



REALIZING HEALTH REFORM'S POTENTIAL

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Why a National High-Risk Insurance Pool Is Not a Workable Alternative to the Marketplace

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Abstract The Pre-Existing Condition Insurance Plan (PCIP) was a national high-risk pool established under the Affordable Care Act (ACA) to provide coverage for individuals with preexisting conditions who had been uninsured for at least six months. It was intended to be a temporary program: PCIPs opened in 2010 and closed in April 2014. At that point, those with preexisting conditions could shop for health insurance in the marketplaces, where plans are prevented from using applicants' health status to deny coverage or charge more. This issue brief draws on the PCIP experience to outline why national high-risk pools, which continue to be proposed as policy alternatives to ACA coverage expansions, are expensive to enrollees as well as their administrators and ultimately unsustainable. The key lesson—and the principle on which the ACA is built—is that insurance works best when risk is evenly spread across a broad population.

OVERVIEW

The Affordable Care Act's (ACA) health insurance reforms were designed to make coverage more affordable and readily available to consumers, including those with health conditions who had often been denied coverage, or charged more, because of their conditions. A key policy in support of this goal went into effect in January 2014: private health plans are no longer able to turn down applicants, or charge them more, because of a preexisting health condition.

The ACA also created a temporary high-risk pool to cover people unable to obtain coverage because of their preexisting conditions. This national pool, which came to be known as the Pre-Existing Condition Insurance Plan (PCIP), was designed to serve as bridge coverage until the 2014 insurance reforms and expansions were in place. The legislation allocated \$5 billion to cover the costs of PCIP coverage from its inception in mid-2010 through December 31, 2013. The legislation also mandated that assistance be provided to PCIP enrollees to help them find coverage in the

marketplaces, via Medicaid expansion, or elsewhere in the last quarter of 2013. States were given the option of administering their own PCIP programs or allowing the federal government to do so. By late 2010, 27 states had elected to run their own programs and 23 states and the District of Columbia had elected to have the federal government administer PCIP for their residents.

Enrollment in PCIP was initially slow but gained momentum over time, with more than 130,000 enrollees as of September 2013.¹ These individuals had a wide range of serious medical conditions including cancer, heart disease, organ failure, diabetes, HIV/AIDS, degenerative bone diseases, and hemophilia.² For some, PCIP coverage literally saved lives by providing access to needed surgeries and treatments.³ In addition, PCIP coverage provided a critical financial lifeline, helping people avoid accruing medical debt until they could access affordable coverage through the Medicaid expansion or marketplaces.

Thirty-five states had operated their own state-based high-risk pools prior to PCIP, but premiums were often very high—up to 250 percent of the average rate in the state. By contrast, PCIP premiums were capped at no greater than the standard rate for individual insurance for a healthy population in each state. PCIP coverage also had to have an actuarial value of at least 65 percent, meaning that, on average, the health plan paid 65 percent of an individual's health care costs. In comparison, silver coverage in the marketplace has an actuarial value of 70 percent (plus subsidies for those with low incomes), while platinum coverage has an actuarial value of 90 percent. In addition, new enrollees in PCIP had no waiting period for coverage of their preexisting condition or conditions, as most states' existing high-risk pools imposed. Finally, annual out-of-pocket costs were capped at \$5,950 (\$6,250 in 2013).⁴

COSTS IN HIGH-RISK POOLS

Due to the high costs associated with having a pool of enrollees with serious health conditions, PCIP programs were allowed to contain costs through a variety of measures that are not allowed to be used by plans operating in the marketplaces. These include imposing cost-sharing on preventive services, charging higher premiums for women, and implementing annual or lifetime coverage caps and dollar or number caps on some kinds of visits.⁵ PCIP plans also were not required to have parity for mental health services, as marketplace plans are required to do.⁶ Finally, age rating was capped at a 4:1 ratio for older versus younger enrollees, which is greater than the 3:1 ratio allowed for marketplace plans. Thus, older enrollees in PCIP—and PCIP enrollment skewed toward older enrollees due to their higher incidence of chronic conditions—paid relatively more for coverage than older consumers in the marketplaces.

Despite these cost-saving measures, PCIP coverage was still very expensive for both enrollees and administrators. One study detailed potential out-of-pocket costs for individuals with varying levels of health care utilization in the federally administered PCIP program and selected state-administered PCIP programs.⁷ Annual premiums could be as high as \$12,264 for a 50-year-old person—more than half of the annual income of someone making twice the federal poverty level in 2014. At the same time, the average expenditure in 2012 per PCIP enrollee was \$32,108, indicating that the program cost far more than it generated in premiums. One state had a per enrollee cost of \$171,909.⁸ State high-risk pools have historically had similar challenges. Even though premiums in state high-risk pools range from 100 percent to 250 percent of standard risk rates (average rates charged to others in

the state’s individual insurance market), premiums on average paid just 53 percent of program costs in 2011.⁹

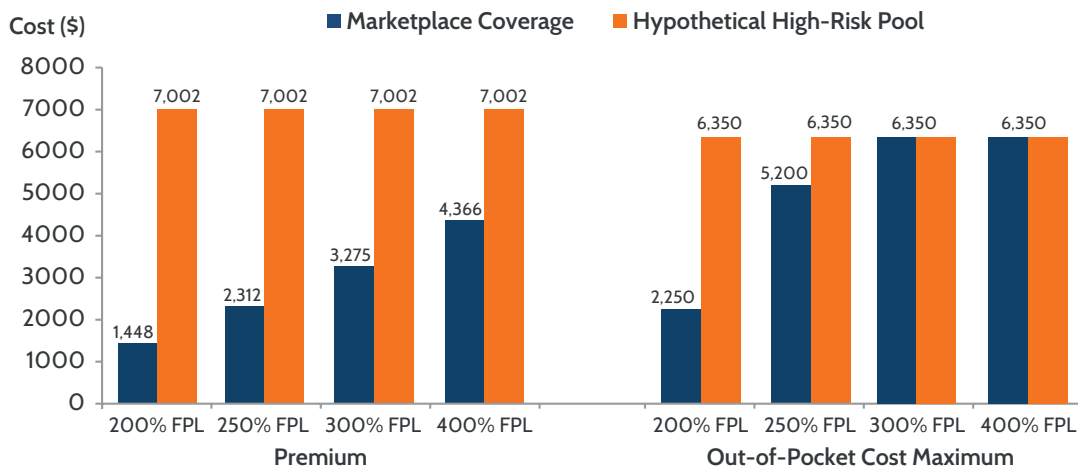
COMPARING HIGH-RISK POOLS TO MARKETPLACE PLANS

Clearly, coverage under PCIP and the state high-risk pools was expensive for both enrollees and administrators. At the same time, the benefits offered were less comprehensive than what is required in marketplace plans, both in the range of covered services and their overall actuarial value. The lack of comprehensive coverage created significant barriers to care for enrollees. Indeed, research on one state’s high-risk pool indicated that high deductibles coupled with limited coverage resulted in significant numbers of enrollees delaying or forgoing needed care.¹⁰ Moreover, the same study found that 72 percent of enrollees were underinsured and nearly 30 percent had medical debt.¹¹

Notwithstanding this experience, some policymakers continue to call for expansion of high-risk pools as an alternative to the coverage expansions under the ACA.¹² Any such expansion, however, would likely make coverage prohibitively expensive for the great majority of individuals with preexisting conditions who were uninsured prior to ACA implementation, of whom about 80 percent have incomes below 400 percent of the federal poverty level.¹³ Exhibit 1 illustrates the premium and out-of-pocket costs for people at varying income levels for a hypothetical national high-risk pool, compared with premium and out-of-pocket costs for marketplace coverage.

Premium estimates for the hypothetical national high-risk pool plan are based on the average standard risk rate for a 50-year-old person enrolled in the extended, or lower-deductible, plan option in the 27 federally administered PCIP programs.¹⁴ These premiums were then multiplied by 150 percent, which is the level allowed in HR 4496, a recently introduced bill that would create a national high-risk pool to be administered by the states. Given that people who enrolled in PCIP had very

Exhibit 1. Premium and Out-of-Pocket Costs for Health Coverage in Marketplace vs. Hypothetical High-Risk Pool



Notes: FPL=federal poverty level. Premium figures are based on those for a 50-year-old single person who has reached the out-of-pocket maximum. Figures based on Kaiser Family Foundation subsidy calculator (<http://kff.org/interactive/-subsidy-calculator/>). Hypothetical high-risk pool uses national standard risk rate based on federally administered PCIP premiums; see J. P. Hall and J. M. Moore, Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable (New York: The Commonwealth Fund, June 2011).

high utilization and costs, the estimates assume that enrollees reach their annual out-of-pocket limit of \$6,350.

As the exhibit shows, national high-risk pool coverage would be unaffordable for people with incomes below 400 percent of the federal poverty level. Moreover, based on the PCIP and state high-risk pool experiences, the coverage individuals could obtain through such a high-risk pool would likely be more limited in scope than that required for marketplace plans.

DISCUSSION

The PCIP experience provides a useful example of the types of enrollees and costs associated with a national high-risk pool. Unquestionably, PCIP fulfilled its intended purpose of providing critically needed coverage to people with serious and often life-threatening conditions on a short-term basis.¹⁵ Even with premiums set at standard rates for the individual market, however, PCIP coverage was too expensive for many uninsured individuals with preexisting conditions, and subsidies were not available for low-income enrollees.¹⁶ This situation likely contributed to adverse selection in the program because people with high needs were more likely to pay the relatively high premiums. Enrollees also tended to be older, even though younger individuals are much more likely to be uninsured. Sixty-two percent were ages 45 and older, reflecting the fact that people are more likely to develop serious health conditions as they age.¹⁷ Owing at least in part to this adverse selection, PCIP program costs were much higher than anticipated.¹⁸ Indeed, in February of 2013, PCIP programs were directed to cease new enrollment to ensure that sufficient funds would be available for the remaining life of the program.¹⁹

Using a national high-risk pool as a permanent alternative to the marketplace would result in many of the same cost and coverage challenges seen in PCIP. An analysis conducted during the 2008 presidential campaign of Senator John McCain's proposed health reform plan estimated the cost of a national high-risk pool at more than \$100 billion per year.²⁰ In estimating this cost, the authors included expenditures for high-cost individuals without employer-sponsored health insurance (\$73 billion per year at that time) and the projected costs of individuals who would lose coverage due to other parts of the McCain plan and therefore enroll in the high-risk pool. The projections did not include any costs associated with subsidies to make the coverage more affordable.

The costs of a national high-risk pool would likely be even higher today. Recent estimates place the number of people with chronic conditions who were uninsured prior to 2014 at between 11.6 million and 19.1 million.²¹ Using the average of these two estimates, we can say some 15.4 million people would require coverage through a national high-risk pool. The Congressional Budget Office recently calculated that, under the ACA, 89 percent of all Americans would have health insurance coverage by 2016, at a net federal cost of \$123 billion for that year.²² Consider what it would cost to cover 89 percent (13.7 million) of the 15.4 uninsured Americans with preexisting conditions through a national high-risk pool. If each enrollee paid \$7,000 in annual premiums and incurred annual medical costs of \$20,000 (much less than in PCIP), the net federal cost to cover them would be \$178.1 billion per year.

The estimated costs for both Senator McCain's proposed high-risk pool and the hypothetical high-risk pool covering 13.7 million people are substantially greater than the \$1.5 billion annual federal allocation for a national high-risk pool in the currently proposed legislation, HR 4496. Moreover,

some 25 million people will have newly obtained coverage by 2016 under current ACA provisions for a smaller federal outlay than that required for covering just 13.7 million through a high-risk pool.²³

A final consideration is that adverse selection seen in PCIP will be mitigated in the marketplace plans, which provide income-based subsidies that are likely to attract younger, healthier individuals as well as those who do have immediate high-cost needs. Thus, the average per person costs in the marketplaces are much lower, as risk is spread across a much larger pool. In addition, marketplace coverage is more comprehensive and therefore more likely to meet the needs of both healthy individuals and those with chronic conditions. On both a cost and coverage basis, then, the marketplace is far more desirable for people with preexisting conditions and for plan administrators.

NOTES

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- ⁸ Center for Consumer Information and Insurance Oversight, *Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program* (Washington, D.C.: CCIIO, Feb. 23, 2012), <http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip-report.pdf>.
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