Start-up Capital Costs for Health Care Co-ops and a Public Plan

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Who We Are

Joint work group of the American Academy of Actuaries and the Society of Actuaries

American Academy of Actuaries

 Assists public policymakers by providing actuarial insights on risk and financial security issues.

Society of Actuaries

- Provides basic and continuing education in the fundamental principles of actuarial science.
- Conducts research regarding actuarial experience and projection techniques.







What the Work Group Has Done

- Developed a model that projects start-up capital needed to develop health care co-ops or a public plan that would compete with private-sector plans on a "level playing field."
- Intent is to assist policymakers by using the model to project capital requirements of various policy/reform alternatives.



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What is Start-up Capital?

- Start-up capital is defined as capital required before operations begin
 and capital required to support the first several years of operations –
 before an insurance program can become self-supporting. Most of the
 capital is required in the 2-3 years before and after operations begin.
- Start-up capital is needed for two purposes:
 - Operating capital to cover development and operating costs until the plan can cover those costs through its operations.
 - Amounts required to meet solvency standards (risk capital), which are meant to ensure that a plan will have enough money to meet its financial obligations in most circumstances, even if its costs are higher than expected.



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What is a Level Playing Field?

- Health care co-ops or a public plan operate according to the same rules that apply to private-sector health plans regarding:
 - · Underwriting (risk selection and coverage restrictions)
 - · Pricing
 - · Regulatory requirements regarding solvency, coverage, reporting, etc.
 - · Consumer protections
 - · State and local taxes, fees, and assessments
 - · Risk adjustment and reinsurance programs
- Health care co-ops or a public plan negotiate provider payment rates rather than use Medicare-like administrative price setting.



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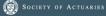


What the Work Group Has Not Done

- Expressed an opinion on the likely success of health care co-ops or a public plan, or the likelihood of any scenario.
- Expressed an opinion on whether health care co-ops or a public plan will reduce health care costs.
- Addressed the impact of health reform on underlying medical costs.
- Addressed the capital requirements of government programs that do not compete with private-sector health plans.
- Projected amounts of subsidies needed to make insurance "affordable" to all.
- Projected the effects of health care co-ops or a public plan on private-sector health plan membership, revenues, or profits.
- Projected the effects of specific risk adjustment or reinsurance programs.
- Projected the effects of the private-sector response to the inclusion of a health care co-op or public plan.



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Results of Modeling

- Start-up capital requirements of health care co-ops or a public plan vary over a wide range, depending primarily on the number of people they cover and the accuracy of their pricing.
- The capital requirements for 12 scenarios six scenarios for a system of 50 statewide co-ops, and the same six scenarios for a single national public plan.

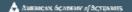


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Six Scenarios Modeled

- Combinations of two enrollment scenarios (low vs. high) and three experience scenarios (accurate pricing vs. underpricing or overpricing).
- Low enrollment 2 million enrollees in first year (2013), no growth thereafter.
- High enrollment 20 million enrollees in first year (2013), growing to 40 million enrollees by 2019.
- Accurate pricing revenue exceeds costs by target margin of 3% of premium.
- Underpricing revenue is less than costs by 5% of premium.
- Overpricing revenue exceeds costs by 5% of premium.



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Projected Start-up Capital Costs – Co-ops

Capital Required to be Infused from Outside Sources During First 10 Years HEALTH CARE CO-OPS (\$ In Billions)

	Low ! (Nationwide er people (consta		2 million	High Enrollment (Nationwide enrollment of 20 million (2013) growing to 40 million (2019))			
	Pre- Operational Capital ^a	Risk Capital ^b	Total Capital	Pre- Operational Capital ^a	Risk Capital ^b	Total Capital	
Accurate Pricing	\$0.8	\$1.6	\$2.4	\$0.8	\$15.6	\$16.4	
Initial Under Pricing	\$0.8	\$3.6	\$4.4	\$0.8	\$44.8	\$45.6	
Initial Over Pricing	\$0.8	\$1.3	\$2.1	\$0.8	\$12.8	\$13.6	

^aPre-operational capital infusions are assumed to be interest-free loans from the federal government; pre-operational capital amounts are shown prior to any potential loan repayments. bRisk capital infusions are assumed to be grants from the federal government.

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Projected Start-up Capital Costs - Public Plan

Capital Required to be Infused from Outside Sources During First 10 Years PUBLIC PLAN (\$ In Billions)

	Low Enrollment (Nationwide enrollment of 2 million people (constant from 2013-2019))			High Enrollment (Nationwide enrollment of 20 million (2013) growing to 40 million (2019))		
	Pre- Operational Capital ^a	Risk Capital ^b	Total Capital	Pre- Operational Capital ^a	Risk Capital ^b	Total Capital
Accurate Pricing	\$0.5	\$1.4	\$1.9	\$0.5	\$14.4	\$14.9
Initial Under Pricing	\$0.5	\$3.3	\$3.8	\$0.5	\$41.0	\$41.5
Initial Over Pricing	\$0.5	\$1.2	\$1.7	\$0.5	\$11.9	\$12.4

^aPre-operational capital infusions are assumed to be interest-free loans from the federal government; pre-operational capital amounts are shown prior to any potential loan repayments. bRisk capital infusions are assumed to be grants from the federal government.





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What Conclusions Can Be Drawn From the Projections?

- Start-up capital requirements can vary over a wide range from \$1.7 billion to \$45.6 billion in the scenarios modeled.
- Start-up capital amounts required to meet solvency standards (risk capital) are much greater than amounts required for operating capital.
- Capital requirements for a public plan that competes on a level playing field with private-sector health plans are slightly lower than the capital requirements for health care co-ops.

NOTE: If a public plan or health care co-ops experience moderate to severe adverse selection, their capital requirements would be much greater than those projected for the scenarios modeled.

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Adverse Selection

- In this context, adverse selection means that a disproportionate portion of the co-op or public plan members would be high-risk/high-cost.
- If this were to occur and no safeguards were in place to prevent a selection spiral, the health care co-ops or public plan would require far more capital than shown in the modeled scenarios to remain viable.
- The likelihood of adverse selection can be reduced by a strong mandate that everyone obtain health insurance; otherwise, individuals are likely to obtain and then drop health insurance as their health care needs change.
- The effects of adverse selection might be mitigated by effective risk adjustment or stoploss insurance programs. However, such programs could not control the effects of adverse selection on the health insurance market as a whole.
- The effects of adverse selection could also be mitigated via financial subsidies to make plans more affordable and/or periodic but infrequent open enrollment times.
- Did not model adverse selection scenarios that project the effects of the optional remedies listed above.

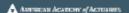
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Open Questions/Next Steps

- Many details of reform legislation remain to be worked out.
- Those details will have a big influence on likely start-up capital requirements.
- The model developed by the joint work group can be used to quantify the start-up capital implications of various policy alternatives.
- The American Academy of Actuaries and the Society of Actuaries are available as an ongoing resource to help policymakers understand the start-up capital implications of policy alternatives.



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