High-Risk Pools Under the AHCA: How Much Could Coverage Cost Enrollees and the Federal Government?

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IN BRIEF

The debate over alternatives to the Affordable Care Act (ACA) includes discussion of federal funding for high-need populations as a mechanism to support coverage for people unable to access adequate insurance in the central nongroup insurance market. The American Health Care Act (AHCA) includes a provision for federal grants states could use to support high-risk pool or reinsurance programs.[1] The former approach separates the high-cost population into a separate insurance pool while the latter keeps the higher-need population integrated in the broader nongroup insurance pool.

We estimate the household and financial costs associated with providing insurance coverage to a high average health care need population via high-risk health insurance pools. High-risk pools require large investments of government dollars, because health care costs for the high-need population are averaged across only the high-need population. Reinsurance takes advantage of cross-subsidization of the low-cost and high-cost populations. The relative government costs of the two approaches are a function of their specific designs, such as reinsurance thresholds and share of costs reimbursed, provider payment rates, benefits provided, cost-sharing requirements, and premium assistance provided.

We estimate government and household health care costs for high-risk pools under the AHCA using two levels of coverage and household subsidies (one similar to that under the ACA and one more typical of traditional high-risk pools) and using two options for identifying the population eligible for a high-risk pool (one that limits eligibility to those who would experience high claims under standardized coverage (narrower eligibility) and one that adds those with chronic conditions (broader eligibility)). In our data, we are only able to identify a limited
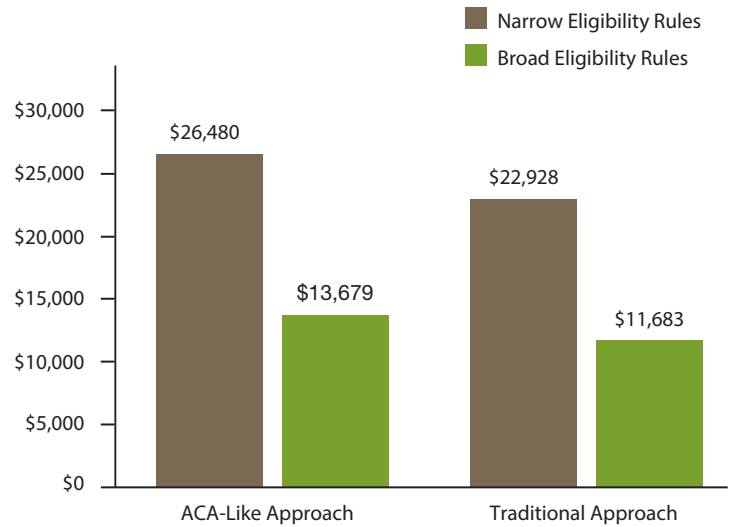
number of the many chronic conditions that were subject to medical underwriting prior to the ACA. The conditions used in this analysis are: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema, and arthritis. All eligible high-risk pool enrollees are drawn from the population that would experience a gap in insurance coverage and thus could be subject to medical underwriting in the nongroup market, depending upon state policy decisions. Our main findings are as follows:

- Under the AHCA, 2.5 million people or 7.6 million people, depending upon the eligibility rules used, could be eligible for a high-risk pool (Figure 1). These people make up 7 percent or 21 percent of those uninsured under the AHCA but account for 38 or 57 percent of the health care costs associated with that group.

- The average total health care costs per person associated with providing high-risk pool coverage for this group is over $22,000 for the narrower population defined by their health care spending and over $11,000 for the broader population that includes individuals with identified chronic conditions who are not necessarily incurring high claims in a given year (Figure 1).

- Roughly 70 percent of eligible people are estimated to enroll in the high-risk pool when ACA-like coverage and financial assistance are offered. When coverage and subsidies consistent with traditional high-risk pools are offered, only 19 to 26 percent of eligible people enroll.

- Government costs for supporting the high-risk pool using ACA-like coverage and subsidies would range

Figure 1.
Number of People Eligible for High-Risk Pool

Millions of People

Narrow Eligibility Rules: 2.5
Broad Eligibility Rules: 7.6
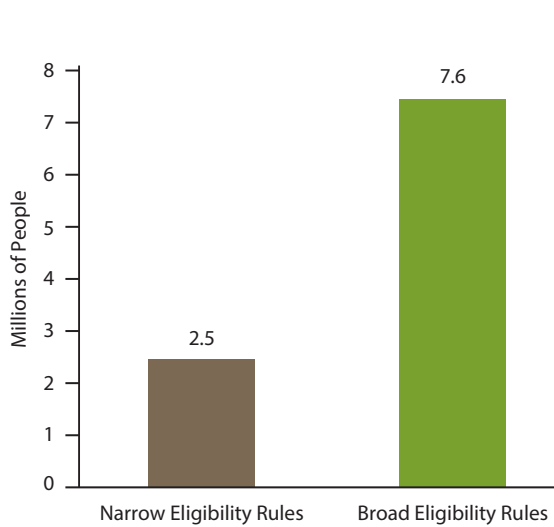
Average Total Health Care Costs Per Person Eligible for High-Risk Pool

Legend:
- Narrow Eligibility Rules
- Broad Eligibility Rules

ACA-Like Approach: $26,480 / $13,679
Traditional Approach: $22,928 / $11,683

Source: HIPSM 2017

Notes: The *ACA-like* approach provides enrollees with income-related premiums and cost-sharing assistance. Premiums are capped at a percent of family income, with lower caps for lower income enrollees. Actuarial value ranges from 70 percent to 94 percent, with higher values (lower cost-sharing) provided those with lower incomes. The *traditional approach* provides enrollees with 60 percent actuarial value coverage at a premium equal to 200 percent of standard coverage; no income related assistance is provided. *Narrow eligibility rules* include people identified by their high claims experience. *Broad eligibility rules* include the high claims group plus those with a list of identified chronic conditions.
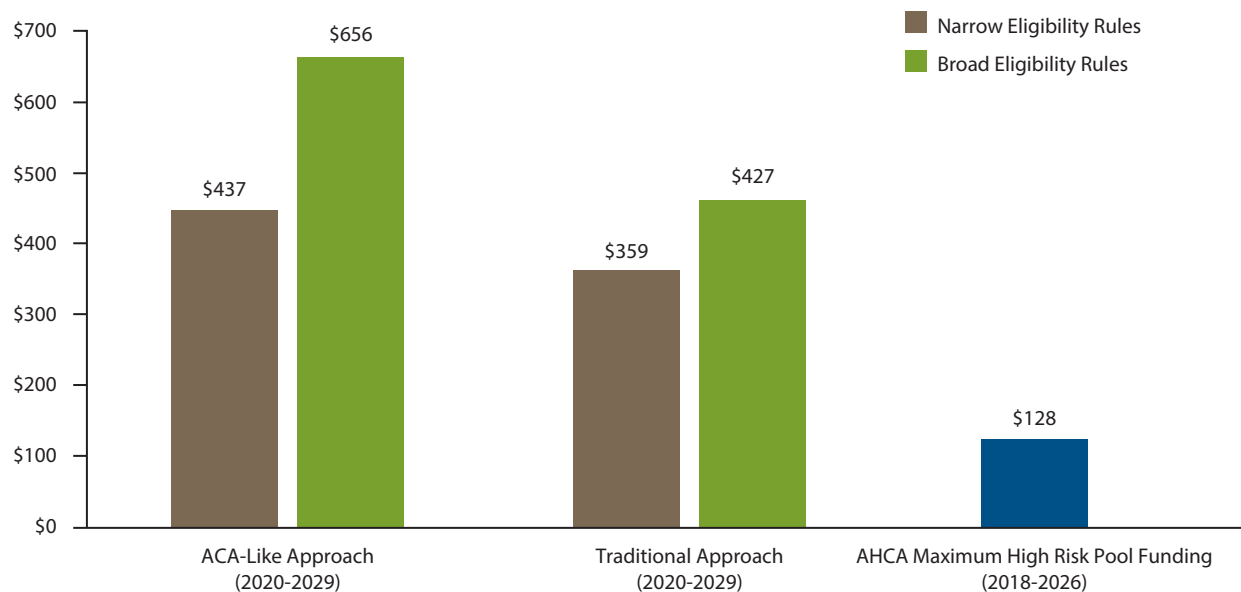
from $37 to $56 billion in 2020 and $437 to $656 billion over 10 years (2020–2029), depending upon the eligibility rules used (narrower versus broader). Government costs for the coverage and assistance typical of traditional high-risk pools would range from $25 billion to $30 billion in 2020 and from $359 to $427 billion over 10 years. (Figure 2)

- The current version of the AHCA suggests that if all federal funds that could be used for high-risk pools were drawn down, approximately $128 billion in government funds ($108 billion federal plus $20 billion-state matching dollars) would be available over 9 years (2018-2026). Yet the least expensive option simulated, the one in which high-risk pool eligibility is defined narrowly and lower actuarial value coverage is provided without income related-subsidies, would cost $359 billion over 10 years. This least expensive approach leads to the lowest enrollment, the highest financial burdens for high-risk pool enrollees, and the highest number of uninsured, yet it would cost more than double the government funds under consideration for such a program.

- This analysis was undertaken at the national level. While not all states would take up the AHCA's option to develop high-risk pools, the critical issue of insufficient funding for individual states remains. Each state would face a share of the high-risk pool costs we estimate here, and

each state is entitled to only a share of the federal funds based on a formula. So regardless of how many states take the high-risk pool option, the relative funding shortfall shown here applies.

- The approach that provides ACA-like coverage and subsidies not only leads to substantially higher enrollment, but also to much lighter financial burdens for those enrolling in the high-risk pool. There is a clear tradeoff between government spending and household spending. The median high-risk pool enrollee would spend 8 to 10 percent of income on health care (premiums plus out-of-pocket costs) under the ACA-like approach, while the median enrollee under the more traditional high-risk pool design would spend 35 to 41 percent of income on health care. The ranges reflect differences under the alternative eligibility rules. The differences in financial burdens between the ACA-like approach and the traditional risk pool design are greatly exacerbated for lower-income enrollees and for those with the highest health care needs.

- As a result of substantially higher financial burdens under the traditional high-risk pool approach, many fewer people would enroll, and more would remain uninsured, compared to the ACA-like approach. Assuming the broader eligibility rules, 2.2 million people with high-cost medical needs and/or a chronic condition would be uninsured

Figure 2. Government Costs Under Alternative High-Risk Pool Options, Compared to Maximum Government High-Risk Pool Funds Available Under the AHCA (in Billions)

Source: HIPSM 2017

Notes: The *ACA-like approach* provides enrollees with income-related premiums and cost-sharing assistance. Premiums are capped at a percent of family income, with lower caps for lower income enrollees. Actuarial value ranges from 70 percent to 94 percent, with higher values (lower cost-sharing) provided those with lower incomes. The *traditional approach* provides enrollees with 60 percent actuarial value coverage at a premium equal to 200 percent of standard coverage; no income related assistance is provided. *Narrow eligibility rules* include people identified by their high claims experience. *Broad eligibility rules* include the high claims group plus those with a list of identified chronic conditions.

under the AHCA if ACA-like coverage and subsidies were provided in the high-risk pool. If the lower government cost approach were taken instead, 6.2 million high-need people would remain uninsured under the AHCA.

■ The estimates presented here are likely to be conservative because only a limited number of chronic conditions can

be identified in the data and we assume that those with nongroup coverage under the AHCA's main reforms do not lose that coverage in the future, and some certainly will. As a result, larger numbers of people than we estimate are likely to become eligible for high-risk pool coverage over time.

INTRODUCTION

Debate continues over the fate of the Patient Protection and Affordable Care Act (ACA) and the American Health Care Act (AHCA) recently passed by the House of Representatives. While members of Congress have yet to coalesce around a single replacement, one feature common to most ACA alternative proposals is federal funding for state-based high-risk pools. Although proposals do not specify the structure of the high-risk pools envisioned, some do indicate the levels of federal funding that would be allocated. For example, the AHCA includes the Patient and State Stability Fund, which can be used for a number of purposes, including establishment of a high-risk pool.

The fund would provide $100 billion in grants to states over nine years, but to receive federal funds, states would be required to contribute matching funds of 7 percent in 2020, phasing up to 50 percent in 2026. If all states took up this

option, the total government funding available for the pool would be approximately $120 billion over nine years ($100 billion federal, $20 billion state), although the Congressional Budget Office estimates that not all states would do so.[2] The Upton amendment introduced on May 3 would add $8 billion to the original $100 billion over five years, and those funds could be used for high-risk pools as well.[3] On April 6, the House of Representatives amended the AHCA to allocate an additional $15 billion over nine years to an "invisible risk pool" that would allow insurers to shift some costs associated with high-cost enrollees to the federal government (it does not seem that state matching funds would be required for this part of the program). How these dollars would be allocated is not entirely clear, but it does seem that the $15 billion is in addition to the $100 billion for the original fund. This invisible risk pool funding would be spread over multiple years but would not be used to finance

high-risk pools, it would be used to cover a portion of claims from the central nongroup insurance market.

The continued policy conversations related to covering health care costs for people with high medical needs highlight the centrality of this issue for health policymaking. The MacArthur amendment would allow a state to waive community rating in the nongroup insurance market, allowing premiums to vary with health status, if the state uses the Patient and State Stability Funds for either a high-risk pool or reinsurance, or if the state uses its share of invisible risk pool funds. The Upton amendment's additional $8 billion is available over the 2018 to 2023 period to states choosing to waive community rating; the funds can be used to provide assistance to reduce premiums or out-of-pocket costs for people charged higher premiums due to their health status. Consequently, we

estimate the household and financial costs associated with high-risk pools, using two levels of coverage and household subsidies and two alternative methods for defining the eligible population.

High-risk pools can be designed in infinite ways, with eligibility rules, enrollee premiums, cost-sharing requirements, and covered benefits set to meet particular goals associated with government spending levels, household financial burdens, access to care, and system-wide insurance coverage. Historically, state approaches to high-risk pool design have varied considerably, and the approach taken under new federal legislation could easily differ from past experience (see box for background information on past high-risk pools). This analysis is designed to highlight the trade-offs inherent in some of these approaches.

Background on High-Risk Pools

Thirty-five states had high-risk pools before implementation of the ACA's nongroup insurance market reforms.[4] These insurance pools were designed to enroll only individuals who had been denied coverage in the nongroup insurance market or who had a condition likely to lead to an outright insurance denial. Specific eligibility rules varied across states.

After passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), most states permitted HIPAA-eligible people to enroll in their high-risk pools as well, to satisfy the new federal requirement that those leaving group health insurance are guaranteed issue of coverage without pre-existing condition exclusions. However, the ACA made these insurance pools largely obsolete as of January 1, 2014, when the federal law prohibited nongroup insurance denials based on health status as well as benefit exclusions for pre-existing conditions. The ACA included federal funding for high-risk pools in the period between passage of the ACA in 2010 and January 1, 2014, to provide those with high health care needs some interim relief until the new insurance market rules were implemented.[5] As of 2016, most high-risk pools had either closed completely or closed to new enrollees.[6]

Proposals to resurrect earlier high-risk pools and/or to create new ones indicate policymakers' expectations that suggested reforms to the central nongroup insurance market would exclude at least some individuals with significant health care needs. If everyone regardless of health status were to have access to adequate coverage through the main insurance pools, high-risk pools would not be necessary.

Even during the peak of high-risk pools, few people enrolled in them. Before passage of HIPAA, the 25 state high-risk pools

had a total enrollment of just over 91,000 people.[7] By the end of 2011 there were 35 state high-risk pools, and they had a total enrollment of fewer than 227,000 people. Further, in only 4 of these did enrollment exceed 20,000 (Maryland, Minnesota, Texas and Wisconsin); 11 states had fewer than 2,000 enrollees. Slightly over 2 percent of people with nongroup insurance in these 35 states received it through a high-risk pool.[8]

High-risk pools pose a substantial financing challenge. The highest-spending 5 percent of the nonelderly population accounts for 50 percent of total health spending in that age group.[9] That means that if those spending the most on health care are segmented into their own insurance pool, such as a high-risk pool, the average cost per person will be extremely high. To make adequate insurance coverage affordable for such a high-cost, high-need population, substantial government assistance would be necessary.

As a result of this reality and government revenue-raising constraints, previous state high-risk pools used a variety of strategies to limit costs, including enrollment caps, pre-existing condition exclusion periods, high cost-sharing requirements, and lifetime and annual benefit limits.[10] In addition, premiums charged enrollees ranged from 150 to 200 percent of standard premiums in the nongroup market. Assistance to make coverage more affordable to those with low incomes was limited to only 19 states, and in most the low-income assistance was limited. As a consequence, high-risk pool coverage was not sufficient to meet the needs of many people who had been denied coverage in the traditional market or who were offered inadequate or unaffordable options as a consequence of their health.

We estimate the government and household costs associated with two possible high-risk pool coverage and subsidy levels and two alternative definitions of the eligible population, assuming passage of the AHCA. Our analysis assumes effective provisions to prohibit those with access to employer-based insurance from enrolling in high-risk pools and a level of employer-based coverage consistent with the AHCA. High-risk pools have been an integral component of ACA "repeal and replace" proposals, and while the next steps on health legislation are currently uncertain, it is important to understand the coverage and cost implications for future debates.

The AHCA would maintain a guaranteed-issue nongroup insurance market, modified community rating, and essential health benefit requirements but would allow states to waive essential health benefits and modified community rating. The AHCA also vastly changes premium tax credits, eliminates cost-sharing reductions, and caps federal Medicaid spending.

METHODS AND KEY ASSUMPTIONS

The Urban Institute's Health Insurance Policy Simulation Model

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate how many people would be eligible for high-risk pools, how much high-risk pool coverage would cost, and whether eligible individuals would decide to enroll in high-risk pools, assuming passage of the AHCA.

The core of HIPSM's population is the combined 2012 and 2013 American Community Survey samples of nonelderly people (under age 65). In other words, the model's baseline consists of the most recent survey data before major ACA coverage provisions took effect. Survey data from 2014 and 2015 represent transition from before the ACA to its full implementation, and are thus unsuitable as a model baseline, particularly one from which ACA repeal scenarios must be simulated. The observations in the 2012 and 2013 data are aged to 2017 based on population projections from the Urban Institute's Mapping America's Futures program.[11] Health care costs and chronic conditions are statistically matched to the core population from the Medical Expenditure Panel Survey—Household Component (MEPS-HC), with costs aged to 2017 based on estimated per capita growth from the National Health Expenditure Accounts.[12]

HIPSM uses a microsimulation approach based on the relative desirability of the health insurance options available to each individual and family under reform. The health insurance coverage decisions of individuals and families in the model take into account factors such as premiums and out-of-pocket health care costs for available insurance products, health care risk, and family disposable income. Our utility model takes into account people's insurance choices as reported on the survey data. We use such preferences to customize individual utility functions so their reported choices score the highest, and this in turn affects behavioral decisions under simulations of reform scenarios. The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature, such as price elasticities for employer-sponsored and nongroup coverage.[13]

Key Assumptions

Eligibility for high-risk pools. We defined two populations that represent the two factors historically used to determine high-risk pool eligibility: those denied access to private nongroup health insurance because of a chronic condition and those denied access because of a history of high claims costs. In practice, eligibility for a high-risk pool can be defined in many ways, and these eligibility rules are likely to reflect both access to care and government financing concerns.

For this analysis, to highlight some inherent tradeoffs, we define two populations: the first includes those identified as high cost by their actual health care spending and the second includes the first population plus those diagnosed with one of a set of chronic conditions. The former definition includes fewer people than the latter but has higher average costs per enrollee. Both populations exclude people eligible for public insurance coverage (e.g., Medicaid, Medicare) and people with undocumented status.

Our analysis is limited to these populations who have high expected health care needs but would be uninsured under the main components of the AHCA. Those uninsured under the main components of the AHCA would have a gap in coverage that could lead to them being medically underwritten when they attempt to obtain insurance.

The high-risk population includes people insurers would consider having a high likelihood for using significant medical services. Actuaries commonly use a definition of "high risk" that encompasses people at or above the 90th percentile of risk. We assume that insurers could identify 90 percent of those with health risk in the highest decile as some people with the highest health care service needs cannot be identified a priori. Risk cannot be predicted perfectly, and some conditions that have led insurers to deny coverage

in the past are not necessarily high cost (e.g., depression, allergies, ear infections), so we assume that an additional 20 percent of those with risk in the highest quartile would also be flagged as high risk.

Diagnosis of a chronic condition is another way in which people may be identified as being at high risk for significant medical expenses. The MEPS-HC identifies those diagnosed with a number of these—diabetes, asthma, heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.[14] People had been denied coverage before the ACA, however, for many other conditions. Just a few examples not identified in the MEPS-HC include AIDS/HIV, cancer (e.g., within 10 years), severe obesity, bipolar disorder, eating disorder, Crohn's disease/ulcerative colitis, epilepsy, hepatitis, cerebral palsy, kidney disease, alcohol abuse/substance use disorder and sleep apnea.[15]

Independent of these conditions, applicants could be denied coverage based on taking certain medications or working in particular occupations. An array of medications and occupations also could lead to coverage denials, and other milder conditions expected to generate losses could lead to other adverse underwriting actions by insurers (e.g., charging higher premiums, excluding benefits, increasing cost-sharing requirements). As a result, our approach may understate how many people could be eligible for a high-risk pool by the number who do not fall into the "high risk" definition described above and the number who do not have a condition identified on the MEPS but take medications, work in occupations, or have other conditions that would lead to denial of coverage.

In addition, we underestimate the size of this pool over time, because we do not take into account that the flow of people who become subject to medical underwriting each year would be larger than the medically underwritten population able to move back into the population charged standard premium rates. For example, some percentage of nongroup enrollees in 2020 would experience a gap in coverage during the course of a future year and then become part of the medically underwritten population. Because medical underwriting could make coverage unaffordable for many people with health conditions experiencing a coverage gap (even taking into account a reinsurance or high-risk pool mechanism), a significant number of those people would become uninsured.

It would be much harder for people facing medical underwriting to become eligible for standard premium rates because they would generally not be able to afford the much higher premiums for 12 months. As a result, the number of people facing medical underwriting if they attempt to purchase nongroup insurance would increase each year, but we have not taken this increase into account.

Coverage and premiums. The AHCA high-risk pool component does not give any details on the coverage that would be available in high-risk pools or on the premiums that would be charged. The bill appears to leave these decisions to states choosing to set up the pools. We assume that the high-risk pools would provide coverage for all essential health benefits covered by the ACA. In addition, we assume, consistent with the current proposals for changes to the nongroup market overall, that age-rating bands would be loosened to 5:1 (i.e., the oldest adult could not be charged more than five times the premium of the youngest adult for the same coverage). We then created two distinct premium and coverage packages to show a range of government costs and household financial burdens. Package 1 provides more financial protection and more generous coverage for the high medical need population, while package 2 lowers government costs and reduces the assistance the ACA now provides high-risk enrollees.

Package 1 is designed to completely offset AHCA changes to the nongroup insurance market for high-risk pool enrollees, allowing those with serious medical needs to access coverage as comprehensive as that under the ACA's marketplaces, including income-related premium tax credits and cost-sharing reductions for low-income people. The package goes somewhat further than the ACA by providing financial assistance for high-risk pool enrollees with incomes over 400 percent of the federal poverty level (FPL), since high-risk pool coverage would be so expensive that very few higher-income people would be able to afford it on their own. This package is structured as follows:

Package 1: A 70 percent actuarial value plan including all the essential health benefits required by the ACA for those with incomes above 250 percent of FPL, a 73 percent actuarial value plan for those with incomes between 200 and 250 percent of FPL, an 87 percent actuarial value plan for those with incomes between 150 and 200 percent of FPL and a 94 percent actuarial value plan for those with incomes below 150 percent of FPL.

a. Eligible individuals would have their premiums capped using the ACA marketplace premium tax credit schedule. This schedule limits an enrollee's premium contribution to 2.04 percent of income for those with incomes up to 133 percent of FPL, with the caps phasing up to 9.64 percent of income for those between 300 and 400 percent of FPL.[16] The actuarial value differences delineated above are consistent with the ACA's cost-sharing subsidies.

b. Assuming most states would be unable to maintain the ACA's Medicaid expansion under the AHCA's lower federal match rates, many with incomes below 100 percent of

FPL would no longer be eligible for Medicaid. As a result, this option would provide poor high-risk pool eligibles with rates capped at 2.04 percent of income and the 94 percent actuarial value cost-sharing reductions.

c. Because the average cost associated with a high-risk pool population is necessarily very high, we also assume that the ACA's highest premium cap, 9.64 percent in 2017, would be extended to all those with incomes above 400 percent of FPL as well. Without any financial assistance, coverage would be unaffordable to most of these higher-income eligibles.

Package 2 is designed to be more consistent with offerings in traditional high-risk pools. The public subsidy is only for claims costs; no income-related subsidies or income-related cost-sharing reductions are provided. We do not assume that the flat tax credits could be used to offset the high-risk pool premiums, as this was not clear in the AHCA language, and significant public dollars are being used to offset the high cost of claims. This package represents an approach with a significantly lower government cost than package 1.

Package 2: A 60 percent actuarial value plan including all the essential health benefits required by the ACA.

a. Eligible individuals would have their premiums set at 200 percent of the standard nongroup market premium. Standard premium is the premium that they would have paid for comparable coverage if they had not been excluded from the main nongroup market. Policymakers could define the standard premium as that faced by

people not enrolled in the high-risk pool market, instead of the broader average used here; this approach was taken by at least some pre-ACA high-risk pools. That alternative would lead to lower financial burdens for households than those simulated here, but would lead to significantly higher government costs.

b. This level of assistance is generally consistent with the typical pre-ACA high-risk pools, however, our package does not impose the pre-existing condition exclusions, annual or lifetime benefit limits, or other limitations that these plans frequently imposed.

High-risk pool enrollment. We assume that high-risk pool enrollment with ACA-like subsidies (package 1) would be consistent with ACA enrollment. In other words, eligible individuals covered in the ACA's nongroup market or by the Medicaid expansion but uninsured under the main components of the AHCA would also enroll in the high-risk pool. There would be additional enrollment beyond ACA levels because those above 400 percent of the FPL gain access to premium tax credits under this approach. We assume enrollment would be much lower under the scenario in which ACA-like subsidies are not provided, because low- and middle-income eligible individuals would face higher premiums and higher cost-sharing requirements. However, enrollment in package 2 would be somewhat higher than typical pre-ACA high-risk pools, because package 2 would include essential health benefits and would not impose pre-existing condition exclusions, annual or lifetime benefit limits, or other limitations generally found in those earlier plans.

Table 1. Size and Health Risk of Potential High-Risk Pools Under the American Health Care Act, 2020

Potential High-Risk Pool, Excluding Those With Private Coverage Under the AHCA	Total Eligible	Total Health Care Cost Index[a]			Share of Total Uninsured[b]	
		50th	90th	Mean	Uninsured Population	Uninsured Health Costs
All uninsured under the AHCA[b]	35,953,000	0.0	1.6	1.0		
High claims population only[c]	2,509,000	0.9	11.3	5.7	7.0%	38.1%
High claims or chronic condition population[d]	7,633,000	0.1	5.6	2.8	21.2%	56.7%

Source: Urban Institute analysis, HIPSM 2017.

a. Health cost index is defined as the individual's estimated total health spending if privately insured divided by average health spending among uninsured and private nongroup enrollees if privately insured.

b. Excludes those age 65 or older, undocumented immigrants and those eligible for Medicaid or other public coverage.

c. High claims population consists of 90% of those in the highest risk decile and 20% of those in highest risk quartile.

d. The chronic condition population consists of those reporting being diagnosed with one of 9 chronic conditions asked about in the Medical Expenditure Panel Survey–Household Component: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.

RESULTS

Size and Relative Health Care Costs of Potential High-Risk Pool Enrollees

Table 1 shows the distribution of health risk and the share of health care costs associated with the potential high-risk pool populations we analyze. In this table, we make no assumptions about individual decisions to enroll or not—here we simply analyze the full potentially eligible population. We draw the potential high-risk pool eligibles from the population that would remain uninsured under the other provisions of the AHCA, excluding those 65 and older, undocumented immigrants and those eligible for Medicaid or other public coverage. We estimate that, under the AHCA, the total number of uninsured in 2020 would be 49 million people (not shown), an estimate close to the 48 million estimated by CBO.[17] Because not all of the uninsured would be eligible for a high-risk pool, as noted above, we estimate that 36.0 million people would be uninsured that year and eligible.

Of those 36.0 million, approximately 2.5 million would qualify for a high-risk pool based upon our high claims criteria described in the Methods and Key Assumption section. Approximately 7.6 million would qualify for a high-risk pool that, in addition to the first, permitted those with at least one chronic condition identified in our data (as also described in the Methods and Key Assumptions section) to enroll. The high claims population constitutes 7.0 percent of the broad uninsured population but accounts for 38.1 percent of the broader uninsured group's total health care costs (assuming a standardized insurance package). Adding in those identified as having a chronic condition leads to a group of eligibles that constitutes 21.2 percent of the broad uninsured population and 56.7 percent of their total health care costs.

The health care cost index data show how those deemed eligible for the high-risk pool based upon our criteria differ from those in the broad uninsured population. Setting the mean health care expenses (given a standardized insurance package) of the broad population to 1.0, the mean health care costs of the high claims population is 5.7 times greater. When the chronic condition population is added, the mean health care costs are 2.8 times greater. Health care costs for the highest-spending 10 percent of people in each group are 11.3 times the average and 5.6 times the average, respectively. The average health care costs for the combined high claims and chronic condition populations are substantially lower than those for the high claims population alone, because significant numbers of people with chronic conditions do not actually incur high medical costs in any one particular year.

The central message of table 1 is therefore that, depending upon how eligibility is defined, 2.5 million people who would be uninsured under the AHCA would qualify for high-risk pool coverage based upon high expected health care claims, and another 5.1 million would qualify based on the chronic conditions we are able to identify. These potential eligibles, while a much smaller share of the uninsured population, account for between 38.1 and 56.7 percent of that population's health care costs, since the health care costs associated with these high-need people are much higher than for the population average.[18]

Household and Government Costs per Person Associated With the Eligible Population

In table 2, we again focus on the two potentially eligible populations, not yet adjusting for estimated enrollment decisions by individual people. We show household and government costs under the two subsidization scenarios defined in the Methods and Key Assumptions section:

1. A scenario that replicates the value of coverage and income-based financial help for which people are currently eligible under the ACA—a base 70 to 94 percent actuarial value plan with ACA-like premium and cost-sharing assistance. (The latter increases actuarial values for those below 250 percent of FPL.)[19]

2. A scenario more similar to many pre-ACA state high-risk pools, where enrollees pay premiums set at 200 percent of standard rates, with no other income-based premium or cost-sharing subsidies, for a high-deductible health plan with 60 percent actuarial value.

The first three columns of the table show that average beneficiary premiums and out-of-pocket payments for medical services would be lowest under the ACA-like subsidization approach, totaling $3,695 ($1,595 for premiums and $2,099 for out-of-pocket costs) when the pool is limited to those with high-cost claims and $2,931 ($1,441 for premiums and $1,490 for out-of-pocket costs) when the pool includes those with high cost claims or an identified chronic condition. Including the chronic condition population in the pool reduces average premiums and out-of-pocket costs, since a significant number do not incur high claims in a given year.

Average beneficiary spending under the ACA-like approach would be considerably lower for those with incomes below 200 percent of FPL ($1,181 to $1,532 for premium and out-of-pocket costs combined, depending upon the eligibility rule used) and would increase with income, averaging $8,303

Table 2. High-Risk Pool Costs per Eligible Person Under Different Eligibility Definitions, Subsidization and Coverage Approaches, 2020

	Beneficiary Cost per Person			Federal Cost per Person			Total Cost per Person
	Average Premiums	Other OOP Cost	Total	Premium	Cost-Sharing Reduction	Total	
High Claims Population Only[a]							
70% to 94% AV, ACA-like subsidies[b]	$1,595	$2,099	$3,695	$20,561	$2,224	$22,785	$26,480
<200% FPL	$398	$1,134	$1,532	$23,484	$3,425	$26,909	$28,441
200–400% FPL	$2,522	$3,313	$5,835	$13,508	$398	$13,906	$19,740
>400% FPL	$5,581	$4,390	$9,970	$20,307	$0	$20,307	$30,277
60% AV, 200% of standard premiums	$7,472	$4,308	$11,779	$11,149	$0	$11,149	$22,928
High Claims or Chronic Condition Population[c]							
70% to 94% AV, ACA-like subsidies[b]	$1,441	$1,490	$2,931	$9,079	$1,669	$10,748	$13,679
<200% FPL	$391	$791	$1,181	$10,044	$2,506	$12,550	$13,732
200–400% FPL	$2,498	$2,481	$4,979	$6,493	$292	$6,786	$11,765
>400% FPL	$5,053	$3,249	$8,303	$9,430	$0	$9,430	$17,733
60% AV, 200% of standard premiums	$6,770	$3,035	$9,804	$1,879	$0	$1,879	$11,683

Source: Urban Institute analysis, HIPSM 2017.

Notes: Assumes the American Health Care Act is in place. Excludes those age 65 or older, undocumented immigrants and those eligible for Medicaid or other public coverage.

Assumes 5:1 age rating and all ACA essential health benefits included in high-risk pool coverage.

ACA = Patient Protection and Affordable Care Act of 2010

AV = actuarial value

FPL = federal poverty level

OOP = out of pocket

a. High claims population consists of 90% of those in the highest risk decile and 20% of those in highest risk quartile.

b. ACA-like subsidies use the premium tax credit and cost-sharing reductions provided under current law, but extend the subsidies currently offered to those with incomes at 100% of FPL (tax credit percentage of income cap and cost-sharing reduction) to those with incomes below 100% of FPL not eligible for Medicaid or other public insurance, who meet other eligibility requirements currently in place. They also provide the same premium tax credit percentage of income cap provided to those at 400% of FPL under current law to those with incomes exceeding 400% of FPL, given the extremely high-cost unsubsidized premiums that would be faced in a high-risk pool.

c. The chronic condition population consists of those reporting being diagnosed with one of 9 chronic conditions asked about in the Medical Expenditure Panel Survey–Household Component: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.

to $9,970 for those with incomes over 400 percent of FPL. By contrast, average beneficiary costs under the 60 percent actuarial value/200 percent of standard premiums approach would be much higher ($11,779 and $9,804, depending upon the eligibility rule used) and would not vary with income (other than age variations correlated with income), since income-based subsidies are not offered. Assuming that 5:1 maximum age bands were permitted in the high-risk pools instead of the 3:1 permitted under the ACA, average beneficiary premium contributions could increase markedly for older adults versus younger adults under the 60 percent actuarial value/200 percent of standard premiums approach.

As a direct corollary of lower beneficiary spending under the ACA-like approach, government costs for that policy would be significantly higher per person than under the other subsidization option. Average government spending under the ACA-like approach would be $22,785 per person

($20,561 for premium assistance and $2,224 for cost-sharing reductions) for the high claims population alone and $10,748 per person ($9,079 for premium assistance, $1,669 for cost-sharing reductions) for the high claims and chronic condition population. This is compared to per person averages of $11,149 and $1,879 for the 60 percent actuarial value/200 percent standard premiums, high claims and high claims plus chronic condition pools, respectively. Total costs (government plus household) are higher per person under the ACA-like subsidization approach, because the coverage has higher actuarial value and individuals therefore would use more care than under the 60 percent actuarial value approach. The government costs per person for the 60 percent actuarial value approach that includes people with chronic conditions are quite low since a significant number of these people incur claims well below 200 percent of standard premiums in a given year; therefore, their premium contributions partially offset the costs of the high claims population.

The central message of table 2 is that the different subsidization and plan generosity levels, as well as the eligibility rules reflected in these approaches, have substantial implications for both the health care financing costs facing beneficiaries and the average government costs per eligible person. ACA-like subsidies that increase in generosity as income decreases lead to the lowest average costs for beneficiaries but the highest average costs for government. The other options would leave substantially higher costs for the beneficiaries themselves (particularly those with incomes below 400 percent of FPL) and would carry substantially lower government costs per person. These costs would be more equally spread across the income distribution of eligibles, since the assistance is unrelated to income. As a result, access to care would be less affordable for those with lower incomes than under the ACA-like subsidy approach.

Household and Government Costs per Person, Taking Likely Enrollment Decisions Into Account

We estimate that slightly over 70 percent of those eligible for a high-risk pool (1.8 million or 5.4 million people, depending on eligibility rule used) would enroll under the most generous options studied, those with ACA-like premium and cost-sharing assistance (table 3). Enrollment is estimated to be significantly lower at the lower level of plan and subsidy generosity, with 18.7 to 26.1 percent enrolling under the 60 percent actuarial value/200 percent of standard premiums option (655,000 to 1.4 million people).

Table 3. High-Risk Pool Enrollment and Household and Government Costs per Enrollee Under Different Eligibility Definitions, Subsidization and Coverage Approaches, 2020

	Eligibles	Enrolled	Take-Up Rates	Beneficiary Cost per Person			Government Cost per Person			Total Cost per Person
				Average Premiums	Average Other OOP Cost	Total	Average Tax Credits	Average Cost-Sharing Reductions	Average Total per Person	
High Claims Population Only[a]										
70% to 94% AV, ACA-like subsidies[b]	2,509,000	1,819,000	72.5%	$1,481	$2,036	$3,517	$18,057	$2,407	$20,464	$23,980
<200% FPL	1,556,000	1,218,000	78.3%	$368	$1,124	$1,491	$18,629	$3,481	$22,110	$23,601
200–400% FPL	633,000	355,000	56.0%	$2,337	$3,460	$5,797	$14,514	$394	$14,908	$20,705
>400% FPL	320,000	247,000	77.1%	$5,745	$4,492	$10,238	$20,326	$0	$20,326	$30,563
60% AV, 200% of standard premiums	2,509,000	655,000	26.1%	$8,699	$5,947	$14,646	$38,583	$0	$38,583	$53,228
High Claims or Chronic Condition Population[c]										
70% to 94% AV, ACA-like subsidies[b]	7,633,000	5,415,000	70.9%	$1,254	$1,431	$2,686	$8,478	$1,839	$10,318	$13,003
<200% FPL	4,858,000	3,802,000	78.3%	$363	$786	$1,150	$8,348	$2,540	$10,888	$12,038
200–400% FPL	1,928,000	1,016,000	52.7%	$2,275	$2,649	$4,925	$7,484	$298	$7,782	$12,707
>400% FPL	847,000	597,000	70.5%	$5,190	$3,465	$8,655	$10,998	$0	$10,998	$19,653
60% AV, 200% of standard premiums	7,633,000	1,430,000	18.7%	$7,999	$4,840	$12,839	$21,012	$0	$21,012	$33,851

Source: Urban Institute analysis, HIPSM 2017. Estimations for 2020 under the AHCA.

Notes: Assumes the American Health Care Act is in place. Excludes those age 65 or older, undocumented immigrants and those eligible for Medicaid or other public coverage.

Assumes 5:1 age rating and all ACA essential health benefits included in high-risk pool coverage.

ACA = Patient Protection and Affordable Care Act of 2010

AV = actuarial value

FPL = federal poverty level

OOP = out of pocket

a. High claims population consists of 90% of those in the highest risk decile and 20% of those in highest risk quartile.

b. ACA-like subsidies use the premium tax credit and cost-sharing reductions provided under current law, but extend the subsidies currently offered to those with incomes at 100% of FPL (tax credit percentage of income cap and cost-sharing reduction) to those with incomes below 100% of FPL not eligible for Medicaid or other public insurance, and who meet other eligibility requirements currently in place. They also provide the same premium tax credit percentage of income cap provided to those at 400% of FPL under current law to those with incomes exceeding 400% of FPL, given the extremely high-cost unsubsidized premiums that would be faced in a high-risk pool.

c. The chronic condition population consists of those reporting being diagnosed with one of 9 chronic conditions asked about in the Medical Expenditure Panel Survey–Household Component: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.

The per person average costs associated with enrollees under the ACA-like option are close to those estimated for the full eligible population, since the higher (ACA-like) level of assistance leads to a generally representative group of enrollees. However, average health care costs of enrollees under the lower subsidization approach (60 percent actuarial value/200 percent of standard) are noticeably higher than the full eligible population estimates, reflecting that people with higher average medical needs would be more likely to enroll when beneficiary costs are higher and the comprehensiveness of coverage lower. Total average beneficiary and government costs per person enrolling in the high-risk pool with the 60 percent actuarial value/200 percent of standard premium option is more than twice the average total costs per person enrolling with the ACA-like subsidies for the high claims population only ($23,980 versus $53,228, and $13,003 versus $33,851), depending upon the eligibility rule.

The central message of table 3 is that higher premiums and lower actuarial value coverage will lead to substantially lower enrollment in the high-risk pool. This lower enrollment also means that those who do enroll will have higher average medical needs than the population that would enroll if the high-risk pool coverage were more comprehensive and income-related subsidies provided.

Aggregate Household and Government Costs, Taking Likely Enrollment Decisions Into Account

Total 2020 federal costs for the ACA-like subsidization approach, taking enrollment decisions into account, are $37.2 billion for the high claims population only and $55.9 billion for the high claims or chronic condition populations when the ACA-like coverage and subsidy approach is used (table 4). Ten-year estimates are $437.4 billion and $656.4 billion, respectively.

Corresponding estimates for the 60 percent actuarial value/200 percent of standard premium option are $25.3 billion for the high claims population only and $30.1 billion for the high cost or chronic condition population (corresponding 10-year estimates are $359.3 billion and $427.0 billion,

Table 4. Aggregate High-Risk Pool Household and Government Costs Under Different Eligibility Definitions, Subsidization and Coverage Approaches, 2020 and 2020–2029

	Aggregate Government Cost (Billions $)		Aggregate Government and Household Cost (Billions $)	
	2020	2020–2029	2020	2020–2029
High Claims Population Only[a]				
70% to 94% AV, ACA-like subsidies[b]	$37.2	$437.4	$43.6	$512.5
<200% FPL	$26.9	$316.3	$28.7	$337.7
200–400% FPL	$5.3	$62.1	$7.3	$86.3
>400% FPL	$5.0	$58.9	$7.5	$88.6
60% AV, 200% of standard premiums	$25.3	$359.3	$34.9	$495.7
High Claims or Chronic Condition Population[c]				
70% to 94% AV, ACA-like subsidies[b]	$55.9	$656.4	$70.4	$827.2
<200% FPL	$41.4	$486.3	$45.8	$537.7
200–400% FPL	$7.9	$92.9	$12.9	$151.7
>400% FPL	$6.6	$77.2	$11.7	$137.9
60% AV, 200% of standard premiums	$30.1	$427.0	$48.4	$687.9

Source: Urban Institute analysis, HIPSM 2017. Estimations for 2020 under the AHCA.

Notes: Assumes the American Health Care Act is in place. Excludes those age 65 or older, undocumented immigrants and those eligible for Medicaid or other public coverage.

Assumes 5:1 age rating and all ACA essential health benefits included in high-risk pool coverage.

ACA = Patient Protection and Affordable Care Act of 2010

AV = actuarial value

FPL = federal poverty level

a. High claims population consists of 90% of those in the highest risk decile and 20% of those in highest risk quartile.

b. ACA-like subsidies use the premium tax credit and cost-sharing reductions provided under current law, but extend the subsidies currently offered to those with incomes at 100% of FPL (tax credit percentage of income cap and cost-sharing reduction) to those with incomes below 100% of FPL not eligible for Medicaid or other public insurance, and who meet other eligibility requirements currently in place. They also provide the same premium tax credit percentage of income cap provided to those at 400% of FPL under current law to those with incomes exceeding 400% of FPL, given the extremely high-cost unsubsidized premiums that would be faced in a high-risk pool.

c. The chronic condition population consists of those reporting being diagnosed with one of 9 chronic conditions asked about in the Medical Expenditure Panel Survey–Household Component: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.

respectively). The aggregate government costs associated with the 60 percent actuarial value subsidization approach are not very different under the two eligibility options, because many people with chronic conditions have costs that fall below 200 percent of standard premiums in any particular year. As a result, the high-risk pool is able to subsidize the costs of the high claims enrollees with premiums paid in by those eligible from having a chronic condition. Aggregate spending is quite different under the different eligibility definitions, but households are paying for a larger share of the difference than is the federal government.

The central message of table 4 is that the coverage and subsidization approach most closely reflecting typical high-risk pool subsidization strategies (60 percent actuarial value coverage with 200 percent of standard premiums) would cost the government significantly less than the ACA-like approach for two reasons:

1. The government would not provide any income-related subsidies, which would depress enrollment.

2. Less coverage would be provided and pool premiums would be higher—thereby reducing the overall amount of net claims losses to be financed. In addition, lower levels of coverage would tend to further depress enrollment, also lowering federal costs. As a result, millions more high-need people would be uninsured.

The least expensive of these options for the government, at $25.3 billion in 2020, would cost substantially more than the most generous allotment provided through the AHCA's Patient and State Stability Fund, which is $15 billion. The earlier version of the AHCA would allocate approximately $120 billion in government funding (federal and state) over nine years if all the federal money were drawn down; CBO estimated that not all of it would be claimed, however. [20] The Upton amendment would add an additional $8 billion over five years. Thus, if all funds were drawn down, the AHCA would provide approximately $128 billion in funding over nine years that could be used for high-risk pool funding, compared to our estimates of 10-year government funding of $359.3 to $656.4 billion to finance this range of high-risk pools. [21]

This comparison does not take into account that the AHCA's federal funding would decrease with time (going down from $15 billion per year to $10 billion per year) and end after nine years, creating a bigger financing gap. And this assumes that states would use all available federal dollars for a high-risk pool,

leaving no funds for cost-sharing assistance, additional premium subsidies, preventive services, or a reinsurance program.

Health Care Financial Burdens for High-Risk Pool Enrollees

Table 5 shows health care financial burdens—insurance premiums plus out-of-pocket health costs as a percentage of income—for families with at least one member enrolling in a high-risk pool under each subsidization/coverage option. [22] Overall, health care financial burdens are substantially lower under the ACA-like approach, compared to the more traditional high-risk pool approach, with median spending under the ACA-like option amounting to 8 to 10 percent of family income (depending upon how eligibility is defined). In comparison, median spending is 35 to 41 percent of family income under the 60 percent actuarial value/200 percent of standard option. Differences in the financial burdens resulting from the two approaches increase substantially for those with the greatest costs relative to incomes (i.e., those at the 75th and 90th percentiles).

Differences across the subsidization/coverage options are especially stark when looking at the low- and middle-income groups, since the ACA-like approach provides additional assistance to lower-income high-risk pool enrollees and the other option does not. At the median, high-risk pool families with incomes below 200 percent of FPL would spend 6 to 8 percent of their income under the ACA-like approach (depending upon eligibility rules), compared to 55 to 71 percent of income under the alternative.

Thus, the central message of table 4 is that the more traditional high-risk pool alternative would place much higher health care financial burdens on enrolled families. Under the ACA-like approach, burdens would tend to be the lowest for people with the lowest income, with those financial burdens increasing modestly as income increases. Under the alternative, the opposite would occur, as financial burdens would increase appreciably as income decreased. In addition, assistance under the ACA-like approach provides financial protection relative to the more traditional alternatives, even for higher-income enrollees at the highest levels of spending relative to income.

Number of High-Risk Pool Eligibles Remaining Uninsured

The last column of table 4 shows how many people with high medical needs or chronic conditions would remain uninsured under each high-risk pool approach. If eligibility is defined

Table 5. Health Care Cost Burdens (premiums plus out-of-pocket spending divided by income) for High-Risk Pool Enrollees and Remaining Uninsured Among High-Risk Pool Eligibles, 2020

	Family Health Care Cost Burden for High-Risk Pool Enrollees[d]			Number of Uninsured With High Cost Claims or Chronic Condition
	Median	75th percentile	90th percentile	
High Claims Population Only[a]				
70% to 94% AV, ACA-like subsidies[b]	10%	17%	26%	5,814,000
<200% FPL	8%	15%	27%	3,640,000
200 - 400% FPL	16%	22%	29%	1,573,000
>400% FPL	10%	15%	21%	601,000
60% AV, 200% of standard premiums	41%	78%	135%	6,978,000
<200% FPL	71%	118%	190%	4,523,000
200 - 400% FPL	41%	55%	70%	1,777,000
>400% FPL	14%	23%	33%	678,000
High Claims or Chronic Condition Population[c]				
70% to 94% AV, ACA-like subsidies[b]	8%	15%	23%	2,218,000
<200% FPL	6%	12%	23%	1,056,000
200 - 400% FPL	14%	20%	27%	912,000
>400% FPL	9%	14%	20%	250,000
60% AV, 200% of standard premiums	35%	66%	114%	6,203,000
<200% FPL	55%	97%	163%	4,099,000
200 - 400% FPL	38%	52%	68%	1,590,000
>400% FPL	12%	21%	31%	514,000

Source: Urban Institute analysis, HIPSM 2017.

Notes: Assumes the American Health Care Act is in place. Excludes those age 65 or older, undocumented immigrants and those eligible for Medicaid or other public coverage.

Assumes 5:1 age rating and all ACA essential health benefits included in high-risk pool coverage.

ACA = Patient Protection and Affordable Care Act of 2010

AV = actuarial value

FPL = federal poverty level

a. High claims population consists of 90% of those in the highest risk decile and 20% of those in highest risk quartile.

b. ACA-like subsidies use the premium tax credit and cost-sharing reductions provided under current law, but extend the subsidies currently offered to those with incomes at 100% of FPL (tax credit percentage of income cap and cost-sharing reduction) to those with incomes below 100% of FPL not eligible for Medicaid or other public insurance, and who meet other eligibility requirements currently in place. They also provide the same premium tax credit percentage of income cap provided to those at 400% of FPL under current law to those with incomes exceeding 400% of FPL, given the extremely high-cost unsubsidized premiums that would be faced in a high-risk pool.

c. The chronic condition population consists of those reporting being diagnosed with one of 9 chronic conditions asked about in the Medical Expenditure Panel Survey–Household Component: diabetes, asthma, coronary heart disease, angina, heart attack, other heart disease, stroke, emphysema and arthritis.

d. Financial burdens shown include health care spending by hight risk pool enrollees' family members, regardless of their source of health insurance coverage.

using the narrower high claims only definition, 5.8 million people with high claims or a chronic condition would remain uninsured using the ACA-like subsidization approach, 1.2 million fewer than under the 60 percent actuarial value/200 percent of standard option (7.0 million).

Many fewer people are eligible for the high-risk pool when we base eligibility on high spending alone, excluding those who are not necessarily high spenders in a particular year but who have an identified chronic condition that could lead to higher spending. When those with chronic conditions are also eligible for the high-risk pool, 2.2 million high-need people would remain uninsured with ACA-like subsidies,

roughly one-third as many uninsured under the 60 percent actuarial value/200 percent of standard approach (6.2 million people). In addition, whereas about half of high-need people remaining uninsured under the ACA-like approach would have incomes below 200 percent of FPL, approximately two-thirds of those remaining uninsured under the 60 percent actuarial value/200 percent of standard approach would be low income. This reflects the lack of income-related assistance under the traditional high-risk pool approach.

CONCLUSION

Segregating a population with high health care needs into its own health insurance risk pool isolates the people with the highest health care costs, necessitating substantially higher insurance premiums when keeping the generosity of their coverage constant. Alternatively, pooling the costs of those with high health care needs together with the general population increases average premiums somewhat for the much more numerous healthy but lowers them much more on average for those with significant needs. This challenge is one of the central conundrums of health policy. [23]

This analysis demonstrates, however, that ensuring access to adequate and affordable insurance through a risk-segmentation approach like high-risk pools requires a large commitment of government dollars. Without them, those with significant medical needs would see access to coverage compromised. In turn, their ability to access necessary care would be severely limited.

We find that 2.5 million people—of the 36.0 million people who would be uninsured under the AHCA and not prohibited from the pool based on their eligibility for public insurance, their age, or undocumented status—would qualify for a high-risk pool based on their likelihood of high health care claims; 7.6 million would qualify based on having either high claims or a chronic condition that can be identified in our data.

The number that could afford coverage in a high-risk pool, and thus the likelihood that they would enroll, would vary substantially with the level of coverage and the subsidies provided through the high-risk pool, specifics not discussed in recent proposals to create them. We estimate that, using a coverage and subsidization approach similar to that provided under the ACA, slightly over 70 percent of eligibles would enroll at a government cost of $37.2 or $55.9 billion in 2020 (depending upon eligibility rules)— $437.4 or $656.4 billion over 10 years.

In contrast, under an approach providing less coverage (60 percent actuarial value coverage for a premium that is 200 percent of standard premiums in the nongroup market) and no income-based subsidies—not atypical of past state high-risk pools—only 19 to 26 percent of eligibles would enroll. As a consequence of this lower enrollment, lower level of coverage provided, and lower subsidies for those who do enroll, federal costs under this alternative would be $25.3 or $30.1 billion in 2020 or $359.3 or $427.0 billion over 10 years.

However, these alternatives that would be appreciably less expensive for the government would still cost 2.5 to 3 times the amounts provided for state grants under the AHCA

and could result in millions more with high medical needs uninsured, compared to high-risk pool options that provide ACA-like subsidies. Since states can use those federal grants for purposes other than high-risk pools, additional funds will not be available for each high-risk pool if not all states choose to create them.

We underestimate the number of people eligible for a high-risk pool under the AHCA and the costs associated with the pools because we limit eligibility to those simulated to be uninsured under the AHCA's main components—those who would clearly experience a gap in coverage. However, some people with high medical needs enrolled in the nongroup market under the AHCA will also experience gaps in coverage, leading them to become eligible for the high-risk pool over time. That increase in the number of high-risk pool eligibles is not taken into account here.

High-risk pool coverage that does not provide income-based premium and cost-sharing subsidies for lower-income people leads to many more low-income, high-need people being uninsured and greatly increases family financial burdens for those who do enroll. Under ACA-like coverage and subsidization, families with incomes below 200 percent of FPL that enroll in a high-risk pool will spend a median of 6 to 8 percent of their incomes on health care. Corresponding financial burdens for the lowest-income enrollees under the traditional high-risk pool would be more than eight times as high—55 to 71 percent of family income. For those at the extremes of the distribution, health care costs would amount to well over 100 percent of family income without income-related assistance.

The AHCA would provide a single Patient and State Stability Fund that would allocate federal funds to states for funding high-risk pools, reinsurance programs, or other policy priorities. States using the funds for reinsurance could also receive waivers to permit insurers to price discriminate against those with health problems who have experienced a gap in insurance coverage. Yet there could be no connection between the reinsurance program implemented and access to adequate insurance for those priced out of the market. The AHCA does not provide states with standards for implementing high-risk pool coverage either. As such, those benefits may be inadequate to meet the needs of this vulnerable population, and direct costs to households may be too high to make access to care affordable.

At its core, insurance is intended to pay for those with high medical needs. If those incurring high claims are taken out

of the broader insurance pool, premiums in the central pool will fall, but a high percentage of the costs insurance had been covering would have to be financed another way. If government places these costs back on those with significant medical needs by not supporting them with substantial financing, access to necessary care will be significantly reduced, more medical needs will go unmet, uncompensated care will increase, and more people will become uninsured. This increase in the uninsured would be on top of the increase already engendered by the elimination of income-related premium and cost-sharing subsidies under the AHCA.

ENDNOTES

1. These funds could also be used for other purposes, such as cost-sharing subsidies and promotion of preventive services.

2. However, the Congressional Budget Office estimates that only $80 billion in federal funds would be claimed by states over this nine-year period. Congressional Budget Office. Cost estimate: American Health Care Act—Budget reconciliation recommendations of the House Committees on Ways and Means and Energy and Commerce. Washington: Congressional Budget Office; 2017. www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

3. Kaplan T, Pear R. With $8 billion deal on health bill, house G.O.P. leader says "we have enough votes." New York Times. May 3, 2017. www.nytimes.com/2017/05/03/us/politics/gop-eyes-8-billion-addition-to-win-a-crucial-vote-to-the-latest-health-bill.html?_r=0.

4. Pollitz K. High-risk pools for uninsurable individuals. Menlo Park, CA: Kaiser Family Foundation; 2017. www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals.

5. Blumberg L. High-risk pools—merely a stopgap reform. N Engl J Med 2011;364(e39). DOI: 10.1056/NEJMp1100112.

6. National Association of State Comprehensive Health Insurance Plans. Pool enrollment survey. 2016. naschip.org/2016/PoolEnrollmentSurvey2016.pdf.

7. Pollitz K. High-risk pools for uninsurable individuals. Menlo Park, CA: Kaiser Family Foundation; 2017. www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals. Communicating for Agriculture. Comprehensive health insurance for high-risk individuals: A state-by-state analysis. Fergus Falls, MN: NASCHIP; 1996.

8. Pollitz K. High-risk pools for uninsurable individuals. Menlo Park, CA: Kaiser Family Foundation; 2017. www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals.

9. Cohen SB and Uberoi N. Differentials in the concentration in the level of health expenditures across population subgroups in the U.S. Statistical brief #421. Rockville, MD: Agency for Healthcare Research and Quality; 2013. meps.ahrq.gov/data_files/publications/st421/stat421.pdf.

10. Pollitz K. High-risk pools for uninsurable individuals. Menlo Park, CA: Kaiser Family Foundation; 2017. www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals.

11. Mapping America's Futures. Urban Institute website. apps.urban.org/features/mapping-americas-futures. Published 2015.

12. Buettgens M. The Health Insurance Policy Simulation Model (HIPSM) methodology for 2016. Washington: Urban Institute; 2016.

13. More detailed methodology is available at Buettgens M. Health Insurance Policy Simulation Model (HIPSM) methodology documentation. Washington: Urban Institute; 2011. www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf

14. The MEPS-HC began identifying those with cancer and those with chronic bronchitis in 2008. Our analysis relies on six years of merged MEPS-HC data (data years 2007 through 2012) because of the small sample sizes of people with some of the chronic conditions. Because cancer and chronic bronchitis were not identified in all six years, they are not included as indicators that would qualify someone for high-risk pool enrollment, decreasing the number of people we would otherwise identify as risk-pool eligible.

15. Claxton G, Cox C, Damico A, Levitt L, Pollitz K. Pre-existing conditions and medical underwriting in the individual insurance market prior to the ACA. Menlo Park, CA: Kaiser Family Foundation; 2016. files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA.

16. These percentage of income caps are the 2017 levels for caps under the ACA; our estimates allow those caps to grow over time, consistent with ACA rules.

17. Congressional Budget Office. Cost estimate: American Health Care Act—Budget reconciliation recommendations of the House Committees on Ways and Means and Energy and Commerce. Washington: Congressional Budget Office; 2017. www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

18. If policies are not put in place to effectively restrict those with employer-based coverage from qualifying for a high-risk pool, or if policies are put in place that decrease the likelihood of employers offering coverage, the number of people eligible for high-risk pools could increase by a factor of six or seven (not shown).

19. The ACA-like approach uses the current-law premium tax credit and cost-sharing reduction schedule, extending the assistance offered to those at 100 percent of FPL to those with incomes below that level who are not eligible for Medicaid or other public coverage, do not have access to employer-based insurance deemed affordable, and are not undocumented. This extension is critical because the AHCA would result in changes to Medicaid eligibility. In addition, we extend the premium tax credit percentage of income cap that the ACA offers to those at 400 percent of FPL to those with incomes above that level who would otherwise meet the eligibility criteria for marketplace assistance. This extension is also critical because without any assistance, high-risk pool coverage would be too expensive even for the bulk of higher-income people.

20. However, the Congressional Budget Office estimates that only $80 billion in federal funds would be claimed by states over this nine-year period. Congressional Budget Office. Cost estimate: American Health Care Act—Budget reconciliation recommendations of the House Committees on Ways and Means and Energy and Commerce. Washington: Congressional Budget Office; 2017. www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf.

21. If all federal funds are not drawn down, remaining funds will be allocated to both states that did and did not put a plan in place. In the case of the latter, the funds would be used to finance and invisible risk pool.

22. While only people meeting the eligibility criteria defined for this analysis can enroll in the simulated high-risk pool, financial burdens take all members of the enrollee's family and their health care costs into account.

23. Blumberg L and Holahan J. "Don't let the talking points fool you: it's all about the risk pool." Health Affairs Blog. 2016. http://www.healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool.

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