

## KEY POINTS

High-risk pools could be structured various ways to cover the costs of high-risk enrollees:

- A traditional high-risk pool, in which enrollees are moved into a separately run insurance pool.
- A high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims above a specific threshold is reimbursed.
- A condition-based high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims for enrollees with a given set of conditions is reimbursed.

The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on the specific approach and how its details are structured, including those related to eligibility criteria, benefit coverage requirements, and funding sources.

It is also important to consider how high-risk pool approaches would interact with other insurance market rules pertaining to insurance issue, benefit coverage requirements, and premium rating.



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# Issue Brief

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## Using High-Risk Pools to Cover High-Risk Enrollees

The distribution of health care spending is skewed, with a small share of the population making up a large share of the spending. As a result, how to provide insurance coverage in the individual market and spread the costs of high-risk individuals is a key public policy question. Under the Affordable Care Act (ACA), individuals with pre-existing conditions are guaranteed that they cannot be denied insurance coverage or charged higher rates based on their health status. Their higher costs are spread across all enrollees. To keep upward pressure on premiums from high-risk enrollment as low as possible, the ACA's individual mandate and premium subsidies were designed to encourage enrollment of lower-cost people, thereby spreading the costs more broadly.

High-risk pools have been suggested as an alternative approach to covering the costs of high-risk individuals in the individual market, and many ACA replacement proposals include high-risk pool provisions. Goals of high-risk pool proposals include providing access to insurance coverage for high-risk enrollees, keeping premiums affordable, and improving stability in the individual market.

This issue brief provides an overview of three potential high-risk pool approaches to covering the costs of high-risk enrollees:

- A traditional high-risk pool, in which enrollees are moved into a separately run insurance pool managed by states or the federal government.
- A high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims above a specific threshold is reimbursed by the high-risk pool.
- A condition-based high-risk pool reimbursement program, in which enrollees remain in the private individual market and a portion of claims for enrollees with a given set of conditions is reimbursed by the high-risk pool.

This issue brief provides a brief description of each approach and current examples that use the approach. Because the impact of a high-risk pool program on insurance coverage, premiums, and government spending depends on the details underlying its structure, the issue brief will examine the implications of various design features including eligibility criteria, benefit coverage, funding sources, and regulatory responsibility.

## Traditional High-Risk Pools

Under a traditional high-risk pool, individuals applying for coverage who are high-risk due to pre-existing conditions are segregated from the conventional individual market risk pool and offered coverage in a separate pool. Taking high-risk people out of the conventional market can help keep premiums lower for those remaining

in the conventional market. However, the costs for the high-risk pool will be high, necessitating external funding if high-risk pool premiums do not fully reflect the higher costs. Examples of a traditional high-risk pool approach include state high-risk pools prior to the ACA and the ACA's Pre-Existing Condition Insurance Plan (PCIP).

Prior to the ACA, 35 states had high-risk pools for state residents who did not have access to employer coverage or public insurance and who due to pre-existing conditions were either charged much higher premiums for individual market coverage, offered coverage excluding certain conditions, or denied coverage altogether. Some states also used high-risk pools to meet the Health Insurance Portability and Accountability Act (HIPAA) requirement that individuals losing group coverage have access to individual market coverage on a guaranteed basis. The choice of high-risk pool benefit plans was limited, although plan cost-sharing requirements were often similar to ones available in the individual market. Some excluded coverage for pre-existing conditions for six months to a year and, like many individual market plans at the time, coverage was usually subject to lifetime benefit limits. States charged premiums for high-risk pool coverage that were typically capped at 150 percent of the standard premium in their state. In addition to premium income, high-risk pools were supported by a combination of state funds, fees assessed on private health insurance carriers, and, to a lesser extent, federal grants. In 2011, 226,000 individuals were enrolled in state high-risk pools at a total cost of \$2.6 billion.<sup>1</sup> The guaranteed availability of individual market coverage at standard rates under the ACA beginning in 2014 reduced the need for

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<sup>1</sup> National Association of State Comprehensive Health Insurance Plans (NASCHIP), "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012," 26th Edition, September 2012.

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state high-risk pools. As of November 2016, most state high-risk pools were either closed entirely or were not enrolling new participants.<sup>2</sup>

To create a bridge to guaranteed issued coverage in 2014, the ACA established the PCIP program, under which state or federally run high-risk pools would be created in every state beginning in 2010. The program was supported by \$5 billion of federal funds. To qualify for PCIP coverage, individuals must have been uninsured for at least six months and either have had a pre-existing condition or been denied coverage. Premiums were based on the standard rates for individual market coverage. Total PCIP enrollment grew from 12,000 in 2010 to 56,000 in 2011 to a peak of 115,000 in 2013.<sup>3</sup>

The Kaiser Family Foundation estimates that 27 percent of adults younger than age 65 have pre-existing health conditions that would make it more difficult to obtain coverage if insurers were allowed to medically underwrite.<sup>4</sup> The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on how the details are structured.

**Eligibility**—The less restrictive the eligibility requirements are for a separate high-risk pool, the higher the high-risk pool enrollment and the larger the premium reduction for those remaining in the individual market. However, higher enrollment also means higher costs for the high-risk pool. Options to determine eligibility include:

- The presence of a specific high-cost medical condition;
- Denial of coverage in a non-guarantee issue individual market;
- Determination that premiums in the individual market are “unaffordable”; and

- Prior coverage or lack of prior coverage requirements.

**Benefit Coverage**—How benefit requirements are set would affect enrollee participation, out-of-pocket costs, overall risk pool spending, and premiums. More comprehensive coverage would provide better access to care and financial protection to enrollees, but would be more expensive. Less comprehensive coverage would be less expensive, but would expose enrollees to higher out-of-pocket costs. Coverage decisions would need to be made regarding:

- Range of benefits covered;
- Cost-sharing requirements;
- Presence or absence of annual and/or lifetime out of pocket limits; and
- Presence or absence of waiting periods for coverage of pre-existing conditions.

**Premiums Charged to Enrollees**—By definition, high-risk pool enrollees are expected to have health costs that far exceed average costs. But high premium rates (and high out-of-pocket costs) can be barriers to enrollment. To keep coverage relatively affordable, premiums can be limited to a specific multiple of standard rates. The lower the premiums, the higher the enrollment, and the more outside funding will be needed. Options for setting premiums include:

- Premium rates set to standard individual market rates or a multiple of individual market standard rates;
- Allow or prohibit third-party payment of premiums; allowing such payments would increase enrollment, but could also increase per-enrollee costs as those payments are typically made on behalf of individuals with especially high health needs;<sup>5</sup> and

<sup>2</sup> NASCHP, “[State Risk Pool Status Report](#),” November 2016.

<sup>3</sup> Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, “[State by State Enrollment in the Pre-Existing Condition Insurance Plan](#),” Accessed January 13, 2017.

<sup>4</sup> Gary Claxton, et al., “[Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA](#),” Kaiser Family Foundation, December 12, 2016.

<sup>5</sup> CCHIO has raised a concern regarding third-party payments in the ACA individual market. Dialysis providers in particular may be steering patients to ACA plans in order to benefit from higher reimbursement rates. Whether this kind of adverse selection would be a concern for high-risk pools depends on whether the pools are intended to be self-supporting and whether they are meant to be the coverage of last resort.

- Allow or prohibit income-related (or otherwise structured) premium subsidies to be used toward high-risk pool coverage.

**Funding**—If premiums charged to high-risk pool enrollees are limited to below what would be required to cover expected claims and expenses, other funding sources will be required to make up the difference. 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. Funding sources can include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

**Regulation and Administration**—Decisions would need to be made regarding which entities would regulate and administer high-risk pools. They can be regulated and administered at the state and/or federal level. Historically, they were regulated by states, and states differed in their eligibility criteria, funding, etc. Federal rules accompanied both HIPAA and the ACA, which reduced the variation across states to differing degrees. But high-risk pool administration stayed largely at the state level.

**Other Considerations**—A key feature of the traditional approach to high-risk pools is that they are separate from the individual market. This separation can raise additional considerations:

- Premium rates and eligibility criteria for high-risk pools can have a material impact on premium rates in the conventional individual market. Generally, the more individuals in the high-risk pool, the lower the rates in the standard pool. This would enhance the affordability and perhaps enrollment in the standard pool, but would also drive the costs of a high-risk pool higher.

- High-risk pool enrollees know that they have insurance that is separate and perhaps different from coverage in the individual market. Enrollee participation can depend on whether there are extra enrollment burdens and the perceived value of high-risk pool coverage.
- When high-risk pools are separate from the conventional individual market, there may be fewer benefit choices, provider options, choice of insurers (i.e., only one choice), etc. than in the individual market.
- High-risk pool costs will depend on provider payment rates. One strategy for lowering costs is to lower provider payment rates. However, providers may be less willing to treat patients with high-risk pool coverage if payment rates are lower than those in the individual market.
- If high-risk pools are not administered by an insurer or another entity with experience in care management, it may be difficult for state and federal regulatory agencies to ensure that high-risk individuals are provided with adequate care coordination and management activities. The lack of such activities could worsen health care outcomes and result in higher spending.
- High-risk pool enrollment numbers, the length of enrollment, and the impact on premiums in the individual market would depend on the individual market's issue rules. For example, if there are open enrollment periods that allow guaranteed issue enrollment, high-risk pool enrollees could move to the individual market. That could reduce high-risk pool enrollment (and costs). It could also limit the reduction of individual market premiums that would result from having separate high-risk pools, depending on whether premiums in the individual market are allowed to vary by health status. If continuous coverage is required in order for insurance to be issued on a guaranteed basis and time enrolled in a high-risk pool counts toward continuous coverage requirements, high-risk enrollees could similarly shift to individual market coverage.

- When using a separate high-risk pool, the risk of covering high-cost enrollees shifts away from insurers and individuals in the conventional individual market. High-cost individuals may bear more of the risk through higher premiums. They also bear the risk of uncertain or fluctuating external funding, which could affect coverage availability.

### **High-Risk Pool Reimbursement—Based on Health Spending**

Rather than setting up a separate high-risk pool, another approach is to use high-risk pool funds to reimburse health plans a portion of the costs of their high-cost enrollees. Individuals with pre-existing conditions would remain in the private individual market. Examples of this approach include Medicare Part D’s reinsurance program, the ACA’s transitional reinsurance program, and recent changes to the ACA risk adjustment program to include high-cost risk pooling.

Under the Medicare Part D reinsurance program, the federal government covers 80 percent of prescription drug spending that exceeds the beneficiary out-of-pocket threshold, with funding mostly from general revenues. Under the ACA, a transitional reinsurance program was in effect from 2014 to 2016. It used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. During the program’s first year, the \$10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.<sup>6</sup> Beginning in 2018, the ACA’s risk adjustment program, which transfers money among insurers based on the relative risk of their enrollees, is set to be altered to include a high-cost risk pooling component. A high-risk outlier payment that covers 60 percent of an enrollee’s costs above \$1 million will be included, funded by a percentage of insurer premiums. In other words, the program will

continue to transfer funds among insurers, with no additional funding source. Although the risk adjustment program is administered at the state level, the outlier payment transfers will be at the federal level.

The key feature of a high-risk reimbursement approach is that high-cost enrollees are covered in the same market as other enrollees. A reimbursement approach’s impact on premiums and government spending depends on several factors, particularly how reimbursements are structured and the source of funding.

**Eligibility**—High-cost enrollees would remain in the same private individual market as other enrollees—the reimbursement process would be invisible to them. Reimbursements to plans would occur when an enrollee’s allowed claims exceed a specified threshold. The lower the threshold and the higher the share of costs above the threshold that are reimbursed, the greater the potential to reduce premiums if reimbursements are externally funded.

**Benefit Coverage**—Because high-cost enrollees would remain in the private insurance market, they would have the same benefit options available to other enrollees.

**Premiums Charged to Enrollees**—Because high-cost enrollees would remain in the private insurance market, they would face the same premiums as other similar enrollees. If external funding is provided to cover the costs of the reimbursements, this approach would lower average premiums. If instead reimbursements reflect transfers of funds among insurers, average premiums would be unchanged.

**Funding**—If a high-cost reimbursement program is structured similarly to the change made under the ACA risk adjustment program, no additional funding would be required; funds would transfer among insurers. As noted, however, no reductions to premiums would result.

<sup>6</sup> American Academy of Actuaries, [Drivers of 2015 Health Insurance Premium Changes](#), June 2014.



The use of external funds would help reduce premiums. As in the traditional high-risk pools above, sources of external funding could include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

Note that under the current premium subsidy structure, the use of external funding would result in premium subsidy savings to the federal government, due to the lower premiums.

**Regulation and Administration**—A high-cost risk reimbursement pool could be structured to be regulated and administered at either the state or federal level. A unified federal reimbursement program would provide more consistent provisions across all states. However, state flexibility in the specific program parameters could be incorporated.

#### **Other Considerations**

- The use of high-risk pool reimbursement would limit the risk to insurers of high-cost outliers. As a result, insurers could reduce the risk margins incorporated into the premiums. In addition, especially in the case of external funding, the need for commercial stop-loss reinsurance could decline, further decreasing premiums.
- Compared with a traditional high-risk pool approach, under a high-risk pool reimbursement approach, insurers and enrollees in the conventional individual market would bear the risks of uncertain or fluctuating external funding. For instance, the reimbursement parameters could become more or less generous depending on funding. This could cause uncertainty for insurers as they develop premiums and for their enrollees who could see premium fluctuations from year to year.

- Retaining the high-cost insureds in the private market could help avoid the solvency and potential funding issues that may arise with separate high-risk pool programs.
- Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. Insurers that are able to attain lower provider payment rates and provide more care management and cost-effective care may benefit less than plans with higher spending. Similarly, insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas. Considerations could be given to whether adjustments to reflect provider payment rates and regional unit cost differentials would be appropriate and feasible.
- To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold.
- Unlike in a separate risk pool, a reimbursement approach may allow for more continued care coordination and management activities.
- The program would not impact rules that might be developed for any continuous coverage requirements or other rules applying to applicants.

#### **High-Risk Pool Reimbursement—Based on Health Conditions**

Rather than using high-risk pool funds to reimburse plans based on spending exceeding a threshold, reimbursements could be based on an enrollee having one or more specified high-risk conditions. Similar to when insurer eligibility for reimbursements is based on spending exceeding a threshold, this type of approach is a virtual risk pool that is invisible to the enrollee.

An example of this approach is the Alaska Reinsurance Program (ARP), which provides payments to insurers for individual enrollees who have one or more of 33 identified high-risk conditions. The program is administered by the state's risk pool board. Insurers must request that the ARP funded pool reimburse all claims for the individuals identified with these conditions. Premium revenue, pharmacy rebates, and other revenues the insurers collect for these individuals is passed to the ARP high-risk fund. In effect, individuals with high-risk conditions are placed in a virtual risk pool separate from the other pool. For 2017, the ARP is funded through state general revenues. Premera, Alaska's only marketplace insurer, reduced its 2017 premium increase request from over 40 percent to just under 10 percent as a result of the ARP.<sup>7</sup> For 2018, the state received approval for a 1332 waiver that would redirect any savings in federal premium subsidies (due to lower premiums) to the high-risk fund. Oliver Wyman projects that Alaska individual market premiums will be 20 percent lower in 2018 with the ARP than they would be without the ARP.<sup>8</sup>

Another example of this approach is the Arizona Medicaid program, which uses a catastrophic reinsurance program to cover all claims for enrollees with three specified conditions as well as the costs of 13 biological prescription drugs.

Most of the design issues of this approach would be similar to those for basing high-risk pool reimbursement on a threshold of spending.

**Eligibility**—High-cost enrollees would remain in the same private individual market as other enrollees—the reimbursement process would be invisible to them. Reimbursements to plans would occur when an insurer files claims to the risk pool for insured enrollees who have been identified as having one or more specified high-risk conditions. The list of conditions

would need to be defined, and the process for identifying enrollees with one or more of the conditions would need to be determined. Ideally, the conditions included would be those that are not susceptible to discretionary diagnostic coding.

If insurers can decide whether to submit claims to the high-risk pool for eligible enrollees, adverse selection against the risk pool could result. For example, adverse selection would result if insurers under this system wait until the end of the year to request reinsurance for those individuals with the identified conditions whose claims are higher than their revenue, rather than requesting reinsurance for all individuals with the conditions. Requiring all insurers to submit claims on all enrollees with the specified conditions eliminates the selection opportunity.

**Benefit Coverage**—Because high-cost enrollees would remain in the private insurance market, they would have the same benefit options available to other enrollees.

**Premiums Charged to Enrollees**—Because high-cost enrollees would remain in the private insurance market, they would face the same premiums as other similar enrollees. If external funding is provided to cover the costs of the reimbursements, this approach would lower average premiums. If instead reimbursements reflect transfers of funds among insurers, average premiums would be unchanged.

**Funding**—If a high-cost reimbursement program is structured similarly to the change made under the ACA risk adjustment program, no additional funding would be required; funds would transfer among insurers. However, no reductions to premiums would result.

<sup>7</sup> Premera Blue Cross Blue Shield of Alaska, [Premera Blue Cross Files 2017 Individual Health Plan Rates](#), July 18, 2016.

<sup>8</sup> Tammy Tomczyk, et al., [Alaska 1332 Waiver Application: Actuarial Analyses and Certification](#), November 22, 2016.

The use of external funds would help reduce premiums. As with the two previous options, sources of external funding could include:

- Assessments on the private health insurance industry;
- Assessments on self-insured health plans;
- Assessments on providers; and
- Federal or state general revenues.

Note that under the current premium subsidy structure, the use of external funding would result in premium subsidy savings to the federal government, due to the lower premiums.

**Regulation and Administration**—A high-cost risk reimbursement pool could be structured to be regulated and administered at either the state or federal level. A unified federal reimbursement program would provide more consistent provisions across all states. However, state flexibility in the specific program parameters could be incorporated.

#### **Other Considerations**

- Using specified conditions means that as high-cost health conditions evolve over time, the list would have to be continually updated. This revision would need to be done in a timely manner each year so insurers can update their administrative systems and properly set premiums.
- The use of high-risk pool reimbursement would limit the risk to insurers of high-cost

outliers. As a result, insurers could reduce the risk margins incorporated into the premiums. In addition, especially in the case of external funding, the need for commercial stop-loss reinsurance could decline, further decreasing premiums.

- Compared with a traditional high-risk pool approach, under a high-risk pool reimbursement approach, insurers and enrollees in the conventional individual market would bear the risks of uncertain or fluctuating external funding. For instance, the list of conditions could narrow or widen, or reimbursements be prorated. Uncertainty could result for insurers as they develop premiums and for their enrollees who could see premium fluctuations from year to year.
- Retaining the high-cost insureds in the private market could help avoid the solvency and potential funding issues that may arise with separate high-risk pool programs.
- To encourage insurers to manage care for individuals with specified conditions, insurers should have to retain the risk for a portion of claims.
- Unlike in a separate risk pool, a reimbursement approach may allow for more continued care coordination and management activities.
- The program would not impact rules that might be developed for any continuous coverage requirements or other rules applying to applicants.

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**This issue brief describes three potential approaches for using high-risk pools to cover the costs of high-risk enrollees. The impact of adopting a high-risk pool approach on access to coverage, premiums, and government spending depends on the specific approach and how its details are structured, including those related to eligibility criteria, benefit coverage requirements, and funding sources. It is also important to consider how high-risk pool approaches would interact with other insurance market rules pertaining to insurance issue, benefit coverage requirements, and premium rating.**

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