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.

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.

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.

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.

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.

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.

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 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	$0.8	$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

[a]Pre-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.
[b]Risk capital infusions are assumed to be grants from the federal government.

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

[a]Pre-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.
[b]Risk capital infusions are assumed to be grants from the federal government.

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.

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 stop-loss 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.

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.