A Better (but Modest) Case for High-Risk Pools

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Key Points

• The relatively modest, but significant, problem of several million Americans at risk of limited or no insurance coverage due to serious preexisting health conditions should and can be addressed more effectively.

• The Affordable Care Act’s combination of adjusted community rating, guaranteed issue, income-related premium subsidies, and a weak individual mandate made its individual insurance market coverage less attractive to younger and healthier individuals.

• A well-targeted and adequately funded high-risk-pool approach would provide a fair and efficient way to ensure insurance coverage without preexisting condition exclusions, reduce premiums in the rest of the individual market, and help expand overall coverage.

This year, much of the current debate about repeal-and-replace alternatives to Obamacare centers on this challenge from defenders of the status quo: How can the new Trump administration and a Republican Congress keep their general promise to protect insurance coverage for individuals with high-risk, preexisting health conditions, without compelling other low-risk insureds to pay higher premiums? It assumes the obvious answer is “not possible,” accompanied by the warning that “tens of thousands of people, or more, will die if you try to do anything else.” Then the rest of this closed-loop political argument kicks in with one seemingly simple solution: The individual mandate under the Affordable Care Act (ACA) remains essential to compel low risks to pay more than the likely costs of their medical claims, so that high risks can pay less than they are expected to cost.

For example, former Secretary Robert Reich made this formulaic claim last month on CNN, and he was slowed only momentarily by an opponent’s comment that the current mandate seems too weak to force enough low risks to enroll in Obamacare’s coverage and sustain the participation of low-risk insureds and insurers in general. On the other hand, the White House and Republican congressional leaders plan to eliminate all penalties under the ACA’s individual mandate, rather than strengthen them, but maintain the law’s prohibition on health-risk rating. On March 13, the Congressional Budget Office estimated that these moves, as proposed in the Republican-sponsored American Health Care Act (AHCA), would substantially increase the number of uninsured Americans, while causing individual insurance market premiums to rise over the next few years.

Even more recently, Harvard economist David Cutler criticized the AHCA for reducing insurance payments for the healthy and necessarily increasing them for the sick. Cutler posits that a large share...
of medical costs are predictable. He claims that
the ACA spreads costs for the less fortunate across
everyone through its combination of adjusted
community rating, reasonably generous benefits,
the individual mandate, and taxes to subsidize their
premiums and out-of-pocket expenses. Cutler
then faults the AHCA for failing to address the
persistently ill.4

### Preexisting Condition Coverage Problems Are Really Just About the Individual Market

These views of how insurance markets can, and do,
operate often manage to be both far too shallow
and sweeping (quite a simultaneous combination!).
They overlook more than just the limitations of
legal mandates to purchase whatever the federal
government deems appropriate.

As a starting point, this issue needs to be confined
to the individual insurance market. Most Americans
who receive coverage in the employer group market
or through Medicare and Medicaid already operated
under other rules and practices established well
before Obamacare policies that pool risks quite
differently.

Individuals who are covered by employer-
sponsored insurance cannot be directly singled out
to pay higher premiums, face coverage restrictions,
or even lose their coverage based on their individual
health status or that of their dependents. That was
largely the case for many decades as a matter of
good business sense by employers (recruiting and
retaining good workers is hard enough), but federal
legislation (the Health Insurance Portability and
Accountability Act of 1996) made those business
practices more uniform and mandatory. That law
also established rules to protect workers switching
jobs to move seamlessly from one employer’s
insurance plan to another such plan, as long as
the worker had maintained so-called “continuous
qualified coverage” for a sufficient period of time.

Enrollees in our two largest taxpayer-subsidized
entitlement programs are either charged the same
premium at a given income level regardless of risk
(Medicare) or do not have any premiums at all
(Medicaid). Medicare essentially pools everyone
over age 65, regardless of their particular age or health
status. Medicaid provides coverage for low-income
Americans of all ages, although the scope and
scale of its benefits differ for various categories of
beneficiaries. (For time and space considerations,
we are oversimplifying some lesser exceptions and
variations to those general rules in the two programs.)

The basic point is that the issue of preexisting
conditions and restrictions on access to insurance
based on one’s health status really applies to only
a small fraction of Americans—those formerly
uninsured seeking coverage in the individual market
or trying to move from one individual market plan to
another. Although the size of that market expanded
under the ACA’s mix of increased taxpayer subsidies,
coverage mandates, and tighter insurance rules, the
total market (including mostly average or low risks)
is still not much more than about 20 million insured
Americans, plus conceivably another 15–20 million
currently uninsured potential customers.

Even here, policy and practice for the individual
market before the ACA was far from the Hobbesian
imagery painted by its critics. Individual insurers,
first voluntarily and then as required by federal
law, promised not to re-underwrite and single out
persons who became high risks for high premiums.
This guaranteed renewability provision was
occasionally ignored or sidestepped by dropping
whole blocs of customers or ones who provided
incorrect information when applying, but those
incidents were rare. Those exceptions faced bad
publicity and legal sanctions from regulators or in
the courts. The real problem for high-risk customers
was limited to those who chose to go without
insurance and then sought it only when they really
expected high benefits from it.

### Sizing Up the Problem: How Many
Americans Cannot Get Coverage Due
to Health Status?

Before considering whether a high-risk-pool approach
can handle most of the preexisting-condition problem,
one needs to know how large the potential population
needing such assistance is. This remains a far from
simple question, and it has been prone to exaggeration
on both sides.

To be blunt, one of the primary ways the Obama
administration “sold” its proposals for health policy
overhaul was to exaggerate the size, scope, and nature
of the potential population facing coverage problems
due to serious preexisting health conditions. For example, the administration’s Department of Health and Human Services (HHS) first suggested in August 2009 that at most 12.6 million Americans recently had been denied coverage or “upcharged.” By itself, that represented a sizable portion—36 percent—of the below-age-65 customers seeking insurance in the individual market who allegedly were “discriminated against” on the basis of their health status in the previous three years.8

When you have trouble finding something, it might be a smaller problem than first assumed.

After a Republican majority took control of the US House in the November 2010 election and planned to repeal the ACA, HHS switched to a far broader set of claims involving a larger population of individuals with chronic conditions, whether or not they currently had insurance, in order to quote a much larger number of Americans at risk. HHS claimed that “up to” 129 million people could be denied affordable coverage without ACA-style health reform if they were all to lose their current coverage.7 The later report blurred the difference between the many people with some existing medical condition, but with coverage through group insurance or other public programs such as Medicaid, and those who were ever likely to be denied coverage due to their health status in the individual market. Other later Obama-era estimates of those who could run into problems ranged from 61 million to 133 million.8

Several other attempts to arrive at a more reliable set of estimates have been made in recent years. In 2008, at the request of HHS, one of us (Pauly), along with colleagues Bradley Herring and Xue Song, examined how people with chronic health conditions, and thus high anticipated health care expenses, actually fared when seeking insurance in the individual market. We found little evidence that enrollees in poor health who obtained or were likely to demand coverage paid significantly higher premiums for individual insurance.9 Nor was the onset of chronic conditions necessarily associated with increased premiums in subsequent years.

Existing “guaranteed renewability” requirements in federal and state law seemed to be working already to protect high risks as long as they kept their coverage. As confirmatory evidence, premiums for individual insurance were found to “front load” premiums for newer buyers to accumulate the excess needed to cover them later when chronic conditions ensued. Moreover, the likelihood that a high risk obtained private coverage in states that permitted risk rating was 96 percent of that in states with Obamacare-like community rating. Turnover across insurance companies could cause problems, but millions already had protection.

What was left? Although the risks of facing coverage exclusions and prohibitive premiums caused by preexisting conditions were by no means universal in the individual insurance market at the time of the ACA’s enactment, many Americans, by choice or bad luck, fell through the cracks. Reasonable estimates from the authors ranged from two to four million, out of a total population of about 260 million people under the age of 65.10

A July 2011 report by the Government Accountability Office (GAO) examined why the ACA’s interim Preexisting Condition Insurance Protection program had enrolled relatively few individuals during its first year of operation. The GAO noted that “the segment of the uninsured population with pre-existing conditions has been difficult to identify and target.” A different observation might be that when you have trouble finding something, it might be a smaller problem than first assumed.

Matching Health Policy Fixes to Risk-Related Problems

By overrating the size and scope of insurance coverage barriers to Americans with predictably high-cost health conditions, ACA advocates then argued that the only way to address those problems was with a heavy dose of (adjusted) community rated premiums and income-related tax subsidies, complemented by an individual mandate. Unfortunately, this combination also made the coverage offered in ACA exchanges less attractive to younger and healthier individuals, who were asked to pay more for insurance that they valued less.
Reasonable minds can disagree in good faith about the merits and parameters of an individual mandate to purchase health insurance, as even the two authors here (Pauly and Miller) have in the past. What is far clearer is that the ACA’s relatively weak version of such a mandate has been ineffective in increasing coverage for individuals who are younger, healthier, or less heavily subsidized by tax credits (i.e., with household incomes above twice the federal poverty level). Hence, many experts concluded that the ACA mandate failed to ensure sustainable risk pools under the law’s age-adjusted community rating rules for individual insurance markets. We ended up with the worst of both worlds, a mandate despised by many (low-risk) consumers that largely failed to accomplish its intended task.

Far less attention and criticism has been directed at the ACA’s rating rules for premiums in the individual market. The sad irony is that although community rating, and its age-adjusted versions, often are advocated as a solution to the higher premium costs that the sickest people are more likely to face in less-regulated individual health insurance markets, they actually make the problem of adverse selection (the sickest people disproportionately purchasing more comprehensive insurance) worse.

When insurers are prevented by law from risk rating in individual insurance markets, they instead raise premiums for everyone to compensate for their higher claims costs, which makes that insurance more expensive for the healthy. Hence, the healthy become less likely to buy insurance. When the policy mix in this market includes community rating, tax subsidies that are generous only to low-income purchasers, and a relatively weak individual mandate, then any increases in the probability that high-risk, sicker individuals are covered is overwhelmed by the probability that low-risk, healthier ones do not obtain or retain coverage.

On the other hand, if insurers are allowed to take into account the predictable health status of individuals when pricing their premiums, more healthy people will encounter lower premiums, and more of them then will voluntarily buy insurance. And when more insurance overall is sold, the administrative loading costs to do so also drop per capita, thereby lowering premiums further.

There’s Got to Be a Better Way

There is an alternative way to finance lower premiums for high risks while also reducing the cost of insurance for everyone else covered in the individual market. The most straightforward policy reform involves a high-risk pool, which ideally offers decent (although not highly generous) coverage to those potential buyers who insurers in their underwriting process have identified as high risk. They would then be covered not at the high premiums their risk level would require to fully cover their claims, but at charged premiums only modestly higher than those set for the remaining average and lower risks, usually 1.5-1.75 times standard-rate premiums. The coverage offered most likely would be a conventional, no-frills plan that covers universally cost-effective care but also includes meaningful cost sharing. (Exact specification, including the level of additional income-related subsidies, is largely a political decision influenced by fiscal constraints and social equity goals)

Obviously the pool will run a deficit at such premium levels, and the deficit would need to be covered, ideally by a subsidy from general taxes sufficient to support this decent coverage at decent premiums. For people with lower incomes, both the premium charged in the high-risk pool and the premiums charged to average risks might well be subsidized further so that the net premium paid accords with a social value judgment of ability to pay.

Thus, in its most comprehensive form, a high-risk pool for all, combined with income-related subsidies for lower-income buyers, would be more equitable than Obamacare’s community rating with a weak mandate. It would be more efficient as well because the lower premiums that private competitive insurers would offer for non-high-risk purchasers (lower because they no longer need to cover a risk-based cross subsidy) will make buying that insurance a more attractive proposition for those purchasers. This greater efficiency means that low risks face premiums tailored to their risk level, and then they are less likely to go without coverage or need to be forced to do so through mandated penalties.

So in principle a high-risk pool is more efficient and equitable than current Obamacare policies. Why are there objections? One fundamental reason is that, compared to age-adjusted community rating,
it makes it much more transparent who is being subsidized, who is paying higher taxes (instead of less-visible higher premiums), and how much the subsidy costs.

Health insurance risk is not distributed uniformly across the population. Setting aside the chronic high-risk population with congenital conditions who would be covered under the disability provisions of Medicare and Medicaid, an even smaller minority remains in the individual market of people with chronic conditions, such as diabetes and asthma, whom insurers would expect to incur above-average claims. Some of them do incur higher-than-average claims over longer periods of time, but many eventually return to average levels after three or four years.33

Virtually by definition, the significantly high-risk fraction has to be less than half. It is unlikely that the population is one in which most people are above average in terms of predictable health risk (with apologies to Lake Woebegone). For example, in 2014 the top 5 percent of the civilian noninstitutionalized population accounted for 50 percent of total expenditures with an annual mean expenditure of $47,498. Average annual spending in the bottom half of the population was $264.34 As suggested earlier, the high-risk population is much less than half.

The more important policy question for insurance coverage and pricing is: How are the costs of predictable high-risk claims actually distributed? One cannot judge the distribution of those risks simply by looking at actual claims incurred and paid, because some low-risk people will end up with high claims, be cured of their illness, and return to low-risk health status. Thus, reinsurance that pays for realized expenses is poorly targeted relative to subsidies devoted to individuals who are determined by insurers to be high risk before the fact.

But no more than 20 percent of the under-65 population, for a given age, has expected expenses at least 1.5 times more than the average.35 Hence, most voters and taxpayers will figure that they will not benefit directly from subsidies in high-risk pools at any particular time.

Those pools still provide some protection to the currently healthy who could be hit randomly with a high-cost condition that lasts beyond a given year and are not otherwise shielded by their existing insurance coverage. However, it is virtually guaranteed that from a financial perspective there are going to be more people who pay taxes to fund the high-risk pool than those who gain. This imbalance between likely losers versus winners helps explain why high-risk pools have struggled to maintain adequate political support.

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Still, both altruistic concerns for their fellow citizens and the possibility that one might somehow become an uninsured high risk should generate support, especially as compared to variations of community rating, which is a less fair and less efficient way of making the same transfers across different sets of individuals. In some states, such as Minnesota and Wisconsin, high-risk pools functioned effectively before Obamacare. But in many states, it was politically difficult for state budgets to support them at a level at which they could afford to take all qualified applicants.

Although high-risk pools were thought to be more expensive relative to community rating, this is a fundamental misperception. The subsidy cost for a high-risk pool for a given population has to equal the total of higher premiums imposed through community rating on lower-risk individuals in that population (who do decide to buy such higher-priced coverage).

However, this population in the individual market is much smaller than the population paying taxes that provide general revenue. The extra “tax” from a much broader tax base has to be lower per person. Moreover, general taxes to support pools can tap the better off who overwhelmingly are covered by job-based insurance, rather than the tiny slice of
younger and healthier, but often lower-income, people forced into community rated individual plans.

The challenges of high-risk pools are far more political than economic. The problem is that taxes to support them are obvious to federal or state legislators, as they show up explicitly in their budget and hit a majority of their constituents, whereas the transfers under community rating are hidden and imposed on a far smaller number of less politically influential citizens. Although high-risk-pool approaches will still have considerable net benefits (e.g., lower overall premiums and more progressive financing of subsidies), the case for them takes more explaining than community rating (which, for example, leads some people to imagine that rich insurers will be absorbing the cost of being compelled to sell to high risks).

Will it not still be administratively costly to “underwrite” each applicant to determine that person’s risk level so as to tailor premiums to that risk? Empirically, the high administrative cost for individual insurance—which typically was about 25-30 percent of premiums for those policies that people actually completed purchases—was not due to the cost of underwriting; that cost was only about 1 percent of premiums. (The total administrative cost or “loading” was in the range of loadings for other individual insurances, such as automobile coverage and homeowners insurance, for which 30 percent was typical and thought reasonable.)

The much larger expenses involve selling and billing costs, necessitated by the difficulty of persuading more people to purchase coverage without the kinds of subsidies offered to the elderly and buyers of group insurance.

Typical underwriting was based on a buyer’s response to a questionnaire about medical care use in the previous five years; direct physical examinations or routine requests for medical records were rare. With a high-risk pool, the underwriting task becomes even easier and less intrusive. Once the insurer has determined the applicant qualifies for the high-risk pool, it does not need to determine the precise risk level above the threshold because out-of-pocket premiums are uniform in the pool and remaining premium costs are covered by subsidies.

Finally, although there usually are some criteria for being admitted to a high-risk pool—such as being uninsured for a period or being turned down by some number of insurers—the fact that it charges somewhat higher premiums for relatively adequate, but not particularly attractive, coverage means there is little incentive for low risks to try to sneak into it, subsidy or no subsidy. As long as the separation into risk classes is supported by both lower risks (who want to stay out) and high risks (who want to get in), along with prescreening by private insurers, little additional monitoring or regulation of membership is likely to be needed.

Conclusion

In summary, a high-risk pool can be a fair and efficient way to provide coverage without preexisting-condition exclusions, free from the worry about what kinds of risks will sign up for market-based coverage. Sensible health policy does not require a mandate to deal with high risks; the proper role of a mandate is to inhibit free riders who are currently low risk but remain uninsured. Skimming off difficult-to-insure, high-risk individuals from the larger market for individual insurance does require better-targeted and sufficiently generous subsidies. They would allow that market to function in an administratively efficient way that encourages competition based on cost and quality while greatly increasing the chances that people will buy insurance when they are lower risks, as they should.

The current version of the AHCA awaiting a vote in Congress only lists high-risk pools as one of several policy options for states to consider implementing, with up to $115 billion in State Innovation Grants allocated to them to stabilize individual and small-group insurance markets over the next 10 years. Choosing the high-risk-pool approach for states’ individual markets would allow their premiums to fall relatively quickly, as the highest-risk individuals are drawn off to those pools. The highest-risk individuals would still be facing reasonably priced premiums compared to their likely claims costs. Lower premiums in the rest of the individual market then would reduce incentives for low-risk individuals to drop coverage, averting the purported adverse-selection cycle of lower enrollment and higher premiums that the Congressional Budget Office otherwise predicts in the early years of the AHCA.
Of course, there are no free lunches in the business and politics of health insurance. Successful high-risk pools will, by definition, require subsidies from federal and state government sources. Taxpayers and other voters will need to decide whether the relatively modest cost of high-risk-pool subsidies, along with somewhat less-generous premium tax credits under the proposed AHCA, compare favorably to the ACA’s current menu of tax and regulatory subsidies.

High-risk pools do not solve larger problems in health care affordability, quality, and value. Income-based subsidies also remain necessary for the much larger challenges facing lower-income Americans. Broader reforms of the incentives and opportunities for delivering health care services in a more competitive, transparent, innovative, and accountable environment reach far beyond the narrow issue of how best to subsidize insurance coverage for identifiably high-risk individuals. But solving one smaller, but manageable, problem effectively is far better than creating a larger one through less well-targeted means.

About the Authors

Mark V. Pauly is the Bendheim Professor of Health Care Management and Professor of Business Economics and Public Policy at the Wharton School, University of Pennsylvania. Thomas P. Miller is a resident fellow at the American Enterprise Institute. Pauly is the intellectual godfather of the individual mandate. Miller is the nonintellectual godfather of opposition to the individual mandate. But they both agree on the need for adequately funded high-risk pools and the drawbacks of community rating in the individual market.

Notes

1. On February 10, 2017, in Anderson Cooper 360°, Reich said, “The only way you replace Obamacare is if you come up with some way of preserving the preexisting condition provision, which depends upon the mandate that requires healthy younger people to get health care. If you don’t have that, you can’t have the preexisting.” CNN, “Anderson Cooper 360 Degrees,” transcript, February 10, 2017, http://transcripts.cnn.com/TRANSCRIPTS/1702/10/ac360.html.


4. Cutler’s article does actually note that the only way society can avoid annual high costs for individuals with chronic conditions is to “reduce the cost of care, not just shift the cost from the healthy to the sick.” However, he essentially defaults to shifting costs from the sick to the healthy instead, while overestimating the persistence of high-cost claims at the individual level in the below-age-65 population and exaggerating the accomplishments of the ACA’s policy mix.


6. The study cited by HHS appears to make broader claims on its “evidence” than its actual methodology, as described, actually involved. Michelle M. Doty et al., “Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families,” Commonwealth Fund, July 21, 2009. The survey was conducted by telephone interviews over a four-month period in 2007, but it apparently was based, for these points, only on responses from 130 adults who had individual insurance coverage at that time, raising issues of sample size and respondent recall.


8. In early January 2017, HHS fired off one final shot on the population-at-risk issue. It claimed that a large fraction of nonelderly Americans have preexisting health conditions: at least 25 percent of Americans (61 million people) using a narrow definition based on eligibility criteria for pre-ACA state high-risk pools, or as many as 51 percent (133 million people) using a broader definition closer to the underwriting criteria used by insurers before the ACA. The report’s inflated conclusion was: “Any of these 133 million Americans could have been denied coverage, or offered coverage only at an exorbitant price, had they needed individual market health insurance before 2014.” Office of the Assistant Secretary for Planning and Evaluation, “Health Insurance Coverage for Americans


10. In a 2001 survey by HHS, respondents were asked if they had “ever been denied health insurance because of poor health.” The data collected indicate that about two million people might be eligible for enrollment in high-risk pools. See Thomas P. Miller, “Fixing Private Health Insurance: Protection Against Health Risk Redefinition” (presentation, American Enterprise Institute, October 21, 2009), slides 6 and 7, http://www.aei.org/events/private-health-insurance-markets-facts-fables-and-fixes/. In a different study, using 2006 data, the Government Accountability Office determined roughly the percentage of uninsured individuals who had at least one chronic health condition and then applied it to census estimates of the average number of uninsured people in each state with an existing Healthcare Reimbursement Plan (HRP). The aim was to get a sense of how many more people might be covered by such pools if they were available to all who needed them. The GAO concluded that as many as four million Americans could be covered by more generously funded high-risk pools—20 times the number then covered by state HRPs. See US Government Accountability Office, “State High-Risk Health Insurance Pools,” GAO-09-730R, July 22, 2009. Pauly subsequently looked at data about the number of people with chronic health conditions whose expected medical expenses are more than twice the national average. He first estimated the total nationwide high-risk group at around 4 percent of the under-65 population, excluding people receiving Medicaid—a number in the low millions. But Pauly ultimately concluded that the number of people who were both high risk and looking for coverage in the individual market at any given point was far lower—on the order of tens of thousands. See Mark V. Pauly, Health Reform Without Side Effects: Making Markets Work for Individual Health Insurance (Hoover Institution Press, 2010), 19–21.


12. Pure community rating requires that all enrollees in an insurance plan be charged the same premium, regardless of their health status, age, gender, or location. Adjusted community rating, as prescribed in the ACA for the individual insurance market, requires that premiums for those insured may only differ within a narrow band of differences in age (no greater than $1 between the youngest and the oldest), plus other adjustments for number of dependents in family coverage and a tobacco use surcharge. The latter’s rating requirements also prohibit premium variations based on individual health status. Age alone is only a partial predictive variable for likely health care costs, particularly at the individual level.


16. A recent analysis of high-risk pool options by the American Academy of Actuaries emphasizes that there are several direct relationships between the levels of individual insurance market premiums, or high-risk pool enrollee premiums, and the amount of “outside” funding from other non-premium sources: “Incorporating outside funding can spread the costs of enrollees over a larger base. The broader the base of funds, the lower the burden on contributing entities.” American Academy of Actuaries, “Issue Brief: Using High-Risk Pools to Cover High-Risk-Enrollees,” February 2017, However, the lower the risk pool premiums charged to its own enrollees, the higher the enrollment, and the more outside funding will be needed. Ibid.

17. Several other trade-offs in the design of high-risk pool approaches involve whether they should organize care of enrollees in separate coverage (greater cost transparency and ex ante risk assessment, plus potentially more focus on reducing the severity and
duration of the most costly chronic or catastrophic health conditions) or rely more on “invisible” financial support of high-cost individuals in the current individual market (less disruptive of existing care arrangements). The latter is more akin to reinsurance, which can either be assisted by external funding or limited to transfer between participating insurers.