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IDEAS AND OPINIONS

High-Risk Pools: An Illusion of Coverage That May Increase Costs for All in the Long Term

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High-risk pools are included as a state option in the American Health Care Act (AHCA) recently passed by the U.S. House of Representatives. These plans segregate persons with preexisting conditions from the broader insurance pool to a much smaller pool with others who have potentially high costs. Historically, high-risk pools have not worked well. They generally have not provided affordable or adequate coverage to persons with preexisting conditions, nor have they made the individual market affordable for others. Moreover, they have cost more than policymakers seem to appreciate on the basis of allocations for high-risk pool programs in past and current legislation. As they consider changes to the Patient Protection and Affordable Care Act (ACA), policymakers seem to have forgotten that high-risk pools operated in 35 states before the ACA was passed. At that time, the United States had 47 million uninsured people, 33 million of whom lived in states with high-risk pools, strongly suggesting that the pools were not making insurance affordable and accessible for people with or without preexisting conditions. Indeed, the Congressional Budget Office estimates similar levels of uninsurance under the AHCA (1). For all these reasons, any legislation reinstituting high-risk pools would constitute a huge step backward for American health care policy.

Who Is "High Risk"?

Contrary to the assertion by at least 1 member of Congress that "people who lead good lives" do not have preexisting conditions (2), the U.S. Department of Health and Human Services (HHS) determined that 51% of Americans have preexisting conditions that may force them into high-risk pools. These conditions range from cancer (11 million people) to high blood pressure (46 million people) (3). Preexisting conditions also include those that people are born with, such as congenital heart problems or asthma, or acquire through no fault of their own, such as head injuries or paralysis. Congress should consider that in some cases before the ACA, persons were denied coverage in the individual market simply for having hay fever or a history of knee surgery (4). In fact, 1 large insurer reported that one third of its applicants were denied coverage because of preexisting conditions, with hundreds of thousands denied nationally every year (5).

Under the AHCA, persons with preexisting conditions would be subject to medical underwriting and high-risk pool coverage only if they allow their existing coverage to lapse. Although many supporters of the bill say that this protection means that few people with preexisting conditions would actually be forced into high-risk pools, HHS found that millions of people with preexisting conditions encounter spells of uninsurance every year because of job changes or periods of financial difficulty (3).

Inadequate Coverage

Historically, high-risk pool coverage had very high premiums and deductibles and serious limits on coverage, including annual and lifetime caps. Indeed, some plans had annual deductibles as high as $25 000 and annual coverage limits as low as $75 000 (6). Because the AHCA allows states to seek waivers on covering essential health benefits and because funding for high-risk pools in the legislation is woefully inadequate (7), high-risk pools developed under the proposed legislation may be expected to have equally or even more stringent coverage limits. In the past, some plans limited prescription coverage to as little as $10 000 per year; mental health and substance abuse treatment to as little as $3000 per year (with a $10 000 lifetime maximum); and combined physical, occupational, and speech therapies to as little as $2000 per year (8). In addition, many plans required the purchase of a separate rider for maternity care, and most imposed waiting periods for coverage of preexisting conditions. Moreover, the AHCA would allow for plans with no caps on out-of-pocket spending, a feature of some high-risk pool programs before the ACA.

Whereas "young invincibles" in good health might seek limited plans that protect only against catastrophic costs, many persons with preexisting conditions forced into high-risk pools have chronic illnesses and, by definition, need comprehensive coverage that allows them meaningful access to care to manage their conditions. Higher premiums, deductibles, and out-of-pocket costs allowed under the AHCA will make high-risk pool coverage unaffordable for many people, cause enrollees to forgo needed care, and ultimately result in worse outcomes. Indeed, research on the Kansas high-risk pool found that despite being insured, many enrollees could not afford access to care, and over time, members transitioned to federal disability programs at a rate 8 times that of the general population (9). In the end, forcing people with chronic conditions into situations and plans in which they cannot afford care only shifts their costs to others.

Alternatives

History shows that segregating sicker people into high-risk pools does not reduce consumer costs in the individual insurance market enough to significantly re-

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duce the number of uninsured. However, in the first year of the ACA, the federal reinsurance program successfully reduced premiums in the Marketplace by 10% to 14% (10). A federal reinsurance program also has worked very well since 2006 to keep Medicare Part D premiums low and private-insurer participation rates high. If Congress truly wants to make health insurance more affordable, funding a robust national reinsurance program is a much more efficient and equitable mechanism than a patchwork of state-based high-risk pools.

Conclusion

Insurance works best when it spreads costs across a large pool of people, limiting the effects of those with higher costs on overall rates. High-risk pools do not work, because they concentrate costs and require subsidies at a level that policymakers have never funded adequately. Perhaps ironically, the AHCA likely will increase the cost of individual insurance, even for the healthiest people, because those with preexisting conditions will make heroic efforts to maintain their coverage in the Marketplace, whereas healthy people may choose to drop out. At the same time, persons with preexisting conditions who have a lapse in coverage will be subject to premiums and deductibles that may make it impossible for them to obtain insurance or to use it when needed. When their conditions worsen because of lack of care, all Americans will share their costs.

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