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Commentary

State Health Risk Pools: Insuring The ‘Uninsurable’
by Susan S. Laudicina

Of the thirty-seven million uninsured Americans, an estimated one to two million are considered “medically uninsurable.” These people are in poor health or perceived to be at high risk of needing extensive health care services. They have found it difficult to afford or even to obtain health insurance in the private market. In response to this problem, fifteen states have enacted laws establishing comprehensive health insurance associations, known informally as “risk pools.” These pools offer to sell health insurance to people who are otherwise unable to purchase it and who might become medically indigent if they became seriously ill.

Risk pools are independent entities governed by a board and administered by an insurance carrier selected by the board. They build upon the existing health insurance system by relying upon private insurers, thus protecting any one insurer from bearing the risk alone. The risk pool association develops and markets a standard, comprehensive health insurance policy following guidelines established in the law regarding benefits, premiums, and deductibles. In fact, the term “risk pool” is somewhat misleading as commonly used to define these comprehensive health associations for high-risk individuals. State risk pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all private health insurers doing business in the state. They do not “pool” health risks by allowing both standard and high-risk patients to be covered. Rather, the pools (with one exception) insure only individuals whose medical risks are uniformly high.

How Successful Are The Pools?

Three factors in assessing how effective state health risk pools have been include: (1) the longevity of the pools and their popularity; (2) the

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growth in enrollment, both in absolute and relative terms; and (3) the degree of financial health. The risk pool concept has met the first criterion of longevity and popularity. Not only have all of the pools in operation over the past ten years remained in business, but their number has doubled over the past two years.

**Risk pool enrollment.** Measuring the pools' success by reference to their enrollment is somewhat difficult. On one hand, total enrollment has grown at a steady pace over the past five years and reached 24,355 by the end of 1987. By the same token, actual pool growth falls significantly short of theoretical target populations in most instances.

On the microeconomic level, several states made initial estimates of the size of the under-sixty-five population who were unable to purchase adequate health insurance due to their medical conditions and, therefore, would be eligible to join a pool. For instance, Wisconsin officials estimated that an enrollment of 3,000 to 5,000 individuals would not be unrealistic. In fact, some 2,476 persons were enrolled by the end of 1987, making the projections appear feasible. On the other hand, North Dakota estimated that its pool would serve 5,000 individuals, but it has reached only roughly 30 percent of the target after five years.

On the macroeconomic level, although there are no solid figures upon which everyone agrees, some experts have estimated that one to two million nonaged individuals are medically uninsurable and could afford to join a risk pool. This figure roughly corresponds to the frequently cited target of 1 percent of the under-sixty-five population as "uninsurable." According to one analyst who has calculated the size of the 1 percent target group in selected states, the Wisconsin pool would need to enroll 42,000 people to reach its potential.

Several factors could affect the ability of these estimates to predict actual pool enrollment: pool benefit levels; the length of waiting period for preexisting conditions; the nature of the eligibility criteria, premium rates, and cost-sharing requirements; and marketing and education efforts, to name a few. Data identifying individuals with chronic medical conditions by income level do not exist, so it is difficult to know whether those with chronic medical conditions could afford the coverage.

Enrollment levels may also change if risk pools were given more consideration as a potential financing mechanism for persons with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC). AIDS and other human immunodeficiency virus (HIV)-infected persons should be eligible to participate in a risk pool because they are generally considered uninsurable from a medical underwriting standpoint. Of course, these individuals also would have to be able to afford the high-priced insurance provided by the pools. There are no statistics on how
many persons with AIDS are enrolled in risk pools. Five states have singled out potential AIDS subscribers for preferential treatment. Iowa, Indiana, Minnesota, Nebraska, and Oregon have placed persons with AIDS (but not ARC or HIV infection) on a presumptive eligibility list, thereby enabling them to enroll without meeting other requirements, for example, having to submit rejection notices from private insurers, or undergoing the customary six-to-twelve-month waiting period.

**Pools’ financial health.** Attempts to measure the success of the risk pool concept by reference to financial health produce mixed results. In spite of rapid premium increases, all the pools continue to lose money. The largest deficits in absolute terms can be found in Minnesota (losses of $9.8 million in 1987) and in Indiana (losses of $4.8 million in 1987). However, these sums should first be put into perspective before a conclusion about the overall soundness of risk pools can be reached.

The Health Insurance Association of America (HIAA) has testified that: “[Risk pools] do not represent a great financial burden on any one insurer if financed by adequate premiums and if the losses are spread equitably over the entire insured population. For example, in 1985 the losses of the Minnesota state pool were approximately $5 million. If spread over all insured lives under age sixty-five in Minnesota, including all protected employees and their dependents, losses would be approximately $1.40 per person per year.” Though a matter for serious reflection, the existence of a deficit has not diminished any state pool’s ability to pay claims or maintain state government support.

**Pool Shortcomings**

Three factors, both structural and legal, limit the ability of state health risk pools to provide access to health insurance for all of the uninsured: cost, the Employment Retirement Income Security Act (ERISA) pre-emption, and lack of cost-containment techniques.

**Cost.** Cost remains the biggest barrier to obtaining health insurance through the risk pools. Premium rates for risk pool coverage are capped by state law and range from 125 percent to 400 percent of the average premium rates for individual standard risks in the state for comparable coverage. In most of the states, however, the actual premium cap in effect is 150 percent. In addition to the premium cost, participants in the pool must meet high deductibles.

What empirical information exists on the relationship between the size of premiums and deductibles and affordability of the pools is limited but persuasive. Fifty-nine percent of respondents to a Wisconsin state survey reported extreme dissatisfaction with premium costs, while an even
higher percentage (72 percent) felt that the deductible was too high.\textsuperscript{8} Anecdotal information from Indiana, where pool premiums have been increasing at a more rapid rate than elsewhere, indicates that the rising cost of the pool has contributed to a decline in enrollment for the past three years. Thus, while existing pools guarantee the availability of coverage, none attempts to address fully the issue of affordability. To date, only the Wisconsin and Maine pools extend any measure of financial relief to low-income policyholders or potential applicants.

**ERISA preemption.** The second limiting factor is the ERISA preemption. Efforts to mandate participation by self-insurers to spread costs across a wider base have failed. Legal challenges by self-insurers in three states (Connecticut, Minnesota, and Wisconsin) have affirmed their position that ERISA exempts them from state insurance regulation and, therefore, from participation in risk pools. The net result of the preemption is that the costs of participating in risk pools fall to a significant degree on private insurers, who currently constitute only 60 to 65 percent of the market nationwide. As a result, these insurers contend that they bear a disproportionate share of the load.

**Lack of cost-containment techniques.** A factor that either has had or will have an impact upon each pool’s balance sheet is the general absence of a comprehensive set of health cost-containment techniques. According to two experts, “Starting these pools at the high end of health risk probably makes them infeasible as a vehicle for reaching other, less needy individuals who also lack insurance, at least as long as the pools operate like conventional insurance and do not directly manage medical spending through controls on providers or other methods.”\textsuperscript{9}

Interviews with state insurance officials and executives from the lead carriers in each pool state reveal that only eight of the fifteen pools have integrated even limited cost controls such as hospital preauthorization, hospital preadmission testing, and mandatory second surgical opinion into their ongoing administrative practices. None of the mature pools has sought explicit authority to use such proven cost-saving approaches as negotiated price discounts with individual providers or case management of an enrollee’s care. While risk pool managers in two states expressed doubt that these two particular options would be viable for their relatively small, scattered pool populations, considerable room remains to improve pool performance in the area of cost containment.

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**Residual Effects Of Risk Pools**

Any analysis of the risk pool experience in this country would be incomplete without an appraisal of the residual or unintended conse-
quences of risk pool policies. Accordingly, in this section I examine the effects of pool operations on employer costs and staffing levels, on state Medicaid costs, and on health care provider costs.

Employer costs/staffing. At the national level, employer associations are not opposed to the concept of risk pooling. However, they have expressed concern over any future tax on employers to finance losses associated with a risk pool.

On June 26, 1986, the US. Senate Committee on Governmental Affairs held a hearing on the proposed “Access to Health Care Act of 1986” (S. 2402/S. 2403). Under the proposal, all states would have been required to form insurance pools for persons not covered by job-based insurance and for persons unable to secure coverage for other reasons. Both group-insured and self-insured employers who do not participate in the pools would be subject to a 10 percent civil penalty levied on the amount that each employer spends on health insurance. The National Association of Manufacturers testified in part that they could not support the legislation because: “The threat of a 10 percent penalty may cause employers to have lesser resources available for payment of basic wages, or might even force them to reduce the level of health benefits they do provide. Finally, since employers would have to pay for costs not covered by premiums— and costs are likely to be enormously high—the expense to the employer community will be great. It would be a further disincentive for employers to offer health insurance benefits.”

Testifying at the same hearing, the U.S. Chamber of Commerce and the National Federation of Independent Business declined to take a formal position on the proposed legislation. They again raised concerns that, because the bill would require employers who offer health insurance to their workers to fund any financial shortfall in the risk pools, it would be a disincentive to offering health insurance.

Turning to the state legislative arena, none of the existing health risk pools is financed by a tax on employers. Some risk pool officials believe that the pools have saved employers money and/or improved an individual’s employment prospects, while others believe that their pools have raised employers’ costs. Still others either had no opinion on the issue or felt their pools were too new to provide adequate information.

In Wisconsin and Indiana, many small businesses’ costs have declined because placing a medically uninsurable employee in the state pool frees them to obtain standard group health insurance for the rest of their employees. This option is potentially available to all employers who contribute toward an employee’s pool premium expense. Wisconsin discovered that 15 percent of its pool enrollees had such a relationship with their employers. As for the impact of risk pools on employment, it
can be argued that they help high-risk individuals to find and hold jobs because they are no longer uninsured liabilities. At the very least, it seems reasonable to conclude that the existence of risk pools does nothing to hurt an individual’s employment prospects.

Risk pool officials in Iowa and North Dakota, on the other hand, assert that risk pools have indirectly increased some employers’ costs because their states instituted a health insurance premium tax on all or some insurers to help pay for pool losses. They feel that the new premium tax could be passed on to an insurer’s standard group health insurance line of business. In the case of Minnesota, the state recently ended its ten-year policy of providing premium tax credits to insurers to offset the cost of their assessment for pool deficits. With the termination of the public subsidy, insurers such as Blue Cross must absorb all pool losses and will probably raise their premium rates to nonpool subscribers.

The countervailing argument, however, is that state health risk pools assist in keeping health insurance premiums in the state at a more reasonable level. The logic here is that the pools assure hospitals and other providers that the costs of treating pool enrollees will be reimbursed. If this is the case, then providers’ bad debt or charity care should be lowered, with a concomitant decrease in the need to shift costs to patients with private health insurance.

**State Medicaid costs.** There is no empirical evidence with which to assess whether the existence of risk pools in general serves to increase or decrease state Medicaid expenditures. None of the fifteen existing pools has ever studied the fiscal relationship between their Medicaid and risk pool programs. Eight of the states’ statutes expressly forbid residents who are eligible for Medicaid from enrolling in the pool. An intuitive argument is that residents of states with risk pools would in theory be spared the expense of “spending down” or depleting their resources to become eligible as medically needy individuals under Medicaid. There is a certain logic to this line of reasoning, and a few state pool administrators believe their pools probably do save Medicaid money in this fashion. On the other hand, should a Medicaid-eligible person succeed in joining a risk pool (as a few have in Minnesota), then a state’s Medicaid costs could increase. This is because the Medicaid program could end up spending more on pool premiums for this individual than it would otherwise have spent under Medicaid’s stricter provider reimbursement limits.

Finally, it also could be argued that the existence of a risk pool is irrelevant to a state’s Medicaid program because the prospective participants are so different that they would not overlap. Pool enrollees are nearly all under age sixty-five, and are, on average, able to pay premiums that are one and one-half times as expensive as the standard individual
rate. Medicaid recipients, on the other hand, either (1) are impoverished and live in dependent families or are aged, blind, or disabled and thus categorically eligible, or (2) have met Medicaid spend-down requirements, thereby qualifying as medically needy individuals.

**Health care provider costs.** When asked whether the presence of health insurance risk pools has had any impact on providers’ bad debt or charity care problems, state officials again respond that they lack any data on which to judge. However, a few believe that the logical correlation of a relationship here is stronger than with the potential impact on Medicaid. This is because individuals who could take advantage of pool protection would no longer be forced into personal bankruptcy when faced with high medical bills. As the Department of Health and Human Services has concluded, some 65 to 75 percent of uncompensated care is associated with the problem of the uninsured. According to a 1986 report, “This means that strategies directed toward the uninsured in the general population and bad debt recovery will reduce the uncompensated care problem substantially.”14 Or, to frame the answer in rhetorical terms: Who would have paid the roughly $50 million in total claims paid by the risk pools in 1987 if they did not exist?

### Conclusions

State health risk pools have had moderate success in achieving what they were designed to do: making comprehensive insurance available to a small segment of the uninsured population that is able to afford the premiums. However, with few exceptions, they offer no assistance to uninsured individuals who cannot afford to enroll.

The risk pools enjoy broad-based support and appear to offer something for everyone. Individuals with unfavorable health histories or conditions are offered the chance to buy comprehensive health insurance in the private market. State policymakers are able to satisfy a subgroup of the population whom they see as deserving, without increasing state budget outlays. Insurers are able to pass along the worst insurance risks to the pools and, for the most part, are absolved of any corporate tax liability for participating in the pool framework. Employers are able to insure high-risk employees at no additional cost to themselves. Hospitals and other health care providers are probably relieved of some of their bad debt burden.

Risk pools probably will remain a small piece of the action in meeting the general problem of the uninsured and underinsured. In fact, a broad expansion of risk pools may not be what is really needed. States have declined to change the basic, limited nature of the pools, in favor of
adopting a variety of strategies to respond to the increases in the uninsured population. For example, a majority of states have laws providing for the continuation of health insurance coverage and/or the right to convert to an individual insurance policy for most laid-off employees. In addition, during 1987 ten state legislatures considered proposals to implement an entirely state-funded and state-administered health insurance program for their indigent residents. Finally, the most popular approach to relieving medical indigence and providing improved access to health care most likely will continue to be to expand state Medicaid programs.

NOTES

1. States that have mandated health risk pools are: Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington, and Wisconsin.
2. Because of turnover in the enrollee population, the number of individuals insured through risk pools at some point during 1987 was actually greater.
6. A deficit is equal to the value of claims paid minus premiums collected plus administrative costs.
7. Statement of the Health Insurance Association of America before the U.S. Senate Committee on Governmental Affairs, Intergovernmental Relations Subcommittee, 26 June 1986.
11. Statement of the National Association of Manufacturers before the U.S. Senate Committee on Governmental Affairs, Intergovernmental Relations Subcommittee, 26 June 1986.
12. Statements of the U.S. Chamber of Commerce and the National Federation of Independent Business before the U.S. Senate Committee on Governmental Affairs, Intergovernmental Relations Subcommittee, 26 June 1986.
15. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 now requires all states to enact such legislation.