

Protecting high-risk patients

The third pillar of the American Medical Association (AMA) reform proposal is “fair rules of the game” that include protections for high-risk patients. High-risk patients are the small portion of the population that has, or is likely to have, very high medical expenses due to a pre-existing medical condition, family history or similar risk factor. Ensuring that even the highest-risk patients have adequate and affordable health care coverage is critical to the success of any health reform effort. The AMA believes that direct subsidies provided through high-risk pools, risk adjustment and reinsurance hold the greatest promise of protecting high-risk patients. This direct approach to protecting high-risk patients stands in contrast to the customary approach, which is to regulate the sale of health insurance, particularly in markets serving individuals and small employers. Market regulations have proven to be a crude and indirect way of protecting high-risk patients that, too often, drive up health insurance premiums and the number of uninsured.

Types of direct risk-based subsidies

- **High-risk pools**—remove high-risk individuals from the regular health insurance market, making premiums more affordable for the general population and offering high-risk enrollees at least one coverage option. Directly providing coverage to those with the highest medical expenses through high-risk pools can markedly reduce the average per-person cost in the regular insurance market. To date, high-risk pools have been used more often than risk-adjustment or reinsurance. More than 30 states operate high-risk pools, in which enrollees pay 125 to 150 percent of standard premiums. Although premium revenues typically fall short of enrollees’ medical expenses, these shortfalls are made up through a combination of government subsidies and insurer revenues from the standard market.
- **Risk adjustment**—adjusts payments to health plans based on the risk of their enrollees (e.g., on the basis of health status, previous health claims and/or age). High-risk individuals remain in the regular insurance market, but additional payments are given to insurers with a disproportionate share of high-risk enrollees. Insurers collect revenues commensurate with projected costs of each enrollee, motivating them to enroll anyone regardless of health risk.
- **Reinsurance**—provides insurance for insurers, whereby the reinsurer pays some share of an individual or group’s medical expenses beyond a pre-specified limit. Whereas high-risk

pools and risk adjustment target individuals projected to have high medical expenses, reinsurance subsidizes care of individuals who have actually incurred high medical expenses.

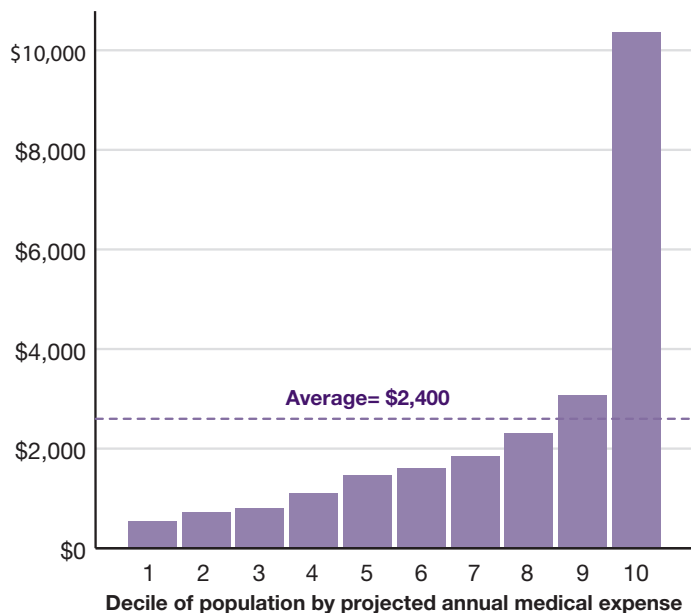
How the indirect approach has backfired

Since the early 1990s, numerous state and federal regulations have been introduced in an attempt to make coverage more affordable and comprehensive for those with predictably high medical expenses. These market regulations include strict community rating of premiums, benefit mandates for coverage of specified medical services and guaranteed issue to health plan applicants. Under “strict community rating” everyone in the same health plan pays the same premium regardless of health risk, so that the cost of covering expensive enrollees is spread across the community of people buying insurance. “Benefit mandates” require health plans to cover specified health services. While any one benefit mandate might have little impact, cumulatively, mandates can add significantly to the cost of health insurance. “Guaranteed issue” requires insurers to accept all applicants.

The idea of these regulations is that relatively healthy people pay higher premiums than they otherwise would, so that those in poor health can pay lower premiums than they otherwise would. In effect, coverage of high-risk patients is subsidized by an unofficial sales tax added to most individuals’ insurance premiums. Elected officials rely on market regulations to finance these subsidies because legislating regulations is generally easier than officially raising taxes.

The figure on the reverse side helps illustrate how these regulations drive up premiums for people in good health and limit affordable health plan options for everyone. Each bar shows the amount of individual medical expenses anticipated for the upcoming year for one-tenth (decile) of the population. The 10 percent of individuals at the far right of this highly skewed distribution have projected expenses of approximately \$10,000, more than three times the next-highest decile (\$3,000) and four times greater than average (\$2,400). A community-rated premium based on average cost of \$2,400 would exceed projected costs for 80 percent of the population and double premiums for the lowest-risk individuals. Faced with community-rated premiums that are inordinately expensive relative to the odds of having unexpectedly high medical expenses, many people opt not to buy health insurance. Not surprisingly, many of the nation’s uninsured are young, low-income workers who may be starting careers and families, but who do not have employee health benefits and cannot afford to buy coverage on their own.

Distribution of projected medical expenses for individuals under age 65^{a,b}



a. Adapted from data contained in Exhibit 1 of Pauly and Herring, *Health Affairs*, May/June 2007.¹
 b. Data is from the 1996–2002 private insurance market and is expressed in 2002 dollars.

Benefit mandates also require coverage to be more generous and expensive than many people would prefer. Furthermore, guaranteed issue regulations invite free-riding by allowing people to postpone buying insurance until they need medical attention. The greater the number of healthy people who go uninsured, the higher the average cost of health care among those with insurance, and the higher premiums must be to reflect and cover average costs. During the 1990s, just such a cycle of rising premiums and diminishing enrollment played out in heavily regulated states such as New Jersey, Vermont and Kentucky. Another unfortunate irony of market regulations is that they give insurers financial incentives to avoid the sick and cherry-pick the healthy. When everyone pays the same premium, health plans lose money on higher-risk enrollees and make elevated profit on lower-risk enrollees.

How the direct approach is better

Direct risk-based subsidies such as high-risk pools, risk adjustment and reinsurance differ from market regulations in the following important respects:

- Risk-based subsidies directly assist high-risk individuals, whereas market regulations, by altering the price and covered benefits of health insurance, indirectly transfer financial assistance from low-risk people to high-risk people.

- Risk-based subsidies provide appropriate incentives for insurers to cover high-risk individuals without requiring high-risk individuals to pay prohibitively high premiums.
- Risk-based subsidies can be financed with general tax revenues rather than insurance premium revenues, thereby avoiding unintended consequences of market regulations, such as raising overall premium levels.

As with any method of protecting high-risk patients, direct subsidies allow high-risk enrollees to pay much less on their own than the premiums required to fully cover their expected medical expenses. In contrast to indirect approaches, however, direct subsidies enable health plans to collect enough revenues to cover costs when enrolling high-risk patients. In contrast to community rating in particular, other enrollees pay lower premiums that are more in line with their costs, thereby expanding coverage for people of all risks.

Financing subsidies to cover high-risk patients with general tax revenues rather than through community-rated premiums avoids pricing standard-risk people out of the insurance market and limiting health plan choice. Addressing the free-rider problem by replacing guaranteed issue with guaranteed renewability would protect those already enrolled in health plans from losing coverage or being singled out for premium hikes should they be struck by illness. Replacing market regulations with risk-based subsidies would also allow greater market flexibility and innovation, such as specialized coverage for people with chronic conditions.

Based on the lessons of states' experience, the AMA believes that market regulations should be replaced with direct risk-based subsidies to protect high-risk patients, while also allowing health insurance markets to function properly for the rest of the population. Fair rules of the game, including direct subsidies for coverage of high-risk patients, are an integral part of the AMA proposal to cover the uninsured and expand choice—and can be implemented independently, at the state or federal level.

Visit www.voicefortheuninsured.org for more information on the AMA proposal and to view additional pieces in this series.

Reference

1. Pauly MV, Herring B. Risk pooling and regulation: policy and reality in today's individual health insurance market. *Health Aff.* 2007;26(3):770–779.

