

2010

Government-Sponsored Reinsurance

Mark A. Hall
Wake Forest University

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Mark A. Hall *Government-Sponsored Reinsurance*, 19 *Annals Health L.* 465 (2010).
Available at: <http://lawcommons.luc.edu/annals/vol19/iss3/4>

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in *Annals of Health Law* by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

GOVERNMENT-SPONSORED REINSURANCE

*Mark A. Hall**

I. INTRODUCTION

Many measures to reform health insurance markets include one of several distinct types of government-sponsored reinsurance. The government serving as a backstop for high-dollar claims is an intriguing idea, one that has resurfaced over many decades. Federally, the earliest known proposal was from President Eisenhower in 1954.¹ Public reinsurance was also a little-noticed feature of Medicaid managed care and of Medicare's new prescription drug Part D benefit established in the Medicare Prescription Drug Improvement and Modernization Act of 2003.² More prominently, public reinsurance featured in Senator John Kerry's health insurance proposal when running for President in 2004 called for the federal government to reimburse employers for 75% of claims exceeding \$30,000.³

Most recently, three different forms of public reinsurance are components of the newly enacted Patient Protection and Affordable Care Act (PPACA).⁴ For early retirees, section 1102 allocates \$5 billion to

* Professor Hall is the Fred D. and Elizabeth L. Turnage Professor of Law and Public Health at Wake Forest University, and the founding Director of its Center for Bioethics, Health and Society. This article draws in part from research done for the Blue Cross and Blue Shield Association, but the author is solely responsible for the contents, and the Association does not necessarily agree with the analyses or conclusions.

1. Norbert Goldfield, *National Health Reform Advocates Retrench and Prepare for Medicare*, 19 *PHYSICIAN EXECUTIVE J*, X1 (1993).

2. Martin Sipkoff, *Health Plans Undaunted By Medicare Part D*, *MANAGED CARE*, May 2005, available at <http://www.managedcaremag.com/archives/0505/0505.pharmacy.html>; Leslie M. Greenwald, *Medicare Part D Data: Major Changes on the Horizon*, 45 *MEDICAL CARE S9*, S10 (2007), available at <http://www.effectivehealthcare.ahrq.gov/repFiles/MedCare/s9.pdf>.

3. Paul B. Ginsburg, *Controlling Health Care Costs*, 351 *N. ENG. J. MED.* 1591, 1591 (2004); Kerry's proposal was influenced by the ideas first developed by Harvard Professor Katherine Swartz in her book. KATHERINE SWARTZ, *REINSURING HEALTH: WHY MORE MIDDLE CLASS PEOPLE ARE UNINSURED AND WHAT GOVERNMENT CAN DO* (2006).

4. Mark A. Hall, *The Several Faces of Reinsurance*, 29(6) *HEALTH AFFAIRS* (forthcoming June 2010).

reinsure eighty percent of claims costs that are between \$15,000 and \$90,000 a year, incurred by employers for former employees ages 55 to 64.⁵ Starting in 2014, when the insurance reforms take full effect, PPACA provides for two additional reinsurance mechanisms. For individual insurance, a reinsurance program will prospectively identify high-risk subscribers based on a list of 50 to 100 expensive conditions and pay scheduled amounts to insurers to offset their expected costs, regardless of how much their actual costs might be.⁶ These costs will be borne by up to \$25 billion in assessments (over three years) on all insurers, in proportion to their total market shares for all commercial health insurance, including the insurance for large groups and claims administration for self-insured employers.⁷ For small-group and individual insurance, PPACA creates a risk adjustment mechanism based on a corridor of +/- 3 percent of each insurer's expected medical costs.⁸ Insurers whose actual costs are 3 to 8 percent greater than expected will receive from the Department of Health and Human Services (DHHS) half of the excess, and those whose actual costs are over 8 percent of expected will receive an additional 80 percent above the higher threshold.⁹ This support will be funded by recouping the same proportions from insurers whose actual costs are 3 percent or 8 percent lower than expected.¹⁰

Among states there are several other examples. The most prominent is the Healthy New York program, which was recently emulated as Healthy Texas.¹¹ Under New York's approach, the state reinsures up to ninety percent of claims costing between \$30,000 and \$100,000 per year, for uninsured and low-income small groups or individuals.¹² A different type of government-sponsored reinsurance was a key component of the insurance

5. The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), § 1102.

6. *Id.* at § 1341.

7. *Id.*

8. *Id.* at § 1342.

9. *Id.* This retrospective risk adjustment is distinct from, and in addition to, another of PPACA's risk adjustment mechanisms (sec. 1343), which will prospectively measure the actuarial risk of each insurer's individual and small-group populations and assess insurers below the state's average in order to subsidize insurers that are above the state's average. Unlike the reinsurance mechanisms, which are limited to three years, this risk adjustment extends indefinitely, indicating that it serves different purposes.

10. The law fails to address the quite likely situation that recoupments owed by low-claims insurers will not equal payments owed to high-claims insurers.

11. TEX. DEP'T OF INS., HEALTHY TEXAS: A PRIVATE/PUBLIC HEALTH INSURANCE PRODUCT (2009), available at <http://www.tdi.state.tx.us/health/documents/lhhealthytx1.pdf>.

12. KATHERINE SWARTZ, HEALTHY NEW YORK: MAKING INSURANCE MORE AFFORDABLE FOR LOW-INCOME WORKERS 1 (2001), available at <http://www.ins.state.ny.us/website2/hny/reports/hnystudy.pdf>; Katherine Swartz, *Government As Reinsurer For Very-High-Cost Persons In Nongroup Health Insurance Markets*, W382 HEALTH AFF. W380, W380-82 (2002); ROBERT WOOD JOHNSON FOUND., PROFILES IN COVERAGE: HEALTHY NEW YORK (2005), <http://www.statecoverage.org/node/482> (last visited Feb. 28, 2010).

market reforms adopted by states beginning in the early 1990s.¹³

Considering the regular recurrence of the reinsurance idea, it deserves more attention in the health policy literature. Why might the government want to structure its financial support in this manner rather than in others? How well has government reinsurance worked in the situations it has been used? And, has public reinsurance resulted in any unintended consequences? This article explains the concepts and rationales of various types of government reinsurance, and it gathers available sources of information on how government reinsurance has performed.

II. REINSURANCE BASICS

A. Reinsurance Generally

Reinsurance, simply put, is insurance for insurers.¹⁴ A primary insurer can reduce its financial exposure by contracting with a larger insurer to reimburse its larger claims.¹⁵ Reinsurance is “invisible” to the subscriber who holds the primary policy, and reinsurance does not relieve the primary insurer of any of its obligations to pay its subscribers.¹⁶

The threshold at which reinsurance takes effect is known as the “attachment point,” which functions like a deductible paid by the primary insurer.¹⁷ Reinsurers usually require the primary insurer to retain a portion of the risk above the attachment point, and reinsurance often operates in layers or corridors defined by an upper limit on the reinsurer’s obligation.¹⁸ For instance, reinsurance might cover eighty percent of claims between \$100,000 and \$1 million a year, and ninety percent of claims from \$1 million to \$5 million, but no claims after that. Reinsurance thresholds and corridors might be based on either individual (per person) claims or on aggregate claims over a group of policies.¹⁹

Insurers purchase private reinsurance to help shoulder high-level risk that

13. BETH WIKLER & CHERYL FISH-PARCHAM, *FAMILIES USA, REINSURANCE: A PRIMER 2* (2008), available at <http://www.familiesusa.org/assets/pdfs/reinsurance-a-primer.pdf>; Mark A. Hall & Janice S. Lawlor, *Reinsurance Pools for Small-Group Health Insurance*, 19 J. OF INS. REG. 638, 642 (2001).

14. SWARTZ, *supra* note 3 at 102.

15. *See id.* at 102-03.

16. *See* RANDALL R. BOVBERG, MO. FOUND. FOR HEALTH, *IMPLEMENTING REINSURANCE: HEALTH INSURANCE REFORM IN MISSOURI 2* (2006), available at http://www.urban.org/UploadedPDF/1001011_CoverMo11.pdf [hereinafter MO. FOUND. FOR HEALTH].

17. WIKLER & FISH-PARCHAM, *supra* note 13, at 7.

18. RANDALL R. BOVBERG ET AL., *REINSURANCE IN STATE HEALTH REFORM 2* (2008), available at http://www.academyhealth.org/files/publications/SCI_Reinsurance08.pdf.

19. KATHERINE SWARTZ, *REINSURANCE; HOW STATES CAN MAKE HEALTH INSURANCE MORE AFFORDABLE FOR EMPLOYERS AND WORKERS 2* (2005), available at http://www.commonwealthfund.org/usr_doc/820_swartz_reinsurance.pdf.

is difficult to predict, or to help bear the capital costs of maintaining adequate reserves.²⁰ For instance, an insurer with insufficient capital reserves may be able to move into a new product or geographic market by purchasing some level of private reinsurance.²¹ Also, reinsurance can reduce the “risk load” that insurers include in their premium rates.²² Insurers must set their premiums to maintain enough capital reserves to meet both their expected costs *plus* an additional cushion in case their actuarial projections are too low.²³ The main function of this risk load is to shelter against the statistical odds that best estimates are wrong, rather than to pay for anticipated claims and administrative costs. Reinsurance could reduce this statistical uncertainty factor and therefore help insurers avoid some of the risk load in their premiums.

B. Reinsurance for Health Insurers

According to the American Academy of Actuaries, “most large, financially strong health plans do not feel that they need reinsurance and therefore do not purchase it.”²⁴ One leading expert explains that, “as a generalization, there is less need in health insurance for reinsurance than in property-casualty lines, where claims frequency is lower and the variance in claims size quite extreme.”²⁵ Accordingly, most established health insurers are able to bear their risk more efficiently than a third party. They have enough subscribers for the “law of large numbers” to make their expected claims highly predictable, and they have enough capital reserves to cover all their risks and to pursue new business development.²⁶ Also, health insurers limit their risk in other ways, such as capping total benefits paid or contracting with doctors and hospitals on a fixed-fee (capitation) basis. Thus, as two experts note, reinsurance with high thresholds “does not address the risk-sharing issues associated with the chronically ill, but rather unexpected episodically high costs. The insurance industry seems well equipped to deal with the latter”²⁷

20. RANDALL R. BOVBJERG & ELLIOT WICKS, BLUE CROSS BLUE SHIELD OF MASS. FOUND., IMPLEMENTING GOVERNMENT-FUNDED REINSURANCE IN THE CONTEXT OF UNIVERSAL COVERAGE 5 (2005), available at <http://bluecrossfoundation.org/~media/Files/Policy/Roadmap%20to%20Coverage/051007RTCPbImplementGvtReinsBovbjerg.pdf>.

21. *Id.*

22. See SWARTZ, *supra* note 3, at 120.

23. See generally GLENN G. MEYERS, INS. SERVS. OFFICE, UNDERWRITING RISK (2006), <http://www.casact.orgpubs/forum/99spforum/99spfl85.pdf>.

24. AM. ACAD. OF ACTUARIES, MEDICAL REINSURANCE: CONSIDERATIONS FOR DESIGNING A GOVERNMENT-SPONSORED PROGRAM (2005).

25. Randall R. Bovbjerg et al., *Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?* 29 INQUIRY 158 (1992).

26. WIKLER & FISH-PARCHAM, *supra* note 13.

27. JOHN HOLAHAN & LINDA BLUMBERG, URBAN INSTITUTE, AN ANALYSIS OF THE

The usual exceptions are when a health insurer is new to a market or product line, and even then the attachment point is usually set very high and in aggregate for a line of insurance, rather than for individual subscribers. This is because the main driver of medical cost increases is general medical inflation (i.e., overall average prices), which depends much more on medium-sized claims than on catastrophic claims.²⁸ And, even when private reinsurance might make sense, health insurers buy as little of it as possible because its costs might exceed its benefits.²⁹

Because reinsurance mainly redistributes rather than reduces aggregate risk, and because it adds an element of expense, there is broad and deep consensus among independent experts, market analysts, and observers that private reinsurance does not, and inherently cannot, significantly reduce the cost of health insurance.³⁰ The Lewin Group, for instance, concluded that reinsurance does “nothing to change the actual cost of health services provided to participants” and “can actually add a small amount to overall health care costs.”³¹ Where reinsurance might reduce capital costs, there is an active national and international market that makes reinsurance reasonably available to any insurer that might need it.³²

III. REASONS FOR GOVERNMENT-SPONSORED REINSURANCE

Without any overt need for private reinsurance or signs of market failure, why should the government intervene? Two possibilities exist: lowering premiums and reducing risk. Each yields distinct types of public reinsurance.

OBAMA HEALTH CARE PROPOSAL 4 (2008), available at http://www.urban.org/UploadedPDF/411754_obama_health_proposal.pdf.

28. See Linda J. Blumberg & John Holahan, *Government as Reinsurer: Potential Impacts on Public and Private Spending*, 41 INQUIRY 130, 131 (2004) (“Government reinsurance for the portion of expenses *exceeding* thresholds as high as \$50,000 per year would have very modest expected effects on private costs . . . because: 1) very few people incur expenditures of this level . . .”); David E.M. Sappington et al., *The Effects of Reinsurance in Financing Children’s Health Care*, 43 INQUIRY 23, 27 (2006) (explaining that state-funded and plan-funded reinsurance only significantly reduced the large financial loss incurred by the typical low-profit plan when the attachment point was reduced to \$10,000, as opposed to \$25,000 or \$50,000).

29. See JOHN SHEILS, GRADY CATTERAL & RANDALL HAUGHT, ACTUARIAL AND ECONOMIC ANALYSIS OF OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE IN INDIANA 39-41 (2004), available at <http://www.statecoverage.org/files/Actuarial%20Analysis%20of%20Policy%20Options.pdf>; MO. FOUND. FOR HEALTH, *supra* note 16; HOLOHAN & BLUMBERG, *supra* note 27.

30. See e.g., BOVBERG ET AL., *supra* note 18, at 1; CAROLYN WATTS ET AL., THE COMMONWEALTH FUND, POOLING AND REINSURANCE IN WASHINGTON STATE HEALTH INSURANCE MARKETS: REVIEW OF THE OIC PROPOSAL 2-3 (2005), available at <http://www.insurance.wa.gov/legislative/reports/CommonwealthPRCCreport.pdf>.

31. JOHN SHEILS, GRADY CATTERAL & RANDALL HAUGHT, *supra* note 29, at 39, 41.

32. See MO. FOUND. FOR HEALTH, *supra* note 16.

A. Lowering Premiums

An obvious purpose of government reinsurance is simply to lower the purchase price of insurance. By paying high-cost claims, the government expects insurers to pass savings on to subscribers.³³ Shifting these costs to the government spreads them across society more broadly, rather than redistributing them within a particular insurance market segment.³⁴ As a result, the hope is that more people will purchase insurance.³⁵

To achieve this goal, public reinsurance typically covers a much greater portion of costs than is covered by private reinsurance.³⁶ Public reinsurance is typically not designed like private reinsurance, because the purposes differ.³⁷ As noted above, attachment points for private reinsurance are usually quite high because insurers want to purchase only what they really need.³⁸ Government reinsurance is intended to subsidize premiums, programs or proposals and typically cover claims down to \$15,000 a person and some even lower.³⁹ For example, the stop-loss reinsurance payments in New York reduced claims costs by about seventeen percent.⁴⁰ To achieve this, it was necessary to lower the attachment point to \$5,000 from \$30,000 where it first began, since \$30,000 covered an unexpectedly small portion of total claims.⁴¹

The New York experience illustrates the basic point, shown by others through statistical modeling, that average or overall medical costs are not greatly affected by the relatively few “catastrophic” or extraordinarily high expenses at the top end of the distribution.⁴² Instead, changes in cost are driven mainly by a larger number of people in an intermediate zone with moderately or substantially high costs.⁴³ Therefore, to reduce overall claims costs substantially, it is necessary to set the attachment point at a much lower level than is often imagined.⁴⁴ For example, Blumberg and Holahan

33. WIKLER & FISH-PARCHAM, *supra* note 13.

34. Blumberg & Holahan, *supra* note 28, at 132.

35. *See id.*; WIKLER & FISH-PARCHAM, *supra* note 13.

36. *See* BOVBJERG & WICKS, *supra* note 20 (explaining that, in private reinsurance, “[t]hresholds tend to be larger than the \$35,000 proposed by the Roadmap [for public reinsurance], and protection is not usually unlimited”).

37. *See id.*; AM. ACAD. OF ACTUARIES, *supra* note 24, at 3.

38. *See* WIKLER & FISH-PARCHAM, *supra* note 13 (“[P]rivate reinsurance is expensive. Although it helps insurance companies get through bad years, ultimately, they still pay the cost of high claims through their reinsurance premiums.”).

39. Swartz, *supra* note 3; BOVBJERG ET AL., note 18.

40. BOVBJERG ET AL., *supra* note 18.

41. *Id.*

42. Blumberg & Holahan, *supra* note 28; Sappington et al., *supra* note 28.

43. Blumberg & Holahan, *supra* note 28.

44. *Id.* at 135, 139; Sappington et al., *supra* note 28.

estimated in 2004 that a threshold of \$15,000 is required for reinsurance to reduce costs between fifteen to twenty percent.⁴⁵ Similarly, Sappington and colleagues similarly estimated in 2002 that savings are “not especially pronounced until the attachment point [is] reduced to \$10,000.”⁴⁶

B. Reducing Risk

Even if the highest-end claims are not the main driver of total costs, they are a strong driver of insurers’ risk selection behaviors.⁴⁷ Therefore, blunting high-end risks reduces insurers’ need to evaluate the health risk of individual subscribers through medical underwriting and other risk selection activities that the government would like to mitigate.⁴⁸ One way states have done this is through industry-funded reinsurance pools, established under government auspices in the 1990s, as part of states’ guarantee-issue and community-rating rules for the small group market.⁴⁹ These pools allow insurers to reinsure high-risk individuals or groups by paying a reinsurance premium that is calculated to cover some, but not all, of the reinsured claims’ cost.⁵⁰ The excess costs are recouped by market-wide assessments of participating insurers in proportion to their market shares.⁵¹ Although these reinsurance pools are funded by the industry rather than by the government, they are operated under government auspices through a public board in order to protect insurers from the predictable

45. Blumberg & Holahan, *supra* note 28, at 136 (“[I]f the government paid 75% of the costs above a \$15,000 threshold, the private costs of employer-sponsored insurance would fall by 16.1%; the private costs of ESI in establishments with fewer than 25 and fewer than 100 workers would fall by over 14%, and the private costs of nongroup policies would fall by 21.2%.”).

46. Sappington et al., *supra* note 28 (“At [a 10%] attachment point, state funded reinsurance reduced the average loss of the low-profit plans by more than 40%.”). More recently, the CBO estimated that by 2014, reinsuring 75% of claims over \$50,000 would result in “roughly 2.6 million people who otherwise would have been uninsured” obtaining private coverage as a result of lower insurance premiums for employers. See CONG. BUDGET OFFICE, BUDGET OPTIONS VOLUME 1: HEALTH CARE 15 (2008), available at <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>.

47. See AM. ACAD. OF ACTUARIES, RISK CLASSIFICATION IN THE VOLUNTARY HEALTH INSURANCE MARKET 3-4 (2009), available at http://www.actuary.org/pdf/health/risk_mar_09.pdf.

48. See DEBORAH CHOLLET, ACADEMY HEALTH, THE ROLE OF REINSURANCE IN STATE EFFORTS TO EXPAND COVERAGE 1 (2004), available at <http://www.statecoverage.org/files/The Role of Reinsurance in State Efforts to Expand Coverage.pdf>.

49. See *id.*

50. Under the standard model (which varies by state), insurers pay 500% of market average rates to reinsure an individual, or 150% of market rates to reinsure a group. Mark A. Hall & Janice S. Lawlor, *Reinsurance Pools for Small-Group Health Insurance*, 19 J. OF INS. REG. 638, 642 (2001). Reinsurance covers 90% of insured medical claims above an attachment point of \$5,000. *Id.* at 640-41.

51. *Id.* at 642.

costs of subscribers who are *identifiably* high risk at the time of enrollment.⁵² Selecting predictably high-risk subscribers to reinsure “prospectively” contrasts sharply with retrospective reinsurance, which covers cases that turn out to be high-cost regardless of their predictability.

In either form, reinsurance can be especially helpful to new insurers, or those that introduce new products or enter a new market.⁵³ This is because risk is more difficult to predict when the insurer has little or no experience.⁵⁴ Actuaries strive for “actuarial credibility,” which means they need real-world data from experience with their companies’ own products to have confidence that predicted claims are reasonably accurate.⁵⁵ Each time an insurer changes its products or enters new markets, it faces increased uncertainty that adds to its statistical risks.

Reinsurance can reduce this uncertainty, thereby enabling more experimentation or innovation, but it can be difficult or expensive to purchase reinsurance for new products or markets precisely because reinsurers also lack real-world claims data.⁵⁶ When a government program or regulation creates this actuarial uncertainty, it might make sense for the government to mitigate the new risk by creating a safer bridge into the new regulatory environment. For instance, when states began to contract with private HMOs for Medicaid services ten to twenty years ago, many states initially provided or required reinsurance to buffer the uncertainties of covering this new population, many of whom had serious chronic illnesses.⁵⁷ Likewise, Medicare’s new Part D coverage of prescription drugs had stop-loss protections for the first several years to encourage participation by hesitant private insurers,⁵⁸ and the newly enacted federal health care reform law contains essentially the same.⁵⁹

52. See WIKLER & FISH-PARCHAM, *supra* note 13, at 9 (describing Idaho’s individual high-risk reinsurance pool).

53. Bovbjerg et al., *supra* note 25, at 2.

54. AMY LUTZKY & RANDALL BOVBJERG, THE ROBERT WOOD JOHNSON FOUND.’S MEDICAID MANAGED CARE PROGRAM, THE ROLE OF REINSURANCE IN MEDICAID MANAGED CARE 7 (2003), http://www.chcs.org/usr_doc/reinsurance.pdf [hereinafter LUTZKY & BOVBJERG].

55. See generally Ragnar Norberg, *Credibility Theory*, in ENCYCLOPEDIA OF ACTUARIAL SCIENCE 398 (Jef L. Teugels, & Bjorn Sundt eds., 2004), available at <http://stats.lse.ac.uk/norberg/links/papers/CRED-eas.pdf>.

56. See Letter from Alfred A. Bingham, Jr., Vice President, Health Practice Council, American Academy of Actuaries.

57. LUTZKY & BOVBJERG, *supra* note 54, at 21-23.

58. Sipkoff, *supra* note 2.

59. Patient Protection and Affordable Care Act, S. 3590, 111th Cong. § 1341 (2010).

IV. EVALUATION OF GOVERNMENT-SPONSORED REINSURANCE

A. Risk Reduction

Scholars who have modeled or studied reinsurance conclude that it does not “dramatically reduce incentives for favorable selection.”⁶⁰ Randall R. Bovbjerg and Elliot Wicks, for example, recognize that “[B]ecause significant costs of the chronically ill and others occur below the level of any reinsurance threshold, some incentive for insurers to avoid such cases would remain, however public reinsurance is designed and implemented.”⁶¹ Therefore, even though reinsurance has some risk-leveling effect, its magnitude “is probably not large, as reinsurance leaves in place substantial variation across enrollees.”⁶²

The fact that reinsurance does not work wonders, though, does not mean that it may not help some. But the risk-reduction role of government-sponsored reinsurance is usually temporary or transitional. Its need is greatly reduced or eliminated once insurers gain sufficient experience with the new programs or market rules.⁶³ For instance, Medicaid HMOs found that, “over time, . . . [they] had less need [for public reinsurance] as plans grew . . . and [they] gained experience”⁶⁴ Likewise, Medicare Part D’s stop-loss protections became progressively less protective after the first year, as insurers gained more experience with the new program.

A similar experience occurred under the industry-funded reinsurance pools that accompanied small-group market reforms in the 1990s. Initially these pools may have helped to keep some insurers from leaving the regulated market until they gained the necessary real-world experience with guaranteed issue and community rating. However, most of these reinsurance pools have ceased to operate (or virtually so) because most insurers no longer feel they need the protection.⁶⁵ Therefore, these reinsurance pools have had no discernible long-term impact on premiums or coverage.⁶⁶

60. Sappington et al., *supra* note 28, at 13.

61. BOVBJERG & WICKS, *supra* note 20, at 13.

62. MO. FOUND. FOR HEALTH, *supra* note 16, at 25.

63. LUTZKY & BOVBJERG, *supra* note 54, at 13.

64. *Id.* at 13.

65. Hall & Lawlor, *supra* note 13, at 649. *See generally* WATTS ET AL., *supra* note 30 (analyzing the Office of the Insurance Commissioner’s proposal for a reinsurance program in Washington state). *See generally* RICHARD RUSH, WYOMING HEALTHCARE COMMISSION REINSURANCE STUDY UPDATE AND DISCUSSION 3 (2005), http://www.wyominghealthcarecommission.org/_pdfs/Reinsurance_Presentation.pdf.

66. *See* RUSH, *supra* note 65, at 3. *See also* Frank A. Sloan & Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults*, 35 INQUIRY 280, 291 (1998).

Moreover, as governments move from reforming voluntary insurance markets to mandating the purchase of insurance, concerns about adverse selection become less pressing. Massachusetts, for instance, did not see the need to adopt government-sponsored reinsurance as part of its individual mandate law.⁶⁷ Instead, the basic affordability of insurance is now the primary concern.

B. Premium Reduction

Based on the foregoing, the strongest reason for ongoing government-sponsored reinsurance is simply to subsidize the price of insurance so that more people can afford it. But, why should government subsidies be provided behind-the-scenes, to insurers, rather than more directly to individual purchasers? This is a question of “target efficiency”⁶⁸ that brings to mind the recent debate over financial bailouts. Should government assistance be given directly to distressed homeowners, or instead more indirectly to the financial institutions that lend money? For health insurance, like financial institutions, there is no easy answer to this question; rather, various insights can be gleaned from experiences to date with various forms of public reinsurance.

1. Costs, Efficiency, and Fairness

On the surface, behind-the-scenes reimbursement to insurers seems more circuitous than giving subscribers a direct rebate or tax credit for purchasing. One indication of the potential efficiency of a direct subsidy is to compare the cost per newly insured (previously uninsured) person with that of a reinsurance subsidy. Such estimates can vary widely depending on the program’s features and the assumptions made by the analyst, but within a given program and set of analytical assumptions the contrast between the two forms of subsidy can be revealing. For example, cost estimates for Senator Kerry’s national health care reform proposals made while running for president calculated that his stop-loss or reinsurance subsidy for employers would amount to more than \$10,000 to cover each previously uninsured person. In contrast, the various direct subsidies he proposed were about three to four times more efficient in reducing the number of uninsured.⁶⁹ The Congressional Budget Office (CBO) estimated that a

67. *But see* William H. Pitsenberger, *The Pool of Bethesda: Equity, Political Problems and Reinsurance Solutions in Mandated Individual Health Insurance*, 11 QUINNIPIAC HEALTH L.J. 145, 168, 175-76 (2008) (arguing that government reinsurance would make an individual mandate more feasible).

68. JAMES MIDGLEY & MICHELLE LIVERMORE, *THE HANDBOOK OF SOCIAL POLICY*, Sage Publications, (2008).

69. JOSEPH ANTOS ET AL., AM. ENTER. INST., *ANALYZING THE KERRY AND BUSH HEALTH*

similar plan in 2014 would cost anywhere from \$15,000 to \$30,000 per newly insured person covered (depending on how it is structured). This is four to eight times more costly than the CBO estimate of increasing coverage through vouchers for low-income uninsured.⁷⁰

This inefficiency results from the simple fact that the federal reinsurance proposals would subsidize many or all subscribers, even those currently purchasing coverage, whereas the premium assistance (voucher) subsidies are targeted more precisely to the uninsured and lower-income segments of the population. In contrast, analysts have estimated that implementing a targeted (New York-style) reinsurance program in certain other states would cost roughly \$1,000 a year per newly insured person covered.⁷¹

Without such targeting, reinsurance across a broad population can become very expensive for only a modest reduction in premiums. For example, Sen. Kerry's reinsurance proposal (seventy-five percent of claims exceeding \$30,000) would have reduced premiums by only ten percent, at an estimated annual cost of roughly \$30 to \$50 billion.⁷² The Commonwealth Fund concluded that "these provisions [in Sen. Kerry's proposal] make coverage more affordable for employers and individuals without covering many additional people."⁷³ The CBO estimated that a

PROPOSALS: ESTIMATES OF COST AND IMPACT 2-3 (2004), http://www.aei.org/docLib/20040913_KerryBushHealthPlans.pdf. See also THE LEWIN GROUP, BUSH AND KERRY HEALTH CARE PROPOSALS: COST AND COVERAGE COMPARED 2-3 (2004), <http://www.lewin.com/content/publications/2983.pdf>. Similarly, analysts estimated in Indiana that a premium assistance proposal that would pay the employee share of employer-sponsored insurance for workers at less than 250% of the poverty level would cost about one third the amount per newly insured person (\$198) as the proposed New York-style reinsurance subsidy. *Id.*

70. CONG. BUDGET OFFICE, *supra* note 46, at 15-16, 19.

71. N.C. TASK FORCE ON COVERING THE UNINSURED, N.C. INST. OF MED., EXPANDING HEALTH INSURANCE COVERAGE TO MORE NORTH CAROLINIANS 148 (2006), <http://www.nciom.org/projects/uninsured/AppendixF.pdf>

(a cost of \$1,112.50 per person). See also SARAH SCHULTE, COLO. COAL. FOR THE MEDICALLY UNDERSERVED, BRIEFING PAPER ON THE HEALTHY COLORADO SMALL BUSINESS PROGRAM 17 (2002), http://www.ccmu.org/PDFs/research_section/CCMUSmlBusPrgm.pdf (a cost of \$720-1954 per person, depending on various assumptions).

72. THE LEWIN GROUP, *supra* note 69, at 5. See also KENNETH E. THORPE, EMORY UNIV., THE IMPACT OF SEN. JOHN KERRY'S HEALTH CARE PROPOSAL ON HEALTH CARE COSTS 1, 3 (2004),

<http://www.sph.emory.edu/hpm/thorpe/nobugthorpe2.pdf>; see also KENNETH E. THORPE, EMORY UNIV., FEDERAL COSTS AND SAVINGS ASSOCIATED WITH SENATOR KERRY'S HEALTH CARE PLAN 1, 3 (2004),

<http://www.sph.emory.edu/hpm/thorpe/kerry8-23-04.pdf>.

73. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, HEALTH CARE REFORM RETURNS TO THE NATIONAL AGENDA: THE 2004 PRESIDENTIAL CANDIDATES' PROPOSALS 13 (2004),

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2003/Sep/Health%20Care%20Reform%20Returns%20to%20the%20National%20Agenda%20%202004%20Presidential%20Candidates%20Proposals/671_Collins_candidates_update_Oct2004%2

similar plan in 2014 would cost \$90 billion a year if all privately insured people were covered or \$32 billion if the plan applied only to individuals and employer groups under one hundred.⁷⁴

A reinsurance subsidy can be targeted to those with the greatest need, but still it tends to be an all-or-nothing subsidy that depends only on threshold eligibility. A direct subsidy, in contrast, can more easily have a sliding scale feature that attunes with greater precision to the extent of individual need. Additionally, a targeted reinsurance program is not easily designed and implemented since it requires a separate insurance plan and administrative structure, as done in New York. A number of reinsurance experts have written at length about the various complex decisions this entails.⁷⁵ In particular, it is often necessary to regulate insurers' rates more closely to ensure that subscribers receive the full benefit of the subsidy rather than it going to cover corporate overhead and profits. In New York, for instance, stop-loss payments reduced rates because regulators required that insurers maintain at least an eighty percent medical loss ratio and most insurers reported actual loss ratios of around ninety percent for their reinsured product.⁷⁶

Despite the greater efficiency of more targeted subsidies, broader-based reinsurance has some political and social appeal because more people would receive this assistance, not just those who have previously avoided purchasing insurance. Also, reinsurance does not carry any "stigma" of a direct government handout. Moreover, in contrast with a tax credit subsidy, reinsurance has the effect of lowering the up-front rate that purchasers first see rather than expecting them to factor in a rebate that they will not receive until later. Finally, reinsurance might be administratively simpler since it entails dozens or hundreds of insurers rather than millions of individual purchasers.

2. Moral Hazard

A potential downside of reinsurance is moral hazard. Reinsurance can make primary insurers less concerned about controlling their own costs for the very cases where costs are the most excessive.⁷⁷ For instance, insurers

0pdf.pdf

74. CONG. BUDGET OFFICE, *supra* note 46, at 15.

75. See generally AM. ACAD. OF ACTUARIES, *supra* note 24. See generally DONALD COHN ET AL., ACADEMYHEALTH, MORE ANSWERS ON REINSURANCE, (2005), <http://www.statecoverage.org/files/More%20Answers%20on%20Reinsurance.pdf>. See generally SWARTZ, *supra* note 3. See generally BOVBJERG & WICKS, *supra* note 20. See generally MO. FOUND. FOR HEALTH, *supra* note 16.

76. Bovbjerg et al., *supra* note 25; Swartz, *supra* note 19. Author's interviews with anonymous insurers in New York.

77. See AM. ACAD. OF ACTUARIES, *supra* note 24, at 5. See also BOVBJERG & WICKS,

might pay claims without investigating them as thoroughly, under-invest in care management, or take excessive business risks. A study of New Jersey's insurance market reforms, for example, concluded that its risk-pooling arrangement caused significant problems by creating "incentives for [smaller] insurers with insufficient capital reserves to offer coverage they [couldn't] deliver and thereby cause[d] other insurers to bear the losses."⁷⁸

Concerns about possible moral hazard have not become a widespread reality, however. A study of reinsurance for Medicaid managed care plans found no evidence of insurers changing their behavior "near the [reinsurance] threshold in expectation of achieving state reimbursement."⁷⁹ Because the number of subscribers covered by reinsurance is relatively small, it would take more effort than it is worth to single them out for different treatment.⁸⁰ Insurers' claims processing and care management systems tend to apply uniformly to all subscribers, both fully-insured and self-insured (for whom insurers similarly bear no direct financial risk). People who work in those functions have no easy way to know whether or not particular subscribers are reinsured or self-insured.⁸¹

Still, some fear insurers' behavior might change if reinsurance became more extensive, covering many or most subscribers and a large portion of claims.⁸² We gain some insight into whether this speculation is likely by looking at the experience of risk pools similar to public reinsurance but under other kinds of insurance, such as automobile, workers compensation, and medical malpractice (for physicians' liability). For these, states have created arrangements such as "residual markets" and "compensation funds" that resemble industry-funded reinsurance pools. Economists who have studied these settings conclude, in general, that there is evidence of some moral hazard, but it is not disabling.⁸³

supra note 20, at 13.

78. SWARTZ, *supra* note 3, at 96.

79. LUTZKY & BOVBJERG, *supra* note 54, at 11.

80. See generally Eric M. Van Barneveld et al., *Mandatory High-Risk Pooling: An Approach to Reducing Incentives for Cream Skimming*, 33 INQUIRY 133, 133-43 (1996). See generally PATRICIA M. DANZON & SCOTT E. HARRINGTON, RATE REGULATION OF WORKERS' COMPENSATION INSURANCE: HOW PRICE CONTROLS INCREASE COSTS (1998).

81. See generally Hall & Lawlor, *supra* note 13, at 642.

82. Bovbjerg et al., *supra* note 25, at 169; See also DANZON & HARRINGTON, *supra* note 80, at 82. See also AM. ACAD. OF ACTUARIES, *supra* note 24, at 7.

83. DANZON & HARRINGTON, *supra* note 80, at 82. See also Scott E. Harrington & Helen Doeringhaus, *The Economics and Politics of Automobile Insurance Rate Classification*, 60 J. OF RISK & INS. 59, 74 (1993). See also Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 268 (2005).

3. White Knight or Trojan Horse?

A final consideration is whether public reinsurance is a path to more socialized insurance markets. One obvious feature of reinsurance is that the lower the attachment point, the more insurance risk is socialized. At some level, a low attachment point coupled with a substantial deductible under the main policy could displace most of what a private health plan normally insures. Thus, government reinsurance might begin to approach a system of social insurance in which the role of private insurers is reduced primarily to claims administration and cost management (as under the current Medicare program). Indeed, noted health economist Henry Aaron once proposed a government reinsurance program as a way to transition to a single-payer system, explaining that “if the [stop-loss] limit were lowered, directly or by erosion due to inflation, the scope of private coverage would shrink, ultimately to the point of disappearing.”⁸⁴

Another socializing element is the fact that public or pooled reinsurance requires a high degree of standardization among insurers, such as a common set of covered benefits and perhaps a uniform beginning date for policy years.⁸⁵ Also, scholars of the government’s role in social risks generally observe that, as the government assumes more responsibility for risks, it also begins to exercise more control over the conditions that cause the risk.⁸⁶

Whether socialization of health risk is a white knight or a Trojan horse depends on one’s social and political perspective. Still, health policy analysts from different perspectives agree that the primary function of government-funded reinsurance is to subsidize, and thereby lower, the price of health insurance, so that more people can afford to buy it.⁸⁷ While reinsurance is not cheaper than other means of subsidy, it does have the potential to be a fairer, more efficient, or more pragmatic subsidy mechanism. Like so much else in health reform, the best approach depends on the often devilish, but sometimes angelic, details.

84. Bovbjerg et al., *supra* note 25, at 168. See generally John V. Jacobi, *Government Reinsurance Programs and Consumer-Driven Care*, 53 *BUFF. L. REV.* 537, 537-75 (2005).

85. SWARTZ, *supra* note 3.

86. See generally DAVID A. MOSS, *WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER*, Harvard Univ. Press (2002).

87. See generally, e.g., Bovbjerg et al., *supra* note 25; SWARTZ, *supra* note 3.