ITUP Insure the Uninsured Project

ACA Watch

Highlighting Issues and Events Affecting Health Reform in California

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About ACA Watch

Under the Affordable Care Act (ACA), California cut the number of uninsured in the state by half and embarked on reforms and system transformations touching all aspects of the state's health care delivery system.

California's reform progress, and progress around the country, is at risk. As the federal repeal and replace debate unfolds, ITUP's ***ACA Watch*** will periodically highlight emerging federal proposals, congressional and administrative actions and potential impacts for health care and health reform in California.

About ITUP

Insure the Uninsured Project is a nonprofit, independent health policy institute located in Sacramento, California.

ITUP advances creative and workable policy solutions that expand health care access and improve the health of Californians.

ITUP conducts policy focused research and convenes broad-based stakeholders on health policy topics. To assist with health reform in California, ITUP hosts an annual statewide conference and facilitates regional and issue workgroups on topics affecting health and health care in California.

The False Equivalency of High-Risk Pools to Replace the ACA

Lessons from the California Experience

Many Republican proposals to repeal, replace or rollback the federal Affordable Care Act (ACA) include some form of high-risk pool to separate the coverage for individuals with pre-existing and high-cost health conditions from the rest of the individual health insurance market.

High-risk pools are not a new idea and prior to the passage of the ACA many states administered such programs. However, that experience demonstrated that high-risk pools leave individuals who, by definition, most need access to comprehensive services, with high premiums, low benefits and insufficient access to coverage.

This issue of ***ACA Watch*** reviews California's high-risk pool experience, the lessons learned and the potential implications for the current policy debate regarding coverage for high-risk, high-cost individuals in a post-ACA environment.

The Pre-ACA Individual Health Insurance Market

Prior to the ACA, health plans selling individual policies routinely denied coverage or hiked premiums based on an applicant's health status or medical history and imposed coverage exclusions for pre-existing health conditions. Health plans in California and most other states had total discretion to collect and use medical and health information to evaluate individual applicants (known as medical underwriting); no two health plans had identical criteria for making coverage and rating decisions.

Kaiser Family Foundation (KFF) estimated that approximately 18 percent of individual coverage applications were denied at the time.[1] In 2009, America's Health Insurance Plans estimated individual market denial rates at 5 percent for children and 29 percent for adults age 60-64.[2]

To compensate for this severe limitation of the pre-ACA individual market, 35 states, including California, administered high-risk insurance pools (separate health coverage programs). Pre-ACA high-risk pools varied by state but generally had similar features, including premiums significantly higher than standard market rates, exclusions for pre-existing conditions, lifetime and annual benefit limits (common in the individual market at the time) and high deductibles.[3] A few states, including California, capped or closed enrollment to limit costs and wait-listed applicants.

Most states funded the net losses – expenses above subscriber premiums – through assessments on health plans, typically offset by state tax credits, but a few states, including California, used other state revenue sources.[4] In some years, federal grant funds were available to states meeting specified criteria, but federal funds represented only 2-12 percent of program expenses in states that received federal funds.[5]

The ACA dramatically changed the individual market, particularly for those with pre-existing health conditions. Health plans must guarantee issue of coverage, which means they must accept all applicants regardless of health status or claims history. ACA also prohibited coverage exclusions for pre-existing medical conditions. The ACA imposed adjusted "community rating," requiring health plans to only vary premiums based on specific demographic factors -- age, geography, family size – but not based on the individual's health status or health risk.

California's High-Risk Pool

Enrolling its first subscribers in 1991, California's Major Risk Medical Insurance Program (MRMIP) was developed and originally administered by the independent Managed Risk Medical Insurance Board (MRMIB). For most of its history, MRMIP was funded through a combination of subscriber monthly premiums (plus subscriber deductibles and copayments) and Proposition 99 tobacco tax revenues. To be eligible for MRMIP, applicants must be unable to obtain adequate individual coverage and ineligible for Medicare Part A and Part B (except for Medicare recipients with end-stage renal disease (ESRD). MRMIP regulations define "unable to secure adequate coverage" to mean being denied individual coverage, being involuntarily terminated for reasons other than nonpayment of premium or being offered coverage at premium rates higher than the individual's first choice MRMIP participating health plan.

MRMIP is now administered by the state Department of Health Care Services. However, since under the ACA health plans can no longer deny coverage to individuals based on health status or pre-existing condition, MRMIP is now primarily a source of secondary coverage for Medicare recipients with ESRD. Recipients under age 65 enrolled in Medicare because of ESRD are ineligible for guaranteed individual Medicare supplement coverage.

MRMIP enrollment has dropped to just under 1,200 from a high of nearly 22,000 subscribers in 1998. MRMIP served more than 100,000 Californians over the life of the program.

The following discussion focuses on the pre-ACA history of MRMIP.

A Tale of High Premiums, Inadequate Coverage, and Waiting Lists

Prior to California's implementation of the ACA, MRMIP offered health care coverage for hard-to-insure individuals through contracted health plans voluntarily participating in the program. Even though MRMIP rates were subsidized, subscribers paid rates significantly higher than those paid by individuals who could pass medical review in the private market. MRMIP rates were capped at 137.5 percent for a comparable benefit package in the private market and varied by the geographic region and health plan selected. Proposition 99 funding was fixed, ranging from $30-45 million per year.

MRMIP benefits were severely limited from the start to stay within the fixed budget. MRMIB capped coverage at $50,000 per year with a lifetime maximum benefit of $500,000 initially and increased coverage maximums to $75,000 per year/$750,000 lifetime in 1999. The program benefits have not been adjusted since 1999. MRMIP benefit limits made California ineligible for federal high-risk pool funds available to states in the pre-ACA period.

Until MRMIP was restructured in 2003 (see discussion of the Guaranteed Issue Pilot (GIP) Program below), capped state funding required the program to limit enrollment and there was nearly always a waiting list. The number who could enroll depended on program cost and revenue estimates developed by MRMIB's contracted actuary, PricewaterhouseCoopers (PwC). PwC recommended a maximum enrollment limit each year to keep the program within budget. In 1999 and 2000, the California Health Care Foundation provided a $2 million grant to preserve available slots that could not be funded with existing program revenues.

In 2001, the MRMIP waiting list reached an all-time high of over 7,000 Californians with maximum enrollment set at 15,715. In 2002, the California Legislature moved to address the waiting list and created the GIP Program, (also referred to as the incubator, the graduate program, or GIP coverage).[6] Under the GIP, individuals covered through MRMIP for 36 months were transitioned out with the option to seek private individual coverage from any health plan selling individual health insurance. The GIP legislation required all such health plans to offer coverage on a guaranteed issue basis to individuals leaving MRMIP at an additional 10 percent above the already high MRMIP rates. GIP coverage had a slightly higher annual benefit limit of $200,000.

By the end of 2003, 9,594 subscribers were disenrolled from MRMIP and 7,832 (82 percent) elected GIP coverage. The MRMIP target enrollment remained at 10,718. In 2005, the state Legislative Analyst's Office (LAO) reported that the GIP had increased MRMIP's capacity to help hard-to-insure Californians using the same level of state resources.[7] At the same time, LAO found a high number of eligible individuals were not enrolling in GIP coverage and many who did enroll subsequently dropped out. According to LAO, anecdotal information at the time suggested that GIP coverage had become unaffordable for some. Ultimately, as the program unfolded, MRMIB and health plans covering GIP subscribers shared in funding costs above GIP subscriber contributions totaling in the tens of millions of dollars.

Enrollment in MRMIP began dropping as prices in the individual market increased from 2002 to 2004, on average 37 percent, triggering dramatic increases in MRMIP premiums.[8] In 2005, rates for a MRMIP subscriber age 40-44 ranged from $276-$695 per month depending on the geographic region and health plan selected. By 2010, the program was serving only 6,941 enrollees. Rates for a person age 50-54 in Sacramento had reached $551 per month for the Kaiser HMO plan and $878 for the Blue Cross PPO plan. In 2011, according to the MRMIP/GIP *Fact Book*, California's high-risk pool enrollment represented less than 1 percent of enrollment in the state's individual market. MRMIP never reached capacity once the GIP started.

Many observers believed at the time that enrollment in both MRMIP and GIP represented only a fraction of the individuals who were eligible. The combination of persistent waiting lists, limited benefits and high premiums likely discouraged many who were eligible from even applying for coverage. A 2016 Kaiser Family Foundation (KFF) study estimated that 27 percent of adults under the age of 65 have health conditions that, prior to the ACA, would have rendered them uninsurable in the pre-ACA individual market.[9]

In the years leading up to the ACA, California policymakers considered multiple bills to address the funding issues in MRMIP/GIP.[10] Most proposals increased funding through an assessment on all health plans in the state or the smaller universe of all health plans selling individual coverage. Repeated bills failed to become law.

Profile of MRMIP Subscribers

In March 2006, MRMIB released the *Fact Book* on MRMIP and GIP, including the results of surveys MRMIB conducted among both groups. The *Fact Book* includes information on the demographics of both populations, claims costs, medical conditions, subscriber satisfaction with MRMIP, and an analysis of the differences between those who decided to accept coverage under the GIP (accepters) and those who did not (decliners).

The *Fact Book* revealed that more than half of MRMIP subscribers were unemployed (57 percent) and of those employed, more than half were self-employed (55 percent). The size of firms for the 43 percent of MRMIP subscribers who were employed varied, with no dominant category (27 percent in firms of less than 5 employees, 27 percent in firms of 6-24 and 31 percent in firms of more than 50 employees.) The largest number of subscribers were in "professional" occupations (26 percent), followed by the service industry (18 percent) and more than 14 percent said they had never been employed. About 80 percent of MRMIP subscribers attended college, including more than 25 percent who completed college. More women than men enrolled in MRMIP (58 percent vs. 42 percent) with an average age of 43.

Between 1999 and 2004, around 80 percent of MRMIP subscribers had medical costs of $5,000 or less per year. During 2004, 19 percent of MRMIP enrollees made no medical claims at all, despite having been determined to be medically uninsurable by insurers who had denied them coverage. More than 18 percent of subscribers had no current medical condition at the time of the survey. Year to year, less than 1 percent of MRMIP subscribers reached the program's $75,000 annual maximum benefit cap.

Other significant findings from the report include:

1) Sixty percent of MRMIP subscribers had incomes below $60,000 per year and paid between 13 and 36 percent of their annual income for MRMIP coverage.

2) Subscriber premiums covered just 62 percent of program costs. Of the $40 million in tobacco tax revenues available for the two programs, $25.4 million was spent on services in MRMIP and $14.6 million on services

in GIP in 2004-05. Insurers provided an additional $14.6 million in subsidies for GIP enrollees through payment of claims in 2004-05.

3) Because most enrollees disenrolled from MRMIP chose the same health plan for GIP, the GIP unintentionally created a disincentive for health plans to participate in MRMIP. All three health plans participating in MRMIP had substantial losses in the GIP.

4) Subscribers in GIP were older than those in MRMIP and had higher claims costs. The *Fact Book* suggests this is likely because the first wave of MRMIP enrollees moving to GIP had been in MRMIP for 36 months or more, many for substantially longer. After implementation of GIP, the MRMIP medical loss ratio (ratio of premiums to medical claims) fell from 154 percent to 129 percent. The GIP loss ratio was around 159 percent.

5) About 65 percent of those eligible for GIP coverage enrolled. Half of those declining coverage managed to obtain alternate health coverage. Decliners of GIP had lower incomes than accepters. More decliners rated themselves to be in very good to excellent health (46 percent vs. 38 percent). More accepters rated themselves in fair or poor health (31 percent vs. 23 percent). More decliners cited affordability as a major factor in choosing to purchase coverage (61 percent vs. 42 percent).

ACA Pre-Existing Condition Insurance Plan (PCIP)

The ACA established a temporary, national high-risk pool program in the lead-up to ACA implementation, 2010-2014. Along with 27 other states, California established a state-run PCIP as a separate program alongside MRMIP.[11] Using a structure like the federal PCIP, MRMIB contracted with an external administrative vendor to process and manage PCIP enrollment and a third-party administrator to contract with providers and pay claims. The federal government operated PCIP in 23 states and the District of Columbia.

ACA provided $5 billion in federal funds for the program and California's allocation was $761 million. By late 2012, the PCIP was operating in all 50 states, had enrolled just over 100,000 individuals and had already consumed nearly half of the $5 billion appropriation.[12]

PCIP addressed many of the shortcomings of state high-risk pools and imposed no waiting periods or annual or lifetime benefit limits. PCIP premiums were set at 100 percent of market rates (adjusted for age and geography) and the program offered comprehensive benefits with a cap on out-of-pocket costs tied to federal IRS rules for high-deductible health plans.[13] PCIP did not impose pre-existing condition exclusions but did limit eligibility to individuals uninsured for at least six months.

Since PCIP rates were set at market rates, PCIP enrollees paid a lesser share of the costs than enrollees in traditional state high-risk pools. In 2011, claims under traditional state high-risk pools averaged 181 percent of subscriber premiums while that same year, PCIP claims averaged 417 percent of premiums.[14] In the face of growing expenses, the Centers for Medicare and Medicaid Services (CMS) adopted changes to limit PCIP program costs. CMS switched to a less expensive provider network and negotiated additional discounts with targeted hospitals. CMS also required state-run programs to achieve similar cost savings or transition to federal administration. At its peak enrollment in March 2013, California's PCIP covered 16,762 enrollees.[15] Faced with the new CMS requirements, California made the decision to transfer PCIP administration and existing enrollees to the federal CMS effective July 1, 2013. The federal PCIP had already closed to new enrollment March 1, 2013 because of budgetary concerns.

ACA Risk Stabilization Strategies

As stated above, the ACA dramatically improved the individual insurance market, especially for high-risk individuals. However, many of the concerns that influenced the pre-ACA individual market remain. Because individuals often bear all, or a sizable portion, of the premiums for individual coverage (in contrast, for example, to employer-sponsored coverage where employers contribute to premiums) there is a real risk of adverse selection.[16] This is because older individuals and those who most need health care have the strongest incentive to purchase coverage, while younger, healthy people may be more willing to forego coverage until they experience an accident or illness. Guaranteed issue requirements mean that those who wait to buy coverage until they know they need health care can obtain coverage without exclusion, subject to open and special enrollment periods, and health plans cannot deny coverage or rate up

those individuals. This also means that despite ACA reforms, health plans still have a financial and competitive incentive to attract the healthiest individuals, and may try to do so by designing benefits, provider networks or marketing strategies that appeal to healthier individuals (risk selection).[17]

The ACA included specific provisions to limit adverse selection; requiring most people to have coverage or pay a penalty (individual coverage requirement), limiting coverage sign-ups to annual and special enrollment periods, and offering income-based subsidies to help with the cost of buying insurance for low and moderate income individuals of all ages. California improved on the ACA with standardized benefit plans adopted by the state's ACA marketplace, Covered California, and requiring in law the offering of those products both inside and outside of the exchange.

The ACA also included three risk stabilization programs to address both adverse selection and risk selection: risk adjustment, reinsurance, and risk corridors. Below is a brief overview of the three ACA programs.[18]

- ***Risk Adjustment***. Risk adjustment transfers funds from health plans with lower-risk enrollees to health plans with higher risk enrollees. The ACA risk adjustment program applies to individual and small group insurance markets (except for grandfathered plans that existed at the time of ACA enactment.) As of 2017, the federal Department of Health and Human Services (DHHS) operates the risk adjustment program in all states, including California. The DHHS methodology estimates financial risk using enrollee demographics, and claims for specified medical diagnoses, and develops an average risk score for health plans by geographic region and market segment. Health plans with relatively low average risk scores make payments into the system and health plans with relatively high average risk scores receive payments. There is a delay in the transfers of about a year while DHHS applies the methodology and audits the results. In 2015, transfers in the individual market averaged 10 percent of premium and 6 percent in the small group market.

- ***Reinsurance***. The temporary ACA reinsurance program was in place from 2014 to 2016. The program transfers funds to individual market plans subject to guaranteed issue who enroll high-cost enrollees. In contrast to risk adjustment, reinsurance is based on actual health care expenses rather than estimated risk or predicted costs. In this way, reinsurance also accounts for low-risk individuals who have unexpected health care costs. All health insurers and self-funded group plans make contributions but the payments are made only to individual market plans. Most states, including California, opted to participate in the federally-administered reinsurance program. Health plans receive reinsurance payments if they have enrollees whose health care expenses reach a specified threshold (attachment point), which was $45,000 in 2014 and 2015 and $90,000 in 2016. Payments are subject to a dollar limit (reinsurance cap) of $250,000. DHHS reimburses health plans a percentage of the costs between the attachment point and the reinsurance cap (coinsurance). DHHS paid 100 percent of the costs in 2014 but for 2015 set the rate at 55.1 percent because program revenues ($6.5 billion) were less than the requests for payments ($14.3 billion).

- ***Risk Corridors***. The temporary risk corridor program was in place 2014 to 2016. The program set a target for insurers to spend 80 percent of premium on health care expenses and quality improvement. This coincides with the ACA medical loss ratio requirement for most individual and small group plans to spend at least 80 percent of premium on medical care and quality improvement or issue a refund to enrollees. Health plans with costs 3 percent less than the 80 percent target must pay in to the program and the funds are used to reimburse health plans with costs that exceed 3 percent of the 80 percent target. The risk corridor program was federally administered. Originally, risk corridor payments were not required to net to zero but in 2015 and 2016 appropriations bills Congress specified that payments could not exceed collections and prohibited the Centers for Medicare and Medicaid Services (CMS) from transferring other funds to pay for the risk corridors program. Total risk corridor claims for 2014 totaled $2.87 billion and contributions only $362 million. CMS is using collections in subsequent years to pay prior year claims. In 2016, CMS stated it would work with Congress to explore other sources of funding to cover claims for the entire period.

Lessons Learned

California had more than two decades of experience with high-risk pools prior to implementation of the ACA. The ACA accomplished what the state could not achieve: access to health coverage for individuals without employer-

sponsored or public coverage, regardless of the person's health history or claims experience. In so doing, the ACA eliminated the costs, and the infrastructure, not to mention the burden on individuals, associated with medical underwriting, and imposed market-wide standards for applying and enrolling in health coverage. Individual applicants are no longer subject to the caprices of each health plan's underwriting policies and practices.

Lessons that can be learned from California's high-risk pool experience include:

- ***Funding must be adequate***. California's experience, and that of other state high-risk pools, serves as a cautionary tale. The costs associated with segregating the highest risk enrollees in one coverage program are extremely high and the political will to fully fund the programs has typically been lacking. Without adequate funding, high-risk pools inevitably lead to reduced benefits, exclusions, exorbitant premiums, capped enrollment and insurer losses that discourage health plan participation in the program. If benefits or enrollment are restricted to accommodate fixed program budgets, the programs ultimately fail to address the health care needs of the sickest enrollees for whom they are intended.

- ***Segregated coverage pools are blunt instruments***. Many high-risk pools made eligibility contingent on coverage denials by health plans or premium quotes above market rates, even though health plan underwriting and rating practices were not standard. In the pre-ACA market, health plan underwriting criteria were very stringent because intense price competition incentivized health plans to avoid any potential risk or costs. Despite health plan underwriting decisions, many MRMIP subscribers ended up with relatively low health care costs and, in many cases, subscribers reported no current medical condition. Only a relatively few subscribers exceeded benefit caps but when they did the costs were significantly higher than the benefits. Other risk stabilization strategies, such as risk adjustment and reinsurance, allow for more refined measures of relative risk and costs among health plans and better targeting of compensating payments.

- ***High-risk pools focused on market inequities before ACA improvements***. High-risk pools were a band-aid in the pre-ACA individual market where many applicants were locked out of coverage because of their health status or medical history. The ACA eliminated the ability of health plans to deny coverage or rate up applicants. It is not clear how high-risk pools as separate coverage programs would be implemented in the post-ACA context, without undermining the core protections of the ACA most policymakers say they intend to protect. Implementing high-risk pools would likely require that health plans once again collect health and medical information from all applicants and would invite the type of discrimination against sick and high-risk individuals that mostly disappeared in the reformed ACA market.

California's experience with high-risk pools suggests that reintroducing the concept will undermine the accomplishments of the ACA and return public policy to supporting an individual market that excludes or treats differently those who are most in need of comprehensive coverage. Guaranteed issue and protection for individuals with pre-existing conditions are among the most publicly well-known and popular provisions of the ACA. Moreover, the President and Congressional Republicans have repeatedly stated their intent to maintain these protections.

Republican Proposals

Republican proposals to repeal, replace or repair the ACA include high-risk pools either as a part of a full ACA repeal and replacement, including repeal of guaranteed issue and individual coverage requirements, *or* in proposals that would retain some ACA consumer protections, such as guaranteed issue requirements, but eliminate the individual coverage requirement and other provisions such as the Medicaid expansion.

Republican proposals that fully repeal the ACA, eliminating guaranteed issue and the individual coverage requirement, offer high-risk pools (and sometimes other risk adjustment options) as an alternative for individuals with pre-existing conditions who could once again be denied coverage or rated up. The proposals would generally provide a fixed amount of federal funds to be divided among states (see a Better Way by the House Republican leadership and Empowering Patients First Act proposed by now Secretary of DHHS, Tom Price. These proposals provide $25 and $1 billion respectively in federal funds for state high-risk pools.)

American Health Care Act

The American Health Care Act (AHCA) would maintain the ACA issue requirement but eliminate the individual coverage requirement (see ITUP analysis of the American Health Care Act, introduced by the House Republican caucus and pending on the House floor). To address the potential for adverse selection in the absence of a coverage mandate, the AHCA requires consumers to maintain "continuous coverage" without any lapses of more than 60 days. Those who do not maintain coverage can lose the right to guaranteed issue or be charged a premium surcharge of as much as 30 percent for up to one year.

The AHCA provides a $100 billion State Innovation Grant and Stability Program to fund state innovations including but not limited to high-risk pools. Proposed amendments would add an additional $15 billion for states to fund "invisible high-risk pools" (see below). Representative Tom MacArthur (R-NJ) is also advancing amendments to the AHCA that it appears would allow states to seek waivers that amend community rating and allow medical underwriting, if the state establishes a high-risk pool. As of this writing, no legislative language for the MacArthur proposal has surfaced.

Invisible High-Risk Pools. Amendments proposed for the AHCA would create a federal "invisible risk sharing program" within the AHCA's Patient and State Stability Fund. The proposal is said to be modeled on similar programs implemented in Maine in 2011 and in Alaska more recently.[19] The amendment appropriates $15 billion for the program from January 1, 2018 through the end of 2026. Insurers would cede a portion of the premiums they receive from qualified individuals to the program. CMS would develop a list of high-cost medical conditions that automatically qualifies individuals for program participation. Individual applicants would presumably have to complete health status forms to identify their eligibility and insurers could also cede individuals who did not automatically qualify at enrollment. States would be able to take over the program in 2020.

Invisible risk sharing is basically a form of reinsurance and has the advantage of not segregating individuals in a separate coverage program with all the defects described above. However, the proposed federal funding level of $15 billion over nine years is likely to be insufficient, even with insurer contributions.[20]

Administrative Action

In addition to federal legislation to repeal or rollback the ACA, the new federal Administration has signaled its intent to move toward high-risk pools through administrative action. In a letter to states dated March 13, 2017,[21] Secretary of Health and Human Services, Tom Price, encouraged states to use the Section 1332 ACA state innovation waiver process to implement state high-risk pool/state-operated reinsurance programs to "lower premiums for consumers, improve market stability and increase consumer choice." The state of Alaska applied for a Section 1332 waiver to reinvest federal premium tax credit savings from anticipated lower premiums into a state reinsurance program.

Discussion

Given the challenges with high-risk pools in the past, it is difficult to see how reintroducing the model following repeal or rollback of the ACA would guarantee coverage for everyone who could not pass medical underwriting. Continuous coverage requirements would ensure some individuals remain covered but those who have a lapse in coverage because of loss of employer-sponsored or public coverage, who could not afford the costs of individual coverage, could be left out or severely penalized. Experience shows that state coverage through high-risk pools will likely subject those eligible to reduced or capped benefits, and possibly waiting lists, as states work to manage program costs.

Beyond the poor track record of state high-risk pools, the Republican proposals now pending raise many policy questions about how state high-risk pools would or could be implemented in a post-ACA context. There are essentially two broad categories of proposals that include state high-risk pools: those where the ACA is fully repealed, and those where some core provisions of the ACA are repealed, such as the individual coverage requirement, but other provisions remain, such as the requirement for health plans to guarantee issue to all applicants. In either circumstance, reintroducing high-risk pools raises issues states will need to address, such as:

- ***Who would be eligible for the programs***? Prior to the ACA, many high-risk pools, including California's program, accepted individuals based on the denial of coverage by health plans selling individual coverage. In addition, California allowed individuals to enroll who received premium quotes above those for MRMIP coverage. However, individual health plan underwriting policies and practices varied widely and there was no predictable way to know who would end up being eligible for the programs. If guaranteed issue of coverage continues, states could determine eligibility based on the presence of specific high-cost medical conditions or other objective criteria. However, history demonstrates that the presence of the conditions themselves does not always lead to high-costs and, moreover, such an approach does not address unexpected high-cost episodes. It is also unclear whether states could impose pre-existing condition exclusions on subscribers in high-risk pools, a practice prohibited under ACA.
- ***What benefits would be covered***? Nearly all pre-ACA state high-risk pools had limited benefits and many had annual and lifetime benefit caps. The ACA prohibits benefit caps but if the ACA is repealed it is possible states could re-impose benefit caps to manage fixed funding. Many Republican proposals that repeal only portions of the ACA would also reduce or eliminate the ACA essential health benefits requirement or allow states to do so. Whatever changes are made to benefits overall, there could be significant pressure on states to reduce high-risk pool benefits or increase subscriber cost-sharing to stay within budget, potentially leaving the sickest patients without adequate coverage to preserve or improve their health.
- ***What rates would subscribers pay***? Subscribers in pre-ACA high-risk pools paid monthly premiums at rates above market rates, averaging 125 to 200 percent of market. The ACA prohibits risk-based rating. Allowing states and health plans to begin charging individuals rates based on health status would be a huge shift for consumers now used to the protections of the ACA and, regardless of whether specific provisions of the ACA remain intact, would undermine the spirit and the intent behind the ACA.
- ***Who would bear the costs***? Republican proposals that promote high-risk pools typically provide a fixed appropriation of federal funds for that purpose. Most observers believe that the funding levels proposed to date would be inadequate to support the costs of covering all individuals who have pre-existing health conditions and might be eligible for state programs. Many pre-ACA high-risk pools raised revenues through assessments on health plans, but California was unable to secure legislation to establish such an assessment. If the funding is inadequate, would states bear the remaining costs? Could states impose waiting periods to manage the program budget? What coverage options would there be for those placed on waiting lists?

While high-risk pools are likely to be inadequate to fully address the impacts of ACA repeal on high-cost patients, within the framework of the ACA, there may be opportunities to use other risk adjustment strategies to reduce premiums for the broader individual market, both inside and outside of exchanges, and improve affordability of coverage. For example, Covered California estimates that using the approach of funding a national reinsurance program at $15 billion as proposed in the AHCA Stability Fund, for 2018 and 2019, would reduce premiums by about 15 percent in 2018.[22] Covered California's analysis highlights the reduced federal costs for ACA premium subsidies if premiums decline, finding that the actual federal cost of such a reinsurance program would be less than $5 billion.

Conclusion

The ACA eliminated the need for high-risk pools through a comprehensive framework that requires insurers to cover eligible applicants during annual and open enrollment periods and includes other elements to reduce adverse selection, such as the individual coverage requirement and premium subsidies. Repealing the ACA coverage requirement is likely to result in adverse selection as well as higher premiums, which the Congressional Budget Office estimates will result in millions of newly uninsured.[23] High-risk pools would be a finger in the dyke if the ACA, or key provisions of the ACA, such as guaranteed issue and the individual coverage requirement, were repealed.

Returning to high-risk pools as separate coverage programs for those with pre-existing health conditions would be a dramatic step backward, as California's history demonstrates. Returning to the era of medical underwriting and risk segregation would undermine the foundational consumer protections the ACA provides. High-risk pools would also likely not preserve the ACA's promise to cover everyone regardless of pre-existing conditions. Ultimately, high-risk pools are a false equivalency to the ACA's comprehensive coverage framework.

Notes

[1] Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,* Kaiser Family Foundation, December 2016, http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/
[2] *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits*, America's Health Insurance Plans, October 2009, https://kaiserhealthnews.files.wordpress.com/2013/02/2009individualmarketsurveyfinalreport.pdf
[3] Karen Pollitz, *High-Risk Pools for Uninsurable individuals,* Kaiser Family Foundation, February 2017, http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/
[4] Pollitz.
[5] Pollitz.
[6] AB 1401 (Thomson), Chapter 794, Statutes of 2002.
[7] *Assessing Recent State Efforts: Health Care for the "Hard-to-Insure,"* Legislative Analyst's Office, December 2005, http://www.lao.ca.gov/2005/ab1401/hardtoinsure_120705.pdf
[8] *Major Risk Medical Insurance Program: 2006 Fact Book,* California Managed Risk Medical Insurance Board, http://www.chcf.org/~/media/MEDIApercent20LIBRARYpercent20Files/PDF/PDFpercent20M/PDFpercent20MRMIPFBV3_23_06.pdf
[9] Gary Claxton et al.
[10] See Assembly Bill 1971 (Chan) of 2006; AB 2 (Dymally) of 2007, vetoed by the Governor; and Senate Bill 227 (Alquist) of 2009, which was eventually the vehicle for California's adoption of the temporary ACA high-risk pool, Pre-existing Condition Insurance Plan.
[11] SB 227 (Alquist), Chapter 31, Statutes of 2010.
[12] Pollitz.
[13] Jeanne Lambreau and Ellen Montz, *States Be Warned: High-Risk Pools Offer Little Help at a High Cost,* Health Affairs Blog, February 28, 2017, http://healthaffairs.org/blog/2017/02/28/states-be-warned-high-risk-pools-offer-little-help-at-a-high-cost/
[14] Pollitz.
[15] *State-by-State Enrollment in the Pre-Existing Condition Insurance Plan*, Centers for Medicare and Medicaid Services, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/pcip-enrollment.html
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[17] Cox et al.
[18] Gary Claxton et al.
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