Health Reform Issue Brief: High Risk Pools
April 2017

Overview

As Congress debates potential changes to the Affordable Care Act (ACA), it is critical to ensure that people living with HIV and hepatitis have continued access to affordable and comprehensive insurance coverage. State high risk pools have long been a limited mechanism for people with pre-existing, high cost conditions to access insurance. Prior to the ACA, 35 states were operating their own state traditional high risk pools and the ACA itself included a temporary high risk pool program called the Pre-existing Condition Insurance Plan (PCIP).

Ongoing debates around the ACA have used the term “high risk pools” in varying ways. Traditional high risk pools, the subject of this brief, group high risk individuals into a separate insurance market rather than allowing them to participate in community-rated, guaranteed issue markets. The term high risk pool has also been used to describe risk transfer pools, which use a formula to redistribute funds across issuers based on the comparative risk of each issuer’s pool. The term is also used to describe high risk pool funding, a publicly funded reinsurance program that compensates issuers for unexpectedly high risk enrollees. Risk transfers and reinsurance programs differ substantially from traditional high risk pools and may offer more market stability and consumer protections than traditional high risk pools.

Traditional high risk pools segment the highest risk populations into a single pool (requiring a particular diagnosis and/or documentation that the individual is uninsurable) and have historically been insufficient to meet the care and treatment needs of people with HIV, hepatitis, and other pre-existing conditions. This is primarily because the operating and consumer costs of high risk pools are prohibitively expensive, necessitating high consumer cost sharing, enrollment caps, and other cost controls that limit access to care. This issue brief will discuss the lessons learned from high risk pools prior to the ACA and the challenges that people living with HIV and hepatitis had accessing care and treatment in these pools.

This issue brief is part of a series NASTAD is publishing highlighting the impact of emerging health policy proposals on HIV and hepatitis prevention, care, and treatment. For questions, please contact Amy Killelea or Sean Dickson.

Consumer Cost Sharing is Prohibitively Expensive in High Risk Pools

The most significant access challenge created by high risk pools is prohibitively high premiums, deductibles, and co-payments for consumers. Premiums for high risk pool enrollees were, on average, between 150 and 200 percent higher than standard market
rates.\(^1\) In addition, high risk pools imposed deductibles as high as $10,000 to control costs, with an average deductible of $6,000.\(^2\) Even with some low-income subsidy programs (the availability of which varied greatly by jurisdiction), this combination of high premiums and high cost sharing made high risk pools simply unaffordable for many low-income people living with HIV, hepatitis, and other chronic conditions.

High risk pool policies that banned third-party payments to help beneficiaries meet their premium, deductible, and co-payments exacerbated these affordability challenges. In several states, regulations that barred third-party payments effectively excluded Ryan White Program AIDS Drug Assistance Programs (ADAPs) from assisting clients with their insurance costs, a common public health function of these programs.\(^3\)

Without financial assistance provided by Ryan White Programs/ADAPs, many people living with HIV simply could not afford high risk pool coverage and depended on a patchwork of safety net services for access to medications – a patchwork that fell far short of comprehensive insurance coverage. While federal regulations promulgated after passage of the ACA included a requirement for issuers that sold individual market Qualified Health Plans (QHPs) to accept Ryan White Program/ADAP payments\(^4\), this requirement remains limited to issuers that sell QHPs unless states enact similar state protections for these public health programs.

<table>
<thead>
<tr>
<th>RYAN WHITE HIV/AIDS PROGRAM FUNDS FOR PREMIUM AND COST-SHARING ASSISTANCE FOR PRIVATE HEALTH INSURANCE</th>
<th>John, age 45, living with HIV, and makes $21,000/year</th>
<th>Avg. Monthly Premium for ADAP Clients</th>
<th>Avg. Annual Premium for ADAP Clients</th>
<th>Avg. Deductible for ADAP Clients</th>
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<tbody>
<tr>
<td>Washington</td>
<td>State High Risk Pool</td>
<td>$1,100</td>
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<td>Marketplace Plan</td>
<td>$330 (with subsidy)</td>
<td>$3,960</td>
<td>$2,000</td>
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<tr>
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<td>State High Risk Pool</td>
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<td>Marketplace Plan</td>
<td>$250 (with subsidy)</td>
<td>$3,000</td>
<td>$3,750</td>
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</tbody>
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**High Risk Pools Often Had to Use Enrollment Aps, Coverage Limits, and Similar Cost Containment Tools That Limit Access**

Because high risk pools are segmenting the highest cost populations at high and hard-to-predict operating costs, many had to impose severe cost reduction mechanisms that served to limit consumer access.

- The vast majority of high risk pools (30 in total) imposed annual or lifetime limits on services, a practice that left people living with chronic conditions unable to access coverage when they needed it most.


\(^4\) 45 CFR § 156.1250.
Considering that the annual cost of treating HIV is $23,000 with a lifetime cost of $380,000, if any other co-morbid condition or non-HIV related health care utilization is taken into account, individuals will easily hit lifetime and annual caps on care. A number of high risk pools imposed enrollment caps, with periodic closure of enrollment. These caps left people who needed and were eligible for coverage unable to access it. The vast majority of state high risk pools (24) varied premiums based on factors that are impermissible under the ACA, including by sex. Nearly all state high risk pools imposed a pre-existing condition exclusion period ranging from 6-12 months.

High Risk Pools Have Struggled to Identify Sustainable Funding to Meet the Needs of Enrollees

The vast majority of consumer access challenges associated with high risk pools stem from the inherent difficulty in accurately predicting operating costs and structuring a risk pool that concentrates the sickest and most expensive enrollees into a single pool. States utilized a combination of funding mechanisms to operate high risk pools, including federal grants, state general revenue, beneficiary premiums, and private insurance assessments.

Even the National Association of State Comprehensive High Risk Insurance Plans (NASCHIP) concedes that high risk pools are not meant to address affordability issues (“It is important to understand that high risk insurance pools were not created to address the issue of affordability.”)

Rolling Back Insurance Access Will Have a Devastating Impact on Progress to End the Epidemic

Over the past several years, states and cities have launched ambitious – but ultimately achievable – campaigns to end new HIV infections. These “Ending the Epidemic” plans marshal public health tools and infrastructure and scientific and technological advances to scale up prevention and treatment, particularly for populations most impacted by HIV. Importantly, these plans have relied on partnership with public and private insurance, with the recognition that we cannot end an epidemic with safety net programs and resources alone. Insurance coverage that is affordable and comprehensive is a critical foundation of plans to end the HIV epidemic, and the traditional structure, cost, and limitations of high risk pools make them an insufficient replacement for the coverage provided through Medicaid and a well-functioning individual insurance market.

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5 Centers for Disease Control and Prevention, HIV Cost-Effectiveness.
6 NASCHIP, supra note 2.
7 NASCHIP, Rate Variables (2011).
9 Kaiser Family Foundation, supra note 1.
10 NASCHIP, How State Health Insurance Pools Are Helping Americans.