AARP Public Policy Institute

# Increasing Health Insurance Coverage for High-Cost Older Adults

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The Urban Institute

Research Report

AARP

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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# EXECUTIVE SUMMARY

## INTRODUCTION

Because a small fraction of individuals account for a large share of total health expenditures, insurers gain more by excluding high-cost people from coverage than by efficiently managing the care of enrollees. The incentives for insurers to avoid high-cost and high-risk enrollees affect not only the likelihood of health insurance coverage for the high-risk population, but also the cost and accessibility of coverage overall in the small-group and nongroup private health insurance markets. This paper identifies public policies that might address these problems in private health insurance markets more effectively and delineates the advantages and disadvantages of each.

## ISSUES AFFECTING ALL POLICY OPTIONS PRESENTED

### Age Group Issues

While the problem of high medical need is not exclusive to prime age adults (ages 50 to 64), there are several reasons to focus attention on this age group. Between the ages of 50 and 64, the rates of onset for many chronic diseases increase rapidly, and the consequences of forgoing care necessary to prevent and manage these health problems become ever greater. At the same time, rates of private insurance coverage in this age group have fallen in recent years as costs have risen.

### Cost Containment

Regardless of the reform approach pursued, the focus of successful cost containment efforts will have to fall on the high-need population, as they account for the lion's share of total health care spending. Most of the strategies being considered as cost containment components of reform require significant up-front investment in analytic work and infrastructure development. Consequently, their greatest benefits are unlikely to be realized until a number of years after implementation.

### Mandatory versus Voluntary Reforms

The question of whether all or some specified groups of individuals should be required to enroll in insurance coverage has important implications for access to affordable coverage for the high-medical-need population. A voluntary system would likely result in significant adverse selection in a new insurance product that is accessible to all without health status rating, potentially compromising its viability. A mandatory system would eliminate the possibility of adverse selection in the insurance market at large, but might still require some risk adjustment. A voluntary system combined with subsidies for high-cost enrollees might be sustainable.

## POLICY OPTIONS FOR THE HIGH-COST/HIGH-NEED POPULATION

### Government-Financed Reinsurance

Publicly financed reinsurance would remove a portion of the financing burden of large claims from insurers and, thus, insurance payers (i.e., individuals and employers), with the broad base of taxpayers paying for that portion of reinsured medical spending. Public reinsurance alone would not have a significant impact on the number of uninsured, nor would it decrease medical underwriting or the incentive for insurers to avoid high-cost

individuals. By decreasing the variance in health spending within the small-group and nongroup markets, however, public reinsurance could increase the stability of these markets.

### Public Program Buy-In

Recent reform proposals suggest allowing otherwise ineligible individuals to purchase Medicare or Medicaid coverage. This approach has the advantage of broad risk pools and pre-existing plan infrastructure. Subsidies for low-income individuals would likely be necessary, and the establishment of actuarially fair premiums would depend on whether participation was mandatory or voluntary. A Medicare buy-in program, which would be feasible only at the federal level, would have the advantage of broad access to providers. States could institute a Medicaid buy-in program, which offers a more comprehensive benefit package than Medicare but may restrict choice of providers.

### Assigning Risk to Private Insurance Carriers

Under this approach, high-cost individuals could apply for random assignment to a private carrier operating in their area. Carriers would be assigned high-cost individuals in proportion to their share of the group and nongroup markets. The enrollees themselves would pay income-related premiums, with the government paying the difference between the individual's portion and the full standard risk premium. Creating incentives for carriers to effectively manage high-cost assignees, even with government subsidization, would be a critical design feature.

### Federal Financing of State High-Risk Pools

A stronger commitment from the federal government—including expanded benefits, income-related premiums, and elimination of pre-existing condition exclusions—could improve existing high-risk pools' ability to serve people with high-cost medical needs. However, using high-risk pools alone to effectively expand coverage to the high-need population maximizes the public dollars necessary to finance coverage for this population. When high-need enrollees are segregated in their own risk pools, their expenses cannot be spread through premiums across a broader, lower-average risk population.

### Purchasing Pools with Low-Income Subsidies as Guaranteed Source of Coverage

Purchasing pools, which have varying design characteristics, provide a structured marketplace through which at least a segment of consumers (e.g., individual purchasers and small employers) are guaranteed accessible insurance coverage with a defined set of benefits, coupled with income-related subsidies. Important design issues impacting access and affordability for the high-medical-need population include: the rules of issue and rating in the pool; insurance regulations outside of the pool; the inclusion of the Medicaid population; and benefits and cost-sharing offered by pool plans.

### COBRA Expansion

Encouraging the use of COBRA coverage through extended periods of eligibility or subsidizing premium costs is another means of increasing coverage of high-risk individuals. This approach has the advantage of reducing their premium costs, since they would be pooled with lower-risk current employees. However, the effect on the premiums of current and former employers could be substantial. In addition, the reach of such an approach would be limited to the recently unemployed with prior employer-based insurance—a relatively small portion of the high-risk population.

### Other Public Policies with Significant Implications for the High-Cost Population

Other reform proposals, although not directed at expanding coverage for the high-cost/high-risk population, could increase risk segmentation in insurance markets, with potentially harmful consequences for access to coverage for the high-cost population. These proposals include: increased incentives to use health savings accounts; increased incentives to use existing private, nongroup insurance markets; and allowing insurance to be bought from out-of-state carriers.

## CONCLUSIONS

Any serious effort to increase or guarantee the high-cost population's access to adequate and affordable health insurance coverage will require a significant redistribution of health care financing. People ages 50 to 64 are particularly vulnerable to the market's shortcomings, as they are more likely to develop high-cost conditions. Yet their private insurance options under the current health care system are deteriorating. Access to regular medical care for this population is not only important to them personally, but also has implications for their costs upon entering the Medicare program at age 65. Comprehensive health reform, if enacted, is likely to address many of the shortcomings of the current system for the high-cost population. However, in the absence of such reforms, there continues to be a compelling public interest in increasing access to coverage for this at-risk population.

## INTRODUCTION

The distribution of health care expenditures is highly skewed; a small fraction of individuals account for a large share of total health care expenditures. Because of this lopsided distribution, health insurers gain more from excluding high-cost and high-risk individuals from enrollment than they can gain from efficiently managing the care of enrollees. The incentives for insurers to avoid high cost/high risk enrollees are therefore substantial.

These incentives affect more than the high-risk population,. They also have a detrimental effect on the cost and accessibility of coverage in the small-group and nongroup private health insurance markets. The small-group and nongroup markets cover a small share of the insured population, but they have the greatest year-to-year variation in medical costs (Blumberg and Holahan 2004). Because of their small associated risk pools, a modest number of high-cost enrollees can have substantial effects on average medical costs within small-group and nongroup insurance policies.

Efforts aimed at redressing these issues through private market reforms have not been satisfactory. Reforms that increase risk segmentation may lead to lower premiums and greater coverage for healthy groups, but only at a substantial cost to unhealthy individuals. The few instances where states have forced greater risk pooling for private insurance have failed because they have been limited to a small population base of voluntary enrollees. If healthy, low-cost individuals or groups opt out of the voluntary coverage, the high costs of other enrollees cannot be distributed broadly.

This paper identifies public policies that might better address these problems in private health insurance markets and delineates the advantages and disadvantages of each. The policies discussed include public coverage options as well as ways of improving the market for private insurers by expanding coverage across the spectrum of health care risk.

## ISSUES AFFECTING ALL POLICY OPTIONS PRESENTED

Specific policy issues relate to all policy options directed at expanding insurance coverage for the high-cost/high-risk population. They include the following:

- How adults ages 50 to 64 (referred to here as “prime age”) with high medical needs differ from the younger population with high medical needs;
- How cost containment figures into health care reforms aimed at expanding health insurance coverage;
- How mandatory reforms (requiring individuals to obtain insurance coverage) compare with voluntary reforms in the context of increasing coverage and accessibility for the high-cost population.

### HOW 50- TO 64-YEAR-OLDS DIFFER FROM OTHER HIGH-NEED GROUPS

The problem of lack of health insurance is not exclusive to prime age adults, but the consequences may be most severe for this age group. First, several recent studies suggest that the health status of individuals nearing Medicare eligibility is significantly worse than

that of younger people. Consequently, Medicare spending is significantly higher and the risk of mortality is greater for those without continuous insurance coverage after age 50 (Baker et al. 2007; Hadley and Waidmann 2006; McWilliams et al. 2007; Polsky et al. 2006).

Second, as individuals near retirement age, demand for health insurance coverage is likely to increase and the availability of affordable coverage decreases. Many chronic diseases that require regular medical attention and can lead to catastrophic spending events begin to develop between ages 50 and 64. People who experience these chronic diseases themselves or observe them among peers—even those who previously considered themselves healthy enough to voluntarily decline employer offers of insurance or take jobs that did not include group coverage—may decide they want health insurance.

At the same time, several factors work to restrict the supply of health insurance at these ages. Workers begin to withdraw from the labor force, either leaving work entirely or cutting back hours on their current job or in another so-called "bridge job." In addition, the current economic downturn has led to higher unemployment, affecting prime age adults as well as the general working population. Consequently, labor force withdrawal after age 50 may be voluntary or may be induced by declines in health or economic circumstances. Meanwhile, employer-sponsored retiree health insurance benefits are declining (McCormack et al. 2002), and part-time employment is less likely to offer coverage. So voluntary or involuntary retirement, unemployment, or reduced work hours will result in reduced health insurance options. If health insurance is obtained through a spouse's job, the spouse's change in employment status will often lead to a loss of coverage.

Finally, as group coverage options decline, the possibility of obtaining individual coverage as an alternative is also reduced. This is especially true for people with chronic health problems—for whom nongroup policies are expensive, likely to include pre-existing condition exclusions, or unavailable altogether. Thus, without affordable coverage options, the likelihood of *involuntary* uninsurance increases at these ages.

## COST CONTAINMENT

Regardless of the reform approach pursued, mechanisms for stemming the rate of growth in health care spending will be a central concern. The focus of successful cost containment efforts will have to fall on the high-need population, as it accounts for the lion's share of total health care spending. For example, in 2003, 85 percent of national health care spending was attributable to the highest-spending 25 percent of the population; 64 percent of spending was attributable to the highest-spending 10 percent (Zuvekas and Cohen 2007). Consequently, any policy changes that make coverage more accessible and affordable for the high-need population have the potential to impact a very large percentage of total national health care spending.

There are strong concerns that health care spending continues to grow significantly faster than gross domestic product (GDP). Consequently, cost containment as a component of serious health care reform has a growing and vocal constituency. There is no magic bullet for containing health care costs. However, multiple strategies have the potential to lower health care spending, each by modest amounts. These strategies, which could be implemented together to generate a more significant impact on health care spending, include the following:

- Development and deployment of an integrated health information technology system
- Further funding of comparative-effectiveness analyses of alternative treatment regimes coupled with a payment policy consistent with the analyses
- Introduction of a public insurance plan option available to all as a potential inducement for greater competition in private insurance markets
- Expanded research and use of disease management and chronic care management regimes
- Simplification of administrative procedures
- Targeted investment in cost-effective preventive care and behavioral disease-prevention activities

Most of these strategies require significant up-front investment in analytic work and infrastructure development. As a consequence, their greatest benefits are unlikely to be realized until a number of years after implementation.

## REFORMS WITH AND WITHOUT AN INDIVIDUAL MANDATE

Whether all or some specified groups of individuals should be required to enroll in insurance coverage (i.e., an individual mandate) or allowed to voluntarily decide whether to participate has important implications for access to affordable coverage for the high-medical-need population. This is because those most likely to purchase insurance coverage under a system without a mandate are those most likely to use medical care.

Setting health insurance premiums based on health care risk encourages lower-cost individuals to enroll in insurance coverage when they have a choice, while imposing large health care financing burdens on those in worse health. Such segmentation of health care risks is taken to an extreme in many nongroup insurance markets, which exclude individuals with high expected costs. The current system has placed substantial barriers to access and affordability of care for many high-medical-need individuals. Assisting this population under reform will require mechanisms for increasing their access to adequate affordable health insurance coverage.

However, absent a mandate, reforms that increase the pooling of health care risk—for example, by providing guaranteed access to insurance coverage and prohibiting basing premiums on health status—will tend to attract a higher-cost population. Risk pooling will discourage the healthier segment of the population from purchasing insurance because their premiums will be higher due to the medical costs of their less healthy counterparts. As a consequence, a voluntary system that guarantees coverage and does not base premiums on health status would likely result in significant adverse selection, with premiums starting off high and possibly increasing over time to unsustainable levels.

An individual mandate with guaranteed issue and no health rating, however, would ensure that all individuals, regardless of health status, enroll in insurance coverage. This would eliminate the possibility of adverse selection in the insurance market at large. If some insurance pools attracted a higher-cost population than average, premium dollars could be moved from lower-cost to higher-cost pools to ensure that risk is spread broadly.

A nonmandate or voluntary system could be sustained, however, if premiums in the guaranteed-issue product were subsidized using a broad-based revenue source. In other words, revenue from a source unrelated to an individual's decision whether to voluntarily purchase coverage could be used to ensure that all taxpayers contribute to the costs associated with the high-need population. Subsidizing premiums would lower the premiums in the pool, making them more attractive to the lower-cost population. But this would require additional government revenue to be raised explicitly, as opposed to having the health care financing burden spread via premiums under a mandatory option. The bottom line is that a voluntary system that provides guaranteed coverage for the high-medical-cost population at premiums unrelated to their health care risk will require more explicit subsidization of that population than a system with an individual mandate in order to keep premiums affordable and attractive to those of all health care risks.

The mandate issue is also relevant for the phase-in of comprehensive reforms. It is unlikely that any system of reform could be implemented all at once. For example, policymakers would have to set up administrative functions—such as purchasing pools, public insurance plan options, and subsidy determination processes—and ensure that they are working effectively before putting a mandate into place. Short-term pricing and market stability issues are likely to arise and would have to be resolved before the system could become mandatory. Consequently, during the phase-in period, a short-term infusion of subsidies for the high-risk population may be necessary to address transition issues.

## POLICY OPTIONS FOR THE HIGH-COST/HIGH-RISK POPULATION

Legislatures and health care analysts have considered an array of options for expanding insurance coverage to the high-cost/high-risk population. This section summarizes the different options and discusses the advantages and disadvantages of each. In addition, this section outlines the policy proposals that, while not specifically designed to expand coverage to this high-need population, could substantially affect their access to coverage.

### GOVERNMENT-FINANCED REINSURANCE

Reinsurance provides financial protection to insurance carriers, reimbursing them for some portion of enrollee claims. In the private reinsurance market, self-funded employers and commercial carriers pay premiums to a reinsurer to insure against particularly large claims. Under the publicly financed reinsurance policy option, the broad base of taxpayers would assume the financing burden of large claims for insurance companies and, thus, insurance payers (i.e., individuals and employers). For example, the government might pay 75 percent (the reinsurance rate) of health care expenditures above $50,000 (the attachment point) for each enrollee whose health care expenses exceed $50,000 in a plan year. The motivation behind publicly financed reinsurance proposals is the sense that local small-group and nongroup insurance risk pools are not large enough to efficiently spread the costs of high-cost cases (Blumberg and Holahan 2004). President Obama included reinsurance as one component of his health care reform proposal during his 2008 campaign (although he did not provide specific details), as did Senator John Kerry in his presidential bid in 2004. The state of New York uses a reinsurance mechanism in its Healthy New York program, and other states have investigated doing so (Bovbjerg et al. 2008). Swartz (2006) has also proposed that government act as reinsurer in the private nongroup insurance market.

Industry experts and many researchers have concluded that government-financed reinsurance will not, by itself, increase availability of insurance coverage for high-risk individuals and will not significantly increase insurance coverage (Blumberg, Clemans-Cope, and Blavin 2005; Bovbjerg et al. 2008). Reinsurance can, however, significantly decrease the variance in spending within the small-group and nongroup markets (Blumberg and Holahan 2004) and can reduce risk segmentation among the currently insured.

There are a number of reasons why public reinsurance alone will not increase access to insurance for those with substantial medical needs.

- First, reinsurance policies at the typical attachment points (e.g., $50,000 or $35,000 in claims) do not decrease the incentives of private insurers to underwrite insurance policies (i.e., assess an applicant's relative health risk and then charge higher premiums to those whose risk is deemed higher than standard) or screen out those with the highest expected medical costs (Blumberg, Clemans-Cope, and Blavin 2005). These attachment points are well above the health care costs of an individual of average risk, leaving incentives as strong as they are today to continue to enroll only the best risks.

- Second, insurers and actuaries explain that while government reinsurance would lower the private premiums in aggregate by the amount of public money spent, no extra premium savings can be expected due to a reduction in carrier risk. In other words, any hypothesized lowering of a health insurance "risk premium" due to reinsurance would not materialize.

- Third, public reinsurance at the typical attachment points and reinsurance rates (e.g., 75 percent or 90 percent) will not significantly lower insurance premiums because most spending, even for those at high-expenditure levels, occurs *below* the attachment point. For example, in their analysis presented in 2004 dollars, Blumberg and Holahan (2004) found that government reinsurance of 75 percent of costs exceeding $30,000 would reduce the premiums of those obtaining their coverage through small firms by only 7 to 8 percent; government reinsurance of 90 percent of spending above $50,000 would reduce premiums for the small-firm insured by only about 5 percent. These modest savings would have very little impact on the extent of insurance coverage.

Yet achieving even these relatively small premium reductions could carry significant government costs. For example, public reinsurance for firms with fewer than 25 workers at a $30,000 attachment point with a 75 percent reinsurance rate would have cost the government about $7 billion in 2004. Lowering the thresholds further to achieve greater premium reductions would quickly increase government costs. However, because the variance of medical expenses is very large in the nongroup and small-group markets relative to the large-group market, reinsurance at these levels could have a very large influence on variance in individual spending, reducing it by 50 percent or more. Such reductions in variance could be expected to increase the stability of year-to-year pricing in these markets. Because variance in the large-group insurance market is already low, reinsurance would not have the same impact there.

In sum, public reinsurance alone would not have a significant impact on the number of uninsured, nor would it decrease medical underwriting or the incentive for insurers to avoid high-cost individuals. By decreasing the variance in health spending within the small-group and nongroup markets, however, public reinsurance could increase the

stability of these markets. Government-sponsored reinsurance could be implemented at the state or federal level.

## BUY-INS TO PUBLIC PROGRAMS

Several politicians have proposed offering otherwise ineligible individuals the option to purchase health insurance through Medicare or Medicaid. In 1998, President Clinton formally proposed the option of a Medicare buy-in for those ages 55 to 64 (American Academy of Actuaries 1998). During the presidential campaign of 2008, several Democratic candidates, including now President Obama, suggested a public insurance buy-in option as part of their comprehensive reform proposals. Senator Baucus included the option in his recent white paper as a temporary measure until private markets could be established as part of an individual mandate. In fact, much of the current discussion of health care reform has focused on whether individuals could choose to enroll in a public sector health insurance plan, one version of which is based on the current Medicare program.

The precedent for individuals to purchase Medicare coverage already exists for those who are age eligible but do not have a sufficient work history. Individuals with fewer than 30 quarters of Social Security–covered employment can purchase Medicare Part A coverage for a monthly premium of $423.[1] The recent proposals for allowing people younger than 65 to buy into Medicare have different premium and benefit structures. But for the policy to be affordable and thus effective in increasing coverage among the high-risk population, some combination of subsidies and broad pooling of risk is likely to be necessary.

Waidmann, Hadley, and Ruhter (2008) examined the implications of a Medicare-like buy-in structure for families in which at least one member was between 50 and 64 years of age. The analysis assumed a benefit package more comprehensive than Medicare's, meant to represent coverage under Medicare Parts A, B, and D, as well as Medigap plans. Their findings suggest that, with an individual mandate and subsidies for low-income families, a public system could be designed that would attract a large number of currently insured and uninsured households of diverse risk levels. In addition, the remaining private insurance risk pool would be lower cost, as the share of older individuals in those plans would fall.

However, the authors found that even broad participation would result in some adverse selection into the buy-in program. Without the mandate and the generous subsidy assumptions these authors make, it is likely that the problem of adverse selection would be greater. Other modifications, such as cutting back the benefit package (to basic Medicare levels) would also make the plan less attractive to the currently insured and the high-cost population. Another key assumption is that administrative costs of the buy-in program would be as low as those of the Medicare program. A publicly regulated private plan may not have the same cost advantage, and this could result in an insurance product that is less competitive with the private market, leading to lower enrollment by healthier individuals, and hence more adverse selection. If creating a self-sustaining public plan is not a primary aim of a buy-in, concerns over adverse selection may not be as worrisome.

[1] Premiums for Parts B and D coverage and private supplemental (Medigap) plans are the same as for the fully eligible Medicare population.

In this case, offering subsidies to high-cost individuals so that net premiums are near those of a standard risk pool and offering additional subsidies to make premiums affordable to low-income individuals may be a way to increase coverage among the currently uninsured while reducing risk in the private market.

A Medicare buy-in program would be feasible only at the federal level, given that Medicare is a completely federal program. At the state level, a natural alternative may be to allow individuals to buy into the Medicaid program. A Medicare buy-in is a potentially attractive option, but the more comprehensive benefit package of Medicaid may be even more attractive to many high-risk individuals. In particular, community and institutional long-term care (available under Medicaid but not Medicare) may be an important part of the health care needs of this population, and some analysts (e.g., Etheredge and Moore 2003) have suggested adding buy-in options as part of broad Medicaid reform. Currently, 33 states offer a Medicaid buy-in option for people above the normal income cutoffs if they have qualified for Social Security Disability Insurance and are returning to work. In addition, a growing number of states allow parents to buy in their children at the full premium when their incomes are too high to qualify for Medicaid or the State Children's Health Insurance Program. Enrollment in both types of these Medicaid buy-in programs is very low, however. As Kenney, Blumberg, and Pelletier (2008) suggest, at low levels of enrollment in voluntary programs such as these, adverse selection is more likely. Any health reform proposal that does not include a mandate will necessitate governments making stronger outreach efforts and, most likely, offering subsidies to make such programs attractive to a larger, more diverse risk pool.

Medicaid is directed at the low-income population, and it may carry some stigma for the higher-income high-cost population. In addition, Medicaid payment rates are generally significantly lower than either Medicare or private payment rates, so some providers may not be willing to participate, creating a barrier to accessing health care (Edwards, Bronstein, and Rein 2002). Therefore, a population with high medical service needs may not be best served by the Medicaid program, unless a buy-in option is coupled with increases in provider payment rates.

Reforms to Medicaid eligibility and enrollment require the approval of the federal government, as Medicaid is jointly financed by the federal government and the states. However, states that fully fund Medicaid expansions can reform their eligibility and enrollment criteria without federal approval.

## ASSIGNING RISK TO PRIVATE INSURANCE CARRIERS[2]

This policy approach focuses on assigning individuals with high-cost medical needs to private insurers. It attempts to spread risk more broadly by requiring all private insurance carriers to provide coverage to some high-cost individuals at standard rates, while also taking advantage of large carriers' expertise at managing high-cost cases. The excess costs associated with high-cost individuals would be partly internalized by the carriers through across-the-board premium increases for all their enrollees and partly financed by the government. The greater the share of costs financed by the government, the lower the

[2] This option was first described in Blumberg, Clemans-Cope, and Blavin (2005) and was based in significant part on ideas developed by health insurance consultant Tom Stoiber.

burden on private premiums, but the incentives for private insurers to efficiently manage the spending of high-medical-need enrollees would also be lower.

High-cost individuals could apply for random assignment to a private carrier operating in their area. Carriers would be assigned high-cost individuals in proportion to their market share, with all private carriers in the group and nongroup markets required to participate in the program. Eligibility of high-cost individuals for the assigned-risk program could be based upon their having specific diagnoses, having been denied coverage or offered substandard coverage in the nongroup market, having out-of-pocket spending that exceeds a threshold, or a combination of these factors. The program could also be limited to those below a particular income level. Carriers could not charge assignees premiums that exceed the premiums charged people of standard risk. The enrollees themselves would pay income-related premiums, with the government making up the difference between the individual's portion and the full standard-risk premium.

Government subsidies and regulations would determine the affordability of the coverage and the adequacy of benefits provided by the carriers. Insurers could be required to provide a level of benefits specified by the government, including specifically defined limits on cost sharing (i.e., deductibles, copays, and out-of-pocket maximums) for added financial protection for this high-need population. While this approach would provide the strongest protections for enrollees, requiring insurers to provide a package of benefits they do not otherwise offer could impose significant administrative costs on the carriers. These administrative burdens could be reduced if carriers were allowed to enroll random assignees into an existing benefit structure but with reduced cost-sharing requirements. The trade-offs between carrier administrative burden and guarantees of benefit adequacy would be an important avenue for investigation.

The assigned-risk approach would be coupled with a new reinsurance pool in which carriers could elect to participate. The pool would allow insurers to protect themselves from catastrophic losses, and each carrier would have to decide whether to participate in the pool for all assigned cases or not at all. The reinsurance pool could be set to reimburse the carrier for a substantial share of claims for the assigned population—e.g., 90 percent of claims that exceed the standard individual premiums paid by the assigned individuals and by the government on their behalf. The individual carriers would be expected to absorb the remaining 10 percent of excess claims by increasing premiums of all its insureds.

A feasible option under this approach would be to have the government share the costs of the reinsurance pool with the insurers. The trade-off would be between higher public costs paid for by general revenues and higher private insurance premiums. In the absence of an individual mandate, rising private premiums across risk classes could dissuade low-risk individuals from enrolling in private insurance. If that were the case, greater reliance on government revenues would ensure that the excess costs of care for high-risk people are spread broadly across the population.

On the other hand, if carriers are required to bear a greater share of reinsurance pool costs, they will have more incentive to effectively managing the care of high-cost cases. In the extreme, for example, full government financing of excess costs would allow carriers to pass all of their losses on to the government, with no financial incentive to contain costs once the spending threshold for the assigned individuals had been reached. If the reinsurance pool premium paid by participating carriers was high, some of the

larger, more efficient insurers might opt out of the pool, relying instead on the adoption or development of effective cost-containment strategies. The larger the government subsidy in the reinsurance pool, the lower incentives for carriers to create efficiencies.

Carrier incentives to settle or dispute claims would also be strongly related to the share of assignees' excess costs borne by insurers versus the government. Carriers opting out of the reinsurance pool and carriers participating in a pool with high carrier premiums would maintain their current incentives to dispute high-cost claims. If more of the claims costs were being passed on to the government through highly subsidized reinsurance, there probably would be fewer claims disputes. This highlights the general importance of balancing incentives for better case management and efficiency with removing impediments to high-quality, necessary care.

This assigned-risk reform could theoretically be attempted at the state level. However, different state departments of insurance may be more or less prepared to implement and monitor the approach, and there could be some complications with the limitations imposed by the Employee Retirement Income Security Act (ERISA) of 1974. The assigned-risk policy does not place new requirements on employers, but the distribution of high-cost individuals across carriers would impact employer premiums in fully insured plans. It is not clear whether any ERISA concerns would be raised as a consequence. Furthermore, if only some states adopt assigned risk, carriers could threaten to stop selling coverage in those states in response to reforms that would potentially increase the costs associated with their enrollment. Such threats would be unlikely if assigned-risk reform is adopted nationwide.

## Federal Financing of State High-Risk Pools

Currently, 35 states have high-risk pools, although the one in Florida is closed to new enrollees and the one in North Carolina only began enrolling people in early 2009 (National Association of State Comprehensive Health Insurance Plans 2008). All of the state pools aim to provide a private insurance option to state residents who are unable to purchase private health insurance owing to their health status. However, all of the pools face significant financial constraints that make it difficult for them to provide the types of support that their target population needs. In 2007, the combined enrollment in all operating high-risk pools nationwide was just over 200,000.

The characteristics of the pools vary considerably in terms of size, eligibility rules, benefits, cost sharing, premium pricing, waiting periods, pre-existing condition exclusion periods, and lifetime benefit maximums. In 2007, for example, enrollment ranged from almost 29,000 in Minnesota to fewer than 350 in Florida. That year, 24 of the 34 working pools had enrollments of fewer than 5,000. Frakt, Pizr, and Wrobel (2004/2005) estimated that high-risk pool enrollment constituted about 8 percent of the medically uninsurable in states that had pools. Premiums in the high-risk pools are high, usually 125 to 200 percent of prevailing individual market premiums, with only a small number of pools providing any subsidies for the low-income population (Chollet 2002). Many of the pools have large deductibles, while some have limits or exclude coverage for prescription drugs, maternity care, and other services. Achman and Chollet (2001) found that some states have lifetime benefit limits below $1 million, while some have annual benefit limits below $200,000. Some pools have enrollment caps as well. Pollitz et al. (2005) found that high premiums and pre-existing condition exclusions in high-risk pools are the

primary reasons why diabetics who need individual coverage and live in states with high-risk pools do not enroll in the pools.

Benefits are limited and premiums are high in many state high-risk pools because of limited funding bases. The population enrolling is, by design, people with very high average health care costs. Even charging premiums up to 200 percent of prevailing private rates, all high-risk pools incur losses. These shortfalls are most often financed through health insurance premium assessments. This approach is obviously unpopular with commercial insurers. In addition, the higher the assessments, the more likely employers will be to self-insure to avoid contributing to the pools.

The Trade Adjustment Assistance Reform Act of 2002 provides federal funds to state high-risk pools. Although the intent of the legislation was to provide financial support to the pools and to encourage their use to expand health insurance coverage, analysis of the early years of implementation found that the funds were largely used to replace existing state funding sources (Pollitz and Bangit 2005). Only one state used its full grant amount to reduce premiums for enrollees, expand benefits, or otherwise expand enrollment. Under subsequent reauthorization of this program, the federal fiscal year 2008 grants of $50 million (Centers for Medicare and Medicaid Services 2008) were split into two types: (1) to offset operational losses incurred in 2007, and (2) to provide additional benefits to current or potential enrollees. If a state did not use all of its allotment for the second type of grant, the remainder was divided up among those states receiving the first type of grant. This implies that the federal funding is primarily intended to replace existing state funding sources, and that expanding coverage, increasing benefits, and making coverage more affordable for enrollees is secondary.

A stronger commitment from the federal government could, however, improve the pools' ability to serve low- and middle-income persons with high-cost medical needs. More federal financial support—coupled with uniform guidelines or requirements for eligibility, benefits, cost sharing, and income-related subsidies—would increase access to the pools while ensuring adequate coverage to meet the needs of this target population. For example, additional substantial federal financial support could be made contingent upon the following (Blumberg, Clemans-Cope, and Blavin 2005):

- Eligibility for all of those with a federally defined set of priority medical conditions, denied coverage or offered coverage with benefit exclusions, or whose medical expenses exceed a defined threshold
- Comprehensive benefit packages that include prescription drugs and devices, maternity care, mental health care, etc.
- Coverage that meets federally defined out-of-pocket maximums that are inclusive of all cost sharing, including copayments
- No waiting periods or pre-existing condition exclusion periods

Benefit costs in excess of premiums would be financed by the federal government or jointly between the federal and state governments. Under a voluntary insurance system, open access to subsidized insurance for those with high medical needs would create some disincentive for individuals to obtain coverage while healthy. However, the pre-existing condition exclusion periods and waiting periods that all high-risk pools currently use to

dissuade such behavior impose tremendous financial penalties on those with serious health conditions and could have serious health consequences. As an alternative, income-related penalties could be charged to the previously uninsured. No penalty would apply to low-income people, but those with adequate financial resources who could have afforded coverage while they were healthy would have to pay a penalty for not having obtained coverage earlier.

The disadvantage of using vehicles such as high-risk pools to expand coverage to the high-need population alone is that it maximizes the public dollars necessary to finance coverage for this population. By design, high-risk pools have very little heterogeneity in risk. Consequently, average costs in the pool are very high, and under a reform policy with more adequate benefits than many pools currently offer, those costs would be even higher. Segregated in their own risk pools, the expenses of these high-need enrollees cannot be spread through premiums across a broader, lower-average-risk population. To make adequate coverage affordable to all of those in need through these pools, substantial income-related subsidies will be necessary.

Because of the highly skewed distribution of health care, a large share of total health care costs could end up being financed through high-risk pools. The costs associated with this population for a given set of health care benefits will be the same regardless of how reform is implemented, but a broad-based coverage reform policy that sets premiums based on a large population of heterogeneous risk would spread many of these costs through privately paid premiums as opposed to financing them explicitly with public dollars. However, the latter may be much more politically difficult to accomplish.

## ENCOURAGING EXPANSION OF COBRA COVERAGE

For those with high health care needs who leave jobs with employer-sponsored insurance, continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) may be the only option for maintaining coverage without underwriting. Under COBRA, a former employee can maintain coverage for up to 18 months by paying 102 percent of the total premium cost. For people who have qualified for federal disability benefits, COBRA coverage can continue for another 11 months or until Medicare coverage becomes available 24 months after the onset of disability. After the original 18 months of COBRA coverage, employers can charge enrollees up to 150 percent of the total premium cost. However, only a small portion of the high-risk population is eligible for COBRA—those with prior employer-based insurance who worked for firms covered by COBRA.

One potential way to expand insurance coverage is to extend COBRA's eligibility period more generally. Because COBRA coverage is expensive, subsidizing the premiums of participants is another way to increase participation. The advantage of such approaches for high-risk participants is that they remain in insurance pools with low-risk individuals. However, employers and current employees covered by the employer's group policy bear the excess costs associated with former employees who have high medical needs. For small firms, the financial burden can be severe. While public subsidies might be used to offset these burdens for smaller firms, government subsidization of only those eligible for COBRA and their employers could be perceived as inequitable. Moreover, it is not clear that subsidies of this type would even be effective; previous experience with health care tax credits suggests they would not (Dorn 2008). Finally, extensions of eligibility periods for COBRA coverage may delay eligibility for coverage under the Health Insurance

Portability and Accountability Act (HIPAA). Generally, individuals do not become eligible for coverage under HIPAA provisions until COBRA eligibility is exhausted.

COBRA coverage is governed by federal statute, but 35 states have so-called "mini-COBRA" laws that extend COBRA protections to employees of firms too small to be covered by ERISA. These programs vary in duration from 3 to 36 months and could be modified by states. Extended eligibility for other employees would require federal action.

## PURCHASING POOLS WITH LOW-INCOME SUBSIDIES AS A GUARANTEED SOURCE OF COVERAGE

Many of the recent proposals for comprehensive health care reform, including those proposed during the 2008 presidential campaign by candidates Barack Obama and Hillary Clinton, as well as the proposals delineated by Senators Ted Kennedy and Max Baucus, have included the development of purchasing pools (also known as exchanges, connectors, purchasing cooperatives, etc.) as a guaranteed source for obtaining health insurance. The reforms recently implemented in Massachusetts include a purchasing pool as well. Purchasing pools, which can have varying design characteristics, provide a structured marketplace through which at least a segment of consumers (e.g., individual purchasers and small employers) are guaranteed accessible insurance coverage with a defined set of benefits (Blumberg and Pollitz 2009). The purchasing pool can contract with private insurance carriers to offer this coverage and may offer an optional public insurance plan as well. In the context of comprehensive reform, purchasing pools would also determine eligibility for income-related subsidies to ensure the affordability of available plans and administer the subsidies.

A number of critical design features will determine how the insurance market inside the purchasing pool will operate and how it will interact with the insurance market outside of the pool. These choices will also determine the extent to which such a pool—in conjunction with income-related subsidies—would provide sufficient access to adequate and affordable coverage for individuals with high health care needs. The first of these design features are the rules of issue and the rating rules within the purchasing pool. Unless all plans participating in the insurance pool are required to accept all applicants (i.e., guaranteed issue), for example, people with high-cost medical conditions may be excluded from coverage. Guaranteed issue in only some plans would perpetuate risk segmentation by plan. If plans within the pool are allowed to set premiums based in part on the applicant's health status, high-need enrollees will continue to face stiffer health care financing burdens than their healthier counterparts, which would limit their access to necessary care. Allowing some age rating within the purchasing pool would increase the financial burdens on older enrollees, but it would reduce the disincentive to participate for younger individuals, who tend to have lower income.

A second set of design issues for purchasing pools is the regulations governing markets outside of the purchasing pool. For example, will individuals be given the option to buy insurance coverage inside or outside the purchasing pool, or will the pool be the only option for at least a segment of the population? If there is an option to buy in or out of the pool, will the outside market be able to offer different types of coverage than those offered inside the pool? Will nonpool plans be priced under different rules than the pool plans? Will states be allowed continued authority to set market regulations, perpetuating the variations across states that have important implications for the spreading of health care risk?

In general, the more options individuals are given, the greater the potential for risk segmentation. Segmentation will, by its nature, increase costs for those with high medical needs and lower costs for the healthy. Protecting the high-cost population in a system that permits or encourages such segmentation will require additional government intervention; for example, subsidies specifically directed to high-cost individuals. Conversely, eliminating risk segmentation to the extent possible—by prohibiting health status rating, making the pool the only insurance option for eligibles, limiting plan variations within the pool, and risk adjusting across pool plans—will lead to risk spreading through premiums. The total costs of providing care to the whole population given a particular set of benefits will be the same, but the costs of financing care for the high-need population can be spread through premiums or through explicit government subsidization, depending upon the design features chosen. As long as individuals have some choices of health insurance, at least some risk adjustment across plans will likely be necessary to broadly distribute the costs associated with the high-medical-need population.

A related issue being considered under comprehensive reform proposals is whether the lowest-income population should be included in a new subsidized purchasing pool or covered separately through the Medicaid program. Since poverty is correlated with poorer health, separating the low-income population and insuring this group through Medicaid is another mechanism for subsidizing a portion of the high-need population through general revenues as opposed to spreading their costs through premiums. The separation approach also offers a straightforward mechanism for providing a more generous benefit package to those who may be in the greatest need of assistance. Alternatively, purchasing pools could define different benefit packages for specific populations, with all benefit packages made available in the private pool plans and the self-funded, government-managed fee-for-service plan. The comprehensiveness of benefits offered within the pool will affect both the costs of coverage and the financial burdens on the high-medical-need population. More cost sharing, less inclusive and/or higher out-of-pocket maximums, or narrower benefits would lower premiums but shift the costs of care more heavily to those who use the most health care services. If the insurance package offers more comprehensive and more generous benefits, premiums would be higher, but the financing burden of the high-risk population would be spread more broadly.

Overall, the greater the desire to preserve substantial portions of the current system with its highly patchwork character, the greater the degree of risk segmentation in insurance markets will be maintained. Conversely, to the extent that reforms adopt a more cohesive, inclusive approach for providing coverage, the extent of risk pooling will be greater.

Holahan, Nichols, and Blumberg (2001) proposed an approach for expanding health insurance coverage through a system of state-based purchasing pools that provide subsidized coverage to those of modest income as well as explicit subsidies for the excess costs associated with the high-medical-risk population. This policy design focuses on the importance of spreading the costs of the high-need population through a broad-based (ideally progressive) tax used to finance it. In other words, all taxpayers would contribute to these excess costs, no matter what type of health insurance they chose or even if they declined to enroll in an insurance program.

This proposal would make purchasing pools available to all individuals and employers. The pools would manage competition among private plans, but each state would also

operate or contract for a managed fee-for-service health plan under which the state would assume the insurance risk. These state plans would ensure sufficient enrollment capacity and should increase competition among the private plans participating in the pools. Premiums in the purchasing pools would be set at the "statewide community rate"— the premium that a competitive insurer would charge if a person of average risk purchased the benefit package offered. This would be an actuarial calculation based on state representative data on sociodemographics, health status, and health care spending. Thus, the premium charged for coverage in the new pools would not reflect the average costs of those enrolled in the pool, but would instead reflect the average cost of all insured individuals in the state. The difference between the costs incurred by those purchasing within the state pools and the statewide community rate would be financed by government (in this approach, a mix of state and federal dollars). Insurance plans offered within the pools would be comprehensive, including all-inclusive, out-of-pocket annual maximums and possibly lifetime out-of-pocket maximums as well.

The pool would be voluntary, so states could maintain the existing private insurance markets outside of the pools. The pool and its subsidy structure would be designed to attract adverse selection and to have the excess costs associated with that selection spread broadly across the population, thus making risk segmentation in insurance markets irrelevant. Rules inside and outside the pool could differ without consequence, because all taxpayers would contribute toward subsidization of any adverse selection in the purchasing pool. Significant income-related subsidies are a component of the approach to make comprehensive coverage affordable for low- and middle-income people, but those subsidies could be phased in over time, if desired. Individual states could implement this type of reform on their own, but they would vary considerably in their financial ability to do so.

## OTHER PUBLIC POLICIES WITH SIGNIFICANT IMPLICATIONS FOR THE HIGH-COST POPULATION

Other reform proposals, although not directed at expanding coverage for the high-cost/high-risk population, have potentially important implications for access to coverage for this group. All health care reform options should be assessed for possible impacts on health care risk pools, as greater risk segmentation tends to impose higher costs and decrease access to medical care for those with the greatest medical needs. Some examples of policies that would increase risk segmentation are increased incentives to offer or use health savings accounts (HSAs); increased incentives to purchase coverage through unreformed, private, nongroup insurance markets; and allowing insurance to be sold across state lines. Each is discussed briefly below, focusing on their implications for health care risk pools.

In general, greater choices in insurance benefit packages, choice among markets in which coverage can be purchased, and reduced regulation of how carriers set premiums will increase health care risk segmentation. However, explicit subsidization of health insurance and out-of-pocket costs for the high-medical-cost population may be able to compensate for such segmentation.

**Increased Incentives to Use Health Savings Accounts.** Senator John McCain (during the presidential campaign) and other members of Congress have proposed expanding or strengthening incentives for employers and individuals to purchase HSAs and associated high-deductible health plans, as opposed to more comprehensive coverage as a mechanism for reducing health care spending (McCain 2008; U.S. Department of Treasury 2004).

However, the most significant premium savings accruing to high-deductible and HSA plan enrollees likely occurs by altering the mix of individuals who purchase coverage of different types (Blumberg 2008; Burke and Pipich 2008; Clemans-Cope 2008). Because of the structure of the tax subsidy and the shift of health care spending to out-of-pocket costs, these accounts are most attractive to high-income people and those expecting low health care expenses. Incentives for healthy individuals and groups to purchase HSA-compatible plans further segment insurance risk pools by health status.

The average medical costs of those purchasing HSA plans will be substantially lower if the high-risk population is left in more traditional comprehensive plans. As the average cost of those in the comprehensive plans increases, so does the premium associated with the coverage. In the extreme risk segmentation circumstance, premiums for comprehensive coverage may increase so much that maintaining that type of coverage is no longer financially viable. Even if high-deductible plans and HSAs are the only coverage option available, the health care financing burden on the high-need population will increase substantially: Fewer medical care costs are included in the insurance component of the plans and more of the costs are incurred as out-of-pocket expenses, falling most heavily on those who use care the most.

This disproportionate financial burden can be avoided in the employment context if both high-deductible and comprehensive plans are offered and employers set premiums for both options independent of the health care risk of those enrolling in each. In other words, premiums for the high-deductible/HSA plan could be set lower than for the comprehensive plan, but only to reflect the difference in actuarial value across the plans, not the differential health care risk of those enrolling in each plan. In essence, each plan's premium would be set as if all employees were enrolled in each plan. Then, a portion of premium collections for the high-deductible/HSA plan could be transferred to the comprehensive plan to subsidize premiums for that higher-cost group.

Of course, it is up to each employer to decide whether to spread risk across its health care plans. In the nongroup market context, the transfer of financial support from the healthy to the less healthy will occur only through regulation or direct government subsidization.

Without some type of intervention by government or employers to spread health care risk more broadly, the practical effect of high-deductible/HSA plans is that the most vulnerable populations (the sick and low-income) bear a greater burden of their health expenses. Because of the implicit price increase attributable to greater out-of-pocket costs, these individuals may decrease their use of health care services and avoid necessary as well as unnecessary care.

**Incentives to Use Existing Private Nongroup Insurance Markets.** Proposals to introduce tax credits or tax deductions as subsidies for the purchase of insurance through current private, nongroup insurance markets, drawing individuals out of the employer-based market, could significantly increase segmentation of health care risk. This is because there is less risk pooling in most states' nongroup markets than in employer-based markets.

Fears of adverse selection and the natural drive among nongroup carriers to maximize profits lead insurers in relatively unregulated nongroup markets to seek a disproportionate share of low-cost enrollees. Insurers use strategic behaviors to accomplish this, such as excluding pre-existing medical conditions from coverage for

defined periods; attaching riders that exclude specific conditions, procedures, or body parts from coverage for the life of the policy; engaging in medical underwriting; or refusing to sell some applicants insurance. Coverage in the nongroup markets also tends to be considerably less comprehensive than employer-based coverage, with more limited benefits and higher cost-sharing levels. Simantov, Schoen, and Bruegman (2001) examined this issue specifically for people ages 50 to 64. They found that those with nongroup insurance coverage were healthier and wealthier than average for their age group, but were also more likely to have high out-of-pocket expenses and more restricted benefits, and to report costs being a barrier to care than their counterparts with employer-based insurance. As a consequence, any policy that undermines employer-based coverage in favor of private nongroup insurance as currently structured will tend to increase premium costs and reduce coverage for those with high medical needs.

In addition to the fact that nongroup coverage generally does not meet the needs of the unhealthy, the amount of the subsidy from tax credits under various proposals does not usually vary with the health status of the recipient. Doing so is widely considered too administratively difficult for the Internal Revenue Service. Consequently, a tax credit that might cover a significant share of a premium for a healthy young person would most likely cover a much smaller share for someone with a current or past health problem (Blumberg 2001). Risk-pool issues may be a primary factor in the outcome of such tax credit policy proposals: some individuals would be unable to access health insurance at all, and others might be unable to find an affordable premium/cost-sharing combination.

**Allowing Insurance to be Bought from Out-of-State Carriers.** One component of Senator John McCain's health care reform proposal during the 2008 presidential campaign would have allowed private insurance carriers to sell insurance across state lines. The intent of this proposal seemed to be to increase competition by increasing the insurance options available. However, the central implication of this type of reform would be to undermine state insurance regulations across the country (Bertko, Nichols, and Carpenter 2008; Blumberg and Holahan 2008).

There is considerable variation in state regulation of private health insurance. In the nongroup insurance markets, only a small number of states require guaranteed issue of health insurance to all applicants or prohibit price variations based on the applicant's health status. As mentioned earlier, most states allow outright coverage denials, benefit exclusions and limitations, and premium adjustments as a function of health status. While federal law requires guaranteed issue of all carriers selling coverage to small employers, variations persist in premium regulations in these markets.

Under a proposed law allowing coverage to be sold across state lines, healthier individuals and groups could purchase coverage from carriers operating in states that have the least regulation—i.e., states with the greatest risk segmentation. The incentives to do so would be strong, as it would shield the healthy from sharing in the health care costs of the less healthy in their states. The average cost of coverage in states that are more regulated would rise, as only the higher-cost populations would continue to seek coverage in those markets. It is reasonable to expect that states would eliminate regulations of these markets designed to pool risk across those of varying health statuses, as states with guaranteed issue would only attract the bad insurance risks. Under such a scenario, those with health problems would find it more and more difficult to obtain coverage at any price. State insurance environments would become a race to the

regulatory bottom, with benefit limitations and exclusions and premium rating flexibility becoming the norm, and state benefit mandates becoming extremely difficult if not impossible to maintain. Such an environment would almost certainly fail to meet the needs of a high-need population, although the increased burden on the unhealthy would occur at some savings to those in good health.

## CONCLUSIONS

The high-cost population accounts for an extremely large share of total national health care spending. Therefore, any serious effort to increase or guarantee this group's access to adequate and affordable health insurance coverage will require a significant redistribution of health care financing. The first broad set of options to accomplish increased coverage involves substantial government subsidization—either directly to the individuals for the purchase of coverage or to the insurance pools in which they participate. The second broad set of options encompasses policies that would increase the pooling of health care risk through premium and market regulation that removes variations and prohibits exclusions based upon health status. However, unless efforts to increase risk pooling also impose an individual mandate, some government subsidization would be necessary under this set of options as well to offset the consequences of low-risk individuals opting out of insurance altogether.

People ages 50 to 64 are particularly vulnerable, as they are more likely to develop high-cost conditions. Yet their private insurance options under the current health care system are deteriorating. Access to regular medical care for this population is not only important to them personally, but also has implications for their costs upon entering the Medicare program at age 65. Comprehensive health reform, if enacted, is likely to address many of the shortcomings of the current system for the high-cost population. However, in the absence of such reforms, a compelling public interest remains in increasing access to coverage for this at-risk population.

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