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POLICY NOTE

High-risk pools work well in covering hard-to-insure patients

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Key Findings

1. The total number of people contributing money to a health insurance pool should be much larger than the number of people in the pool who actually need health care at any given time.
2. Unless the health coverage risk pool is quite large, a few high-cost users of health care can financially devastate a given group of insured people.
3. Research shows that a very small percentage of patients account for a very high percentage of total health care costs.
4. It is good public policy to financially protect high-users of health care and at the same time protect other members of their insurance pool.
5. High-risk pools work best with a stable and predictable funding source, one that is protected from politics.
6. If permitted by federal law and successfully operated by states, high-risk pools can be an effective alternative to forcing everyone to pay higher health insurance premiums because of a few people with costly pre-existing conditions.

Introduction

Health insurance should function like any other type of insurance. The total number of people contributing money to the insurance pool should be much larger than the number of people in the pool who actually need health care at any given time. In this way, the insurance company would have enough money in its reserve fund to cover the expenses of those enrollees who use medical services.

The health insurance market is different than home-owner or automobile insurance markets, however. There are many more insurance risk pools in the health care system. For example, the vast majority of large employers self-insure and have their own risk pool. Medicaid has a different risk pool for every state. The individual market is divided by multiple insurance carriers in each individual state. Unlike drivers and homeowners, there are many different ways people receive health coverage.

Unless the health coverage risk pool is quite large, a few high-cost users of health care can financially devastate a given group of insured people and cause financial destruction of that particular pool. For that reason, high-risk pools can be used to financially cover those individuals who consume an extremely large amount of health care.

In the past, individual states set up high-risk pools with varying degrees of success. Each state had its own enrollment criteria. Washington state's program began in 1988 and was one of the better functioning programs. In 2010, the Affordable Care Act (ACA) essentially eliminated them because of the pre-existing insurance mandate and the elimination of life time limits on insurance payments.

Opponents of high-risk pools claim the pools are not effective insurance, do not hold medical costs down, and should not be reinstituted.

However, high-risk pools can offer a practical and compassionate alternative to the pre-existing condition mandate in the ACA. This Policy Note reviews the history of high-risk pools, examines what the successful ones had in common, and makes recommendations for the viability of creating future high-risk pools.

Composition of high-risk pools

High-risk pools began operating 41 years ago in Minnesota and Connecticut. By 2011, 35 states, including Washington, had such programs.[1] The Affordable Care Act, which became law in 2010, initially provided a federal high-risk pool, but it was closed in 2014 when the health benefit exchanges and the expansion of Medicaid began. The ACA, with its subsidies and mandates, effectively took the place of high-risk pools.

The size of high-risk pools varied by state. In 2011, Washington's program covered 3,800 individuals, who represented 1.1 percent of the people in the state who were not enrolled in other government or employer insurance plans.

Four groups of people could potentially enroll in high-risk pools. Each state had its own criteria for inclusion. The largest group was composed of people who were essentially uninsurable because of extremely high medical costs. The second group was composed of seniors in the Medicare program who needed supplemental financial help. The vast majority of people in Washington's high-risk pool were from these two groups.

The third and fourth groups included certain people who had lost their group health insurance plans yet had pre-existing medical conditions and some people who lost jobs that were in trade-related industries. The people in the last two groups were protected by federal law which allowed them access to state-run high-risk pools.

Common features of high-risk pools

High-risk pools were structured differently, but they all had certain features in common.[2] Premiums were priced 150 percent to 200 percent above the standard non-group rate. Washington's were placed at 150 percent, although the state did provide subsidies to people with low-incomes.

Most states had deductibles paid by patients. Washington's deductible was only $500 annually and was on the low end of the spectrum.

All states covered people with pre-existing medical conditions, but each had a waiting period ranging from six to twelve months before the insurance coverage would begin.

Life time dollar limits on benefits varied, but most states had limits in the $1 million to $2 million range. Washington had no lifetime dollar limit on benefits.

Many states limited enrollment or had significant waiting lists for enrollment. The size of Washington's waiting list varied over time.

Most high-risk pools had less income than expenses and operated at a loss, with the difference made up by government payments. Income sources included health insurance premiums, assessments on insurance plans outside the high-risk pool, and government grants. Washington state had one of the most financially stable pools. In 2011, expenses were $95.8 million with an income of $97.2 million. One third of this income was from premiums, the other two thirds came from assessments on non-group health insurance premiums in the state. A very small percent came from taxpayers.

1 "High-risk pools for uninsurable individuals," by Karen Pollitz, The Henry Kaiser Family Foundation, February 22, 2017, at http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/.

2 Ibid.

Objections to high-risk pools

People on both the left and the right have objections to high-risk pools. People on the left argue that enrollees should not have to pay higher premiums and, if they have pre-existing conditions, they should not be excluded or have to wait for coverage to begin. They are also concerned that high-risk pools may have trouble remaining financially solvent and that because of abrupt closure of the pool, enrollees are always in danger of losing their health insurance.[3]

People on the right object to high-risk pools because of the taxpayer support and the assessments or surcharges imposed on other insurance premiums.

Policy analysis

Research shows that a very small percentage of patients account for a very high percentage of total health care costs.[4] In 2014, just one percent of all patients accounted for almost a quarter of all health care expenditures. These are not the same patients year after year.

Excluding the government programs of Medicare and Medicaid, private health insurance is divided by multiple groupings or standard risk pools. Many people with jobs have employer-paid insurance, through which each company forms its own pool of insured employees. People in the individual insurance market are segregated by state and by specific insurance companies.

Consequently, there is a high likelihood that these smaller risk pools will contain a person who develops a high-cost medical condition. There needs to be a way for these high-cost patients to continue receiving their medical treatment without financially destroying their existing risk pool or incurring unsustainable expenses.

It is good public policy to financially protect high-users of health care and at the same time protect other members of their insurance pool. This needs to be done in a financially responsible way. Because of the unstable and capricious nature of government budgets, taxes are not a guaranteed source of money. Although taxes may have a small subsidizing role, total funding of high-risk pools through taxes would make patients more dependent on government and politics, with the potential for more regulations and controls.

Solutions

High-risk pools work best with a stable and predictable funding source, one that is protected from politics. They should not punish enrollees with exorbitantly high insurance premiums. They should seamlessly transfer patients from the original insurance pool to the high-risk pool. The administration of high-risk pools should be efficient, should have independent oversight, and ideally should be administrated in the private sector.

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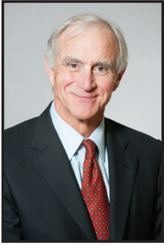
3 "Why high risk pools (still) won't work," by Jean Hall, The Commonwealth Fund, February 13, 2015, at http://www.commonwealthfund.org/publications/blog/2015/feb/why-high-risk-pools-still-will-not-work.

4 "Overview of who uses health care and incurs what percentage of health care costs," by Roger Stark, MD, Policy Note, Washington Policy Center, February 21, 2017, at http://www.washingtonpolicy.org/publications/detail/overview-of-who-uses-health-care-and-incurs-what-percentage-of-the-health-care-costs.



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Maine had an excellent example of an efficient and effective high-risk pool.[5] Starting in 2011, prior to the ACA pre-existing condition mandate, Maine established its high-risk pool for the individual market. People could continue their existing health insurance at the same premium rate or could change to a new plan at lower cost in the new pool. No one's plan was cancelled.

Insurance companies were encouraged to stay in the market by barring their re-entry for five years if they left the market. All enrollees filled out a health questionnaire which targeted eight specific medical conditions. A person with any of these medical conditions was placed in an "invisible" high-risk pool either upon enrollment or whenever that patient developed the condition. In other words, enrollees were not in a separate pool.

Maine set up a re-insurance company, the Maine Guaranteed Access Re-insurance Association (MGARA), which managed the high-risk pool. Insurance companies were required to pay 90 percent of their high-risk premiums to MGARA and, through a formula, were at risk for $10,000 per enrollee. MAGARA withheld premium funding if insurance companies were too aggressive about transferring people to the high-risk pool.

Forty percent of the funding for the high-risk pool came from the 90 percent of premiums paid to MGARA. The remaining funding came from a $4 per month per member charge on all policies in the original risk pool.

The state found that premiums decreased by up to 70 percent and all age groups experienced these decreases. It also found that enrollment for younger people increased substantially. Most importantly, Maine was able to provide health insurance for its high-cost, high-user patients, so the people with even the most serious medical conditions received care.

Conclusion

The Maine experience is an excellent example of a successful high-risk pool. The critical policy features are:

- The seamless transition of people into the high-risk pool.
- The sharing of the funding among all enrollees in the original pool with a small premium surcharge.
- The identification of high-cost health care users and their medical conditions.
- The ability of insurance companies to lower their premium rates and attract more young and healthy individuals into the system.

In Maine, all these policy goals were achieved through voluntary incentives, not coercion or mandates.

If again permitted by federal law and successfully operated by states, high-risk pools can be an effective alternative to forcing everyone to pay higher health insurance premiums because of a few people with costly pre-existing conditions. They should be seriously considered in the ongoing health care reform debate. High-risk pools can provide quality health care for the hardest-to-insure patients, while keeping health coverage affordable for everyone else.

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5 "Invisible high-risk pools: How Congress can lower premiums and deal with pre-existing conditions," by J. Allumbaugh, T. Bragdon, and J. Archambault, Health Affair Blog, March 2, 2017, at http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/.