessment of the participating carriers. A significant difference in the funding of this pool in comparison to the Oregon high-risk pool is that all Idaho licensed insurance carriers (life, health, disability, property, etc.) support the pool through the portion of premium they pay to help finance the program. In Oregon, the assessment for the high-risk pool is levied against only licensed health insurers and is based on the number of Oregon insured lives covered.

### **Non-Subsidized Comprehensive Model: Massachusetts Connector Model**

In Massachusetts, three reinsurance methodologies are used inside its exchange (Massachusetts Connector) to minimize adverse selection that could occur in the Commonwealth Care portion of the Massachusetts exchange. Commonwealth Care is the portion of the exchange that provides subsidies to low-income enrollees. No reinsurance methodology is used for the non-subsidized portion (Commonwealth Choice) of the exchange.

The concern when establishing the exchange was that one carrier might attract a disproportionate share of unhealthy individuals. This could lead to disruption and instability in the premium structure of the exchange and could disadvantage one or more carriers because of adverse selection. The three reinsurance programs used by the Massachusetts Connector are very similar in concept to those programs enacted by the Federal PPACA.

- Reinsurance: Each of the participating plans in the exchange pays a portion of the premium they receive into a fund that is then used to reimburse plans that have individual enrollee

claims above a specified level. The pool pays the plans at the end of the year based on their pro-rata share of the total claims eligible. No additional funding is provided and thus only those funds collected are redistributed to the plans.

- Risk-Corridor: The second mechanism uses a risk corridor to transfer premium dollars to plans whose losses exceed 103 percent of expected claims from plans whose losses are less than 97 percent of expected claims. Again, it is a transfer of premium dollars from one plan to another; no additional dollars are added to the pool.
- Risk Adjustment: Demographic information and claims experience are used in adjusting rates between participating plans. For example, if a plan has an enrollment where the average age is higher than other plans, an adjustment factor is applied to the premium (in this example, resulting in a higher premium) and an adjustment factor is then provided to other plan's premiums that have a lower average age (in this example, resulting in a lower premium).

There are no additional (public) dollars provided to subsidize these three programs. Funding is shifted from one plan to another, using the Connector as the intermediary. The objective is to provide for adjustments to premiums based on risk or claims experience so that no plan is disadvantaged because of selection issues in the enrollment process.

## **Other Models**

A successful "mini" model that uses risk adjustment among participating plans is the Washington State Public Employee Benefit Board (PEBB). The Washington PEBB uses a program based on demographics, prior and projected claims experience, and year-to-year plan migration in adjusting the premiums paid to the participating carriers. This is done both prospectively (based on demographics) and retrospectively (based on claims experience and enrollment changes). In essence, this adjustment, through revenue transfers, spreads the health costs or risk of unhealthy enrollees among all plans, leveling the playing field for all plans.

Additionally, Arizona has used a reinsurance model to "infuse" additional funds into its small group markets in order to reduce the premiums for those employers electing to enroll. The enrollment into the Arizona Health Care Group is limited to small employers who have not offered insurance for a period of six months, and strict participation requirements based on the number of employees eligible to enroll.

In each of the state programs described above, several factors affect whether a reinsurance program is successful, including the size of a particular market, its regulatory framework, underwriting and rating rules, whether carrier participation is mandatory or voluntary, and, in the case of subsidized reinsurance, the availability and sustainability of state resources. The lesson is that there is no one strategy that will necessarily work across all states given the differences in their market environments.

Moving toward 2014, the reinsurance and risk adjustment strategies to be developed under the PPACA will change how states operate their reinsurance programs or will determine whether the programs continue to exist at all. Those decisions will be made based on the regulations and guidelines established by the Department of Health and Human Services (HHS) over the next two years and how the state programs line up against the federal requirements.

## Federal Reform and a Changing Market

The PPACA includes major market reforms that will alter the structure of Oregon's health insurance market. Several of the PPACA reforms, outlined below, will affect premium pricing paid by both individuals and groups. While both the state and the insurance industry will work hard to evaluate the effect of these reforms on benefits and premium rates, much of the hard evidence, measured by who will purchase and what they will buy, will not be available until the reforms have been implemented.

Major federal reforms effective 2014 include the following:

- *Guaranteed issue:* Beginning in 2014, insurance carriers selling health plans in the individual and small group markets must accept every employer and individual in the state who applies for coverage and must renew the coverage at the option of the employer or individual.
- *Individual mandate:* All individuals will be required to have a minimum level of coverage or face a financial tax penalty.
- *No pre-existing condition exclusion:* Health insurance carriers will not be allowed to impose any pre-existing condition exclusion.
- *Rate-bands and rating rules for the individual and small group markets:* Premiums charged by a health insurance carrier for coverage (excluding grandfathered plans, which are plans in existence prior to the passage of federal reforms) offered in the exchange and the individual or small group markets may vary only by certain factors (individual or family coverage, geographic area, tobacco use, and age). The variation in age rating is limited to 3:1, meaning the highest premium rate charged can be no more than three times the lowest rate charged for the same benefits.
- *Expansion of small group market to 1-100 employees:* The definition of small group expands from Oregon's current two to 50, to one to 100. The state has the option of postponing the expansion above 50 until 2016.
- *Public subsidies and expansion of Medicaid eligibility:* Federal reforms include significant public tax credit subsidies for those earning less than 400 percent of the federal poverty level (and not eligible for Medicaid) and a small business tax credit for employers with fewer than 25 employees and average wages under \$50,000. To be eligible for these subsidies beginning in 2014, the individual or small employer must purchase coverage through a health insurance exchange. Additionally, income eligibility for Medicaid is expanded to all individuals up to 133 percent of the federal poverty level.
- *Health insurance exchange for both the small group and individual markets:* Each state is required to establish an individual market health insurance exchange and a Small Business Health Options Program (SHOP) effective Jan. 1, 2014, for individuals and small employers with one to 100 employees (from 50 to 100 employees by 2016 at the state's option). Beginning in 2017, the state may expand employer eligibility to those with greater than 100 employees. Additionally, at the state's option, the individual and SHOP exchanges may be combined into one exchange.
- *Risk pooling:* Beginning in 2014, with the establishment of the health insurance exchanges, the federal reforms require insurers to pool the risk of enrollees enrolled in individual plans in the

exchange with those enrollees purchasing individual plans outside the exchange. Similarly, insurers in the small group market will be required to pool the risk of all enrollees, including those who do not enroll through an exchange, into a single risk pool. Grandfathered plans and non-grandfathered plans are pooled separately.

Additionally, premiums charged outside the exchange must be the same as those charged inside the exchange for the same benefits. These provisions are essential to ensure the exchange is not adversely selected against and put at a rating disadvantage to markets outside the exchange.

There is a potential for significant adverse risk selection and changes or disruption in premium pricing in Oregon's individual and small group markets as a result of the federal reforms. The following summarizes the potential impact on Oregon's market today in relation to the new federal reforms effective 2014:

- *Guaranteed issue:* Oregon currently has guaranteed issue in the small group market and any employer with between two and 50 eligible employees can buy insurance from any small group carrier, regardless of the employees' health history or claims. However, there is no guaranteed issue in the individual market. If turned down for coverage for health reasons, an individual is eligible to obtain coverage through the state's high-risk pool at a higher cost than the general market. Guaranteed issue in the individual market may lead to significant adverse selection issues for some carriers, and depending on how effective the individual mandate is in bringing healthy lives into the pool, it could result in significant adverse selection, not only to a particular carrier, but also to the market as a whole.
- *Individual mandate:* In Oregon, as with almost all other states, the decision to purchase health insurance is currently voluntary. An individual mandate is intended to bring into the market many of those who have chosen not to enroll because they viewed themselves as healthy. However, the mandate will only be successful if the penalties, subsidies, and benefits provide sufficient incentive for the young and healthy to enroll.
- *No pre-existing condition exclusion:* Oregon carriers currently have the ability to impose pre-existing condition exclusions for persons 19 years or older, within certain durational limits. Because of guaranteed issue, an individual could postpone purchasing insurance (despite the mandate) until he or she gets sick and needs it. Again, this behavior would result in carriers providing coverage for high-cost claims without the benefit of collecting premiums over a period of time.
- *Rate-bands and rating rules for the individual and small group markets:* Oregon's individual market uses what is called a natural rate band where premiums are actuarially based on the health care costs of people of similar age. The natural rate band is generally around 5:1, meaning a person at the higher end of the age brackets will pay about five times the premium of the youngest. Federal reforms compress this to 3:1 and, again, depending on how the rate band is distributed between the younger and older enrollees, if premium rates for the young are too high, young adults could choose not to enroll, thus pushing rates significantly higher for older enrollees.
- *Expansion of small group market to 1-100 employees:* Currently, the premium rates in the 51- to 100-employee group market are neither regulated nor subject to rate bands. Rather, rates

are determined by the experience or underlying risk of the group as negotiated or determined by the carrier. Expanding the small group market to groups of 100 employees will subject premiums for the 51- to 100-employee groups to the 3:1 rate band. Additionally, these two groups will now be pooled together, where the 51- to 100-employee groups are currently not pooled. As with Oregon's experience when it combined the 2-25 employee group market with the 26-50 market, some groups may see a significant increase in premium rates while others may see a decrease.

- *Public subsidies and expansion of Medicaid eligibility:* Expanding the availability of public subsidies, coupled with guaranteed issue and the individual mandate, should bring many previously uninsured people into the market. While recent evidence indicates that this population may be healthier than many of those insured today, if the subsidies only attract the unhealthy lives or if the healthier opt not to be covered, premium rates could be negatively affected.
- *Health insurance exchange for both the small group and the individual markets:* The federal reforms include provisions related to risk pooling that will equalize the risk pools inside and outside of the exchange. Coupled with the requirement that the premiums charged for the same benefit plan must be the same inside and outside the exchange, the risk-pooling requirement outlined next will equalize risk between those two markets.

Much of the discussion (and concern) about the new health insurance exchanges is whether or not they will be adversely selected against (whether more unhealthy lives eligible for subsidies will enroll). The federal requirement to pool risks, coupled with the proposed reinsurance models, are intended to minimize the impact of any adverse selection between those who enroll in an exchange and those who enroll in the outside market. Again, those in the exchange are in the same risk pool as those outside the exchange and must be charged the same premium rate for the same benefit.

To address the potential risk selection that may occur in the fully reformed market and lessen the effect of premium disruption during the initial transition period, the PPACA includes reinsurance and risk adjustment programs to support both the individual and small group markets.

## **Federal Reinsurance and Risk Adjustment Mechanisms Effective 2014**

Federal reform includes reinsurance and risk adjustment mechanisms that will be implemented and effective Jan. 1, 2014. The goal of these programs is to minimize the effect of adverse selection by providing carriers with increased incentives to cover individuals or groups that have high health care costs. The models are intended to minimize the ability of carriers to "cherry-pick" only the healthy risks, equalize risk across all carriers, and provide protection from potential selection problems for those carriers participating in the health insurance exchanges.

Conceptually, each of the programs is intended to minimize the potential price disruption brought on by the reforms, focusing on the redistribution of premium dollars from those carriers with healthier enrollees to those with less healthy enrollees. This will also allow carriers to compete on quality,

customer service, outcomes, and other strategies, leading to improved health and health care delivery rather than risk avoidance.

### **Transitional reinsurance**

The PPACA requires all states to establish or contract with a nonprofit reinsurance entity for 2014, 2015, and 2016. This entity will collect payments from all insurers in the individual and group markets and from third-party administrators of self-insured group plans, and will make payments to insurers in the individual market and those selling individual plans through the exchanges that cover high-risk individuals.

The primary objective of this program is to ensure that enrolling (under guaranteed issue) a disproportionate share of unhealthy lives is not a disadvantage to any one carrier. Additionally, it will provide some protection to individual market carriers in those states that have high-risk pools phasing out at the end of 2013, where there is a potential for a large number of unhealthy lives enrolling with one carrier under the guaranteed issue provisions of the PPACA.

This program is similar to the assessment mechanism used by the Oregon Medical Insurance Pool (OMIP), the state's high-risk health insurance pool. OMIP assesses Oregon licensed health insurers, based on the number of Oregon lives they cover, for the medical and administrative costs above the premiums that are paid by OMIP enrollees. Thus, the high medical costs of about 15,000 OMIP lives are spread or pooled with about 1.6 million Oregon insured lives, keeping premiums significantly lower for those insured through OMIP. If those costs were spread to just the individual market, or one specific carrier, the premiums for that market or carrier would be substantially higher. The transitional reinsurance program will play a key role in stabilizing premiums as those enrolled in the state's high-risk pool move into the regular individual market by protecting those carriers receiving an unequal share of these less healthy higher-cost lives.

### **Risk Adjustment**

The PPACA provides only a brief description of the risk adjustment program that begins Jan. 1, 2014. However, in general terms, the legislation requires each state to assess individual and small group health plans if the actuarial risk of all its enrollees is less than the average risk of all enrollees in fully-insured plans. The state will then make payments (based on the assessments received) to individual and small group health plans whose enrollees have an actuarial risk that is higher than the average actuarial risk of all enrollees in all plans in the state. This risk adjustment will apply to plans in the individual and small group markets, excluding grandfathered and self-insured plans. The HHS secretary, in consultation with the states, will establish the criteria and methodology for this program. Unlike the risk corridor and reinsurance programs, there is no sunset on the risk adjustment program and it is intended to provide an ongoing program to mitigate risk selection, and thus price stability, in the individual and small group markets.

### **Risk Corridors**

The HHS secretary will establish and administer a risk corridor program effective Jan. 1, 2014. Based on the risk corridor program for Medicare Prescription Drug Plans, health plans will receive payments if their ratio of non-administrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103 percent. Plans must make payments if the ratio is below 97 percent. This will apply to qualified health plans (grandfather plans are excluded) in the

small group and individual markets and is set to end in 2016. Like the transitional reinsurance program, the intent is to mitigate the initial risk shock that may occur with the implementation of the federal reforms.

The following table provides a summary outline of the three federal reinsurance/risk adjustment programs:

	<b>Transitional Reinsurance Program</b>	<b>Risk Adjustment</b>	<b>Risk Corridor</b>
<b>Groups Benefiting</b>	Individual market plans with high risk (excluding grandfathered plans)	Individual <u>and</u> small group plans with high actuarial risk enrollment (excluding grandfathered plans)	Individual <u>and</u> small group plans with allowable costs above 103% of target (excluding grandfathered plans)
<b>Who Pays</b>	All insurers and TPAs administering group health plans ( <u>includes</u> grandfathered plans)	Individual <u>and</u> small group plans with low actuarial risk enrollment (excluding grandfathered plans)	Individual <u>and</u> small group plans with allowable costs below 97% of target (excluding grandfathered plans)
<b>Basis of Adjustments</b>	Number of high-risk individuals covered (defined by a condition list or other comparable method)	Criteria and methods established by HHS in consultation with states	Allowable costs are an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered. Targets are established by the amount of premiums less the administrative costs of the plan.
<b>Who Administers</b>	State administered not-for-profit entity established by the state per federal criteria	State administered	Federal – HHS administered
<b>Time Frame</b>	Three years: 2014-2016	Permanent	Three years: 2014-2016

These reinsurance models, when implemented, are intended to support an environment where competition between insurers is focused on quality, efficiency, outcomes, networks, and other factors rather than just premium price and the avoidance of risk. Whether they succeed in reaching those goals will be dependent on the effectiveness of their design and the ability of the states and federal government to effectively implement them.

## Conclusions

In the absence of federal reforms, reinsurance could be useful in combating the effect of adverse selection, minimize the impact of unexpected high cost claims on a carrier, provide stability in premium variations between carriers and allow for a more equitable market based on competitive factors other than risk selection or avoidance.

Depending on the availability of state resources, it could also provide a way to subsidize premiums making coverage more affordable for either individuals or small employers. However, states that have provided subsidies to their reinsurance programs have had significant challenges in increasing the level of funding required on a year-to-year basis. They have shown that it is important to not only have a

steady and dedicated source of funding, but one that can keep pace with rising health care costs, which have far outpaced the general rate of inflation.

Although their approaches are varied and with different degrees of success, other states' experiences with reinsurance have provided several models for consideration as federal and state policymakers develop the operational guidelines and regulations for the federal reinsurance programs.

While reinsurance programs could be useful in today's market environment, they become critical in a reformed market. With the major federal reforms scheduled to take effect in January 2014, it is essential that the mandated reinsurance programs be structured and implemented to minimize the potential for market disruption, specifically focused on the impact of risk selection between markets, the exchange and individual and small group insurance carriers.

The three reinsurance strategies created under the PPACA are intended to provide for a more stable, competitive, and equitable market during the implementation of the federal market reforms. One goal is to facilitate the transition to a market that is incorporating significant changes, including guaranteed issue, an expansion of the small group market, coupled with an individual mandate and public subsidies. Additionally, the reinsurance strategies will be important in making sure that there is a level playing field for those providing or purchasing coverage through a health insurance exchange and those providing or purchasing outside the health insurance exchange.

If the risk mitigation programs are designed correctly, the markets, between carriers and inside and outside the exchange, should be equalized, from a risk pool perspective. The reinsurance strategies will minimize the impact of adverse selection with either individuals or groups, and enrolling unhealthy lives will not disadvantage insurance carriers as it would in the absence of these strategies. The reinsurance strategies may also serve as a disincentive to carriers from attempting to "cherry pick" the healthy risks because carriers would be subject to the reinsurance risk assessments levied on all carriers based on the risk profiles of their enrollees and/or their claims experience.

A key variable in the success of the health insurance exchange will be the ability to mitigate the risk selection between those in the exchange and those outside the exchange, and between carriers within the exchange.

Coupled with state and federal initiatives relating to evidence-based or value-based benefit design, administrative simplification, delivery systems, and cost, the federal reinsurance strategies should provide for a more stable insurance market or, at the least, minimize the potential for risk selection given the changes to the insurance market that will occur beginning 2014.

But there are caveats. First, two of the three reinsurance programs are temporary and the potential market disruption may require an extension of the time beyond 2016 to make sure Oregon's market is given adequate time to stabilize as a result of the federal reforms. Secondly, Oregon's high-risk pool and portability markets, together comprised of approximately 35,000 enrollees, may require a more state specific reinsurance mechanism to ensure the impact of those enrollees moving to the general market under guaranteed issue. Finally, the expansion of the small group market from 2-50 to 1-100 employees may present unintended pricing consequences and significant small group enrollment expansion or contraction may present risk selection challenges that go beyond what the federal reinsurance initiatives anticipate. Each of these caveats will require the state to provide careful analysis and tracking during both the design and implementation phases of the reinsurance programs.

## Next Steps

Because of the complexity and comprehensiveness of the PPACA, it will most likely be another six months to one year before the HHS secretary releases the additional guidance and regulations on the two reinsurance programs for which the state will be responsible (the reinsurance and risk adjustment programs) and the risk-corridor program for which HHS will administer. This additional guidance is necessary in order for states to align legislative proposals to fully implement the reinsurance program requirements under the PPACA.

- In the interim, the DCBS and OHA will track the national discussion of the reinsurance programs for which the state will have the responsibility to administer. Through our participation in the NAIC, there will be an opportunity to consult with HHS in the design of the programs and the state will be in a position to fully evaluate the methodology, options, and potential impact on Oregon's insurance market.
- DCBS and OHA will continue to respond to questions from HHS regarding the design and operation of the state health insurance exchange and the administration of reinsurance programs. This will ensure that information related to Oregon's insurance market is taken into consideration in the development of guidelines and operational requirements.
- Under a federal grant, DCBS and OHA will analyze the impact of expanding the small group market from 2-50 to 1-100 employees. Based on that analysis, policy options may be presented for legislative action.
- DCBS and OHA will analyze the key policy and design issues related to the effectiveness of the Federal reinsurance models. A determination can then be made as to whether additional risk adjustment strategies will be required beyond those proposed under the PPACA, and, if necessary, legislative proposals may be developed for consideration during the 2012 or 2014 legislative session.
- The Legislature should consider designating a legislative committee to review the federal models when proposed and provide input and direction to DCBS and OHA regarding the development of state-specific legislative proposals.
- Finally, DCBS and OHA will present to the 2012 Legislature specific legislative proposals for the implementation of the reinsurance programs, based on federal design, regulations and operational requirements.

Designing the reinsurance programs under the PPACA to promote premium and market stability are worthwhile goals and will be critical to the successful implementation of the major market reforms effective in 2014. DCBS will provide more detailed information on these programs that the state will be required to administer and will report to the appropriate legislative committee or committees as necessary. If there are questions in the interim, please contact Rocky King, Senior Policy Advisor on Health Reform, at 503-947-7061.

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The following publications provided background information of state reinsurance programs:

*Issue Brief - The Role of Reinsurance in State Efforts to Expand Coverage*, by Deborah Chollet, Ph. D, State Coverage Initiatives, Vol. No. 4, October 2004

*Issue Brief - Reinsurance: A Primer*, by Deborah Chollet, Ph. D, Mathematica Policy Research, Families USA, April 2008

*Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers*, by Katherine Swartz, Harvard School of Public Health, Commonwealth Fund pub. No. 820, July 2005

*Updated Timeline for Health Care Reform Implementation: Health Insurance Provisions*, The Commonwealth Fund, April 2010, Updated August 2010