WebMemo
Published by The Heritage Foundation

No. 1568
July 26, 2007

State Health Care Reform: The Benefits and Limits of "Reinsurance"

Edmund F. Haislmaier

In the debate over health care reform, some federal and state lawmakers are asking whether some type of reinsurance system might make health insurance more affordable. In exploring that rather arcane area of insurance practice, policymakers should have a strong understanding of the concepts involved and the potential benefits and limits of "reinsurance" mechanisms for health insurance markets.

When most people refer to "reinsurance" in health care, what they really mean is the related concept of risk transfer or risk-pooling arrangements. Such arrangements are designed to remove the obstacles faced by high-risk individuals and groups in getting health care coverage. Although risk transfer arrangements can help in this regard, they do not lower overall health care costs. Furthermore, policymakers must design arrangements to encourage universal participation from insurers and remove incentives for them to transfer costs to taxpayers.

Selection Risk and Its Discontents. In the classic definition, reinsurance can be thought of as an insurance company buying insurance for itself. In most cases, the primary insurer is buying protection against the possibility that some rare set of circumstances might produce losses that it is unable to fund on its own. The practice is more common in areas like property and casualty insurance. Such companies could take heavy losses if multiple natural disasters struck within a short time frame, for example. The possibility of a "perfect storm" of large losses induces insurers to buy reinsurance on the commercial market.

However, those kinds of scenarios are not as plausible in other lines of insurance, such as life or health (except for very small carriers). While one can never say "never" in insurance, the risk that a large life insurance company will see half its customers die in the same year is virtually zero. The risk is equally low that a majority of customers of a large health insurance company will need major operations and hospitalization in the same year.

In the context of health insurance, what is usually meant by "reinsurance" is really insurance against a different kind of potential risk. The risk in question can best be described as "selection risk": the risk that an insurer will acquire a larger-than-average share of costly customers.

In the current individual and small group markets, insurers' first line of defense against selection risk is the practice of underwriting. Through underwriting, insurers seek to determine the risk profile of individuals or groups before issuing coverage. After identifying the high-risk applicants, the companies then either deny coverage altogether, limit coverage for pre-existing medical conditions, or charge higher premiums.

In the group market, particularly in the small group market, insurers also use "minimum partici-

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm1568.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

pation" to guard against selection risk. The insurer will not issue group coverage to an employer unless the employer ensures that a minimum share of its workers (usually 75 percent to 80 percent) participate in the coverage. That way, the insurer limits the possibility that only high-risk employees will enroll in the insurance plan.

While these practices help protect health insurers against selection risks, they also create problems for individuals and employer groups, particularly small employers, because:

- They can make health insurance unaffordable, or even unavailable, for individuals in poor health.
- They make it more difficult for insured individuals who develop medical conditions to retain coverage. A change in circumstances (such as in employment or residence) could result in a loss of coverage and a subsequent inability to get new coverage.
- They create obstacles to employers offering group coverage to their workers. In particular, smaller employers often find it difficult to induce enough of their employees to take up coverage and thus meet the insurer's minimum participation requirement for covering the whole group.

"Inclusionary" and "Exclusionary" Risk Transfer Mechanisms. To address the above problems with selection risk, lawmakers have designed various risk transfer concepts. For the purposes of this paper, the concepts are divided into two basic types, "inclusionary" and "exclusionary."

The "exclusionary" mechanisms segregate high-risk individuals from the low-risk population, subsidizing them in a separate pool. The "inclusionary" mechanisms keep high-risk individuals in the same pool as everyone else but seek to redistribute and/or subsidize their more expensive claims.

A common exclusionary mechanism is a state-run "high-risk pool" for the individual health insurance market. The pool offers coverage to people who have been refused coverage in the individual market due to poor health status. Although coverage carries high premiums, the premiums are not enough to cover the cost of claims by enrollees. To make up the difference, lawmakers use a mix of assessments on private insurers and public subsidies. In some states, the losses are funded entirely out of assessments on insurers and, thus, ultimately included in the premiums paid by everyone with health insurance coverage. In other states, the losses are funded primarily out of general revenue appropriations and, thus, are ultimately born by all the state's taxpayers. Still other states use a mix of both funding sources.

Inclusionary risk transfer mechanisms operate on essentially the same principle, except that high-cost individuals are not given separate coverage. Instead, some portion of their claims is pooled and then proportionately redistributed among the carriers in the market. As with high-risk pools, public subsidies may also be used to offset some of the cost of claims. This type of mechanism is often called, somewhat inaccurately, a "reinsurance pool." A more precise termed is "risk-transfer pool."

Lawmakers should take into account the following considerations in designing and implementing health insurance risk transfer arrangements:

1. **Inclusionary designs offer more individual choice.** Under an inclusionary design, the risk transfer mechanism is opaque to the insured—meaning that the individual is not aware that a portion of his claims is being ceded to the pool. In contrast, under an exclusionary design, the insured is given separate primary coverage (through the pool). Thus, with an exclusionary risk transfer mechanism such as a high-risk pool, individuals lose choice of coverage in a health insurance market. With an inclusionary risk transfer mechanism, high-risk individuals retain choice of coverage.
2. **Exclusionary designs offer modest potential for controlling claims' costs.** Under an exclusionary design, it is possible to contract with an entity to "case manage" the care of pool enrollees. In theory, this could result in lowering the aggregate cost of claims for high-risk individuals, compared with what it might have been had they remained in the general market. However, the extent of any such savings is heavily dependent on whether the pool will really do a better job of case management than the carriers issuing primary coverage in the market.

3. **Inclusionary designs must include incentives for primary insurers to control costs.** Under an inclusionary design, the pool does not manage the costs of claims. Therefore, policymakers must require the primary insurer to retain a portion of claims it cedes to the pool. Typically, such rules specify that the pool will only accept ceded claims above a certain threshold (called the "attachment point"), and that the primary insurer must pay a premium for ceding the risk to the pool. Above that attachment point, the ceding carrier also remains responsible for paying a portion of all claims (called a "risk corridor"). For example, the rules might specify that a primary insurer can pay a premium to cede claims in excess of $50,000 (the attachment point), and must continue to pay 20 percent of the claims above $50,000 (the risk corridor).
4. **Risk transfer mechanisms do not lower general health care costs.** Regardless of design, risk transfer mechanisms only shift or redistribute costs among funding sources. Specifically, risk transfer mechanisms offer ways to more equitably redistribute the costs of a small number of expensive cases or individuals across a broader population. While these features enable health insurance markets to function more smoothly, they are *not* a solution for controlling health care costs in general.
5. **Government subsidies for risk transfer mechanisms do not reduce health care costs.** Whether for inclusive or exclusive designs, subsidies simply shift costs onto taxpayers. Nevertheless, a reasonable argument can be made for partial public funding of health insurance risk transfer arrangements. When pool losses are funded through assessments on commercial insurance carriers, the costs are spread *only* among those covered by commercial insurance. Partial taxpayer funding is a way to ensure that pool costs are borne by a broader swathe of the public, including: workers in self-insured firms, seniors with Medicare coverage, and the uninsured. In sum, any proposal for public funding of a risk transfer arrangement should be evaluated based on the equity of its distributional effects—not on any expectations for health system savings.
6. **The broader the redistribution of costs under a risk transfer mechanism, the less burdensome it will be and the fewer distortions it will create in the market.** As with any kind of insurance arrangement, the objective is to spread the high claims of a few individuals among a large number of payers; the more payers, the smaller the cost to each. Consequently, costs will be spread more broadly if a state creates a single risk transfer mechanism for health insurance than if a state creates, for example, separate pools for its individual market and its small group market.
7. **Support for risk transfer mechanisms will vary among insurers based on differences in their business practices and market size.** In general, larger insurers, particularly those that are dominant in a state's market, will be less supportive of risk transfer mechanisms and less inclined to participate if they are organized on a voluntary basis. Those carriers may feel that they are large enough to handle potential selection effects internally, giving them a competitive advantage over smaller carriers. Conversely, a risk transfer mechanism requiring all health insurers to participate will have the effect of giving smaller insurers first entering the state's market a more level playing field on which to compete against larger and more entrenched companies.

   Similarly, carriers that rely more on underwriting as a key part of their business model are more likely to favor exclusionary mechanisms, such as state high-risk pools, that enable them to continue refusing coverage to applicants in poor health.

   Complicating the equation is the fact that a particular risk transfer design may present any given carrier with both advantages and disadvantages. For example, an inclusionary risk transfer pool might favor smaller carriers by giving them a more level playing field in competing with larger carriers, but simultaneously force them to end the practice of turning down applicants in poor health. The same scenario would mean that a dominant carrier that offers coverage to applicants in poor health (such as a Blue Cross plan required by law to be the "insurer of last resort")

could shift more of the costs of high-risk policyholders onto the broader pool, but might also face increased competition from smaller carriers.

8. **A risk transfer mechanism will be more successful if all carriers in a state are required to participate in it**. The terms must give all carriers equal rights (to cede risks to the pool) and equal responsibilities (to pay assessments to fund pool losses proportionately based on each carrier's number of policyholders). Furthermore, the fairest way to determine the rules governing the pool is by agreement of all the carriers in the state, under the regulatory supervision of the state's insurance commissioner.

Conclusion. The biggest limitation of health insurance risk transfer mechanisms is that they do not directly reduce general health care costs. However, such mechanisms *do* give policymakers a tool that, in conjunction with other reforms, can create a smoother-functioning health insurance market.

The ability of individuals to choose and keep their preferred health insurance coverage is the key to creating a consumer-centered health care system. Choice and portability would create the right incentives for insurers and providers to compete in offering consumers better value in both health insurance and medical care—that is, more benefit at a lower cost.

But if consumers are to be induced, or even required, to obtain health insurance coverage when they are in good health, then they must also be assured that if their heath status changes in the future they will be able to keep, and periodically switch (if they desire), coverage at standard rates. An important component in creating such a consumer-centered health insurance system is an inclusionary risk transfer pool in which all insurers in a state participate. Such a mechanism assures consumers that their ability to choose coverage will not be restricted in the future due to changes in their health status. At the same time, it assures carriers that when consumers in poor health pick their plans, a portion of their higher costs will be spread among all policyholders in the market, and not just among those enrolled with that particular carrier.

Finally, lawmakers must remember that while it is acceptable, for reasons of equity, to provide public subsidies to offset some of the costs associated with health insurance risk transfer arrangements, any such subsidies should be fixed and limited so as to avoid unintentionally creating incentives for carriers to transfer more of their risks onto taxpayers.

—Edmund F. Haislmaier is Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation.