HEALTH POLICY

High-Risk Pools for the Sick and Uninsured Under Health Reform: Too Little and Thus Too Late

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Democrats and Republicans have turned to the concept of "high-risk pools" to provide health care for those Americans who face the dual challenge of uninsurance and serious health difficulties. Under the Patient Protection and Affordable Care Act (PPACA), these "high-risk" individuals will receive extensive help and regulatory protections, in concert with a new system of health insurance exchanges. However, these federal provisions do not become operational until 2014. As an interim measure, PPACA provides \$5 billion for temporary, federally funded high-risk pools, now known as the Pre-Existing Condition Insurance Plan (PCIP). This analysis explores the adequacy of such funding. Using 2005/06 data from the National Health and Nutrition Examination Survey (NHANES), we find that approximately 4 million uninsured Americans have been diagnosed with emphysema, diabetes, stroke, cancer, congestive heart failure, angina, or a heart attack. To provide adequate health care for uninsured individuals with chronic diseases, the federal PCIP appropriations would need to be many times higher than either Democrats or Republicans have proposed.

KEY WORDS: high risk pools; insurance; health reform; patient protection and affordable care act.

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ECONOMIC AND POLICY CHALLENGES FACING HIGH-RISK POOLS

Democratic and Republican policymakers have turned to the idea of high-risk pools (HRPs) as a core element of health reform. Specifically, the Patient Protection and Affordable Care Act (PPACA) of 2010 provides \$5 billion for HRPs as a stopgap measure to cover uninsured individuals facing costly illnesses between 2010 and 2014. After 2014, state health insurance exchanges and other main elements of PPACA become operative.¹ During 2008, John McCain proposed a significantly enlarged HRP program as a principal strategy to help Americans rendered medically uninsurable by diagnoses of serious and costly ill-

nesses. Recent Republican proposals envisioned \$4 billion in annual federal expenditures to enlarge these arrangements.²

Given bipartisan policy attention paid to HRPs, it is important to scrutinize what such arrangements can—and cannot—accomplish in assisting "uninsurable" patients who face the dual challenge of uninsurance and serious illness. To start, it is helpful to consider the basic medical, public health, and financial functions served by insurance coverage. The most immediate medical function of health insurance is to finance needed procedures, therapies, medications, and services for individuals with serious injury or illness. From a population health perspective, health coverage is also important to promote timely and appropriate use of primary, secondary, and tertiary prevention services. From an economic perspective, health coverage provides basic financial security for individuals and secures proper financing for medical providers, particularly providers of safety-net care.

Building on and updating prior work,³ this commentary argues that HRPs are poorly designed to perform any of these functions well. Using 2005/06 data from the National Health and Nutrition Examination Survey (NHANES), I show that a properly designed HRP program would be approximately 20 times the size of current efforts. Such a program would not be a small add-on to current policy efforts. It would instead require tens of billions of dollars in additional expenditures to properly address the needs of eligible patients. Even if such funds were provided, these programs' basic structures pose inherent obstacles to effective medical care and public health policy.⁴

HRPs IN CURRENT PRACTICE AND UNDER HEALTH REFORM

HRPs now cover a small but important subset of uninsured Americans who lack access to group coverage, and have preexisting conditions that either prevent them from qualifying for individual health coverage or that greatly raise the cost of such coverage. The most basic challenge to HRPs is posed by sheer numbers. Almost 200,000 people—1 out of every 230 uninsured Americans—currently participate in HRPs in 35 states.⁵

Organizational details of HRPs differ across the states. Under current policy, roughly 54 percent of HRP program costs are financed through premiums.^{5,6} HRPs offer insurance coverage comparable to private group or individual policies. States impose waiting periods before eligible individuals can participate in HRPs. Given the high expected costs of HRP participants, premiums are markedly higher than what healthy individuals pay for similar

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coverage within employer-based group plans. Many state programs have closed, capped enrollment, or have otherwise constrained the number of participants.⁴

Current HRP's do not always provide financial security to HRC participants, violating a major economic goal of health insurance programs.⁷ Annual premiums average about \$5,800.⁵ High premiums provide one barrier to participation, especially given the \$41,000 average household incomes of HRP participants.⁶⁻¹⁰ An individual can easily spend 25% of her pre-tax income on HRP health insurance premiums. Some states now offer subsidies to assist low-income respondents; many do not.^{5,6}

Funding has now begun for this program, known as the Pre-Existing Condition Insurance Plan, which continues to impose significant limits on HRP programs and individuals. Eligibility will be confined to individuals who have been uninsured for at least 6 months and who have a preexisting condition. HRP programs will also be required to limit premiums and out-of-pocket medical expenditures. Many state programs do not currently meet these requirements.

The new HRP's are designed to build on existing state plans. States may choose not to administer such a plan, in which case the federal government would establish its own program within the state. At this writing, 30 states have chosen to implement HRP's themselves. Twenty have instead chosen the federal option.¹¹

WHAT IS NEEDED TO SERVE THE HRP-ELIGIBLE POPULATION?

How much additional funding would be required to serve the large population of individuals facing the dual challenges of costly illness and lack of health insurance coverage? National Health and Nutrition Examination Survey (NHANES) data provide some answers—combining both patient interviews/surveys and physician examination data to assess important aspects of health and disease. Sponsored by the CDC, this set of surveys interviews a representative sample of roughly 5,000 Americans per year, oversampling older and minority groups.

The 2005/06 NHANES provides especially valuable population health and insurance coverage data to gauge the magnitude of the HRP expansion. NHANES includes detailed medical information on respondents, including clinical examination results to identify important undiagnosed conditions (such as diabetes and hypertension) that are widespread in the American population. These data have been used to examine the health benefits of Medicare¹²⁻¹⁵ and other matters. To account for the weighted and stratified nature of NHANES data, all analyses were conducted using the STATA 10.0 software package.

Within this NHANES sample, 1,882 respondents reported that they were currently uninsured. This corresponds to an estimated 47.6 million uninsured Americans (95% CI: 44.7 million, 50.4 million). This point-in-time estimate corresponds closely to those reported in US Census data over the same period.¹⁶ NHANES does not capture how long individuals have lacked health coverage. Data from the Survey of Income and Program Participation (SIPP) indicate that almost 80 percent of individuals who are uninsured at any point in time will experience a spell lasting at least 1 year.¹⁷

Table 1 below shows the estimated point prevalence (and accompanying 95 percent confidence intervals) of selected serious

Table 1. Prevalence of Serious Conditions Among Uninsured in US Population (Source 2005/06 NHANES)

	Point estimate	95% CI lower limit	95% CI upper limit
Ever told by a doctor that they had			
Emphysema	458,984	155,347	762,621
Diabetes	1,667,681	1,132,977	2,202,386
Stroke	440,402	138,864	741,940
Cancer	1,262,719	685,639	1,839,798
Congestive heart failure	503,655	197,833	809,478
Heart disease	352,468	91,561	613,374
Angina	455,223	179,511	730,935
Heart attack/MI	538,381	165,101	911,661
At least one of the above serious conditions	4,064,830	3,170,699	4,958,960

medical conditions among uninsured individuals based on these NHANES data. I considered uninsured respondents to be plausible HRP participants if they reported ever being told by a doctor that they had emphysema, diabetes, stroke, cancer, congestive heart failure, heart disease, angina, or heart attack. I chose these particular conditions because they rank among the most serious and prevalent mortality risk factors, and because each condition is associated with either the denial of insurance coverage or markedly increased premiums in the individual insurance market.¹⁸

By this measure, an estimated 4.06 million uninsured Americans are plausible participants for an HRP. Many of these individuals also face economic challenges that may occasion or require public help. Forty percent of NHANES respondents identified within this group reported incomes below 133 percent of the Federal Poverty Line—the threshold for Medicaid eligibility under PPACA.

Although the above list of conditions is necessarily somewhat arbitrary, these point estimates are similar to those obtained by the Government Accountability Office (GAO), which used a different methodology, and data from the Medical Expenditure Panel Study to conclude that "nearly 4 million additional individuals to be potentially eligible for enrollment in an HRP based on their uninsured status and preexisting health conditions."⁵ Others provide even larger point estimates.¹⁹ Put differently, an effective national HRP would need to serve on the order of 20 times the number of participants being served in current HRP efforts. The likely path under current appropriations is to implicitly or explicitly impose exclusion criteria or enrollment caps to manage excess demand for the program.¹³

These estimates are especially striking when one considers other illnesses and conditions that lead one to become medically uninsured. Excluding the estimated 4.06 million individuals described above, another 1.7 million uninsured Americans reported diagnoses of chronic bronchitis. More than 4.6 million reported diagnoses of asthma. Still others are diagnosed with severe mental illnesses or substance use disorders, hepatitis C, or HIV/AIDS²⁰—conditions that I did not include in this analysis. Many individuals with these conditions become eligible for Medicaid or other public coverage. Yet significant numbers remain uninsured or are currently on waiting lists for health coverage after qualifying for public disability programs.²¹

Table 1 also does not include people with *undiagnosed* diabetes^{22,23} or cancer, or other conditions (such as traumatic injury²⁴), that lead some individuals to experience serious illness

and uninsurance. The point estimate of 4.06 million therefore likely understates the true demand for HRP participation.

FISCAL CHALLENGES OF EXPANDED HRP PROGRAMS

The large number of potentially eligible participants raises significant financial concerns for states and for the federal government, and ultimately for individual participants themselves. In 2008, average annual claims in current programs were approximately \$9,436 per person.⁵ A recent analysis by Merlis indicates that HRPs' required subsidy per individual to achieve federally mandated actuarial coverage of between \$6,000 and \$7,000.¹⁹ A national high-risk pool serving 4.06 million people would thus likely require annual public expenditures exceeding \$24 billion, amounting to cumulative expenditures exceeding \$80 billion before 2014.

Even if such large expenditures were made, HRPs would still impose measures that create or perpetuate hardship among program participants. Current programs impose mandatory waiting periods before coverage can begin for patients' most serious condition. Individuals diagnosed with serious illness or recovering from serious injury must therefore endure months of uninsurance before they become eligible for HRP-related coverage. Given the reality of constrained budgets, such measures may be required to focus resources on the most needy participants²⁵ and to minimize adverse selection (that is, the sorting of the most costly individuals from other public or private coverage into HRPs).

PREVENTION CHALLENGES FACING HRPs

Finally, these arrangements do not provide the most beneficial preventive care benefits associated with insurance coverage. Many studies indicate that insurance brings the greatest health benefits to individuals who experience chronic cardiovascular disease and accompanying risk factors.²⁶ As indicated by the 2005/06 NHANES, more than 7 million uninsured people have diagnosed or undiagnosed hypertension. Almost 16 million have elevated total serum cholesterol. Few of these men and women are plausibly eligible for an HRP. Yet this group is in great need of diagnostic screening and accompanying preventive care.

CONCLUSION

High risk pools are slated to play an important part in health policy, particularly before the year 2014. HRPs are not the only mechanism enacted under PPACA to address the needs of individuals with costly health conditions. Within 6 months of enactment, PPACA prohibits preexisting conditions exclusions for children (except in cases of fraud). The act imposes other regulatory measures of particular interest to individuals with costly illnesses, including curbs on health insurance industry practices such as rescission and lifetime benefit caps.¹ Finally,

PPACA includes increased expenditures for federally qualified health centers (FQHCs) that provide care for many individuals with chronic illnesses.

Still, HRPs play a central role prior to the enactment of health insurance exchanges, and these arrangements display serious limitations, even as a stopgap measure. Major expenditures would be required for HRPs to be effective, far above the levels contemplated by either Democratic or Republican lawmakers. Even if HRPs received sufficient funding to serve the entire pertinent population, they would not provide many economic and public health benefits associated with universal coverage.

HRPs could be complemented by additional measures that reach larger numbers of Americans facing the dual challenge of uninsurance and serious illness. One feasible proposal would be to repeal or to shorten the mandatory Medicare waiting period for individuals found eligible for federal disability programs.²¹ Another proposal would be to allow states the option to implement health insurance exchanges, with their accompanying protections, before 2014. Still another proposal would be for the federal government to provide sufficient funds to enroll every eligible individual with incomes below 133% of the federal poverty line.²⁷ Adding resources for FQHCs provides another strategy to assist both patients and the broader health financing system.

Whatever pathway is chosen, some urgency is warranted. Millions of medically uninsured Americans cannot wait 4 years before receiving effective help.

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