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issue brief

The Role of Reinsurance in State Efforts to Expand Coverage

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Recently, some states have revisited the concept of reinsurance to spread risk in insurance markets, improve the predictability of claims, and reduce the mark-up of premiums that insurers charge as a buffer against unanticipated claims.

Over the past several decades, many states have sought to stabilize health insurance markets and to expand coverage by developing reinsurance programs, which assume a portion of insurers' high-cost claims. In the 1980s, some states sponsored these programs in an effort to reduce steep premium increases for small employers with high claims experience. By the early 1990s state reinsurance programs to support the small-group market generally had ended as discussion of national health insurance reform increased.

The failure of more ambitious reform proposed by the Clinton administration ultimately led to enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires guaranteed issue of group coverage and renewal of individual coverage but does not address either the cost of coverage or insurers' rating practices in the group or individual markets.

Recently, some states have revisited the concept of reinsurance to spread risk in insurance markets, improve the predictability of claims, and reduce the mark-up of premiums that insurers charge as a buffer against unanticipated claims. Connecticut, Idaho, New Mexico, and Massachusetts currently use reinsurance to support small-group coverage, improve individual access to coverage, or both. Arizona and New York also operate reinsurance programs that subsidize health insurance for small groups or low-income workers.

Conventional Reinsurance Programs

Background

As insurers began to underwrite more aggressively in the 1980s, small employers had increasing difficulty finding and keeping coverage. Some states responded to this problem by curbing insurer underwriting directly, enacting small-group insurance reforms to require guaranteed issue and renewal of policies, prohibiting within-group underwriting, and banning rating on the basis of health status as well as durational rating (i.e., setting rates higher for small groups that had renewed for a number of years, diminishing the initial effects of underwriting).

Many states proposed reinsurance programs as a way to address insurers' incentives to underwrite in the first place, reasoning that uniform reinsurance levels for all carriers would reduce their motivation to compete on the basis of underwriting.

While few insurers greeted proposals for mandatory reinsurance warmly, the largest insurers actively opposed them. They argued that their large business was not a source of market instability, and therefore mandatory

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reinsurance made no sense for them from either a business or public policy perspective. In response, state reinsurance programs rarely, if ever, required Blue Cross and Blue Shield plans to participate, and many made the entire program voluntary.

Without the support of the largest insurers, most states ultimately abandoned reinsurance programs; whether they were or could have been effective was never evaluated. Eventually, HIPAA probably achieved some of the same general objectives in the small-group market: It required all small-group insurers to guarantee issue and renewal, and prohibited underwriting within groups.

Combined with state regulations that limit how small-group insurers price coverage, HIPAA forced carriers to abandon their most aggressive underwriting in this market. But in doing so, it likely reinforced the wave of mergers and acquisitions that swept the health insurance industry during the late 1990s, as well as most group insurers' focus on "larger" small businesses—groups of at least five employees.

Currently, at least 21 states have reinsurance pools, though many have very low enrollment and some are inactive.[1] Connecticut, Idaho, Massachusetts, and New Mexico offer a range of examples of such pools: these states operate reinsurance programs to support (variously) the small-group and individual markets, guaranteed issue of standard individual "high-risk pool" products, and a state-created alliance of insurers for small groups including sole proprietors.

Connecticut's Small Employer Health Reinsurance Pool

Established in 1990, Connecticut's small-employer reinsurance pool was the nation's first such pool, and became the National Association of Insurance Commissioners (NAIC) model for reinsurance.

The pool reinsures all small-group carriers; in Connecticut, these insurers are required to guarantee issue coverage to groups of 1 to 50. Any small-group insurer in the state may reinsure individual covered workers or dependents, or entire small groups, in the reinsurance pool within 60 days of issuing coverage. Insurers have additional opportunities to reinsure the smallest groups, with just one or two employees, every third year at the anniversary date of first issue.

Only permanent employees who work at least 30 hours per week (and their dependents) are eligible for reinsurance.[2] The program accepts each insurer's minimum enrollment requirement for coverage. Insurers may not disclose to employers, employees, or dependents whether they are reinsured.

Insurers pay a $5,000 deductible per reinsured life; above that amount the reinsurance pool pays all claims. Premiums are based only on demographics; rating for health status, location, tobacco use, or other characteristics is prohibited in statute.[3] Since its inception, 37 carriers have enrolled more than 27,000 employees and dependents in the pool. As of October 2004, 3,116 were enrolled for an average reinsurance premium of approximately $4,500 per year.[4]

The pool is funded by the reinsurance premiums paid by insurers who cede risk to the pool, as well as an annual assessment on all licensed health insurers in Connecticut based on their respective shares of the small-group market. The pool may assess carriers as much as 1 percent of their small-group premium base, but annual assessments have never reached that level.

The pool is credited with maintaining a relatively large number of insurers in Connecticut's small-group market, easing the transition to modified community rating of small groups, and reducing incentives to rate up the smallest groups. These assertions have not been formally evaluated.

Idaho's Small-Group and Individual Reinsurance Pools

Idaho has operated its Small Employer Health Reinsurance Program since 1994. Because all carriers may be assessed to cover any net losses to the program, in effect all insurers participate in it. Within 60 days of issue, any small-group insurer may notify the program of intent to reinsure an entire group, an individual employee, or an eligible dependent.

Reinsurance is effective as of the date the primary coverage took effect. However, the insurer may not use actual claims experience during the 60-day period to determine whether to cede the business to the program, and may not notify the employer, employee, or any other eligible individual or dependent that they have been reinsured.

The reinsurance benefit limits mirror the benefit designs of the small-employer plans established by Idaho's Small Employer Health Insurance Availability Act.[5] The small-group carrier is responsible for the first $12,000 of claims for each reinsured employee or dependent each calendar year, and 10 percent of the next $13,000 (basic), $88,000 (standard), or $120,000 (catastrophic). As of April 2004, Idaho reinsured eligible employees and dependents in 44 small-group plans.

As in Connecticut, the pool is funded by reinsurance premiums paid by insurers that cede risk to the pool and an additional assessment on all insurers as needed to cover pool losses. In 2003, the total assessment was just $538,062.

Since 2001, Idaho also has operated an Individual High-Risk Reinsurance Pool. This pool reinsures the four "high-risk pool plans" that all individual (nongroup) carriers must offer guaranteed-issue. Idaho's High-Risk Reinsurance Pool sets premiums for the high-risk pool plans; both premiums and benefit designs are the same for every individual carrier in the state.[6] (Individual carriers may deny applicants for other products and also set premiums within rate bands to reflect health status.)

Each carrier is responsible for the initial $5,000 of benefits paid per calendar year for each enrollee in a high-risk pool plan, as well as 10 percent of the next $25,000. Above these amounts, the High-Risk Reinsurance Pool fully reinsures the enrollee. As of March 2004, Idaho reinsured 1,358 individuals in high-risk pool plans. The High-Risk Reinsurance Pool has been fully funded by reinsurance premiums and a portion of the state premium tax.

Massachusetts' Nongroup and Small-Group Health Reinsurance Plans

Massachusetts also operates small-group and individual reinsurance programs, but enrollment in both is very low. The Massachusetts Small Employer Health Reinsurance Plan reinsures all commercial small-group health coverage written in the state; health maintenance organizations (HMOs) do not participate. In operation since 1992, this program accepts only full-time permanent workers (who work 30 hours per week and are hired to work 5 months or more) in firms with 50 or fewer employees, sole proprietors or partners, and dependents.

As in Connecticut, small-group insurers may cede whole groups or specific, eligible workers or dependents within groups within 60 days of their enrollment in a small-group product. However, the Massachusetts program requires that the insurer have enrolled at least 75 percent of reinsurance-eligible employees in the small group (at both issue and renewal)—a provision intended to minimize adverse selection.

Insurers that cede risk to the reinsurance plan must pay the first $5,000 in covered claims expense and 10 percent of the next $50,000. The reinsurance plan fully pays claims above $55,000 per year. Premiums per person per month vary from $300 (for whole-group reinsurance) to $2,100 (for individual reinsurance). In 2004, the average premium paid was $800 to $1,000 per person per month—approximately twice the level of premiums in Connecticut's reinsurance pool.

While all commercial insurers are members of Massachusetts' small-employer reinsurance pool and may be assessed for unanticipated program losses, premiums are set to avoid an assessment. As of October 2004, 8 plans were reinsuring just 13 lives. Low enrollment in the small-group reinsurance plan is probably due not only to high premiums but also to the fact that HMOs do not participate. In Massachusetts, HMOs account for a significant share of the new enrollment that might be ceded to a reinsurance plan.

The Massachusetts Nongroup Health Reinsurance Plan is intended to support the state's requirement that insurers offer individual coverage guaranteed-issue and rate without regard to health status. Massachusetts also constrains individual rate variation overall.[7]

Within 60 days of the start of coverage, nongroup insurers may reinsure any individual in the plan. The primary insurer must cover the first $10,000 of claims plus 10 percent of the next $40,000; the reinsurance program fully pays all claims above $50,000 per year. Massachusetts' nongroup reinsurance plan has operated since December 2001. Reinsurance premiums range from $4,000 to $6,500 per adult member per month and $4,500 to $7,800 per child member per month, depending on the primary plan type (HMO, PPO, or indemnity) and whether it offers drug coverage.[8]

All nongroup insurers—including HMOs—are required to be members of the reinsurance plan: any nongroup insurer may cede risk and also may be subject to paying an assessment on their total premiums to cover any plan deficits that occur. By statute, the assessment may not exceed 1 percent of earned premiums. Premiums for the nongroup reinsurance plan, like those for the small-group reinsurance plan, have consistently been set high enough to avoid an assessment.

Enrollment is very low—in October 2004, just three individuals were enrolled. This is probably for reasons similar to those that explain low enrollment in the small-group reinsurance program: the reinsurance premiums are steep, and benefits are low. In addition, Massachusetts' individual market is extremely concentrated, further reducing the demand for conventional reinsurance.[9]

The New Mexico Health Insurance Alliance

Created in 1994, the New Mexico Health Insurance Alliance (NMHIA) partners with insurance carriers to offer coverage to employees in small groups (with 50 or fewer employees who work 20 hours per week or more), self-employed workers, and individuals who have lost coverage involuntarily. NMHIA does not require an employer contribution to qualify for group coverage, but stipulates that at least half of eligible employees must participate.[10] For self-employed workers and their families, NMHIA is the only source of guaranteed-issue coverage in the state.

Enrollment in NMHIA has been as high as 8,800 but fell in recent years with the loss of community-rated HMO plans and premium increases.[11] At present, NMHIA contracts with 11 carriers to cover nearly 4,000 lives; approximately 35 percent of these are individual policies, and 65 percent are in small groups.

NMHIA does not directly subsidize premiums, but instead provides reinsurance for participating carriers, withholding a reinsurance premium from premiums paid to NMHIA carriers. For small groups, the reinsurance withhold is 5 percent in the first year of coverage and up to 10 percent in renewal years. For individuals, the withhold is up to 10 percent of premiums in the first year and up to 15 percent for renewal years. The average reinsurance withhold for the overall premium has been 10 percent.[12]

Each year, the reinsurance fund pays participating insurers the amount by which incurred claims and reinsurance premiums exceed 75 percent of earned premiums. An annual loss that exceeds the reinsurance fund's resources triggers an assessment on all carriers' premium income (not just those writing NMHIA coverage) to compensate the participating carriers for net expenses in the prior year. The claims loss assessment was triggered in each year of NMHIA's operation through 2003 to cover losses of up to $4.5 million (in 2003). Alliance members may offset 50 percent of the assessment against their state tax liability, but otherwise the program is unsubsidized.

Subsidized Reinsurance Programs

Two states—Arizona and New York—have established programs with subsidized reinsurance to encourage coverage among small groups, low-wage workers without coverage, or both. Each state sponsors a primary insurance program that operates as a purchasing pool, contracting with insurers for coverage. In each program, the reinsurance component assumes some or all of the risk of high-cost care for qualifying small groups or self-employed individuals, but does not subsidize premiums directly. Neither program replaces the role of employers in sponsoring insurance coverage. In fact, administratively, the programs are invisible to employees. While these programs target the small-group market, they also enroll self-employed individuals and their families.

Health Care Group of Arizona

Arizona's Health Care Group (HCG) contracts with insurers to offer coverage to small firms and self-employed individuals; HCG reinsures that coverage. There are no income criteria for participating employees.

Historically, HCG has not required that self-employed individuals be insured previously or that employers not have offered coverage before participating in HCG. However, to protect the program against adverse selection, HCG requires high employee participation for an employer group to qualify. For groups of six or more, 80 percent of employees must participate, and smaller groups must have 100 percent employee participation. No employer contribution is required, and, as in the general market, HCG premiums are age-rated.

Participating carriers must guarantee issue of coverage to all HCG applicants, including self-insured workers and their families who are not guaranteed issue in the commercial market. In return, HCG protects them from the highest costs. In fiscal years 2004 through 2006, the state has appropriated $4 million per year to protect HCG plans from medical losses that

Lessons for States

The programs described in this brief offer a number of useful lessons for states that may be considering reinsurance programs to expand small-group or individual coverage. These include the following:

- **Reinsurance programs can be useful in states with very different market rules, and for both individual and small-group markets.** Massachusetts and New York operate reinsurance programs in markets with extensive regulation guaranteeing access to group and individual coverage throughout the market. New York's program, in particular, is intended to address the remaining problem of affordability for low-income workers. In Connecticut, small-group reinsurance helps to support guaranteed issue to groups of one.

  In contrast, Arizona and Idaho operate their reinsurance programs in lightly regulated markets, and each principally addresses problems of access. Arizona's program accepts self-employed individuals who otherwise have no access to group coverage and no underwriting protections in the individual market. Idaho's mandatory program supports specific guaranteed-issue products in the individual market; in all other products, insurers can reject individual applicants with health problems.

- **Reinsurance premiums, benefits, and insurer participation rules are important to the success of the pool.** Connecticut's reinsurance pool offers high benefits: It pays all claims that exceed the $5,000 deductible. In addition, all insurers in the small-group market participate. The pool also offers a recurring chance for insurers to reinsure their smallest groups, every three years after first issue. As a result, enrollment in the pool is relatively high, and the pool is believed to have stabilized premiums for the smallest groups and helped to hold insurers in the small-group market.

  In contrast, premiums in Massachusetts' small-employer pool are approximately twice as high as in Connecticut and benefits are lower: the plan pays 90 percent of claims above $5,000 and fully pays claims above $50,000. Insurers have one chance to reinsure covered lives, and HMOs do not participate. Massachusetts' pool is extremely small.

- **Even with reinsurance, state health insurance purchasing programs are vulnerable to adverse selection when they attempt to do what the market does not.** If the primary insurance program attracts an unusual volume of high-cost groups or individuals, the cost of reinsurance, and, therefore, the cost of the whole insurance package, will be higher. In New Mexico's small-group market, insurers may deny issue to self-employed workers and price coverage to micro-groups (with two to five employees) to discourage enrollment. The Alliance accepts both for standard premiums, but premiums in the Alliance have historically been 15 to 25 percent higher than those of commercial carriers.[18]

- **States can ease protections against adverse selection in a reinsured health insurance purchasing program—and widen access to the subsidies that the program offers—by balancing program rules and market rules.** Because New York's small-group and individual markets play by the same rules—guaranteed issue and pure community rating—as Healthy New York (NY), the program can operate with few barriers to access and without undue adverse selection.

- **Expanding reinsurance programs that offer even modest subsidies to small groups may raise issues of crowd-out.** In aiming to capture a larger segment of the uninsured workers and their families, Arizona's HCG admitted commercial insurers as HCG carriers and then acceded to their concerns about crowd-out; the program now requires that small groups be uninsured for at least six months before enrolling in HCG.

  Healthy NY targets a more uniform market segment—low-wage workers, individually or in small groups, who are unlikely to afford health insurance without a subsidy. This strategy may narrow the appeal of the program but reduce concerns about crowd-out. Even so, Healthy NY requires a 12-month period of no coverage prior to application.

1 Silow-Carroll, S. et al. *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont*, The Commonwealth Fund, February 2003, available at www.statecoverage.net/statereports/ multi3.pdf.

exceed 86 percent of premiums and to buy commercial reinsurance for annual claims of $100,000 or more.

As of August 2004, HCG covered 11,734 lives, of which about 70 percent are sole proprietors. HCG operates as a separate organization within the Arizona Health Care Cost Containment System (AHCCCS, called "Access"), which manages the state's Medicaid program. HCG does not subsidize premiums, and eligibility is not based on income or wages.

Historically, HCG has contracted with three HMOs that also serve as AHCCCS managed care contractors. HCG health plans may earn up to a 2 percent margin on premiums without contributing to the reinsurance pool. Participating carriers are required to report both financial and medical data to HCG, helping it to manage the overall cost of the program and to predict reinsurance needs.

As part of an initiative to expand enrollment in HCG, commercial insurers will be allowed to participate in HCG in fiscal year 2005 without also participating as an AHCCCS carrier. In addition, responding to commercial insurers' concerns that small groups would leave commercial plans to enroll in the same (or other) carrier's HCG plans, the program will require HCG-eligible small groups to have been uninsured for at least six months before applying for HCG coverage.

Healthy New York

Established in 2001, Healthy New York (NY) targets the employers of middle- to low-wage workers, sole proprietors, and individuals. Employers with 50 or fewer employees may participate if at least 30 percent of their employees earn less than $32,000 annually (an amount that is adjusted each year), and the employer did not offer or contribute substantially (more than $50 per month) to comprehensive group coverage in the prior year.

Healthy NY also sets participation rules to protect the program from adverse selection. For example, at least half of eligible employees must participate and the employer must contribute at least half the premium. As of July 2003, qualifying small employers may select the level of premium contribution they make on behalf of part-time employees.

Sole proprietors and individuals may participate if the applicant (or his or her spouse) is employed full- or part-time, or was employed at some time during the prior year; if their gross household income does not exceed 250 percent of the federal poverty level; and if they have been uninsured for the last year and are ineligible for Medicare.[13] However, applicants with COBRA coverage or public program coverage in New York may enroll directly in Healthy NY.

Since its inception in 2001, Healthy NY has enrolled more than 101,665 workers. As of August 2004, the program had approximately 67,000 active enrollees and was averaging 5,500 new enrollees per month. In December 2003, 59 percent of enrollees were working individuals, 21 percent were sole proprietors, and 21 percent were small-group employees. Of those enrolled individuals, 61 percent were enrolled without dependents.[14]

Healthy NY contracts only with HMOs; 24 currently participate. All are required to enroll all applicants and to community rate—consistent with New York's requirement that individual and small-group coverage throughout the state be guaranteed issue and "pure" community-rated.[15] In addition, participating carriers are required to set a single premium for small groups, sole proprietors, and individuals, regardless of enrollment category.

The program's reinsurance strategy differs from that used by HCG. Participating carriers may receive reimbursement for 90 percent of claims between $5,000 and $75,000 for any member in a calendar year. This risk corridor (the range of claims that participating carriers may reinsure) is lower than that which Healthy NY used when the program started, and represents an increase in funding and subsidies effective July 2003.[16]

In an independent evaluation conducted in 2003, the Lewin Group estimated that Healthy NY financed about 3.6 percent of medical claims costs in calendar year 2002 through its corridor reinsurance arrangement—before the program lowered the corridor. Had the lower corridor been in place in calendar 2002, Healthy NY would have financed about 13.5 percent of medical costs.[17] For calendar year 2003, state payments for Healthy NY's corridor reinsurance are projected to reach about $12 million.

Conclusion

In most states, it is unlikely that a reinsurance program could entirely solve the complex problem of making coverage accessible and affordable for everyone. However, by addressing several problems at once, a state-level reinsurance program can be an efficient strategy for stabilizing coverage and perhaps expanding it. Especially when subsidized, a reinsurance program can moderate the high premiums that make coverage unaffordable for low-wage workers and discourage small employers from offering it. Reinsurance programs also can improve access to coverage for self-employed workers and individuals.

However, reinsurance programs must be designed carefully to succeed. In market-wide reinsurance programs, high premiums and less-than-universal participation by insurers are obvious formulas for very low enrollment. In states that use reinsurance to subsidize a primary insurance program, the reinsurance component can spread risk among participating insurers but it ultimately cannot compensate for significant adverse selection in the primary insurance program, if it occurs. Therefore, states considering such programs need to balance the program and market rules and design eligibility with the potential for adverse selection in mind.

About the Author

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Endnotes

1 States with reinsurance pools with at least one person enrolled include Alaska, Connecticut, Florida, Idaho, Indiana, Massachusetts, Nebraska, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, and Wyoming. States with inactive reinsurance pools include Arizona, Colorado, Iowa, Minnesota, Nebraska, Kansas, and Oregon.

2 Insurers may reinsure newborns only if the mother is reinsured as of the date of birth, and all newborn dependents of reinsured persons are automatically reinsured.

3 The authorizing statute for Connecticut's Small Employer Health Reinsurance Pool is available at www.cga.state.ct.us/2003/pub/Chap700c.htm#Sec38a-569.htm, accessed October 5, 2004.

4 Karl Ideman, Plan Administrators, Inc., personal communication October 5, 2004.

5 Idaho Rule 18.01.70 implements Idaho's Small Employer Health Insurance Availability Act and specifies benefit designs for the small employer basic, standard, and catastrophic health benefit plans that all small-group carriers must offer (www2.state.id.us/adm/adminrules/rules/idapa18/0170.pdf and www3.state.id. us/cgi-bin/newidst?sctid=410470012.K, accessed July 20, 2004).

6 High-risk pool plan benefits vary by the level of the deductible ($500 to $5,000), maximum lifetime benefits ($500,000 to $1 million), coinsurance levels (20 to 50 percent), and annual out-of-pocket limits ($10,000 to $20,000).

7 Insurers in Massachusetts are prohibited from denying individual coverage, issuing riders that eliminate coverage of care related to the individual's health status. Premiums may vary within rate bands by age and geographic area, and to reflect the actuarial value of the benefit level (not reflecting the specific characteristics of the population covered).

8 The higher reinsurance premium for children probably reflects the high expected cost of newborns who may be ceded to the reinsurance pool (Karl Ideman, personal communication October 5, 2004).

9 Chollet, D. et al. *Mapping State Health Insurance Markets, 2001: Structure and Change*, The Robert Wood Johnson Foundation's State Coverage Initiatives Program, September 2003, available at www.statecoverage.net/pdf/mapping2001.pdf. In 2001, just three insurers held 97 percent of Massachusetts' individual market. All else being equal, larger insurers are relatively unlikely to seek reinsurance.

10 NMHIA also covers HIPAA-eligible individuals: Those who have had at least 18 months of prior coverage from an employer, church plan, or government program with not more than a 63-day lapse in coverage; who have exhausted their COBRA options if available; and who are currently ineligible for an employer group health plan.

11 Silow-Carroll, S. et al. *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont*, The Commonwealth Fund, February 2003, available at www.statecoverage.net/statereports/multi3.pdf.

12 NMHIA also retains 3.5 percent of the plan premium for plan administration.

13 The Lewin Group. Report on the Healthy NY Program 2003, prepared in partnership with Empire Health Advisors for the New York State Insurance Department, available at www.statecoverage.net/statereports/ny24.pdf. Individuals may also qualify if coverage during the prior 12 months was terminated for any of a number of reasons: loss of employment; death of a family member or subscriber; change to a new employer without health insurance; change in residence; discontinuation of a group product; expiration or termination of continuation coverage (COBRA); legal separation, divorce or annulment; loss of eligibility for group health insurance; or reaching the maximum age of dependency.

14 Lewin, *supra* note 13. Healthy NY enrolls families in three premium tiers: two-adult, one parent with child(ren), and two parents with child(ren).

15 In New York, insurers may not vary group or individual premiums to reflect the characteristics of individual firms or enrollees. Premiums may vary only by geographic area, family size, and the specific plan selected.

16 Lewin, *supra* note 13. Before July 2003, Healthy NY had covered 90 percent of specific losses between $30,000 and $100,000. Most plans reduced their premiums by approximately 17 percent effective July 2003 to account for the lower reinsurance corridor. Also effective as of July 2003, prescription drug coverage is optional.

17 Lewin, *supra* note 13. The health plans participating in Healthy NY experienced an average unadjusted loss ratio on the business (excluding Healthy NY reinsurance payments) of 92.5 percent in calendar year 2002. Including the program's reinsurance payments, they experienced an average adjusted loss ratio of 88.9 percent. However, every plan was participating at low volume (none had yet reached enrollment of 3,000 program members), and they were enrolling large numbers of individuals for whom they had to verify eligibility. As a result, the plans reported high per capita administrative costs relative to their typical commercial business.