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Resource Paper

The Role of Reinsurance in Medicaid Managed Care

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250

Table of Contents

Executive Summary	2
Introduction	3
Data and Methods	5
Key Findings	6
Reinsurance is Perceived as Very Important for MMC	6
The Basic Design of Public Reinsurance for MMC is Similar across States	7
Operational Policies Differ More across States	10
Over Time, States and Plans Have Shifted Toward Commercial Reinsurance	13
Comparisons between Public and Commercial Reinsurance	14
The Place of Reinsurance within the Spectrum of Risk-Mitigating Measures	16
What Explains States' Preferences for Public versus Private Reinsurance?	21
Lessons Learned	22
Appendix A: Tables and Figure	25
Appendix B: Models of Reinsurance among 34 States	30
Appendix C: State Program Summaries	31

Executive Summary

Reinsurance can be very important to overcome managed care organizations' (MCOs) reluctance to assume open-ended risks of very high losses. It operates as a secondary insurance mechanism for primary risk bearers such as managed care organizations, to limit potential losses. This Resource Paper addresses states' reinsurance provisions and trends over time, with a particular focus on Medicaid managed care (MMC) enrollment of people with disabilities.

Our information comes from a literature review, national expert interviews, and case studies of six states. The case studies focused on states that have run their own reinsurance programs. Geographic diversity and state experience with the disabled/SSI population also were important selection criteria. The states selected were Arizona, Maryland, Massachusetts, New York, Oklahoma, and Pennsylvania.

Our key findings included that:

- The perceived need for reinsurance varies by circumstances, and over time, the continuing need for reinsurance can be met by private rather than state coverage.
- Public reinsurance normally covers expenditures above a specified annual threshold (“attachment point”) per individual per year. Variations exist in subpopulations covered, definitions of covered losses, level of attachment points, and coinsurance provisions. Three of six study states created special provisions affecting their disabled populations.
- Attachment points ranged from a low of \$5,000 per enrollee per year in one Arizona program to a high of \$200,000 for some Pennsylvania MCOs. Plan coinsurance ranged from zero to 25 percent.
- Operational policies differed across states, including rate making methods and processes for claims review and payment.
- States and plans have shifted toward commercial reinsurance, but some state officials vigorously support public reinsurance. Perceived advantages of commercial reinsurance are: consistency with other lines of business, flexibility of benefit structure, better service (especially speedy claims resolution), competitive prices, and additional ancillary services including pre-qualified networks of vendors for certain high-cost services. Perceived advantages of public reinsurance include unlimited daily and total benefits and more generous claims administration.
- Reinsurance is used in conjunction with other risk-mitigating measures. Some mechanisms operate from the time of enrollment, including higher capitation rates by enrollee class or condition, health-based risk adjustment to capitation rates, and “carve-outs” of certain services from capitation. Other measures operate ex post, including not merely reinsurance, but also maternity “kick” payments and risk corridors.

- Age of Medicaid managed care program and general state attitudes about public intervention in health care do not explain reinsurance preferences.

Based on our findings there are seven lessons to be learned about MMC Reinsurance:

1. Reinsurance is important for implementing a viable MMC program.
2. States use reinsurance and other risk-mitigating mechanisms to create a stable and fair Medicaid marketplace that rewards successful management of care and punishes poor management.
3. The model most used by states was—reinsurance of excess losses above thresholds of annual individual spending, typically limited to inpatient spending, and with a coinsurance obligation to reduce moral hazard.
4. State policy differed most notably in the extent of reliance on public reinsurance. Cross-state variation would have been even more notable had we not used presence of public reinsurance as one selection criterion for the study.
5. Running a good public reinsurance system calls for having very good data systems for MMC.
6. Enrollment of disabled beneficiaries in MMC is seen as calling for some differences in reinsurance practices but not in basic program design.
7. The pros and cons of public and private reinsurance noted above were described in similar fashion by most state officials and by health plan and reinsurer interviewees alike.

Introduction

Reinsurance became an issue for Medicaid programs when states moved to Medicaid managed care. To participate in capitated MMC, health plans have to accept the financial risk of covering all necessary care for beneficiaries. Health plans may be reluctant to participate if overexposed to the risk of very high losses that can occur with fixed capitation. A large share of total spending is concentrated among the highest cost cases.¹ Reluctance may be strongest where risks are unfamiliar, otherwise hard to predict, or apt to be high and variable. Even after participation, unusually high claims costs might drive some plans out of the program or even out of business; other plans might seek to accept and retain beneficiaries selectively, despite state requirements of open enrollment.²

Reinsurance is one risk-mitigating tool that states use to attract and retain MMC health plans and to encourage management of care. Reinsurance is an insurance mechanism through which a primary risk bearer—like an MCO—limits its potential losses for some

¹ Berk M. L. and Monheit A. C. “The Concentration of Health Care Expenditures, Revisited.” *Health Affairs*, 2001; 20(2): 9-18.

² Freund D. A. and Hurley R. E. “Medicaid Managed Care: Contribution to Issues of Health Reform.” *Annual Review of Public Health*, 1995; 16:473-495.

or all enrollees.³ Reinsurance also is called “stop-loss,” as the primary plan often transfers all risk above a certain threshold. Reinsurance is also purchased by private health plans; many states require other forms of reinsurance for their reforms of small-group and individual health insurance markets; and at least one state, New York, has used state-financed reinsurance to backstop participation by private health plans serving the previously uninsured.^{4,5,6,7}

This project examined reinsurance, or stop-loss, and related provisions in Medicaid programs’ design of managed care for their TANF-AFDC and SSI populations (Temporary Assistance for Needy Families, Aid to Families with Dependent Children, and Supplemental Security Income). Of special interest is how reinsurance practices have been influenced by the addition of high cost/high utilization beneficiaries, such as those with disabilities into MMC.^{8,9,10} This project was designed to address a number of questions/issues, including:

- How important was reinsurance perceived to be in starting and running managed care programs for the TANF-AFDC and SSI populations Medicaid?
- What is the basic nature of the reinsurance provisions including risk-bearing, mandatory participation, limits on protection, and regulation?
- How is the reinsured risk defined?
- How do reinsurance provisions relate to other design elements of MMC, like risk-adjustments for rates, special provisions for maternity expenses, or carve outs of particular benefits (e.g., behavioral health) or particular enrollees (e.g., the SSI population)?
- How high are reinsurance premiums, relative to primary capitation rates and how were they negotiated?

To answer these and other questions, the project reviewed two national surveys and other literature, conducted interviews with national experts, and undertook case studies of six states.

³ Vaughan E. J. and Vaughan T. M. *Fundamentals of Risk and Insurance* (New York: John Wiley & Sons), January 1999.

⁴ Bovbjerg R. R. “Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?” *Inquiry*, 1992; 29:158-175.

⁵ Tiller J. E., Jr. and Tiller D. F. *Life, Health & Annuity Reinsurance* (Actex Pubns Inc., 2nd Rev edition), October 1995.

⁶ Lewin Group. *Establishing an Analytical Framework for Measuring the Role of Reinsurance in the Health Insurance Market*. Prepared for the Office of the Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services. March 1997.

⁷ Swartz K. “Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?” *Inquiry*, 2001; 38(2): 133-145.

⁸ Tanenbaum S. J. and Hurley R. E. “Disability and the Managed Care Frenzy: A Cautionary Note.” *Health Affairs*, 1995; 14(4): 213-219.

⁹ Tobias C. “Managed Care for People with Disabilities: Designing the Benefit Package.” Center for Health Care Strategies, Inc., March 1998.

¹⁰ Regenstein M. and Schroer C. “Medicaid Managed Care for Persons with Disabilities: State Profiles.” Washington, DC: Kaiser Commission for Medicaid and the Uninsured, December 1998.

Data and Methods

This study used a literature review, national expert interviews, and focused case study methods. We found no published literature directly focused on Medicaid reinsurance as such¹¹, and even lengthy case studies of Medicaid managed care often omitted provisions for reinsurance.¹² Published literature did supply general descriptions of risk-mitigating tools including reinsurance, risk-adjustments for capitation rate setting, and other features of MMC that influence risk bearing by participating plans.¹³ Such information came from general publications on Medicaid managed care, including a number of reports from the Center for Health Care Strategies.^{14,15,16,17} Materials on HIV/AIDS under MMC often discussed various risk-mitigating mechanisms and their uses, from risk adjustments and carve outs to risk corridors and reinsurance.¹⁸

Two national surveys provided more detailed, state-specific background on MMC reinsurance practice. The Medicaid Managed Care Payment and Implementation Survey^{19,20} obtained responses from 34 state Medicaid departments with some information on reinsurance. Another national survey reviewed Medicaid managed care contracts with providers.²¹ For some states, it provided very brief mentions of reinsurance provisions in the contracts.

Further background came from national interviews with knowledgeable individuals, including consultants, academics, and former state officials. They provided context about MMC practice including reinsurance, and also suggested states of interest

¹¹ For example, on-line Entrez-PubMed searches for “Medicaid” together with “reinsurance” and then with “stop-loss” each time found eight (overlapping) publications of only tangential relevance. To the extent that articles addressed reinsurance, their focus was stop-loss purchased by medical providers accepting sub-capitation from health plans, e.g., Anderson and Weller 1999.

¹² For example, the detailed case study of Maryland by Gold, Mittler and Lyons (1999) runs 173 pages without mentioning reinsurance.

¹³ We use the term risk-mitigating for these various approaches that reduce the risk assumed by participating MCOs. At least one authority calls these “risk sharing” mechanisms (Tucker Alan 2000, pp. 2, 29ff.), which sounds akin to “cost sharing” and could be misleading. Many risk-mitigating measures do not really share with regard to the particular risk they apply to—a carve out transfers all of the risk involved to the state, as does complete stop-loss reinsurance (with no coinsurance).

¹⁴ Kronick R. and Drefus T. *The Challenge of Risk Adjustment for People with Disabilities: Health-Based Payment for Medicaid Programs*. Center for Health Care Strategies, November 1997.

¹⁵ Bachman S., Burwell B., Albers L. A., Herz L., and Jackson B. *Medicaid Carve-Outs: Policy and Programmatic Considerations*. Center for Health Care Strategies, 2002.

¹⁶ Moore H., Kaelin J., Johnson S., Mussman M., and O’Brien J. *Risk Adjustment for Asthma: Variations by Methodology and Implications for Providers*. Center for Health Care Strategies, December 2001.

¹⁷ Allen K. and Croke A. *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities*, espec. Section on “Finance.” Center for Health Care Strategies, October 2002.

¹⁸ HRSA/KFF. HIV Capitation Risk Adjustment: Conference Report (Health Resources and Services Administration, Kaiser Family Foundation and other sponsors, conf. of May 28 & 29, 1997, 07/31/1997 < www.kff.org/content/archive/1321/128a.pdf#coverage > last accessed May 23, 2003.

¹⁹ Urban Institute. *Medicaid Managed Care Payment and Implementation Survey*. The Urban Institute, Health Policy Center. 2002

²⁰ Holahan J. and Suzuki S. “Medicaid Managed Care Payment Methods and Capitation Rates in 2001.” *Health Affairs*, 2003; 22(1): 204-218.

²¹ Center for Health Services Research and Policy. “Reinsurance” in *Negotiating the New Health System, 4th Edition*. George Washington University, Center for Health Services Research and Policy, May 2000.

because of their significant reinsurance features. The states selected for detailed study were Arizona, Maryland, Massachusetts, New York, Oklahoma, and Pennsylvania, all of which operate significant MMC programs (Table 1).

Key Findings

Reinsurance is Perceived as Very Important for MMC

MMC reinsurance is a form of risk sharing whereby a reinsurer covers a health plan's unusually high costs of enrollee care in exchange for a premium. A reinsurer insures a health plan in much the same way as a health plan insures its enrollees. A health plan can need reinsurance for the same fiscal reason that an individual needs health coverage—to guard against unforeseeable losses that would be very large relative to available resources.^{22,23} Because reinsurance decreases the fiscal pressure on health plans serving high-cost individuals, it also helps protect health plans against adverse selection. Unusually high risks were a particular concern with the inclusion of persons with disabilities in MMC.²⁴

All state officials who were interviewed said that reinsurance for health plans is a key element of MMC. Many interviewees used terms like “really” or “very important;” two termed reinsurance “vital.” States' actions confirm their words: All six states studied require that participating MCOs have some form of reinsurance, public or private (Table 2). Two states allow exceptions: Maryland allows plans to self-insure; and Pennsylvania officials may waive the reinsurance requirement if satisfied that plans have alternative risk protection or if they otherwise deem reinsurance unnecessary. Pennsylvania reported that in practice only one waiver has ever been granted.

Interviewees within health plans also emphasized the importance of reinsurance as a means of limiting their exposure to high-cost outlier cases:

- One plan manager noted that reinsurance was important even though the plan's MMC program has one of the best risk-adjustment mechanisms in the country (good risk adjustment assures that capitation is sufficient to cover average losses even for high-risk enrollees). But risk adjustment alone, he continued, gave insufficient protection against “shock” losses (large, unusual, non-recurring expenses, as from a severe accident).
- Another plan interviewee also termed reinsurance “absolutely vital” because it makes it possible to financially “survive a million dollar neonatal intensive care case.”

²² Tiller, et al., op.cit.

²³ Vaughan, et al., op. cit.

²⁴ GAO. *Medicaid Managed Care: Serving the Disabled Challenges State Programs*. The General Accounting Office, no. GAO/HEHS-96-136, July 1996. <<http://www.gao.gov/archive/1996/he96136.pdf>> last accessed April 21, 2003.

Public reinsurance was considered particularly important during the early years of Medicaid managed care implementation. Interviewees reported a number of reasons for creating public reinsurance (Table 3):

- At the inception of MMC, it was hard to predict risks. Participating health plans were sometimes unfamiliar with the program or its beneficiaries. MMC was new and good baseline data were often scarce. Participants were often inexperienced and ill-suited to absorb costs of unexpectedly big cases, especially smaller health plans (in terms of enrollment and capital), provider-based plans, and Medicaid-only plans.
- Private reinsurers could also be unfamiliar with the risks involved in MMC at start-up.
- Start up non-commercial plans had no experience in purchasing commercial coverage, and during the early years of MMC, it was not readily available to them. State Medicaid agencies often stepped in to reinsure, acting as “de facto insurance companies with the associated risks and resource requirements.”²⁵

Some enrollees’ health status may put MCOs at especially high risk of incurring very high costs—a non-random risk that can be assessed in advance, unlike that of shock losses. Predictably higher risks of loss encourage adverse selection, which states address in a number of ways, including control over enrollment processes and differential capitation rates by risk class. Reinsurance was not seen as such a mechanism; at least, state interviewees did not cite desire to reduce incentives for adverse selection as a reason for creating reinsurance programs (Table 3).

We had hypothesized that MMC managers and health plans might see less need for reinsurance past the initial implementation of MMC. Over time, claims data improve, participating health plans increase in size and sophistication as they mature, reinsurers become more familiar with MMC populations and risks, and state capitation rate-setting can more accurately match resources to risks. However, many informants believed that reinsurance remains very valuable because it protects against “unmanageable risk” and the “luck of the draw” that can expose a plan to high cost cases. Many perceived the continuing need for reinsurance could be met by private rather than state coverage, as considered more below.

The Basic Design of Public Reinsurance for MMC is Similar across States

Public reinsurance can be designed in different ways. Many states’ small group market reforms have reinsurance arrangements that allow regulated health plans to designate particular enrollees in advance, all of whose risk is transferred to a reinsurance pool for which all carriers share in losses.²⁶ More commonly, private reinsurance covers not high-risk individuals but the high end of spending on claims, either by individuals or in

²⁵ GAO, op.cit.

²⁶ Bovbjerg, op.cit.

the aggregate for some group or territory.²⁷ Under such reinsurance, a primary risk bearer is protected from very large, unexpected losses by transferring some or all of its high-end risk to a reinsurer.

Those reinsurers normally cover most or all expenditures that exceed a specified annual threshold of spending per individual or for a group—similar to an enrollee’s deductible in a primary insurance plan, but for reinsurance usually termed an “attachment point.” Above the deductible, risk is often shared through coinsurance, under which the plan and the reinsurer each pay a percentage. Alternatively, the reinsurer may cover all losses above the threshold, thus ending further losses for the primary plan. The latter arrangements are commonly called “stop-loss,” although many people use the term stop-loss even when the primary plan has a coinsurance obligation and continues to share in paying for losses above the threshold.²⁸

State reinsurance provisions may apply to all MMC enrollees or may vary by coverage population. Across states and populations the basic structural features of public reinsurance are similar. Design features include:

- What populations are reinsured, including any special arrangements for disabled enrollees.
- What types of claims losses are reinsured.
- How high attachment points are.
- The nature of any coinsurance provisions.

The following discussion emphasizes these commonalities but notes exceptions or unusual state practices.

Targeted Populations within MMC

State reinsurance may cover all MMC enrollees (as in Arizona, Maryland, and New York) or only some populations (Massachusetts and Oklahoma). Within the populations covered, a state may create separate reinsurance provisions for each population covered (Arizona) or have only a single set of provisions for all enrollees reinsured (all other states). Pennsylvania’s requirement for private reinsurance applies to all MMC enrollees and sets the coverage rules for all.

Our initial hypothesis was that states would significantly alter reinsurance provisions to address the predictably higher spending levels of the SSI population when the latter joined MMC, typically after TANF-AFDC populations. Among others, GAO²⁹ suggested SSI motivation for reinsurance. This expectation proved only partly correct for our six study states (Table 3). Two states that require public reinsurance for all MMC enrollees simply put SSI/disabled enrollees into the same reinsurance system as others (Maryland and New York). Pennsylvania also set no special standards by population in its mandate for private coverage.

²⁷ Vaughan, op.cit.

²⁸ Wehrwein (1998) suggests that managed care executives usually refer to reinsurance, whereas medical providers use the term stop-loss; we found that many interviewees used stop-loss to mean any kind of reinsurance.

²⁹ GAO, op.cit.

The other three states did create special provisions affecting people with disabilities (Table 3). Oklahoma has no general public reinsurance, but created special reinsurance provisions for its ABD enrollees. Massachusetts created public reinsurance for only two of its six capitation rating categories—its disabled population and those eligible for its Basic coverage, the latter including Emergency Aid to Elders and Disabled Children as well as adults who are unemployed for 12 months or more. Arizona set up the most complex system, including separate reinsurance regimes for different enrollee categories. Arizona created different provisions for people based on their need for long-term care (reinsurance for long term care, or ALTCS, and for high cost behavioral health) or catastrophic diagnosis (for example, hemophilia, Gaucher’s Disease, transplants).

Nature of Risk Reinsured

State reinsurance covers extra-high losses per enrollee, per year; the reinsurance protection focuses on per-person spending, not on aggregate losses for an entire enrollee population. Typically, reinsurance begins to pay once a set level of cumulative expenses is accrued during a year. These expenses may be defined as inpatient only, or a broader scope of services. The rationale for focusing on hospital care is that it tends to predominate for high-claims enrollees, and tracking smaller physician and other outpatient expenses imposes high administrative costs. Arizona’s ALTCS program, Massachusetts, and Oklahoma include all MCO-approved services per member per year. Arizona altered its catastrophic provisions over time in response to the spread of expensive medical technology.

Attachment Points

In all six states, reinsurance provisions apply above a specified “attachment” point of annual spending per enrollee, after which the state or commercial reinsurer covers all or most of the costs. Attachment points (deductible or threshold for reinsurance) vary widely by state, and even within states. Attachment points ranged from a low of \$5,000 per enrollee per year in one Arizona program to a high of \$200,000 for some Pennsylvania MCOs. A very specialized Arizona program for patients with particular “catastrophic,” very high-cost conditions like transplants has two attachment points for two levels of coinsurance—zero for 85 percent reinsurance and \$650,000 for 100 percent.

Coverage Proportion

Most state reinsurance coverage is written to cover costs above an attachment point on a “proportional” basis, also called “pro rata.” This operates much like primary-coverage coinsurance, e.g., an 80/20 split between reinsurer and MCO. The main alternative is complete “excess of loss” coverage under which reinsurance covers 100 percent of

losses above the attachment point, like primary coverage after a deductible. However, under Arizona’s Prior Period Coverage program, the state pays 100 percent after an attachment point of \$5,000. Arizona’s Catastrophic Reinsurance program covers 85 percent of all costs up to \$650,000, thereafter 100 percent. Similarly, in New York, coverage is proportional between \$100,000 and \$250,000, and 100 percent beyond \$250,000.

Maximum Reimbursements

Typically, public reinsurance does not set any maximum limits on the reimbursement that plans can collect from state reinsurance—whether per-service, per-day, or per-year. Private insurance almost universally sets a policy maximum payout per year (or per lifetime of an insured) and often specifies additional “internal limits” as well, such as maximum payments per hospital day or stay.

Operational Policies Differ More across States

Methods for Establishing Reinsurance Premiums

Like private insurers, state reinsurance programs charge a premium for the protection they provide. These are typically collected as an offset to capitation payments otherwise due to participating health plans. Premium levels are determined differently across states. Arizona sets reinsurance premiums by examining MCO encounter data from prior years and pricing reinsurance by rate cell. In New York, inpatient hospital reinsurance premiums are set based on projected fee-for-service claims. In 2000, however, the state revised its reinsurance rate setting methodology and lowered reinsurance rates significantly (35-40 percent) because reinsurance claims were lower than anticipated, and the state was earning significant and unintended “profits.” Rather than basing reinsurance premiums on one year of data, the rate setting method was revised to pool several years of fee-for-service data. This smoothed out variation and made the rates more accurate. In addition, under the new method, fee-for-service data were risk-adjusted to better reflect the differences between the managed care and fee-for-service populations. For outpatient and mental health reinsurance, New York uses Medicaid upper payment limits to establish premiums. Massachusetts’ reinsurance premiums are set using three years of outlier expenditure experiences from the MCOs, as well as four years of outlier expenditure experiences from the Primary Care Clinician Plan to calculate actuarially sound stop-loss premiums.

Reinsurance premiums as a percentage of capitation rates vary between one percent in New York to seven percent in Arizona (Table 6). Stop-loss premiums tend to be higher for more costly groups, such as people with chronic illnesses and disabilities. SSI enrollees generate much higher costs in the high, “excess” layers of health care spending as well as the low, “first-dollar” levels of risk. For example, Massachusetts’ stop-loss premiums for the long-term unemployed are lower (3.9 percent) than the

premium percentage for the SSI population (6.3 percent). According to interviewees familiar with private reinsurance, premium rates there are typically two or three times higher for the people with disabilities than for TANF enrollees in MMC.

We were not able to directly compare public with private premiums for reinsurance coverage for a number of reasons: There is no “going rate” for MMC reinsurance, as each reinsurer quotes its own tailor-made premiums for each health plan, which may vary by location, for each population covered, by specific policy provisions selected, and with adjustments over time for prior claims experience and market conditions. We lacked a complete set of multi-year data with public and private premiums by state, and we lacked the ability to actuarially adjust rates to achieve comparability given differences in relevant risks assumed and coverages purchased.

A number of interviewees felt that private rates were more favorable than public: This conclusion is qualitative and somewhat tentative, as much of the shift to private coverage occurred in the late 1990s, when reinsurance rates worldwide were perceived to be unusually low, owing to strong competition. The private reinsurance market has since “hardened,” and a few interviewees thought that private reinsurance was no longer a bargain.

Claims Processing and Payment

The state programs reviewed and processed all reinsurance claims “in house.” Because thresholds are stated in terms of spending per enrollee per year, plans have to document services whose approved expenses meet the applicable threshold, then document services and associated costs above the threshold. Although MMC generally operates through monthly capitation, reimbursement under reinsurance operates essentially on a fee-for-service basis. In New York, for example, health plans’ reinsurance claims are actually paid through the same state MMIS system that processes fee-for-service claims from participating medical providers serving beneficiaries not enrolled in capitated MMC. Typically, the state requires that a plan give notification when expenses reach a large fraction of the threshold; yet, interviewees did not report that any action was taken in response, such as reviewing near-threshold services for appropriateness. Some interviewees noted that they saw no evidence of “moral hazard” or changed plan behavior near the threshold in expectation of achieving state reimbursement.

The same payment issues can arise for reinsurance as come up under FFS practice: were services actually rendered, medically necessary, and otherwise within the scope of Medicaid benefits; and what is the allowable rate of payment for each? Resolving those questions takes time and resources. Both health plan and state interviewees noted that reinsurance claims settlement can be slow—a frequent complaint about provider payments generally. New York State’s reinsurance process was often perceived as cumbersome—and, after a while, more than half of MMC plans had opted for private reinsurance. State administrators, believing that their “product” provides superior protection for MCOs, then sought to attract back their “customers” by streamlining reinsurance processing, notably by allowing plans to summarize claims. Officials reported that some plans had returned to public reinsurance in response.

The number of claims having to be processed is affected by many factors, including the level of the threshold to be surpassed and the degree of aggregation acceptable in claims documentation. Its complexity depends on the amount of documentation and verification required. For Massachusetts in SFY 2001, the number of enrollees who surpassed the annual threshold ranged from six in one MCO to 49 in another. Arizona's reinsurance program processes about 7,400 claims per month.

Arizona performs medical audits on reinsurance submissions based on random sampling. Initially the state used a paper-based claims system, but officials found that they were not getting enough information to resolve claims expeditiously. When they moved to electronic claims processing, they not only processed claims faster and more accurately, but also received readily usable information with which they could redefine definitions of covered risk and have multiple types of reinsurance with different attachment points. Electronic claims processing also allows state officials to consider whether to alter reinsurance provisions by running various simulations from claims data about different possible tradeoffs between reduced risk and higher administrative costs.

Maryland's "claims processing" approach is unique. Like New York, the state uses its FFS capabilities to pay reinsurance claims. However, instead of reimbursing health plans for above-threshold payments to providers, the state takes over the plan's responsibility to pay providers. The state pays providers *directly* once a plan documents that the annual threshold has been met by plan payments. The state then recoups the plan's coinsurance obligation (10 percent) by subtracting it from capitation and other payments due to the health plan. The state program insists upon accounting for below-threshold payments in strict chronological order by date of service in order to take over payment responsibility at the correct time. The system works well only when a single hospital stay is involved, and the plan approves and pays that hospital's claims in a timely and chronological fashion. When multiple hospital stays are involved or when payment for care does not come in the order care was incurred, payments are often delayed while the state establishes which claims chronologically fall before the attachment point (and are the plan's responsibility) and which claims fall after the attachment point (and are the state's responsibility). The administrative complexity of this system results in cash flow problems for both the providers and plans.

Maryland's reinsurance claims processing system was set up this way to allow the state to perform concurrent review of high-cost inpatient care to avoid fiscal fraud and implement case management. However, the state found it impractical to perform case management and believes that a retrospective audit would be more administratively feasible to prevent fraud. Arizona's reinsurance program conducts such retrospective audits on a random basis.

Over Time, States and Plans Have Shifted Toward Commercial Reinsurance

Decrease in Both Demand and Supply for Public Reinsurance

The extent to which reinsurance was public versus commercial has changed over time, according to our interviews with state officials and health plans. Although the purchase of reinsurance coverage was mandatory in our sample, the method of obtaining reinsurance has shifted from largely public at the onset of Medicaid managed care to more commercial. Currently, the procurement of reinsurance in our sample varies from exclusively public in Arizona to exclusively commercial in Pennsylvania, with most of the sample states having a mixture of public and commercially reinsured plans (Table 2).

States have a mixture of public and commercially reinsured plans in one of two ways. Either (1) the state offers reinsurance to MCOs at a specified rate, but permits them to choose commercial reinsurance instead; or (2) the state requires plans to purchase public reinsurance for a subset of managed care populations and other populations are commercially reinsured. In Maryland, Massachusetts, and New York, state reinsurance competes with private; in Oklahoma plans must purchase public reinsurance for the ABD population and private coverage for other populations. All of the states in our sample that have commercially reinsured plans have retained the right to approve or disapprove the reinsurance carrier or policy. However, no state reported ever having an issue with a plan's selection of carrier or policy. Pennsylvania actually takes the management of commercial reinsurance one step further and defines minimal attachment and coinsurance levels.

Over time, public reinsurance has been perceived as less important for various reasons: Plans had less need as plans grew (in terms of enrollment and capital) and gained experience, commercial reinsurance became a more viable option; and as commercial plans began to participate in Medicaid managed care and were accustomed to purchasing private reinsurance for their commercial lines of business. A third factor is that the supply of public reinsurance has fallen as states have decided to "get out of the business" of reinsurance for various reasons, including the administrative complexities involved.

A National Picture

Our sample states were selected for having offered public reinsurance, whereas most states do not (Appendix B). According to an Urban Institute survey, 20 out of 34 responding state MMC programs reported having exclusively commercial reinsurance plans, 12 reported a mixture of public and commercially reinsured plans, and only two (including Arizona) had entirely public reinsurance (Urban Institute 2002). However, it is important to note the difficulty in obtaining complete and accurate information on Medicaid reinsurance in the course of a broader national survey. Many states did not respond at all, and several participating states did not fully respond to questions about reinsurance. Also checked for this project was a survey by the Center for Health

Services Research and Policy, which analyzed provider contracts as of May 2000. Not only was some of this information outdated by 2002, but also some states with reinsurance provisions were not noted. Nevertheless, combining information from both surveys provided some very basic information on the trends of obtaining reinsurance for the Medicaid managed care population.

Comparisons between Public and Commercial Reinsurance

In lieu of public coverage, in many states MMC health plans may buy commercial reinsurance; and some well established, large commercial health plans own a “captive” reinsurer. How does public reinsurance for MMC health plans compare with private?

In broad outline, private and public policies are similar. Private reinsurers, like their public counterparts, cover specified types of spending per enrollee beyond a specified annual threshold. Attachment points tend to be between 75,000 and 150,000, and the plans’ responsibility for cost-sharing tends to range between 10 and 20 percent. Premiums are set by category of enrollee and are much higher for SSI populations than for TANF-AFDC. Terms of coverage, such as definitions of covered services, do not ordinarily vary by population (e.g., TANF versus SSI). Private reinsurance, like public, may include spending on many types of services but is often limited to inpatient services. Both private and public reinsurers require early notice about potential claims as an enrollee’s spending nears the threshold of reinsurance coverage.

Beyond these basic structural similarities, private reinsurance differs from public in important ways. These differences often were perceived as advantages by health plans. These preferences constitute the demand-side rationale for the observed shift by MMC programs to commercial reinsurance.

Advantages of Commercial Reinsurance

A number of strengths of private commercial reinsurance for MMC were described across numerous interviews. They include:

- **Consistency with other lines of business**—Many commercial health plans already were familiar with purchasing private reinsurance for commercial lines of business. Thus, as states gave plans the option of choosing between public and private reinsurance, it was a natural choice for some plans to standardize the procurement of reinsurance from private entities across both Medicaid and commercial lines of business.
- **Flexibility**—Public reinsurance tends to be defined with the same target population, attachment points, and cost-sharing for all plans participating in MMC. Private reinsurance offers more flexibility in defining these terms and conditions. Flexibility may be appealing to some plans that wish to purchase a higher/lower attachment point and cost-sharing ratio depending on their perception of risk or the nature of their enrollee population. In addition, commercial reinsurers offer flexibility in terms of the types of services covered.

Larger, older, better capitalized plans usually buy coverage for only inpatient services, but smaller, newer, less well capitalized plans tend to want reinsurance for additional risks, including outpatient or rehabilitation services. One health plan we interviewed noted that its state's "one size fits all" approach to reinsurance was an important factor in seeking a more flexible policy in the commercial market.

- **Better service**—Perceived levels of comparative service varied, but overall, private reinsurers during this period were seen as offering better service. The most commonly noted advantage was in speed of claims resolution. Commercial reinsurers tend to offer more automated and sophisticated claims processing, enabling them to provide more efficient and timely payment. Turnaround time for commercial reinsurance to process a claim and provide reimbursement was most commonly said to be some 30-60 days. In contrast, public reinsurance claims could take a year to process in Maryland and 90 days in Massachusetts. Spurred by loss of customers, New York has sought to attract health plans back with speedier payment.

Private reinsurers are perceived as imposing less administrative "hassle" on plans. Sometimes plans create a captive reinsurer to further improve efficiency and responsiveness.

- **Competitive price**—Private reinsurance premiums vary by health plan and by reinsurer, unlike the standardized rates charged by public reinsurers, so MCOs shop for coverage, often using brokers. During the late 1990s, private reinsurers were perceived to offer lower rates (adjusting for differences in coverage), which was attractive to plans that felt they could manage the higher risks of accepting private plans' limits (see below). Some interviewees expressed concern, however, about rapid increases in private reinsurance rates since 2000—a worldwide phenomenon partly due to the dynamics of reinsurance markets as well as cost trends in MMC.³⁰
- **Additional ancillary services**—Commercial reinsurers also appeal to plans by offering some additional ancillary services, including advice on rate setting and on management of risk. Reinsurers also supply networks of vendors already certified and available at pre-negotiated, favorable rates—for example, specialty pharmacies, neonatal case management companies, centers for organ transplants. Use of the reinsurer's network for high-cost services may be required. Private brokers also offer after-sales service, such as helping to assure that reinsurance claims are complete before final submission.

Advantages of Public Reinsurance

Public reinsurance also has advantages. Accordingly, plans have some reasons to prefer public to private coverage when given a choice.

³⁰ "Reinsurance: Love on the Rocks." *Economist*, April 17, 2003.

- **Unlimited total benefits**—First and foremost, public reinsurance is more comprehensive than commercial reinsurance. Whereas commercial coverage sets overall limits on covered spending per enrollee, annual or lifetime, states offer unlimited reinsurance. For example, the reinsurer Allianz typically has a \$2 million lifetime limit per enrollee and \$2 million annual limit per enrollee.
- **Unlimited daily benefits**—Commercial coverage has daily maximums by coverage type (e.g., inpatient services), often called “internal limits” in contrast to outer or overall policy limits. Interviewees noted that internal limits for inpatient services commonly are \$2,500 - \$3,500, \$1,000 - \$1,500 for outpatient hospital services, \$500-\$1000 for acute rehabilitation services, and about \$500 for home health services. It is not uncommon for commercial reinsurance to have limits on the number of covered days in a skilled nursing facility (generally 90-100 days). Such internal limits are common in MCO reinsurance for private business as well as for Medicaid managed care, but Medicaid MCOs often choose lower limits, plausibly because Medicaid FFS payment limits can affect their maximum responsibilities.

A broker’s survey of reinsurance provisions for physicians groups accepting capitation and self-insured employers found that daily inpatient limits averaged only about \$2,300—dangerously, only a fraction of the average billed daily hospital rates for neonatal and other high-cost care in California, New York, and Pennsylvania.³¹ MMC interviewees suggested that MCOs faced the same danger of being unable to control hospital rates and hence to face potentially very large losses under common limits for private reinsurance.

- **More generous claims administration**—Although public reinsurance was perceived as slower to pay than private coverage, it also was reported to review and approve claims less stringently. Private coverage typically limits coverage to claims submitted within a year; at least some public reinsurers allow later claims (15 months in Arizona, for instance). Interviewees at several health plans that had switched from public to private reinsurance noted that the private entities were stricter in determining allowable expenses, in enforcing early-notice requirements, and in reviewing submitted claims.

Just as opinions of state officials differed on the importance of continuing to run public reinsurance rather than rely on private reinsurers, opinions among health plan interviewees differed on the relative advantages and disadvantages of public and private reinsurance.

The Place of Reinsurance within the Spectrum of Risk-Mitigating Measures

Reinsurance is one of “a family of risk-limiting measures to get plans to participate in managed care,” as one state interviewee noted. The risk-mitigation family has two

³¹ Evergreen Re. *Fifth Annual Evergreen Re Managed Care Indicator*. Glendale, CA: Evergreen Re, 2002.

general branches, distinguished by whether measures have a predictable impact from the time of enrollment or only well after enrollment. We term these ex ante and ex post.

Ex Ante Measures that Mitigate Risk at Time of MMC Enrollment

Some MCO-payment-related provisions address the risk assumed by a capitated MCO at the time of MMC enrollment. Such ex ante provisions seek to increase the willingness of plans to participate in MMC. The provisions also encourage MCOs to accept all enrollees more or less equally, reducing the incentive to engage in risk selection, what insurers call “underwriting” of risk when they are allowed to assess applicants openly. Almost by definition, ex ante measures are particularly applicable where risks are known in advance and, often, apply generally to an entire class of enrollees, as for disabled beneficiaries.³²

- **Higher capitation rates by enrollee class**—MMC programs often pay higher capitation rates for certain populations, including persons with disabilities and chronic illnesses. Similar rate setting methods are used to establish rates separately for different categories of enrollees. Thus, rates may be set within “cells” defined by demographics and by enrollment category. This approach generates higher payments for higher risks by class or enrollee. Most of our six case study states used this approach (Table 6).
- **Higher capitation rates by conditions**—A MMC program may “set aside” a higher capitation fee for enrollees with certain conditions, such as renal failure, organ transplants, or HIV/AIDS. Three of our states used this mechanism (Table 6). This approach is akin to basing capitation on health factors, but using only a few factors.
- **Health-based risk adjustment**—This is the most sophisticated ex ante mechanism, adjusting capitation rates according to expected costs projected from prior spending or utilization using a method that determines risk by health-related groupings. Two risk-adjustment methodologies are best known. One determines risk by assessing prior experience within Adjusted Clinical Groups (ACGs). ACGs were initially developed as Ambulatory Care Groups, at Johns Hopkins University.^{33,34,35,36} The other is the Chronic Illness and Disability Payment System (CDPS), which was developed at the University of California at San Diego.^{37,38,39} These methods take into account far more diagnoses or conditions than simple condition-based capitation adjustment. Using its version

³² Palsbo S. and Post R. *Implementing Risk Assessment and Risk Adjustment for People with Disabilities in State Programs: Six Case Studies*. NRH Center for Health and Disability, November 2001.

³³ Johns Hopkins University. ACG Case-Mix System (Web page with description, history, bibliography, etc.) <<http://acg.jhsph.edu/index.htm>> last accessed May 21, 2003.

³⁴ Weiner J. B., Starfield B. H., Steinwachs D. M., and Mumford L. M. “Development and Application of a Population Oriented Measure of Ambulatory Care Case-Mix.” *Medical Care*, 1991; 29(5): 452-472.

³⁵ Weiner J. P., Tucker A. M., Collins A. M., Fakhraei S. H., Lieberman C. A., Trapnell G. R., and Folkner J. G. “The Development of a Risk-Adjusted Capitation System: The Maryland Medicaid Model.” *Journal of Ambulatory Care Management*, 1998; 21(4): 29-52.

³⁶ Moore, et al., op. cit.

³⁷ UCSD. CDPS—The Chronic Illness and Disability Payment System (Web page, description, manual, etc.) San Diego: University of California at SD. <www.medicine.ucsd.edu/fpm/cdps> last accessed May 21, 2003.

³⁸ Kronick, et al., op. cit.

³⁹ Kronick R., Gilmer T., Dreyfus T., and Lee L. “Improving Health-Based Payment for Medicaid Beneficiaries: CDPS.” *Health Care Financing Review*, 2000; 21(3): 29-64.

of ACGs, for example, Maryland generates rates within fully 63 rate cells, 18 of which are risk adjusted.

Among our states, three used one of these two methodologies (Table 6). Two others were expecting to move in this direction for at least part of their capitation programs (so not included in table).

Implementing risk adjustment calls not only for software but also data processing capabilities and large amounts of relevant data. Maryland, the first state to move to risk adjustment,⁴⁰ contracted out the process to a specialist center within a state university. Academic research suggests that risk-adjusting methods predict only a minority of the variation in health spending,⁴¹ but for practical purposes, they constitute a significant advance. One Maryland health plan respondent noted that the state's adjusted capitation rates were reasonably accurate, and "vastly better" than using rate cells distinguished by geographic and demographic criteria alone.

- **"Carve out" of certain services**—Here, states remove certain services from capitation, paying separately for them within a different delivery system. Carved-out services commonly include behavioral health or certain prescription medications. MCOs know up front that they are not responsible for such expenses.^{42,43,44} A separate, more specialized entity is responsible for managing the care carved out. That manager may or may not bear risk; fee-for-service payments appear to be common.⁴⁵ Five of our six states used carve outs for some services.

Two additional ex ante risk-mitigating mechanisms are noteworthy, although not typical:

- **Rare and Expensive Case Management**—Maryland's REM program offers a voluntary, case-managed, fee-for-service alternative to joining a capitated MCO for MMC recipients with rare and expensive conditions. REM enrollees are mainly children with chronic, severe health conditions like cystic fibrosis, spina bifida, and HIV/AIDS.⁴⁶
- **Risk pooling for high-cost enrollees**—As noted above, this mechanism is often considered a form of reinsurance, but it applies ex ante, at time of enrollment. Among our states, only one had such a provision. Pennsylvania runs a risk pool to cover HIV/AIDS enrollees under capitated MMC. Rather than capitating each

⁴⁰Palsbo, et al., op. cit.

⁴¹Newhouse J. P. "Risk Adjustment: Where Are We Now?" *Inquiry*, 1998; 35(2, Summer): 122-131.

⁴² Andrews J., Anderson G., Han C., and Neff J. "Pediatric Carve Outs: The Use of Disease-Specific Conditions as Risk Adjusters in Capitated Payment Systems." *Archives of Pediatric Adolescent Medicine*, March 1997; 151:236-242.

⁴³ Maguire A., Powe N., Starfield B., Andrews J., Weiner J., and Anderson G. "Carving Out' Conditions from Global Capitation Rates: Protecting High-Cost Patients, Physicians, and Health Plans in a Managed Care Environment." *The American Journal of Managed Care*, 1998; 4(6): 797-806.

⁴⁴ Bachman, et al., op. cit.

⁴⁵ Palsbo, et al., op. cit.

⁴⁶ University of Maryland, Baltimore County, Center for Health Program Development and Management. "Rare and Expensive Case Management." 2003. <www.umbc.edu/chpdm/expertise/rem/> last accessed May 21, 2003. The program is said typically to shift care from inpatient to community settings, which achieves high satisfaction ratings from participants.

MCO, the state pays its contribution to a pool, from which MCOs all receive pro rata funding according to their share of HIV/AIDS enrollment in MMC. This resembles one form of reinsurance used under individual and small group market reform of private health insurance, risk pooling of any applicants not accepted by private insurers, but does not allow MCOs to designate pool participants.

Ex Post Measures that Mitigate Risk at Time of MMC Spending on Enrollees

In the ex post branch of risk mitigation we include lump-sum maternity payments, reinsurance, and risk corridors—which protect MCOs from the risk of unexpectedly high spending.

- **Maternity “kick” payments**—Many states pay an additional lump sum payment for pregnancy, delivery, and newborns, on top of capitation payment for the enrolled mother. The lump sum recognizes that childbearing imposes higher costs yet maintains an incentive for prudent management of spending. (Even under fee-for-service payment, many states pay “global” lump sums for perinatal care.) “Kick” payments are similar to ex ante carve outs, in that they move costs for one predefined set of services out of capitation; also, pregnancy is often known at enrollment in Medicaid, as it is a major pathway to eligibility. Five of our states made such payments (Table 7). One national survey reports that nine states of 42 respondents with capitated MMC made such payments outside of capitation.⁴⁷
- **Reinsurance**—Reinsurance of individual enrollee’s above-threshold spending applies only after enrollment, to offset levels of spending that might otherwise impair an MCO’s financial viability and willingness to continue participating in MMC. It serves to protect against unanticipated high spending on any one enrollee. As one state official commented, “reinsurance should be [an] adjunct to other risk-mitigating measures because it only addresses risk associated with high-cost outlier cases.” Because reinsurance protects a plan only after it loses money, it does not remove the negative incentive that capitation gives plans to avoid high-risk enrollees or to underserve high-cost beneficiaries after enrollment.⁴⁸
- **Risk corridors**—Risk corridors limit participating MCOs’ profits or losses in the aggregate, sharing them with the state according to a predetermined formula.⁴⁹ Where an MCO’s losses rise beyond a preset amount (related to expected spending), its state reimburses it for all or a share of succeeding losses. Conversely, where the MCO profits from incurring expenditures below another

⁴⁷ Schwalberg R., Anderson Mathis S., Giffen M., Mohamadi L., Zimmerman B., and Sines E. *Medicaid Coverage of Perinatal Services: Results of a National Survey*. Health Systems Research, Inc., Kaiser Family Foundation report no. 2218) <www.kff.org/content/2001/2218/2218.pdf> last accessed May 21, 2003.

⁴⁸ GAO, op. cit.

⁴⁹ Westmoreland T. “Medicaid Managed Care, Sect. V. Financing Issues in Medicaid Managed Care.” *Medicaid and HIV/AIDS Policy: A Basic Primer*, espec. Chapter 5m, 1999; Federal Legislation Clinic of Georgetown University Law Center, Prepared for The Henry J. Kaiser Family Foundation, July 1999 <www.nastad.org/PublicPolicyResources/1891-KFF.pdf> last accessed May 23, 2003.

preset amount, it must return some or all of the unexpectedly large gains. Both plans and states are thus protected against significant variation from expected spending. The corridor is the middle range within which the risk sharing differs from the extremes. At the high end (above the corridor), the arrangement normally operates as aggregate stop-loss reinsurance—the state pays for all unexpectedly high spending. At the low end, an MCO may have to return all profits earned by holding spending very far below expectations.⁵⁰

Risk corridors differ from conventional reinsurance in two main ways: First, the state shares risk both above and below the target level. Second, the shared risk is normally defined in terms of *aggregate* annual spending rather than the *individual* spending covered by reinsurance. The focus is overall plan profit or loss on all enrollees rather than extraordinarily high spending for a single enrollee.⁵¹

Three of our sample states use risk corridors for specific high-cost populations (Table 7). Massachusetts has a risk corridor with one health plan that provides prepaid care for the severely disabled.⁵² Arizona has a risk corridor around all capitated retroactive eligibility (started out with a band and then went to 100 percent reconciliation) and has a risk corridor around the Title XIX waiver capitation group (for both prospective and retroactive capitation). New York has two different risk corridors—for certain managed long-term care plans and for the Special Needs Plans serving individuals with HIV and their dependent children.⁵³

States' Choices among Forms of Risk Mitigation

Most of these risk-mitigating provisions are complementary to one another. That is, they can be used in combination—for example, paying higher capitation rates for disabled enrollees at enrollment and also providing reinsurance that covers above-threshold spending after enrollment. Reinsurance, risk corridors, and risk pooling provisions are mainly seen as substitutes for each other.

⁵⁰ GAO, *op. cit.*

⁵¹ Risk corridors could be used for individual spending as well, but seem not to be in Medicaid. Reinsurance also can apply to aggregate spending, although it seems not to be in Medicaid, certainly not in these six states. In private reinsurance markets customers can focus either on individuals with “specific” reinsurance, or on total expenditures with “aggregate” reinsurance (Lewin Group 1997). Most private HMOs buy specific reinsurance akin to the state plans described above; some private self-insured employers contract with third-party administrators to share risk using risk corridors around an expected level of fee-for-service spending (a kind of virtual capitation). A “minimum premium” health plan that provides partial self-insurance to some workplace groups also essentially shares risk around a kind of corridor: The group pays the plan administrator a minimum premium every month, self-insures for fee-for-service spending above that up to an aggregate annual ceiling above which stop-loss reinsurance covers all expenses to some specified maximum.

⁵² Formerly, according to the GAO, *op. cit.*, Massachusetts “plans serving those who are severely disabled must return to the state any profit that exceeds 10 percent of the capitation payments they received.”

⁵³ New York’s two sets of provisions apply sharing indefinitely, never giving the state 100 percent of gains or losses. State contracts with SNPs specify a target medical loss ratio of 85 percent (of the capitation amount). Each plan and the state share equally in gains or losses in excess of two percent (above 87 or below 83). Plans are fully at risk for administrative expenses. Certain managed long-term care plans must also share equally in gains and losses outside a corridor of plus or minus five percent, with approved administrative expenses at 25 percent in the first year of operation, phased down to 15 percent in the third and subsequent years of operation.

All interviewees agreed that reinsurance is one of many measures used to reduce undue risks to health plans and improve participation, and some agreed that reinsurance is relatively less important if other measures are in place. Some interviewees pointed out that the risk addressed by reinsurance—the occasional very high-cost enrollee or continuing episode of care—is quite different from the systematically more expensive day-to-day care needed by beneficiaries with chronic illnesses and disabilities. Thus, reinsurance has little effect on capitation’s potential incentive to “stint” on expensive care for high-cost enrollees. These observations match those of some experts.⁵⁴ No particular pattern seems evident in how our six states’ programs combined the available risk-mitigating provisions (Tables 6 & 7).

What Explains States’ Preferences for Public versus Private Reinsurance?

Given cross-state variation in public versus private reinsurance for participating MMC health plans, the question arises, why did states choose as they did? At the very beginning of Medicaid managed care, one reason for providing state reinsurance was practical necessity. This reportedly occurred in Washington State, when private reinsurers would not agree to write the brand new program in the absence of any data on likely experience.⁵⁵ Maryland interviewees described a similar situation at the start of voluntary MMC in the 1980s, when the only participation was by a single provider-based entity with no experience in risk bearing.

Past the start-up phase, however, especially with the participation of commercial health plans, private reinsurance definitely becomes feasible. Whether or not a state continues to offer or require public reinsurance might plausibly be related to the nature of the state’s overall public involvement in providing or regulating services, especially in health care. For example, it might be asserted that New York’s strong public reinsurance program reflects the state’s generally pro-regulatory culture, or that Oklahoma’s low involvement with public reinsurance is related to the state’s overall low level of public interventionism. Overall, however, the observed public/private split on reinsurance in our six states did not fit this pattern (Figure 1).

Consider especially the examples of Arizona and Maryland. Arizona is normally oriented toward private-sector operations. It was the last state to accept federal assistance for Medicaid, only beginning to operate its AHCCCS program once it got approval to run Medicaid as an unconventional, managed-care-based program that sets prices by bidding and negotiation rather than by public rate making. Yet Arizona arguably goes further than any other state in running public reinsurance. Current and former Arizona officials strongly believe that public reinsurance is a better value for its health plans and hence for its AHCCCS program. Arizona also places great emphasis on public data and management capabilities, which are needed to run a good reinsurance program.

⁵⁴ Westmoreland, op.cit.

⁵⁵ Nichols L., Leighton K., Norton S., and Wall S. *Health Policy for Low-Income People in Washington*. Urban Institute/Assessing the New Federalism, December 1997.

Maryland, on the other hand, has almost wholly withdrawn from the public reinsurance it started with. Yet, Maryland traditionally has been seen as a very regulatory state—the last to maintain hospital rate regulation even of private rates. Maryland also developed great sophistication in use of data for MMC rate making, to a considerable extent by contracting out to a state university. Those capabilities, however, are focused on setting basic capitation rates, not on reinsurance methods or premiums.

With regard to Arizona’s somewhat surprising stance on state reinsurance, we noticed that different governments play a large role in AHCCCS, as county health departments are often a winning bidder and the largest plan in their area. Follow-up interviewing, however, showed that for-profit health plans were the large supporters of public reinsurance, not the county plans.

We suspect that many factors about MMC, its health plans, its insurance markets, and local history and culture affect state choices. The variation in state policy also is broader than observed in this targeted case study, as some states neither offer public reinsurance nor require private reinsurance, leaving that choice to plan discretion. More information on a much larger number of states is needed to develop a more robust explanation of state policies on required MMC reinsurance.

Lessons Learned

Many interviewees used words like “vital” in assessing the importance of reinsurance. At the inception of Medicaid managed care, the reinsurance often had to be public, as private reinsurers were unavailable owing to the newness of the market. After the accumulation of some experience, however, reinsurance could be obtained privately.

Reinsurance is one of a family of risk adjusting or sharing mechanisms needed to create a stable and fair Medicaid marketplace that rewards successful management rather than cream skimming and punishes poor management rather than ill luck or lack of size to accommodate a small number of very costly enrollees or episodes of care. Some mechanisms operate in advance, at the time of enrollment, to adjust for variation in predictable risk—notably by varying capitation rates. Some operate after the fact to share risk of unusually expensive, unpredictable experience—like reinsurance and risk corridors. Reinsurance and risk adjustment are generally perceived to be complementary tools with similar goals rather than substitutes or alternatives for accomplishing the same thing.

All state interviewees emphasized the value of reinsurance in protecting Medicaid managed care plans from random high-cost cases. Most viewed very high spending in individual cases as an unpredictable, unmanageable expense. They supported reinsurance requirements as a way to focus MCOs’ energies on managing levels of expense that they can manage—below the reinsurance threshold. Nonetheless, almost all state (and private) reinsurers require coinsurance by MCOs even above the threshold; one state interviewee specifically mentioned an earlier plan review that found reduced management by a health plan above a threshold, after which the state increased MCOs’ coinsurance obligation. Only one state’s interviewees mentioned using reinsurance as one way to help mitigate incentives to avoid high-cost enrollees.

The state programs reviewed were converging on one basic model of reinsured risk sharing—above-threshold annual spending for an individual beneficiary, typically limited to inpatient spending and with a coinsurance obligation on the MCO as a check on moral hazard. Reinsurance of above-threshold risk on an aggregate, plan-wide basis was not observed, although in three states some small categories of coverage had risk corridors sharing risk both above and below expected levels of spending. All six states studied also were similar in that they require MMC to have reinsurance, either public or private. This similarity is partly due to our selection of states for this study.

State policy differed most notably in the extent to which our six states run public reinsurance programs. Cross-state variation would have been even more notable had we not used presence of public reinsurance as one selection criterion for the study. In most states, reinsurance coverage is exclusively private (Appendix B). Even among our six states, most had become less reliant upon public coverage, more upon private. The biggest shift occurred in Pennsylvania, which ended its public reinsurance program in 1997 and now has plans purchase commercial reinsurance. Maryland, which would like to “get out of the reinsurance business,” gave MCOs a one-way option to switch out of public coverage, and now have only one small MCO purchasing state reinsurance. Massachusetts mainly relies on plans purchasing private reinsurance, except for two of the six coverage groups where they see a need for public reinsurance.

The most active public reinsurers in our state sample are New York and Arizona. In New York, the program has actively competed with private reinsurance to win back MCOs through streamlining administrative process and changing rates. Arizona requires all plans to purchase state-offered reinsurance, using five different types of reinsurance programs targeted at specific populations. Arizona officials believe that reinsurance is less administratively burdensome than using some other means of mitigating risk, including risk-adjusting software programs. Arizona officials also noted that reinsurance is a useful tool for mitigating selection effects of enrollment.

Some of the difference in extent of public coverage seems attributable to demand-side factors such as:

1. Structure of the managed care markets.
2. States with MCOs that are more experienced, larger, commercial, and abundantly capitalized rely more on private reinsurance.
3. Supply side influences also exist, in the form of state preferences about public versus private operations.

Running a good public reinsurance system calls for having:

- Very good data systems for MMC.⁵⁶
- Automated submission and processing of reinsurance claims.

⁵⁶ Kaye N. and Fralich J. *Collection and Use of Data: State Operated Managed Care Programs for Dual Eligibles*. Prepared for the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program and the University of Maryland Center on Aging. University of Maryland Center on Aging, February 1998. <www.hhp.umd.edu/AGING/MMIP/TApapers/TApaper2.pdf> last accessed May 1, 2003.

At least MCOs very much appreciate automation, sometimes citing it as one reason to prefer private reinsurance. Having good data systems enables the state to operate several different programs of public reinsurance. Arizona officials most strongly asserted a preference for public reinsurance and also pride in data capabilities; the attitudes and capabilities seem mutually reinforcing. New York officials believe that they can do accurate reinsurance rate setting because they have a large, actuarially credible database on fee-for-service claims and the analytical expertise to use it. Conversely, Maryland had significant operational problems because of reliance on a claims-handling system set up to receive claims directly from hospitals rather than from health plans. Some interviewees noted that running a reinsurance program gives information about risk and spending relevant to the entire program; below-threshold services have to be tracked to document attaining the reinsured layer of expense.

Enrollment of SSI beneficiaries in MMC is seen as calling for some differences in reinsurance practice but not significant differences in basic program design. These beneficiaries are classified separately for reinsurance rate making, as they are for setting capitation rates; and the premiums charged (capitation withheld) for that reinsurance vary by these categories as well. But in almost all cases, other reinsurance provisions were the same, usually including even the attachment point (deductible) to be met before reinsurance begins to pay, and claims are handled in the same ways. Only in Massachusetts was the disabled population's threshold different. Other risk-mitigating mechanisms, like carve outs and risk adjustments routinely varied for disability status or by particular conditions, including hemophilia and HIV status.

Attachment points do vary across states and in some states across reinsurance provisions for different risks. Higher deductibles are often appropriate for larger and more experienced health plans. Lower deductibles can be appropriate for less manageable risks where a high deductible might lead to undesirable selection effects, e.g., transplants.

The pros and cons of public and private reinsurance were described in similar fashion by most state officials and by health plan and reinsurer interviewees: The chief advantage of public reinsurance is more comprehensive protection; private coverage is subject to significant internal and overall limits. The chief advantages of private reinsurance are more flexibility, lower prices (at least in the late 1990s), better claims services (mainly automation and speed of processing), and more consistency with private business practice (especially for commercial MCOs). Ability to offer some ancillary services including high-cost case management and centers of excellence seemed a lesser attraction. A few interviewees speculated that private coverage could be losing its price advantage, in light of large recent premium increases in private reinsurance markets.

Appendix A: Tables and Figure

Table 1: Characteristics of States' Medicaid Managed Care Programs, 2002

State	Percent of Medicaid Enrollees in MMC	Populations Voluntarily Enrolled	Populations Mandatorily Enrolled	CSHCN in MMC	Number of Plans Participating	Rate-setting Methodology
AZ	88 percent	None	Aged/Blind/Disabled, Foster Care, XXI, AFDC/TANF, SOBRA, spend-down population.	Yes, capitated, but in different MMC program	10	Risk-adjusted groups defined by age and sex for TANF, SSI Medicare eligibility, extended family planning program, XIX waiver, and geography.
MD	80 percent	None	AFDC/TANF, Blind/Disabled, Foster Care, XXI.	Yes	6	Enrollees assigned to risk adjusted groups after six months of eligibility.
MA	67 percent	AFDC/TANF, Blind/Disabled	None	Yes, small number, most in PCC	4	Negotiates rates annually based on UPLs, geography, inflation, and covered services. Risk adjusted groups defined by eligibility category, age, and sex.
NY	~50 percent	Blind/Disabled, Foster Care	AFDC/TANF	Yes ²	27	Negotiates rates with each plan individually. Rates defined by age, sex, geography, and eligibility (TANF, safety net, SSI).
OK	34.2 percent (risk-based)	None	AFDC/TANF, ABD, XXI	Yes	4	TANF, ABD rates set using FFS data trended forward, adjusted by geography. Adjusted annually for inflation and new services. Beneficiaries placed in risk adjusted cells after 90 days.
PA	76 percent	None	AFDC/TANF, ABD, Foster Care.	Yes	7	Rate schedules by geography and eligibility. HMOs allowed to suggest revisions. Rates are updated annually.

Source: Authors' compilation of documentary and interview materials; Notes: 1. From KFF (2003), includes PCCM, as of December 31, 2001; 2. MMC enrollment is voluntary and rates relevant to children are adjusted depending on number of CSHCNs; 3. Data from Regenstein and Schroer (1998, note 10 above).

Table 2: Source of Medicaid Reinsurance, by State, 2002

State	Public Only	Private / Commercial Only	Mix
AZ	X		
MD			X ²
MA			X
NY			X
OK			X ³
PA		X ¹	

Source: authors' compilation of documentary and interview materials; Notes: 1. Public reinsurance was discontinued; 2. One plan still has public coverage; all others must have private; 3. State coverage required for ABD, commercial reinsurance for other populations.

Table 3: States' Motivation for Public Reinsurance at Inception of MMC

State	Plans unfamiliar with Medicaid recipients /services	Lack of data made full-risk capitation too risky	Small (enrollment and capital) plans	Not feasible for plans to purchase commercial reinsurance	Protection from adverse selection	Concern regarding SSI/Disabled in managed care
AZ			X	X		
MD	X	X	X			X
MA			X			
NY	X	X	X	X		
OK						X
PA			X	X		

Source: authors' compilation of interview materials.

Table 4: Specific Features of Reinsurance Design, by State, 2002

State	Population Covered	Definition of Reinsurance Risk (approved spending)	Attachment Point(s)	Coinsurance Ratio - Reinsurer: MCO
AZ				
Regular Acute Prospective	All acute-care MMC enrollees. ¹	Per enrollee, per year for inpatient costs (formerly all costs).	\$15,000 to \$50,000 (initial attachment point), depending on plan enrollment, whether enrollee eligible under new waiver; \$650,000 (second point)	75:25 below \$650,000; 100:00 above
Prior Period Coverage	All acute-care MMC enrollees. ¹	Inpatient services.	\$5,000	100:0
Catastrophic	All MMC enrollees (acute and ALTCS) diagnosed with hemophilia, von Willebrand's Disease, and Gaucher's Disease. Major organ or tissue transplants handled separately.	Per enrollee, per year for all costs, subject to medical review.	\$0 (initial attachment point); \$650,000 (second point)	85:15 below \$650,000; 100:00 above 85:15 for transplants
Arizona's Long Term Care System (ALTCS)	All ALTCS members.	Per enrollee, per year for all acute costs (formerly inpatient only).	\$5,000 and \$20,000 depending on plan enrollment and Medicare eligibility.	75:25
High Cost Behavioral Health	All ALTCS enrollees.	Per enrollee, per year, for institutional and home and community based care.	\$0 initial attachment point; \$650,000 (second point)	75:25 below \$650,000; 100:00 above
MD	All MMC enrollees.	Per enrollee, per year for inpatient costs.	\$30,000 ²	90:10
MA	Disabled, and Basic population which includes: Emergency Care for Elders and Disabled Children and adults unemployed for 12 months or more. ²	Per enrollee, per year for MCO-covered services.	\$100,000 for persons with disabilities; \$50,000 for Basic population.	80: 20
NY	All MMC enrollees.	Per enrollee, per year, for inpatient costs.	\$50,000 (initial attachment point), \$250,000 (second threshold); mental health: 20 outpatient visits, 30 inpatient	80:20 for \$50,000 - \$250,000; 100:0 thereafter; 100:0 for mental health above att. pts.
OK	ABD population.	Per enrollee, per year, for all medically necessary services.	\$62,376 (initial attachment point), \$249,500 (second point)	80:20 for \$62,376 - \$249,500; 100:0 thereafter.
PA	All MMC enrollees (mandatory purchase of commercial reinsurance).	Per enrollee, per year, for inpatient costs.	\$200,000 \$100,000 for plans deemed less experienced/stable.	80: 20

Source: Urban Institute Medicaid capitation survey, materials from state programs, interviews. Notes: 1. In AZ, effective 10/01/01, Tit. XIX waiver enrollees have combined prospective-prior-period coverage with a single attachment point of \$15,000 and 75:25 coinsurance. 2. Level reduced to \$30,000 for only MCO still getting state reinsurance from earlier level of \$61,000.

Table 5: Relative Premiums for State-Offered Reinsurance, 2002

State	Reinsur. Rate as Pct of State's Capitation Rate
AZ	3.0-7.0%
MD	5.0%
MA	3.9%-6.3% ¹
NY	0.25-1.0%
OK	5.4%
PA	NA

Source: authors' compilation of documentary and interview materials; Note: 1. Rating Categories V, II (V: Emergency Aid to Elders and Disabled Children and Adults who are unemployed for 12 months or longer; II: disabled population); NA: not applicable

Table 6: Ex Ante Risk-Mitigating Measures in MMC, by State 2002

State	Separate Rate Cells for persons with Disabilities	Higher Capitation or Supplement Based on Condition	Health-Based Risk Adjustment	Carve-outs	Other
AZ	X	HIV drugs		MH, SA; breast & cervical cancer care.	
MD		HIV/AIDS	ACG	MH, School-based health services, LTC (over 30 days), personal care/adult care.	REM ¹ program.
MA	X			BH, MH, Dental.	
NY	X			Pharmacy, Personal Care, SA/MH inpatient services over 30 days, MH outpatient services over 20 days, Dental optional, Non-emergency Transportation Optional.	
OK	X	Transplants, Hemophiliacs, Sickle Cell Anemia, Schizophrenia, Supplement for Exceptional Need Coordinators	CDPS for ABD		
PA	X		CDPS	Non-emergency transportation.	Risk pool for HIV/AIDS.

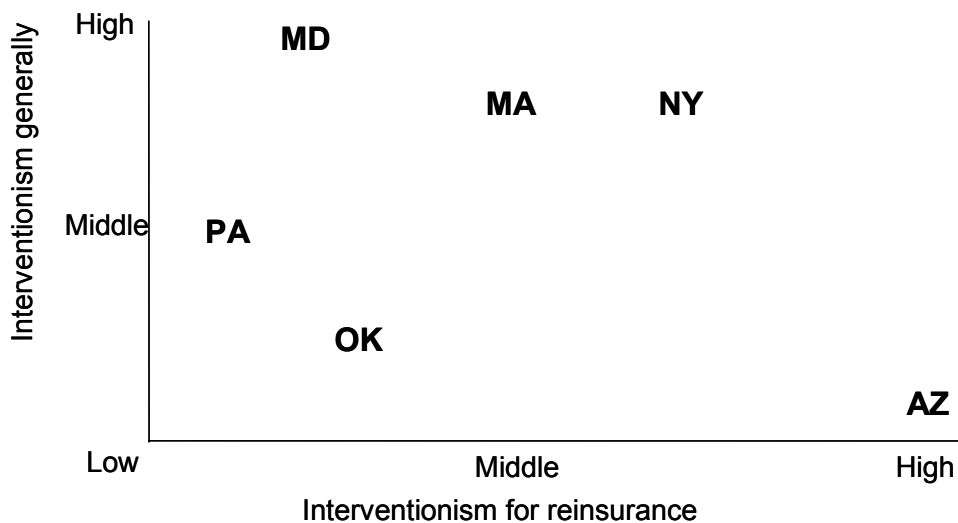
Source: authors' compilation of documentary and interview materials; Notes: 1. The Rare and Expensive Case Management (REM) Program is a case managed fee for service alternative to HealthChoice Managed Care Organization (MCO) participation for recipients with specified rare and expensive conditions. ABD=Aged, Blind, and Disabled; ACG=Adjusted Clinical Groups; BH=behavioral health services; CDPS=Chronic Illness and Disability Payment System; LTC=long-term care; MH=mental health services; SA=substance abuse services.

Table 7: Ex Post Risk-Mitigating Measures in MMC, by State 2002

State	Maternity “Kick” Payment	Reinsurance (Public or Private)	Risk Corridors	Comments on Risk Corridors
AZ	X	X	State shares in risk in a band around estimated spending for period of retroactive eligibility, and for Title XIX waiver population.	Bands still exist; plans may select either four percent up and two percent down or one percent up and one percent down. Bands adopted due to uncertainty about accuracy of capitation for a new population or new time period not previously covered by the health plans.
MD	X	X	Never had risk corridors.	N/A
MA		X	Had risk sharing for a few years for the populations now reinsured.	In SFY 2001, stopped offering risk sharing except for a small severely disabled population in one contracting MCO. Stop-loss reinsurance seen as preferable.
NY	X	X	Have no corridors for main populations; two special populations have bands.	Two bands still exist: for Special Needs Plans (HIV-related beneficiaries) and certain capitated long term care plans.
OK	X	X ¹	??	??
PA	X		None	Concept was considered for a recent procurement and rejected.

Source: authors’ compilation of documentary and interview materials; Notes: 1 Oklahoma has state-offered stop-loss for the ABD population only (Aged, Blind, and Disabled).

Figure 1: Extensiveness of States’ Roles in Health Care: In General vs. in Medicaid Reinsurance



Appendix B: Models of Reinsurance among 34 States

State	Public Only	Commercial Only	Mix
AZ	X		
CA			X
CO		X	
CT			X
DE		X	
DC		X	
FL		X	
HI	X		
IL		X	
IN		X	
IA			X
KS		X	
KY			X
MD			X
MA			X
MI		X	
MN		X	
MO		X	
MT			X
NV			X
NH		X	
NJ		X	
NM		X	
NY			X
OH		X	
OK			X
PA		X	
RI			X
SC		X	
UT			X
VA		X	
WA		X	
WV		X	
WI		X ¹	
Total	2	20	12
Sources: Center for Health Services Research and Policy (2000); Urban Institute (2002); Notes: 1. Wisconsin offers public reinsurance, but no HMO has ever purchased it.			

Appendix C: State Program Summaries

Information in the following summaries was primarily obtained through interviews with state officials. All states were given the opportunity to review their state program summary, and five of the six responded.

Arizona

Development

Arizona began its managed care program, the Arizona Health Care Cost Containment System in 1982.⁵⁷ From early in the program, the state offered public reinsurance and “deferred liability” payments to shield plans from the full burden of high-cost cases, so as to increase plan participation. AHCCCS officials chose state reinsurance on the ground that the state is a more efficient risk bearer. They believed that private coverage would cost about a quarter more, which would be passed through to the state in capitation rates. The state’s deferred liability provision helped plans cope with immediate high costs for certain newly enrolled beneficiaries, including those hospitalized at the time of enrollment, receiving active chemotherapy, or enrolling in the last two weeks of a high-risk pregnancy. It paid reimbursed plans on a fee-for-service basis for 80 percent of such early care. Reinsurance helped protect plans from unpredictable high-cost cases among their more typical enrollees. The state self-insures its reinsurance obligations.

Unlike other states, Arizona was not especially concerned to protect fledgling non-profit, provider-based, or public health plans. Indeed, it appeared that the more “financially motivated” plans were most supportive of AHCCCS efforts to limit high-cost risk through deferred liability and reinsurance, in part because such plans had accounting systems able to demonstrate the need for mitigating risk.

However, experience suggested that deferred liability payment did not provide enough incentive for plans to manage care. Consequently, in October 1994, the state eliminated deferred liability in favor of offering plans lower reinsurance attachment points.⁵⁸ The state also made other changes to its reinsurance program to make it more cost-effective, such as limiting basic, acute care reinsurance to inpatient services only. Outpatient services had previously been included, but they had been found to account for a very high share of processing costs but a very low share of reimbursable expenses. For certain catastrophic conditions and long-term care enrollees, reinsurance does cover outpatient services.

AHCCCS also experimented with varying degrees of coinsurance before arriving at its current levels. Officials concluded that covering 90 percent of costs was too high because plans lost incentive to manage care, but 60 percent was too low because plans were placed at too much risk. Currently, most reinsurance covers 75 or 85 percent of

⁵⁷ Kirkman-Liff B.L., Christianson J. B., Kirkman-Liff T. “The Evolution of Arizona’s Indigent Care System.” *Health Affairs* 6(4): 46-58.

⁵⁸ GAO, op.cit.

expenses over the attachment point.⁵⁹ The state increased protection against very high losses effective October 1, 2002, after which MCOs were reimbursed 100 percent for all medically necessary covered expenses above \$650,000 for an enrollee in a year, excluding transplants. The AHCCCS changes made over time tried to shift manageable risk to health plans while still offering them protection against unmanageable, high-end risk.

Design

Health plans participating in Arizona's Medicaid managed care program must purchase reinsurance from the state, not from a private reinsurer. The reinsurance provisions are quite complex. Five main types of reinsurance cover health plans' expenses for different types of beneficiary or in different circumstances, corresponding to different risks of high expense for a health plan. Reinsurance benefits are based upon the lower of the AHCCCS contract provider payment rates or the participating health plan's contracted amount.

The following describes reinsurance features as of early 2003:⁶⁰

1. Regular Acute Prospective Reinsurance covers 75 percent of approved inpatient costs above attachment points ranging between \$15,000 to \$50,000 per member per year, for members with acute medical conditions. (Nursing facility stays immediately after hospitalization or in lieu of hospitalization count as inpatient services.) The applicable attachment point depends on size of plan enrollment and whether a member is enrolled under a Title XIX waiver (single adults and childless couples above traditional Medicaid income levels). Larger plans get higher attachment points but may opt for lower ones. After a plan meets its attachment point, the state covers 75 percent of eligible costs up to \$650,000 and 100 percent of eligible costs above that.
2. Prior Period Coverage (PPC) for services rendered prior to 10/1/03, covers 100 percent of inpatient services above \$5,000 during the first few weeks of coverage—after a member's qualifying date for AHCCCS but before they choose or are assigned to a health plan. Health plans are responsible for paying for PPC care; and, because many members enroll after becoming ill, these first few weeks of coverage are more expensive than contemplated by regular capitation rates. Formerly, the state had a risk band around expenses for that period and made health plans whole for PPC costs. Since 1997, AHCCCS has capitated plans for expected PPC costs then reinsured very high expenses. PPC expenses do not count toward a plan's meeting the applicable attachment point of its Prospective Reinsurance. After September 2001, Prospective and PPC Reinsurance were combined for plans' Title XIX waiver members, with a single attachment point.

⁵⁹ AHCCCS. 2002a. *AHCCCS Overview, October 1, 2001 To October 1, 2002*. Arizona Health Care Cost Containment System. <www.ahcccs.state.az.us/Publications/overview/2002/2002AHCCCSOverview.pdf> last accessed April 21, 2003.

⁶⁰ AHCCCS. 2002a. *Reinsurance Claims Processing Manual*. Arizona Health Care Cost Containment System. <www.ahcccs.state.az.us/contracting/bidderslibrary/manuals/ri_clms_proc_manual_102102_v2.pdf> last accessed April 21, 2003.

3. Catastrophic reinsurance covers 85 percent of all annual costs of members diagnosed with hemophilia, von Willebrand's Disease, and Gaucher's Disease. The "attachment point" is thus zero. All care is subject to medical review. Starting in October 2002, the state's share rose to 100 percent of catastrophic conditions' annual costs above \$650,000.

AHCCCS also recently added 100 percent reinsurance for all expenses of breast and cervical cancer treatment, in a kind of carve out.

Transplant reinsurance applies to those members receiving major organ or tissue transplants (not counting bone grafts or cornea transplants). It pays 85 percent of the AHCCCS contracted amount or the plan's paid amount, whichever is lower, with no upper limit to cost sharing.

4. Arizona Long Term Care System (ALTCS) reinsurance applies to members of Arizona's managed long-term care program. It is defined per enrollee, per year, for all medically necessary acute care, inpatient, and outpatient services. Attachment points range between \$10,000 and \$30,000 depending on plan enrollment and Medicare eligibility. Beyond the attachment point, the state covers 75 percent of costs medically necessary acute inpatient and outpatient care, even dental services. Earlier, ALTCS reinsurance covered only inpatient expenses.

5. ALTCS members qualify for High Cost Behavioral Health/Traumatic Brain Injury reinsurance. The state covers 75 percent of all costs for institutional and home and community-based care per enrollee, per year, from zero up to \$650,000. Beyond the \$650,000 attachment point, the state covers 100 percent of eligible costs incurred by the health plan. Qualifying members include those with severe psychiatric conditions and other high cost categories. Such members' ordinary expenses are covered under regular reinsurance using separate guidelines. Placement into an institutional setting or appropriate home- and community-based services (HCBS) must be approved in advance by AHCCCS.

Operations

Arizona sets reinsurance premiums by examining health plans' past encounter data and then pricing reinsurance by capitation rate cell. The reinsurance claims payment process begins with an AHCCCS review of plan encounter data for cases exceeding the reinsurance threshold(s). It is then determined whether the services listed were medically necessary and within the scope of AHCCCS benefits. AHCCCS then reimburses the health plan for costs incurred in excess of the attachment point, subject to coinsurance percentages (if applicable). The state processes about 7,400 reinsurance encounters per month. AHCCCS performs medical audits on reinsurance cases to validate appropriate length of stay and level of care. Audits of prior period and prospective reinsurance are based on a random sampling and results may be extrapolated to the entire population for purposes of recoupment; MCOs are warned of audits in advance and afterward may give further justification and appeal final audit findings.

Experience/Lessons Learned

Arizona's reinsurance program has evolved over the years as the state gained experience monitoring encounter data. For example, the state was able to determine that it made more sense (from an administrative and cost perspective) to eliminate the deferred liability program and make changes to the reinsurance program's definition of risk. The state attributed its successes in managing its reinsurance programs to its ability to analyze reinsurance encounter data, automation of data flows, maintaining communication and soliciting feedback from health plans, and its overarching goal of transferring only manageable risk to health plans.

Maryland

Development

Maryland's reinsurance program has undergone a number of changes as the need for public reinsurance has diminished along with the state's interest in administering a stop-loss program. The state first included a Medicaid managed care plan on a demonstration basis in the 1980s. There was only one participating, provider-based plan, and state officials at the time perceived that public stop-loss reinsurance was essential for its fiscal stability. With the implementation of mandatory Medicaid managed care under the state's Health Choice program in 1997, the state provided public stop-loss coverage for all plans. The state saw a need to limit all plans' risk and believed that smaller, non-commercial plans would have difficulty purchasing reinsurance in the private market. As Maryland's Medicaid managed care program quickly matured, the state changed its policy, now favoring commercial reinsurance for Medicaid. Participating plans also appear to prefer private coverage because of the complexity of Maryland's system for covering high-cost cases and because after 1999 private reinsurance was less expensive than the public program, at least for larger HMOs.

Design

At the onset of mandatory Medicaid managed care in 1997, Maryland required plans to purchase public stop-loss coverage with an attachment point of \$61,000 with state reinsurance for 90 percent of costs thereafter. (The unusual threshold was created by starting with a \$50,000 attachment point in the base year for capitation rate making, then trending it forward to the time of program implementation.) Maryland's stop-loss works differently from conventional reinsurance, however, as past the first \$61,000 of inpatient expense in a year, the state assumes direct responsibility for paying further hospital bills. Rather than reimbursing a health plan for expenses already incurred, the state pays the hospital and then obtains reimbursement of 10 percent from the participating health plan, typically by offsetting that amount against capitation or other payments due to the plan. The 90:10 split continues until the end of the year; there is no maximum on plan responsibility, so the reinsurance does not truly stop the losses of participating health plans.

After April 1, 1999, the state encouraged existing plans to leave state reinsurance and purchase commercial reinsurance, and also barred new plans from the state stop-loss coverage (MDHMH 2001a). All existing plans obtained private reinsurance, except for two small plans, Prime Health and Jai Medical Systems. Prime Health has since been acquired by AmeriGroup, which purchases commercial coverage. Jai, with roughly 7,000 members, is the only plan (out of six participating plans) that still purchases public reinsurance. Jai will remain Maryland's only reinsurance client as the state after 1999 does not offer public reinsurance to any other participating Medicaid managed care plan. Although the cost-sharing ratio has remained the same, Jai negotiated a lower attachment point of about \$30,000. Maryland's reinsurance program does not have any daily or lifetime maximum limits on the amount of reinsurance that a plan can collect.

Another change made after the third year of Medicaid managed care was to extend the stop-loss period at the end of a year for hospital stays continuing past the end of the year (MDHMH 2001b). Previously, at the end of the year, state reinsurance had stopped paying for a case, and payment responsibility had shifted back to the plan. Neither hospitals nor plans had liked that provision.

Operations

Maryland's unusual reinsurance system calls for the state to take over paying hospitals when a health plan's annual expense for a member reaches \$61,000. Rather than the typical method of having an insurer pay the hospital and then claim reinsurance from the state, Maryland pays the hospital itself (90 percent) and then gets partial reimbursement from the health plan (10 percent). The system works well only when a single hospital stay is involved and the plan approves and pays claims in a timely and chronological fashion. When multiple hospital stays are involved or when a health plan's payment for hospital care does not come in the order care was incurred, the system becomes very complex. Only claims beyond \$61,000 in chronological order of care delivered are the state's responsibility, so any deviation from chronological order often results in delayed payments to hospitals, as the state establishes which claims chronologically fall before the attachment point (and are the plan's responsibility) and which claims fall after the attachment point (and are the state's responsibility). On occasion, the state has had to require a health plan to recoup a payment already made to a hospital, then allow the state to make the payment and assess the plan for its 10 percent coinsurance. The administrative complexity of this system resulted in cash flow problems for both the providers and plans.

Maryland's reinsurance claims processing system was set up this way to allow the state to perform concurrent review of high-cost inpatient care so as to avoid fiscal fraud and allow for case management. However, the state found it impractical to perform case management and believes that a retrospective audit would be more administratively feasible to prevent fraud.

Currently, Maryland's reinsurance premiums for Jai are approximately five percent of capitation rates. When the attachment point was initially set at \$61,000, reinsurance premiums were approximately two-three percent of capitation rates, but increasing costs of care have moved more expense over the unchanged threshold amount.

Experience/Lessons Learned

Maryland state officials believe that public reinsurance is valuable at the onset of Medicaid managed care and is still valuable to small plans, such as Jai, that may not be able to purchase commercial coverage. However, due to the administrative burden of their reinsurance claim processing, the state is no longer interested in running a reinsurance program for plans that can obtain stop-loss coverage from the commercial market. In particular, Maryland officials noted that a claims processing system that requires the state to intervene with provider payments is not practical, and suggest that it is preferable for state reinsurance programs to reimburse plans for allowable costs. Plans also have demonstrated a preference for purchasing commercial reinsurance, citing more timely claim processing, and in some cases, better rates.

Massachusetts

Development

To mitigate plan risk, the Massachusetts Division of Medical Assistance (DMA) initially negotiated risk corridors with each of its participating plans for the disabled and long-term unemployed populations. However, it became apparent that plans mainly needed protection from the expensive outlier cases. In 2001, DMA stopped offering risk corridors, except for a small severely disabled population with one of the contracting MCOs, and began offering stop-loss coverage. DMA decided that it was important to offer plans stop-loss coverage for persons with chronic illnesses and disabilities and long-term unemployed enrollees because these specific rating categories are small and unstable, relative to the larger and more predictable family population where it is easier to absorb most outlier costs. State stop-loss or similar private reinsurance was perceived as a critical element of the Medicaid managed care program particularly because of the small size and Medicaid-only nature of two of the four participating plans.

Design

Massachusetts' Medicaid managed care program offers stop-loss coverage to participating plans for individuals falling into specific rating categories. Enrollees in Rating Category II (persons with disabilities) have an attachment point of \$100,000 per person per year for all MCO-covered services. Stop-loss coverage for Rating Category V (Emergency Aid to Elders and Disabled Children and long-term unemployed) has an attachment point of \$50,000 per person per year for all MCO-covered services. Once an enrollee in these two categories exceeds the attachment point, the state reimburses the plan for 80 percent of further costs. Massachusetts' stop-loss program does not have any daily or lifetime maximum limits on the amount of reinsurance plans can collect. However, the Upper Payment Limit (UPL) serves as a limit, meaning DMA only will cover 80 percent of outlier costs above the threshold up to the UPL. Starting July 1, 2003, according to the BBA Managed Care Regulations implemented by the Centers for Medicare and Medicaid Services, stop-loss insurance will be actuarially sound, and there will be no limit because the Upper Payment Limit will no longer apply. Plans must purchase reinsurance for individuals in these two rating categories, but have the option of either purchasing it from the state or from a commercial reinsurer. One plan

once negotiated an alternative arrangement to purchasing private reinsurance, whereby the plan has setup a restricted reserve account.

Operations

Massachusetts' reinsurance premiums are set using three years of outlier expenditure experiences from the MCOs, as well as four years of outlier expenditure experiences from the Primary Care Clinician Plan to calculate actuarially sound stop-loss premiums. In SFY 2003, the stop-loss premium for Rating Category II was about 6.3 percent of the capitation rates for the two MCOs offered stop-loss. The stop-loss premium for Rating Category V was about 3.9 percent of the capitation rate for the one MCO that chose to purchase reinsurance for this population.

When a plan's expenditures for all MCO-covered services for an enrollee exceed the annual per enrollee stop-loss threshold, the plan submits claims to DMA documenting all expenditures for that enrollee. After DMA reviews and approves the claims, the reconciliation process begins. In SFY 2001, the number of enrollees who met the annual threshold ranged from six in one MCO to 49 in another.

Experience/Lessons Learned

Massachusetts' state officials believe that reinsurance is an important mechanism for limiting plan risk, particularly for "unstable" populations such as the disabled. Although risk corridors provided plans with more protection because the attachment point was lower, officials feel that stop-loss is a preferable risk-mitigating mechanism because it is easier to administer. Specifically, Massachusetts' system of charging plans a reinsurance premium, banking the premium, and then returning losses to plans, allows the state to budget appropriately. Moreover, officials believe that allowing plans to recoup net savings from stop-loss insurance encourages plans to control costs associated with outliers. Offering public stop-loss coverage also allows the state to manage (in a cost-review sense) high cost cases for the populations reinsured.

New York

Development

New York State began its public reinsurance program for reasons similar to the other states in this study—concern that some plans would have difficulty purchasing reinsurance in the private market. In the late 1980s, when voluntary managed care began in New York, participating plans were mostly provider-sponsored and very concerned about high inpatient costs. At this time, it was difficult for plans to purchase reinsurance from the private market because insurers believed that the Medicaid population was too risky. Nor was there a lot of commercial managed care in the state, in part because of the state's hospital rate setting system.⁶¹ When commercial reinsurance was available, it was considered expensive and consequently, MCOs elected to purchase reinsurance from the state.

⁶¹ Holahan J., Evans A., Liu K., Sulvetta M., Haslanger K., and Cantor J. *Health Policy for Low-Income People in New York*. Urban Institute/Assessing the New Federalism, State Report, November 1997. <www.urban.org/UploadedPDF/HP_nwyrk.pdf> last accessed May 24, 2003.

In the 1990s, New York experienced considerable growth in the number of plans participating in Medicaid managed care and an increased number of commercial plans, a trend that accelerated with deregulation of hospital rates and approval of a waiver for a mandatory MMC program in 1997. With the increase in commercial plans, the trend has been to purchase private reinsurance because many of these plans already have stop-loss arrangements negotiated with insurers. In addition, the state is not offering reinsurance to those plans participating in Child Health Plus (New York's SCHIP program) or Family Health Plus (New York's Medicaid expansion for adults) because the reinsurance premiums are based on fee-for-service claims data and Family Health Plus does not have a fee-for-service component. Out of the 27 plans that participate in New York's Medicaid managed care program, ten purchase stop-loss coverage from the state.

Design

New York requires that all participating managed care plans purchase reinsurance for all capitated premium groups. Plans have a choice to either purchase the coverage from the state or from commercial vendors. New York offers stop-loss coverage with an attachment point starting at \$50,000 for inpatient hospital claims per person, per year. Cost-sharing in New York's program is staggered by attachment point: Health plans pay 20 percent of costs exceeding the \$50,000 attachment point and have no cost-sharing responsibility once the second attachment point of \$250,000 is reached. Prior to 1996, the attachment point varied by plan. In the early years of managed care, some plans were so risk-averse that they requested attachment points as low as \$15,000, with very high premiums. In 1996, the state's actuary recommended a common attachment point of \$50,000 for all plans to ease the administration of the program. New York's reinsurance program does not have any daily or lifetime maximum limits on the amount of reinsurance plans can collect.

Although plans are given the option of purchasing inpatient stop-loss from the state or from a commercial vendor, they are required to purchase the state-offered reinsurance for mental health and chemical dependence inpatient rehabilitation/treatment services. Health plans are compensated for mental health treatment outpatient visits in excess of 20 visits or inpatient mental health/chemical dependence treatment in excess of 30 days in a calendar year.

Operations

For inpatient hospital reinsurance, the premiums are set based on projected fee-for-service claims. In 2000, however, the state revised the reinsurance rate setting methodology and lowered reinsurance rates significantly (35-40 percent) because MCO penetration of reinsurance was lower than estimated and the state was making a profit. Rather than analyzing one year of data, the rate setting method was revised to pool several years of fee-for-service data to smooth out variation and make the rates more accurate. In addition, the fee-for-service data are now risk-adjusted to better reflect the differences between the managed care and fee-for-service population. Currently, premiums for public stop-loss coverage are approximately .25 to one percent of capitation rates. Capitation rates are negotiated with each plan, by rate cell, and are adjusted to reflect the cost of stop-loss coverage. Although there are no stop-loss

provisions specific to the disabled/SSI population, stop-loss premiums are higher for this group than other less costly groups. For inpatient mental health/chemical dependence and outpatient mental health reinsurance, the state calculates the fee-for-service equivalent cost for the reinsurance and adjusts the Medicaid upper payment limits accordingly. In addition, the state uses the actual reinsurance recoveries paid to the plans to adjust the medical component of the premium rates negotiated with the plans.

The state handles the adjudication and processing of reinsurance claims in-house. Reinsurance claims are paid through the state's MMIS system, just like a fee-for-service claim. MCOs found the state's claim adjudication process lengthy and cumbersome, but the state has recently made efforts to streamline the process by allowing plans to summarize claims.

Experience/Lessons Learned

New York officials believe that reinsurance is a successful mechanism to address plans' concerns about risk. However, officials noted that reinsurance should be adjunct to other risk-mitigating measures because it only addresses risk associated with high-cost outlier cases. Officials believe that cost-sharing provisions are an important aspect of reinsurance design because holding plans accountable for a portion of the costs gives the plans an incentive to manage care. New York would like to continue providing reinsurance to MCOs and has made administrative and rate changes to maintain and attract plan participation in its public reinsurance program.

Oklahoma

Development

Oklahoma's Medicaid managed care program began in 1995 with the enrollment of its AFDC and AFDC-related beneficiaries in urban areas.⁶² During the first year of the program, the state offered plans the option of purchasing state reinsurance to minimize risk and thereby encourage plan participation. However, plans were not interested in purchasing public reinsurance for the TANF population, primarily because commercial coverage was perceived as more administratively efficient and the TANF enrollees were not believed to be all that risky. In 1999, Oklahoma began enrolling the aged, blind, and disabled (ABD) population into Medicaid managed care and made it mandatory for plans to purchase state-offered reinsurance for this population. The state wanted to encourage plan participation despite the enrollment of these higher-risk beneficiaries and believed it might be more difficult for plans to purchase commercial reinsurance for the ABD population. Thus, all four of the health plans currently participating in Oklahoma's Medicaid managed care plan have public reinsurance for the ABD enrollees.

⁶² Oklahoma Senate Staff. "Medicaid and Managed Care." *Overview of State Issues*, November 2000. <www.lsb.state.ok.us>

Design

Oklahoma's reinsurance provisions for the ABD population stipulate an attachment point of \$62,376 in "medically necessary" services per person per year. When this threshold is met, the state covers 80 percent of the costs of medically necessary services up to a second attachment point of \$249,500. Beyond this second attachment point, the state covers 100 percent of all medically necessary services within the year.

Oklahoma's reinsurance program does not have any daily or lifetime maximum limits on the amount of reinsurance plans can collect. Although the cost-sharing ratios between state and plan responsibility have not changed since the start of public reinsurance in 1999, the attachment points have risen over time.

Operations

Reinsurance premiums are set in conjunction with ABD capitation rates. Public reinsurance premiums for the ABD population are approximately 5.4 percent of the capitation rate. Reinsurance claims are processed and adjudicated in-house. Although Oklahoma does not offer plans public reinsurance for the TANF population, they do require plans purchase it commercially and reserve the right to approve or disapprove the reinsurance carrier and policy.

Experience/Lessons Learned

Although Oklahoma noted that plans were not interested in public reinsurance for the TANF population at the onset of Medicaid managed care, it was reported that one plan would now like to purchase public reinsurance. With Heartland serving 60-65 percent of all Medicaid managed care enrollees, the plan believes they have inordinate risk. The state, however, is not interested in expanding the public reinsurance market. To further reduce plan risk, the state may consider further risk adjustment for TANF capitation rates.

Pennsylvania

Development

Pennsylvania's Medicaid program began mandatory managed care in 1986 for Philadelphia, with the implementation of HealthPASS.⁶³ The state did not provide reinsurance for the HealthPASS contractor, but HealthPASS contracts provided for additional payments by the state if the cost of the state's fee-for-service program proved to be higher than anticipated when each year's HealthPASS rates were established. In 1989, Healthcare Management Alternatives (HMA) won the HealthPASS contract. To address concerns about their ability to cover risk, HMA purchased reinsurance to cover aggregate risk above a threshold. Requirements for this reinsurance were negotiated between HMA and the state, and were included in the contract.

In 1997, Pennsylvania's HealthChoices program was introduced in Philadelphia and four other Southeastern counties. This program replaced HealthPASS, which covered

⁶³ Birnbaum M. "Health Policy for Low-Income People in Pennsylvania" Washington, DC: Urban Institute/Assessing the New Federalism Highlights, November 1998; <www.urban.org/UploadedPDF/PA_health.pdf> last accessed May 24, 2003.

about one-third of Philadelphia. Like HealthPASS, this program is mandatory for TANF, SSI, and General Assistance recipients.

The HealthChoices program also replaced contracts that the state had with several HMOs to provide Medicaid benefits to recipients who enrolled voluntarily. For several years, the state provided individual stop-loss reinsurance for the voluntary HMOs. The state covered losses in excess of a threshold, for each enrolled recipient, for each year. This reinsurance was discontinued a few years before HealthChoices was implemented. The Voluntary HMO program had become larger, and the HMOs were making profits. The administrative burden and uncertain costs of the reinsurance for the state no longer seemed worthwhile.

Design

Pennsylvania requires HealthChoices contractors to purchase commercial reinsurance for all populations enrolled in Medicaid managed care. The commercial coverage must be defined per enrollee, per year, for inpatient costs (although plans may choose to purchase reinsurance for a broader scope of services). The maximum attachment point allowed is \$200,000, unless the plan meets any of the following criteria and then the maximum threshold is \$100,000: the contractor has been in operation for less than three years; the contractor has not complied with the contract requirement for net worth; or the contractor did not earn cumulative net surplus over the previous three years. The reinsurance must cover at least 80 percent of the costs beyond the attachment point. The state may waive the requirement to purchase commercial reinsurance if the plan proposes an alternative risk protection arrangement that is acceptable to the state.

Experience/Lessons Learned

Once well into the development of MMC, state policymakers believed that public reinsurance was not sufficiently beneficial to warrant continuing to bear its administrative costs and financial risks to the state.