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Health Care Reform – High-Risk Pools

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act (AHCA) by a vote of 217-213 to repeal and replace the Patient Protection and Affordable Care Act (ACA). The AHCA makes significant changes to current law affecting health insurance coverage, costs, and the stability of the health insurance marketplace. One way states can attempt to stabilize insurance markets is through the establishment of high-risk pools. Understanding the application of high-risk pools provides context for evaluating their utility under the AHCA.

History of High-Risk Pools

Prior to the enactment of the ACA, insurance companies exercised considerable discretion in determining who they would insure. Often insurers extended coverage to healthy individuals and denied coverage to those who would likely require care. This adverse selection (also known as cherry-picking) created a population of "medically uninsurable" individuals, many of whom were poor. These individuals had two choices: forgo care or receive necessary but unaffordable treatments.

In theory, high-risk pools provided a safety net by allowing individuals who had been denied coverage by private insurers to obtain insurance through a state-run program. High-risk pools functioned similarly to private insurance programs. Enrollees paid premiums and deductibles in return for covered services. Due to the large proportion of enrollees with high medical claims, high-risk pools operated at a loss to the state.

Inadequate funding posed one of the greatest threats to the success of high-risk pools. To control costs, most high-risk pools included provisions to limit the number of enrollees. These included the exclusion of coverage for pre-existing conditions up to 12 months after enrollment, premiums 1.5- to 2-times higher than standard non-group market rates, high deductibles, and annual or lifetime limits. Some states capped enrollment in an effort to further contain expenditures. These barriers made coverage less accessible to individuals in need, undermining the effectiveness of the programs.

The Missouri Health Insurance Pool

Individuals enrolled in Missouri's high-risk pool, called the Missouri Health Insurance Pool (MHIP), confronted financial barriers to coverage and care. On average, MHIP enrollees paid $626 per month in premiums (approximately 1.3 times the prices charged to individuals insured through the standard non-group market). The majority of members carried a $5,000 in-network deductible. Premium subsidies were offered to enrollees under 300 percent of the federal poverty level, but the subsidies were small and provided little relief. Furthermore, coverage limitations prevented enrollees from accessing needed services. In addition to a $1 million lifetime maximum for medical claims, enrollees seeking treatment for alcohol and substance abuse disorders were limited to a lifetime maximum of 10 episodes of care. In 2012, approximately 4,000 individuals enrolled in MHIP, while 834,000 Missourians remained uninsured.

High-Risk Pools and the ACA

The ACA increases affordability for individuals with pre-existing conditions by requiring insurers to place all covered individuals into a single risk pool. Insurers are prohibited from denying coverage to individuals with pre-existing conditions and cannot charge higher premiums based on health status. Insurers price their products using a community rating system with all enrollees paying the same price regardless of usage.

The law also imposes a 3:1 age rate band, which prevents insurers from charging older enrollees (aged 55-64) more than 3-times the prices charged to other enrollees. When combined with the individual mandate, these and other consumer protections provide a mechanism by which individuals with pre-existing conditions can access affordable health insurance. With the protections afforded by the ACA making high-risk pools irrelevant, the majority of states (including Missouri) stopped operating them.

High-Risk Pools and the AHCA

Eliminating income-based tax credits, cost-sharing subsidies, and expanding age rating bands as proposed in the AHCA would increase premiums for older and low-income individuals, many of whom have pre-existing conditions. Some of these individuals would be "priced out" of coverage, increasing the nation's uninsured. High-risk pools have been proposed as a way to increase protections for people with pre-existing conditions despite their lack of proven effectiveness. While the AHCA does not explicitly propose to establish high-risk pools, several provisions provide states with the flexibility to do so. One provision called the Patient and State Stability Fund appropriates $100 billion over 10 years to help states attract insurers and lower costs for consumers. States could use these funds to establish high-risk pools, or finance other programs designed to stabilize their insurance markets.

Since the bill's introduction, a number of amendments related to high-risk pools have been introduced, including the Invisible Risk-Sharing Amendment, the MacArthur Amendment, and the Upton Amendment.

The Invisible Risk-Sharing Amendment

The Invisible Risk-Sharing Amendment, proposed by Representatives Gary Palmer (R-AL) and David Schweikert (R-AZ), appropriates $15 billion over 9 years to establish a "federal invisible risk-sharing program" within the Patient and State Stability Fund. Invisible risk-sharing programs, also known as invisible high-risk pools, combine characteristics of traditional high-risk pools with reinsurance programs. Under these programs, people purchasing insurance on the individual market are required to complete a health questionnaire prior to enrolling. Insurers use the questionnaires to assess each person's health status, placing individuals who are likely to require expensive medical care in the invisible high-risk pool. Insurers forfeit a large portion of high-risk pool enrollees' premiums to a governing entity (in this case, the federal government) and are reimbursed a percentage of the claims the individuals incur above a certain threshold. The programs are called "invisible" because high-risk pool enrollees are often unaware that their insurer has entered such an arrangement.

The federal invisible risk-sharing program proposed in the amended AHCA models a program currently operating in Maine. Maine's program, called the Maine Guaranteed Access Reinsurance Association (MGARA), substantially reduced premiums in the state's individual marketplace. Under MGARA, monthly premiums for some plans dropped 50-70 percent. This translated to approximately $5,000 per year in savings for individuals in their 20s and $7,000 per year in savings for enrollees age 60 and up. It is important to recognize that some of these savings resulted from increases in co-insurance and out-of-pocket maximums. Covered benefits for newly offered plans also became less generous. For example, the state's largest insurer (Anthem) eliminated coverage for maternity care.[1]

An actuarial analysis conducted by the firm that evaluates MGARA suggests that the $15 billion proposed would likely fall far short of the amount required to successfully run a federal invisible high-risk pool. In reality, the program would require an estimated $3.3 to $17 billion per year, not including insurers' contributions. Over 9 years, the required amount could exceed $153 billion.

[1] Prior to 2014, when the ACA required insurers to cover maternity care as an Essential Health Benefit

The MacArthur Amendment

The MacArthur Amendment authorizes states to seek waivers from the U.S. Department of Health and Human Services to exempt insurers from a number of requirements set forth in the ACA. Examples of these waivers include:

- ***Expanding the age rating band.*** States receiving this waiver could allow insurers to charge older enrollees more than 5-times the prices charged to younger enrollees. This would decrease prices for younger people and substantially increase costs for older people who are more likely to have pre-existing conditions.
- ***Redefining minimum Essential Health Benefits.*** The ACA requires plans in the individual and small group markets to cover 10 minimum Essential Health Benefits (EHBs). This waiver would exempt insurers from the ACA's requirement, allowing states to define their own EHBs. The amendment's supporters believe this will enable states to best meet the needs of their unique populations. Opponents argue that dissolving the national standard will have negative impacts, such as loss of healthcare access and weakened consumer protections.
- ***Opting out of the community rating system.*** This waiver would allow insurers to set premiums for individuals who fail to maintain continuous coverage based on health status, under the condition that the state establishes a high-risk pool, reinsurance program, or participates in the proposed federal invisible risk-sharing program.[2] Authorizing insurers to set premiums based on health status would increase costs for individuals who do not maintain continuous coverage. This would be particularly harmful for low-income wage earners, whose less predictable incomes may result in temporary loss of insurance coverage.

The Upton Amendment

The Upton Amendment provides $8 billion from 2018-2023 to assist individuals whose premiums and out-of-pocket costs rise as a result of the waivers proposed in the MacArthur Amendment. The text does not specify how states must use their allotments. For example, the money could be used to fund state high-risk pools or provide subsidies directly to consumers. The fund's adequacy will ultimately depend on the number of states that are granted waivers and the nature of the proposals.

Conclusion

Many of the AHCA's provisions will increase health insurance costs for individuals with pre-existing conditions. Decreased affordability will lead to a greater number of people with health problems becoming uninsured. The AHCA relies on high-risk pools and other market stabilization programs to offset rising uninsured rates. However, states' experiences with high-risk pools cast doubt on the programs' efficacy. Although high-risk pools provided a safety net for some, high premiums, deductibles, and coverage limitations prevented many from obtaining meaningful insurance. In fact, estimates suggest that high-risk pools covered less than 1 percent of the population they intended to insure. As Congress continues to debate the future of the ACA, policymakers at the state and federal levels should look to these experiences for lessons learned.

Endnotes available upon request.

[2] Failure to maintain continuous coverage is defined as a lapse in coverage for 63 days or more within the last year