Insight

Invisible High-Risk Pools

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One of the many challenges to limiting growth in health insurance premiums is how unevenly health care costs are distributed across the population, with a small portion of people making up a large portion of spending. This challenge becomes even greater in a world where some form of guaranteed issue and community rating exist. On April 6, the House Rules Committee discussed an amendment to the American Health Care Act (AHCA) that would allocate $15 billion over 9 years to be used to develop an invisible high-risk pool (IHRP)—a risk-sharing mechanism meant to alleviate issues caused by the uneven distribution of health care costs.[1]

WHAT IS AN INVISIBLE HIGH-RISK POOL?

An invisible high-risk pool program is meant to help spread the risk of high cost enrollees without penalizing either the insurers or the enrollees. It might be easiest to think of an IHRP as a synthesis of a reinsurance program and a traditional high-risk pool. Like a traditional high-risk pool, high-risk individuals are identified and targeted. Like a reinsurance program, extra funds are disbursed to insurers to help cover the costs of individuals with high levels of health care expenses.

However, unlike a traditional high-risk pool, an IHRP is meant to spread risk among the entire insured population. Therefore, it does not isolate high-risk individuals outside the marketplace and charge them higher premiums, nor does it deprive them of the ability to choose their insurer and their health plan. Presumably, a person included in an IHRP would not know they are in one if they were to compare premiums to other beneficiaries with the same plan.

Also, different than a traditional reinsurance program, insurers are only reimbursed for a targeted population. Under a traditional reinsurance program, insurers are reimbursed whenever claims for a particular person pass a certain threshold regardless of whether or

not the person has a history of illness. IHRPs, however, require insurers to place high-risk enrollees into the program if they want to be reimbursed for any future claims that person might accrue. For any person not placed in the IHRP the insurer is not reimbursed for any claim amount.

HOW DO IHRPS WORK?

Correctly identifying and targeting the high-risk—and consequently high cost—population is essential to create a well-functioning IHRP. Therefore, at the outset of the plan-year, enrollees would complete some sort of report on their own health. Insurers would use this to identify which of their enrollees would qualify as a high-risk individual.

Once insurers identify the high-risk individuals in their own population, they would cede those individuals and a portion of their premium payment into the IHRP program. Presumably, the fact that insurers cede a high portion of the premiums for any person placed in the program deters insurers from placing low-risk people into the program. Then insurers are reimbursed by the program once the claims cost for an individual in the IHRP passes a certain threshold.

Maine's implementation of their own IHRP program in 2011 is a good example of how these parameters could be set.[2] Under the Maine program, insurers placed beneficiaries into the program based on eight conditions that were determined to drive costs. Insurers ceded 90 percent of those individuals' premiums into the program, while a $4 per-member-per-month fee was charged to each non-group policy for good measure. Insurers then began to be reimbursed when a member placed in the risk pool passed a certain threshold in claims costs. Insurers were reimbursed for 90 percent of claims between $7,500 and $32,500, and they were reimbursed for 100 percent of claims over $35,000.

In the proposed House amendment, it is specified that the Centers for Medicare and Medicaid Services (CMS) Administrator would outline criteria for individuals that would qualify for the IHRP, the amount of the premium payments that insurers would have to cede for those eligible, the threshold at which insurers begin to be reimbursed for a high-cost beneficiary, and the rate at which the insurer would be reimbursed.

THE POTENTIAL FOR PREMIUM REDUCTION

Ideally, a well-functioning invisible high-risk pool would result in lower premiums for the entire population, which would consequently increase enrollment to help create a younger, healthier pool. This, in turn, would create a more sustainable individual health insurance

marketplace and reduce premiums even further.

The likelihood of IHRPs actually reducing premiums are dependent on a few variables. First, how CMS defines who is eligible for this program is critical, as incorrectly identifying who is high-risk will lead to inefficiencies within the program. CMS also needs to tailor the regulation and funding of the program to the specific needs and conditions of each state as much as possible. There is considerable variation between states with regards to demographics, costs, and various other issues that relate to health care that could lead to significant deficiencies in a national IHRP program if this is not done.

A workable IHRP must also be well-funded, beyond the funding provided by premium payments, otherwise many of the challenges that insurers and consumers are facing in the current health insurance marketplace will remain and will likely be amplified. It is probable that the $15 billion currently allocated by the bill would not be enough to properly fund a national IHRP in the long-term, therefore other funding means will need to be explored, similar to Maine's $4 per-member-per-month fee on all policies.

CONCLUSION

In a marketplace with some form of guaranteed issue, efficient risk-spreading mechanisms are a must. The creation of a IHRP program is a logical next step. However, if the program is improperly funded and fails to account for geographical differences between states and regions, it will only result in a marketplace marked by the same problems plaguing the current marketplace: rising premiums and lack of insurer competition.

[1]https://rules.house.gov/sites/republicans.rules.house.gov/files/115/AHCA/Palmer-Schweikert%20Amendment.pdf

[2]https://thefga.org/wpcontent/uploads/2017/02/MGARAAnnualReporttoLegislature_2013.pdf