May 4, 2017

The Water's Fine: High Risk Pools After Obamacare

1. Relatively few people would ever need to enroll in an HRP. In 2014, enrollees in a temporary Obamacare pre-existing condition plan peaked at roughly 114,000 nationwide.
2. Those who do need an HRP cause massive rate increases for everyone else.
3. Some, but not all, state-run HRPs have achieved relatively reasonable prices for enrollees.

Debate regarding health insurance reform has reignited interest in high-risk pools (HRPs).[1] One form of an HRP is the "invisible risk pool," which the Joint Economic Committee Republicans have covered previously.[2] It is "invisible" because the high-risk enrollee is tagged for reinsurance support, but stays in the individual market. A traditional HRP involves the higher-risk enrollees shifting from the individual market into a separate insurance pool. Moving enrollees that require substantially more care would bring down costs for everyone else in the individual market, and allow for a more transparent subsidy for their insurance. Below are three facts lawmakers should consider as policy discussions move forward.

1. Most people won't ever dive into the pool.

The majority of working-age adults have insurance coverage through employer-sponsored health insurance.[3] Under the Health Insurance Portability and Accountability Act, health insurers cannot deny coverage or charge employees higher premiums because of health status if they switch to another employer with a different insurance plan.[4] Elderly Americans are covered by Medicare;[5] low-income Americans have access to Medicaid; and other programs serve veterans and other special populations. Effectively, this narrows the field to people seeking insurance in the individual market.

The American Health Care Act[6] with the proposed MacArthur amendment[7] states that no person can be turned down for insurance because of a pre-existing condition. Additionally, people with pre-existing conditions cannot be charged higher premiums based on their health if they maintain insurance coverage. States could apply for a waiver to base insurance premiums on health status, but only for those who don't maintain coverage. No waiver would be granted unless the state maintains an HRP or similar structure to help cover costs for people with pre-existing conditions.

Based on pre-ACA studies, the number of potential high-risk insurance customers in the individual market ranges between tens of thousands[8] to around 2 million people.[9] In fact, Obamacare instituted a temporary Pre-Existing Condition Insurance Plan until 2014 for people denied insurance due to a

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[1] Scholars at the American Enterprise Institute have written a longer form paper that offers a more significant insight into the possible benefits of a well-developed high-risk pool for states. See "A Better (but Modest) Case for High-Risk Pools," by Mark V. Pauly and Thomas P. Miller, https://www.aei.org/publication/a-better-but-modest-case-for-high-risk-pools/

[2] Joint Economic Committee Republicans, "The Invisible Risk Pool: State Innovation at Work," April 10, 2017, https://www.jec.senate.gov/public/index.cfm/republicans/analysis?ID=BECF5427-B59F-4D30-AFD2-1BE1E6A8E2E4

[3] Kaiser Family Foundation, "Employer Health Benefits Survey 2016," September 14, 2016, http://kff.org/health-costs/report/2016-employer-health-benefits-survey/

[4] 29 U.S.C. §1182(a)(1)(A)-(H)

[5] CMS, "Medicare Program – General Information," https://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html

[6] H.R. 1628, the American Health Care Act of 2017, does not amend the pre-existing conditions protection under the ACA. https://www.congress.gov/bill/115th-congress/house-bill/1628/text#H8183DE5DEE394A99AC198EDB2439EC36

[7] Section 137 (b) No Limiting Access to Coverage For Individuals with Preexisting Conditions, http://www.politico.com/f/?id=0000015b-a790-d120-addb-f7dc0ec90000

[8] Pauly, Mark V., "Health Reform Without Side Effects: Making Markets Work for Individual Health Insurance," The Hoover Institute, 19-21, 2010, http://www.hoover.org/sites/default/files/uploads/documents/9780817910440_1.pdf

[9] Frakt, Austin B., Steven D. Pizer, Marian V. Wrobel, "High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects," Medicare & Medicaid Research Review, 2004, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194867/#fn4-hcfr-26-2-073

medical condition,[10] and at its apex this nationwide HRP covered roughly 114,000 people.[11] Again, given the proposed protections for people with pre-existing conditions,[12] the number of potential participants in a separate HRP is very small.

2. High-risk enrollees cast wide insurance premium ripples.

While the proportion of high-risk individuals in the individual market is relatively small, they have a significant impact on health care costs. According to the Kaiser Family Foundation, 50 percent of health care spending is driven by five percent of the population.[13] These examples can be found at the state level as well. In Alaska, 500 residents who require more care drove up insurance rates for 23,000 other customers.[14] Under Obamacare, insurers are required to use limited tools to differentiate rates for various enrollees. Using this "community rating" method meant that those with costly care could not be charged more than healthy individuals and healthy individuals pay more for insurance than they would if premiums were based on health status.[15]

Separating these high-risk individuals into a separate pool would be a more transparent way to subsidize high-risk enrollees while decreasing premiums for everyone else in the individual market.[16]

3. There are success stories.

HRPs were run by states and thus could vary in cost and effectiveness. For example, Wisconsin ran an HRP beginning in 1979 and covered 20,000 people. Though some enrollees could receive state subsidies based on income, a 40-year-old enrollee without a subsidy could enroll in a plan for a $368 per month premium with a $2,500 deductible in 2013.[17] In 2014, the average silver plan in Wisconsin for a 40-year-old enrollee without a subsidy was a comparable $333.[18] A 2008 Government Accountability Office (GAO) report found that 77.8 percent of enrollees in the most popular high-risk pool plans had out-of-pocket spending limits of $5,000 or less. The 2017 spending limit was $7,150 under Obamacare.[19] According to GAO, 76.5 percent of high-risk pool enrollees had deductibles of $2,999 or less; the average annual deductible was $1,593.[20] In contrast, the average deductible for a silver Obamacare plan is $6,092.[21]

If properly supported, HRPs could offer a meaningful and comparable health insurance option for people who could face higher prices due to a lapse of coverage and high-cost medical condition.

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[10] CMS, "Pre-Existing Condition Insurance Plan," https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Pre-Existing-Condition-Insurance-Plan.html

[11] The Center for Consumer Information and Insurance Oversight, "About the New Pre-Existing Condition Insurance Plan," CMS.gov, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preexistingconditioninsuranceplan.html

[12] For more details on these protections see the JEC's Health Care Q&A: I Have a Pre-Existing Medical Condition. What Will Happen? https://www.jec.senate.gov/public/index.cfm/republicans/analysis?ID=9E5DAD1F-8F9E-4870-9900-FE2C6AD2DB26

[13] Kaiser Family Foundation, "How Do Health Expenditures Vary Across the Population," 2014, http://kff.org/slideshow/how-health-expenditures-vary-across-the-population-slideshow/

[14] Raice, Shayndi and Anna Wilde Mathews, "Alaska's Novel Plan to Cut Health Premium Costs," WSJ, November 22, 2016, https://www.wsj.com/articles/alaskas-novel-plan-to-cut-health-premium-costs-1479825777

[15] American Medical Association, "Improving the Health Insurance Marketplace," 2015, https://www.ama-assn.org/sites/default/files/media-browser/public/modified-community-rating.pdf

[16] Pauly, Mark V. and Thomas P. Miller, "See "A Better (but Modest) Case for High-Risk Pools," AEI, March 2017, https://www.aei.org/wp-content/uploads/2017/03/A-better-but-modest-case-for-high-risk-pools.pdf

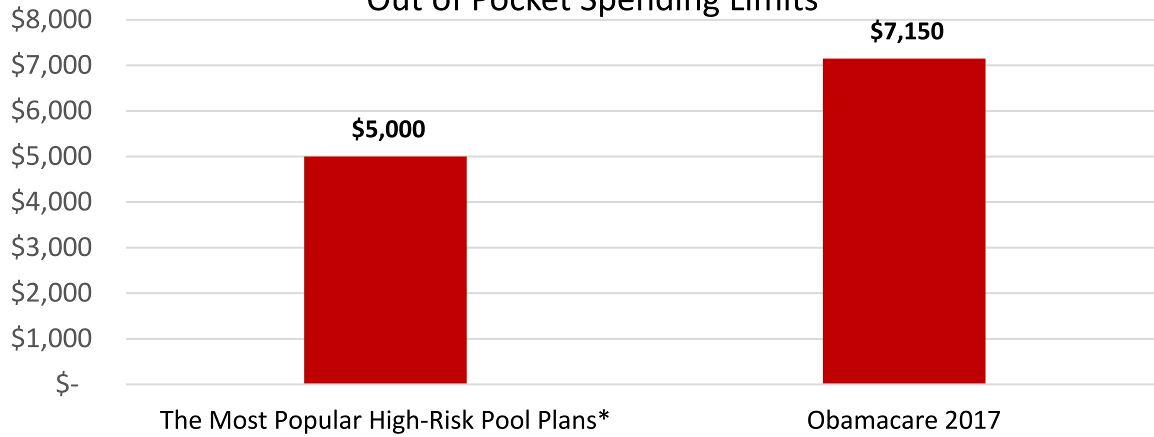
[17] Wieske, J.P., "Patient Relief from Collapsing Health Markets," Testimony before the U.S. House Committee on Energy and Commerce. Subcommittee on Health, February 2, 2017, http://docs.house.gov/meetings/IF/IF14/20170202/105506/HHRG-115-IF14-Wstate-WieskeJ-20170202.pdf

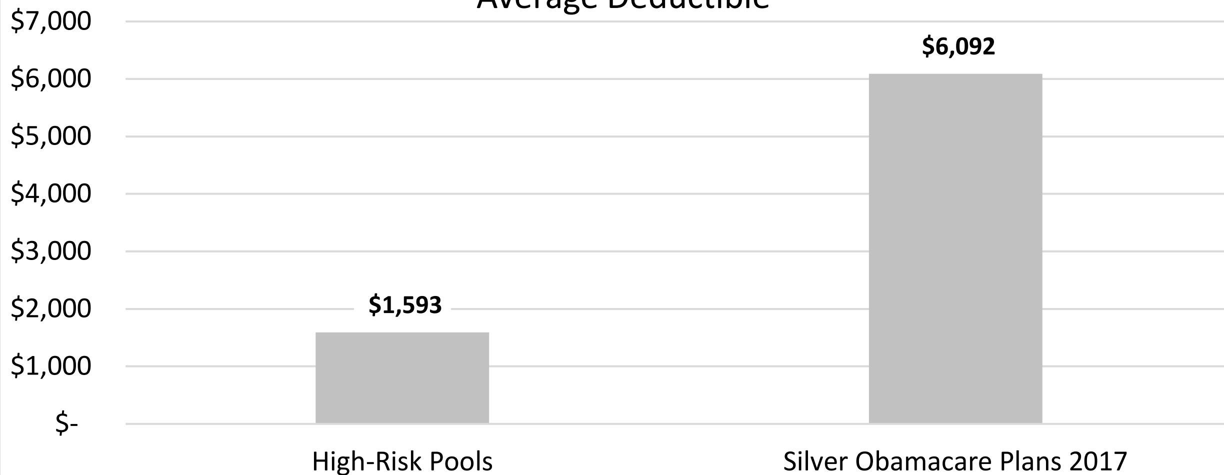
[18] Cox, Cynthia, Larry Levitt, Gary Claxton, Rosa Ma, and Robin Duddy-Tenbrunsel, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," KFF, January 6, 2015, http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/

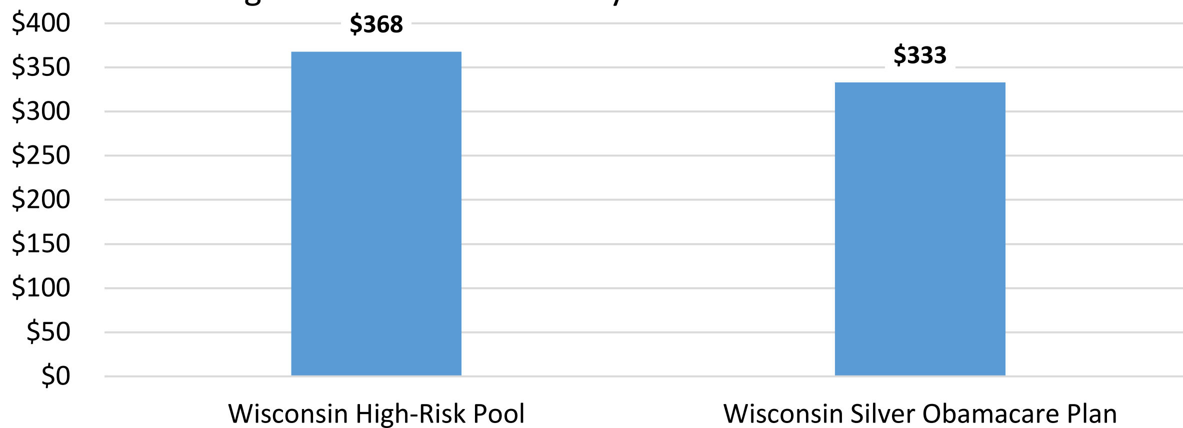
[19] HHS, "Out-of-Pocket Maximum/Limit," Healthcare.gov, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

[20] GAO, "Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools," p. 11, July 2009, http://www.gao.gov/assets/100/96314.pdf

[21] Coleman, Kev, "Aging Consumers without Subsidies Hit Hardest by 2017 Obamacare Premium and Deductible Spikes," HealthPocket.com, October 26, 2016, https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WQjGGfnyuUk


Out of Pocket Spending Limits
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-
$5,000
$7,150
The Most Popular High-Risk Pool Plans*
Obamacare 2017
*GAO reported that 77.8 percent of enrollees in the most popular HRPs had spending limits of of ≤ $5,000.
Source: HHS, GAO


Average Deductible
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-
$1,593
$6,092
High-Risk Pools
Silver Obamacare Plans 2017
Source: GAO, Healthpocket.com


Average Unsubsidized Monthly Premium for a 40-Year-Old
$400
$350
$300
$250
$200
$150
$100
$50
$0
$368
$333
Wisconsin High-Risk Pool
Wisconsin Silver Obamacare Plan
Source: KFF, U.S. House Energy and Commerce Committee