Reinsurance Options for New Jersey's Health Insurance Markets

January 2007

State of New Jersey
Department of Human Services

In Collaboration with
Rutgers Center for State Health Policy

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Table of Contents

Executive Summary vii
Introduction 1
Why Consider Reinsurance? 1
Health Insurance Reforms in New Jersey 3
Selecting Markets and People to Reinsure 6
Structure of Reinsurance 7
Source of Funding 10
Conclusion 12
Appendix 15
Endnotes 21

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Executive Summary

Reinsurance may be used to control premiums and stabilize health insurance markets. Reinsurance allows insurance carriers to share the risk of high cost cases with other carriers or the government, thereby reducing the risk of high claims for all health insurance carriers in the market. This lower risk allows insurers to charge enrollees lower premiums. Reinsurance mechanisms cover claims within a defined corridor. In this way, when claim costs reach a certain amount, the reinsurance mechanism begins to cover some or all claims until a dollar threshold is reached. At that time, the originating insurance carrier again assumes full responsibility for claims. Funding to cover reinsured claims may come from premiums or assessments paid by the originating insurance carriers or from state funding. Typically, reinsurance is used in the individual or small group markets, and several states have already implemented reinsurance programs using a variety of structural mechanisms and with varying success.

New Jersey policymakers have been considering the potential benefits of applying a reinsurance mechanism to the state's individual and small group health insurance markets. The primary goal of the reinsurance mechanism would be to stabilize premiums in these markets and attract greater enrollment. Policymakers would need to define the reinsurance corridor taking into consideration the funding mechanism, percent of risk assumed, and whether the goal is to reinsure high costs of chronic illness or acute catastrophic health events.

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Introduction

Reinsurance is a mechanism for sharing the risk of high health care claims among health insurance carriers or between carriers and government, in the case of publicly sponsored reinsurance. Through reinsurance, a carrier shares or transfers some or all of the claims of one or more covered people with another carrier, a group of carriers, or a public agency in the case of government reinsurance. Reinsurance can improve the functionality of health insurance markets and can serve as a mechanism for providing public subsidies for high cost cases. Reinsurance can stabilize the claim costs to the primary carrier, and it can also reduce the overall cost of coverage if it results in a lower cost of capital, or if it involves an external subsidy.

This report will serve to provide an outline of fundamental reinsurance design choices including selection of reinsured population, structure of the reinsurance mechanism, and source of funding, as well as offer examples of reinsurance implemented or considered in nine other states (Arizona, Connecticut, Idaho, Massachusetts, New Hampshire, New Mexico, New York, Rhode Island, and Washington) and the impact of design features on enrollment. Lastly, this report will elaborate on the implemention of reinsurance in the context of New Jersey's health care market.

Why Consider Reinsurance?

The growth in the numbers of uninsured in New Jersey (see Table 1) has policymakers and interest groups concerned about the accessibility and affordability of insurance coverage in the state. Recent research has shown that over the 25 year period from 1979 to 2004, the U.S. has seen significant shifts in the labor market resulting in greater numbers of sole proprietors and small group employees without employment based health insurance.[1] Today, middle income workers are more likely to be employed in the service sector than in the manufacturing industries that have traditionally provided

generous health insurance benefits. These workers are also more likely to have non-permanent employment or work on a contract basis as entrepreneurs or employees of small firms, without health insurance benefits.

Table 1: New Jersey Percent Uninsured by Age Group

Age	2001	2005	% Change 2001-2005
0 – 18	11.5	11.3	-1.7
19 – 24	27.1	30.4	12.2
25 – 34	24.9	27.7	11.2
35 – 44	13.4	17.4	29.9
45 – 54	10.2	12.8	25.5
55 – 64	11.3	13.0	15.0
Total*	13.1	15.2	16.0

* Includes a small number of uninsured persons over age 65.
Source: U.S. Census Bureau, Current Population Survey[2,3].

In recent years several states, including New York and Arizona, have looked to reinsurance to increase the accessibility of health insurance by stabilizing health insurance premiums. This is because health insurance spreads the risk of low probability, high cost health events across many enrollees and determines the price, or premium, for the policy based on the average expected cost of covering the enrollees. The goal of reinsurance is to stabilize health insurance markets by providing separate funding to pay for these high cost cases, potentially reducing premiums for the pool. By reducing premiums, markets can attract other enrollees while maintaining a lower risk of incurring high medical costs because the insurance product is more affordable.

Insurers generally reinsure high cost cases with reinsurance companies so that some percentage of costs above a certain threshold, or within a certain corridor or range of costs, is covered by the reinsurer. The original insurer pays a premium to the reinsurer to assume these costs. In health insurance markets, the reinsurance premiums paid by insurers are generally higher than those in other markets because reinsurers must also consider the chances of adverse risk selection based on the age and health characteristics of the group they are reinsuring.[1] State-run reinsurance mechanisms usually reinsure specific groups of enrollees across all insurers within a selected health insurance market.

Therefore, the risk of high cost health events is pooled among a large number of enrollees from several different insurance carriers.

Reinsurance is generally considered within the context of the individual and small group health insurance markets (though it can also be used for larger groups or public health insurance programs[4]) because these markets tend to be most vulnerable to high cost members. Smaller groups, and certainly people with individual coverage, have a much greater risk of incurring high health care costs than members of larger groups for two reasons. First, workers tend to be healthier than non-workers and non-workers (as well as sole proprietors) purchase health insurance in the individual market, so premiums in the individual health insurance market tend to be more costly than those in group health insurance markets. Second, insurers report that small groups tend to adjust their health insurance coverage more frequently in response to the health needs of employees. This increases the likelihood of higher-than-average costs for enrollees in these small groups, and as a result, insurers charge higher premiums for these groups. This vulnerability is even greater in New Jersey's individual and small group markets, which require guaranteed issue and therefore cannot exclude people with existing health conditions (a pre-existing condition exclusion can temporarily deny coverage, but this expires after time, and is not operative if the person had previous creditable coverage).

Health Insurance Reforms in New Jersey

New Jersey, like other states, has struggled to keep health insurance affordable. New Jersey reformed its individual and small group health insurance markets in 1992 in the hopes of making health insurance more accessible to those not employed by large firms. As part of this reform, the small employer health benefits program (SEHBP) was created, which allowed for standardized health insurance plans to be sold to small employers using modified community rating (allowing for some variation in premiums based on age, gender, and geography) with rating bands of 2 to 1 around the average small employer premium. While health insurance premiums in this market tend to remain somewhat higher than premiums paid by large group enrollees (in 2003 single coverage was $3,972 on average for small firms compared to $3,754 for large firms, while family coverage was $10,956 on average for small firms compared to $9,983 for large firms[5]), New Jersey's small group market has maintained a relatively stable enrollment (currently

about 900,000) since its inception. Still, 48.4% of New Jersey's small employers did not offer health insurance coverage to their employees in 2003[5].

Also created in 1992 was the individual health coverage program (IHCP), the regulations of which require pure community rating (i.e., no premium variation by health status or demographics) as well as guaranteed issue. This market experienced high levels of enrollment initially, but as the membership became older and less healthy over time, premiums increased, and enrollment of young, healthy, adults declined. It is likely that structural factors that were subsequently corrected contributed to the decline in this market, but the market rating and access rules of the IHCP made coverage in this market unaffordable for many.[6] In 2003, the Basic & Essential (B&E) plan was established in the individual market by statute. The B&E plan was intended to be made affordable by providing a minimum benefit package; permitting modified community rating with 3.5 to 1 rate bands; and allowing variation in premiums based on age, gender, and geography. Health insurance carriers have found that by adding additional benefit riders to the B&E plans they can create a more extensive benefit package at a lower premium for younger individuals. Enrollment in B&E plans has been growing from 814 enrolled persons in 2003 to 7,845 in 2005, to 16,251 as of the end of June 2006.[7]

Despite these reforms, New Jersey policymakers and insurers remain concerned that high premiums in the individual and small group market prevent many, especially young adults, from enrolling in health insurance, either because the premiums are too high on an absolute basis, or because the premiums in these markets are so much higher than their expected annual medical costs. Reinsurance may be one tool that government could use to reduce premiums sufficiently to attract and insure more low-risk enrollees, and thereby, to help to stabilize premiums for all enrollees in the market.

Reinsurance Design Choices

Selecting Markets and People to Reinsure

- Decide whether to reinsure small groups (2-50 employees), sole proprietors, and/or individuals (other markets or pools may also be reinsured as needed),
- Decide whether reinsurance will be available for all enrollees in the market or only a subset of enrollees meeting certain qualifications,
- Decide whether any requirements should be imposed on those being reinsured, i.e. minimum employer contribution requirements, minimum participation requirements, and periods of uninsurance before enrolling in a reinsurance program, and
- Decide whether to reinsure all enrollees in the market or allow the insurer to choose enrollees to reinsure.

Structure of Reinsurance

- Decide whether to reinsure based on aggregate insurer losses or excessive claims on an individual, and
- Determine the loss threshold where reinsurance will begin assuming some responsibility for covering claims, the threshold where reinsurance will end and the original insurer will resume full responsibility for claims, and the percentage of claims within the reinsurance corridor that will be covered through the reinsurance mechanism.

Source of Funding

- Decide whether to pay for claims that qualify for reinsurance with state funds or insurance carrier funds, and
- If using insurance carrier funds, decide whether funding will come from all insured or those insured in the reinsured market(s).

Selecting Markets and People to Reinsure

As described earlier, reinsurance is often used to stabilize vulnerable health insurance markets by removing high claims costs. Lower premiums attract more low-cost enrollees to the market, with the potential of stabilizing premiums at a level similar to those charged to large groups. Therefore, states have generally chosen to use reinsurance in their non-group and small group health insurance markets to help stabilize and reduce premiums (Table 2). New Mexico, Arizona, and Connecticut only reinsure small groups and sole proprietors, while Idaho, Massachusetts, and New York reinsure small groups, sole proprietors, and individuals. New Hampshire and Rhode Island have recently created reinsurance pools that apply only to small groups.

States reinsuring workers and their dependents may require that the worker be a permanent full-time employee (Table 2), and there is variability in how states define full-time status. In Connecticut and Massachusetts, reinsured workers must work at least 30 hours per week to qualify. In New Mexico, reinsured workers must work at least 20 hours per week to qualify. New York sets income qualifications on reinsured enrollees. In New York, small groups are eligible for Healthy New York, the reinsurance program, if at least 30% of the employees earn $34,000 or less per year, and sole proprietors and individuals only qualify if they earn less than 250% of the federal poverty level. Rhode Island's proposed reinsurance program would only apply to small businesses with average employee salary falling below a certain level that is not yet defined.

A few states, New York, New Mexico, and Arizona included, created health insurance programs, separate from the private market, where those enrolled in the program are reinsured by the state. States with reinsured health insurance programs may impose minimum participation requirements for small groups to enroll in the program (Table 2). New York and New Mexico require that at least half of eligible employees choose to enroll in coverage. Arizona requires that all employees working 20 or more hours per week in small groups with five or fewer employees enroll in coverage, and 80% of eligible employees in small firms with six or more employees.

States without separate reinsurance programs allow insurers to choose enrollees to reinsure (Table 2). Connecticut, Idaho, and Massachusetts allow insurers 60 days from issuing the policy to choose to reinsure an enrollee. Idaho and Massachusetts allow insurers to reconsider this annually, while Connecticut only allows changes every three years. Insurers can usually choose enrollees to reinsure based on a standardized

underwriting form and not based on claims experience during the initial 60 days. States with separate reinsurance programs reinsure all enrollees in the program.

New Jersey might consider using reinsurance in the small group and individual health insurance markets (including sole proprietors). Applying reinsurance to the existing markets would be less administratively burdensome than creating a separate reinsurance program with its own insurance products. New Jersey does not allow medical underwriting (determining health insurance premiums based on health status or past medical claims) in either the individual or small group market so allowing insurers to choose individual enrollees to reinsure based on health would add an administrative layer that does not currently exist. New Jersey may choose to target reinsurance subsidies to low income enrollees, although targeting reinsurance to low-income populations would be more costly to administer than reinsuring all in the market because income would need to be verified by a centralized authority on a regular basis. Also, limiting the group eligible for reinsurance may limit the effectiveness of the reinsurance program by spreading the burden of high-cost claims across a smaller number of insured. However, targeting subsidies for reinsurance to disadvantaged income groups may be a more efficient use of public funds.

Structure of Reinsurance

The structure of the reinsurance mechanism has a direct effect on cost and the ability to reduce premiums in the targeted market. As described earlier, reinsurance can reduce health insurance premiums by taking some of the financial risk away from the originating insurer. However, the impact on premiums will also depend on other design choices.

The most basic decision to be made when creating a reinsurance mechanism is whether to protect insurers from high aggregate losses across all plan enrollees or to protect them from high losses on individual enrollees. When reinsuring high aggregate losses, a threshold or deductible is set after which the reinsurance covers the claims costs. This threshold can be a total dollar amount or a loss ratio, defined as the ratio of claims paid to premiums collected. Two states, New Mexico and Arizona, currently have aggregate loss reinsurance programs (Table 2). Both reimburse insurers based on a loss ratio threshold. New Mexico reimburses insurers when claims are greater than 75% of premiums, and Arizona reimburses insurers when claims are greater than 86% of

premiums. Aggregate loss reinsurance is most useful when the goal is to attract more competition to the market because it allows newer insurers with fewer enrollees to set competitive premiums. The risk is that insurers may set premiums too low and depend on the reinsurance mechanism to keep them financially viable.

When the IHCP was initially created, a loss assessment mechanism was a major feature of the program. The goals of the loss assessment were to distribute disproportionate risk in the market and to encourage carriers to participate in the individual market by offering a mechanism by which aggregate losses (including medical and administrative expenses) above 75% of premiums would be reimbursed through an assessment paid by other carriers. In the initial years after the market reforms were adopted, some insurers were able to attain a high enrollment because they set premiums lower than expected costs, knowing that other insurers would cover their first dollar losses through the assessment mechanism. While the loss assessment mechanism did attract new insurers to the market, some were never financially viable because they depended on the assessments from larger insurers to cover claims.

The loss assessment mechanism was significantly modified by legislation in 1997. Beginning that year, the mechanism was changed to limit reimbursable losses to those occurring over a 115% loss ratio, excluding non-medical losses, before they would be eligible for any reimbursement. With this change, many of the smaller carriers that were unable to withstand these losses abandoned the market. Experience with the IHCP loss assessment strategy suggests that it is important for originating health insurance carriers to retain a significant financial incentive to control claims.

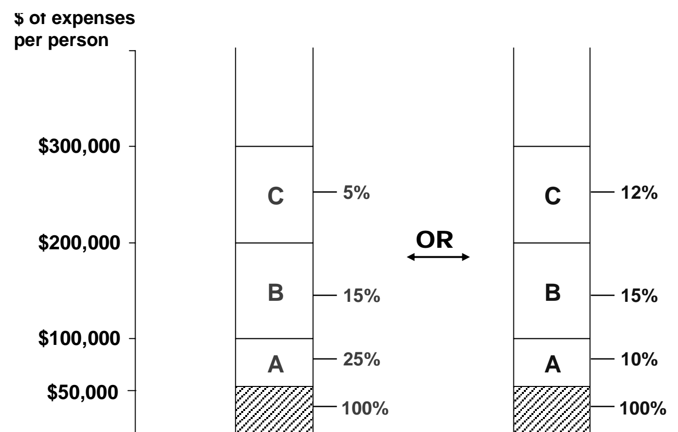
The goals of reinsurance are to improve the functioning of insurance markets by providing equitable risk protection to all insurers and a mechanism for broadly spreading the cost catastrophic and chronic medical services associated with covering high-cost members.

When covering high individual claims the reinsurance structure is set to reinsure a predetermined range in health care claims, at a certain percentage (see Figure 1). The range in health care claims is sometimes referred to as the "*corridor*". The corridor begins at the claim amount at which the reinsurer takes on some responsibility for the enrollee's costs (also known as the *deductible*) and the corridor ends at the claim amount at which the reinsurer ceases to be responsible for any of the enrollee's costs. The reinsurer will also cover a certain percentage of the claims within that corridor so that the originating insurer remains at least somewhat at risk for medical expenses incurred

within that range. The originating insurer maintains some risk for expenses within the corridor to provide incentive to efficiently manage enrollee costs and prevent them from being higher than necessary. Reinsurance mechanisms may have one corridor with one coinsurance rate, or it may have a few corridors with different coinsurance rates.

Selection of the corridor's start and end points and the percentage of risk retained by the originating insurer determine the premium cost savings and the cost of the reinsurance mechanism. The lower the percentage of risk maintained by the originating insurer, the greater the reduction in health insurance premiums for enrollees. Also, reinsurance corridors that begin at a lower claim amount may reduce premiums more than a corridor of the same range that begins at a higher claim amount. This is because a greater number of enrollees will incur lower costs and fewer will incur higher costs. Another factor in the determination of the reinsurance corridor is also guided by the goals of the reinsurance mechanism. Setting a lower reinsurance corridor would result in reinsuring expenses for chronic illness, while setting the reinsurance corridor at a higher level would reinsure expenses incurred from acute, catastrophic events or accidents.

Figure 1: Risk Sharing by Layers of Reinsurance: % of Risk Retained by Insurer



Source: Illustration by Katherine Swartz presented at *Strategies to Strengthen Private Health Insurance Markets: An Expert Panel Dialogue on Reinsurance.*[7]

Most states using reinsurance to stabilize health insurance markets have chosen to reinsure high enrollee claim costs (Table 2). Reinsurance based on the individual rather than on aggregate claims encourages insurers to manage enrollee costs. This

occurs because well-managed costs are likely to remain well below the reinsurance deductible and result in greater profits for the insurer. Connecticut, Idaho, Massachusetts, and New York have reinsurance mechanisms in place to protect against high losses on an individual enrollee. Most of these states set the reinsurance deductible, or point at which reinsurance pays for some or all medical claims incurred, to $5,000, especially those reinsuring the individual market. Idaho and Massachusetts have separate reinsurance programs for their small group and non-group markets and those two states set higher deductibles for their small group market than for the non-group market. New York's reinsurance program applies to individuals, sole proprietors, and small businesses. New York originally set the reinsurance deductible at $30,000 but found that few enrollees incurred such high costs and that lowering the deductible to $5,000 allowed a significant reduction in premiums, while staying on budget. The top of the corridor varies across states. The percent of risk retained by the insurer also varied across states, and ranged between 0% to 10% of claims.

New Jersey maintains individual and small group markets with several insurers selling in each market. Thus, the primary goal of a reinsurance mechanism would not be to attract more insurers to the market, but instead to stabilize premiums and increase enrollment. Reinsuring enrollees who experience high claims would address this need without shifting all of the risk from the originating insurer. New Jersey policymakers would need to decide on the appropriate reinsurance corridor and percent of risk retained by the originating insurer. The option chosen will depend on the funding mechanism and whether the goal is to reinsure high costs related to chronic illness or only acute catastrophic health events.

Source of Funding

Reinsurance pays for high claims costs with financing from a larger pool of people in order to bring premium costs down. The larger the group contributing to funding a reinsurance pool, the more effective reinsurance is in distributing the risk and costs of high medical care, thereby making premiums more affordable. State run health reinsurance programs are generally funded in one of two ways, either by the health insurers through premiums paid per reinsured enrollee or by assessments based on the carrier's share of enrollment in the market, or through state funding.

When health insurers fund the reinsurance mechanism, they pass reinsurance costs on to those they insure through higher premiums. Insurers may fund reinsurance by spreading reinsurance costs across those in the reinsured market or they may spread reinsurance costs across all insured members. For large insurers, the benefit of reinsuring certain enrollees will be negligible because their enrollment base may already be large enough to absorb the risk. Instead, funding for reinsurance may come from an assessment or premium tax on the carrier's entire insured business. When this is the case, the risk and burden of high cost claims is spread broadly across all those who choose to purchase health insurance. Premiums for those in the reinsured markets might decrease slightly, while premiums for those insured in larger markets would likely increase somewhat.

The other option is for the state to finance reinsurance with general funds or other public funding sources. State financing spreads the burden of high health care costs in a vulnerable market across the entire state's population. In this way, the cost per person to reinsure is small and those who have chosen to purchase health insurance are not bearing an additional burden. This option eliminates the risk of high claims from health insurance markets entirely. General fund financing of reinsurance can be an efficient and equitable way to subsidize private health insurance, making it more affordable and reducing the number of uninsured. Moreover, state subsidization of reinsurance provides public financial support for requirements that insurers enroll high-cost cases under state guaranteed issue regulations.

Most states finance reinsurance with funding from insurance carriers (Table 2). In Connecticut, Idaho, and Massachusetts reinsurance is paid for by premiums from insurers and from an assessment on insurers if those premiums do not cover the claims. The premiums are paid by the insurers for each enrollee that they choose to reinsure. The assessment is based on total enrollment in the reinsured market. New Mexico finances the Health Insurance Alliance's reinsurance mechanism through a premium surcharge for those enrolled in the program. If funding from the surcharge does not cover total claims then all insurers in the state are assessed for additional funding. One state, Idaho, uses funds from the state's premium tax if reinsurance premiums do not cover claims in the individual high-risk reinsurance pool.

Currently, two states use state funding to reinsure. New York finances their reinsurance program entirely with state funds. In 2003, the state spent $13 million on *Healthy NY*. Research is not yet available that analyzes the extent to which *Healthy NY*

helps to reduce charity care and medical bankruptcy. However, since many of those enrolled in Healthy NY would have been uninsured, at least some of the reinsurance payments made by the state must be recouped through reductions in charity care payments and bad debt. Arizona has been using state funding to reinsure the Health Care Group for the past three years, $4 million each year. State funding for the program will cease in 2007 and the program will be expected to operate independently.

New Jersey's individual and small group health insurance premiums are high compared to other states.[8] Any reinsurance assessment on insurers that was passed on to enrollees would more broadly spread the burden of paying for high costs cases across all purchasers of coverage in the affected markets, however on *average* premiums would be reduced little. State general funding for reinsurance would more effectively promote affordable coverage. New Jersey has been grappling with severe budget constraints for the past four years so it would be challenging to identify a viable public funding source for such a subsidy. The benefit to using state funds to finance reinsurance is that some risk is taken out of the insurance market so premiums in the market would be significantly lower thereby encouraging greater enrollment of uninsured people. As a result, state funding of reinsurance could help reduce the burden of financing uncompensated care in the state.

Conclusion

Reinsurance is a viable option for stabilizing health insurance markets, especially the individual and small group markets. Six states have implemented reinsurance mechanisms and only one state has been relatively unsuccessful with the approach. Researchers have found that a state's reinsurance design choices have a significant effect on the cost of the reinsurance and the extent to which it can reduce premiums and increase enrollment in the reinsured market.[1,7,9]

New Jersey policymakers have recently considered using reinsurance to help stabilize the state's individual or small group markets, or both. Here, the reinsurance mechanism might be applied directly to the existing market structure or a new program incorporating the reinsurance could be created. Since New Jersey does not allow medical underwriting in either the small or non-group markets, a reinsurance model in those markets should be broadly applied rather than targeted to specific classes of enrollees such as high-risk persons identified through underwriting. While more difficult

to administer than a broad reinsurance strategy, New Jersey might choose to target reinsurance subsidies to groups most likely to be uninsured, such as low-income adults, young adults, or very small groups.

Applying the reinsurance mechanism to individual enrollees experiencing high health care claims would better serve New Jersey's needs than aggregate loss coverage, since the primary goal of implementing a reinsurance mechanism here would be to reduce and stabilize premiums in the affected market rather than attracting new insurance carriers to the market. This approach is also less administratively burdensome because only claims for an individual exceeding the reinsurance threshold would have to be reviewed, rather than an insurer's entire loss experience. The reinsurance corridor should be chosen based on available resources to finance reinsured claims and whether policymakers are more interested in reinsuring high cost chronic illness (a lower corridor) or acute catastrophic events (a higher corridor).

Finally, perhaps the most critical design decision to be made when reinsuring a vulnerable health insurance market is choosing the source of funding to pay reinsured claims. Some states finance reinsurance with assessments or premiums paid by insurers. These costs are ultimately passed on to enrollees through higher health insurance premiums. While this approach can be expected to spread the cost of reinsured cases more widely than markets without reinsurance, the impact of internally financed reinsurance on affordability of coverage would be less than more broadly funded reinsurance. Given the fact that New Jersey currently has among the highest health insurance premiums in the country,[8] policymakers might consider the ramifications of further burdening the insured population with even greater premium increases. Furthermore, insurers currently participating in New Jersey's individual and small group markets are well established, so charging premiums and assessments based on enrollment in the reinsured market may not stabilize premiums because most insurers are already able to adequately spread risk across enrollees.

The broadest external source for a reinsurance mechanism would be state general funds. When state funding is used, the beneficial impact on premiums and enrollment is far greater, as is evidenced by high enrollment in Healthy NY and Arizona's Health Care Group. This occurs because the cost of high-risk cases is removed from the market. State funding for reinsurance can also be easier to administer than implementing a system to collect reinsurance funds from insurers.

New Jersey policymakers, insurers, and other stakeholders continue to explore promising initiatives to help increase the affordability of insurance coverage and stabilize health insurance markets. Reinsurance has the potential to contribute to these goals. Decisions about which markets and which enrollees would be reinsured, the structure of the reinsurance, and financing for reinsured claims will play an important role in determining the success of any state health reinsurance initiative.

Appendix

Table 2: Reinsurance Design Choices of Other States

State	Name of Program (Year Established) / Enrollment	Market(s) and Participation	Funding Source	Structure (Corridor / % of Risk Retained by Insurer)
Arizona	*Health Care Group* (2004) : 20,798 people as of 5/2006 (about 70% were sole proprietors)	• Small groups (2-50) that have not provided insurance within the past 6 months and sole proprietors. • At least 80% of small groups with 6 or more employees working 20+ hours per week must enroll. • For smaller groups 100% of employees working 20+ hours per week must enroll. • Guaranteed issue, unlike the commercial market, premiums are age-rated.	State appropriated $4 million per year for 2004 - 2006 to pay losses and to buy commercial reinsurance for annual claims of $100,000 or more.	Reimburse insurers the amount that total claims exceed 86% of total premiums charged to enrollees.
Connecticut	*Small Employer Health Reinsurance Pool* (1990): 3,116 people as of 10/2004	• Small groups (2-50), sole proprietors. • Permanent employees working 30+ hours/week and/or their dependents. • May reinsure specific enrollees within 60 days of issuing the policy or on each three year anniversary.	Insurers pay premiums per person (as of Oct. 2004 average premiums were $4,500/yr) and assessment based on market share (not more than 1% of small group premium base).	$5,000 and up 0% of claims

State	Name of Program (Year Established) / Enrollment	Market(s) and Participation	Funding Source	Structure (Corridor / % of Risk Retained by Insurer)
Idaho	*Small Employer Health Reinsurance Program* (1994): Enrollment Unknown	• Small groups (2-50). • May reinsure specific enrollees within 60 days of issuing the policy or at renewal.	Insurers pay premiums per person and assessment on all insurers in the market.	• $12,000 - $13,000 (basic plan), $88,000 (standard plan), or $120,000 (catastrophic plan) • 10% of claims
	Individual High-Risk Reinsurance Pool (2001): 1,358 people as of 3/2004	• Standard plans, guaranteed issue, modified community rating based on health. • May reinsure specific enrollees within 60 days of issuing the policy or at renewal.	• Insurers pay premiums per person. • Supplemental funding from a state premium tax.	• $5,000 - $25,000 10% of claims • $25,000 and up 0% of claims
Massachusetts	*Small Employer Health Reinsurance Plan* (1992): 13 people as of 10/2004	• Small groups (2-50), sole proprietors. • Permanent employees working 30+ hours/week and/or their dependents. • May reinsure specific enrollees within 60 days of issuing the policy or at renewal if reinsuring at least 75% of eligible employees in the group. • HMOs may not reinsure enrollees.	Insurers pay premiums per person (in 2004, premiums ranged from $800 to $1,000 per month)	• $5,000 - $50,000 10% of claims • $55,000 and up 0% of claims

State	Name of Program (Year Established) / Enrollment	Market(s) and Participation	Funding Source	Structure (Corridor / % of Risk Retained by Insurer)
Massachusetts (continued)	*Non-Group Health Reinsurance Plan* (2001) : 3 people as of 10/2004	• Guaranteed issue market. • May reinsure specific enrollees within 60 days of issuing the policy or at renewal.	Insurers pay premiums per person (in 2004, premiums ranged from $4,000 to $6,500 per adult member per month $4,500 to $7,800 per child member per month, depending on plan type and coverage) and an assessment of up to 1% of market premiums is possible but has never been used.	• $10,000 - $40,000, 10% of claims • $50,000 and up 0% of claims
New Hampshire	*Small Employer Health Reinsurance Pool* : (legislated in 2005 and implemented in 2006)	• Small groups (2-50). • May reinsure specific enrollees within 60 days of issuing the policy or on each three year anniversary.	Insurers pay premiums per person and possibly an assessment equal to a percentage of premiums for covered lives.	$5,000 and up, 0% of claims

State	Name of Program (Year Established) / Enrollment	Market(s) and Participation	Funding Source	Structure (Corridor / % of Risk Retained by Insurer)
New Mexico	*New Mexico Health Insurance Alliance* (1994) : 4,000 people as of 10/2004 (about 35% were sole proprietors)	• Small groups (2-50), sole proprietors. • Employees working 20+ hours/week and/or their dependents. • At least half of eligible employees in small firms must choose to enroll. • For individuals this is the only guaranteed issue health insurance plan in the state.	Premium surcharge of up to 5% in the first year and up to 10% in renewal years for small groups and up to 10% in the first year and up to 15% in renewal years for individuals (on average 10%) and assessments on all insurance carriers in the state to cover losses which were $4.5 million in 2003.	Reimburse insurers the amount that total claims and reinsurance premiums exceed 75% of total premiums charged to enrollees.
New York	*Healthy NY* (2001) : 106,944 people as of 12/2005 (about 80% were individuals or sole proprietors)	• Small groups (2-50) if at least 30% of employees are middle to low wage workers (defined as $34,000 in 2006) and the employer did not provide coverage in the past year. • Employers must pay half the premium and at least half of eligible employees must participate. • Sole proprietors and individuals accepted if income is at or below 250% FPL and have been uninsured the past year. Guaranteed issue, community rated market.	• State paid about $13 million of claims in 2003. • In 2002, state financed 3.6% of medical claims. Projections showed that by reducing the reinsurance corridor, as they did in 2003, they would have paid about 13.5% of claims in 2002. • Reduction in corridor reduced premiums for enrollees by 17%.	• $5,000 - $75,000 10% of claims • Prior to July 2003: $30,000 - $100,000 10% of claims

State	Name of Program (Year Established) / Enrollment	Market(s) and Participation	Funding Source	Structure (Corridor / % of Risk Retained by Insurer)
Rhode Island	*Small Employer Health Reinsurance Fund* : (legislated in 2006)	Small groups (2-50) if average pay falls below a specified amount still to be determined.	Funding source uncertain.	• Not yet determined. • Dependent on funding available.
Washington	Considered, Rejected : (2005)	Small group (2-50), sole proprietors, individuals.	Insurer assessments up to 12% of covered person premiums.	$25,000 and up, 25% of claims

Sources: Most of the information presented in this table comes from a State Coverage Initiatives Issue Brief authored by Deborah Chollet[9]. Other information was gleaned from *Strategies to Strengthen Private Health Insurance Markets: An Expert Panel Dialogue on Reinsurance* binder materials[7], a paper on *Pooling and Reinsurance in Washington State Health Insurance Markets*[10], a Commonwealth Fund report titled, *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers* by Katherine Swartz[11], information on the recent New Hampshire legislation on the State Coverage Initiatives website[12], and information on the recent Rhode Island legislation in the Kaiser Daily Health Policy Report, July 10, 2006[13].

Note: States in gray do not have reinsurance mechanisms in place. New Hampshire is set to begin its reinsurance program this year. Rhode Island passed legislation for a reinsurance fund in 2006. Washington seriously considered reinsurance but found that the reinsurance mechanism they were considering would not be effective in their markets.

Endnotes

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