



## **Use of High Risk Pools under the AHCA and BCRA**

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High risk pools were operational throughout the country before the Affordable Care Act (ACA) was implemented. As Congress considers changes to the ACA, re-creating high risk pools has been discussed as a potential viable policy option.

- High risk pools have potential to offer:
    - ✓ Added medical management of chronic conditions
    - ✓ State specific solutions with oversight and transparency to stabilize the individual market
    - ✓ Relief in the form of premium reductions for the individual market
  - The experience of Wisconsin's former high risk pool – called the Health Insurance Risk Sharing Plan (HIRSP) – is an example of an efficiently run pool pre-ACA that addressed a critical need in the market.
  - Although the market dynamics have changed, and the purpose of a high risk pool might differ under the AHCA and BCRA, risk pools could be considered as a feasible policy option. In doing so, it is critical to understand how risk pools should be structured, their role in the market, and their overall sustainability and funding needs.
  - Several questions have been raised in the context of risk pools:
    - ✓ How can the market be stabilized?
    - ✓ How can coverage be made affordable?
    - ✓ How can individuals with pre-existing conditions be assured of coverage?
    - ✓ How can benefits be supplemented in states that waive essential health benefits?
  - In this analysis, given the market as it would exist under the House-passed version of the AHCA and the current version of the BCRA, we conclude:
    - ✓ Risk pools, properly structured and funded, have the potential to stabilize the market.
    - ✓ Risk pools cannot simply be a place to enroll individuals who otherwise cannot afford coverage. Further, risk pools cannot and should not be structured simply as a response to what to do about pre-existing conditions and what to do in states that waive certain essential health benefits.
      - Structuring risk pools in this manner will result in a pool that is unstable and unsustainable.
  - The attached paper assesses the proper role of risk pools under the AHCA and BCRA and how these bills should be modified to give states additional flexibility and sufficient funding to create sustainable risk pools.
  - A summary of our recommendations to the above four questions is on the following page. A full analysis follows.
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## **SUMMARY OF RECOMMENDATIONS**

### **1. How can the market be stabilized?**

- a) Allow states flexibility to have a real or virtual risk pool. A “real” risk pool is a separate structure and pool enrolling individuals with certain conditions and managing their care. Under a “virtual” pool, enrollees remain with their insurer with funding mechanisms (similar to a reinsurance model) in place to offset the risk to insurers. The bill should specify that the pool is for people with certain conditions to reduce the risk in the overall individual market. Conditions can be determined by the state to address the needs within the state.
- b) It is unclear if all of the funding sources under the AHCA (the Patient Safety and Stability Fund as well as the Federal Invisible Risk Sharing Pool) or the BCRA could be used by the state for establishing and maintaining a risk pool. The bills should specify that all the funding sources can be used for states to establish risk pools.
- c) Additional funding would likely be necessary. Congress should work with federal actuaries to develop estimates of needed funding for states.
- d) The current distribution formula for the \$100 billion Patient Safety and Stability Fund under House passed version of the AHCA will put states like Wisconsin, again, at a significant disadvantage.
  - ✓ Under the distribution formula, 85% of the funds are to be distributed based on incurred claims. Incurred claims is a function of utilization. States like Wisconsin that are providing high quality care with lower utilization will be penalized in such a formula. The formula should instead recognize and reward states that provide high quality health care.
  - ✓ The distribution formula should be changed to remove the requirement that 15% of the funds be distributed based on the uninsured population below 100% FPL and/or for states that have fewer than 3 insurers in the Exchange in 2017. This provision particularly penalizes Wisconsin for expanding Medicaid to all with income below 100% FPL, and for having a robust insurance market with 15 insurers in the exchange market in 2017 across the state.
  - ✓ The distribution formula should also be changed so that the funds would be distributed to states based on the insured population, not the uninsured population. This will incent states to insure more people and make sure that dollars are used for those who are in the pool.
- e) The House-passed version of the AHCA requires a state contribution to the federal funding distributed to the state through the Patient Safety and Stability Fund. The AHCA should ensure that any federal funds made available to the state and for which a state contribution is made are under the purview of the state and cannot be redistributed by the federal government outside of the state.

### **2. How can coverage be made affordable?**

- a) The bill should ensure the sufficiency of the tax credits and cost sharing reductions. This will help people afford coverage, and more importantly maintain coverage over time.
  - ✓ Under the AHCA, the new refundable tax credits are based on age, not income, and will penalize states like Wisconsin that relied on the subsidies available in the exchange to make coverage affordable for low income populations. Combined with

expanding Medicaid to childless adults with income below 100% FPL, Wisconsin was able to reduce our uninsured rate by 38%.

- ✓ Under the AHCA, the tax credits would range from between \$2,000 and \$4,000 per year. By contrast, the average credit currently provided to exchange enrollees in Wisconsin is \$4,000 per person – the higher end of this range. Some low-income individuals in Wisconsin rely on credits as high as \$10,000 to help them maintain coverage.
  - ✓ Under the BCRA, the tax credits are based on both age and income. However, tax credits for individuals with income 350% to 400% FPL would be eliminated, which could result in increases in uninsured.
  - ✓ The loss of cost sharing subsidies under both bills is of concern to providers. This means those purchasing coverage will have higher cost-sharing for services.
- b) To help pay for tax credits, the bill could allow for more equitable Medicaid funding between expansion and non-expansion states. For Wisconsin, those additional funds could be used to boost tax credits for low-income and older consumers in the individual market.
3. How can benefits be supplemented in states that waive essential health benefits?
- a) A state waiver under either bill could include waiving the ACA requirement that the Essential Health Benefits (EHB) in a state must be equal to a typical employer plan. While being equal to a typical employer plan might not meet the goal for reducing cost, the waiver should still require that the EHB be ‘similar to’ a typical employer plan. This would address concerns that the plans otherwise would be so limiting as to not constitute “creditable coverage”.
  - b) The state should also be required to get public input and periodically review the EHB to ensure it is on an ongoing basis meeting the needs of its residents.
  - c) Finally, as we know from the ACA, comparing benefit plans is difficult. It will be even more difficult if benefit plans can all cover different services. The bill should include funding for states to help with education and outreach.
4. How can individuals with pre-existing conditions be assured of coverage?
- a) Recognizing that the AHCA as passed by the House allows health status rating only if someone does not maintain coverage, as noted above the bill should include funding for federal agencies or states to conduct significant and meaningful education and outreach about maintaining coverage.
  - b) Instead of health status underwriting, the bill could include another way to incent maintaining coverage. For example, Medicare plans require higher premiums on an ongoing basis for people who do not sign up within the first twelve months of their eligibility. In other words, higher premiums over time and for a longer period of time for people who do not sign up and maintain coverage.

## **Use of High Risk Pools under the AHCA and BCRA Bills**

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### **Overview**

High risk pools were operational throughout the country before the Affordable Care Act (ACA) was implemented. As Congress considers changes to the ACA, re-creating high risk pools has been discussed as a potential viable policy option.

In particular, with the addition of the MacArthur Amendment to the House version of the AHCA, high risk pools have been suggested as a way to mitigate concerns about rating based on health status (people with pre-existing conditions) and to address needs of individuals who may not have certain services covered if essential health benefits are waived in their state.

Our analysis concludes that high risk pools established to be a resource for people with pre-existing conditions or who have shortcomings in their benefit packages would be unsustainable given the current policies under which the risk pool would operate. While some high risk pools like the one in Wisconsin addressed critical needs pre-ACA, such as coverage denials, the market dynamics have changed. For example, guaranteed issue remains under both the AHCA as passed by the House and under the draft BCRA, which thus changes the purpose and structure of a risk pool.

This paper describes the potential functionality of a high risk pool for stabilizing the individual market, and offers recommendations for establishing risk pools under the AHCA and BCRA. Further this paper offers recommendations to address issues such as health status rating, essential health benefits and coverage affordability.

It should be noted that these solutions all work together as a package, and should be taken in their entirety as a potential means to provide stability to the individual market.

### **Individual Market Challenges**

There are several reasons why the individual market has historically been unstable and has been in need of subsidization. Risk in any health care pool is typically born by the individuals across whom that risk is spread. The individual market is comprised of people who do not have access to public coverage such as Medicare or Medicaid, and are not eligible for employer sponsored coverage. There is generally no employer contribution in the individual market. As a result, these individuals must bear the cost of the pool themselves.

Although there are now subsidies for individuals with lower income to seek coverage on the exchange, those subsidies are not available to all. Some may wait to seek care when they are sick, making the pool even more expensive to cover costs for those individuals. Finally, the market tends to be comprised of “older” individuals who have more health care needs. This is because many young healthy below the age of 26 remain covered on their parents’ policies, and incenting the young and healthy to sign up for coverage has historically been extremely challenging.

For all of these reasons, it is necessary to subsidize the individual market to make premiums affordable and to prevent the market from moving into a “death spiral”.

## **Wisconsin's Pre-ACA High Risk Pool**

Wisconsin operated the Health Insurance Risk Sharing Plan (HIRSP) through the end of 2013. In 2013, HIRSP had over 21,000 enrollees. HIRSP was largely created to help provide coverage for individuals who were denied coverage in the individual market. Thus, when guaranteed issue was implemented and the insurance exchanges became operational beginning with benefit year 2014, the HIRSP program was sunset.

The HIRSP Authority was the administrator of the plan, and functioned as an independent body. HIRSP was governed through statutory provisions that specified that it function with a Board of Directors and also specified some of the eligibility criteria for the program. The Authority set HIRSP's annual budget, monitored its fiscal management, paid the plan's operating and administrative expenses, and established procedures for the timely collection of premiums and payment of benefits.

The HIRSP program in Wisconsin was efficiently run. The Board of Directors included insurers, providers and consumers, all of whom had a stake in its funding. In 2013, the HIRSP program's budget was approximately \$220 million. These costs were funded through a combination of enrollee premiums (60% of the cost), insurer contributions (20% of the cost) and provider discounts on services (20% of the cost).

Medical management was a key part of helping to keep costs down, according to some former HIRSP board members. HIRSP worked with its third party administrator to implement new care management programs and to hold the administrator accountable for helping it meet its care management outcome goals. Having a pool of individuals with similar characteristics was seen as an advantage in being able to design and administer these programs.

## **High Risk Pools' Potential under the AHCA and BCRA**

Separating out some of the risk in the individual market into a separate "risk pool" has potential for stabilizing the market. The pool itself however must be stable to be sustainable.

Since the passage of the AHCA in the House and the release of the BCRA discussion draft in the Senate, much has been reported about the waivers that would allow insurers to underwrite based on health status, and waivers of essential health benefits. Some have suggested that risk pools be established to address concerns about these provisions. However, risk pools established to meet these concerns would be unstable and thus unsustainable themselves.

Risk pools also aren't designed to directly address affordability for an individual consumer who might have low income, for example, and not be able to afford premiums. Tax credits and cost sharing reductions are designed for that purpose. However, the idea of a risk pool is to take some risk out of the individual market, subsidizing it, and thus lowering premiums for all. This could help with affordability, but most importantly it should help to stabilize the market overall.

### Pre-existing Conditions

#### ***See Recommendations 4a and 4b***

The AHCA as passed by the House would allow insurers to rate based on health status, but only under certain conditions. Such rating would be allowable in states that received a waiver, and could only be applied to a person who does not maintain continuous coverage. Further, the health status rating could only be applied to that person for up to a year. As a result, a person would revert back to a standard premium in the individual market after a year.

The rationale for rating based on health status is that it is a mechanism to help incent individuals to instead maintain continuous coverage. Creating a high risk pool to offset the costs to that individual for higher premiums would mitigate that incentive. Instead, individuals would wait to sign up for coverage knowing that they could enroll in the high risk pool. Further, because these individuals would see a higher premium only for a year, there would be significant churn in the high risk pool, causing instability.

Instead of a risk pool, Congress could consider how to incent people to maintain coverage. First, Congress should ensure the tax credits and cost sharing reductions are sufficient for particularly lower income individuals to be able to afford coverage. Second, an overall education and outreach strategy should be funded and operated either at the federal level or state level. More importantly, Congress could consider alternatives to rating based on health status. A short term increase in premium likely will not be enough to incent individuals to sign up for coverage. Medicare, for example, has a much longer term “penalty” for not signing up for coverage, which is a 10% increase in premium per month for as long as you have the coverage.

### Essential Health Benefits

#### ***See Recommendations 3a, 3b, and 3c***

Some have also suggested that a new risk pool could help supplement coverage for a condition that is no longer covered in a state that has waived essential health benefits. We do not see this as a feasible option. Would individuals receive all other benefits from the individual market, while receiving just maternity coverage, for example, or just mental health coverage from a high risk pool?

Structuring a high risk pool as a supplement in this way also has the potential for significant churn as individuals could seek coverage in the high risk pool only to have their pregnancy and maternity care covered, for example, and then revert back to the individual market after those services are no longer needed.

To address concerns about essential health benefits, Congress could consider requiring that state waivers of essential health benefits must ensure that the benefits are similar to a typical employer plan. This would allow flexibility yet address concerns that the plans otherwise would be so limiting as to not constitute “creditable coverage”. The state should also be required to get public input and periodically review the EHB to ensure it is on an ongoing basis meeting the needs of its residents. Finally, as we know from the ACA, comparing benefit plans is difficult. It will be even more difficult if benefit plans can all cover different services. Congress should include funding for states to help with education and outreach for consumers to understand their plan options.

### Affordability

#### ***See Recommendations 2a and 2b***

A high risk pool is not designed to address affordability for a particular individual to purchase health insurance. Indeed, the market could not function even with a high risk pool if individuals who have lower health risks cannot afford to purchase coverage. A risk pool cannot stand in place of the tax credits and cost sharing reductions that help individuals purchase coverage at standard rates.

The new refundable tax credits under the House passed version of the AHCA are based on age, not income, and will penalize states like Wisconsin that relied on the subsidies available in the exchange to make coverage affordable for low income populations. Combined with expanding

Medicaid to childless adults with income below 100% FPL, Wisconsin was able to reduce our uninsured rate by 38%.

Under the AHCA, the tax credits would range from between \$2,000 and \$4,000 per year. By contrast, the average credit currently provided to exchange enrollees in Wisconsin is \$4,000 per person – the higher end of this range. Some low-income individuals in Wisconsin rely on credits as high as \$10,000 to help them maintain coverage. Although the Senate bill would include subsidies based on both age and income, subsidies for individuals are eliminated for those with income between 350% FPL and 400% FPL (compared to the ACA), which may result in some individuals no longer being able to afford coverage.

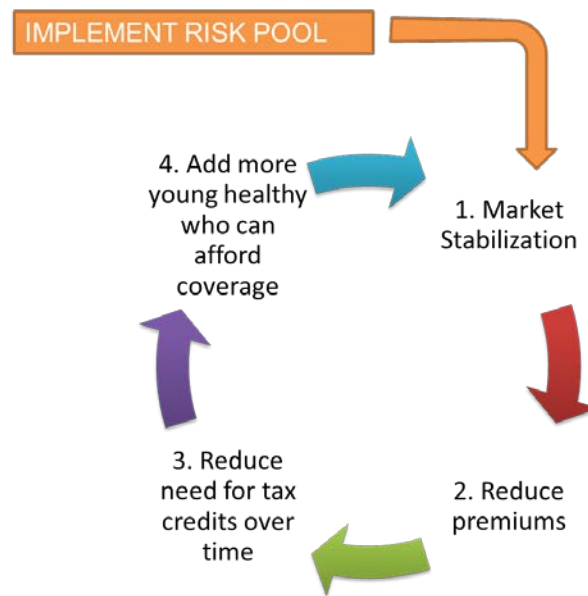
The loss of cost sharing subsidies under both bills is also of concern to providers. This means those purchasing coverage will have higher cost-sharing for services.

The bills should, instead, ensure the sufficiency of the tax credits and cost sharing reductions. This will help people afford coverage, and more importantly maintain coverage, over time. To help pay for these tax credits, the bills could allow for Medicaid expansion only to 100% FPL. Savings can be moved into tax credits for low-income and older consumers in the individual market. When Wisconsin did this, we found 65,000 people with income below 150% FPL enrolled in the exchange market (numbers not available for the population below 138% FPL.)

#### Market

#### ***See Recommendations 1a through 1e***

An appropriately structured and subsidized high risk pool has the potential for stabilizing the individual market, thus leading to reduced premiums in the individual market. As noted earlier, Gorman Actuarial estimated that moving the high risk population pre-ACA into the individual market in Wisconsin would increase premiums in the individual market by 16%. Similarly, taking risk out of the market, should reduce overall premiums and help make the individual market more stable. Ultimately, as premiums are reduced, there should be less of a need for premium tax credits. Further, more young and healthy would find it attractive to participate in the market, reinforcing its stability. This is reflected in the following picture:



### Risk Pool Structure

**Recommendation:** *A risk pool could be structured in various ways. We recommend the specific structure be left to each state to determine what would work best given their population, number of insured, number of insurers, and overall health care markets.*

Some states might wish to implement a physical pool – like Wisconsin’s former HIRSP Authority. Individuals with certain conditions would be enrolled in the pool at the same rate they would receive in the individual market and the pool would be subsidized with federal and state funds as provided for in the AHCA. The physical pool would be responsible for managing medical conditions, and all of the financial and operational aspects of providing health care services to their enrolled population.

Other states might wish to have a virtual pool – that is, a pool which is largely invisible to enrollees. Enrollees are left on the commercial insurer’s rolls, with health insurers being subsidized for those enrollees. The commercial insurers individually would be responsible for medical management and the financial and operational aspects of providing services to their enrolled population. Along with this, the state might wish to have an administrative entity to receive any federal funding and ensure transparency in the operation of the funds.

Still other states might find the best solution is some new reinsurance model.

We recommend that the AHCA not be prescriptive in how the risk pools must be established, given the wide variation in state health insurance markets.

### Eligibility and Enrollment

**Recommendation:** *We recommend the AHCA specify the purpose of a risk pools is to reduce risk and offset costs for high risk individuals, either based on clinical condition or on cost, but not be prescriptive in how the state must establish its pool.*



Based on information conversations with insurers, it is our understanding that the cost in the individual market comes primarily from a number of individuals who have certain long term/chronic conditions that can cost \$25,000 to \$75,000 per year. Actuaries are able to identify these conditions, which may vary by region of the country. We believe this should be the target group for a high risk pool, but also recognize that each state would want flexibility to establish its own criteria.

Wisconsin has data from a publicly available all claims database (called WHIO). Data on commercial claims is consistent with other national studies that find that 5% of enrollees with the most spending represent over 50% of the total cost. The 1% of enrollees with the most spending accounts for over 25% of the total cost.

We estimate that in Wisconsin there are approximately 300,000 people in the individual market. Five percent of the total is about 15,000 people. Although additional actuarial analysis would be needed to obtain more precise estimates of enrollment, we anticipate a risk pool structured based on medical condition or top costs in Wisconsin would cover between 15,000 and 50,000 people.

### **Costs and Funding**

***Recommendation: Work with federal actuaries to determine the amount of funding that would be needed to sufficiently fund states to form high risk pools. Further, clarify that the current funding in the bills can be used by states to establish high risk pools and allow states flexibility in how those pools can be established. Finally, ensure the methodology for funding distribution does not penalize states that have low uninsured rates or competitive markets. We also recommend that, regardless of structure, the dollars that are distributed to the state and the state contribution should remain within the state, and not be redistributed in any way to offset costs in other states as we have seen with Medicaid expansion.***

### Per Enrollee Cost

Additional actuarial analysis would be needed to estimate cost per enrollee in a risk pool. However, several national studies can be used to provide a range of estimates.

Total Cost per enrollee in a high risk pool could range from \$15,000 to \$30,000. These estimates include:

- Records from the Pre-Existing Condition Insurance Plan, the program that provided coverage to high-cost enrollees until the exchanges became available, show that average annual claims costs were \$32,108 in 2012.
- Researchers from the Center for American Progress also estimated about \$31,000 per year in costs for those with pre-existing conditions enrolled in a high risk pool.
- The former Wisconsin HIRSP program had annual costs per person of about \$10,500. However, the HIRSP population was very stable over time, and offered high deductible health plans. About 70% of the individuals didn't meet their deductible in a given year. Given cost growth since 2013, and that initially this population may not be as stable as the HIRSP program, we believe the \$10,500 is an underestimate of the actual cost.

### Total Cost for Wisconsin

The following table shows the range of costs under varying assumptions.

The total cost ranges are derived from the total cost estimate above (\$15,000 to \$30,000), less an average premium of \$5,460 which would be funded by the consumer using tax credits and their own out of pocket funds. The \$5,460 estimate is the average premium in the insurance exchange in Wisconsin for 2016. Using a middle assumption that Wisconsin would have 30,000 enrollees at a total cost of \$20,000 per person, the amount of subsidy needed would be approximately \$436 million, far short of the estimate for Wisconsin under the current funding and funding formula included in the AHCA as passed by the House.

|                            |                               |                |                |
|----------------------------|-------------------------------|----------------|----------------|
| total cost                 | \$ 30,000                     | \$ 20,000      | \$ 15,000      |
| average premium            | 5,460                         | 5,460          | 5,460          |
| <b>net cost</b>            | <b>24,540</b>                 | <b>14,540</b>  | <b>9,540</b>   |
| <b>Number of Enrollees</b> | <b>Estimated Funding Need</b> |                |                |
| 15,000                     | \$ 368,100,000                | \$ 218,100,000 | \$ 143,100,000 |
| 30,000                     | 736,200,000                   | 436,200,000    | 286,200,000    |
| 50,000                     | 1,227,000,000                 | 727,000,000    | 477,000,000    |

### AHCA Funding

It could be assumed that a total of \$138 billion goes to financing the risk pool over 10 years, including the entirety of the AHCA's \$100 billion Patient and State Stability Fund; the \$15 billion federal invisible risk-sharing program; and the \$8 billion of funding from the 5 year FIRSP program; and the \$15 billion set aside for maternity and behavioral health services.

- This is high-end estimate of the total funding that would be available for the risk pool, and means that no funding would be available for the stability fund's other purposes, including public health efforts or reinsurance to bring down premiums for the broader health insurance market.

The current version of the AHCA as passed by the House is not clear that all of these funds could be used for high risk pools, nor does it allow sufficient flexibility to states for how those pools can be established.

Further the current formula for distributing the Patient Safety and Stability Fund is flawed. First, 85% of the funds are distributed based on incurred claims. Incurred claims are based on utilization. States like Wisconsin with high quality and low utilization are penalized under such a formula. Instead, funds should consider quality of care within each state and ensure that states that are providing high quality care are recognized.

Second, funding to stabilize the market should be distributed for those in the market – those who are insured. Instead, under the House-passed version of the AHCA, the funding is distributed in part based on the state's share of uninsured below 100% FPL, and if the state has fewer than three insurers participating in the exchange in 2017. This kind of formula penalizes Wisconsin for having a low uninsured rate. Further, it penalizes Wisconsin for having a competitive market. This formula should be changed to instead incentivize states to help their populations stay insured and maintain a competitive insurance market. A formula could be developed for example that gives states a per person amount for individuals in their state who are insured and it could vary based on age.

Not only will it be important to ensure dollars are fairly distributed, but also that any dollars identified for these purposes remain under the purview of the state. This is particularly important as a state contribution is required to obtain the funds. A key principle for the AHCA should be that federal dollars distributed to a state and state contributions should be allowed to remain with the state.

### **BCRA Funding**

The BCRA eliminates the \$138 billion under the AHCA, and instead includes \$112 billion across two new funds:

- \$50 billion for a short term stability fund over four years from 2018 through 2021.
  - These funds would be provided directly to insurers from CMS. Insurers would have to submit a letter of intent to CMS to participate in the program.
  - These funds would be provided to help stabilize premiums, promote choice and participation in the individual market.
- \$62 billion for a long term stability fund over 8 years from 2019 through 2026
  - These funds would have to be matched with state dollars beginning in 2022.
  - The methodology for distributing these funds to states would be determined by the CMS Administrator.

These funds could be used: to establish a program to provide financial assistance to help high-risk individuals; for arrangements with health issuers to stabilize premiums and help promote market participation; for payments for health care providers as specified by the Administration; and for assistance to reduce out-of-pocket costs.

The dollars included in the BCRA may not be sufficient for states to establish risk pools. Further, as with the AHCA funding, it is important to ensure dollars are fairly distributed, and also that any dollars identified for high risk pools remain under the purview of the state. This is particularly important if a state contribution is required to obtain the funds. A key principle for the AHCA/BCRA should be that federal dollars distributed to a state and state contributions should be allowed to remain with the state.

### **Impact on Individual Market**

Additional actuarial analysis is needed to identify the specific impact on premiums in the individual market.

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