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THE PRESENT AND FUTURE OF GOVERNMENT-FUNDED REINSURANCE

JOHN V. JACOBI*

INTRODUCTION

The structure of health insurance is changing due to concerns over inflation, uninsurance, and medical injuries. This article will briefly discuss the current health insurance reform framework, focusing on one aspect of many insurance reform proposals: government-provided reinsurance. Through reinsurance programs, government can stabilize private insurance markets, reduce premiums, and spread the cost of catastrophic care at a relatively modest price for taxpayers. Reinsurance programs are, therefore, important components of current health finance reform measures and are worthy of discussion. More significantly, considering the place of governmental reinsurance in American health finance suggests a way to break through a barrier that exists in health reform between those who propose (unrealistically?) “fundamental” reform and those who propose (merely?) “incremental” reforms.

American health coverage has historically been premised on employment-based insurance. Employment-based insurance is eroding, however. The causes are contested, but globalization and changing employment structures appear to be the major culprits. The extent to which the erosion is irreversible is also contested, although I will argue here that employer-based coverage will inevitably continue to shrink absent some major structural changes. I also argue that the *structure* of reinsurance programs is a guide to the changes that could respond to the erosion of the employment-based insurance system. The insight driving this argument is that both government-focused reinsurance programs and market-focused consumer-driven health care programs share a vision of catastrophic care as a *social*, rather than an *individual* responsibility. That is, both programs see the risk of catastrophic health costs as amenable to broad pooling in a way that more routine health costs need not be.

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Reinsurance programs are, then, important components of short term health reform and are also essential templates for redistributions of health finance responsibility that can usher in a new era of American health finance.

The return of health finance reform to the forefront of the public policy agenda is, at least in retrospect, inevitable. Congress and the states punted on the health reform movement of the early 1990s. In the absence of solutions to festering health finance problems, sharply rising prices and insurance premiums, shrinking access to coverage, and dismay over increasing evidence of quality shortfalls have created a crisis atmosphere. Part I of this article will briefly describe the crises in cost, quality, and coverage that propel reform discussion. It will then briefly describe responsive reform proposals that have included calls for a lessening of governmental involvement in health finance and greater reliance on private contractual, market-governed arrangements and contrary calls for *more* governmental involvement in the form of single-payer, national health coverage. Finally, it describes the emerging form of statutory reform, which forges a path between the extremes and incrementally changes the current health regulatory structure.

Part II introduces health reinsurance and describes the importance of governmental reinsurance of health risk to emerging statutory health insurance reforms. The utility of governmental health reinsurance is premised on the dramatically skewed nature of health spending, as the sickest 2% of the population accounts for almost 40% of health costs, while half the population uses little or no care in any year.¹ Through reinsurance programs, government can induce private plans to participate in precarious individual and small group markets by agreeing to accept part of the risk of the sickest, highest cost members. Government reinsurance programs can, in the short-term, stabilize private markets, reduce premiums, and improve access to coordinated complex care, all at a reasonable cost to taxpayers.

Part III explores the longer-term implications of governmental reinsurance programs. It explores the justifications for broad social responsibility for the higher costs of the very sick in society, and the (somewhat surprising) agreement among very different advocates that catastrophic costs are properly subject to social pooling. It then describes the benefits of a broader application of government reinsurance programs. Such programs can work a reconfiguration of the American public-private health insurance partnership. They can shift to government truly social costs for conditions often requiring case management over a multi-year, even lifetime perspective, while maintaining the familiar relationships among patients, physicians, and primary insurers. These programs create a different kind of incremental change in

1. See KATHERINE SWARTZ, REINSURING HEALTH: WHY MORE MIDDLE-CLASS PEOPLE ARE UNINSURED AND WHAT GOVERNMENT CAN DO 61–62 (2006); John V. Jacobi, *Consumer Driven Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 562–63 (2005).

health finance. They permit metered shifts in the financial responsibilities for health care and create political space for consideration of further evolution of the governmental role in American health finance.

I. REFORM REDUX

Costs are up, coverage is down, and quality is under question. It is time again for health reform discussions in America. That most agree that it is time to reform our health finance system does not, of course, suggest that real reform will come. Repeated cycles of reform efforts in the Twentieth Century did not net comprehensive reform, notwithstanding good reasons for such reform and good contemporaneous examples from abroad.² Another cycle is in process, and the public policy analysis and political positioning is in full swing.³ This part will briefly set out the crises motivating the latest cycle of reform discussions, describe the range of systemic and incremental proposals that have surfaced, and describe the state-based reforms that these discussions have generated.

A. Stormy Health Policy Weather

1. Access, Cost, and Quality

Our health care system is sick, and it appears to be getting sicker.⁴ National health expenditures reached almost \$1.9 trillion, or 16% of the gross domestic product (GDP), in 2004.⁵ Spending is projected to increase to over \$4 trillion, or 20% of the GDP, in 2015.⁶ While the rate of annual increase in health expenditures slowed slightly from 2000 to 2005 (from 11.5% to 9.2%), the rate is well above the rate of background inflation and is projected to continue at 7% or more through 2015.⁷ In constant dollars, national health expenditures are expected to nearly triple from 1993 to 2015.⁸

2. See JILL GUADAGNO, ONE NATION UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (2005); Jonathan Oberlander, *The Politics of Health Reform: Why do Bad Things Happen to Good Plans?*, HEALTH AFF., Aug. 27, 2003, at W3-391, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.391v1.pdf>.

3. See MARC J. ROBERTS ET AL., GETTING HEALTH REFORM RIGHT: A GUIDE TO IMPROVING PERFORMANCE AND EQUITY 21–37 (2004) (describing the flow and components of the “health reform cycle”).

4. See Victor R. Fuchs & Ezekiel J. Emanuel, *Health Care Reform: Why? What? When?*, 24 HEALTH AFF. 1399, 1399–1400 (2005) (discussing cost, quality, and access concerns).

5. Christine Borger et al., *Health Spending Projections Through 2015: Changes On The Horizon*, HEALTH AFF., Feb. 22, 2006, at w61, w62, <http://content.healthaffairs.org/cgi/reprint/25/2/w61.pdf>.

6. *Id.*

7. *Id.* at w63.

8. *Id.* at w62.

The rate of health insurance coverage is deteriorating. Between 2000 and 2004, the number of uninsured persons in the United States increased by 6 million, and the rate of uninsurance among the non-elderly rose from 16.1% to 17.8%.⁹ The “snapshot” rate of health uninsurance tends to mask the extent of the problem; in the two-year period from 2002 to 2003, over 81 million Americans were uninsured for some period, and over 53 million were uninsured for at least six months.¹⁰ The connection between uninsured status and health status is also increasingly clear. The old saw that lack of coverage is not a health factor because the uninsured get treatment regardless has lost its power. People without health coverage are at an increased risk of early death and experience lower health status than those with insurance.¹¹ This is particularly true for people with chronic illness, as continuity of care and routine medical monitoring take on heightened importance for this population.¹²

Our faith in the quality of the American health care system is shaken even for those with health coverage. Reports from the Institute of Medicine in 2000, 2001, and 2006 laid bare a statistical case that adverse outcomes are disturbingly common in hospitals and other health care settings.¹³ Medication errors, for example, were identified as causing thousands of deaths per year¹⁴ and add \$3.5 billion to the cost of health care.¹⁵ The most recent of these studies further reported that medication errors cause non-fatal injuries to 1.5 million patients per year.¹⁶ In addition, variations in treatment from region to region without any apparent clinical explanation diminish quality outcomes, calling into question the faith historically placed on physician judgment.¹⁷ Further, quality of the care that is provided seems to vary on the basis of the

9. John Holahan & Allison Cook, *Changes In Economic Conditions And Health Insurance Coverage, 2000–2004*, HEALTH AFF., Nov. 1, 2005, at W5-498, W5-499–W5-500, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.498v1.pdf>.

10. FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002–2003 1, 3 (2004), available at http://www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf.

11. INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 86–87 (2002) (stating that adults without health insurance coverage “*have poorer clinical outcomes and poorer overall health than do adults with private health insurance*”) (emphasis in original).

12. *Id.* at 57–80.

13. INST. OF MED., PREVENTING MEDICAL ERRORS (2006) [hereinafter PREVENTING MEDICAL ERRORS]; INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001); INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999) [hereinafter TO ERR IS HUMAN].

14. TO ERR IS HUMAN, *supra* note 13, at 32.

15. *Id.* at 117.

16. PREVENTING MEDICAL ERRORS, *supra* note 13, at 112.

17. See M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 266–67 (2003) (citing studies).

race of the patient, with people of color less likely than white patients to receive a wide range of therapeutic interventions.¹⁸ Confidence that ours is “the best health care system in the world”¹⁹ is fundamentally challenged.

Concerns about cost, quality, and access have reactivated interest in international comparisons. It is well-understood that we pay more for health care than any other nation in the world—dramatically so if the difference is measured in dollars, but still substantially so if the difference is measured by share of GDP.²⁰ This is true even though the industrialized countries with which we compare ourselves provide coverage for almost all residents, while about one-third of Americans under age 65 were uninsured for some period during 2002 to 2003.²¹ While we pay more, our health status lags that of more parsimonious OECD nations on measures such as life expectancy, “healthy life expectancy,” and infant mortality,²² although many factors other than health care influence health status.²³ Americans, then, pay exorbitantly for health coverage that leaves a large group of citizens uncovered, and that leaves us sicker, and dying younger, than people in other relevantly similar countries. It is no wonder that Americans are again turning to health reform; they increasingly believe, as Woolhandler and Himmelstein suggest, that we pay for universal health coverage, but we do not get it.²⁴

2. The Erosion of Employment-Based Health Insurance

Most Americans obtain health insurance as a fringe benefit of employment, and we therefore think of our system of health coverage as anchored by private job-based coverage. Employment-based coverage was recently described as “a cornerstone of the U.S. health care system, as vital in some ways to the health

18. See INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* 77–79 (2003); David R. Smith, *Race, Health, and Health Care*, 48 ST. LOUIS U. L.J. 13, 29–33 (2003).

19. See Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 552 (2006) (citing U.S. Department of State release regarding President George W. Bush’s comments).

20. See Gerald F. Anderson et al., *Health Spending In the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 905 (2005).

21. See Jost, *supra* note 19, at 540.

22. *Id.* at 553 (discussing OECD data); Bruce Spitz & John Abramson, *When Health Policy Is the Problem: A Report from the Field*, J. HEALTH POL. POL’Y & L. 327, 328 (2005) (discussing OECD data).

23. See Jost, *supra* note 19, at 552; see also, RICHARD WILKERSON, *THE IMPACT OF INEQUALITY: HOW TO MAKE SICK SOCIETIES HEALTHIER* 105–110 (2005) (relating poor health status in the United States to high levels of socioeconomic inequality); David Mechanic, *Disadvantage, Inequality, And Social Policy*, HEALTH AFF., Mar.-Apr. 2002, at 48 (explaining that disparities in access to jobs, education, and income support are, along with disparities in access to health care, important determinants of health status).

24. Steffie Woolhandler & David U. Himmelstein, *Paying For National Health Insurance—And Not Getting It*, HEALTH AFF., July-Aug. 2002, at 88.

care of Americans as the drugs, devices, and medical services that the insurance covers.²⁵ But the employment-based system is eroding. In the four-year period at the beginning of this decade, the number of non-elderly Americans with job-based coverage shrank by almost 5 million, as the non-elderly population rose by 10 million.²⁶ The number covered by public insurance rose during that time, as did the number of uninsured.²⁷ The rate of employment-based coverage for the non-elderly declined from about 68% to about 60% in the five years from 2000 to 2005, evidencing a trend or erosion of employment-based coverage,²⁸ and further driving health reform interest; it is difficult to justify standing pat with a system that is slowly disappearing.²⁹

Some disaggregation of the erosion phenomenon helps to inform the reform impulse. One aspect is the translation of the high cost of health care to the cost of health coverage. The annual cost of employment-based coverage has risen to over \$4,000 for individual coverage and to almost \$11,000 for family coverage.³⁰ The increased cost of coverage is, of course, closely connected to inflation in the underlying costs of health care; in addition, however, the for-profit health insurance firms that dominate the employment-based insurance market have consciously adopted business plans over the last several years that emphasize increased profit margins even at the cost of reducing their targets for membership.³¹ This business plan, which reduces emphasis on both increasing enrollment and reducing costs in favor of improving returns on investments, has been criticized by some industry analysts as impairing the viability of the employment-based insurance market.³²

25. David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 82 (2006).

26. Holahan & Cook, *supra* note 9, at W5-499–W5-501.

27. *Id.* at W5-501.

28. See KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 34 (2005), available at <http://www.kff.org/insurance/7315/upload/7315.pdf> [hereafter KFF/HRET 2005 SURVEY]; see also SWARTZ, *supra* note 1, at 44; Holahan & Cook, *supra* note 9, at W5-501.

29. See Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?*, HEALTH AFF., May 28, 2003, at W3-237, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1.pdf>.

30. Jon Gabel et al., *Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues to Erode*, 24 HEALTH AFF. 1273, 1275 (2005) (reporting on 2005 data).

31. See Vanessa Fuhrmans, *After Streak of Strong Profits, Health Insurers May See Decline*, WALL ST. J., July 31, 2006, at A1.

32. *Id.* (quoting analyst Robert Laszewski: “Where is this industry in four, five years if it can’t control health-care costs? . . . It’s on a long walk off a short pier.”).

But cost alone does not explain the drop-off in coverage; large firms continue to offer coverage nearly universally.³³ Several factors combine to explain the erosion. First, new jobs in today's economy are likely to be lower-paid service jobs in small firms, not manufacturing jobs, where unionization and full benefits are the norm.³⁴ Offers of coverage in very small firms dropped dramatically from 2000 to 2004, from 57% to 47%.³⁵

Second, the rate of inflation in the cost of health insurance, while it has moderated a bit in recent years, is still substantially above the rate of background inflation.³⁶ Health economists largely agree that the cost of employment-based health coverage is merely a component of compensation and that the effects of cost increases therefore are just translated into reductions in other forms of compensation. However, premium increases that repeatedly outstrip inflation rates raise special problems. As the cost of family health coverage has now outstripped the value of an entire year's pay at minimum wage, there is increasingly nowhere for the cost to be shifted for employers of low- and moderate-wage workers.³⁷ Third, many businesses are shifting a growing percentage of their workforce from the status of employee to that of independent contractor—in large part to avoid the cost of fringe benefits, health insurance in particular.³⁸ Unless the American economy reverses course and returns to the halcyon days of high-paid lifetime employment in large firms, the drain on employment-based coverage threatens to continue. In an age of globalization, such a reversal seems unlikely.

These factors driving the erosion of employment-based insurance are accelerating the push for health reform. To some, these factors might suggest that the time for reliance on the workplace as a source of coverage is past, and fundamental reform is now necessary. Short of that conclusion, others may conclude from the rate of erosion in job-based coverage that some incremental reform is needed in the near future.

B. *Renewed Interest in Reform*

Renewed concern over cost, quality, and access has reinvigorated public policy debate. The full breadth of the debate will be only quickly sketched out here. The landscape of the reform discussion is usually described as defined

33. See KFF/HRET 2005 SURVEY, *supra* note 28, at 35 (reporting that 98% of firms with over 200 workers offer health coverage); Gabel et al., *supra* note 30, at 1277 (same).

34. SWARTZ, *supra* note 1, at 22–23.

35. Gabel et al., *supra* note 30, at 1277 (reporting on firms with three to nine employees). There is good reason to believe that coverage for small firms is also more expensive on a per-employee basis than it is for large firms. See SWARTZ, *supra* note 1, at 51–54; see also *infra* Part II.C. But see Gabel et al., *supra* note 30, at 1275.

36. See KFF/HRET 2005 SURVEY, *supra* note 28, at 17.

37. Gabel et al., *supra* note 30, at 1275.

38. SWARTZ, *supra* note 1, at 23–28.

by two poles with a vast middle ground between. The first pole stakes out the view that market forces and consumerism, if set free from excessive regulation, could improve efficiency, lower the rates of health inflation, improve quality, and enhance consumer satisfaction. Essentially associated with this pole is the view that genuine reform entails allowing the marketplace and free contracts to control health transactions. From this perspective, government interference in markets is inevitably harmful, and government should therefore limit itself to protecting markets (through, for example, enforcement of anti-trust rules). In addition, government may provide direct financial support to the poor to enable them to participate in a free market, but that support should go directly to the poor, preferably in the form of refundable tax credits, in order to avoid distortions to the market.³⁹ Health insurance coverage should be stripped of intermediaries to allow (through health savings accounts or similar mechanisms) consumers to make their own choices.⁴⁰ These views are advanced by, for example, the Heritage Foundation⁴¹ and the Cato Institute.⁴²

The second pole regards health care as largely a non-market good and regards direct government action as necessary and appropriate to achieve universal health coverage. Advocates of universal governmental coverage question the value of markets in health financing and delivery to a greater or lesser extent and instead advance a system in which government (usually the federal government) is the “single-payer” for health services⁴³ or the purchaser

39. One model for a very comprehensive and highly detailed description of such a tax credit system for the low-income uninsured is found in Lawrence Zelenak, *A Health Insurance Tax Credit for Uninsured Workers*, 38 INQUIRY 106 (2001).

40. See John C. Goodman, *Designing Health Insurance for the Information Age*, in CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 224 (Regina Herzlinger ed., 2004).

41. The Heritage Foundation’s Health Care Reform web page opens with the following statement:

The Healthcare system in the United States is in desperate need of significant reform. Policy makers should take decisive steps to move today’s bureaucracy driven, heavily regulated third-party payment system to a new patient-centered system of consumer choice and real free-market reform.

Heritage Foundation, Issues: Health Care: Health Care Reform, available at <http://www.heritage.org/research/healthcare/healthcarereform/index.cfm> (last visited Feb. 28, 2007).

42. See Michael F. Cannon et al., *Combining Tax Reform and Health Care Reform With Large HSAs*, TAX & BUDGET BULL. (Cato Inst., Washington, D.C.), May 2005, available at <http://www.cato.org/pubs/tbb/tbb-0505-23.pdf>.

43. See JULIUS B. RICHMOND & RASHI FEIN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT (2005); Physicians’ Working Group for Single-Payer National Health Insurance, *Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance*, 290 JAMA 798 (2003).

of vouchers for coverage for all.⁴⁴ Others advocate universal governmental coverage without specifying a blueprint for such a program, although they often accompany such advocacy with descriptions of national health programs in other nations.⁴⁵ These advocates share a belief in the primacy of providing access to health care for all, a rejection of markets as suitable mechanisms for health reform in favor of regulatory solutions, and a belief that universal-coverage systems can, in addition to resolving the access crisis, also provide the means to address rising costs and uneven quality. These views are advanced, for example, by the Commonwealth Fund,⁴⁶ the Children's Defense Fund,⁴⁷ and Physicians for a National Health Program.⁴⁸

Between these poles is a large group of incrementalists. Incrementalists approach problems of cost, quality, and access by positing that our current financing structure is unlikely to see dramatic change in the future and then proposing changes within the current framework. Some would target vulnerable populations for coverage by existing public insurance programs.⁴⁹ Others would empower consumers with information and purchasing power, with the goal of forcing change over time in response to market pressure.⁵⁰ Others would focus on insurance law, shoring up crumbling individual and small group markets by changing the law on mandated benefits, pooling of small groups, regulating (or deregulating) state rate setting, or adding subsidies to moderate high prices.

A number of reforms have been adopted in recent years at both the federal and state levels. The emphasis in federal reform efforts has been on increasing

44. See Ezekiel J. Emanuel & Victor R. Fuchs, *Health Care Vouchers—A Proposal for Universal Coverage*, 352 NEW ENG. J. MED. 1255 (2005).

45. See INST. OF MED., *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* 153–54 (2004) (advocating statutory universal coverage, and recommending “principles” to guide the selection of a mechanism for such coverage, but not recommending any particular mechanism); TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 277–79 (2003) (after extensive discussion of other nations' national health programs, advocating a legal entitlement to care under a national health coverage model).

46. See Karen Davis, *Universal Coverage in the United States: Lesson from Experience of the Twentieth Century*, ISSUE BRIEF (Commonwealth Fund, New York, N.Y.), Dec. 2001, available at http://www.cmwf.org/usr_doc/davis_universal.pdf.

47. See Press Release, Statement by Marian Wright Edelman for “Cover the Uninsured Week” (May 10, 2004) (advocating “health insurance coverage for every American”), available at <http://www.commondreams.org/news2004/0510-05.htm>.

48. The website for Physicians for a National Health Program describes the organization as “a nonprofit organization of 14,000 physicians, medical students and health professionals who support single-payer national health insurance.” PNHP: Physicians for a National Health Program, <http://www.pnhp.org/> (last visited Feb. 28, 2007).

49. See Richard P. Nathan, *Federalism And Health Policy*, 24 HEALTH AFF. 1458 (2005).

50. See Greg Scandlen, *Consumer-Driven Health Care: Just a Tweak Or A Revolution?*, 24 HEALTH AFF. 1554 (2005).

consumer responsibility and authority for health purchasing decisions. These “ownership society” reforms center on the facilitation of the creation of consumer-driven health plans, which combine tax-favored spending accounts (health savings accounts) and high-deductible health insurance.⁵¹ While consumer-directed health care had been discussed in policy circles for many years,⁵² I.R.S. confirmation that contributions to health savings accounts are entitled to favorable tax treatment provided a spur to its adoption.⁵³ Section 223 of the Medicare Modernization Act of 2003 codified the I.R.S. ruling, further enhancing the status of consumer-driven care.⁵⁴ The consumer-driven plans springing up as a result of these reforms are intended to incrementally advance the goals of attacking health care cost-inflation by treating health care as a consumer good and encouraging consumers to shop for price and quality as they would in any other context.⁵⁵ Reducing prices is a key to increasing access to coverage.⁵⁶

State reforms have been quite varied in recent years. Some of the measures are narrowly targeted toward one group of residents. Illinois’ All Kids program, for example, makes coverage available to all children in the state without charge (for very low-income children) or on a sliding scale basis.⁵⁷ Arkansas, using some state funding and some federal funding, has created a program offering very basic coverage of services for low-income employees of small businesses.⁵⁸ New Jersey has required insurers to make coverage available under a parent’s plan for their unmarried, otherwise

51. See Jacobi, *supra* note 1, at 549–55; Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 791–94 (2006).

52. See JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER: SOLVING AMERICA’S HEALTH CARE CRISIS* (1992); Mark V. Pauly & John C. Goodman, *Tax Credits For Health Insurance and Medical Savings Accounts*, 14 HEALTH AFF., Spring 1995, at 125, 126.

53. See Rev. Rul. 2002-41, 2002-2 C.B. 75; I.R.S. Notice 2002-45, 2002-28 I.R.B. 93; see also Jacobi, *supra* note 1, at 550; Monahan, *supra* note 51, at 794.

54. Medicare Modernization Act, Pub. L. No. 108-173, § 223, 117 Stat. 2066, 2471–72 (2003). See Jacobi, *supra* note 1, at 550; Monahan, *supra* note 51, at 795–96.

55. See Jacobi, *supra* note 1, at 556–57; Monahan, *supra* note 51, at 901–05.

56. The addition of pharmaceutical benefits to the Medicare program suggests that the current federal administration is not entirely adverse to “big government” solutions to access concerns. Even there, however, pharmaceutical benefits were added to Medicare using market mechanisms foreign to much of traditional Medicare. But the pharmaceutical benefit was added with a market twist. While Medicare maintains insurance functions “in-house” for most other services for most beneficiaries, beneficiaries must access pharmaceutical coverage through private insurers.

57. See State of Illinois, About All Kids, <http://www.allkidscovered.com/about.html> (last visited Feb. 24, 2007); State of Illinois, All Kids Income Standards & Cost Sharing Chart, <http://www.allkidscovered.com/income.html> (last visited Feb. 28, 2007).

58. See ARHealthNet, What is ARHealthNet?, <http://www.arhealthnet.com/> (last visited Feb. 28, 2007).

uninsured children up to age 30.⁵⁹ Maryland enacted a law that requires very large employers to either devote 8% of its total employee compensation payment to health care costs, or to pay the difference between its expenditures on employee health and the 8% floor to the state.⁶⁰ Although a federal court found the statute preempted by the Employee Retirement Income Security Act (ERISA),⁶¹ many other states are considering similar legislation.⁶²

Many states have reconfigured or are considering reconfiguring their Medicaid programs after the Medicaid amendments contained in the Deficit Reduction Act of 2005 (DRA).⁶³ In particular, states are taking advantage of the DRA's grant of flexibility to modify covered benefits and to increase beneficiary cost sharing. Florida, in a program which was created before the passage of the DRA but has received federal approval, will limit the coverage available to Medicaid beneficiaries to a pre-set annual limit; with some exceptions, neither the state nor the plan will have any responsibility for coverage once that benefit limit is reached.⁶⁴ West Virginia's Medicaid program will create two tiers of Medicaid coverage for children and their parents: the "basic" plan limits prescription drug coverage and mental health and diabetes coverage, while the "enhanced" plan has enriched prescription drug benefits and mental health and diabetes care benefits.⁶⁵ The enhanced benefits are available only to families who sign and comply with a pledge to engage in "responsible" health behavior.⁶⁶ Kentucky's Medicaid reform combines increased beneficiary cost-sharing and reduced benefits with the promise of increased disease management.⁶⁷

Several states have adopted more far-ranging plans, cobbling together several components to reduce their rates of uninsurance. Massachusetts

59. N.J. STAT. ANN. 17B:27-30.5 (West 2006).

60. MD. CODE ANN., LAB. & EMPL. § 8.5-101.

61. Retail Industry Leaders Ass'n v. Fielder, 435 F. Supp. 2d 481 (D. Md. 2006).

62. See National Conference of State Legislatures, 2006-2007 Fair Share Health Care Fund Or "Pay or Play" Bills: Can States Mandate Employer Health Insurance Benefits?, <http://www.ncsl.org/programs/health/payorplay2006.htm> (last visited Feb. 28, 2007).

63. Pub. L. No. 109-171, 120 Stat. 4 (2006); see Robin Rudowitz & Andy Schneider, *The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act*, POL'Y BRIEF (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Aug. 2006, available at <http://www.kff.org/medicaid/upload/7550.pdf>.

64. See *Florida Medicaid Waiver: Key Program Changes and Issues*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), Dec. 2005, available at <http://www.kff.org/medicaid/upload/7443.pdf>.

65. *West Virginia Medicaid State Plan Amendment: Key Program Changes and Questions*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), July 2006, available at <http://www.kff.org/medicaid/upload/7529.pdf>.

66. See *id.*

67. See *KyHealth Choices Medicaid Reform: Key Program Changes and Questions*, MEDICAID FACTS (Kaiser Comm'n on Medicaid & Uninsured, Washington, D.C.), July 2006, available at <http://www.kff.org/medicaid/upload/7530.pdf>.

adopted its reform act in 2006.⁶⁸ Although the plan remains to be fleshed out in regulation, it aims to increase access by subsidizing some insurance coverage, expanding its Medicaid program, and using a “health insurance connector” to act as a purchasing tool for individuals or employees of small businesses.⁶⁹ Most controversially, it will eventually require all individuals to purchase coverage and will impose a small annual cost on employers that do not provide coverage to their employees.⁷⁰

Vermont also adopted its health reform statute in 2006.⁷¹ It provides needs-based subsidies for the purchase of insurance, creates a mechanism for coordinating insurance purchase for individuals and employees of small businesses, and relies on expansion of its Medicaid program.⁷² In addition, it features extensive use of chronic care management techniques as a method of increasing quality and reducing costs.⁷³ Maine’s Dirigo Health Reform Act was enacted in 2003.⁷⁴ It provides subsidies for insurance for uninsured individuals and employees of small businesses, along with initiatives to contain cost and improve quality.⁷⁵ New York’s Health Reform Act, passed in 1999, similarly provides some subsidy for insurance for uninsured individuals and employees of small businesses.⁷⁶ New York’s plan, called “Healthy NY,” applies its subsidy differently than the other reforming states’ programs: instead of providing subsidy directly to reduce the price of insurance purchase, New York uses its subsidy to fund reinsurance for the highest-risk persons

68. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch. 58, available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

69. See Edmund F. Haislmaier, *The Significance of Massachusetts Health Reform*, Apr. 11, 2006, <http://www.heritage.org/research/healthcare/wm1035.cfm>.

70. See David B. Kendall, *Massachusetts Raises the Bar for Health Care Reform*, FRONT & CENTER (Progressive Pol’y Inst., Washington, D.C.), Apr. 17, 2006, available at <http://www.ppionline.org/ndol/print.cfm?contentid=253823>.

71. An Act Relating to Catamount Health, 2006 Vt. Acts & Resolves, Act no. 190, available at <http://www.leg.state.vt.us/HealthCare/catamount.htm> (Click link for “Act 190”); An Act Relating to Health Care Affordability for Vermonters, 2006 Vt. Acts & Resolves, Act no. 191, available at <http://www.leg.state.vt.us/HealthCare/catamount.htm> (Click link for “Act 191”).

72. See Details About the 2006 Health Care Affordability Act, http://www.leg.state.vt.us/HealthCare/Q&A_Details_on_Health_Care_Affordability_Act_H_861.htm (last visited Feb. 28, 2007).

73. *Id.*

74. An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs, 2003 Me. Laws 1305–1339.

75. See JILL ROSENTHAL & CYNTHIA PERNICE, NAT’L ACAD. FOR STATE HEALTH POL’Y, DESIGNING MAINE’S DIRIGOCHOICE BENEFIT PLAN: STRIVING TO IMPROVE HEALTH AS AN AFFORDABLE PRICE 1 (Dec. 2004), available at http://www.nashp.org/Files/Dirigo_Issue_Brief_on_Benefit_Design_final_hp.pdf.

76. See SWARTZ, *supra* note 1, at 132–33; see also *infra* Part II.C.2.

covered by Healthy NY.⁷⁷ This reinsurance provision is discussed in more detail below.⁷⁸

The federal and state reforms that have recently been adopted span the ideological spectrum and, whatever the reformers' ideological bent, are incremental in the sense that they build on rather than overthrow the basic structure of American health finance. The balance of this article examines one important potential component of incremental reform: government-sponsored reinsurance. It examines the significant power of reinsurance as a part of incremental reform and argues for its adoption by virtue of its potential immediate payoffs in cost and access, as well as its ability to serve as a bridge to future, for more comprehensive reform.

C. Reinsurance

At the end of the 1990s, American health care and health finance seemed increasingly dysfunctional. Health inflation returned with a vengeance. Rates of coverage were stable in the 1990s only because Medicaid expansions were able to make up for the erosion of private coverage; in the 2000s, the absolute number of uninsured persons was again on the rise. For a time, public policy responses to these problems were quite thin, and governments seemed paralyzed. More recently, public policy discussion has been robust from all political perspectives, and although the federal government has limited its response to largely symbolic support in the form of tax policy, state governments are beginning to consider a range of corrective steps, some discrete and targeted, some more expansive.

Much ongoing work evaluates these policy proposals and governmental initiatives. This article will not do so. Rather, the pages below will consider one component of reform proposals and initiatives: governmental reinsurance of privately-financed primary insurance. Part II provides background on reinsurance in general and governmental reinsurance in particular. It also explains the rationale for including governmental reinsurance as a component of a broader reform program and the structure for such inclusion. Part III considers some of the broader implications of governmental reinsurance as Americans continue to grapple with the rising costs of care. In particular, it suggests the potential for governmental reinsurance serving as a focus for a reform discussion that might provide a means for reconsidering sharp divisions between pro-government and pro-market reformers and between advocates of incremental and fundamental reform.

Three insights drive this emphasis on governmental reinsurance: one epidemiological, one structural, and one political. The epidemiological insight, discussed in Part II.A., is that health expenditures are dramatically skewed,

77. See SWARTZ, *supra* note 1, at 132–33.

78. See *infra* Part II.C.2.

with most people using little health care each year, and a small number using the lion's share. Cost, quality, and access concerns in the Twenty-First Century have to internalize this fact; we must break free of average expenditures to see the real landscape dominated by the high costs of treating chronic conditions. The structural insight is derived from the consumer-driven health care movement. As that movement describes, what we currently think of as health insurance is divisible into two pieces. The first piece covers the routine cost of primary care and other everyday care. The second covers the high cost of extraordinary care, whether it is the expensive ongoing care of chronic illnesses, such as chronic obstructive pulmonary disease, or the one-time cost of treating serious traumatic injuries. This division is important as reforms focus on moral hazard as a key to cost-containment; while moral hazard may be a useful concept for cost-containment in the first piece of health insurance, it seems to have far less relevance to the second.⁷⁹ Rather, the non-routine costs of health care are properly considered a pooled social cost.⁸⁰ The political insight is that the structure of governmental reinsurance may have appeal across a broad swath of the political spectrum. Market advocates may appreciate that it can leave intact the relationships among physicians, patients, and primary insurers for most transactions. Public coverage advocates may appreciate that it permits government to take responsibility for and assure access and quality of care for the sickest and most vulnerable among us—those poorest served by an unreformed marketplace.

II. REINSURANCE AS A VITAL COMPONENT TO INCREMENTAL REFORM

A. *Smooth or Skewed: The Population Distribution of Health Spending*

We can expect the population distribution of the consumption of some important goods and services to be more or less smooth. Although some of us have greater appetites than others, we can expect the consumption of food, on average, to vary by no more than a factor of two or so, and we can profitably use average consumption in thinking of food policy. Similarly, while some people are homeless and others have a second vacation home, most Americans have only one dwelling place, and we can profitably think in terms of one home per person when thinking of housing policy. Health expenditures do not fit that mold.

79. See John Nyman, *Is "Moral Hazard" Inefficient? The Policy Implications of a New Theory*, HEALTH AFF., Sept.-Oct. 2004, at 194.

80. I do not wish to paper over significant divisions over how this social cost should be covered, and centrally over the role of private insurance and government. See *infra* Part III.A. The structure of insurance coverage for the first piece of cost is also contested, but this dispute is not central to my argument. See *id.*

National health expenditures are extremely skewed. Each year, 90% of Americans use relatively little health care, accounting for only 30% of total expenditures.⁸¹ The sickest 10% in any year, then, account for about 70% of health care costs.⁸² Even more significantly, half of all Americans use little or no health care each year, as the 50% who use the least health care account only for 3% of expenditures.⁸³ At the other end of the distribution, the sickest 2% of the population accounts for about 40% of costs, and the sickest 1% in any year accounts for more than a quarter of total costs.⁸⁴ This skewed distribution endures over time.⁸⁵

This lopsided distribution has significance in the context of this article in two ways. First, this distribution is an important factor in shaping any effort to reduce the rate of health care inflation, either through regulatory supply-side efforts or through market-based demand-side efforts. The effect of this distribution on cost containment measures is discussed below in Part III. Second, this distribution affects the stability of insurance markets and in particular the markets for individual and small group insurance. The effect of this distribution on insurance markets is discussed below in Part II.C.

B. Reinsurance: Smoothing Out the Risks

1. Private Market Reinsurance

Insurance protects the purchaser (the insured) from the cost of an unlikely but catastrophic loss, such as a fire destroying his home, a disabling injury preventing him from earning a living, or the imposition of a tort judgment beyond his means to satisfy. The protection arises from an insurance contract, through which the insured pays a premium to an insurer, thereby obliging the insured to pay a manageable amount (often each year) in return for transferring the risk of the realization of the cost of the catastrophic cost to the insurer. The insurer is better able to bear the risk of the loss through diversification; it aggregates premiums from a large pool of insureds and holds the funds (less a “loading fee” representing administrative costs and profits)⁸⁶ in reserve against

81. See Marc L. Berk & Alan C. Monheit, *The Concentration Of Health Expenditures, Revisited*, HEALTH AFF., Mar.-Apr. 2001, at 9, 12; see also SWARTZ, *supra* note 1, at 61 (updating Berk & Monheit).

82. Berk & Monheit, *supra* note 81, at 12; see also SWARTZ, *supra* note 1, at 61.

83. Berk & Monheit, *supra* note 81, at 12; see also SWARTZ, *supra* note 1, at 61–62.

84. Berk & Monheit, *supra* note 81, at 12; see also SWARTZ, *supra* note 1, at 61–62.

85. Berk & Monheit, *supra* note 81, at 12; see also SWARTZ, *supra* note 1, at 61–62.

86. See J. David Cummins & Mary A. Weiss, *The Global Market for Reinsurance: Consolidation, Capacity, and Efficiency*, in BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES 2000 (Robert E. Litan & Anthony M. Santomero eds., 2000), at 159, 161–62.

the realization of one or more losses.⁸⁷ Individuals and businesses purchase insurance to decrease uncertainty of risk of loss.⁸⁸ Purchasers are risk-averse and are willing to pay more than the expected value of their loss to transfer the risk to an insurer.⁸⁹ Insurers sell the service of accepting risk in return for a premium. They set their premiums in reliance on actuarial methods for assessing risk across a pool of purchasers.⁹⁰

Actuarial methods provide some assurance to insurers that they will be able to set premiums at the proper level to bear the cost of realized risks while remaining solvent.⁹¹ Actuarial methods are not perfect, however, and predictions can be complicated by information asymmetries between insured and insurers, subjecting insurers to the risk that the accumulation of their insureds' losses will subject the insurer to catastrophic losses. Insurers therefore seek out firms to accept their risk in return for payment.⁹² Firms that accept such risk, that is, the firms that insure insurers, are *reinsurers*.⁹³ "Reinsurance" is the insuring of insurers.⁹⁴ Reinsurers engage in second-order pooling by accepting risk from a number of insurers, further spreading the risk of loss.⁹⁵ Insurers purchase this second-order coverage for several reasons. They purchase reinsurance to lessen the risks of fluctuating levels of claims.⁹⁶ The purchase allows them to reduce their level of reserves, permitting them to expand their business and use reserved funds for other purposes.⁹⁷ In addition, insurers, ironically, are very risk-averse. They purchase reinsurance to lessen the risks of catastrophic loss.⁹⁸

Health insurers (usually small insurers or those insuring small groups), like other insurers, purchase private reinsurance.⁹⁹ They purchase reinsurance to

87. See GEORGE REJDA, *PRINCIPLES OF RISK MANAGEMENT AND INSURANCE* 22–23 (4th ed. 1992).

88. See ROBERT I. MEHR & EMERSON CAMMACK, *PRINCIPLES OF INSURANCE* 10 (7th ed. 1980).

89. See Cummins & Weiss, *supra* note 86, at 159, 161–62.

90. See *id.*

91. See MEHR & CAMMICK, *supra* note 88, at 561–62.

92. See Leah Wortham, *Insurance Classification: Too Important To Be Left To Actuaries*, 19 U. MICH. J.L. REFORM 349 (1986) (explaining uncertainties rife in actuarial practice).

93. Cummins & Weiss, *supra* note 86, at 162.

94. See MEHR & CAMMICK, *supra* note 88, at 600.

95. See SWARTZ, *supra* note 1, at 102–03.

96. See REJDA, *supra* note 87, at 611.

97. See *id.*

98. See *id.*; Cummins & Weiss, *supra* note 86, at 162.

99. "Reinsurance" is also purchased by self-funded employer plans. SWARTZ, *supra* note 1, at 102–03. In such plans, an employer offers health coverage to employees, employing an administrator expert in claims handling, but retaining the risk of loss itself rather than contracting with an insurer to do so. See *id.* at 103. Self-funding is motivated in part to avoid state laws mandating the benefits that must be provided by insurance products. See *id.* The excess coverage purchased by such employers is "reinsurance" in the sense that the coverage runs to the plan, and

smooth out claims experience, to free up reserves, and to protect against catastrophic losses.¹⁰⁰ Health insurers can purchase reinsurance in several different forms. The most common are aggregate stop-loss and excess-of-loss coverage. Under aggregate stop-loss coverage, the reinsurer begins paying when the losses of an entire group or book of business exceeds a contractual threshold, protecting the primary insurer from the risk that group-wide costs will unexpectedly exceed the actuarial expectations underlying the premium charged.¹⁰¹ Health reinsurance is also purchased on an excess-of-loss basis, by which the reinsurer begins paying when one member of a group's costs exceed a contractual threshold; the reinsurer's obligations under this method are determined on a member-by-member basis.¹⁰² Commercial reinsurance for health insurers, then, permits primary insurers—particularly those in the relatively riskier business of insuring small groups and individuals—to lay off some of their risk, at a price that roughly reflects the expected experience of the reinsured business, to add predictability to their loss experience.

2. Government and Reinsurance: The '80s and '90s

The previous subpart describes the business case for insurers to reinsure in order to stabilize their business outlooks. But government has also had a long interest in the stability and health of insurers of marginal groups. Incremental reforms in the last three decades have attempted to expand access to health coverage through Medicaid expansions.¹⁰³ Reforms have attempted to balance this public program response with efforts to stabilize the private voluntary health insurance market. As is discussed above, the problem is not with large employers, who cover nearly all their employees, but rather with small employers and self-employed persons who seek coverage in the small group and individual markets. The small group and individual markets tend to be more expensive than large group markets,¹⁰⁴ in part due to economies of scale, and in part because insurers expend more time and resources attempting to screen for high risks.¹⁰⁵ While insurers have a high degree of confidence that

not to the member, and attaches only when the plan's or a member's experience exceeds a contractually-set threshold. *See id.* It is not, however, reinsurance in the literal sense, as the coverage runs to a self-funded employer plan and not to an insurance plan. *See id.*

100. *See id.* at 103; Randall R. Bovbjerg, *Reform of Financing for Health Coverage: What Can Reinsurance Accomplish?*, 29 INQUIRY 158, 159–161 (1992).

101. *See* SWARTZ, *supra* note 1, at 104–05; Bovbjerg, *supra* note 100, at 161.

102. *See* SWARTZ, *supra* note 1, at 105; Bovbjerg, *supra* note 100, at 161.

103. *See* Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 11 (2001); *see also* Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFF. 1458, 1465 (2005) (describing a federal-state dynamic by which Medicaid has expanded to cover additional populations and services).

104. *See* SWARTZ, *supra* note 1, at 51; Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89, 96 (2001).

105. *See* SWARTZ, *supra* note 1, at 52–54.

the employees of a large employer form a reasonably representative risk pool, they are skeptical of smaller groups and individuals, fearing that out-of-the-ordinary risk can render the small group's or individual's premium to be significantly below the costs of covered care.¹⁰⁶ Incremental reform efforts aimed at shoring up both the individual and small group markets have used reinsurance in several ways.

Most states have high-risk pools for individuals who, due to medical underwriting in the state's individual insurance market, are otherwise uninsurable,¹⁰⁷ or who are insurable only at an extremely high price.¹⁰⁸ The coverage usually comes with significant cost-sharing, a period of exclusion from coverage for pre-existing conditions, can be accompanied by low annual or lifetime limits on benefits,¹⁰⁹ and can have thinner benefits than normal individual insurance policies.¹¹⁰ The reinsurance aspect of high-risk pools arises because the pools cannot be sustained by participants' premiums, even though those premiums are substantially higher than average non-group premiums.¹¹¹ The shortfall is usually made up through assessments on insurers, although some states provide limited funding from other sources.¹¹² The pools covers only about 8% of the target high-risk uninsurable population—approximately 178,000 people in 2003¹¹³—due to high premiums and caps on enrollment due to shortfalls in funding to supplement premium income.¹¹⁴ A small amount of federal funding has recently been appropriated to address these shortcomings, thus far with little effect.¹¹⁵

During the 1990s, almost all states reacted to weakness in the individual and small group insurance markets by adopting insurance reform laws designed to improve access to private plans, particularly for the sick, who both

106. *See id.* at 53–54.

107. *See* Karen Pollitz & Eliza Bangit, *Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?*, ISSUE BRIEF (Commonwealth Fund., New York, N.Y.), Nov. 2005, at 1, available at http://www.cmwf.org/usr_doc/Pollitz_highriskpools_875.pdf. States that do not permit medical underwriting in their small group markets do not have—do not need—high-risk pools.

108. *See* LORI ACHMAN & DEBORAH CHOLLET, COMMONWEALTH FUND, *INSURING THE UNINSURABLE: AN OVERVIEW OF STATE HIGH-RISK HEALTH INSURANCE POOLS 2* (Aug. 2001), available at http://www.cmwf.org/usr_doc/achman_uninsurable_472.pdf.

109. *See id.* at 5–8; Pollitz & Bangit, *supra* note 107, at 2.

110. *See* Pollitz & Bangit, *supra* note 107, at 2.

111. *See* ACHMAN & CHOLLET, *supra* note 108, at 9–11; Pollitz & Bangit, *supra* note 107, at 2.

112. *See* SWARTZ, *supra* note 1, at 91–92; ACHMAN & CHOLLET, *supra* note 108, at 9–11.

113. *See* Pollitz & Bangit, *supra* note 107, at 2. Another study counted only 116,000 enrollees in high-risk pools in 2000. Austin B. Frakt et al., *High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects*, 26 HEALTH CARE FIN. REV. 73, 76 (2004).

114. Frakt et al., *supra* note 113, at 76–77; Pollitz & Bangit, *supra* note 107, at 2.

115. Pollitz & Bangit, *supra* note 107, at 9–10.

need insurance coverage the most and are the most unattractive customers for health insurers.¹¹⁶ These reforms attempted to decrease uninsurance by requiring insurers to issue policies to all regardless of health status and limit the duration of pre-existing illness provisions.¹¹⁷ In addition, many of these reforms constrained premium rate setting by compressing the range of prices that may be charged to members or even by requiring “community rating,” or the charging of all insureds in the same insurance pool the same premium.¹¹⁸ These regulations impinge on insurers’ self-protective mechanisms, restricting their ability to use underwriting methods to counter information asymmetries, and to use premium differentiation on the basis of expected risk as a means of avoiding disproportionately high-risk members.¹¹⁹ These reforms of state insurance law were calculated to serve states’ insurance expansion goals.¹²⁰ To accomplish these goals, states had to keep the insurers in the game.

The way states chose to keep insurers in the game, having limited their preferred means to select risk, was to build reinsurance into the reform plan.¹²¹ The reinsurance plans, both proposed and adopted, varied in structure. In some, insurers could cede the entire risk for any individual or group upon payment of a reinsurance premium. Under this model, the primary insurer paid the reinsurer a premium (set at some multiple of the primary insurer’s premium), and the reinsurer accepted the full risk for that ceded individual or group.¹²² The arrangement permitted a primary insurer to shed high-risk individuals prospectively.¹²³ Other models examined the aggregate experience of the insurers in the regulated market, determining which of the insurers did well and which did poorly, presumably reflecting the health status of their insureds. Funds from the “winning” insurers then transferred to the “losing” insurers.¹²⁴ Under this model, the reinsurance would partially compensate insurers for accepting a riskier book of business they experienced as a result of the state’s market reforms. The goal of coverage for the riskiest applicants was to be served by depriving insurers of the tools to screen them out, and the reinsurance mechanism assured that participating insurers would share equitably the cost of the high-risk insureds.¹²⁵

116. See Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 111–13 (2005); Colleen M. Grogan, *Hope in Federalism? What Can the States Do and What Are They Likely to Do?*, 20 J. HEALTH POL. POL’Y & L. 477, 481 (1985); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 369–75 (1997).

117. See Jacobi, *supra* note 116, at 372–73.

118. See Bovbjerg, *supra* note 100, at 165–66; Jacobi, *supra* note 116, at 373–74.

119. See Swartz, *supra* note 104, at 96–97.

120. See *infra* Part II.C.

121. See Jacobi, *supra* note 116, at 375.

122. See Bovbjerg, *supra* note 100, at 166–67.

123. *Id.* at 166.

124. See Jacobi, *supra* note 116, at 375.

125. *Id.*

The reinsurance efforts of the 1980s and 1990s attempted to shore up individual and small group markets, reflecting the belief that attempts to increase access by private insurance required attention to the risk selection methods to which insurers in these markets were naturally drawn. These efforts attempted to improve access for applicants who were or were perceived to be high-risk by reducing uncertainty and lessening the risk exposure resulting from lessening the intensity of risk selection. Because, however, most of these reinsurance efforts added little or no new public money, but only moved around the money already in the insurance system, they did not reduce overall premiums, but rather shifted the burden from the higher risk to the lower risk members.¹²⁶ To the extent reformers wanted to do more than expand use of reinsurance for the risk-planning benefits available in private reinsurance markets, and instead to increase access to coverage for the uninsured, the vision needed to be expanded.

C. Reinsurance in New Incremental Reform Planning

After a hiatus, cost, quality, and access concerns have spurred new interest in health reform. Reform proposals run the gamut, although it is fair to say that those reforms actually adopted by federal or state governments are incremental in character and build on existing structures including private insurance markets. It is the individual and small group components of the insurance market that are critical to the success of incremental reform, as it is these sub-markets that must serve the working uninsured if private insurance is to continue to be the anchor of American health finance. Those advocating access, cost, and quality-enhancing reform initiatives often tinker with small group and individual insurers' underwriting, pricing, and design practices directed at avoiding high-risk enrollees.¹²⁷ These practices conflict with the goals of reform efforts because they run counter to the goal of bringing those most in need of coverage into the insurance pool.¹²⁸ Incremental reform often addresses these practices directly. Reinsurance's function in this reform environment is to address the adverse selection concerns that arise by the very nature of the markets and are exacerbated by restrictions on underwriting, pricing, and design practices.¹²⁹

A number of thoughtful analyses have examined the lessons of the past and the potential for the future of reinsurance in health reform. These analyses agree that reinsurance targeted at the individual and small group markets has a positive but bounded role to play in incrementally improving the health

126. See Mark Hall, *An Evaluation of New York's Reform Law*, 25 J. HEALTH POL. POL'Y & L. 71 (2000).

127. See SWARTZ, *supra* note 1, at 78–81; Bovbjerg, *supra* note 100, at 164–66.

128. See SWARTZ, *supra* note 1, at 78–81; Bovbjerg, *supra* note 100, at 164–66.

129. See Bovbjerg, *supra* note 100, at 166.

insurance system,¹³⁰ and often suggest that reinsurance should be coupled with other regulatory changes to increase access and moderate the cost of health coverage.¹³¹ Reinsurance programs can assist in incremental reform efforts by shoring up small group and individual markets, reducing insurers risk selection efforts to exclude potential high-risk members, and marginally reducing the cost of some coverage.

1. Shoring Up Small Group and Individual Markets

Two factors explain the importance of small group and individual insurance markets in incremental health reform. First, these markets tend strongly toward increased selectivity, pinching down on an important source of access to coverage. Beginning in the 1980s, more aggressive underwriting practices in these markets caused dislocations, as individuals and members of small groups increasingly found themselves rated out of coverage.¹³² These practices were not irrational, as “financial risks associated with adverse selection are greatest for small groups and for individuals—markets where the variances of costs are the largest.”¹³³ The rationality of risk selection has only increased, as the health care costs have risen and as it becomes increasingly clear that a high percentage of health costs come not from random acute illnesses, but from expensive chronic illnesses, many of which could be identified through underwriting practices. These markets, then, are increasingly closed to those persons reformers most want covered.

Second, these markets are the only sources of private coverage for most of the uninsured. As is described above, large employers already cover nearly all of their employees. Many of the uninsured are employees of small businesses or dependents of such employees. In addition, a shift in the American economy in recent decades from large manufacturing enterprises to smaller service-sector workplaces has increased the focus on small group insurance.¹³⁴ Improving the ability of small employers to provide coverage for their employees is therefore a significant strategy of incremental reformers.

130. See SWARTZ, *supra* note 1, at 130–31 (arguing that government-sponsored reinsurance is only one component of a broader reform agenda); Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage*, STATE COVERAGE INITIATIVES: ISSUE BRIEF (Acad. Health, Washington, D.C.), Oct. 2004, at 5, available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>; David E.M. Sappington et al., *The Effects of Reinsurance in Financing Children's Health Care*, 43 INQUIRY 23, 29 (2006) (explaining that reinsurance may reduce variations in experience among insurers of SCHIP insurers, but cannot by themselves eliminate effects of unfavorable selection).

131. See SWARTZ, *supra* note 1, at 130–31; Bovbjerg, *supra* note 100, at 166.

132. See Chollet, *supra* note 130, at 1.

133. Linda J. Blumberg & John Holohan, *Government as Reinsurer: Potential Impacts on Public and Private Spending*, 41 INQUIRY 130, 131 (2004).

134. See SWARTZ, *supra* note 1, at 19–23.

Individual insurance has been important for similar reasons, as self-employed persons, like employees of small businesses, find themselves subject to increasingly difficult conditions for obtaining coverage.¹³⁵ Katherine Swartz argues persuasively in addition that the individual market's importance in health reform is increasing due to changes in the American labor market.¹³⁶ Swartz describes the growing phenomenon by which employers adjust their relationships with workers to transform them from "employees" to "independent contractors."¹³⁷ Rather than hire (or retain) employees, firms increasingly contract with contingent or "temporary" workers to do the work formerly done by employees. The firms benefit by shedding responsibility for paying some payroll taxes and in addition avoid the need to pay fringe benefits such as pension, disability insurance, and health insurance they provide to their employees.¹³⁸ Many workers experience this shift "in place;" they may be laid off as employees and then retained as contract workers on an independent contractor basis to do the same tasks.¹³⁹ Without access to employment-based coverage, they must obtain coverage, if at all, through the individual market.

Incremental reform, then, depends to some degree on the vitality of small group and individual insurance plans being widely available. The dynamics that have weakened the small group and individual markets flow from the increased selectivity of insurers using increasingly aggressive risk screening criteria for coverage. Reinsurance programs attempt to counter the effects of this trend by reducing the need for insurers to engage in aggressive risk selection activities, allowing insurers in small group and individual markets to accept a wider range of risks, and increasing access for those most in need of coverage. In addition, reinsurance can support the small group and individual insurance markets by reducing the cost of coverage through encouraging plans to reduce resources devoted to risk selection, reducing the risk premium experienced by insurers when the risk market is volatile, and providing direct subsidy for small group and individual coverage. These two functions are discussed in the following subpart.

2. Increasing Access in Small Group and Individual Markets

Insurers prefer good risks over bad for obvious business reasons. Reinsurance funded by insurers themselves in both voluntary markets and in markets created through small group and individual market reforms did little to change this preference. While such reinsurance reduces the risk of insurers experiencing catastrophic losses, insurers must, in most cases, pay a risk-

135. See Blumberg & Holohan, *supra* note 133, at 131.

136. See SWARTZ, *supra* note 1, at 23–25.

137. See *id.*

138. *Id.* at 23.

139. *Id.*

related premium to reinsurers.¹⁴⁰ The existence of a market for excess risk does not itself reduce the incentives to risk-select so long as reinsurance premiums are risk-sensitive. As Randall Bovbjerg has noted, “Reinsurance alone does not make carriers eager to accept high risks, for the high premium they must pay to the reinsurer along with ceding the high risk assures that they will lose money on each [high-risk] case.”¹⁴¹ While these reinsurance measures helped the business case for insurers remaining in the small group and individual markets, they had little effect on the plans’ preference for low-risk insureds and their natural tendency to exploit any possibility to prefer good risks within their states’ regulatory structures. Recent innovations in state reinsurance add an important additional component: substantial state financing of reinsurance. Healthy NY is the most developed and studied example of a state’s subsidization of reinsurance in the small group and individual markets.

Healthy NY is a program initiated by New York State in 2001 to shore up the small group and individual insurance markets to improve access to coverage for the uninsured.¹⁴² It was intended to reform New York’s small group and individual insurance markets in order to “promote access to quality health care through increased availability of insurance coverage.”¹⁴³ It is designed to supplement and not supplant existing sources of coverage. To avoid “crowd out” of existing coverage, it permits the enrollment of only those who would otherwise be uninsured by disqualifying small employers and individuals who have been covered by insurance within the previous 12 months.¹⁴⁴ The program modified individual and small group markets by

140. Private market reinsurers have the same incentive as primary insurers to charge risk-related premiums. See SWARTZ, *supra* note 1, at 105–08. Most of the reinsurance components of the small group and individual reform proposals in the late 1980s and early 1990s similarly contemplated insurers’ purchase of reinsurance. See Bovbjerg, *supra* note 100, at 166–68.

141. See Blumberg & Holohan, *supra* note 133, at 132; Bovbjerg, *supra* note 100, at 169. This is not to say that reinsurance programs have no effect on insurers’ approach to high-risk enrollees. As Bovbjerg points out, the structured reinsurance components of the first wave of small group and individual insurance reforms makes compliance with restrictions on risk selection “more tolerable and less likely to be evaded.” *Id.*

142. The legislation requiring reports of the program refer to it as the “healthy New York” program. See N.Y. INS. LAW § 212 (McKinney 2006). The New York Department of Insurance and the annual reports produced pursuant to § 212 refer to it as “Healthy NY.” See EP&P CONSULTING, INC., REPORT ON HEALTHY NY PROGRAM 2005 (Dec. 31, 2005), available at <http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf>; N.Y. Dep’t of Ins., Healthy NY: Reports, <http://www.ins.state.ny.us/website2/hny/english/hnyrep.htm> (last visited Feb. 28, 2007). I adopt the latter designation here.

143. 1999 N.Y. Laws 1, 2 (codified as note following N.Y. INS. LAW § 4326 (McKinney 2006)).

144. See N.Y. INS. LAW § 4326(c)(1)(A)(i) (McKinney 2006) (providing that sole proprietors with coverage in the previous twelve months are disqualified); § 4326(c)(1)(B)(ii) (providing that small employers with coverage in the previous twelve months are disqualified); §

permitting a reduction in mandated benefits, tightly-controlled networks, and higher cost-sharing.¹⁴⁵ But the “most important” feature of Healthy NY is its state-financed stop-loss reinsurance provision.¹⁴⁶

Healthy NY’s reinsurance is excess-of-loss coverage, by which the primary insurer and New York share the risk that covered individuals will experience a high loss. As initially designed, the primary insurer was responsible the first \$30,000 of costs for each insured, with New York picking up responsibility for 90% of the costs for expenses between \$30,000 and \$100,000 for each individual; the primary insurer was responsible for the remaining 10% and all costs exceeding \$100,000.¹⁴⁷ In July 2003, the range of expenses subject to reinsurance changed; New York now pays 90% of all costs between \$5,000 and \$75,000 for each covered individual.¹⁴⁸ This form of reinsurance is the subject of discussion in other states as a component of reforms directed toward increasing access to coverage and reducing uninsurance.¹⁴⁹

Healthy NY appears to have been quite successful at meeting its goals of expanding access to coverage. It has enrolled over 200,000 people since it initiated enrollment; its active enrollment of over 106,000 people as of December 2005 represented a 40% increase over the course of one year.¹⁵⁰ The anti-crowd-out measures suggest that this enrollment represents net increases in coverage, and therefore, a reduction in uninsurance for the population of New York. This surmise is supported by coverage trends. The uninsured rate in the United States rose slightly from 1996 to 2004 (from 15.6% to 15.7%) and dropped substantially in New York during the same

4326(c)(3)(A)(i) (providing that an applicant who is an employed individual is disqualified if covered by insurance over previous twelve months); *see also* LEWIN GROUP, REPORT ON HEALTHY NY PROGRAM 2003 3 (Dec. 31, 2003), *available at* <http://www.ins.state.ny.us/website2/hny/reports/hnylewin.pdf>.

145. § 4326(d) (listing covered services); § 4326(e) (listing copayments and deductibles); *see* KATHERINE SWARTZ, COMMONWEALTH FUND, HEALTHY NEW YORK: MAKING INSURANCE MORE AFFORDABLE FOR LOW-INCOME WORKERS 9 (Nov. 2001), *available at* <http://www.ins.state.ny.us/website2/hny/reports/hnystudy.pdf>.

146. SWARTZ, *supra* note 145, at vii. The funding for the reinsurance in Healthy NY comes from New York’s tobacco settlement proceeds. *Id.* at 10, n.14. The reinsurance aspects of Healthy NY are described at N.Y. INS. LAW § 4327.

147. *See* § 4327(b); *see also* LEWIN GROUP, *supra* note 144, at 3–4.

148. *See* SWARTZ, *supra* note 1, at 133; LEWIN GROUP, *supra* note 144, at 3–4.

149. *See* Stuart H. Altman & Michael Doonan, *Can Massachusetts Lead the Way in Health Reform?*, 354 NEW ENG. J. MED. 2093, 2094 (2006) (discussing Massachusetts’ health reforms; suggesting that “refinements” might include adding reinsurance for high-cost cases); Katherine Swartz, Comments at Conference: Strategies to Strengthen Private Health Insurance Markets—An Expert Panel Dialogue on Reinsurance, The Role of Reinsurance in Reducing the Number of Uninsured (June 14, 2006) (describing early version of Massachusetts’ reform legislation as including reinsurance component).

150. EP&P CONSULTING, INC., *supra* note 142, at II-1; SWARTZ, *supra* note 1, at 133.

period from 17% to 14.2%,¹⁵¹ and New York was one of only three states to show a statistically significant reduction in the two-year average rate of uninsurance between 2003 to 2004 and 2004 to 2005.¹⁵² Tellingly, the largest rate of decrease in uninsurance in New York between 2001 and 2003 was in households in the income range served by Healthy NY (those below 200% of the poverty level), while households in this income range experienced increasing rates of uninsurance during the same period elsewhere.¹⁵³

3. Reducing the Cost of Small Group and Individual Coverage

Reducing a purchaser's cost of coverage is an essential part of any strategy for increasing rates of insurance coverage in any system in which coverage is voluntary. State-funded reinsurance can reduce the purchaser's cost of coverage in two ways. Most obviously, it is a form of subsidy because the state contributes a part of the cost of coverage. Second, by reducing insurers' exposure to the effects of covering high-cost members, it can lessen the expense of insurers' risk selection activities and reduce the "risk premium" attached to underwriting decisions.

It is widely agreed that the principle barrier to coverage expansion goals is the cost of coverage, particularly for individuals and employees of small firms, and particularly for those with low- and moderate-incomes. A state-funded reinsurance program serves as a frank subsidy. Money flowing in from government to subsidize the cost of coverage directly reduces price, whether the subsidy comes in the form of a per person voucher discounting the market premium, a grant directly to insurers to defray part of the cost of doing business, or a fund providing reinsurance for high-cost members. New York, for example, allotted between \$49 million and \$110 million per year to state-funded reinsurance,¹⁵⁴ and its actual expenditures for 2004 (the first full year of experience under the current reinsurance attachment points)¹⁵⁵ was approximately \$38 million.¹⁵⁶ The state's expenditure of \$38 million on the Healthy NY program amounted to approximately \$500 in subsidy per covered life during 2004.¹⁵⁷ The application of a \$500 subsidy directly to the purchase of insurance would surely have some effect on increasing coverage.

151. *Id.* at II-18.

152. See CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005 25–26 (2006), available at <http://www.census.gov/prod/2006pubs/p60-231.pdf>.

153. EP&P CONSULTING, INC., *supra* note 142, at II-19.

154. *Id.* at I-4.

155. LEWIN GROUP, *supra* note 144, at 3-4.

156. EP&P CONSULTING, INC., *supra* note 142, at I-4.

157. This estimate results from dividing the amount expended by New York for reinsurance in the Healthy NY program in 2004 (\$38 million) by the number of Healthy NY members as of

But state-funded reinsurance adds value beyond mere subsidy. The application of subsidy as reinsurance rather than straight premium reduction does double duty because, in addition to slicing off a portion of premium cost, it can reduce the incentive for insurers to engage in administrative risk-selection actions. If the cost exposure from high-risk members is reduced, insurers will have less incentive to compete on the basis of avoiding those members¹⁵⁸ and will therefore reduce their spending on efforts to screen for high-risk indications.¹⁵⁹ As Professor Swartz has described this phenomenon:

A reinsurance program reduces the risk of extremely high-cost people in the small-group and individual markets to a level comparable for large groups. At that point, the benefits from using the mechanisms will be less than the costs, and insurers will reduce their use.¹⁶⁰

The point at which reinsurance would have this salutary effect is uncertain; it seems reasonable to assume, however, that reinsurance programs' assurance of coverage for the extraordinary costs of covering high-risk members will affect the extent to which insurers will expend resources to avoid those members.

Closely associated with the savings realized from reduced risk-selection activities is the somewhat more speculative savings that could be realized from a reduction in the risk premium as a result of the stabilizing effect of government-funded reinsurance. Insurers charge more for coverage attended by higher degrees of uncertainty. If an insurer rates two groups as likely to experience \$2,000 per person in costs, but the insurer's confidence of that prediction is lower for the smaller group (because a small number of outliers could more readily affect the average loss), it will charge a higher premium—adding a “risk premium”—to compensate for the additional exposure, even though it has confidence in its actuarial analysis pegging the expected cost of both groups as equal.¹⁶¹ The application of government-funded reinsurance reduces the magnitude of this uncertainty and could lead to reductions in premium.

Incremental reform seeks to retain much of the structure of our current health finance system while improving cost and access through targeted reforms. As a component of incremental reform, government-funded reinsurance can perform three closely-related functions. It can help to stabilize the individual and small group markets for health insurance—an important goal, as most uninsured persons can find coverage in the private market, if at all, only with insurers offering individual or small group policies. It can

December 2004 (76,297). See EP&P CONSULTING, INC., *supra* note 142, at I-4, II-2. 76,297/\$38 million = \$498 per member.

158. See ACHMAN & CHOLLET, *supra* note 108, at 1; Sappington et al., *supra* note 130, at 28.

159. See Blumberg & Holohan, *supra* note 133, at 132.

160. SWARTZ, *supra* note 1, at 121.

161. *Id.* at 54–55.

reduce uninsurance by reducing the incentive of insurers to reject high-risk applicants—those persons who most need coverage. And it can reduce the cost of coverage both through subsidy and through reducing insurers' incentives to expend resources in risk-selection activities. The interest in government reinsurance as a component of incremental reforms is therefore sensible, as it can apply needed subsidy that can cost-effectively shore up teetering individual and small group markets, expand access to coverage, and reduce the cost of coverage. The next Part addresses the longer-term benefits of reinsurance programs.

III. GOVERNMENT REINSURANCE AS A BRIDGE TO SYSTEMIC REFORM

Health reforms that dramatically change our health finance system are unlikely in the near future, not because there is dispute that such reform is needed, but because there is no political or policy consensus on the shape of broad reforms.¹⁶² As a result, near-term reform efforts will be limited to incremental reform, such as those described above in Part II. In the process of shaping those incremental reforms, however, there is room for compromise across ideological divides to achieve progress toward universal coverage and other goals.¹⁶³ But which incremental steps to increase access will gain traction?

Compromise here can be tricky.¹⁶⁴ It is tricky because all incremental reform is motivated by a larger vision of the ideal health finance system. To put it another way, all incremental reforms are motivated by and directed toward a long-term strategy of reaching a more radically reformed system structured according to particular political and ideological beliefs. Incremental choices may well shape broader future changes, as Alan Weil has noted:

Increments can achieve short-term objectives, but depending upon how they are structured, they may make the longer-term goal of universal coverage easier or harder to attain. Even though comprehensive reform seems unrealistic today, we must continue to discuss and define what the health care

162. See, e.g., David M. Frankford, *Unchanging New Leadership*, 28 J. HEALTH POL. POL'Y & L. 509, 515 (2003) (arguing that only the federal government can lead true health finance reform, and as to the prospects for such leadership, stating: "I would not hold your breath"); Fuchs & Emmanuel, *supra* note 4, at 1411 (stating that "the short-run prospects for [comprehensive reform] seem dim"). Timothy Jost is only slightly more optimistic. See Timothy Stoltzfus Jost, *Why Can't We Do What They Do?: National Health Reform Abroad*, 32 J. L. MED. & ETHICS 433, 439 (2004) ("One can, just barely, imagine a scenario in which a universal health care system might become politically viable in the U.S.").

163. See Mark V. Pauly, *Conflict and Compromise Over Tradeoffs in Universal Health Insurance Plans*, 32 J. L. MED. & ETHICS 465 (2004) (suggesting means to bring together "liberals" and "marketists").

164. Or as Professor Pauly notes, "[I]t may be that things will have to get worse before they get better." See *id.* at 473.

system of the future should look like. Then we can judge incremental reform proposals not only on the basis of who they cover today, but whether they move us in the right direction for the future.¹⁶⁵

Incremental reforms likely to gain traction are those not inconsistent with the core programs of either market advocates or regulatory advocates.

Reinsurance is a component of incremental reform that is a plausible ground for compromise between market-oriented advocates and those committed to a regulatory program. As the discussion below describes, reinsurance advances goals of access, quality, and cost-containment. Significantly, however, it does so without forcing a choice between the broad philosophical views of either camp. I do not argue that reinsurance programs are in themselves the basis for long-term reform or even that they will be central components of a future, better system. Rather, I argue that they are positive in themselves and are a module of reform that can fit into or be adapted to many different versions of long-term systemic change, allowing significant incremental improvements in the health finance system while the larger debate continues. There are three important characteristics of governmental reinsurance programs that permit them to fit, Zelig-like, into various systems. First, reinsurance programs pool risk at an optimal level, where personal security can be assured for care not reasonably amenable to individual consumer direction. Second, they are flexible in both funding and program design. They can be geared up gradually, employed to shore up different sub-markets of insurance, and modified to enhance management of high-cost, long-term care. Third, they can address cost, quality, and access for that population segment driving the crisis: high-risk, high-cost persons with complex chronic conditions. Without attention to this group, any program of health reform will fail.

A. *Pooling at an Optimal Level of Care*

This argument for government funding of catastrophic care comes in two steps, one easy and one harder. The first step concerns the recognition that advocates across the spectrum of insurance reform accept that the pooling of resources for the provision of catastrophic care is appropriate. Advocates of consumer-driven care argue that cost and quality improvements will be generated by empowering consumers.¹⁶⁶ Giving (or returning to) consumers responsibility and authority for health care decisions will unleash market power, incentivizing them to compare cost and quality before purchasing and allowing the sum of these purchasing decisions to encourage cost and quality based competition.¹⁶⁷ The mechanism for this transfer of responsibility and

165. Alan Weil, *Increments Toward What?*, HEALTH AFF., Jan.-Feb. 2001, at 68, 81.

166. See GOODMAN & MUSGRAVE, *supra* note 52, at 29–30.

167. See *id.* See generally Pauly & Goodman, *supra* note 52.

authority, of course, is individual spending accounts, or health savings accounts, owned and controlled by consumers from which they will draw funds for their health care purchases.¹⁶⁸ From this perspective, advancing cost and quality goals calls for less mediation of all sorts between consumers and the market.¹⁶⁹

Some question whether giving individual consumers market power is likely to achieve the ends described by advocates of consumer-driven care.¹⁷⁰ But the extent of the disagreement should not be overstated. Advocates of using spending accounts to unleash market discipline recommend the use of the accounts for routine, relatively low-cost services, not for catastrophic care. For coverage of catastrophic care, financing in the form of traditional insurance is called for.¹⁷¹ With respect to catastrophic costs, then, advocates of markets and government agree: broad pooling of costs is appropriate. This agreement is significant in light of the concentration of health costs in the care of chronically ill persons.¹⁷²

The second step in this portion of the argument is harder: should the pooling of funds for the payment of catastrophic costs take place in the private insurance market or through governmental funding? For market advocates, the need to pool resources entails the need for private insurance to be responsive to consumer demands and spread the risk of catastrophic costs over the purchasers of coverage. For advocates of government intervention, the need to pool resources is closely connected with the argument that coverage of the costs of at least some forms of health care is a public good and is therefore appropriately insured by government.¹⁷³ The ground for agreement is the need for pooled and not individually controlled funding for the coverage of catastrophic risks.

It may be that agreement would founder on the provision of reinsurance by government and not a private firm. Well-understood failures of the insurance market may, however, overcome this objection. First, reinsurance attaches

168. See Cannon et al., *supra* note 42; Pauly & Goodman, *supra* note 52, at 126.

169. See Goodman, *supra* note 40, at 237; Heritage Foundation, Issues: Health Care: Health Care Reform, <http://www.heritage.org/research/healthcare/healthcarereform/index.cfm>.

170. Some observers question whether consumers are likely to have the information, or the ability to use information, necessary to make sound purchasing decisions under current conditions. See Jon B. Christianson et al., *Consumer Experiences in a Consumer-Driven Health Plan*, 39 HEALTH SERVS. RES. 1123, 1125 (2004). Others question more fundamentally whether cost and quality concerns can ever be solved by increasing consumer-directed competition in health care. See Thomas Rice, *Can Markets Give Us the Health System We Want?*, in HEALTHY MARKETS?: THE NEW COMPETITION IN MEDICAL CARE 27, 30–38 (Mark A. Peterson ed., 1998).

171. See GOODMAN & MUSGRAVE, *supra* note 52, at 44; Pauly & Goodman, *supra* note 52, at 129.

172. See *supra* Part II.C.

173. See Deborah A. Stone, *Beyond Moral Hazard: Insurance As Moral Opportunity*, 6 CONN. INS. L.J. 11, 43–45 (1999).

only when a person's medical costs have crossed a high threshold, and therefore, addresses only the level of risk agreed to be suitable for social pooling.¹⁷⁴ Second, it applies a government subsidy to an area in which private insurance fails to serve at least some of its social tasks. Private reinsurance does not reduce anti-selection activities of health insurers in small group and individual markets, as primary insurers are required to pay risk-related premiums to reinsurers.¹⁷⁵ Public reinsurance both spreads risk and subsidizes, as the payment for truly catastrophic costs comes not from the insurance pool, but from government. Market advocates commonly accept some governmental financing role for those unable to pay for coverage.¹⁷⁶ Here, government would finance the catastrophic care for people unable to pay for such care. Governmental pooling would, in addition, resolve some of the failures in the private reinsurance market for small group coverage. Governmental assumption of this financial risk would hold stable the sub-catastrophic components of the health insurance system, permitting breathing room for further debate and experimentation from a variety of principled perspectives.

B. *Short-Term and Long-Term Flexibility*

Advocates of a governmental resolution of the health finance crisis of course support governmental funding of coverage, either through a governmental single-payer system¹⁷⁷ or through governmental purchase of private coverage.¹⁷⁸ As was suggested in the previous subpart, market advocates do not categorically oppose government subsidies. Instead, they recognize that some government subsidies are necessary to provide coverage for those unable to meet market prices for insurance,¹⁷⁹ so long as the form of the subsidies does not interfere with consumers' incentives to exercise careful judgment as to cost and quality in health care.¹⁸⁰

The common ground supporting government-funded reinsurance as a component of incremental reform could arise from the fact that it does not interfere with consumers' relationships either with health care providers or primary insurers. Government-funded reinsurance can add subsidy to any sort of primary insurance, from first-dollar traditional insurance to consumer-driven plans with spending accounts. In addition, the amount of subsidy can be adjusted from year to year. This flexibility is important because it will allow a

174. See *supra* Part II.B.1.

175. See Bovbjerg, *supra* note 100, at 169; see *supra* Part II.B.2.

176. See, e.g., Pauly & Goodman, *supra* note 52 (describing a system of tax credits to fund insurance for low-income persons); Zelenak, *supra* note 39 (describing the same system).

177. See RICHMOND & FEIN, *supra* note 43, at 243.

178. See Fuchs & Emanuel, *supra* note 4, at 1402.

179. See Pauly & Goodman, *supra* note 52 (describing a system of tax credits to fund insurance for low-income persons); Zelenak, *supra* note 39 (describing the same system).

180. See Pauly & Goodman, *supra* note 52, at 126–28.

reinsurance program's funding to be increased or decreased in response to accumulated experience regarding the level of reinsurance necessary to serve access goals. In addition, this flexibility has political appeal, as the programs can be reduced or increased in response to budgetary conditions without seriously disrupting underlying insurance relationships.

The flexibility of this component of health reform has long-term benefits. Because reinsurance programs can grow and adapt alongside a wide range of system modifications, investment of intellectual and financial capital in the development of reinsurance systems is likely to pay dividends. If the past is any guide, the American health finance system two decades hence will look structurally similar to the American health care system two decades or even four decades ago: a mixture of private and public insurance and a mixture of public and private institutions of care. Although we are witnessing the steady erosion of employment-based health coverage,¹⁸¹ it is too soon to sound the death knell for that form of coverage. There is, however, a need for some substantial reimagining of the relationship between the public and private health financing sectors. Publicly funded reinsurance embodies one mechanism for the interaction of public and private spheres of influence and responsibility and may form the basis for enduring structures of public-private partnership.

C. *Emphasis on High-Risk Persons*

As described above, yearly health expenditures are extremely skewed. The sickest 2% of any insurance pool accounts for 40% of the cost, and the sickest 10% accounts for 70% of the costs.¹⁸² In addition, the most expensive people in any insurance pool tend to be people with chronic conditions.¹⁸³ The number of people with chronic conditions, and the percentage of health care costs devoted to the care of people with chronic conditions, is increasing over time.¹⁸⁴ This increase is in large part a function of the technical improvement of health care. As physicians are better able to cure infectious diseases, repair us when we are subject to trauma, and treat us with new drugs and devices that extend our lives, we are more likely to develop chronic illnesses that require ongoing, sometimes expensive treatment.¹⁸⁵ Relatively current calculations suggest that people with chronic illnesses “account for nearly 76% of hospital

181. *See supra* Part I.A.2.

182. *See supra* Part II.A.

183. *See* Catherine Hoffman et al., *Persons With Chronic Conditions: Their Prevalence and Costs*, 276 JAMA 1473, 1477 (1996); Jacobi, *supra* note 1, at 563–64.

184. *See* ROBERT L. KANE ET AL., *MEETING THE CHALLENGE OF CHRONIC ILLNESS* 28 (2005).

185. *Id.* at 28–31.

admissions, 80% of total hospital days, 55% of emergency room visits, 88% of prescriptions, 96% of home health care visits, and 72% of physician visits.”¹⁸⁶

Improving the quality of treatment and containing the cost of medical services for people with chronic illness requires the adoption of mechanisms for the coordination and management of their care.¹⁸⁷ Meeting these goals also requires the identification and nurturing of interdisciplinary teams that specialize in the treatment of particular chronic illnesses.¹⁸⁸ The concentration of effort and the focusing of funding on recognized centers of excellent care is a central component of the consumer-driven care movement.¹⁸⁹ It has received increasing attention in discussions of government-focused expansions of insurance.¹⁹⁰ Vermont’s 2006 broad-ranging health insurance reform measure is to some extent organized around the treatment of chronic illness. It seeks to adopt a “chronic care model” that will be available to people with the new government-subsidized coverage as well as people in private health plans.¹⁹¹ Both advocates of consumer-driven care and those advancing expansions of governmental insurance argue that increased attention on the management of chronic care can increase quality and reduce the overall cost of care.¹⁹²

The primary purposes of government reinsurance programs are financial; they are intended to reallocate risk for catastrophic costs in order to stabilize insurance markets, reduce the cost of coverage in small group and individual markets, and increase access for those low- and moderate-income workers most at risk of losing coverage. These purposes are achieved by separating the financing of routine care from the financing of catastrophic care, which is often care for those with complex chronic illness.

This financial segmentation may serve a programmatic goal as well. The financial focus on complex chronic care can enhance the understanding of the drivers of the health insurance crisis and can further interest in solutions based on the adoption of emerging methods of improving care and controlling cost for people with chronic illness.¹⁹³ The congruence of the financing system and the care system will help to facilitate the transformation of the health care

186. *Id.* at 36 (citing to 1996 and 2002 studies).

187. *See id.* at 76–89.

188. KANE ET AL., *supra* note 184, at 106–07.

189. *See* CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 105–11 (Regina E. Herzlinger ed., 2004) [hereinafter CONSUMER-DRIVEN HEALTH CARE].

190. *See Details About the 2006 Health Care Affordability Act*, http://www.leg.state.vt.us/HealthCare/Q&A_Details_on_Health_Care_Affordability_Act_H_861.htm (last visited Feb. 28, 2007).

191. *Id.*

192. *See* CONSUMER-DRIVEN HEALTH CARE, *supra* note 189, at 105–11; *Details About the 2006 Health Care Affordability Act*, http://www.leg.state.vt.us/HealthCare/Q&A_Details_on_Health_Care_Affordability_Act_H_861.htm

193. *See generally* KANE ET AL., *supra* note 184.

system from one based on episodic, discontinuous care for the highest cost patients to one in which care is coordinated and provided in settings able to combine efficiency with state-of-the-art excellence.

CONCLUSION

The crisis in American health care has spurred renewed creativity in reform discussions. Unfortunately, substantial principled differences impede any movement toward comprehensive reform, and the best that can be expected in the near-term is incremental reform that does more good than harm. Recent work by a number of scholars has increased interest in reinsurance as an important component of incremental health reform. Reinsurance can shore up, at least temporarily, individual and small group insurance markets by reducing the cost of coverage and facilitating the entry of the currently uninsured into these forms of coverage. Reinsurance, in addition, can perform these services while fitting comfortably with a wide range of other incremental reform efforts motivated by diverse views of the proper shape of long-term reform.

In addition, the use of government-funded reinsurance provides political breathing room, allowing some motion toward increased access and improved quality without running afoul of central tenets of divergent political positions on long-term insurance reform. It serves the goals of cost control and quality improvement without interfering with existing health care or primary insurance relationships; it is flexible programmatically and financially, and it focuses attention on the chronically ill—the population whose care must be a focus of any meaningful long-term reform. Government-funded reinsurance, then, serves as a valuable component to current incremental reform efforts, and also acts as a bridge between our current fractured discussion of health reform to a future comprehensive, but as-yet undetermined, comprehensive reform.

