Hybrid High-Risk Pools

How an Idea from the Past Can Be Modernized for the Future

DECEMBER 2019

The individual health insurance market is inherently different than the employer-sponsored market. Adverse selection, or people waiting until they are sick to purchase coverage, is a significant problem under the best of circumstances and can increase the cost of coverage dramatically by affecting the balance of health risks in the overall pool of covered individuals. In the employer-sponsored market, because plan enrollment is strictly controlled, adverse selection is not a big problem. The employer's financial contribution and the fact that plan enrollment is governed by date of hire and date of employment termination prevents employees from enrolling only when they know they have an existing health condition.

Prior to the Affordable Care Act, because of the problem of adverse selection, health insurance coverage in the individual market in most states was medically underwritten, meaning health questions could be asked of the applicant and if a person's health condition was serious enough, the application for coverage could be turned down. Many states at that time established high-risk pools to provide coverage to those individuals who were unable to qualify for individual health insurance coverage. Most of these pools charged the high-risk individual an increased premium and most of the pools were funded by assessments on insurance carriers.

In today's post-ACA world, we now have guaranteed issue of coverage in the individual health insurance market and no preexisting-condition exclusions as well as a mandated essential benefits package. No person is charged more for coverage just because he or she has a health condition. Insurers are required to accept applicants during open-enrollment periods and certain special enrollment periods.

In spite of specified enrollment periods, we are still seeing adverse selection in the individual market, most likely because individuals have the best knowledge of whether they may have or be predisposed for a health condition and may be more likely to enroll at that time. The result is that the pool of covered individuals at any given time has become sicker overall and since the biggest part of a health insurance premium is governed by the cost of medical care, health insurance premiums have increased as a result.

Although there are a number of strategies that can be developed to address adverse selection in the individual market, one of the most effective would be creation of a new style of high-risk pool designed to function in today's world. Health insurance coverage would still be issued without

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health questions during specified enrollment periods and there would be no preexisting-condition exclusions. However, a new state **hybrid** high-risk pool, sometimes called an **invisible** high-risk pool or a **reinsurance** pool would be available, not for the purpose of issuing coverage at higher rates to those with health conditions, but rather for the purpose of providing financial backing for carriers issuing coverage to higher risk individuals.

These new hybrid pools are designed for today, and are not the pools that existed before the Affordable Care Act or even the federal high-risk pool that existed during the initial years of the ACA.

The new pools would be less expensive to operate since they would operate solely to back up the risk of high-risk individuals, not issue coverage to them with all of the costs of claims processing and other administrative tasks associated with the actual provision of benefits. The high-risk individual would most likely not be aware that part of the risk of insuring her had been ceded to such a hybrid high-risk pool, but doing so would lower costs for everyone purchasing coverage in the individual market. The covered individual would receive coverage through the carrier of her choice and could purchase the plan of her choice. The carrier would have the option of ceding part of the financial risk of providing coverage to the hybrid high-risk pool. This means that the carrier would retain the first part of the risk, lowering pool-operating costs compared to the old pools that covered 100% of the risk. If claims reached a certain level, the pool would be responsible for costs for the remainder of the calendar year.

One idea that might be used by some pools to encourage both smaller regional carriers and larger national carriers to participate in the market would be to offer more than one ceding level in the pool, allowing smaller carriers to cede risk sooner than larger carriers that could safely retain a higher level of risk. There would be a relatively small cost to the carrier related to ceding risks to the pool with a higher cost for a lower level of retained risk and a lower cost for carriers that retained a larger share of the risk. In any case, the carrier would retain enough of the risk to have a clear incentive for using good medical-management techniques.

To be clear, these ceding costs would represent only a small part of the cost of operating the pool. Other funding would be necessary. Some sources of funding could be Section 1332 waivers but even when combined with ceding costs additional funding would likely be needed.

Since coverage in the individual market would still be required to be issued without regard to health status, the financing mechanism of the past high-risk pools – carrier assessments – would not be appropriate. Some level of federal funding would ensure pool stability and ensure that a more competitive market with lower costs for consumers could exist.

New hybrid high-risk pools are one of an important set of ideas to improve the cost, plan choice and healthcare provider options available to consumers in the individual market. They would serve as an important market stabilizer and should be a first priority in actions taken to improve healthcare in the individual market.

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