

REPORT OF THE COUNCIL ON MEDICAL SERVICE

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Subject: Reinsurance and the Health Insurance Market

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1 Council on Medical Service Report 5 (A-05), "Containing Catastrophic Costs" discussed
2 approaches to reducing the level of high medical costs that create unpredictable claims, which are
3 very costly for both insurers and enrollees. The report did not address, however, specific strategies
4 to finance and/or manage catastrophic costs, such as through the use of reinsurance.
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6 This report, which is presented for the information of the House of Delegates, describes the concept
7 of reinsurance; discusses how reinsurance is utilized in the health care industry; and describes
8 several federal and state reinsurance models that can be used to better understand the benefits and
9 limitations of reinsurance policies.

10 11 WHAT IS REINSURANCE?

12
13 The concept of reinsurance first emerged in the private sector to cover catastrophic casualty and
14 property claims, but now is being used in the health insurance industry. To reduce risk, reinsurance
15 is used to compensate primary insurance carriers for costly claims. When primary insurance
16 carriers reinsure, they transfer some of their financial risk to another company (the reinsurer),
17 which helps them to stay financially viable even when their claims are higher than expected. The
18 primary insurance carrier pays the reinsurer a premium in order for the reinsurer to finance the
19 insurance company's most complex risks.
20

21 Reinsurance contracts vary; some limit risk for an individual contact, a group of contacts, or a set
22 portion of the insurer's business. The financial risks are transferred to the reinsurer, at the
23 attachment point, which is the threshold level at which the reinsurer agrees to reimburse the
24 insurance carrier for a portion of its claims (e.g., reinsurer pays 75% of the primary insurer's claims
25 that exceed \$100,000). Reinsurance affects the availability and affordability of insurance coverage
26 (Swiss Re, January 2005). Therefore, carriers are hopeful that reinsurance policies will help them
27 to minimize the financial impact of their claims.
28

29 After the events of September 11, 2001, the market for reinsurance hardened and reinsurers have
30 become more reluctant to insure health related risk since it is somewhat unpredictable. Since 2002,
31 25 of 50 private health care reinsurance carriers have withdrawn from the reinsurance market.
32 (America's Health Insurance Plans, March/April 2004). According to Standard & Poor's,
33 reinsurers in various sectors did not face significant losses in 2004, yet primary insurance carriers
34 with losses were paying out up to 35% more to continue coverage, impacting the sustainability of
35 their businesses (Crain Communications, January 2005). In 2005, some reinsurance premiums
36 reportedly have decreased, but there has not been an overall market decline in the rates.

1 HEALTH CARE AND REINSURANCE

2
3 Reinsurance policies are typically used to stabilize premiums and expand coverage for small
4 employers and individuals with nongroup coverage. To spread risk, reinsurance compensates
5 health insurance carriers for large claims such as organ transplants, cancer, severe trauma, burns,
6 and other catastrophic illnesses such as HIV/AIDS, which, in turn, reduces market segmentation to
7 lower the cost of premiums for individuals and groups (*Best's Review*, July 2003). Typically,
8 reinsurance policies are purchased by employer groups, HMOs, disease management companies,
9 and other program managers. In general, reinsurance is not a significant issue with larger, more
10 well-financed insurance companies, including experienced self-funded employers, since they insure
11 numerous enrollees it allows them to share risk more broadly.

12
13 Reinsurance and insurance underwriting is comprised of underwriters selecting risk by assigning
14 rates for the insurance company which are deemed acceptable and affordable rates for claims. For
15 health care, insurance underwriting appears to be more appropriately designed for chronic
16 conditions such as diabetes, arthritis, and hypertension where costs are incurred consistently from
17 year to year, at a somewhat predictable rate. However, other conditions covered by reinsurance
18 often have less predictable claims (e.g., trauma, burns) and medical expenses may vary year-to-
19 year (Galen Institute, September 2004).

20
21 Selection mechanisms used by insurance companies often assume that someone who is a high-cost
22 utilizer will continue to incur high medical expenditures through his or her lifetime. However,
23 several longitudinal studies conflict with this common assumption, particularly for the nonelderly
24 population (Swartz, American Economic Association, May 2003). Since underwriting can be
25 somewhat distorted in the health care industry, reinsurance pooling probably will not have an
26 influence on underwriting practices. However, reinsurance policies do make selection mechanisms
27 much easier for the primary insurer and, at the same time, lower their liability.

28
29 In addition, reinsurance has been used to fund care related to epidemics such as the spread of
30 infectious diseases including SARS, the West Nile Virus, malaria, influenza, and tuberculosis. In a
31 time of crisis, reinsurance helps to insure that ample materials such as equipment and drugs are
32 available. Epidemics are very costly for reinsurers, and can be for carriers depending upon the
33 threshold level they agreed upon with the reinsurer (*Best's Review*, July 2003).

34
35 Overall, the financial goal of a primary health insurer is to either try to avoid risky claims or to
36 charge higher premiums to stay in business. Therefore, financing health insurance, especially
37 costly expenses, through reinsurance, allows primary insurers to include more enrollees, especially
38 low-risk individuals as they assume less financial risk. With reinsurance, insurance companies
39 have fewer incentives to select only low-risk individuals. The advantages to a primary insurer to
40 reinsure its policies include sustaining claims volatility, retaining capital, reducing administrative
41 costs, and minimizing adverse selection. For individuals, the principal benefits are lower premium
42 rates and more opportunities to enroll in more affordable health plans.

43
44 HIGH MEDICAL SPENDERS

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46 As discussed in Council of Medical Service Report 5 (A-05), 5% of patients account for
47 approximately one-half of all health care expenditures in a given year, while the least costly 50% of
48 individuals account for only 3% of total expenditures. The aggregate spending for the 10 most

1 expensive medical conditions totals nearly 50% of all health expenditures. Nevertheless, Berk and
2 Monheit (*Health Affairs*, March/April 2001) found that although age and poor health status are
3 associated with being among the top 1% of spenders, a slight majority of top spenders did not
4 report fair or poor health and were not elderly. In fact, the most costly 2-3% of individuals in a
5 given year do not remain in the extremely high-cost category in subsequent years, making it more
6 difficult to select the most appropriate, low-risk enrollee. In addition, it is difficult to accurately
7 estimate an individual's future medical care expenses, which creates unpredictable claims for
8 insurers (Swartz, American Economic Association, May 2003). In some cases, many individuals
9 have experienced truly unpredictable illnesses or injuries and recover or die by the following year.
10 Because medical spending is disproportionately skewed to a very small portion of the population,
11 reinsurance can help individuals with high, variable expenses afford their medical care, as well as
12 find insurance carriers willing to offer them insurance.

13

14 REINSURANCE MODELS

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16 Federal Reinsurance

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18 A 2004 study by Blumberg and Holahan reached several conclusions regarding the potential effects
19 of the federal government as a reinsurer, especially in the nongroup market and for small
20 employers –two segments that often lack a large number of healthy enrollees to absorb high
21 medical care costs (Blumberg and Holahan, *Inquiry*, Summer 2004). First, since high medical
22 costs are skewed towards a smaller portion of the population, the federal government acting as a
23 reinsurer could both help to reduce concerns among insurance carriers to enroll high-risk
24 individuals, and reduce administrative costs in searching for the most ideal enrollees. Second,
25 public reinsurance gives high-risk individuals more choice, since company fees are partly covered
26 by the government. Third, reinsurance spreads health care costs among high and low-risk
27 individuals, the government, and private insurers, thereby making premiums more affordable even
28 for people with higher than expected costs.

29

30 A key issue that arises is how the government would reduce public medical spending as well as
31 lower variation. For example, lower thresholds on spending (e.g., expenditures at or above
32 \$15,000 per year) are much more expensive for the government, but reduce variance in employer
33 spending, while higher thresholds (e.g. expenditures at or above \$50,000 per year) create the
34 opposite effects. In other words, if the government reimburses carriers above a particular
35 threshold, that threshold must be low enough in order for private carriers to feel the effects. For
36 each of the thresholds, the study used various reimbursement levels after claims reached the
37 threshold level (e.g., 75%, 90%, and 100% reimbursement rates). Besides thresholds, Blumberg
38 and Holahan also looked at the impact of reinsurance policies where the government pays
39 expenditures for the top 3%, top 10%, or top 25% of the expenditure distribution of the private
40 insurer market. For example, when 75% of the carriers' costs in the top 10th percentile are
41 reimbursed, private payers gain an additional 30% of savings in the employer-based insurance
42 market and 37% savings in the private nongroup market. In this case, private savings rise as the
43 government percentage of reinsurance coverage increases. The lower the threshold, the less
44 incentive the insurer has to contain costs of expensive medical cases, especially if reinsurance picks
45 up 100% of costs after the threshold. Overall, Blumberg and Holahan found that government
46 reinsurance pools are likely to reduce premiums by lowering insurers' risk of high cost claims, and
47 may result in an increase in coverage within the nongroup market and small employer groups,
48 which may potentially decrease the number of uninsured.

1 In recent years, several members of Congress have expressed interest in developing a better
2 solution to increasing health insurance coverage and financing the high cost of care through a form
3 of reinsurance. During the 2004 presidential campaign, for example, Sen. John Kerry (D-MA)
4 proposed a reinsurance program with a premium rebate where the federal government would have
5 paid 75% of the cost of claims over \$30,000 beginning in 2006, and over \$50,000 by 2013. In
6 order to participate in the rebate pool, employers would have had to cover all employees, offer
7 disease management programs and services, and pay a portion of their premium rebate savings to
8 their employees. Over a 10 year period, the Lewin Group projected that the Kerry plan would have
9 cost the federal government \$725.7 billion, with about \$1000 premium savings per family health
10 plan (Moffit et al, The Heritage Foundation, October 2004).

11
12 State Reinsurance Initiatives

13
14 Currently, approximately 21 states have reinsurance pools, and 19 of the states have enacted model
15 National Association of Insurance Commissioners (NAIC) reinsurance programs (National Council
16 on State Legislatures, December 2004). States fund reinsurance pools from reinsurance premiums,
17 state premium taxes, indirectly subsidized premiums from a purchasing pool, or some combination.
18 The majority of reinsurance program participants are small group insurers. Many large insurance
19 companies declined to participate in state reinsurance pools since they do not find them beneficial
20 to their business plans.

21
22 The success of state reinsurance programs have been relatively mixed, where some lack enrollment
23 or the benefits are too low, while other states have been able to create effective programs with a
24 high degree of participation. For example, Connecticut's Small Employer Health Reinsurance
25 Pool, developed in 1990, was the first of its kind, and serves as a model for reinsurance for the
26 NAIC. Under this program, premium costs are based on a variety of factors such as patient
27 demographics, health status, tobacco use, and geographical location. The pool is funded by
28 reinsurance premiums and an annual fee from all health insurers dependent upon their share in the
29 small group market. Reinsurers pay for medical claims exceeding \$5,000. In October 2004,
30 Connecticut's reinsurance pool had about 37 participating carriers and 3,116 enrolled workers in
31 the pool. For the most part, Connecticut has been successful in implementing a health reinsurance
32 pool, since the state offers generous benefits and allows insurers recurring opportunities to reinsure
33 their small groups, every three years.

34
35 The Massachusetts Small Employer Health Reinsurance Plans began in 1992. Participants must be
36 full-time workers (at least 30 hours a week) working 5 months or more, sole proprietors, partners,
37 or dependents. The small group plan reinsures various commercial plans but not HMOs. In order
38 to minimize adverse selection, carriers are required to enroll 75% of their reinsurance eligible
39 employees. Insurers pay claims up to \$5,000 and 10% of the next \$50,000, and are fully
40 reimbursed if claims are over \$55,000. Premiums vary, on average, from \$800-\$1,000 per person
41 per month. As of October 2004, eight insurance plans were covering only 13 individuals. The
42 likely cause of low participation rates in the Massachusetts reinsurance program were costly
43 premiums, almost twice the level of the Connecticut reinsurance pool. In addition, HMOs could
44 not participate in the program even though a large share of their enrolled population would have
45 most likely ceded to a reinsurance plan.

46
47 New York developed its own state reinsurance program that subsidizes and focuses on small
48 groups and low-income workers without coverage. Similar to Massachusetts, in order to reduce

1 adverse selection, employers must allow at least half of their employees to participate and pay at
2 least half of the employees' premiums. The Healthy New York Reinsurance Program participants
3 include sole proprietors, low-income individuals, and previously unemployed individuals within
4 the year who cannot afford health insurance without a subsidy. Since 2001, the Healthy New York
5 Program has enrolled more than 101,665 workers, and in 2003, it had 39,661 enrollees of which
6 59% were working individuals. The New York purchasing pool assumes most or all of the risk of
7 the enrollees, but the premiums are indirectly subsidized. In order to balance the insurance market
8 with state regulations, all participating insurance carriers are required to comply with New York's
9 guaranteed issue and "pure" community rating laws. In addition, the program requires carriers to
10 set a single premium rate for all individuals regardless of their enrollment category. Insurance
11 carriers are reimbursed for 90% of their claims from \$5,000-\$75,000 annually. Overall, the
12 Healthy New York Program reduced premiums by 50-70% for individuals, and by 15-30% for
13 small groups since 2001. In comparison to other state reinsurance programs, New York targets a
14 smaller segment of the uninsured population. Therefore, it is easier for Healthy New York to
15 capture potential enrollees and not face crowd-out issues (i.e., people dropping private coverage for
16 public coverage). The Healthy New York Program has been successful in lowering health
17 insurance costs for low-income workers by reducing the opportunities for adverse selection,
18 thereby increasing enrollment by targeting a uniform market of enrollees (Chollet, Academy
19 Health, October 2004).

20

21 Publicly Subsidized, Mandatory Privately Pooled Reinsurance

22

23 Some policymakers have proposed a mandatory pooled reinsurance fund, which would be funded
24 by general revenues and by the nongroup private insurance market to compensate high-risk
25 subsidized individuals. The idea of creating compulsory participation in a privately financed pool
26 allows federal and state governments to aid private insurers in setting up reinsurance pools, which
27 would spread the cost of high-risk patient care across many sectors. Under such a system, a pool
28 would be created where members of a state or region place their high-cost claims in a pool that is
29 funded by a per-covered life assessment on all insurers. Insurance carriers would make
30 contributions to the fund dependent upon the number of enrollees they cover, and would be used
31 according to the level of risk of each enrollee. The reinsurance pool would minimize the range of
32 enrollee premiums, and insure that private insurance companies continue to have incentives to offer
33 high medical risk financing (Moffit et al, The Heritage Foundation, October 2004).

34

35 A mandatory reinsurance program to insure against the threat of terrorism currently exists in
36 France. In 2001, France created GAREAT, a mandatory casualty reinsurance program covering
37 commercial risks that includes chemical, biological, radiological, and nuclear attacks. The
38 GAREAT agreement runs until December 31, 2006 (Congressional Budget Office, January 2005).

39

40 RELEVANT AMA POLICY

41

42 Current AMA policy is supportive of the concept of reinsurance. The AMA has supported the
43 study of reinsurance as a mechanism for retrospectively adjusting risk in the Medicare program
44 when adverse section cannot be controlled through other methods (Policy H-330.933, AMA Policy
45 Database). In terms of health insurance market regulation, the AMA believes that risk-related
46 subsidies such as subsidies for reinsurance should be financed through general tax revenues (Policy
47 H-165.856[3]).

1 The AMA also has established policy on risk pools and risk adjustment that are relevant to
2 reinsurance. AMA policy supports the development of state insurance risk pools that do not
3 impose preexisting condition limitations, and are focused on individuals that are medically
4 uninsurable, cannot afford private individual insurance, and do not have group coverage (Policies
5 H-165.979, H-165.988, H-165.991, H-165.995, and H-20.968). Policy H-165.920[13] encourages
6 the AMA to continue experimentation with and monitor the success of approaches to minimizing
7 or compensating for adverse selection among the individually purchased and owned health expense
8 plans available, including risk adjustment across plans, reinsurance pools, and limiting enrollment
9 and disenrollment opportunities through such mechanisms as multi-year policy contracts.

10
11 DISCUSSION

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13 Financing health care services through reinsurance has become a part of the mainstream health
14 insurance marketplace. As primary health insurers reinsure their claims, they transfer a portion of
15 their financial risk to a reinsurer, which allows them to reduce the volatility of claims, retain
16 capital, minimize adverse selection, and lower administrative costs. With reinsurance, insurers
17 who were generally reluctant to enroll high-risk individuals are provided with a mechanism to stay
18 in the market and potentially lower their liability.

19
20 Individuals also benefit from reinsurance since they often receive lower premium rates, and low-
21 risk individuals have more opportunities to enroll in affordable health plans. When costly claims
22 are partially financed by a reinsurer, primary insurers are less pressured to raise premiums to
23 sustain their businesses. When premium rates are lowered, low-risk and uninsured individuals,
24 who may have opted out of health insurance coverage in the past, have additional opportunities to
25 enroll. At the same time, high-risk individuals are more able to find primary insurance carriers
26 who are willing to cover their costly medical expenses.

27
28 Some of the debate on reinsurance for policymakers revolves around whether or not the
29 government should provide a direct subsidy to employers or help to “backstop” the cost to
30 insurance carriers. Several reinsurance proposals have suggested a collectively financed program
31 that balances specific market regulations (e.g. premium rating, guaranteed issue) with the free
32 market (e.g. the private insurance market). The National Association of Health Underwriters, has
33 suggested that the federal government could fund reinsurance policies to state reinsurance pools, so
34 that “the government would subsidize reinsurance premiums paid by the participating insurers and
35 federal money would allow greater savings and spur creation of more state pools” (The
36 Commonwealth Fund, February 2005).

37
38 Moreover, in the past, health insurance market regulations pertaining to reinsurance pools and risk
39 pools to finance health insurance have not been entirely effective. In the 1990s, a mandatory
40 reinsurance pool was difficult to enforce since large insurance companies did not foresee any
41 financial incentives by contributing to the pool. The Health Insurance Portability and
42 Accountability Act (HIPAA) included insurance coverage regulations that varied according to firm
43 size. However, the small group insurance market did not benefit significantly from the new
44 regulations (Nichols and Blumberg, *Health Affairs*, May/June 1998). In addition, between 1989
45 and 1996, 47 states passed small group or individual insurance market reform bills in order to
46 decrease market segmentation within the health insurance market through risk pooling. Yet, over
47 time, small firms still are much less likely to offer health insurance to their employees than large
48 firms.

1 State risk pooling initiatives to increase health insurance coverage have had mixed success, and
2 some have not been particularly effective in stabilizing premiums and expanding coverage.
3 Nevertheless, some lessons have been learned that can be applied generally to both the private and
4 public sector:

- 5
- 6 • Reinsurance programs typically fare well in a less concentrated individual insurance market.
7
- 8 • Enrollment in reinsurance programs is dependent upon the generosity of benefits given to
9 enrollees; and the insurer's number of recurring opportunities to reinsure lives, specifically to
10 small groups.
11
- 12 • Reinsurance programs that offer even modest benefits to small groups face issues of crowd-
13 out; therefore, a reinsurance policy that targets a smaller segment of the uninsured population
14 that is uniform and highly specified (e.g., small groups that have been uninsured for a year,
15 low-income workers who are unlikely to afford health insurance without a subsidy) will allow
16 reinsurance programs to enroll the majority of their potential enrollees.
17
- 18 • Reinsurance programs are less likely to face adverse selection when such programs are created
19 that have rules and regulations that balance with the free market (Chollet, Academy Health,
20 October 2004).
21

22 The AMA generally supports the concept of reinsurance and health insurance market regulations
23 that are risk-adjusted in order to minimize adverse selection, especially in the nongroup market. In
24 addition, the AMA supports health insurance initiatives that increase access to health care for the
25 uninsured through various methods, including the use of risk pools.
26

27 Accordingly, the Council believes that reinsurance could potentially be an appropriate financing
28 method for the small group and nongroup market to cover more individuals, including the
29 uninsured, at various risk levels. In order to create an appropriate reinsurance pool, the Council
30 also believes that additional research on reinsurance pools, accompanied by market regulations that
31 specify premium rating and terms of issue regulations within the context of AMA policy, may
32 achieve greater health insurance coverage.

References for this report are available from the AMA Division of Socioeconomic Policy
Development.