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Reinsurance: A National Snapshot

Authors

Marilia Mochel

Heather Isbell

Section 6

Charles Roehrig, Ph.D

Paul Hughes-Cromwick, Ph.D

Contact Information

Project Director: **Dr. Douglas Klayman**

DKlayman@socialdynamicsllc.com

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Prepared for:

U.S. Department of Labor

Office of Disability Employment Policy (ODEP)

200 Constitution Avenue, NW

Washington, DC 20210

Prepared by:

Social Dynamics, LLC

843 Quince Orchard Blvd Suite H

Gaithersburg, MD 20878

Office: 301 990 1105

Fax: 301 990 1270

Issue Statement:

Access to health care is important to all people, including people with disabilities (PWD), who sometimes have greater than average health-care needs. And as with many people, access to health care for people with disabilities is often directly tied to employment status (Livermore, Nowak, & Stapleton, 2001). Rising health-care costs and the high cost of providing health insurance for PWD are believed to be major contributors to the low rate of employment among this population in the United States (Burkhauser, Butler, & Gumus, 2003; Bureau of Labor Statistics, 2009a; Census Bureau, 2009). This is particularly salient relative to small employers and small business owners because historically the inability to spread risk, given their smaller employee base, has contributed to higher premiums in the small-group market (National Coalition on Health Care, 2009). With evidence that PWD are more likely to be employed by small businesses or self-employed (U.S. Department of Labor, 2009), many PWD who need health-care coverage may not have access to employer-sponsored insurance. This environment creates disincentives for PWD to work. However, there are many strategies to contain health-care costs and make health insurance more affordable. One such strategy, public reinsurance, emerged in the 1990s as a viable option to stabilize the insurance market and reduce premiums for small businesses and individuals. This paper examines public reinsurance programs as a way to make health insurance more affordable for small employers and the self-employed and improve access for PWD. It looks at different state programs, analyzing how their various components influence a reinsurance program's impact. It also presents an econometric simulation that assesses the potential of reinsurance programs to reduce the number of uninsured PWD in the labor force. Finally, it offers recommendations for future research related to reinsurance programs as a means to improve health insurance access for persons with disabilities and/or chronic conditions.

1.0 Background:

The 25 million working-age people in the United States with a sensory, physical, mental, or self-care disability (Houtenville, Erickson, & Lee, 2007) are at a considerable disadvantage in the labor market when compared with the working-age population without disabilities. According to the Bureau of Labor Statistics (2009a), working-age PWD have an overall employment rate of 38.5 percent, compared with 83.7 percent for working-age people without disabilities.¹ Approximately 38.8 percent of PWD between the ages of 25 and 34 are employed, compared with 87.6 percent of their counterparts without disabilities, a difference of 48.8 percent (Stoddard, Jans, Ripple, & Kraus, 1998). Disability researchers believe that the low rate of employment among PWD in the United States is due in part to increases in the cost of health care and providing health insurance coverage to PWD, creating disincentives for employers to employ PWD and for qualified PWD to seek employment (Burkhauser et al., 2003; Bureau of Labor Statistics, 2009a; Census Bureau, 2009).

Another important issue regarding access to health care is the lack of affordable health insurance for employed PWD who *do* have access to employer-based health insurance. With average annual premiums of nearly \$12,700 for a family of four and \$4,700 for one, employed PWD, who earn on average two-thirds the income of workers without disabilities, are unlikely to be able to afford employer-based health insurance (National Coalition, 2009). Premiums have been rising steadily above the national rate of inflation. As a result, more employers are dropping coverage and when it is offered, fewer employees are opting for it (Kronick & Gilmer, 1999).

¹ McNeil (2000) reported a disability employment rate of 47.3 percent for the 9.2 million PWD who do not participate in Social Security Disability Insurance or Medicare.

The problem is more severe for employees of small businesses and the self-employed. Whereas 12.7 percent of employees of large businesses are uninsured, 32.2 percent of employees of businesses with less than 25 workers lack coverage (Kaiser Family Foundation, 2008). Small employers are less likely to offer coverage, with the smallest being the least likely (72 percent of those with 10 to 24 employees offer insurance, while only 47 percent of those with three to nine employees do so (National Conference of State Legislatures [NCSL], 2009). The small-employer and private health insurance markets are plagued by high costs and difficulties in obtaining comprehensive coverage and policy underwriting. Individuals with preexisting conditions find it difficult to get coverage in the private market without high price tags and exclusions in coverage (National Coalition on Health Care, 2009). Small businesses often find it unaffordable to obtain coverage because of their inability to spread the risks of even one high-cost employee across a larger group (National Coalition on Health Care, 2009). Furthermore, small employers have been hit with higher premium costs, leading to their higher likelihood to shop for new insurance providers (Kaiser Family Foundation, n.d., as cited by NCSL, 2009). It is estimated that 20 million out of the estimated 45 million Americans without health insurance are employees of businesses with 50 or fewer employees (Wityk, 2009). All these pressures have led small businesses to drop employee health insurance coverage at a fast pace (National Coalition on Health Care, 2009).

This state of affairs complicates the prospect of increasing access to employer-based health insurance, which may be critical to people with certain types of disabilities that necessitate a high level of health care. PWD are more likely to be self-employed or employed by small businesses (Department of Labor, 2009). Low rates of coverage in the small business and individual group markets have the potential to deter individuals with disabilities from full integration into the workforce. The uncertainties of employer-provided health insurance explain in part why PWD relying on public health insurance programs report fear of losing health care coverage as a major obstacle to work (Hanes, 2000; Hill, Livermore & Houtenville, 2003; Krueger, Ellinson & Milfort, 2006; O'Day, Stapleton & Horvath-Rose, 2007). To increase the incentive for PWD to work, employer-provided insurance must be made available and affordable.

In response to the difficulties faced by small businesses in providing health insurance to their employees, some states have created incentives (NCSL, 2009). Many have adopted tax benefits, some have developed special assistance programs that include subsidies, and still others have adopted reinsurance programs (Hsieh, 2009). The latter has the goal of spreading the costs of high-risk individuals across all insurance carriers in the small-group market, thereby reducing the burden of high-risk cases on individual insurers. The experiences some states have had using such programs is the focus of this issue paper.

There is little agreement among policymakers on the most effective strategies to contain health-care premiums. Several strategies, including price controls, health information technology, wellness programs, and free market competition, have been discussed as potential cost-saving measures. Although there is no single answer to the rising cost of health insurance in the United States, the longtime practice of reinsurance, when applied to health-care financing, has led to reductions in premiums in the small-group and individual market in some states. Therefore, reinsurance is one cost-control² measure that may help improve access to health insurance for high-risk individuals. Insurance companies look to reinsurance as a means of managing risk by spreading the burden of high-cost claims

² It is important to emphasize that whereas reinsurance may help reduce premium costs for small employers and individuals, it does not address the issue of skyrocketing premium increases. (Hailsmaier, 2007)

across participating carriers. Put more simply, reinsurance provides a safety net for health insurance carriers because high-cost claims are shared by all carriers in some programs or by government subsidies in others. In essence, it provides insurance for insurance companies, as it pays for losses of high-cost cases (Bovbjerg, Garret, Clemans-Cope, & Masi, 2008).

In the last two decades, some states have taken steps to stabilize health insurance in the small-group and private markets using reinsurance, resulting in substantial reductions in premiums in some cases. Other states have been evaluating the potential impact of implementing their own reinsurance programs. Reinsurance programs on their own do not guarantee access to insurance to people with disabilities and/or chronic conditions, as most states have had to add a guaranteed-issue provision in their programs. Still, by spreading the risk of high-cost cases across all carriers, early reinsurance programs make insurance companies more willing to accept guaranteed-issue legislation in the small-group market.

This issue paper explores state experiences with health care reinsurance programs. As a snapshot of reinsurance programs across the country, it focuses on several aspects of these policy initiatives. First, in Section 2, it describes how reinsurance programs work and how they affect the enrollment of high-cost individuals, including those who may have disabilities and chronic conditions. Section 3 then presents several examples of subsidized and nonsubsidized reinsurance initiatives. Section 4 looks at federal and state regulations that bear directly on the creation and operation of state reinsurance programs. Section 5 discusses several aspects of the design of reinsurance programs that lawmakers should take into account when considering their implementation. Section 6 presents an econometric simulation of the impact of reinsurance programs on uninsured PWD in the workforce. This analysis seeks to determine how the premium reductions that emerge from reinsurance subsidies would affect those individuals with disabilities in the workforce who do not have health insurance. Finally, Section 7 re-summarizes the issue paper and presents a series of recommendations for future research on reinsurance initiatives.

2.0 State Reinsurance Programs

There are two general types of reinsurance programs: (1) government-administered/commercially financed programs, which are financed completely with private funds; and (2) government-administered/publicly subsidized programs, which at least in part receive public funding. The type of program a state chooses predominantly depends on the goals that the state has for its reinsurance program, such as increased competition in the small-employer and individual markets, stabilization of these markets, or reduction of premiums.

Although some reinsurance programs operate without government funding, recent research indicates that programs that include government subsidies are more likely to result in lower premiums and, as a result, higher enrollment (Bovbjerg et al., 2008). Subsidized programs seem to be more effective because of the diminished risk to insurers of individuals with very high expenses, who may include people with chronic diseases and certain types of disabilities. In the subsidized programs, state governments reimburse health insurance companies when medical expenses for an individual or a small group reach a certain threshold. In doing so, they reduce the premium costs of the policies sold under these programs.

In nonsubsidized programs, risks are spread across all carriers in the market, which benefits small carriers since they do not have to bear all the costs for high-risk individuals on their own. Still, all

the funding for the high-cost claims comes from reinsurance premiums and assessments on carriers, reducing the potential impact in premium reductions for members.

Regarding the decision as to which individuals will be reinsured, reinsurance programs can be separated into two groups. In one, carriers must offer coverage to all small groups who request it. They must then decide on whether to place an individual or the entire group into the reinsurance pool, through which their expenses will be reimbursed in the cost corridor established by law. This is considered ceding the risk. If insurers choose to cede an individual or group to the pool, they must pay a reinsurance premium. Additionally, carriers may have to pay an assessment to cover any claims that cannot be paid for by the contributed reinsurance premiums. All carriers in the state small-group and/or individual markets must pay the assessment, regardless of whether they have ceded any lives to the pool. This practice benefits small carriers, as it leads large carriers to contribute to the costs of high-cost cases that small companies have, reducing barriers of entry into these markets and promoting competition. The other type of program places all policyholders into the reinsurance pool upon enrollment in any of the plans sponsored under the state reinsurance program. This type of program is usually subsidized, universally reinsuring everyone enrolled.

Because health insurance companies are subject to reinsurance premiums and assessments, which translate into higher premiums (Wikler & Fish-Parcham, 2008), government-administered/commercially financed models do very little to offset the rising cost of health insurance. Although nonsubsidized programs were created to spread risk and reduce risk aversion on the part of carriers that had to face guaranteed-issue legislation, a few states have implemented reinsurance programs with more ambitious goals, attempting to reduce premium costs for small employers and individuals by using government subsidies. In the case of subsidized programs, public funds are used to reimburse insurers for high-cost cases. The structure and viability of reinsurance programs vary by state. Six states have established reinsurance programs (Arizona, Connecticut, Idaho, Massachusetts, New Mexico, and New York) and another three are still in the planning stage (Washington, New Hampshire, and Rhode Island) (Belloff, Cantor, Koller, & Monheit, 2007). State reinsurance programs tend to reflect each state's goal(s) of reducing premiums in certain markets and/or increasing access to coverage by spreading the risk of high-cost cases among health insurance carriers or through subsidized programs to taxpayers (Wikler & Fish-Parcham, 2008).

Reinsurance and Market Competition

Evidence exists that large health insurance companies may be more adept at participating in risk assessment than smaller health insurance companies. The logic underlying reinsurance (risk sharing) is that it may create a more favorable environment for small health insurance carriers and thus a more equitable market. Smaller insurance companies have long bought reinsurance through private insurance companies to cover catastrophic claims and to remain competitive in an increasingly concentrated market. Economic theory suggests that the effect of high market concentration and low market competition is price escalation. To mitigate the impact of market share concentration, public reinsurance programs allow smaller carriers to offset in part the costs of insuring who have higher-than-average health care costs by purchasing protection against catastrophic claims in the form of reinsurance. Public reinsurance spreads the costs of such protection across carriers and, in the case of subsidized programs, to the wider public.

The next section discusses the main features of several state reinsurance programs. The reinsurance programs are separated into two types: subsidized and nonsubsidized.

3.0 Examples of Reinsurance Programs:

3.1 Government-Regulated/Subsidized Reinsurance Programs

3.1.1 The Healthy New York Program

New York's Healthy New York program, one of two reinsurance programs in the state, uses an excess-of-loss retrospective model. All individuals who get their insurance through Healthy New York are automatically reinsured for their high-cost medical expenses. When expenditures exceed a limit, the program reimburses carriers for the costs above the established threshold (Families USA, 2006). The primary insurer pays 100 percent of claims up to \$5,000. Above that level, the insurer and the program share the costs; within the cost corridor of \$5,000 to \$75,000, the reinsurance program pays 90 percent and the primary insurer pays 10 percent. Upon exceeding \$75,000 in covered costs, the primary insurer assumes full responsibility for the claims once again. Healthy New York provides health insurance coverage to uninsured employees of small businesses with fewer than 50 employees, the self-employed, and low-wage workers (Wikler & Fish-Parcham, 2008). All health maintenance organizations (HMOs) in the state are required to offer policies through the program to cover those markets.

Healthy New York contracts with HMOs to offer a standard benefits package that includes coverage of the following health care services: diagnostic screening; treatment services; postoperation home health care for up to 40 visits; 30 postoperative visits for inpatient hospital services; outpatient surgical facility charges; preadmission testing; maternity care; adult preventive services; preventive and primary care for dependents; diagnostic x-ray and laboratory services; emergency services; radiology, chemotherapy, and hemodialysis services; and an optional drug benefit. These benefits generally meet the needs of relatively healthy individuals, but they fall short for those who have higher health care needs, such as those with chronic illnesses (Wikler & Fish-Parcham, 2008). Services not covered include mental health, alcohol or other drug abuse treatment, chiropractic care, hospice care, ambulance, dental, vision, and durable medical equipment. Premiums are based on county of residence and family composition, and funding is generated by an assessment on participating health insurance providers, a state government subsidy, and a tax on tobacco products (Wikler & Fish-Parcham, 2008).

Healthy New York is considered a successful venture in government-subsidized reinsurance (Belloff et al., 2007; Swartz, 2005; Wikler & Fish-Parcham, 2008) as premiums decreased by 17 percent when the attachment point³ was lowered from \$30,000 to \$5,000 (Wikler & Fish-Parcham, 2008). The program has increased coverage access for the uninsured both in the small employer and individual markets due to its reduced premiums, with an average of 150,000 lives insured annually.

3.1.2 New York's Direct Payment Stop-Loss Relief Program

New York's Direct Payment Stop-loss Relief Program is designed to reduce premiums and stabilize the state's private (individual) insurance market (Wikler & Fish-Parcham, 2008). This program offers comprehensive coverage to any individual regardless of income. Through a law passed in 1995 (Law SS 4321 4322, popularly referred to as the Point-of-Service Law), all New York-based HMOs are required to offer two standard health insurance packages: one that offers out-of-network options and one that cannot base underwriting decisions on preexisting conditions (Wikler & Fish-Parcham, 2008). Reinsurance on direct payment stop-loss claims comes from a designated fund from tobacco settlements and taxes, proceeds from the conversion of nonprofit health organizations into for-profit

³ The attachment point is a term used in reinsurance programs to describe the set point in costs at which a reinsurance program will begin to pay any or all of the claims made by an individual or group.

ones, an annual assessment on health insurance companies in the state, and hospital and laboratory surcharges (Wikler & Fish-Parcham, 2008). However, because public funding for the program have been frozen at 2003 levels, its ability to pay claims has been significantly reduced, with only about 40 percent of claims between \$20,000 and \$100,000 being paid as of 2006 (Wikler & Fish-Parcham, 2008). As a result, the program's premium reduction effects have been greatly hindered.

Healthy New York and Direct Pay Compared

Healthy New York and the Direct Payment Stop-Loss Relief Program (Direct Pay) differ in critical ways. Direct Pay offers more comprehensive coverage. As a result, an individual with high health care needs would prefer to enroll in one of its plans. This creates a risk selection problem, as less healthy individuals flock to this program and drive up costs, while healthier people drop coverage due to the higher premiums. The average "standard" Healthy New York premium (drug coverage, no deductible) is approximately 70 percent lower than the average Direct Pay premium and roughly 40 percent less than the average small-group premium (L. Basini, personal communication, May 22, 2009). The underfunding of the Direct Pay reinsurance program directly affects people with high health care needs, such as people with chronic illnesses or certain types of disabilities, as they have to bear high premium costs for comprehensive health insurance coverage. Finally, unlike Healthy New York, Direct Pay does not have any income eligibility requirements. To enroll in Direct Pay, an individual must not have been able to purchase insurance in the private market and not be eligible for employer-based insurance.

3.1.3 Idaho Individual High Risk Reinsurance Pool

The Idaho Individual High Risk Reinsurance Pool (HRP) legislation passed in January 2001 with the goal of making health insurance coverage more accessible to the high-risk uninsured and those who are close to reaching the lifetime expense limit of their health coverage (Idaho Department of Insurance, 2008). The Idaho HRP is a mandatory excess-of-loss program for all carriers in the individual market in the state. It is funded through premiums paid by insurance carriers combined with some revenues from a premium tax. A governing board reviews the surveys of comparable plans and sets the rates at no more than 150 percent above the rates in the healthy market (Idaho Department of Insurance, 2008).

All insurance carriers use the same premium rate for the different coverage options (B. Deal, personal communication, May 11, 2009). All health insurance companies in the state must offer five standard health plans and enroll individuals without regard to their current health status. The primary carrier pays 100 percent of claims up to \$5,000 annually and 10 percent of claims between \$5,001 and \$25,000. It has a zero percent liability for claims of \$25,000 and above. Primary insurers use a community rating scale based on an individual's gender, age, and smoking status. Primary insurers have 60 days to cede the risk of an individual to the high-risk reinsurance pool (Belloff et al., 2007). In practice, when an individual applies for a policy in the private market, the insurance carrier has to offer him coverage. If the person is deemed to be a high-cost risk, he is offered the same coverage he applied for, but under the HRP program rates, with reinsurance reimbursements for the carriers once the thresholds are reached (B. Deal, personal communication, May 11, 2009).

The Idaho HRP has a steady enrollment number of approximately 1,400 to 1,500 each year. State officials and insurance companies are very pleased with its performance, as it sets a reasonable standard of expanding access to affordable health coverage to a small targeted population. In addition, although the plan design allows for an assessment on carriers if the public funds are not enough to cover reimbursement costs, since its implementation, there has never been a need to exercise this option (B. Deal, personal communication, May 11, 2009).

Challenges in the Small Group Market

Idaho has another reinsurance program, the Small Employer Health Reinsurance Program. This initiative combines a reinsurance component with a program to encourage small employers to offer health insurance. Its reinsurance bands are different from those of the HRP, and it does not receive state subsidies. Although designed to stabilize costs in the small-group market, the Small Employer Health Reinsurance program does not produce a substantial reduction of premium rates. The results of this program have been less impressive than those of the HRP, with only 102 individuals currently insured (see Table 2). Part of the reason for this low performance is related to the substantial burden health insurance poses to small businesses. Even cheaper insurance may be out of reach to small employers.

3.2 Nonsubsidized Reinsurance Programs

3.2.1 Connecticut's Small Employer Health Reinsurance Program

Connecticut's Small Employer Health Reinsurance Program was the first of its kind when created in 1990 (Wikler & Fish-Parcham, 2008). The program receives no government funds, and participation is mandatory for the state's health insurance companies. The program is designed to spread the cost of catastrophic claims across all health insurance carriers in the state. Each insurer has 60 days from enrolling an individual or small group to decide whether to cede the individual or small group to the risk pool. If the insurer decides to cede the risk, it must pay a premium to the risk pool for that individual or small group. The program does not allow insurers to charge small employers higher premiums (Wikler & Fish-Parcham, 2008) and uses the reinsurance pool to spread the costs among all insurers, increasing market competition and ensuring survival of smaller insurance companies when faced with catastrophic illness claims by an individual or group.

Connecticut has served approximately 2,000 small business employees and their dependents each year through this program. The state serves in an administrative capacity, but a third-party administrator manages the pool. Requirements for participation include being an employee of a small business or sole proprietor and working 30 or more hours a week. Once an insurer decides to cede the risk of an individual, the carrier pays a reinsurance premium and up to \$5,000 of the individual's claims. Above \$5,000, the reinsurance pool picks up 100 percent of the medical costs for that member (Belloff et al., 2007). Because reimbursement claims to the pool cannot be fully paid from the reinsurance premiums, carriers in the state must pay an assessment to cover the reimbursement losses. Fifty percent of the costs for the program are paid with funds from these assessments (K. Ideman, personal communication, May 20, 2009).

3.2.2 Arizona Health Care Group

The Arizona Health Care Group (HCG) was created in 1985 by the Health Care Cost Containment System, a division of Arizona's Medicaid program. It was designed to provide guaranteed coverage to self-employed individuals and employees of small businesses. This program's reinsurance component was introduced in 2001. The Arizona HCG is "guaranteed issue" (i.e., individuals cannot be denied coverage for any reason). Enrollment is voluntary, with an aggregate stop-loss component; reinsurance kicks in after a threshold⁴ has been reached and covers the remaining costs (Families USA, 2006). Until

⁴ A threshold is an agreed-upon point, like an attachment point, at which a plan's reinsurance will begin to pay all or some of the claims costs. A threshold is associated with aggregate stop-loss programs rather than excess-of-loss programs. However, some literature considers the two terms interchangeable.

2007, premiums varied based on age, gender, and geographical region in the state. The program did not consider health status to determine premiums, which in practice meant lower costs for individuals with chronic illnesses or preexisting conditions. By subsidizing individuals and protecting insurers from risks of above-average expenditures, HCG had achieved its goals of providing coverage to small employers and sole proprietors while also reducing premiums (Swartz, 2005).

Until 2006, Arizona operated a hybrid reinsurance program, using state funds for claims between \$75,000 and \$100,000 and premiums paid by participating insurers for costs above the maximum. In addition, the program provided aggregate stop-loss coverage for claims exceeding 86 percent of the health plan contractors' total capitated premium paid by HCG (Wikler & Fish-Parcham, 2008). Arizona appropriated \$8 million per year to HCG until 2004, at which time, through "aggressive medical management" (Arizona Health Care Group, n.d., as cited in Swartz, 2005, p. 8), this was decreased to \$4 million without a reduction in benefits or efficiency. In 2006, the state attempted to stop paying subsidies for the reinsurance program, but high medical costs and expenditures prevented the passage of such legislation (Wikler & Fish-Parcham, 2008).

Ending HCG's State Subsidies

In 2007, HCG suffered heavy losses. As a result of a systemwide audit, the state legislature stopped its subsidies. In addition, legislative changes allowed carriers to include health status and group size as variables when determining premiums. Changes also included new fine-tuned incentives for insurers to contain costs and the suspension in enrollment of groups of one (those already enrolled were able to keep their membership). As a result, HCG's premiums increased by double digits, hitting groups of one particularly hard. Higher premiums and the more stringent eligibility requirements led to a drop in enrollment from approximately 27,000 members in the beginning of 2008 to roughly 15,000 in May 2009 (M. Steigerwald, personal communication, June 09, 2009).

3.2.3 New Mexico Health Insurance Alliance

The New Mexico Health Insurance Alliance (NMHIA), created in 1994, was designed to increase access to health insurance for small businesses and the self-employed, who constitute a significant part of New Mexico's economy. NMHIA receives no state government funding. Participation by local health insurers is voluntary, except that all health insurance carriers that do business with state institutions must offer plans under NMHIA (M. Onstott, personal communication, June 3, 2009). Participating plans must agree to offer the full range of health plans to all participating businesses (NMHIA, 2009). NMHIA is offered with no medical screening or underwriting, has no employer contribution requirements, and uses a guaranteed-issue clause, wherein individuals cannot be rejected or rated up for health or occupation. It comes with continuous coverage and includes prescription drugs, hospital services, physician and outpatient services, mental health services, and preventive and wellness care (NMHIA, 2009).

NMHIA is funded through a premium surcharge of up to 5 percent for the first year and 10 percent in subsequent years for small groups and 15 percent for renewal of individuals (Belloff et al., 2007). If the program suffers a loss, assessments on all participating insurance carriers cover those losses. The program reimburses insurers the amount of total claims that exceed 75 percent of the premiums they collect from individual policyholders. The premiums charged to an individual are based on the average premium rate of comparable packages offered by other carriers in the small-group market as dictated by New Mexico law (New Mexico Law 59A-23E-12). Therefore, NMHIA premiums are competitive but not substantially lower than those of competitors in the small-group market.

4.0 Regulatory Framework for Reinsurance Programs

This section looks into existing federal and state regulations that directly impact the creation and operation of state reinsurance programs. It presents the federal legislation governing health insurance plans that applies to the coverage offered under the state programs discussed. However, federal regulation of health insurance is not very comprehensive. States have retained much power in regulating the insurance business. Thus, this section also explores aspects of state legislation that regulate reinsurance programs. In the 1990s, many states passed legislation to regulate the small-group market. In particular, this section addresses two types of state regulation that directly relate to reinsurance, guaranteed-issue laws and mandated benefits.

4.1 Federal Regulation

In 1974, Congress passed the Employee Retirement and Income Security Act (ERISA). ERISA was enacted to address the solvency of employee pension plans, which until then had been regulated at the state level. Although ERISA is very detailed in its regulation of pension plans, it is very limited in the standards it sets for self-funded health insurance plans, both when compared with state-regulated health insurance plans and federal standards for Medicaid and Medicare contractors (Mariner, 2006). For instance, ERISA does not prescribe any substantive standards for health plans. It requires only that the plan provide employees with a brief summary of the plan's main terms, invest its funds prudently, and report to the Department of Labor. It does not require plans to offer any specific benefits or any standards usually present in health insurance regulation (Mariner, 2006). Whereas at the time of ERISA's passage only a small percentage of health coverage was provided through self-funded plans, the number of employees covered by ERISA plans climbed steadily to reach 132.8 million in 2006 (Pierron & Fronstin, 2008). ERISA prevents these plans from being regulated by state governments.

Since the passage of ERISA, federal legislation on health insurance has been expanded. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted to regulate the continuation of health coverage at group rates for certain individuals when their health care coverage is lost due to specific qualifying events, such as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life changes. COBRA applies to group health plans sponsored by employers with 20 or more employees⁵ (Department of Labor, 2009). It gives workers and their families who lose health benefits the right to choose to continue the coverage provided by their group health plan for limited periods of time. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan. In practice, this translates into a substantial increase in health care costs for individuals, as they have to make up the share previously paid for by the employer contribution. While COBRA coverage is substantially more expensive to individuals than when sponsored by one's employer, the premium rate charged under COBRA is the same as the group rate, which is still generally lower than the cost of comparable coverage in the individual market, with an additional 2 percent for administrative costs. Due to its costs, it has been estimated that only one in 10 qualifying persons takes advantage of COBRA continuation coverage. COBRA take-up among eligible workers is even lower among low-income individuals (Doty, Rustgi, Schoen, & Collins, 2009). Furthermore, by law, individuals with disabilities can be charged up to 150 percent of the group premiums under COBRA.

In 1996, Congress once again moved to assert its regulatory power in health insurance matters with the Health Insurance Portability and Accountability Act (HIPAA). HIPAA amended ERISA to provide

⁵ 40 states have their own legislation to extend the COBRA coverage period to small businesses (State Health Facts, 2009)

new rights and protections for participants and beneficiaries in group health plans. HIPAA set a federal floor of consumer protections for all private health insurance, with exceptions for state and local government employers (Kofman & Pollitz, 2006). HIPAA includes protections for coverage under group health plans that (1) limit exclusions for preexisting conditions, (2) prohibit discrimination against employees and dependents based on their health status, and (3) allow a special opportunity to enroll in a new plan to individuals in certain circumstances. All plans that offer creditable coverage must issue certificates to guarantee HIPAA benefits. The certificates are used to guarantee coverage without exclusion for preexisting conditions when the individual changes his or her health coverage. The standard method of crediting coverage under HIPAA counts health insurance coverage occurring without a break of 63 days or more. HIPAA applies to group health plans, including self-funded plans (Kofman & Pollitz, 2006)

ERISA, COBRA, and HIPAA constitute the bulk of the federal regulatory framework on health insurance currently in place. Additionally, the federal government has special regulations for the health insurance coverage of federal government employee health care plans and standards for Medicaid and Medicare coverage. States are free to regulate health insurance matters that are not covered by federal law and to expand the benefits and protections in areas that are. In other words, whereas both COBRA and HIPAA offer a floor of protections and benefits regarding health care, states may choose to raise the level of mandated benefits offered (Kofman & Pollitz, 2006).

Although ERISA does not apply to the state reinsurance programs, as they are not available to self-insured businesses, all reinsurance programs are required to comply with federal regulation regarding extension of coverage under COBRA and HIPAA guarantees. Still, it is important to bear in mind that some of the reinsurance programs started before the passage of these pieces of legislation, and in certain cases reflected state attempts to address the problems arising from the absence of protections in the small-group market.

4.2 State Regulation

State laws that regulate health insurance plans are usually aimed at different health insurance markets. There are three distinct markets in health insurance: the large-group market, the small-group market, and the individual market (Fernandez & Hearne, 2008). In general, more regulatory zeal focuses on the large-group market. Table 1 displays how the regulatory framework applies to these separate markets.

Table 1. Health Insurance Markets and Regulation

“Market” for Insurance	Characteristics of Health Insurance	Regulation
Individual	<ul style="list-style-type: none"> - Purchased by individuals separate from employer group. - Almost 7 million people. 	<ul style="list-style-type: none"> - Some benefit mandates apply; 17 states with rate regulation.
Small group	<ul style="list-style-type: none"> - Sponsored by small employers—most state regulation applies to firms with 50 or fewer employees. - About 21 million privately insured people in plans 	<ul style="list-style-type: none"> - More than 1,900 benefit mandates; 47 states with rate regulation.

	sponsored by firms with 50 or fewer employees.	
Large group	<ul style="list-style-type: none"> - Sponsored by larger employers—can be traditional insurance or employers can self-fund plans. Many employers offer choice of plans. - Around 83 million people in plans sponsored by firms with more than 50 employees. 	<ul style="list-style-type: none"> - When health plans are self-funded, state laws are preempted from applying. When health plans include traditional insurance products, those products would be subject to all state laws that apply to the business of insurance.

Source: Fernandez & Hearne, 2008.

Due to the employer tax exclusion, the largest market in health insurance for the nonelderly is the large-group market, which is offered to eligible employees and their families by employers with more than 50 employees. The smallest market is the individual private market, where individuals purchase their coverage directly from insurance carriers. The individual market is also the one with the least protective regulations in place. The lesser protections in these two markets can make individuals with disabilities and chronic conditions particularly vulnerable, as they may be more likely to be denied coverage on the basis of risk assessments and preexisting conditions. The share of uninsured individuals is much higher for those working in small and very small businesses than for those employed by larger firms. While the national uninsured rate was 18.2 percent in 2007, among employees of small firms (less than 25 employees), it was 32.2 percent. The share of uninsured individuals who are self-employed was also higher, at 26.6 percent (Kaiser Family Foundation, 2008).

Although states use their regulatory power to address several aspects of health insurance, we focus here on two types of regulations that directly affect access to health care in the reinsurance programs analyzed, namely, state law on guaranteed issue for the small and individual markets and mandated benefits.

4.2.1 Guaranteed Issue

In the early 1990s, many states passed guaranteed-issue and community rating reforms in the small-group market (Wachenheim & Leida, 2007). Guaranteed issue mandates that insurers accept any small employer who applies for coverage, regardless of the group's claim history or health status. States passed guaranteed-issue legislation because the unregulated small business market had prevented many small businesses from accessing coverage for their employees. For instance, one high-cost employee could lead insurance companies to turn down the entire small group. The costs at which policies were offered were prohibitive, discouraging healthy employees from choosing the coverage, which in turn further inflated premiums.

Early reinsurance programs were adopted as part of comprehensive policy to address the deficiencies of the small-business market. States hoped reinsurance programs would spread the risk of high-cost cases across insurers, promote more equitable premium rates across small groups, and keep insurers operating in the small-group market. The early programs were targeted to make these goals compatible, as guaranteed issue was being implemented in the small-group market in these states (D.

Skye, personal communication, May 18, 2009). These measures were supplanted in part in 1996 with the passage of HIPAA, which established guaranteed issue in the small-group market (for employers with at least 20 employees). Still, until that time, guaranteed issue was being decided at the state level in the same way that today some states have guaranteed-issue provisions for the individual market while other states do not.

4.2.2 Mandated Benefits

States also have regulations that establish mandated benefits, which all carriers in the state must offer as part of their plan coverage options. A mandated benefit is a law that requires a health insurance policy or health plan to cover (or offer to cover) specific providers, procedures, benefits, or people (Craig Bunce, Wieske, & Prikazsky, 2006). In 2006, the Council for Affordable Health Insurance estimated that there were 1,843 health insurance mandates across the United States. States vary substantially in the number of mandates they require. Insurance groups claim that mandates are responsible for a substantial part of premium increases (Craig Bunce & Wieske, 2008). However, empirical research on the direct impact of mandated benefits on premiums has been less conclusive (Monheit & Rizzo, 2007). The impact on premium costs of mandates depends on several factors, including how highly consumers value the benefit, how common the benefit is in current insurance policies, and whether the firms primarily affected are large or small (according to the Congressional Budget Office cited by CA Roundtable(Cubanski & Schauffler, 2002).

State reinsurance programs deal differently with mandated benefits legislation. Subsidized reinsurance programs that aggressively target premium reduction and depend on public revenues usually have plans that comply with fewer state-mandated benefits. Because the reinsurance programs are passed by state legislatures that have power over mandated benefits, reinsurance programs can be excluded from compliance with state regulations. As a result, some mandated benefits may not be part of the policies offered under such programs. On the other hand, when substantial premium reduction is not the primary concern, the plans offered can be very generous, albeit at a substantially higher cost. Reinsurance programs that require individual risk assessment by carriers (usually the nonsubsidized type) offer policies under the reinsurance program that are indistinguishable from coverage that is not reinsured in the same market, except evidently for its price. That is, they comply with all applicable state-mandated benefit laws.

5.0 Important Components of Reinsurance Programs

This section discusses several aspects of the design of reinsurance programs that lawmakers should take into account when considering their implementation. These include the target population of the program, how to address the regulatory environment of health insurance in each state, the use of public subsidies, and measures to impose cost control. Table 2 summarizes the most important features of the state reinsurance programs studied in this report.

Table 2. Public Reinsurance Programs in the United States

		Funding	Reinsurance Bands	Benefits/Coverage	Eligibility	Enrollees (2009)
Connecticut	Small Employer Health Reinsurance Program	Reinsurance premiums + assessment on carriers	\$5,000 and up, 0% of claims	Comprehensive coverage that complies with state mandates	Small groups (2–50), sole proprietors; permanent employees working 30+ hours/week and/or their dependents	1,836
Idaho	Small Employer Health Reinsurance Program	Reinsurance premiums + assessment on carriers	\$12,000–\$13,000 (basic plan), \$88,000 (standard plan), or \$120,000 (catastrophic plan), 10% of claims	Comprehensive coverage that complies with state mandates	Small groups (2–50)	102
	Individual High Risk Reinsurance Pool	Reinsurance premiums + assessment on carriers + share of state premium tax	\$5,000–\$25,000, 10% of claims; \$25,000 and up, 0% of claims	Comprehensive coverage that complies with state mandates	Individuals, guaranteed issue, modified community rating based on age, sex, and smoking status	1,387
New Mexico	New Mexico Health Insurance Alliance	Reinsurance premiums + assessment on carriers ^a	Reinsurance covers expenses once they reach 75% of premium in a year	Comprehensive coverage that complies with state mandates	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. Premiums vary by age, gender, and family composition.	4,673
New York	Healthy New York	\$149 million in state funds	\$5,000–\$75,000	HMO coverage that does not offer all the state mandated benefits. Excludes mental health coverage among other services.	270% of the federal poverty level for individuals and sole proprietors. Guaranteed issue, community rated market.	155,000
	Direct Payment Stop-Loss Relief Program	\$40 million in state funds for past several years	\$5,000–\$75,000	Comprehensive coverage (premiums are 70% higher than Healthy New York)	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.	36,057
Arizona	Health Care Group	After 2005, the legislature abolished the subsidies. Fully funded through premiums.	Above \$125,000/member year is paid for by private reinsurance company	Coverage does not include mental health benefits. Focus on preventive care by not charging deductibles for primary care physician visits. Coverage less comprehensive than the commercial market.	Small groups (2–50) that have not provided insurance within the past six months. At least 80% of small groups with six or more employees working 20+ hours/week must enroll. For smaller groups, 100% of employees working 20+ hours/week must enroll. Premiums are based on age, group size, sex, geographic location, and health status. No longer enrolling self-proprietors.	14,770

Sources: Adapted in part from Belloff et al. 2007, pp. 15–19. 2009 Enrollment data were graciously provided by state program managers.

^a Insurance companies get a premium tax break equal to 50% of what they are charged in assessments for NMHIA.

5.1 Target Population

Reinsurance programs were enacted to stabilize and increase access to health insurance in two main markets: the individual and small-employer markets. These two groups constitute a significant share of the insurance business. But, they also have the highest levels of workers without health insurance. Whereas 18.2 percent of the total workforce lacks insurance, the rate rises to 26.9 percent among self-employed individuals and 32.2 percent for employees of companies with less than 25 employees (Kaiser Family Foundation, 2008). Policymakers considering reinsurance options must address what target population is expected to benefit from the program: the self-employed and uninsured, small business employees, or both. In addition, the program must establish eligibility criteria within the target groups.

Among the top concerns of policymakers when designing eligibility criteria for reinsurance programs is the establishment of provisions to prevent individuals and small businesses currently insured from dropping their coverage in order to procure cheaper coverage through a public reinsurance plan. To avoid the criticism from insurers and free-market proponents that the public reinsurance program will crowd out the private market, plans usually have rules that small businesses must not have offered coverage to their employers for a given period of time in order to be eligible. In the individual market, some programs require individuals to have been denied coverage in the private market to qualify.

Eligibility rules sometimes include income criteria for individuals and employees of small businesses that qualify. These provisions are meant to ensure limited public funds assist those who need the most and have the least capacity to afford coverage.

Finally, programs may adopt policies on the percentage take-up by eligible employees and on the percentage of the premiums that small businesses must contribute in order to curb adverse risk selection. In other words, such provisions attempt to increase participation by healthy employees so as to prevent the concentration of only costly cases in the program. These provisions, however, make determining eligibility rules more difficult. Policymakers must keep in mind that many employees may choose not to take up coverage for several reasons, including their eligibility for coverage through a spouse's plan. The second provision, regarding employer premium contributions, speaks to preserving the role employers have played in health insurance coverage in the United States in the last decades, while making premiums more affordable to employees.

5.2 Regulatory Environment

The first issue that must be considered in the regulatory design of a reinsurance program is which carriers will participate and whether their participation should be voluntary. Mandatory participation is seen as a way to ensure that companies that would otherwise choose not to participate do not have an undue advantage. Larger insurance companies usually are able to spread the risk of high-cost cases across their multitude of members. As a result, if they choose not to contribute to the reinsurance pool (which at the very least would include assessments on all carriers), they would receive an unfair advantage. Insurer participation mandates, however, do not mean that carriers must place any members in the reinsurance pool. They may choose not to cede anyone; however, they will still be

asked to pay the assessment to make up the difference in reimbursement costs and the reinsurance premiums.⁶

A second regulatory issue to address in designing a plan relates to what type of compliance with state regulations lawmakers envision. Although insurance plans must comply with federal regulations regarding the coverage and market they provide, there is considerable room for exceptions regarding state regulations, as it is up to state lawmakers to pass legislation that sets the plan's characteristics. Nonsubsidized plans usually solve this question by offering the same policies to individuals and groups who are ceded to the pool as those who are not in the reinsurance pool. Such policies comply with all state-mandated benefit coverage laws. For programs that take in public funds, however, the decision to comply with state regulations has a direct impact on costs and, therefore, premiums. As a result, most subsidized plans (with the exception of Idaho's HRP) have skirted some items of mandated coverage in the states in which they were enacted.

5.3 Subsidies

As discussed, broadly speaking, states have chosen one of two different paths to reinsurance: the government-administered/commercially financed or the government-administered/publicly subsidized.

Nonsubsidized programs need support and legislation for implementation, but they do not depend on public funding sources. On the other hand, subsidized programs have a mix of funding sources that includes public revenues. Because of the dizzying rise in health-care costs over the last decade, funding for these programs must be adjusted regularly for the impact of the subsidies to be felt in lower premiums.

Attention to funding levels and political support for subsidies are crucial for the long-term prospects of any reinsurance plan that aims to aggressively cut premium costs and expand access to health insurance. However, it is important to keep in mind that although reinsurance programs can be effective in reducing premiums by capping the losses insurers are liable for, such programs do not address the roots of spiraling health care costs in the United States (Haislmaier, 2007). In fact, there is some evidence that the private reinsurance market (health insurance companies buying policies from private insurance companies to protect themselves against high claims) is changing due to the rapidly rising proportion of very-high-cost cases in all insurance markets (Crispin, 2009).

5.4 Cost Control

⁶ Some states have adopted a more imaginative approach to participation. For instance, instead of making participation compulsory, New Mexico mandates only carriers that offer insurance coverage to any state organization to participate. The state feared that a broad mandate would drive carriers out of the state, with its small population and low income levels (M. Onstott, personal communication, June 3, 2009). In New York, participation in the reinsurance programs is mandated to all HMOs operating in the state, but other health insurance plan types, such as point-of-service plans and preferred provider organizations, may voluntarily decide to offer plans under the programs. New York policy focuses on HMOs because they excel in cost-effective care management, essential for a program that aims to reduce premiums through cost control and reimbursement of high-cost care.

Cost-containment measures for the health insurance provided can be a crucial aspect of the design and regulation of a reinsurance program. Because reinsurance is, in practice, insurance for insurance companies, there is at least theoretically a moral hazard for insurers administering the health insurance policies: once an individual is ceded to the pool, the insurer may lose the incentive to control the costs of care for that individual. After all, the reinsurance pool will pay once the individual reaches the attachment point.

Reinsurance programs in general have specific rules in place to keep the insurers' practices in check with regard to cost control. To keep insurers from skirting their cost-containment measures, the nonsubsidized reinsurance programs (and also Idaho's HRP) require that participating companies maintain the same cost-containment measures for individuals/small groups ceded to the pool as they use for those who are not ceded. Audits may be conducted to verify that the billing/charging practices are uniform across the two groups (K. Ideman, personal communication, May 20, 2009). In addition, insurers must pay a reinsurance premium per individual/small group ceded to the reinsurance pool. As a result, they must be careful about individual risk assessment, instead of just placing as many individuals as possible in the pool.

Subsidized reinsurance programs take more decisive steps in dealing with cost containment and premium reduction. As these programs use public funds to pay reinsurance claims, they have more ambitious public policy goals that depend on the parsimonious use of those funds. They explicitly aim to reduce premiums in order to increase access to health care coverage. Therefore, cost containment should be a central concern in designing any subsidized reinsurance program.⁷

Indeed, reinsurance programs' impact on premium reduction has been more noticeable on subsidized initiatives. The aggressive cost-control measures have been effective in reducing premiums by double-digit margins. Still, some of the cost-control measures may have deleterious effects on access to health care for individuals with certain disabilities and/or chronic conditions. The limited benefits offered, for instance, may exclude entire disability categories from coverage, most notably mental health conditions. Second, high cost-share arrangements may be particularly burdensome on individuals with conditions that require frequent medical attention. There are clear trade-offs involved in obtaining coverage through some reinsurance programs, especially those with less comprehensive benefit coverage.

Healthy New York Cost-Control Measures

Healthy New York is exempt from state-mandated benefits laws that apply in the individual and small-group markets. For instance, Healthy New York does not offer mental health coverage. It has higher cost-sharing levels for services offered in the plan (Swartz, 2001). While the standard Healthy New York plan has no deductibles, the co-pay rates for several services can be high. Healthy New York uses public funds to reimburse insurers for claims within the reinsurance corridor. The reimbursement structure reduces the impact of high-cost cases on premiums, while ensuring HMOs have incentives to manage costs of enrollees, as they are still liable for part of the costs within the reinsurance band, and all of the costs above it (Wikler & Fish-Parcham, 2008). Carriers are required to spend at least 80

⁷ After ending subsidies, Arizona's HCG adopted an incentive system to promote the adoption of cost-management practices. Carriers that follow cost-management benchmarks designed by an outside consultant can have access to a 4 percent premium in reserve to make up for medical losses (M. Steigerwald, personal communication, June 9, 2009).

percent of the premium dollars they collect through the program on medical care, and not on administrative costs or profit (Wikler & Fish-Parcham, 2008).

6.0 Impact of Reinsurance on Access to Health Care for Persons with Disabilities

This section explores the potential impact of premium reductions on uninsured individuals with disabilities in the workforce. Using data from the Annual Social and Economic Supplement of the Community Population Survey (Bureau of Labor Statistics, 2009b), the microsimulation estimates the potential of reinsurance programs to increase access to health insurance coverage by uninsured individuals with disabilities in the labor force.

In order for an increase in access to occur, two conditions must be met: (1) the person is seeking insurance in the individual or small-group market, and (2) the reinsurance program reduces premiums enough to make insurance affordable when it was previously unaffordable. The quantitative analysis addresses each of these conditions.

The population potentially affected by public reinsurance consists of those who purchase insurance in the individual and small-group markets. The population of interest in this study is persons with disabilities in the labor force (PWD-LF). The overlap between these two populations consists of PWD-LF whose access to insurance is through the individual or small-group markets (Figure 1).

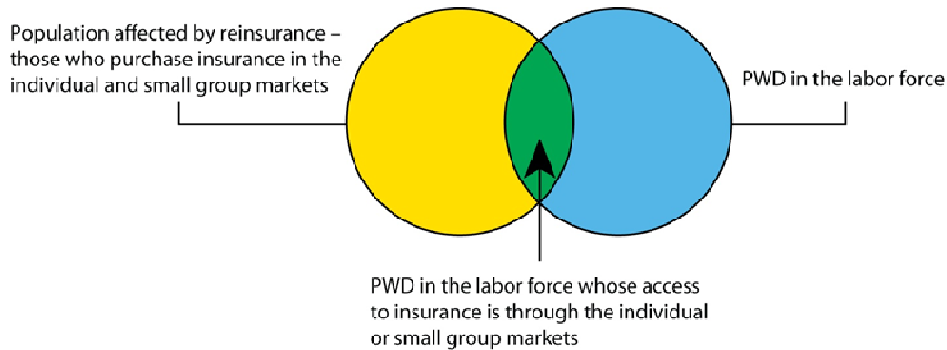


Figure 1. Schematic of Reinsurance Study Population

For PWD-LF in this overlap, public reinsurance programs should lead to reductions in health insurance premiums. For the programs examined in this issue paper, premiums were reduced by as much as one-third, depending how much states contributed to the subsidies. We are interested in the impact such reductions would have on the availability and affordability of insurance. Toward that end, this analysis developed a profile of PWD-LF that will help identify those who are in the overlap and, among those, how many will find insurance through these programs newly affordable.

This analysis uses micro-data from the ASEC to the 2009 CPS, released September 10, 2009.⁸ For March 2009, the data reports 6.1 million PWD in the civilian labor force, of which 5.3 million were employed and 803,000 were unemployed. The profile contained in Table 3 and Table 4 shows the estimated numbers broken down by family income and insurance categories for both employed and unemployed PWD.

Table 3: March 2009 Profile of *Employed* PWD-LF

Poverty Level (%)	Source of Insurance				Total
	Employer	Individual	Public	Uninsured	
<100	74,981	35,626	156,305	159,981	426,892
100 - 150	142,002	33,954	144,183	142,261	462,400
150 - 200	220,601	42,008	87,598	116,481	466,686
200 - 250	231,785	57,008	65,940	83,577	438,310
250 - 300	262,823	51,831	78,367	68,235	461,256
300 - 350	312,252	31,686	53,392	52,292	449,622
350 - 400	263,620	30,128	42,946	53,558	390,251
400+	1,760,806	181,448	146,177	103,298	2,191,728
Total	3,268,868	463,688	774,907	779,682	5,287,145

Source: 2009 Bureau of the Census (Department of Commerce)

Table 4: March 2009 Profile of *Unemployed* PWD-LF

Poverty Level (%)	Source of Insurance				Total
	Employer	Individual	Public	Uninsured	
<100	13,734	8,822	97,552	96,821	216,929
100 - 150	33,548	7,945	56,194	33,272	130,959
150 - 200	25,518	4,541	10,442	29,952	70,453
200 - 250	42,782	4,212	15,529	37,630	100,153
250 - 300	31,961	2,927	4,938	16,712	56,537
300 - 350	25,191	0	9,514	11,000	45,705
350 - 400	26,952	630	9,339	17,010	53,931
400+	99,546	4,198	9,931	14,357	128,032
Total	299,232	33,274	213,438	256,755	802,699

Source: 2009 Bureau of the Census (Department of Commerce)

The first task is to identify PWD who are reliant upon the individual or small-group markets for their health insurance. In this profile, we were able to identify those who are insured through the individual market and those who are uninsured and who, therefore, would be considering insurance through the individual market. Among the employed group (Table 3), there are 464,000 who purchase insurance in the individual market and 780,000 who are uninsured. Among the unemployed (Table 4),

⁸ See Appendix A for additional information on this data as well as on the Medical Expenditure Panel Survey (MEPS).

there are 33,000 with individually purchased coverage and 257,000 who are uninsured. Summing across these categories yields about 1.5 million, or roughly 25 percent, of PWD-LF who rely on the individual market for insurance $((463,688+779,682+33,274+256,755) / (5,287,145+802,699))$. Of this group, slightly over 1 million are uninsured. These data do not identify those with employer-sponsored insurance through the small group market. However, reinsurance could be important to this group as well because it would reduce the risk of having their employers decide to discontinue insurance coverage.

The remainder of this analysis will focus on PWD-LF without insurance and how their access to coverage would be influenced by publicly financed reinsurance programs such as those reviewed in this paper. As noted earlier, our review of such programs suggests that they could lead to reductions in premiums of up to 25 percent. Thus, we would like to determine what portion of the 1 million uninsured PWD-LF would find insurance affordable if premiums were to fall by 25 percent.

There is no exact method for determining the price at which insurance becomes “affordable,” but the recent health reform in Massachusetts provides a useful rule of thumb. In Massachusetts, individuals are mandated to purchase health insurance, and the government subsidizes those who cannot afford it on their own. Those below 150 percent federal poverty level (FPL) are fully subsidized and those above 300 percent are assumed able to purchase insurance on their own. Those in between receive partial subsidies on a sliding scale. Following this logic, those below about 300 percent FPL require a subsidy of more than 25 percent to make insurance affordable.

Of the 1 million uninsured PWD-LF, nearly 785,000 have incomes below 300 percent FPL. Applying the Massachusetts affordability algorithm suggests that a reinsurance program that reduced premiums by 25 percent would not be sufficient to make insurance affordable to this group. Rather, only about 20 percent of currently uninsured PWD-LF would find insurance newly affordable.

Even this modest impact is likely to be an overestimate because PWD-LF are, on average, at greater risk for health care spending and, therefore, could be charged higher-than-average premiums. Table 5 compares per capita healthcare expenditures of PWD-LF with those of their non-disabled counterparts according to employment status. For the employed group, both the mean and median expenditures per capita are more than three times higher for PWD versus people without disabilities. Patterns are roughly similar for the unemployed group. These high expenditure levels for PWD-LF suggest that a 25 percent reduction in premiums, even for those near or above 350 percent FPL, may not result in affordability.

Table 5: 2006 Per Capita Health Expenditures⁹

	Mean	Median
<i>Employed</i>		
PWD	\$7,770	\$2,519
Other	\$2,492	\$717
<i>Unemployed</i>		
PWD	\$12,511	\$6,452
Other	\$3,914	\$1,083

Source: 2008 U.S. Department of Health and Human Services

In summary, this analysis suggests that reinsurance alone seems unlikely to significantly affect access to health insurance for the vast majority of PWD-LF who are currently uninsured due to the combination of low income and high risks. This is consistent with the findings of Bovbjerg et al., who observe that “reinsurance alone will not make coverage available to higher risk people unless regulation requires that they be offered coverage and pools losses so as to create affordable premiums.” (2008, p.1)

7.0 Conclusion and Recommendations

This issue paper explored the experiences some states have had using reinsurance programs to increase access to health insurance for small businesses and individuals. Such programs seek to spread the risk of high-cost cases across all insurance carriers in a state in order to prevent insurance companies from denying coverage to small groups because of the health status or history of employees. Some such programs also targeted individuals who could not obtain coverage in the private market. More ambitious programs adopted a subsidized reinsurance component in order to drive down premium costs, addressing a primary culprit of the low rates of coverage among small businesses and low participation by employees.

Determining the potential for reinsurance to increase access to health care for PWD is important because there is evidence that PWD are more likely to work for small businesses or be self-employed than people without disabilities (Department of Labor, 2009). Current problems in the private and small-group health insurance markets have the potential to negatively affect people with disabilities and/or chronic conditions, and other individuals who may be perceived as high-risk cases. Small employers may be discouraged from hiring individuals whose risk is seen as the cause of higher insurance premiums. In addition, the low rates of health insurance in the small business and individual group markets limits the possibilities and discourages individuals with disabilities, for whom access to health care may be a critical consideration, from working.

The microsimulation presented here suggests that the premium reductions provided by reinsurance subsidies fall short of benefiting a large percentage of PWD, whose health care expenses are, on average, three times higher than those without disabilities. The estimates indicate that only 20 percent of currently employed but uninsured PWD would be able to afford the cheaper coverage certain

⁹ All methods for estimating data from the Annual Social and Economic Supplement (ASEC), the Current Population Survey (CPS), and the Medical Expenditure Panel Study (MEPS) are documented in the Technical Appendix.

reinsurance programs offer. Public subsidies to reinsurance reimbursement are central to reducing insurance premiums, as they effectively shrink the burden of high-cost cases on insurers. Publicly subsidized programs provide lower premium rates and have had a much higher enrollment rate. However, they also offer less comprehensive coverage, creating a potential burden for some people with chronic conditions and certain disabilities.

In light of these conclusions, research on reinsurance programs should be directed toward filling important gaps in the understanding of such initiatives, as follows:

- Additional research should be devoted not only to modeling the direct impact of reinsurance programs but also to simulating what the state of small business and individual markets would have been like without reinsurance programs. In particular, nonsubsidized programs did not appear to have a substantial impact on premium reduction in the way that subsidized initiatives did. However, such programs were not designed to reduce premiums, but rather to stabilize the small-group and individual markets. It would be interesting to simulate what the costs of insurance would be for small businesses that currently benefit from reinsurance if they had to purchase the same coverage without it. No such research has been done, although there is considerable speculation that they would have to pay higher premiums.
- Health care reform is currently under intense debate in the U.S. Congress. There has been considerable discussion about what health reform will ultimately look like, but not much attention has been paid to the small-group market. However, there is some evidence that insurers may oppose more regulations (Abelson, 2009a) and small employers may oppose employer-mandated coverage (Abelson, 2009b). More attention should be paid to the potential of well-crafted reinsurance programs to overcome such resistance, as they could reduce risks for carriers and make insurance more affordable for small employers.
- Additional research should focus on comparing the impact of comprehensive coverage vis-à-vis reinsurance bands on premium levels and coverage. In the Healthy New York initiative, dramatic premium drops followed changes in the reinsurance reimbursement bands. However, the reinsurance literature is not clear about the potential impact of more generous coverage offerings with fine-tuned bands and a well-funded reinsurance component. In other words, although trimmed-down coverage options do help reduce costs, the research has not been specific on the separate impacts of reinsurance reimbursements and benefit packages on premium costs. More comprehensive coverage is critical for people who may have high health care needs, such as those with chronic conditions and certain disabilities. This is crucial in understanding the potential impact of reinsurance programs on access to health care for PWD, as less comprehensive coverage may provide subpar health care and (1) delay or block work, and (2) aggravate the negative impact of health care access inadequacies on the marginalization of PWD in the workplace.
- Although some programs have conducted surveys on the use and performance of their programs (Healthy New York), most have not. This study relies extensively on interviews with program managers and government employees with direct experience with the reinsurance initiatives. It does not, however, look into the perspectives of small employers and individuals, especially those with higher health care needs. The fact that we do not have direct accounts of

program users on reinsurance's strengths and weaknesses constitutes a lacuna in the literature on reinsurance. Additionally, it would be helpful to compare the expressed concerns of small business owners and beneficiaries of these programs with those of counterparts who do not participate.

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Appendix A

Technical Appendix

Impact of Reinsurance on Access to Health Insurance for Persons with Disabilities

The analyses and estimates presented in the quantitative modeling of the effects of reinsurance – a quasi-microsimulation approach – were based on the construction of a profile of persons in the labor force with a disability. This profile, in turn, relied on three survey databases that individually did not contain the full set of required variables. This technical appendix briefly describes how the datasets were analyzed and synthetically merged to create the profile.

The Annual Social and Economic Supplement to the 2009 Current Population Survey

The Annual Social and Economic Supplement (ASEC) is the featured dataset upon we have built the profile required to conduct the simulation estimates. Adding to the monthly Current Population Survey (CPS) questions that largely address employment, each spring additional topics are addressed by the ASEC.¹⁰ These data are cleaned; they and a report were released on September 10, 2009.¹¹ The value of the ASEC comes from the inclusion of questions covering topics such as: household and family characteristics; marital status; income; poverty; work status/occupation; and health insurance coverage. Its value is also a function of the sample size, i.e., about 77,000 interviews. Most important for our profile is ASEC's data on income, poverty, and health insurance status (yes/no) and type (employer-based, individual coverage, Medicare, Medicaid, etc.)¹²

Before this 2009 release there was no standardized method to identify persons with disabilities. The six questions that are currently used in the CPS to identify PWDs were, for the first time, incorporated into the 2009 ASEC. Accordingly, programming that Altarum (and others) have done to remedy this deficiency for earlier years is no longer required (the Altarum program language is available for those who wish to conduct analysis using previous ASEC data releases). Thus, we believe the work shown in the modeling section above represents the first time when the six questions to identify PWDs have been combined with the rich data contained in the ASEC, particularly regarding employment, income levels (poverty), and insurance status.

The 2006 Medical Expenditure Panel Survey

¹⁰ Formerly these added questions were fielded in March which explains why this became known as the “March Supplement.” This process now unfolds over the February, March, and April timeframe (personal communication with Steve Hipple, Bureau of Labor Statistics, April 14, 2009).

¹¹ DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-236, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Government Printing Office, Washington, DC, 2009.

¹² As a technical matter, the CPS employment data for March 2009, first released in April 2009, differs slightly from that shown in this report which is based on the 2009 ASEC. The latter data incorporate updated weighting factors to adjust the survey to be nationally representative.

To further delve into variations on definitions for persons with disabilities, and to complete our profile by obtaining a snapshot of healthcare expenditure information, we programmed the 2006 Medical Expenditure Panel Survey (MEPS) – Household Component (HC). The 2008 MEPS Codebook states:

This survey provides nationally representative estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian non-institutionalized population. The MEPS Household Component (HC) collects data in each round on use and expenditures for office- and hospital-based care, home health care, dental services, vision aids, and prescribed medicines. Data were collected for each sample person at the event level (e.g., doctor visit, hospital stay).

The complete data file was released on November 17, 2008 and included 34,145 respondents. The central programming challenge was to identify individuals in MEPS who would roughly match those now being identified in the CPS via a “yes” response to at least one of the six disability questions (Exhibit 1).

Table. A.1: The CPS Six Questions (beginning June 2008)

1. Is anyone deaf or does anyone have serious difficulty hearing?
2. Is anyone blind or does anyone have serious difficulty seeing even when wearing glasses?
3. Because of a physical, mental, or emotional condition, does anyone have serious difficulty concentrating, remembering, or making decisions?
4. Does anyone have serious difficulty walking or climbing stairs?
5. Does anyone have difficulty dressing or bathing?
6. Because of a physical, mental, or emotional condition, does anyone have difficulty doing errands alone such as visiting a doctor’s office or shopping?

Fortunately, MEPS contains variables that closely align with these six questions. Exhibit 3 displays the MEPS variables we used, which values we selected, and how many persons with disabilities (aged 16 and over) were identified.

Table. A.2: MEPS Variables to Match Six CPS Questions & Number Identified (16 years of age and older)

Variable	Description	Values	# Identified
HEARNG42	HEARING IMPAIRMENT	Major (4) or Deaf (5)	958,219
VISION42	VISION IMPAIRMENT	Blind (5)	712,057
COGLIM53	COGNITIVE LIMITATIONS	Yes	10,352,151
STPDIF53	DIFFICULTY WALKING UP 10 STEPS	Some Difficulty (2) A Lot of Difficulty (3) Unable to Do (4) Completely Unable to Walk (5)	17,360,717
ADL3M053	ADL HELP 3+ MONTHS	Yes	3,806,976
IADL3M53	IADL HELP 3+ MONTHS	Yes	7,598,799

Note: ADL is Activities of Daily Life (e.g., eating, getting out of bed, dressing, bathing); IADL is Instrumental Activities of Daily Life (e.g., using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping).

Overall, this mapping identified 23.938 million persons with disabilities (at least one limit from these six variables), 4.845 million of whom were employed (MEPS does not allow one to determine who is in the labor force and unemployed as is the case with the Bureau of Labor Statistics protocol). Exhibits 3 and 4 show the relevant counts, and the healthcare expenditures, respectively from MEPS using the above algorithm. Once PWDs are estimated, we take total annual health care expenditures directly from MEPS calculations. For simplicity, we show the mean and median total annual expenditures in Exhibit 5. As an example, MEPS shows that employed PWDs had average annual health care expenditures of \$7,770 in 2006. This compares with an average of \$2,492 for people without disabilities who are employed.

Table. A.3: Employed Status and Disabled Status Counts Using Six MEPS Variables

	Cohort	Weighted Cohort
DERIVED EMPLOYED FLAG		
Employed	14,703	148,350,923
Unemployed	10,207	83,321,328
	24,910	231,672,250
DERIVED DISABLED FLAG		
Disabled	2,931	23,938,317
Not Disabled	21,979	207,733,933
	24,910	231,672,250

Table. A.4: MEPS Healthcare Expenditure Data for Employed/Unemployed, Disabled/Not Disabled

		Cohort	Weighted Cohort	Mean Expense	Median Expense	Total Expense
DERIVED DISABLED FLAG		DERIVED EMPLOYED FLAG				
Disabled	Employed	504	4,844,918	7,770	2,519	37,645,189,245
Disabled	Unemployed	2,427	19,093,399	12,511	6,452	238,876,883,211
Not Disabled	Employed	14,199	143,506,005	2,492	717	357,669,538,605
Not Disabled	Unemployed	7,780	64,227,928	4,244	1,442	272,571,166,144
		24,910	231,672,250	3,914	1,083	906,762,777,205

Appendix B

Qualitative Methodology

The qualitative research presented in this issue paper is based on two data-gathering methodologies: (1) a comprehensive review of the literature on reinsurance programs in the United States, and (2) a series of interviews with stakeholders in such programs. For the literature review, the authors identified published, peer-reviewed research *and* unpublished studies/documents, program evaluations, and policy analysis reports that provided information on the design, implementation, and efficacy of existing reinsurance programs, as well as reports commissioned by states exploring reinsurance initiatives to boost the small-group and individual health insurance markets.

Using an approved protocol, the authors contacted eight individuals at several state insurance departments to request a one-hour telephone interview on the workings and the performance of their reinsurance programs. In total, seven interviews were conducted regarding the programs in six states. The list of key stakeholders was proposed by the researchers and was preapproved by the Office of Disability Employment Policy. The protocol included detailed questions about the origins of the state program and the regulatory and legislative framework in place, its management, impact, and performance, obstacles the program encountered, and potential expansion in the future, as well as a confidentiality agreement and a consent form that all interviewed stakeholders were required to fill out prior to the interview.

The following approved script was used for the interview regarding Connecticut's Small Employer Health Reinsurance Program. Similar questions were adapted for other state programs.

- 1) We have reviewed the literature on reinsurance and understand that it is a risk management mechanism for insurers. We know that there is considerable variability from one reinsurance program to another and we would like to obtain a better understanding of your program through this interview. Our focus is on the nature of the benefits offered, the target audience, and the program's costs. Would you please take a moment to describe the Connecticut reinsurance program?

Interviewer should skip any question below that has been clearly addressed in response to question 1.

- 2) What was the impetus for this program? How did it come to be developed?
- 3) Are there state laws that impact or regulate your program?
 - a. **[If yes]** Can you tell us a little more about that?
 - i. What laws are they?
 - ii. What impact do they have?
- 4) Are there federal laws that impact or regulate your program?
 - a. **[If yes]** Can you tell us a little more about that?
 - i. What laws are they?
 - ii. What impact do they have?
- 5) Do you expect this program to be time-limited or to go on for some time (barring huge changes in the health care system currently in place in the U.S.)?
- 6) Do you expect any changes in the size of the program over time, either in terms of the population it serves or the services it provides?

- 7) What are the goals of this program?
 - a. reduce premiums, stabilize the insurance market, improve access to health care?
- 8) To what extent do you feel those goals have been achieved?
 - a. **[If little or not at all]** Can they be attained?
 - b. **[If greatly]** What's next? What are your plans for the future of the program?
- 9) What population do you target with this program? What are the eligibility requirements?
 - a. To what extent do you think you've reached this population?
 - b. **[If individuals with disabilities not included in response]** Has the program focused in any specific way on people with disabilities?
 - c. **[If persons with disabilities targeted]** To what extent do you think people with disabilities have achieved more access to health care because of the program?
- 10) What is your cap on services?
- 11) Tell me about the participants' premiums or copayments.
- 12) Do self-funded plans qualify for your public reinsurance plans? Can they be compelled to participate?
- 13) What is the benchmark insurance contract to be honored by your reinsurance program? If there is variation in the features of the plans, is there variation in reinsurance premiums paid?
- 14) How do you think President Obama's universal health care plan will impact your program if it is enacted?
- 15) Connecticut has a mandatory reinsurance program that is not state subsidized. (Is that right?) How much of your funding comes from the state?
 - a. How is the program funded? [If multiple funders, get percent of funding of each.]
 - b. Can the program be self sustaining with the funding sources it has now?
 - c. What sort of impact might state or federal subsidies have on the program?
- 16) How does your program manage costs?
 - a. Is there a board, for example, that addresses the insurance companies' cost management practices?
 - b. What are the incentives the insurers have to contain costs?
- 17) To what degree would you say the program is cost effective?
 - a. Why do you say that?
 - b. What more would you like to do?
- 18) Has any research or evaluation been conducted on your program?
 - a. What were the findings?
 - b. Are there reports or data we can access that would provide us with more detail?

- i. **[If yes]** Can we find these on line or would you prefer to send them via e-mail or regular mail? **[Provide appropriate address.]**
- 19) If you had it to do over, what would you do differently?
- 20) What advice would you have for someone planning to design and implement a reinsurance program?
- 21) Would you recommend this particular program as a model for others to adopt or adapt?
- 22) We've talked with you at some length now about your program. Is there anything you would like to add that you think would enhance our understanding of reinsurance in general or your program in particular?

Thank you for taking the time to talk with us today. We really appreciate your help. If you have any comments or questions about this study, [and/or if there are research documents to be sent] please send them to Social Dynamics.