12-1-2018

The Private Insurance Market: Not Very Big and Not Insuring Much, Either

Jacqueline R. Fox

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Introduction

Currently, the United States spends more than $10,000 per person each year on health care, roughly 18% of gross domestic product[1] and far more than other high-income countries.[2] At the same time, close to 80% of the population consistently worry about access to necessary care.[3] There are news reports of turmoil in the individual insurance marketplace, with insurers raising prices and threatening to leave markets in the face of both political instability and market pricing problems as state governments, Congress and CMS attempt numerous schemes for the purpose of supporting private insurers so that insurance is available and affordable.[4]

It is not a leap, in light of these facts, to question what private insurance offers the United States and if creating a single, tax payer funded national pool would, in fact, cause upheaval or loss by disturbing this industry.

On July 29, 2018, the Centers for Medicare and Medicaid Services (CMS) approved a waiver for the Wisconsin healthcare marketplace.[5] This waiver, known as a §1332 waiver,[6] creates a federally and state funded reinsurance or stop-loss program for individual insurance policies sold on the state exchange. Between 50% and 80% of claims between $50,000 and $250,000 will be paid with tax dollars, with a predicted 83% of the $200 million cost of the program coming from federal funds.[7] The assumption underlying the waiver is that volatility and pricing problems in the marketplace will be reduced by this plan, reducing federal premium subsidies overall, which reduction, in turn, will fund the waiver.

This waiver and its economic assumptions are one example of why a national health insurance pool, funded by tax dollars, will not destabilize the economy by interrupting a functioning and effective private insurer marketplace but, rather, will bring stability and lead to a more efficient and rational insurance pool. The waiver's very existence is evidence that health insurance is not functioning well. As explained below, these problems extend beyond the individual marketplace into the entire industry.

With the Wisconsin 1332 waiver, the federal government takes on the task of providing insurance,

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The Journal of Law, Medicine & Ethics, 46 (2018): 877-882. © 2018 The Author(s)
DOI: 10.1177/1073110518821983

using tax dollars to both shore up the health insurance industry's ability to handle health care costs and continue providing the money to pay premiums, as they are too expensive for many people to afford themselves. Realistically, these are the only two jobs health insurers have, providing insurance with affordable premiums, and in Wisconsin's waiver, we see they cannot perform them.

Given that health care is a significant portion of the United States economy, however, it is important to consider how large the financial implications of dramatically changing the health insurance industry truly are. As discussed in more detail below, the health insurance industry is not primarily involved in actually handling the tasks associated with insurance for the majority of Americans, given that it only insures a relatively small percentage of them, is heavily subsidized by federal and state tax dollars, and has a business model that shifts risks of medical costs to other parties, carrying relatively little of it itself. Additionally, insurance companies already handle claims processing for Medicare[8] and could do so for a new pool, further minimizing any disruption.

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The Relatively Small Size of the Private Health Insurance Marketplace

There are 328 million people in the United States. Of these, 27% (87 million) have insurance provided by a private health insurance company as defined here. This is a significant number, but not an exceptionally large market share. As of 2018, 44% of the population (around 146 million people) are provided health insurance through programs run by federal or state governments. According to Centers for Medicare and Medicaid Services (CMS) data, as of 2018, 59.1 million people were enrolled in Medicare (federal health insurance for the elderly or disabled);[9] and 80 million people were enrolled in Medicaid (combined federal and state health insurance for low income people) and CHIP (a federal program for children of families with low income).[10] Additionally, 9.4 million people receive coverage through Tricare (federal health insurance for active duty military and their families)[11] and more than 9 million people are cared for by the Veteran's Administration (VA) (federal health insurance for military veterans).[12] The coverage numbers above are then reduced by the people who are enrolled in both Medicare and Medicaid (known as dual coverage), which totaled 11.7 million people in 2016[13] thus totaling 146. Additionally, as of 2016, around 28 million people had no health insurance, meaning they were not currently enrolled in any program.[14]

Almost half of the country receives health insurance through a family member's or their own employer (49%,[15] 161 million people as of 2018) but, due to efficiency concerns and federal law incentives, a large number of employer insurance plans are "self-insured," meaning that the company is responsible for paying all healthcare costs rather than purchasing group coverage from an existing insurance company.[16] Overall, 60% of all employees (96.6 million people) with employer-sponsored coverage are in self-insured plans, the majority of them in large companies.[17] While these self-insured companies often hire health insurance providers to manage the benefits offered, the health insurance companies are not insuring the beneficiaries.

Widespread Use of Stop Loss Insurance and Reinsurance

Private insurers carry relatively little risk of having to pay for expensive medical care due to their widespread use of stop loss insurance. This can be provided by governments, as in the example from Wisconsin given above, purchased from reinsurance or stop loss companies, or provided through complex financial transactions with sophisticated investors. The idea that health insurers are not actually insuring is counterintuitive, but in fact they often function as middlemen, bundling and selling risk.[18]

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For purposes of this discussion, it is helpful to think of a typical health insurance policy as allocating risk of loss. The funds insurers use to pay healthcare expenses come from premiums that are put into a pool. Purchasers of insurance are the beneficiaries of this pool. Beneficiaries who require care also have additional expenses in addition to their premiums. A policy generally has a deductible (the amount the beneficiary must pay before the insurance company pays anything). There is often a co-payment (a small amount paid for every doctor or hospital visit) and co-insurance (the set percentage of costs that the beneficiary will pay after paying the deductible), as well. Finally, most insurance policies have a cap on beneficiary payments, past which the insurance company covers the full cost of care for the rest of the calendar year. A typical plan might have a $1000 deductible for an individual, a $20 co-payment, 20% co-insurance, and a cap of $12,000.[19] There might also be separate deductions and co-payments for pharmaceuticals.

Looking at the arrangement described above, the risk of loss in the plan is transparently broken into a few tranches (or segments). The beneficiary has the risk of loss for the first $1000 of care they might need in any given year. They are, in effect, self-insured for this. Once they exceed $1000, they share the risk with the insurance company, 20/80, until they have spent $12,000 and then bear no risk of loss for medical costs until the next year. Their total self-insurance liability is $12,000. With no reinsurance, an insurance company would then bear the risk of loss for any expenses that exceed the amount paid for by the beneficiary. That loss, in turn, would be paid from the pool of all beneficiaries' premiums.

Given that health insurance companies divide risk into the tranches described above in most insurance contracts, it is not surprising that they also purchase reinsurance for specific levels of claims or costs from numerous companies. Simply put, the money to purchase the reinsurance comes from the pool of premiums and is used to insure the pool. This behavior is commonplace in the insurance marketplace and not nefarious. However, it highlights how health insurance companies often do not actually function as traditional insurers in that they generally do not bear the risk for larger and/or catastrophic costs, instead purchasing coverage from other entities.

The use of reinsurance and stop loss coverage for both private insurers and self-insured employers highlights the risk exposure benefits of large health insurance pools and its corollary, the increased exposure of smaller ones. It is extremely difficult to devise an insurance product that can cover a small population for a small chance of an extremely expensive event. It is possible, even likely, that the expensive event will never occur, but if it does, the cost is beyond what a small group can reasonably collect by pooling their resources. In a bigger pool, it is far more likely the event will happen, but the cost is spread out.

An example would be if a small community decided to create its own fire insurance pool. Accounting for the chance of the occasional fire would be fairly easy. A fire that spread across an entire neighborhood would be catastrophic, rare, and most likely drain the insurance resources. Multiple neighborhood fires would be even more rare and more financially unbearable. If the pool contained thousands of diverse small communities, however, the larger pool could flatten that spike of risk exposure. Having multiple communities in the pool increases the likelihood of a spreading fire, but the risk would be spread across many more people.

The same logic that applies to the fire insurance example above applies to health insurance, but with healthcare many more potentially catastrophic events have to be considered, making it more complex to predict for a small group.[20] Premature births, motorcycle accidents with brain injuries, and multiple organ transplants happen, but rarely. The larger and more diverse the pool, the easier it is to flatten all risk spikes across all participants because a small chance of something happening becomes a known cost if the population is big enough and those costs can be accounted for.

For both self-insured employers and private insurers, these spikes are managed by purchasing reinsurance from large reinsurance companies. There are two main types of reinsurance, ones that protect an insurer from excessive claims overall (generally referred to as reinsurance), and ones that function, like the Wisconsin waiver, to cover expensive claims (known as stop loss insurance for self-insured plans and as excess medical reinsurance for health insurers). Little data exists regarding the dollar amount of individual claims for which insurers or self-insured plans purchase reinsurance. However, it is possible to deduce common levels by examining laws seeking to limit exceptionally low stop loss coverage (also known as the "attachment point"). Maryland, for example, recently temporarily raised its limit from $10,000 to $22,500.[21] In 2002, the National Association of Insurance Commissioners proposed a model law that prohibited the sale of stop loss insurance with an attachment point below $20,000.[22] In addition, 60% of reinsurance of this type sold in the United States has an attachment point "less than" $150,000 per covered individual.[23]

Revisiting the typical insurance contract described above, the beneficiary has the first $1000 of risk, and then has some share of risk up to $12,000. Using the co-payments outlined above, a patient would have

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$56,000 of medical bills by the time they reached their maximum out of pocket costs. The insurance company would have $44,000 of liability. It is plausible, given the availability of stop loss insurance products with low attachment points, that the beneficiary could be bearing a share of the risk while a different company bears the rest.[24]

It is unclear how commonplace these contracts are with private insurers, as there is no reporting requirement and the companies, themselves, rarely acknowledge this system apart from within filings required from publicly traded, for profit companies. The products, however, are widely available and the reinsurance marketplace reports consistent growth in healthcare.

The individual health insurance marketplace is a relatively public and transparent area where one can clearly observe the limitations of the private insurance companies. Close to 12 million people purchase their insurance on a health insurance exchange created by the Patient Protection and Affordable Care Act (ACA). The ACA also created a series of temporary risk management programs to help smooth spikes of cost in small, new, and/or untested pools as the individual insurance market expanded. These programs, known as the Three Rs, included risk adjustment (shifting money from insurers who had less risky populations to those with riskier populations), reinsurance (collecting money from all health insurers and using that finite pool of funds to offset relatively expensive claims histories), and risk corridors (a method of redistributing outsized insurance company profits to companies with higher costs).

Federal and State Subsidies in the Individual Marketplace

The individual health insurance marketplace is a relatively public and transparent area where one can clearly observe the limitations of the private insurance companies. Close to 12 million people purchase their insurance on a health insurance exchange[25] created by the Patient Protection and Affordable Care Act (ACA).[26] The ACA also created a series of temporary risk management programs to help smooth spikes of cost in small, new, and/or untested pools as the individual insurance market expanded. These programs, known as the Three Rs, included risk adjustment (shifting money from insurers who had less risky populations to those with riskier populations), reinsurance (collecting money from all health insurers and using that finite pool of funds to offset relatively expensive claims histories), and risk corridors (a method of redistributing outsized insurance company profits to companies with higher costs).[27] The Three Rs, in a limited manner, combined the pools of all insurers in an area, using the combined funds to offset spikes that any one individual insurer had in its smaller pool and did so to encourage insurers to enter these marketplaces.

As the Three Rs wind down, the 1332 waivers such as Wisconsin's are now appearing, offering direct federal subsidization through stop loss coverage under the theory that this will reduce the cost of insurance overall, rendering the subsidies budget neutral. It should be noted that the Congressional Budget Office (CBO) does not necessarily agree with HHS and Wisconsin projections regarding the cost of this type of program, as it predicted a similar nationwide stop loss program would cost the federal government $6.8 billion each year.[28]

Wisconsin's waiver is important because it shows that a national taxpayer-based funding mechanism is uniquely situated to spread risk across the broadest possible population and that this is likely to reduce insurance costs. The waiver also shows that private insurers are not functioning well in the insurance marketplace, given that such a subsidy is required.

Looking at the insurance contract example again, with Wisconsin's waiver, the beneficiary would stop paying co-insurance when their care reached a cost of $56,000. The federal government would begin paying for their care when it reached $50,000. Assuming a prudent insurance company that has purchased

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reinsurance for claims that exceed $250,000 (the end of the federal subsidy), the insurance company would have a maximum risk of loss of $38,000 for that beneficiary.

Conclusion

In conclusion, the private insurance market insures a relatively small proportion of the country, and, due to reinsurance, stop loss coverage, and various forms of governmental subsidies, does not provide a substantial amount of actual insurance. Furthermore, private insurers cannot actually carry the risk of the small pools they work with. This flaw is deeply embedded in the system itself, as they cannot escape exposure to ruinous spikes of loss without cobbling together numerous inefficient methods of offsetting these risks to others. A national health insurance pool would be more efficient at spreading risk and less volatile. Given the industry's current business model, where it appears to do relatively little insuring and instead primarily manages benefits and serves as a middleman that arranges for other insurers to carry its risks, shifting the industry to managing benefits for a federal program would not be a change of sufficient magnitude to justify forgoing the benefits of a national pool.

Note

The author has no conflicts to disclose.

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