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Brief

What CHROs Need to Know About High-Risk Pools

High-Risk Pools – a Way to Broaden Cost-Sharing of Certain High-Cost Claimants?

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Highlights

- Starting in 1976, various States created 'high-risk' health care claim pools as a way of lowering the cost of individual-market health care insurance by funding (or socializing) the cost of high utilizers over a broader revenue source.
- By the time the Patient Protection and Affordable Care Act (ACA) was enacted, 35 States used high-risk pools to stabilize their individual medical insurance market with varying results.
- The ACA changed high-risk pools by requiring insurers to 'community-rate' individual coverage (i.e., throwing everyone's medical claims into a single pool and only charging people a different rate based on where they live and their age). To broaden the insured base, ACA required all individuals to have medical coverage or pay a penalty.
- To ease the transition to a community-rated insured system, the ACA authorized $5 billion for a "Pre-existing Condition Insurance Program" (PCIP), which saw minimal enrollment.
- With both PCIP and ACA's mandated community-rated approach in place, stand alone State high-risk pools that had previously operated to moderate the individual insurance markets ceased operations.
- The House Republican alternative to repeal and replace the ACA called for reforming the individual insurance markets. One aspect of that strategy was the creation and funding of State-run high-risk pools. These pools would spread high-cost claims across a broader revenue base to keep individual insurance more affordable. Given an affordable option, people would be expected to buy and maintain coverage without the need for an explicit mandate.
- Although the latest GOP efforts to repeal and replace the ACA have failed, it is important to understand the mechanism of high-risk pools as one proposed solution to the affordability problems that face the ACA. There will be continued interest in this option as Congress looks to stabilize the individual market.

High-Risk Medical Pools, What are They? High-risk medical pools started as separate insurance pools offering coverage to uninsurable individuals. The coverage offered typically cost far more and provided less coverage than insurance available to insurable individuals. Attempting to keep coverage somewhat affordable, States frequently capped the cost of coverage at 150% of what insurers charged for non-high-risk coverage. This forced States to look for other sources of revenue to keep these high-risk pools solvent, but in most cases, these other

sources of revenue were insufficient for that purpose with the result that the pools ended or needed to impose limitations admission or accessing benefits. As time passed, States also extended high-risk pool coverage to individuals who needed Medicare supplemental coverage, guaranteed issue coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other similar situations.

State-Run High-Risk Pools, The Pre-ACA Experience Connecticut and Minnesota introduced high-risk pools in 1976. But while high-risk pools have been around for quite some time, their financial viability has been spotty at best. The root cause was the lack of sufficient and diverse funding sources necessary to keep the program financially viable. The initial use of high-risk pools was for ‘pre-existing’ conditions. The high-risk pools were set-up to give insurance access to people who were otherwise ‘uninsurable.’ In 1996, Congress passed HIPAA that required individual medical insurance policies to be offered on a ‘guaranteed issue’ basis (i.e., available with no pre-existing condition exclusions) to qualified individuals who had lost group medical coverage. Many States expanded their ‘high-risk’ pools to include HIPAA individuals. By the time the ACA was enacted, 35 States were operating high-risk pools for their respective individual policy markets covering several different groups of individuals (i.e., not just individuals who were uninsurable).

The ACA’s Impact on State-Run High-Risk Pools The passage of the ACA changed the focus from the availability of affordable individual medical coverage to mandating that everyone have coverage (or pay a penalty), implicitly assuming that if everyone was forced to maintain coverage, enough people would be paying into the insurance system such that the cost of coverage could be economically spread across the insured population. ACA allows very few differences in the cost of coverage, primarily differences in age and geography. Individuals who could not prove that they had qualifying medical coverage for the entire year are charged a penalty on a month-by-month basis. The amount of the penalty is only a fraction of the cost of purchasing coverage. To ease the transition to the ACA exchanges, Congress funded $5 billion for a “Pre-existing Condition Insurance Program” (PCIP). The PCIP was available to subsidize the cost of medical coverage for individuals with pre-existing conditions and other health-related issues who needed to purchase insurance before the ACA exchanges were available. With the passage of ACA and the mandate that all insurance coverage be priced using essentially a single claim pool approach, State-run high-risk pools became unnecessary and ended.

State-Run High-Risk Pools, The Renewed Interest The unsuccessful House Republican “American Health Care Act” bill has renewed the discussion around State-run high-risk pools. From an overarching perspective, the House Republican approach to ACA ‘repeal and replace’ was to institute insurance markets reforms at the State-level designed to increase competition thus lowering the cost of individual coverage. Trusting that people will do the right thing given reasonable choices, the House Republican proposal looked at ways to make individual coverage more affordable with one of the center pieces being funding of State-run high-risk pools. The idea is that States would have Federal funds to pay for high-cost claimants thereby keeping the insurance costs down for low health care utilizers. The belief is that given an acceptable price point, low health care utilizers will spend the money on reasonably affordable insurance.

Potential Impact on Employer-Sponsored Coverage About two-thirds of all individuals receive medical coverage through an employer-employee relationship (including dependents). To the extent that reforms in the individual coverage marketplace mean more people are covered, the cost of their coverage should be borne by the insurer (or the government). Historically, the government (as a payer of health care) does not pay 100 cents for every dollar of health care the government consumes. This results in unreimbursed or under-reimbursed health care costs being shifted to employer-sponsored plans. The cost growth that private employers have experienced is the result of absorbing both general cost increases in medical care related to their covered lives, as well as the cost-shift that occurs from greater covered lives on government programs that are not fully compensating providers for the cost of goods and services consumed. Whether State-run high-risk pools help or hurt employer-sponsored coverage will largely depend on how many additional covered individuals utilize medical services and the extent to which those costs are covered (or not covered) by government reimbursements.

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