

## **Making Private Insurance Work: The Role of Invisible Risk-Pools or Reinsurance in Reforming the Affordable Care Act or in a Replacement**

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The Republican Senate Healthcare Reform bill crafted behind closed doors is supposed to be revealed today. One concern impacting Arizona would be any reduction in federal support for Medicaid (AHCCCS) as that would pose grave budgetary challenges for the state as well as imperil health coverage for 400,000 Arizonans—both childless adults below the poverty line whose coverage was reinstated after Arizona expanded Medicaid (317,135 enrolled) as well as the expansion adult population (82,228 enrolled). GCI will have a blog out detailing that aspect once the bill is released. (see AHCCCS June 1: Population Report [https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2017/June/AHCCCS\\_Population\\_by\\_Category.pdf](https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2017/June/AHCCCS_Population_by_Category.pdf))

However, for nearly 200,000 Arizonans, their care comes from the private healthcare exchange and anyone losing Medicaid coverage as a consequence of any new action by Congress signed by the President would fall into the private marketplace (see <http://grandcanyoninstitute.org/aca-and-ahca-part-1-the-big-picture-in-the-individual-market-50000-arizonans-50-face-huge-cost-increase-by-2020-under-gop-proposal/>).

As such, it makes sense to explore one key policy fix that would vastly improve the Affordable Care Act and is absolutely necessary to make any Republican alternative have any chance of being a functional replacement. The policy fix is adding invisible high-risk pools to either the Affordable Care Act (ACA) or any effort to replace it. Alternatively, reinsurance could be done to accomplish the same end. Both are invisible means of trying to cap exposure to insurance companies and lower premiums.

June 21<sup>st</sup> (yesterday) was the deadline for insurance companies to submit applications to provide coverage in the private market exchanges for next year, though, as was the case in Arizona last year, late applications may still come in for areas not covered. Based on analysis by the *Washington Post*, for 2018

Arizona's Healthcare Insurance Exchanges under the Affordable Care Act will continue but premiums may be rising up to 20 percent because of issues with the Trump Administration's enforcement of the ACA. Like this year every county in Arizona will continue to be served by a lone insurer except Pima which will be served by two.

Properly funded invisible high-risk pools have the ability of bringing in additional insurers into these markets as well as lower premium costs before subsidies. They are a means where people buy into insurance markets just like everyone else at community-pricing based on age bands, but in the case looked at here based on medical histories the top ten percent of enrollees with the highest anticipated health costs would have their cost to insurance companies capped with government providing the remainder of the cost of their care. While the House American Health Care Act (AHCA) included these risk pools, they were insufficiently funded. The Affordable Care Act used instead a reinsurance system that reimbursed insurers for any enrollees whose costs were above \$45,000 (<http://healthaffairs.org/blog/2017/04/12/making-sense-of-invisible-risk-sharing/>). However, that program ended in 2016, which coincided with many companies leaving the marketplace and rates rising substantially.

### ***ACA Exchange Design, Practice and Undermining by Trump***

The ACA Exchanges were designed to work so that the insurance mandate would ensure a wide mix of people would enroll, subsidies and cost sharing would assist those with lower incomes to participate, and competition within the market between insurance companies would assist in controlling costs.

If it worked as designed, say you'd have 10 people insured. One has a chronic condition costing \$30,000. The others 9 are relatively healthy costing on average \$2,000—except for one of the nine will need more expensive treatment of \$10,000. In this case the total health care costs are \$56,000 and each person might be charged \$5,600 (See ACA Risk-Pool Goal).

You can see the challenge here—those costing \$2,000 need to pay almost three-times as much even though they have a small chance of needing to pay that. The Affordable Care Act though shielded lower income folks from the higher costs, so that disincentive only existed for those without any subsidies above 400 percent of the federal poverty level (FPL). The subsidies were greater for those with lower incomes and those below 250 percent of the FPL were eligible for cost-sharing subsidies that reduced out of pocket expenses outside of the premium. This illustration simplifies age differences. The ACA also allows older people to be charged up to three times younger people, but subsidies tied to income protected many of them from the higher costs. For our purposes we should assume everyone is in the same age-band.

However, reality didn't quite work like that. The mandate's penalty was modest. It started out at a nominal amount and insurers were provided added subsidies to compensate, but those payments to insurance companies ended in 2017 when the mandate phased in fully. Today the full penalty is 2.5 percent of household income or \$695 per adult whichever is higher. If your income is \$50,000, then

your penalty is \$1,250. Many people would rather pay \$1,250 than say a premium of \$5,600. So the risk-pool ended up being tilted more toward folks who had more health issues—consequently costs were higher, and when added transitional reinsurance subsidies to insurance companies stopped in 2017 many insurance companies departed the market.

So say two healthy people drop out because of the mandate’s fines being low compared to the cost of

### ACA Risk-Pool Goal



insurance. Instead of 10, you have 8 people insured. One has a chronic condition costing \$30,000. The other 7 are fairly healthy costing on average \$2,000—except for one will need \$10,000 in care. In this case total health care costs are \$52,000 and each person might be charged \$6,500. Still the Affordable Care Act shields lower income people from this cost—so the market functioned, but those without subsidies absorbed the higher cost (See ACA Risk-Pool in Practice).

### ACA Risk-Pool in Practice



The Trump Administration has further undermined the ACA Exchanges. They aren’t enforcing the individual mandate, meaning the person with a \$50,000 household income won’t face a \$1,250 fine, which makes it less likely that healthier people enroll. They have been noncommittal about cost sharing subsidies to help cover out of pocket expenses for those between 100 and 250 percent of the federal poverty line. If the payments aren’t made, insurance companies are responsible for them—creating added financial uncertainty.

### ACA Risk-Pool under Trump



Finally, it’s likely little outreach and advertising will be done at the time of open enrollment—further curtailing the number of healthier people enrolling.

The net result is the risk pool for 2018 should be worse than it is for 2017. So instead of 8 people, you have two more healthy people leave so you have only 6 people insured. One has a chronic condition costing \$30,000. The other 5 are fairly healthy costing on average \$2,000—except for one will need \$10,000 in care. In this case total health care costs are \$48,000 and each person might be charged \$8,000. Still the Affordable Care Act shields lower income people from this cost—so the

market will still function, but those without subsidies absorb the higher cost (See ACA Risk-Pool under Trump).

### ***Republican House AHCA***

Republican efforts to lower costs under the American Health Care Act (AHCA) have generally been by reducing what the insurance covers. The ACA requires insurance pay for at least 60 percent of your expected health care costs for people in your community-rating age band. The AHCA allows plans to cover less and allows for the essential coverage requirements of the ACA to be loosened at a state's discretion. Obviously, plans that cover less will be cheaper, but then out of pocket expenses will be proportionately higher.

The House bill also raised the prospect of lifetime caps or allowing pricing based on pre-existing conditions as options for states—both of which make it far less likely the person with the chronic condition that costs \$30,000 gets coverage. In fact, the Congressional Budget Office (CBO) analysis of House bill indicates that allowing pricing based on pre-existing conditions would likely cause the community-rated plans to implode. Say you're a healthy person in a community-rated plan (same pricing for all in an age-band) and the state decides as a way to lower premiums for healthy people to allow pricing based on pre-existing conditions. Those people all move to the lower priced plans, and you only have people with pre-existing conditions in the community-rated plans. Their premiums skyrocket. So essentially that part of the bill is dysfunctional despite the \$8 billion assigned to address this issue in the bill (see <https://www.cbo.gov/publication/52752>).

By providing fixed subsidies based on age and not income but allowing older people to be charged five times younger people instead of three-times, but the older subsidies are not five time higher, the House bill favors younger people over older people. Younger people have less health-risk, so that aims to push the risk-pool in a more favorable direction in terms of cost, but undermines certainty of care for some of the people who most need it. So the second source of a reduction in premiums in the House bill is also suspect, the people buying it are on average younger. Worse, the people no longer able to afford coverage are primarily lower income, older or both, and this number is far greater under the AHCA than the ACA as 23 million fewer people including a reduction of 9 million in the private market (including any younger people who add coverage due to the AHCA) are projected to not have insurance by 2026 compared to the ACA as projected by the CBO.

Consequently, the House bill on the private insurance end, leaving aside its reduction of Medicaid funding, had substantial shortcomings compared to current law.

### ***Invisible Risk Pools (Or Reinsurance)***

A better way was present in the House bill, invisible risk pools. The funding in the House bill was unlikely to cover its cost, or people needing it would have found the insurance unaffordable, even with community-pricing due to insufficient subsidies.

As the illustrations show health insurance is premised on healthier people subsidizing the care of those who have greater health needs, but when that cost is not sufficiently broadened then healthier people may choose not to participate—even though we’re all better off as a society if we all have access to healthcare.

One solution is to allow the 10 percent of enrollees expected to have the most need for care and cap the cost for insurance companies. As a consequence, premiums for healthier people can go down without reducing what’s covered. In the examples above, if the \$30,000 person only costs the insurance company \$10,000, then premiums drop.

In the ACA reform with mandate scenario, the drop should be enough to entice younger and healthier people back into the market, the \$5,600 premium drops to \$3,600.

In the ACA as it was actually operating before the election of Donald Trump, the premium drops from \$6,500 to \$4,000. Technically since this pool had 8 people, it places 12.5% in the invisible high-risk pool.

And finally in the ACA non-enforcement of the mandate scenario, the premium drops from \$8,000 to \$4,667. Technically since this pool had 6 people, it places 16.7% in the invisible high-risk pool.

While the numbers are theoretical and the drop in premiums more dramatic than would be experienced in a full insurance pool, the design is premised on some of what’s known regarding the cost of high-risk individuals in the transition into the Affordable Care Act Exchanges and how Maine structured its invisible high-risk pool (details on these in notes at end). Part of the irresponsibility in the drafting of the Republican healthcare replacement has been a failure to hold hearings to determine detailed estimates of how much premiums could be reduced and how much the invisible-risk pool would need to be funded.

In each of these hypothetical cases \$20,000 of cost has been transferred out of the market. It needs to be paid for. Under the ACA, if premiums drops, then less income-based subsidies are needed, so it’s possible the drop in premiums could pay for a very large share of the added high-risk pool expense.

### ***Inadequacy of Invisible High Risk Pool Funding under House AHCA***

Under the Republican House plan, the subsidies are a fixed amount, so reduced premiums don’t save subsidies, but they do serve to make the product more affordable so more people will take advantage of it. However, it will only work if the plan provides sufficient funding to cover that \$20,000, and unfortunately, the House plan did not.

The House plan provided \$117 million over ten years that could arguably be used for invisible risk pools (<https://www.cbo.gov/publication/52752>). The Center for American Progress estimates Arizona’s share would be around \$200 million a year—so essentially it starts out maybe funding half of the needed cost to make it work well—and then that funding diminishes since it’s not adjusted for inflation.

If we start with the premise that 20,000 Arizonans in the Healthcare Exchange would need to be enrolled in an invisible high-risk pool and the average subsidy from government to cover their cost of care was \$20,000, then \$400 million would be needed to fund the program sufficiently. The AHCA provides half that—and if that figure is not adjusted for inflation over ten years, then by the end of ten years, I would likely be paying only a quarter of what was needed.

As a result the AHCA as passed in the House would likely lead to some combination of these high-needs folks without insurance they can afford and/or force the premiums higher for everyone else (<https://www.americanprogress.org/issues/healthcare/news/2017/05/02/431698/house-health-care-plan-not-enough-keep-high-risk-pools-afloat/>).

So as the Senate Bill is introduced one thing to watch for is whether this \$117 billion is significantly higher over 10 years.

### ***Cost Issues beyond Invisible Risk-Pools***

Invisible risk-pools are only part of a solution, but they are an essential part of a fix to the ACA or of any replacement to it. They are not a fix for other challenges. The United States has bar far the highest prices for healthcare services in the world ( see [https://www.washingtonpost.com/news/wonk/wp/2013/03/26/21-graphs-that-show-americas-health-care-prices-are-ludicrous/?utm\\_term=.29e9e61b5930](https://www.washingtonpost.com/news/wonk/wp/2013/03/26/21-graphs-that-show-americas-health-care-prices-are-ludicrous/?utm_term=.29e9e61b5930)) In addition, obesity rates that correlate with more health care costs. Medical device makers and pharmaceuticals are two of the highest profit margin industries in the country. Most other countries cap prices in the context of their private medical markets or allow government to intervene, if necessary (see [https://www.washingtonpost.com/news/wonk/wp/2014/01/13/what-liberals-get-wrong-about-single-payer/?utm\\_term=.1e5333a9782b](https://www.washingtonpost.com/news/wonk/wp/2014/01/13/what-liberals-get-wrong-about-single-payer/?utm_term=.1e5333a9782b)).

*This is the second in a series of blogs on healthcare related to the possible repeal and replacement of the Affordable Care Act. Read the first installment here: <http://grandcanyoninstitute.org/aca-and-ahca-part-1-the-big-picture-in-the-individual-market-50000-arizonans-50-face-huge-cost-increase-by-2020-under-gop-proposal/>*

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**Notes:**

When the ACA was first implemented before the Exchanges began, a Pre-Existing Condition high cost plan was made available and the average health care usage was \$32,000, which is the basis of the \$30,000 care needs in the examples above. That data was from 2012, so given medical cost inflation it may understate costs. On the other hand, enrollment was cut off due to a \$5 billion budget limit, so it may have also not reflected all high-needs consumers (see [https://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip\\_annual\\_report\\_01312013.pdf](https://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_report_01312013.pdf))

Maine's Public Law 90 was passed in 2011 and only in effect for 18 months before it was superseded by the ACA, so how impactful Maine's invisible high-risk pool is debated. The state provided funding to reimburse insurers for those pre-identified for the high-risk pool for 90 percent of the cost between \$7,500 and \$32,500 and 100 percent thereafter. Hence, high-cost patients did not cost insurers more than \$10,000 total (\$7,500+ 10% of 25,000). That's also modeled in a simplified manner in these examples by suggesting that anything above \$10,000 would be paid for by the government. In Maine's case about 14 percent of enrollees were placed in the invisible risk-pool.

Whether or not high-risk pools function depends critically on the adequacy of their funding (see [https://www.washingtonpost.com/opinions/do-high-risk-pools-work-it-depends/2017/05/08/586b95f4-319c-11e7-8674-437ddb6e813e\\_story.html?tid=a\\_inl&utm\\_term=.1ce6471973f4](https://www.washingtonpost.com/opinions/do-high-risk-pools-work-it-depends/2017/05/08/586b95f4-319c-11e7-8674-437ddb6e813e_story.html?tid=a_inl&utm_term=.1ce6471973f4)).

Two views on the Maine law can be found here. One glowingly positive one is here: <http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/>

A second view that suggests the assessment above has some limitations and says ultimately success depends on sufficient funding can be found here. It also suggests reinsurance is a less complicated means than invisible risk-pools to accomplish the same end:

<http://healthaffairs.org/blog/2017/04/12/making-sense-of-invisible-risk-sharing/>

A 2013 study found the top 5 percent of healthcare consumers age 18-44 consumed half the costs of those in that age group and likewise among those 45-64, the top 5 percent consumed 45 percent of the costs. The illustrations above use the top 10 percent instead of the top 5 percent, because those who have greater health needs are more likely to sign up for insurance-so among those in the Exchanges, the top 10 percent are more representative of the top 5 percent if everyone including those with employer-provided insurance in the age-group were included. (Medical Expenditure Panel Survey:

[https://meps.ahrq.gov/data\\_files/publications/st354/stat354.shtml](https://meps.ahrq.gov/data_files/publications/st354/stat354.shtml)).

While this blog has focused on invisible risk-pools. Reinsurance is an equally workable option. A system of reinsurance, where expenditures beyond a certain amount are reimbursed by the government, requires an analysis of the distribution of cost by enrollee to determine an appropriate threshold-as in that case instead of the qualifying patients being fixed at 10 percent as illustrated, the qualifying reimbursement amount is fixed.