



HIGH-RISK POOLS

BACKGROUND

A stable health insurance market relies on the premiums paid by healthy individuals to subsidize costs for those with high medical and drug costs. The Affordable Care Act (ACA) fundamentally restructured the health insurance market in the U.S. by requiring insurers to sell to all customers, regardless of health status, and not charge beneficiaries higher premiums due to pre-existing conditions. Despite a requirement to purchase insurance and financial assistance, exchanges have struggled to attract a balanced pool of healthy and more expensive beneficiaries, creating market instability.

Many Members of Congress have proposed creating high-risk pools to provide insurance to individuals with substantial health care needs as an alternative to the ACA. High-risk pools have potential to shift the general market risk pool, making insurance premiums in the general market more affordable and attractive to young, healthy individuals. However, prior experience with high-risk pools in the U.S. shows that they do not serve as an adequate way to offer affordable and meaningful coverage to those with more significant health needs without a significant amount of funding.

OVERVIEW OF HIGH-RISK POOLS

High-risk pools were designed to provide access to care for high-cost individuals. Typically, high-risk pools consisted of private and self-funded health plans regulated by states. Historically they were funded through an assessment on insurers, general state funding, and earmarked funding.¹ These plans were made available to the high-risk population that met enrollment requirements and did not have access to health insurance in the group market. Benefits for those covered in high-risk pools often resembled those which one could find on the individual market, although enrollees' costs were typically higher, given the likelihood of a higher utilization of services.

High-risk pools had very limited success extending health care coverage to certain individuals with pre-existing conditions. If compared to the coverage options associated with the ACA, high-risk pools, as historically constructed, were often underfunded, expensive, and featured limited plan choices with less robust benefits.

HISTORY OF HIGH-RISK POOLS IN THE STATES

Before the passage and implementation of the ACA, 35 individual states used high-risk pools to provide non-group health insurance for various segments of their populations. High-risk pools often provided coverage through state contracts that were negotiated directly with local insurance providers. The state's subsidy for these programs was paid in the form of premium assistance to the individual and/or a promise of risk protection for the carrier. Fifteen of these pools provided low-income premium subsidies that varied in comprehensiveness, while the other pools required people to pay their full premium, regardless of income.²

Historically, state-run high-risk pools generally targeted one of three populations:

- **The medically uninsurable:** defined as individuals who are not members of an employer plan and who had a past/present medical condition.
- **Individuals guaranteed coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA):** In accordance with the HIPAA, states may use high-risk pools to provide coverage to people who lost employer-sponsored coverage.

¹ The Council for Affordable Health Insurance. (2002, December). Issues and Answers: A State Checklist for Creating High-Risk Pools. Issue Brief Number 111.

² <http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>

- **Certain Medicare beneficiaries seeking supplemental coverage:** Eleven states extended coverage to Medicare beneficiaries who were unable to secure Medigap coverage due to medical reasons.³

People in most high-risk pools faced many barriers to access. For example, the pools often limited eligibility to individuals who had been uninsured for six to 12 months prior to enrolling. In addition, state high-risk pools often excluded coverage for pre-existing conditions, and 33 of the 35 states imposed lifetime or annual limits on benefits. Costs were also much higher. Premiums were 125-200 percent higher than the general insurance market and only covered about half of the cost of care.⁴ Overall, high-risk pools with minimal barriers to enrollment carried significantly greater costs, rendering many of them unable to insure all people with pre-existing conditions due to limited funding.

HIGH-RISK POOLS UNDER THE ACA

The ACA also created a temporary high-risk pool at the national level. The program, known as the Federal Pre-existing Condition Insurance Program (PCIP), was implemented in 2010 and provided coverage for the uninsured with pre-existing conditions through 2014. Like the exchanges, the PCIP program could be operated either through state or federal governments. Twenty-seven states chose to administer the program independently, while 23 states and Washington, DC deferred to the federal government. Unlike the previous high-risk pools operated by states, PCIP premiums varied by age, and low-income subsidies were not available. At the same time, PCIP included no annual or lifetime limits and capped out-of-pocket costs. PCIP participation was also only extended to individuals who had been uninsured for at least six months prior to enrolling. PCIP coverage ended as private non-group policies became available through the exchanges.

Originally, \$5 billion had been appropriated by Congress to run the PCIP program in its entirety through 2014. Enrollment in these plans was suspended in 2013 because officials projected the funding would not last through the year. In 2012, average per enrollee claims costs for PCIP were 2.5 times greater than the average per enrollee claims costs (\$12,471) under traditional state high-risk pools.

CONCLUSION

As lawmakers attempt to pursue high-risk pools as an alternative coverage source to the exchanges, it is important to understand the challenges they have created in providing meaningful and affordable coverage for those who most need it.

A number of factors indicate that high-risk pools will require very significant funding to be successful. Other challenges associated with high-risk pools include: costs of administration, costs to enrollees, and likely less generous coverage (e.g., exclusion of care for pre-existing conditions). In the past, state pools generally operated at a loss—i.e., medical claims are higher than premiums collected. Therefore, states were forced to draw financial support from additional sources or limit enrollment. Further, the enrollees who had significant health care needs were exposed to higher costs that often included high premiums and out-of-pocket costs on top of annual and/or lifetime spending limits. These factors indicate that high-risk pools may offer less generous and more expensive coverage for patients with pre-existing conditions, compared to the exchanges.

However, some stakeholders have proposed a novel solution that blends the concept of high-risk pools with the individual market. This “invisible high-risk pool” would allow for the creation of a state-based, reinsurance-like program. Reinsurance funding would ensure that plans enrolling higher-cost individuals have appropriate funds to pay for covered care. An invisible high-risk pool would provide funds to help states establish the program and could also contribute a portion of the funds required to maintain/fund the pool. Such a program has the potential to effectively mitigate risk for issuers while maintaining sufficient access and protections for higher cost patients, who might otherwise be at-risk under a more traditional high-risk pool program.

³ Karen Pollitz, “High-Risk Pools for Uninsurable Individuals,” August 2016. Kaiser Family Foundation.

⁴ Trish Riley and Barbara Yondorf, “Access for the Uninsured: Lessons from 25 Years of State Initiatives,” National Academy for State Health Policy, January 2000.