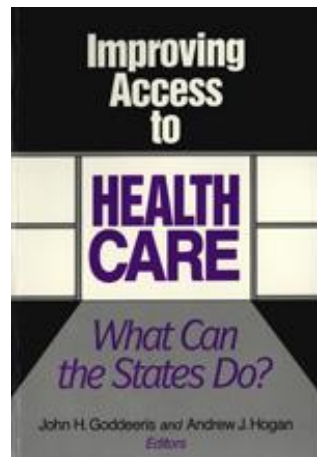

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5.4

High-Risk Pools

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High-risk pools are created by states to expand the availability of private health insurance for individuals who have serious medical conditions and have difficulty purchasing insurance. Such pools are relatively attractive politically as a mechanism for reducing the size of the uninsured population in a state and do, in fact, permit some medically (not economically) needy individuals to purchase health insurance.

There is a sizable and growing population of individuals with medical conditions or past medical experiences that indicate the potential for high medical bills in the future. Private insurance companies consider these people “bad risks” and may substantially increase their premium, exclude treatment for the pre-existing condition, or refuse to sell them insurance (Griss 1988, p. 43). Such actions make it impractical or impossible for some people to buy coverage, particularly if they are not part of a group plan. Estimates of the size of this population vary, but they are often in the vicinity of 1 percent of the total population or 1 percent of the under 65 population (Bovbjerg and Koller 1986, p. 111; Intergovernmental Health Policy Project 1988, p. 13). The Health Insurance Survey of Michigan found that 1.5 percent of the state’s total population had no insurance, ranked their health status as fair or poor, and/or felt they had a disabling condition (Bashshur, Webb, and Homan 1989). There is agreement that, regardless of the precise size of this population today, it is growing and will continue to for the foreseeable future.

The numbers of the difficult-to-insure are growing for several reasons. First, early detection and medical treatments are increasing the survival rates for many diseases. Second, screening programs are detecting

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diseases at earlier stages, before symptoms become evident (U.S. Congress 1988a,b). Third, competitive pressures on insurers to hold down premiums lead them to reduce risks by taking action when possible against those with specific, known medical conditions. And, fourth, employers are under pressure to minimize their costs and are tempted to take corresponding actions against the same individuals. Future trends in medical technology and health care cost inflation point toward an expanding population of the medically uninsurable. High-risk pools appear to be an obvious answer to this problem.

What Is a High-Risk Pool and How Does It Work?

Organization

The general structure of high-risk pools is similar from state to state, although there is some variation in the details. The pool is created by state legislation, which forms an association of all health insurance companies doing business in the state and establishes an independent governing board. Some states also require health maintenance organizations (HMOs) to participate. Self-insured plans are not included because of their exemption from state regulation under the Employee Retirement Income Security Act of 1974 (ERISA). The pool is governed by a board including representatives of the insurance industry, state government officials, and consumers. It is responsible for setting the package of benefits, recommending premium rates, and contracting with a private insurance company to administer the program on a daily basis as the lead carrier. Insurance agents receive a fee fixed by the pool for enrolling new members. It is less than a commission would be and provides some savings on administrative costs. The state insurance department provides oversight for the program.

Benefit Package

The enabling legislation generally requires the pool to offer insurance coverage of a full and traditional range of major medical services similar to that offered in large group plans. The benefits are not designed

specifically to include all the providers and treatments often needed by individuals with chronic and/or handicapping conditions, just those standard for acute medical care. Where there are service limits, they tend to be relatively high and provider reimbursement is reasonable. There is a maximum limit on total dollar lifetime benefits and also annual limits on out-of-pocket spending (stop/loss). Copayments are usually at 20 percent, and there are deductibles with amounts that vary from state to state. Some pools offer different deductible levels, depending on which option/premium level the enrollee chooses (see Table 1). Some states include in their benefit package some cost-containment mechanisms, such as utilization controls.

Premium

The state enabling legislation imposes a limit on the premiums that can be charged. The maximum is a percentage (generally 150 percent) of the average premium rates for standard health risks with comparable coverage (see Table 2). The premiums are rated for age and sex. While the pools start with premiums below the maximum, they rapidly increase to the limit as the costs become evident.

Financing

Most pools operate at a loss because the utilization and health care costs of high-risk individuals are significantly greater than 150 percent of the average, but their premiums are capped. The losses most often are paid by the member insurance companies, based on their market share in the state. In a few states, the companies must treat this assessment as part of the costs of doing business in the state. Elsewhere, the companies are permitted a credit against their state tax bills for the full assessment (see Table 2).

Eligibility

The pools are designed primarily for the medically “uninsurable” and require evidence from the applicant of that status. They reject the insurance concept of spreading the risk broadly across a heterogeneous population and anticipate the inevitable adverse selection. Even states

Table 1
State High-Risk Pools: Eligibility and Benefit Structure

State	Eligibility	Benefit package for individual		
		Deductibles (\$)	Out-of-pocket annual limit (\$)	Lifetime maximum (\$)
Connecticut	All residents ineligible for Medicare	400-1,500	2,000	1,000,000
Florida	Resident ineligible for Medicaid, plus Rejected by 2 insurers, Received notice of benefit reduction, or Premium increase exceeded pool rate	1,000-2,000	2,500-3,500	500,000
Illinois	Residents ineligible for Medicaid, plus Rejected by 1 insurer, Premium increase exceeded pool rate, or Certain medical conditions covered automatically Also, groups of 10 or less if 1 or more meets above criteria	250-1,500	1,500	500,000
Indiana	Residents ineligible for Medicare, plus Rejected by 2 insurers, Received notice of benefit reduction, Premium increase exceeded pool rate, or Certain medical conditions covered automatically	200-1,000	1,000-2,000	none 50,000 limit on mental and nervous disorders
Iowa	Residents ineligible for Medicaid, plus Rejected by 1 insurer, Premium exceeded pool rate, or Certain medical conditions covered automatically	500-1,000	1,500-2,000	250,000
Maine	Residents ineligible for Medicare or Medicaid, plus Premium exceeded pool rate	500-1,000	5,000	250,000

Minnesota	Rejected by 1 insurer, Restrictive rider limits coverage, Premium exceeded pool rate, or Certain medical conditions covered automatically	500-1,000	3,000	500,000
Montana	Rejected by 2 insurers, or Restrictive rider limits coverage	500-1,000	5,000	250,000
Nebraska	Residents ineligible for Medicare or Medicaid, plus Rejected by 1 insurer, Restrictive rider limits coverage, or Premium exceeded pool rate	250-1,000 (10% co-insurance)	5,000	500,000
New Mexico	Residents ineligible for Medicare or Medicaid, plus Rejected by 1 insurer, Restrictive rider limits coverage, or Premium exceeded pool rate	500-1,000	1,500-2,000	none
N. Dakota	Rejected by 1 insurer, or Restrictive rider limits coverage	150-1,000	3,000	250,000
Tennessee	Residents ineligible for Medicaid, plus Rejected by 1 insurer	500-2,000	1,500-2,500	500,000
Washington	Residents ineligible for Medicaid, plus Rejected by 1 insurer, or Restrictive rider limits coverage	500-1,000	1,500-2,500	500,000
Wisconsin	Residents ineligible for Medicaid, plus Rejected by 1 insurer, or Received notice of benefit reduction, or Premium exceeded pool rate	1,000 (deductible subsidized for low-income individuals)	500-2,000	500,000

SOURCES: Communicating for Agriculture, Inc 1988; Intergovernmental Health Policy Project 1988, p. 5; and U S General Accounting Office 1988, pp. 11-14.

Table 2
State High-Risk Pools: Financial Features, 1989

State, date operational	Enrollment	Premium cap (percent)*	Premiums collected (\$)	Claims paid (\$)	Pool funding mechanism
Connecticut 1976	2,127	125-150	3,460,000	6,565,000	-insurers assessed; tax credit
Florida 1983	4,849	150-200	4,618,650	8,582,000	-insurers assessed; tax credit removed 1989 -limit on assessments: ≤ 1% of health insurance premiums written in state
Illinois 1989	2,560	135	NA	NA	-legislative appropriation of general revenues
Indiana 1982	2,610	150	5,607,908	9,640,519	-insurers assessed; tax credit
Iowa 1987	1,495	150	1,197,800	1,250,000	-insurers assessed; tax credit
Maine 1988	109 (300 enrollees maximum set by legislature)	125	15,178	0	-new tax of up to .0015% on hospital gross patient services revenue
Minnesota 1976	14,386	125	14,197,219	27,098,596	-insurers and HMOs assessed; no tax credit since 1987

Montana 1987	109	150-400	97,026	65,374	-insurers assessed; tax credit
Nebraska 1986	1,750	135-165	6,005	185,000	-insurers assessed; tax credit
New Mexico 1988	698	150	233,053	127,399	-insurers assessed; no tax credit until member's assessment \geq \$75,000, then 30% credit allowed for excess amount over \$75,000
N. Dakota 1982	1,551	135	1,197,903	3,340,441	-insurers assessed; tax credit
Tennessee 1987	3,933	135-150	2,794,650	2,807,000	-insurers assessed; tax credit -state cap of \$3 million/yr. on state funds to pay pool costs
Washington 1988	1,153	150	385,100	18,680	-insurers assessed; tax credit
Wisconsin 1981	4,497	150 (premium subsidy for low-income individuals)	4,056,671	5,518,189	-insurers assessed; no tax credit -\$200,000 tax relief from general revenues as of 1/1/88

SOURCES: Burda 1989, p. 54, Communicating for Agriculture, Inc. 1988, Intergovernmental Health Policy Project 1988; Marvin 1990; and Tripler 1990.

*These percentages represent the limit on pool premiums relative to the average premium charged in the state for comparable policies for standard health risks.

that permit normal-risk applicants to enroll expect primarily high-risk individuals. Adverse selection tends to have a snowball effect and eventually drives out normal-risk individuals who can find lower premiums elsewhere.

What Has Been the Impact of High-Risk Pools?

Historical Growth

The first high-risk pools were created in Connecticut and Minnesota in 1976, and since then 17 more states have passed enabling legislation. Of those 19, 5 are not yet operational—California, Georgia, Oregon, South Carolina and Texas. Many states are currently considering such legislation (Marvin 1990). The concept is popular politically because the high-risk pool appears to serve a needy and deserving population, is operated through the private sector, and provides an indirect and seemingly limited role for the state government. However, while there may be no public discussion of a sizable appropriation to fund the pool's deficit, legislators are becoming more aware of the financing limitations of the traditional pool concept and the implications of the tax credit.

Costs and Losses

As pool enrollments grow, so do their losses. This may not be a serious problem during the first years of a program, in part because of pre-existing conditions clauses and the normal time lag of medical bills. Also, the total deficit starts out relatively small because there are few enrollees. However, the average enrollee generates greater costs than the premium he or she pays—even in Connecticut, where more normal risks are included in the pool. The 14 pools operating in 1988 showed a total of more than \$65 million in claims paid compared to \$39 million in premiums collected (Burda 1989, p. 54). (See Table 2.) Administrative costs of 12 to 15 percent of total pool spending increase the deficits even more (Bovbjerg and Koller 1986, p. 118).

The claims costs per enrollee vary widely, depending in part upon the maturity of the program and the medical cost index in each geographic

area. Minnesota found that 1 percent of its enrollment generated 30 percent of its claims costs. Such data are unavailable for other states. Since Minnesota has less adverse selection than some states because of its relatively low premiums, it may have a relatively large group that generates few claims. Nonetheless, it is likely in all pools that a small portion of enrollees generate a disproportionately large share of the costs (Tripler 1990).

Cost Burden

It is not entirely obvious who bears the costs of the high-risk pools. The premium, which is itself only part of total costs, is normally paid by the enrollee (except in Wisconsin and Maine, where the state provides a direct subsidy of premiums for low-income enrollees). However, some enrollees have their premium paid by their employers. In some states, there are indications that 15 to 20 percent of the pool's enrollees may have such an arrangement. This means that employers and perhaps their group insurers are taking advantage of the existence of a high-risk pool to off-load their high-risk employees and to keep their group plan costs at a more reasonable level. The employer and other employees benefit because the premiums will be lower without high-cost employee members. Also, high-risk workers seeking employment do not have to fear discrimination in hiring based on employers' fears about high group medical costs.

On the other hand, the state is usually picking up the deficits from those high-risk employees who previously had been covered privately. Certainly, many pool boards are very concerned about this phenomenon (Marvin 1990).

Since the premium covers substantially less than the full program costs, who pays the deficit? In the states that permit the insurance companies to offset their assessment as a tax credit, the result is a dollar-for-dollar reduction of general revenues. It represents a tax expenditure and its effect is the same as a direct appropriation. Hence, the taxpayers in the state bear that burden. Tennessee's recently passed legislation places a limit of \$3 million on annual pool costs to the state. In states such

as Minnesota, which eliminated the tax credit for pool deficits, the insurers bear the deficits as a cost of doing business. Thus, the insurance companies' owners and/or customers (employers, employees and private, nongroup enrollees) pay the extra costs. Members of self-insured plans are unaffected. Those plans are growing in popularity, to some extent because of their competitive advantage. Illinois and Wisconsin recently passed legislation to fund all or part of the deficit through an appropriation of general revenues, and thus the burden is spread broadly across all taxpayers. Maine funds its deficit by a new tax on hospital gross patient services revenue, so the cost is shifted to hospital users who pay their own bills and to third parties and their enrollees.

Enrollment Growth

Although there have been fluctuations in enrollment within pools, in total, there has been steady, moderate growth over the years. The latest enrollment figures show almost 42,000 individuals covered nationally (Burda 1989, p. 54). (See Table 2.) That is a small fraction of the medically uninsurable population, an estimated two to three million in the U.S. It is also much less than those who could afford to join (Fraser 1988, p. 202). Clearly, annual premiums of several thousand dollars are a barrier to all but those with middle- to upper-level incomes. And only 30 to 40 percent of the uninsured have incomes above \$20,000. Nevertheless, the participation of those with sufficient income is also low, perhaps because the marketing of the pools has not been very effective.

While the total enrollment of 42,000 seems low, it underestimates the total number of individuals served, since it is reflective of only one point in time. More individuals are served during the year as many move in and out of the program. For example, a high-risk individual would drop out if he or she became eligible for group coverage from a new job. The exact turnover rate in various pools is unknown, since most pools collect very little administrative data.

Cost-Containment

By definition, the high-risk pools suffer from adverse selection and have a relatively large share of heavy users of health services. Given

their high volume and cost of services, cost-containment mechanisms are crucial to high-risk pools. Unfortunately, only half the pools have used cost controls as a standard part of their administrative practices (U.S. General Accounting Office 1988). They have adopted a few selected cost-containment measures, such as preadmission certification for hospital care and second surgical opinion programs. However, much remains to be done in all the pools to initiate efforts to ensure effectively and efficiently run programs.

What Are Policy Issues to Consider Before Initiating a Pool?

Is There an Insurer of Last Resort in the State?

Eleven states and the District of Columbia require Blue Cross-Blue Shield plans to offer open enrollment for individual (nongroup) coverage. The plans are not permitted to discriminate according to health status. If the premiums charged for this coverage are state-regulated as closely as would be a pool's premiums, there would be little need for a separate high-risk pool. If the state does not have an open enrollment regulation, it might be worth examining the operation of this regulation in other states to determine whether it might be feasible and preferable to a high-risk pool. It is important to consider how and by whom the excessive costs of high-risk members would be covered in such an arrangement. Note that the existence of an open enrollment requirement does not provide a total solution to the medically uninsurable problem. It has the same limitation as does the pool—expensive premiums.

How Does the State Regulate Insurance Underwriting Currently?

The medically uninsurable population is defined, to some extent, by the insurance industry, which is regulated by the state. The existence and nature of restrictions placed on underwriting practices, methods for defining group plans, and so forth, can affect both the population left without coverage and the reaction of employers to the creation of

a high-risk pool. For example, can employers and/or insurers define the members of a group plan based on the health status of individuals? Are insurers limited in the medical screening they can do? Can pre-existing conditions be excluded from coverage when an employer switches plans?

Who Would Pay the Pool Losses and How Visible Should the Mechanism Be?

Ultimately this will be a political issue, but it is also useful to analyze it explicitly during the development of the proposal. It must be recognized from the start that losses are inevitable and will grow as the pool more successfully serves its target population.

How Can the State Promote Equitable Treatment of Both Private Insurance Plans and Self-Insured Groups?

The choice of financing mechanisms will affect the balance. Until federal legislation is passed to change the ERISA exemption, indirect methods and taxes may be necessary if the state wants to tap a broader funding source than just the private insurance plans.

What Should Be the State's Position Concerning the Shift of High-Risk Individuals from Employer Plans to the High-Risk Pool?

If the state is aware of the advantages and disadvantages of such shifting from the private sector to the public, it could design pool details, such as regulatory controls, monitoring mechanisms, or employer taxes to create an equitable impact. Basically, is it preferable for the costs of employed high-risk individuals to be covered privately through employer groups or publicly through the pool's premium and deficit? What are the state's broader goals concerning private employer coverage?

What Cost-Containment Mechanisms Could Help Limit the Pool's Losses?

The state could look to efficiently run private and Blue Cross-Blue Shield insurance plans in its area, as well as to the current evaluation

literature to see what mechanisms work and might be suitable to its population, medical providers, and so forth. Some administrative procedures and controls might be built into the benefit package and administrative program during development, while others require a critical mass of enrollees in order to be practical.

Are the Pool Costs (Losses) Worth the Benefits in Terms of State Health Priorities and Population Needs?

Is a high-risk pool just a politically attractive, “doable” program compared to other proposals for the uninsured, or is it really serving high-priority needs? Are the higher-priority programs not feasible at the moment and does the pool appear worthwhile even if of limited impact on the numbers of uninsured? Could the pool’s deficit dollars be better spent on Medicaid expansion or a public health service program for poor children? Would those dollars be available for these possibly higher-priority populations?

Could the High-Risk Pool Be Adapted to Serve Other Priority Needs?

What kind of premium subsidies would be necessary to serve the medically uninsurable of low-to-moderate income who are not covered by Medicaid? Where would the money come from? Could the premiums be reduced by opening the pool to the uninsured of normal risk, and what changes would be necessary to attract them?

Conclusions

High-risk pools have been in operation since the late 1970s. None have failed. All have grown and are successfully making private health insurance available to those who can pay the premium. However, their costs to the public are not insignificant, though they are frequently not obvious. Also, while the program serves a politically attractive population, it may not be meeting a high-priority policy need. The political and administrative costs as well as financial costs and time necessary

to create and operate a high-risk pool should be weighed against the expected benefits from such a program. If it is a useful program for the state, care should be taken in the policy development process to incorporate effective cost controls, premium subsidies if necessary to serve priority populations, and an equitable financing mechanism.

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