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High-Risk Health Insurance Pools

A step toward an individual insurance market

SUMMARY: Health insurance should act like insurance, not a payment plan for regular medical needs. It should also be available for individuals to purchase in a deregulated market. A high-risk pool for health insurance, as in other insurance markets, would keep premiums affordable for the small percentage of those with significant care needs without raising costs for the entire market. The state of North Carolina should finance any high-risk pool entirely through the General Fund and existing taxes, rather than assessments on insurers or other hidden taxes. Money for a high-risk pool can come from Medicaid savings.

Health insurance is the only type of insurance that is purchased to be used. Insurance does not cover the regular costs of home ownership or car maintenance, but health insurance typically does cover the day-to-day costs of health care. Traditional health insurance is so thorough in covering health maintenance costs that individuals pay less than 14 percent of costs on their own, with private insurers and government covering the other 86 percent.[1]

Health insurance also differs in that most policies are not purchased directly by the insured. Employers may provide a range of health insurance options for employees to choose from or as few as one for its employees. With smaller employers, this can raise the cost for younger and healthier employees compared to what they would face if they purchased insurance on their own.

There are a number of proposals to address the lack of individual choice in health care and health insurance. Some have suggested tax credits for individuals to purchase insurance and a cap on the tax exclusion for employer-provided health benefits.[2] Another step to improve health care would make health insurance more like other forms of insurance and create health savings accounts (HSAs), tax-free investment accounts that can be used to pay for health expenditures.

Why a High-Risk Pool?

High-risk pools can reduce the need for traditional government-run programs such as Medicaid and can help to improve the effectiveness of HSAs.

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Critics of HSAs contend that they do not help those with the greatest health needs,[3] despite research that suggests otherwise.[4]

North Carolina could create a high-risk pool as a first step toward expanding the insurance market for individuals and the transformation of health insurance from "prepaid" health care to true insurance. Already, 33 other states have high-risk pools for health insurance.

High-Risk Pools in Other States

In the last 30 years, 33 states have created high-risk health insurance pools. In most states, the pool guarantees insurance coverage with premiums up to 50 percent higher than the average. The federal government provides grants to states that create or have created high-risk pools.

Minnesota's high-risk pool covers six percent of those with private insurance (covered lives) in the state. Oregon and Nebraska's pools reach two percent of the privately insured. No other state has even one percent of those with private insurance in its high-risk pool.[5]

With premiums capped, high-risk pools cannot cover the costs of coverage for the pools' members. States use several methods to subsidize high-risk pools including: general revenues or other state funds, taxes (called "assessments") on insurers based on the number of covered lives or the value of premiums collected, and assessments on hospitals. Legislation considered by the North Carolina General Assembly in 2006 (HB1895) would also have used lower reimbursement rates for doctors and other medical care providers as a way to finance the high-risk pool through cost savings.

Most people with insurance are covered through their employer, and many of the largest employers self-insure with no reinsurance. Federal rules mean assessments cannot apply to self-insured companies unless those firms are so small that they need to purchase reinsurance, which is insurance for their insurance plan. As a result, insurer assessments make a small part of the insured population pay for high-risk pools. Maryland and West Virginia avoided this problem by assessing hospital capacity instead of insurer coverage.

Maryland and other states created politically appointed boards to make decisions on premiums and coverage under the high-risk pool. The Maryland board of directors has greatly increased enrollment, and operating losses, in that state's high-risk pool through its decisions. Losses in the second year of the Maryland Health Insurance Plan were $20 million, but will reach $44 million this year, according to Executive Director Richard Popper. In a presentation to the North Carolina House Insurance Committee, Popper said, "Larger losses were the direct result of board decisions, not market dumping [or other actions]."[6] HB 1895 would have given the same authority to the board of directors for North Carolina's high-risk pool.

General Fund revenue should cover the high-risk pool's shortfall. North Carolina should not rely on health insurers or providers to pay for the high-risk pool's losses. Assessments on insurers are hidden taxes that often are incorporated into the price of insurance for those not in the high-risk pool. Setting low reimbursement rate for health care providers has led doctors to stop accepting Medicaid or Medicare patients. There is no reason to expect doctors facing the same rates to be any more willing to treat members of a high-risk pool. Savings from Medicaid rule changes could provide more than enough to cover the cost.

How to Fund a High-Risk Pool

The North Carolina Institute of Medicine estimated that a high-risk pool with no premium subsidies would enroll 9,000 subscribers and have a shortfall of $40 million per year. Subsidizing premiums based on income would expand enrollment to 18,000 subscribers and increase the program cost to $113 million.[7]

A readily available source of state money to fund the high-risk pool is Medicaid. The state spends $2.6 billion on Medicaid. The $40 million high-risk pool would represent about two percent of state Medicaid spending; the $113 million pool would be four percent.

In its biennium budget, the General Assembly saved $137 million on expected Medicaid costs in fiscal year (FY)

Figure 1. Sources of Funding Used by States with High-Risk Pools

State	Year Established	Enrollment	Allocation of State Funds	Assessment of Health Insurers	Assessment of Health Insurers with Tax Credit	Other
Alabama	1998	3,500			X	
Alaska	1993	480		X		
Arkansas	1996	n/a			X	
California	1991	8,500	X			Health insurer funds for GIP
Colorado	1991	4,800	X			Also Unclaimed Property Fund
Connecticut	1976	2,300		X		
Florida	1983	500			X	
Idaho	n/a	n/a	X	X		
Illinois	1989	16,409	X	X		
Indiana	1982	8,000	X	X		
Iowa	n/a	100			X	
Kansas	n/a	1,750			X	
Kentucky	2001	3,300	X	X		
Louisiana	1992	1,200	X	X		Service charge on providers
Maryland	2003	5,078				Assessment on Hospitals
Minnesota	1976	30,000	X	X		
Mississippi	1992	4,300		X		
Missouri	1991	2,800			X	
Montana	n/a	n/a			X	
Nebraska	1986	5,600	X			Uses a premium tax as the funding source rather than an assessment.
New Hampshire	2002	350		X		
New Mexico	1998	1,500			X	
North Dakota	1982	1,700			X	
Oklahoma	1995			X		
Oregon	1990	12,400		X		
South Carolina	1990	2,200			X	
South Dakota	2003	600	X	X		Reduced Provider Rates at 115% of Medicaid
Tennessee	n/a	n/a	X			
Texas	1998	27,000		X		
Utah	1991	3,000	X			
Washington	1988	3,086		X		Remittance of Excess Loss Ratio by Individual Carriers
West Virginia	2005					Assessment on Hospitals
Wisconsin	1981	18,000		X		
Wyoming	1991	690			X	

Sources: Robert Wood Johnson Foundstion, California Major Risk Medical Insurance Program

2006-07 simply by freezing reimbursements to providers at their level in FY 2004-05.[8] An improved economy and the Medicare Part D prescription drug benefit saved the state an additional $150 million in FY 2006-07.[9] Administrative savings of five percent would yield between $130 million and $150 million. If North Carolina were able to bring its Medicaid program in line with neighboring states through eligibility and benefit changes, it would save $200 million.

Eliminating wasteful care (i.e., care that provides no medical value), which accounts for roughly one-sixth of Medicaid spending, would save the state and counties $500 million. If it were possible to stop all Medicaid waste, this would allow the state to take over the county share of Medicaid and pay for a high-risk pool without premium subsidies. Just cutting half of this wasteful spending would save the state more than $200 million to establish and manage a high-risk pool.

North Carolina's Medicaid program is the most generous in the region. A high-risk pool would be able to assist individuals most in need of health insurance for less than five percent of what the state currently spends on this one program. The state saved more on Medicaid in fiscal year 2006-07 without even trying. If the General Assembly brings benefits and eligibility in line with other states, or undertakes other reform and cost-cutting efforts, it could save enough from Medicaid to pay for a high-risk pool.

Other Considerations

The state could limit high-risk pool eligibility based on income to ensure the high-risk pool truly helps those

who cannot afford health insurance and avoids disrupting the market for private insurance by pulling those who would otherwise purchase insurance on their own.

The legislature should have final approval over the pool's policies and premiums to avoid Maryland's experience of board decisions doubling losses in one year. Legislative responsibility and oversight are critical to the fiscal health of the high-risk pool whether it is financed through assessments or through taxes.

Figure 2. Medicaid Savings and a High-Risk Pool

Estimated Cost of High-Risk Pool	
High-Risk Pool without Subsidy	$40 million
High-Risk Pool with Subsidy	$113 million
Actual Savings FY2006-07	
Reimbursement Freeze	$137 million
Economic Improvement and Medicare Part D	$150 million
Potential Savings	
Five Percent Administrative Savings	$130 million
Align Program with Neighboring States	$200 million
Eliminate Half of Valueless Care	$200 million

Because the high-risk pool only applies to insurance purchases by individuals and not to group plans, the General Assembly should consider two additional steps that would benefit these consumers. From 1997 to 2001, North Carolina provided tax credits for purchases of health insurance for children and of long-term care insurance. Reinstating these tax credits would make it possible to provide better care to individuals while saving money in Medicaid and North Carolina Health Choice, the state children health insurance program. Taking the additional step of providing a tax deduction or credit to individuals who purchase health insurance on their own would also eliminate the penalty for those who do not receive insurance through their employer.

Conclusion

A high-risk health insurance pool is the least disruptive way to guarantee coverage for individuals with pre-existing conditions or other characteristics that would make traditional coverage expensive. The state should pay for a high-risk pool's losses through the General Fund, not hidden taxes such as assessments on insurers. Lawmakers can make changes to the Medicaid program to save money to cover the cost of a high-risk pool, even one that subsidizes premium payments for lower income participants. However the high-risk pool is funded, the legislature should have continuing responsibility for premiums and eligibility. If the General Assembly chooses to rely on insurer assessments, it should also have final approval of their amount. Means-testing would guarantee only those who truly cannot afford coverage benefit from the high-risk pool. Other tax credits would further help the individual insurance market develop and take up the slack from employers who cannot afford to provide insurance.

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Notes

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3. Edwin Park and Robert Greenstein, "LATEST ENROLLMENT DATA STILL FAIL TO DISPEL CONCERNS ABOUT HEALTH SAVINGS ACCOUNTS," Center on Budget and Policy Priorities, January 20, 2006, www.cbpp.org/10-26-05health2.htm.
4. See, e.g., Dahlia K. Remler, Ph.D. and Sherry A. Glied, Ph.D., "How Much More Cost-Sharing Will Health Savings Accounts Bring?" *Health Affairs* July/August 2006, 25(4): 1070–78, www.cmwf.org/publications/publications_show.htm?doc_id=382001.
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6. Richard Popper, presentation to House Insurance Committee, June 8, 2006.
7. Mark Holmes, Ph.D., "NC IOM Task Force on Covering the Uninsured: High Risk Pool," presentation to House Insurance Committee, June 8, 2006.
8. "Overview: Fiscal and Budgetary Actions, 2005 Session," North Carolina General Assembly Fiscal Research Division, January 2006.
9. Senate Bill 1741.