State Reinsurance Pools for Small Group Health Insurance†

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Summary

In the early 1990s, small group health insurance reform was popular legislation in response to perceived underwriting abuses that exacerbated the problem of the uninsured. More than half the states with small group market reforms have authorized reinsurance pools to help minimize the market disruption that might result from adverse selection. These reinsurance pools have been largely overlooked in the many evaluations of health insurance market reforms to date. This article reports on the nature, purpose and performance of public reinsurance, based on a study of six states with small group reinsurance pools: Colorado, Connecticut, Florida, Iowa, North Carolina, and Ohio. It concludes that reinsurance pools have been used much less extensively than was originally anticipated and that they play

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only a very minor role in the small group market. The authors discuss the reasons for a sharp contrast in utilization between Connecticut and the other states studied here.

Nevertheless, the authors suggest that administered reinsurance may counteract the temptation by insurers to circumvent the law when faced with very bad risks. Also, reinsurance may encourage small insurers to remain in, or enter, the small group market. The most significant conclusion drawn from this study is that for state fostered reinsurance to have a larger role in spreading a significant amount of risk across the health insurance market, participation should be mandatory. This is contrary to the design in most states.

Background

This article reports on the performance of the public reinsurance mechanisms that are part of health insurance market reforms, mainly in the small group market. These market reforms are intended to allow anyone who wants health insurance to purchase and keep coverage with any carrier in the market, at rates that do not greatly exceed the carrier's market averages (Hall, 1992; Hall, 1994). These reform laws consist of three essential components: 1) a guaranteed issue requirement that prohibits refusing coverage to any qualified applicant; 2) rating restrictions, which limit the extent to which rates can vary based on health risk; and 3) portability and continuity of coverage provisions, which require guaranteed renewal, limit the use of pre-existing condition exclusions, and allow policyholders to switch to another carrier without undergoing a new exclusion period (ibid.). The reform laws originated from the National Association of Insurance Commissioners' model laws, followed by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Most states define a covered small group to be 2–50 workers, but states vary considerably in their rating restrictions. Also, some states include the self-employed, and a few states extend these reforms to individual [non-group] purchasers.

1. HIPAA implemented on a uniform, national basis the guaranteed issue, continuity, and portability provisions of small-group reforms that many states had enacted in the preceding five years. Rating restrictions remain the province of state law.
The Purpose of Reinsurance

Health insurance reform laws are intended to stabilize the market and to improve its competitive dynamic. These reforms are not intended, by themselves, to reduce greatly the number of people without insurance, or to lower dramatically the average cost of insurance. Rather, these reforms attempt to move in the direction of reduced costs and increased coverage, especially for those who most need insurance. Market reforms require insurers to issue coverage to risky purchasers at rates far below their expected claims.

Insurers are expected to absorb losses from high risk subscribers by increasing their overall rates modestly. However, insurers still have a very strong incentive to avoid the highest risks, possibly using indirect and surreptitious ways such as targeted marketing, gerrymandered benefit packages, selective poor service, or “field underwriting,” which is informal screening by agents [Hall, 2000b; Hall, 2000c]. Also, this exposure to the most catastrophic risks may deter some smaller insurers from remaining in the market if they believe their book of business is too small to bear these risks. Therefore, a critical component of insurance market reforms is some mechanism for sheltering insurers from extreme excess claims.

The primary mechanism for sheltering insurers is a state-administered reinsurance pool, which is included in more than half of the states with small group reform laws [NAIC, 2001]. Four states also have reinsurance pools that cover non-group insurance sold to individuals [American Academy, 1996]. Several states created or expanded reinsurance pools in response to HIPAA, in order to cover high risk people moving from group to individual coverage. Reinsurance pools have been largely overlooked in the many evaluations of health insurance market reforms to date. This article reports on the nature, purpose and performance of public reinsurance, based on an extensive qualitative study in six states with small group reinsurance pools.

How State-Administered Reinsurance Works

Reinsurance pools allow insurers to decide at the time they issue coverage whether or not to pay a reinsurance premium and pass their highest risks over to an industry-funded pool. The pool pays the issuing carrier 90 percent of any claim that exceeds a stated deductible,
usually $5,000 per person. Reinsurance is transparent to the policyholder. All reinsurance transactions are behind the scenes, between the carrier and the pool. Policyholders deal only with the issuing carrier. Prospective reinsurance is an alternative to either: 1) allowing insurers greater leeway to increase their premiums for higher risks, or 2) a retrospective risk-adjustment mechanism that spreads the costs of high claims for all insurers based on their actual claims history (Bovbjerg, 1992). Prospective reinsurance is preferred to greater pricing flexibility because it helps keep the premiums affordable for higher risks. Reinsurance is preferred to risk adjustment because risk adjustment entails a more overt regulatory intervention, and the formula used for adjusting risk is always open to criticism from those who believe they are disadvantaged.

Reinsurance is an option for insurers to decide on a case-by-case basis whether to keep the premium and assume the risk of a particular subscriber or forego the premium and pass the risk on to the other carriers who participate in the reinsurance pool. Without reinsurance, an insurer would randomly, or perhaps systematically, suffer the full brunt of bad risks above the allowable rating limits, with no avenue for relief. Reinsurance also reduces the need for intensive policing of possible tactics for gaming or circumventing market reforms. In essence, it creates an incentive-based system for encouraging compliance with guaranteed issue and rating restrictions, without having to carefully monitor the way in which the industry conducts its business.

There is considerable disagreement among various sectors of the insurance industry over whether public reinsurance is necessary and, if so, what form it should take (Bovbjerg, 1992). Some commercial insurers insist that reinsurance is essential if they are to engage in guaranteed issue subject to rating restrictions. HMOs view it as unfair that they would be taxed proportionately for the excess costs of reinsured claims when, in their view, their managed care techniques contribute lower-than-average costs to the pool. Other insurers, including the Blue Cross plans, think reinsurance is fine for those who need it, but feel they are large enough to bear their own risks and don't want to participate in a subsidy system they don't benefit from. Therefore, in most states with small group reinsurance, participation is voluntary, although four states have mandatory reinsurance. In either structure, the decision of which subscribers to reinsure is made by the insurer. However, in mandatory reinsurance, all insur-
ers must contribute to the assessments used to fund the pool and may cede risks, in contrast with voluntary reinsurance where insurers may decide whether or not to participate at all.

The principal funding for the reinsurance entity is from the reinsurance premium paid when a participating insurer cedes a group or individual to the pool. Under the National Association of Insurance Commissioners' small group model, which is used by most states with small group reinsurance, insurers may cede either high risk groups, or individuals within groups, on payment of a reinsurance premium that for groups is 150 percent, and for individuals is 500 percent, of the market average for the particular benefits package and case characteristics (age, gender, family composition) in question. Since insurers will reinsurance only those groups and individuals they predict will have reimbursable claims that are higher than the reinsurance premiums, the reinsurance entity is expected to suffer net losses above the reinsurance premium. These net losses are spread back to the insurance market through assessments against participating insurers in proportion to their small group market shares.

This reinsurance mechanism differs from high risk pools in 29 states that cover uninsurable individuals. These also pool and spread risk, but they issue coverage directly to individuals, and they pass part or most of the higher costs on to the subscribers, in the form of higher premiums. In contrast, reinsurance is invisible to the public, in that the decision to reinsurance is made solely by the insurer (the "ceding" insurer) when the policy is issued. The decision to reinsure does not affect allowable rates charged to the subscriber, or other terms of service. Higher costs are offset by the reinsurance premium paid by the ceding carrier, and the ceding carrier remains responsible for plan administration. The reinsurer merely indemnifies the issuing insurer for its claims expenses. This administered reinsurance mechanism also differs from conventional, private market reinsurance because it is used selectively for groups that are expected to be higher risks than the allowable premium reflects. In contrast, conventional reinsurance covers all of an insurer's risk pool for the unpredictable chance that an actuarially accurate premium will not be sufficient. Commercial reinsurance also does not have a redistributive funding mechanism (Bovbjerg, 1992).

Public reinsurance is subject to several criticisms and potential problems. First, it introduces complexity and overhead costs. Some
opponents note that accurate decisions about whether or not to re-
insure require the sort of medical underwriting evaluation that mar-
et reforms seek to minimize. Second, minimizing the insurer’s cost ex-
posure for the highest cost cases removes some of the incentive to
control costs and manage care for the cases where this may be most
important. Third, administering reinsurance pools may prove to be
burdensome, contentious, or even unnecessary, depending on how
widely and actively these pools are used.

To date, the performance of reinsurance pools has not been as-
essed in the United States. However, one report about a similar
structure in the Netherlands found that reinsurance pools there sub-
stantially reduce incentives for risk avoidance without sacrificing
incentives for efficiency and cost containment (van Barneveld et al.,
1996).

Methods

To evaluate how reinsurance pools have functioned within health
insurance market reforms, six study states were selected in 1996 to
reflect a range of intensity in small group reforms as well as different
demographic, economic, and market characteristics. In each study
state, in-depth interviews were conducted with the two to four reg-
ulators who have the most knowledge of these laws, including the
reinsurance pool administrator, and with actuaries and underwriters
at three to four of the top insurers, including Blue Cross, leading
HMOs, and commercial indemnity insurers. Interviews were also
conducted at 11 national insurers with business in some or all of
these study states, and with the firm that provides administrative
support to most of the pools nationwide. In all, more than 50 subjects
were interviewed in 1997, and over 60 percent of these [or their sub-
stitutes] were interviewed again in 1998. Interviews lasted approxi-
mately one to two hours each and were based on an interview guide,
but the discussions were free-ranging and the coverage of topics var-
ied somewhat among them. Most interviews were in person and one-
on-one, but a few were over the phone or in groups of two to five
subjects. Finally, documentary information was collected and ana-
lyzed using primarily qualitative methods. The information in-
cluded insurers’ operating data, data reported to state regulators and
pool administrators, prior public policy and industry studies, and
news articles in local and national publications. Operating data on reinsurance pools in five of the study states were updated in late 2000; the sixth state (Vermont) never implemented its reinsurance pool. We also received data in 2000 on Connecticut, which was not originally part of our study but which offers an approach to reinsurance that contrasts with those in our primary study. Table 1 identifies select reform elements in these seven states.

Findings and Discussion

Operating Statistics

In each study state, there has been much less reinsurance activity than was initially expected. Colorado is closing its pool, reinsurance activity in Iowa has been minuscule throughout the life of its pool, and the reinsurance pools in the remaining study states constitute only a microscopic portion of the market (Table 2). For instance, in Florida, which has the most volume, reinsurance at its peak (1995) accounted for fewer than 2 out of 1,000 people in the small group market, and in 2000 accounted for fewer than 2 out of 10,000 small group enrollees. The percentages in North Carolina and Ohio are similar.

Our survey found several explanations for this low level of activity. First, guaranteed issue is bringing fewer very bad risks into the market than insurers initially imagined. This is supported by other published research (Kilbreth et al., 1998; Swartz and Garnick, 1999). Insurers feared a flood of previously uninsurable groups, and so it was expected that the reinsurance pools would grow to be a substantial portion of the market. This has never come close to materializing. Second, it is difficult and costly to evaluate in borderline cases whether reinsurance is worth the cost. All of the larger insurers we interviewed, and some of the smaller ones, decided the administrative costs of the intensive review needed to make good ceding decisions simply wasn’t worth the payoff, and so opted out of the reinsurance pools.

For instance, in Florida, most indemnity insurers except for the very largest initially opted to participate, but since then the number has dropped off dramatically. Virtually no HMOs have ever participated. HMOs and the largest indemnity insurers opted out because
### TABLE 1
Reform Elements in Each Study State

<table>
<thead>
<tr>
<th>State</th>
<th>Reinsurance</th>
<th>Small Group Rating</th>
<th>Guaranteed Issue pre-HIPAA</th>
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<tbody>
<tr>
<td>Colorado</td>
<td>Voluntary</td>
<td>Adjusted community rating</td>
<td>Designated products</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Mandatory</td>
<td>Rating bands</td>
<td>Designated products</td>
</tr>
<tr>
<td>Florida</td>
<td>Voluntary</td>
<td>Adjusted community rating</td>
<td>All products</td>
</tr>
<tr>
<td>Iowa</td>
<td>Voluntary</td>
<td>Rating bands</td>
<td>Designated products</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Voluntary</td>
<td>Rating bands</td>
<td>Designated products</td>
</tr>
<tr>
<td>Ohio</td>
<td>Voluntary</td>
<td>Rating bands</td>
<td>Limited open enrollment</td>
</tr>
<tr>
<td>Vermont</td>
<td>Enacted but never implemented</td>
<td>Nearly-pure community rating</td>
<td>All products</td>
</tr>
</tbody>
</table>

Source: National Association of Insurance Commissioners, “Compendium of State Laws on Insurance Topics,” 2001. These study states are a sampling of the 29 states that initially authorized or created such risk spreading mechanisms. In a few states, these mechanisms were not implemented or were disbanded.

they feared that smaller insurers would use this mechanism more aggressively, thereby forcing the larger ones or those who are inexperienced in medical underwriting to pay assessments—which are based on market share—out of proportion to their use of the reinsurance pool. As reinsuring carriers gained experience with the Florida small group reforms, the larger participating insurers withdrew until at the end of 1996, participating insurers composed only 7.4 percent of the small group market. Most participating insurers have minuscule market shares. At the end of 1996, the largest participating insurer had 2.2 percent of the small group market, the next largest had 1.7 percent, the third largest .8 percent, and everyone else had less than .7 percent. Twenty-five of the 36 participating insurers had
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</thead>
<tbody>
<tr>
<td><strong>Colorado</strong> (1995 inception, closure in process in 2000)</td>
<td></td>
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<tr>
<td>Ceding carriers</td>
<td>15</td>
<td>16</td>
<td>16</td>
<td>15</td>
<td>9</td>
<td></td>
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<tr>
<td>Market share of</td>
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<tr>
<td>reinsuring carriers</td>
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<tr>
<td>Lives ceded</td>
<td>198</td>
<td>258</td>
<td>133</td>
<td>142</td>
<td>27</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Premiums $</td>
<td>535,574</td>
<td>877,910</td>
<td>327,400</td>
<td>430,955</td>
<td>332,269</td>
<td></td>
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<tr>
<td>Claims/life $</td>
<td>2,184</td>
<td>3,101</td>
<td>2,897</td>
<td></td>
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<td></td>
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<tr>
<td>Loss ratio</td>
<td>.81</td>
<td>.91</td>
<td>1.18</td>
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<tr>
<td><strong>Florida</strong> (1993 inception)</td>
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<td>Ceding carriers</td>
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<td>15</td>
<td>13</td>
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<tr>
<td>Market share</td>
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<td></td>
<td></td>
<td></td>
<td>22.7%</td>
<td>7.4%</td>
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<tr>
<td>of reinsuring carriers</td>
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<tr>
<td>Lives ceded</td>
<td>702</td>
<td>1,847</td>
<td>1,963</td>
<td>1,119</td>
<td>760</td>
<td>226</td>
<td>351</td>
<td>335</td>
<td></td>
</tr>
<tr>
<td>Premiums $</td>
<td>940,000</td>
<td>4,380,000</td>
<td>6,900,000</td>
<td>4,870,000</td>
<td>4,344,962</td>
<td>1,697,620</td>
<td></td>
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<tr>
<td>Claims/life $</td>
<td>1,352</td>
<td>4,482</td>
<td>5,448</td>
<td>5,310</td>
<td>6,860</td>
<td>9,389</td>
<td></td>
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<tr>
<td>Loss ratio</td>
<td>1.01</td>
<td>1.89</td>
<td>1.55</td>
<td>1.22</td>
<td>1.20</td>
<td>1.25</td>
<td></td>
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<tr>
<td><strong>Iowa (1994 inception)</strong></td>
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<tr>
<td>Ceding carriers</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>Market share of reinsuring carriers</td>
<td>&lt;15%</td>
<td>&lt;15%</td>
<td></td>
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<tr>
<td>Lives ceded</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums $</td>
<td>65,692</td>
<td>71,857</td>
<td>54,275</td>
<td>46,051</td>
<td>17,475</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims/life $</td>
<td>70</td>
<td>4,014</td>
<td>19,647</td>
<td>23,633</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss ratio</td>
<td>.02</td>
<td>.28</td>
<td>2.17</td>
<td>2.05</td>
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</tbody>
</table>

| **North Carolina (1992 inception)** |      |      |      |      |      |      |      |      |      |
| Ceding carriers | 13   | 18   | 17   | 19   | 19   | 20   | 20   | 20   | 20   |
| Market share of reinsuring carriers |      |      |      |      |      |      |      |      |      |
| Lives ceded | 80   | 293  | 292  | 401  | 405  | 315  | 228  | 220  |      |
| Premiums $ | 11,331 | 535,054 | 893,492 | 1,266,207 | 1,323,101 | 899,707 | 687,948 | 128,111 |      |
| Claims/life $ | 0    | 656  | 721  | 3,566 | 3,173 | 3,037 |      |      |      |
| Loss ratio | 0    | .36  | .24  | 1.13 | .97  | 1.06 |      |      |      |

| **Ohio (1994 inception)** |      |      |      |      |      |      |      |      |      |
| Ceding carriers | 3    | 8    | 10   | 14   | 11   | 11   | 10   |      |      |
| Market share of reinsuring carriers | Not Available |      |      |      |      |      |      |      |      |
| Lives ceded | 13   | 43   | 49   | 77   | 86   | 110  | 146  |      |      |
| Premiums $ | 21,983 | 101,038 | 195,749 | 252,295 | 320,597 | 352,509 | 123,352 |      |      |
| Claims/life $ | 722  | 1,345 | 3,025 | 7,428 |      |      |      |      |      |
| Loss ratio | .43  | .57  | .76  | 2.27 |      |      |      |      |      |

Sources: Data compiled from state insurance departments and from reinsurance pool administrators and annual reports. Data for 2000 are as of September. Most states allow insurers two years to submit claims, so claims and loss ratios are reported only through 1997 in most cases. Blank cells indicate pool not operating in that year, or data not available.
less than .1 percent market share. In subsequent years, participation continued to fall precipitously, to 5 percent of the market in 1997, and still lower in 1998 (Table 2).

For insurers who continued to participate in reinsurance, several in different states reported that, initially, they were reinsuring too readily. Thus, they were ceding risks whose eventual claims payout was less than the reinsurance premium. Some insurers initially reinsured any case automatically that they previously would have rejected, but they quickly found this approach is not economical. This is reflected in the fact that the loss ratios (claims cost paid divided by premiums received) for the reinsurance pools in all states except Florida were well below 100 percent in their early years (Table 2).

As a consequence, insurers became much more selective about which cases to cede. One insurer observed that, because of the substantial premium and the large deductible, one has to expect $10,000–15,000 of claims in the first year for an individual or $20,000–25,000 for a group before reinsuring pays off. As a result of greater selectivity, the number of ceded lives dropped substantially in all of our study states except Ohio (and Iowa, which has had extremely low activity since inception). Loss ratios for reinsured cases climbed, significantly in the cases of Iowa and Ohio (Table 2). More selective ceding also can be seen in the several-fold increase in claims per ceded life that occurred in all states except Colorado (Table 2).

The same pattern is seen in the need for assessments to fund reinsurance pools. Initially, such assessments were modest or nonexistent in most states since the reinsurance premium was sufficient to pay most or all of the claims made to the pools. However, as ceding became more selective, the rising loss ratios have required more significant assessments in some states. Assessments are proportionate to the small group market share of insurers who participate in the reinsurance pool.

In contrast with the states we surveyed, Connecticut has an active reinsurance pool. It is noteworthy because of certain design features that account for its greater activity. One knowledgeable person observed that it is helpful to distinguish two purposes for reinsurance pools. The standard type of reinsurance pool functions only as a limited “safety net” to protect insurers against the most catastrophic cases. The alternate version seeks to redistribute a large portion of the higher risks that all carriers have, by inducing market
wide participation and by encouraging more ceding. Connecticut follows the second model by requiring that all insurers participate in paying assessments for excess losses. Once insurers are subject to these assessments, they are much more willing to cede risks in order to receive their share of the benefits of reinsurance. In addition, the mandatory model as practiced in Connecticut provides incentives to carriers to cede lives to the pool by offering lower risk retention limits and reduced administrative requirements than pools in other states. It also encourages insurers to market to one- and two-life groups by allowing these groups to be ceded to the pool after the carrier has covered the group for two years. Thus in Connecticut, 21 out of 30 carriers (representing about 95 percent of the market) have used the pool for some significant period over the course of the last 10 years.

Despite this broader participation, the Connecticut reinsurance pool still accounts for only a small share of the market. At the end of 1999, there were 3,457 lives in the pool, which is roughly 1 percent of the market. The Connecticut pool pays out approximately $12 million a year in claims, which accounts for roughly 2 percent of all claims in the small group market. However, even these small percentages are one or two orders of magnitude (10 or 100 times) greater than the reinsurance activity in most other states.

Industry Views

When market reforms were being proposed in the early 1990s, major portions of the insurance industry insisted that a reinsurance mechanism was essential for reforms to succeed [Hall 1992, 108–24]. However, by 1997, very few of the insurers we spoke to thought highly of public reinsurance. Larger insurers that initially supported the idea in concept quickly found from initial experience that it was not necessary for them since they could purchase their own commercial reinsurance, so they soon withdrew from the voluntary reinsurance pools or never joined in the first place. This has resulted in a dynamic in which the reinsurance pools have progressively shrunk in most states. As larger insurers withdrew, medium-sized insurers found that they were required to pay the largest portion of assessments, and so they reconsidered their decision to participate, leaving even smaller insurers at the top of the list. One observer said that, when an insurer's share of the reinsurance pool grows to 20 percent, it
starts to get nervous about its exposure to assessments. Like a game of musical chairs, no insurer wants to be the largest one standing when the music stops. Accordingly, participating insurers in the re-insuring states we studied account for at most only about one-third of the small group market (North Carolina), and in other states only 2–15 percent of the market.

Because of this "musical chairs dynamic," pooling mechanisms in the individual market are usually mandatory. In the individual market, there are far fewer participants and market concentration tends to be much greater, which produces a much greater potential that voluntary participation will result in too small a base to support a pooled assessment structure. Moreover, even with mandatory participation, it may be necessary to spread the pool's costs beyond the individual market to carriers in the group market, as is done, for example, in New York and New Jersey (American Academy, 1996).

In the small group market, most of the smaller insurers that have remained in the reinsurance pools do not look on them with great favor. Most feel that, on balance, they lost money, especially in the early years when experience with reinsurance was still new. Those that have come out ahead feel that the amount of protection is not substantial, perhaps accounting for only 1–2 percent of their loss ratios. One small insurer called reinsurance a "shell game" that smooths out some of the worst risks but has no long-range impact on costs or profitability, and another explained that this is exactly how it is meant to function. Both large and small insurers fear that their competitors will use the reinsurance mechanism more aggressively or accurately than themselves, thereby forcing them to pay assessments out of proportion to their use of the reinsurance pool. To come out ahead, an insurer has to gain more from ceding than the assessments it will receive based on its market share. Therefore, one subject explained that insurers engage in "defensive ceding," meaning they cede risks not because they believe they can't bear the risk, but instead because they don't want to be less aggressive in ceding than are the other insurers whose ceding forms the basis for assessments.

Other subjects explained that it is not so much the volume of ceding that determines success but its accuracy, which requires "keen underwriting" and a much more hand-picking type of evaluation than some insurers are accustomed to. Larger insurers complain that this is a type of underwriting that smaller insurers have
more mastery of and so the larger insurers' chances of "hitting the jackpot" are lower, or they have to "double underwrite" to make sure they aren't missing bad cases that others are picking up. If a larger insurer's prediction ability is not as good as the smaller insurers', then not only might the larger carrier end up paying more reinsurance premium than it receives in reinsured claims benefit, it might also end up paying through the assessments for the excess claims generated by the insurers that are more accurate. The same complaint was also heard from some smaller insurers, and one subject noted that HMOs have superior risk selection skills because of their greater access to medical expertise and medical data.

Underwriting gains and losses and total gains and losses in fact vary considerably among participating insurers. In Florida, for instance, according to an analysis by the Lewin Group, one-third of the 21 insurers with ceded lives in the pool in 1995 made money that year, based on premiums paid versus claims paid. Gains ranged from $22,018 to $2,713,173. The other two-thirds lost amounts ranging from $1,304 to $959,166. After including the assessments that were paid (based on market share), four insurers came out ahead, with gains ranging from $36,281 to $1,927,262. Reinsurance losses were as high as $1,133,169, but most were less than $100,000. Although the two largest insurers in 1995 came out ahead, the next four largest were among the top money losers, confirming that the larger participating insurers feel greater exposure.

This is not simply an issue of rivalry within the industry, however. Because reinsurance naturally tends to favor insurers with better risk selection skills, it is in tension with one of the purposes of small group reform, namely, to reduce administrative costs and to focus competitive energies on managing the costs of care. One person involved in Colorado's reinsurance administration regrets that this mechanism has institutionalized the very underwriting techniques and efforts that small group reform was intended to reduce or eliminate: "Because of the way the [reinsurance] system is set up, ... underwriting now is just as important to an insurance company as it ever was. Because otherwise how do I know who I reinsure?" However, this form of risk selection occurs behind the scenes, and it enhances rather than impedes the availability or affordability of insurance for higher risk subscribers.

Several other positive comments were made by interview subjects, indicating that reinsurance might be serving useful functions
even if it is not much used. First, reinsurance has some positive effect on insurers' willingness to accept higher risks. For instance, one subject reported that some insurers encourage agents to pursue and write business more aggressively without worrying about health conditions because reinsurance is available up to two months later if serious conditions emerge on the health statement. This subject also noted that reinsurance might be especially helpful in encouraging insurers to accept self-employed applicants, which are not covered by the federal guaranteed issue law (HIPAA).

Second, some subjects noted that the reinsurance premium serves as a modulating device that regulators can use to influence market conditions as a whole. If reinsurance appears too expensive and regulators detect increasing signs of covert risk selection, they can lower the premium to take pressure off insurers and encourage taking more risky groups. Or, if the reinsurance pool is being used excessively and assessments are mounting, the reinsurance premium can be raised.

Third, reinsurance might be important for insurers with small market shares to remain in a state, so they can continue trying to compete in a guaranteed issue environment without too much fear that they will suddenly receive a disproportionate batch of bad risks. One insurer with small market shares said that it did not remain in markets with adjusted community rating unless there was a reinsurance or risk adjustment mechanism. For instance, this carrier withdrew from Vermont but remained in New York and New Jersey. Another small insurer confirmed that reinsurance is an important factor in its decisions about which states to compete in. This effect is assuming increasing importance as the number of insurers participating in small group markets has dropped significantly in recent years.

However, it is questionable how many insurers enter or leave markets based on reinsurance. One insurer we interviewed, who said it does well under reinsurance, also said reinsurance has "no influence" on its strategic marketing decisions. In Florida, a 1996 survey by the Lewin Group of 13 reinsuring carriers found that most (61 percent) would stay in the Florida market even if reinsurance were not available, and only one of the 13 would definitely leave the market. In Vermont, insurers never encouraged regulators to implement the reinsurance mechanism called for by the law, even though Vermont has one of the most stringent versions of the reform law. How-
ever, most insurers eventually left the market, in part because of problems of adverse selection (Hall 2000a). There is no indication from our research whether a reinsurance mechanism would have improved this situation.

Conclusion

Small group market reforms appear to be modestly successful in achieving their limited goals (Sloan, Conover, and Hall, 1999). However, public reinsurance has not been a crucial ingredient to successes achieved. The performance of market reforms appears to bear little relation to whether a state has a reinsurance pool. Small group reinsurance pools have been used much less extensively than was originally anticipated. This may be due to the fact that small group reforms have not prompted large numbers of new, high risk subscribers to purchase coverage, as was first feared. Also, larger insurers would prefer to absorb the excess costs of high risk subscribers than be subject to paying assessments for reinsured losses attributable to other, smaller insurers. As a consequence, participation has dropped, and reinsurance plays only a very minor role in the small group markets we studied.

Despite the low and diminishing level of use, reinsurance pools may still have a beneficial effect on small group markets. They counteract the primary insurer's temptation to circumvent the law when faced with very bad risks. Moreover, they encourage the smallest insurers to remain, or enter, the market, which promotes greater choice and creates the potential for more competition.

Reinsurance pools spread only a very small portion of abnormally high health risk across the market as a whole. For reinsurance to play a greater role in spreading risk, participation in pools must be mandatory, unlike the current situation for small group pools in most states. Mandatory participation requires all insurers to contribute to assessments according to their respective market shares, but still allows each carrier to decide when it is advisable to cede individuals or groups to the pool (which requires paying a reinsurance premium). As illustrated by Connecticut, and by the pools in non-group (individual) markets, this can result in a reinsurance pool playing a larger, but still limited, role in how the market functions. On the other hand, mandatory assessments may discourage some
insurers from remaining in or entering the small group market in a particular state. Therefore, a third alternative to consider is to use government revenues to partially or entirely subsidize excess costs, as is done with some state high risk pools.

The major disadvantage to administered reinsurance is that it encourages insurers to compete and profit by using underwriting and risk selection techniques, rather than with efficiency-enhancing innovations. However, the only viable alternatives to prospective reinsurance are either to allow insurers to increase their rates for higher risks, or a mandatory system of retrospective risk adjustment, which creates an administrative formula for measuring and adjusting insurers' relative risk pools. In theory, administered risk adjustment could be superior to reinsurance if a good risk adjustment measure were developed, but so far the ones in use are flawed (Newhouse, 1998). Perhaps in the small group market, it is possible to implement reforms without either reinsurance or risk adjustment, but some method to deal with catastrophic cases is essential for implementing comprehensive reform of the individual market.

References


