



High-Risk Pools in the ACA: *Funding and Considerations*

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Executive Summary

Federal and state legislators are currently grappling with instability and rising premiums in the Affordable Care Act (ACA) individual markets. A wide range of solutions are under consideration to address these issues. Regulators are considering various forms of high-risk pools (HRPs) or reinsurance programs to subsidize claim costs and reduce premiums. Proposed HRP solutions are taking one of two forms:

1. Stand-alone risk pools, which pre-date the ACA. These pools carve high risk members out of the single risk pool and manage their care and costs separately.
2. Invisible risk pools maintain a single risk pool but cede high risk members through a reinsurance pooling mechanism. The invisible high risk pool differs from traditional reinsurance because eligibility is defined by those with a specific health condition instead of claim level.

We estimate that a high-risk pool mechanism would require \$11.7 billion of outside funding in order to reduce premiums by 10% nationwide in 2019.

Wakely analyzed the premium impact of an HRP and the funding required to achieve the potential premium savings. Our analysis reveals that implementing an HRP, whether

stand-alone or invisible, will require approximately \$11.7 billion¹ of outside funding in order to reduce premiums by 10% nationwide in 2019. Wakely has estimated that a sufficient portion of those costs, 35% to 40%, could be eligible for “pass-through funding” via a 1332 waiver due to Advanced Premium Tax Credit (APTC) savings to the federal government, while the remainder will need to be funded through other sources, such as assessments. These results are national and will vary significantly by state.

¹ This funding estimate ignores any additional administrative costs required to operate a HRP program. The estimate also assumes no changes to enrollment, member benefits, cost sharing, or other plan characteristics between the base year (2015) and 2019.

In addition to premiums and funding, Wakely has identified a few key considerations for regulators and insurers when considering an HRP solution in the ACA market.

- HRPs require a significant amount of funding in order to have a material impact on premiums. This is partly because overall claims and administrative costs are not reduced in an invisible HRP structure. Claims will likely continue to be paid at reimbursement rates negotiated by each insurer and administrative costs will remain the same.
- If claims for high-risk members are 100% ceded to an invisible HRP, there is little incentive for insurers to manage claims costs, which could have an adverse effect on cost and dampen the impact of premium reductions. For this reason, it will more effective to partially cede claims in an HRP. If insurers remain liable for a portion of the claims costs, they are more likely to engage in activities designed to control costs for their high-risk members.
- HRPs, whether stand-alone or invisible, cover only the riskiest members in an insured pool. Identifying high-risk and high cost members can be a time-consuming and costly process. HRP eligibility may be determined through risk scores, condition prevalence using HCCs or diagnosis codes, questionnaires, or a variety of other methods. It is imperative to develop a clear set of eligibility requirements prior to implementation, and to determine if eligibility will be assigned prospectively or concurrently.
- The risk adjustment implications of an HRP depend on program structure and differ drastically between stand-alone and invisible HRPs. From a transfer perspective, the risk-adjustment impacts of a stand-alone HRP are more straightforward and easier to quantify. In an invisible HRP, it may be necessary, depending on the program structure, to account for the risk adjustment transfer payments of members ceded to the HRP. Insurers will need to adjust their pricing accordingly.

Background

With the arrival of guaranteed access protections under the ACA, state-run HRPs largely ceased to exist. As a result, the individual ACA market contains these high-risk members, who are a small subset of the market but have a large impact on claim costs. These high cost members make it difficult for insurers to assess adequate premium levels, which is one cause of instability in the individual marketplace.

Several states are pursuing “State Innovation Waivers” under Section 1332 of the ACA (Section 1332 waiver) to create solutions for their individual market. In a May 2017² letter to issuers, CMS indicated their openness to review state proposals and released a checklist for states seeking to use HRPs and reinsurance to stabilize marketplaces. To qualify for a Section 1332 waiver, states must demonstrate that their proposals achieve four goals: 1) residents will continue to have access to the same of level of comprehensive coverage; 2) coverage will be at least as affordable; 3) at least the same enrollment levels; and 4) that the federal deficit will not increase.

To date, approximately a dozen³ states have started or have completed their Section 1332 waiver applications. While stand-alone HRPs were a key component of early “repeal and replace” legislation,

² <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-16.html>

³ <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>

no state has proposed one as a solution. States are generally pursuing reinsurance or invisible HRP solutions, with Alaska being the first to propose and have a 1332 waiver approved that included an invisible HRP. Alaska found that their proposal limited rate increases to 7.3% in 2017 instead of the anticipated rate increases of 40%. Additionally, every county in the state is now covered, where there was previously a high risk of no issuer participation.

For more detail on previous and ongoing HRP proposals, refer to Appendix A.

Funding a Statewide High-Risk Pool

Premium reductions by HRPs generate federal savings as an HRP lowers the second lowest cost silver plan and therefore reduces total APTC spend. If a state can get approval for a 1332 waiver, the federal savings, in the form of lower Advanced Premium Tax Credits (APTC), would be passed through

States have the potential to receive 35% to 40% of their high-risk pool funding through federal cost savings.

back to the state. The result would be that the state would need to fund only a portion of the HRP dollars needed to reduce premiums. The state required funding can be collected through an assessment on commercial health insurers,

managed care organizations, providers or other sources. Wakely calculated the approximate pass-through amount on a national basis. CMS reported that approximately 84% of 2016 on-exchange members received APTCs at an average of \$290 per member per month⁴. The aggregate APTC dollars represented approximately 40% of total 2016 premiums⁵ paid in the individual ACA market. The APTC savings generated by an HRP means that states have the potential to receive 35% to 40% of their HRP funding through federal cost savings⁶, with the remainder funded through assessments or other sources. The proportion of the individual ACA population qualifying for APTCs varies widely between states⁷, as does the average APTC amount. It is essential for states to account for the APTC enrollment and amounts in their market when budgeting for an HRP or reinsurance program.

⁴ <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>

⁵ Total 2016 on- and off-exchange premiums were calculated using the premium and member months published in the CMS summary report: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>

⁶ Federal APTC savings are partially offset by a reduction in revenue from fees such as the Exchange User Fee and the Health Insurance Provider fee, which are charged as a percentage of premium.

⁷ [See footnote 4](#)

Disclosures and Limitations

Wakely has developed the estimates described in this paper using a large data set of 2015 Individual ACA enrollment, premiums and claims, as well as publically available data on the ACA marketplace. This paper presents national results and is intended for discussion purposes only. Any actual state or federal policy decisions should be informed by modeling state-specific markets and assumptions, and should include sensitivity analysis. Readers of this paper should rely on their own experts in developing estimates specific to their market and membership. Please contact Suzanna-Grace Sayre at suzannagrace.sayre@wakely.com or Julie Andrews at julie.andrews@wakely.com with any questions or to follow up on any of the concepts presented here.

Appendix A

Previous and Ongoing HRP Proposals

Several of the health reform proposals recently proposed or currently under consideration include creation of stand-alone HRPs or invisible HRPs. These HRPs are intended to cover enrollees with high cost and high-risk conditions. Additionally, several states are in the process of applying for Section 1332 waivers that include establishing state reinsurance protection for individual market issuers, either for high cost claimants generally or those with specific high-risk conditions.

- Tom Price’s “Empowering Patients First Act of 2015”⁸ proposal would “provide a grant to each state for HRPs or reinsurance pools to subsidize health insurance for high-risk populations and individuals” separate HRP. The proposed funding amount was \$1 billion per year.
- The Palmer-Schweikert amendment to AHCA⁹, proposed in April 2017, would create an “Invisible Risk-Sharing Program” funded with \$15 billion over nine years
- Alaska submitted a Section 1332 waiver on January 3, 2017 to create a state operated pool, the Alaska Reinsurance Program (ARP)¹⁰. The ARP program will cover enrollees in the individual market with high-cost diagnoses. The ARP covers 33 high-cost conditions and is funded by a 2.7% premium tax on all insurers in the state (including non-health entities).
- Several other states are also progressing through the Section 1332 waiver application process, including but not limited to: Washington, New Hampshire and Iowa. These states are considering several different proposals and are considering an HRP option.
- Minnesota, Oregon and Oklahoma have submitted or are in the process of applying for a Section 1332 waiver to establish state-based reinsurance programs. These states have elected not to apply for a high-risk pool and are instead pursuing a parameter-based state reinsurance program.

⁸ <https://www.congress.gov/bill/114th-congress/senate-bill/2519>

⁹ <https://rules.house.gov/sites/republicans.rules.house.gov/files/115/AHCA/Palmer-Schweikert%20Amendment.pdf>

¹⁰ <https://www.commerce.alaska.gov/web/Portals/11/Pub/Alaska-1332-Waiver-Application-with-Attachments-Appendices.pdf?ver=2017-01-05-112938-193>