

“Protecting America’s Sick and Chronically Ill”

House Committee on Energy and Commerce

Subcommittee on Health

Thomas P. Miller, J.D.

Resident Fellow

American Enterprise Institute

April 3, 2013

## Summary Points

- Pre-existing condition insurance plans represented a poorly designed, half-hearted gesture within the ACA, aimed primarily at minimizing political risks rather than addressing a serious problem more immediately and comprehensively. The PCIP program never received sufficient funding to do its job seriously.
- The political ideology behind the core policies of the ACA trumped targeting the smaller, but significant, problem of several million Americans with limited or no insurance coverage due to serious pre-existing health conditions and addressing it more effectively.
- The PCIP program managed to solve less of the problem (fewer enrollees), at a higher per-person cost, while still running out of money. At the same time, it discouraged continuation beyond 2013 of better, tested, state alternative mechanisms (better-funded high-risk pools).
- Instead, we should commit a generous amount of a series of capped annual appropriations to support continued operations of state HRPs and/or restructured PCIPs, to be revisited upon subsequent evidence of larger enrollment demand or higher (but medically necessary) costs. Avoid early commitments to open-ended entitlement formulas
- Keep as many older state HRPs as possible in business post-2013, as an “insurance” policy against major problems in exchange implementation and individual mandate enforcement/compliance. Allow such coverage to be considered “qualified insurance” under ACA to minimize post-2013 disruptions in the continuity of coverage and care.
- Remember that the pre-existing condition issue is still a largely limited, modest problem. Solve it, instead of using it as a political excuse to hijack the REST of the private insurance market.

Thank you Chairman Pitts, Vice Chairman Burgess, Ranking member Pallone, and members of the Subcommittee for the opportunity to speak this morning on protecting America's sick and chronically ill.

I am speaking today as a health policy researcher, a resident fellow at the American Enterprise Institute (AEI) and author of several chapters on pre-existing health condition problems in books published by AEI and the Pioneer Institute, respectively. I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based think tanks.

The subject of this hearing involves a limited, but chronic, problem whose condition was not improved, and arguable may have been worsened, by the Affordable Care Act (ACA). My testimony will highlight the various shortcomings of the Pre-existing Condition Insurance Plan (PCIP) components of the ACA; analyze the overall law's faulty diagnosis of the size, scope, and causes of coverage problems for Americans with high-risk/high-cost health conditions; summarize what we should have learned; and propose some alternative policy reforms going forward.

Better options have been limited, if not completely foreclosed, under current law, but that is no excuse for tolerating an unsatisfactory situation or making it worse.

Basically, the PCIP provisions in the ACA were drafted as a politically cosmetic afterthought. They were poorly designed and underfunded, because they were seen as little more

than a temporary, tenuous bridge to a far grander political scheme for a radically reshaped set of health insurance arrangements (beginning in January 2014).

### *PCIP's Political History & Legislative Provisions*

For several decades before the ACA, a majority of states (eventually reaching 35 in the year before its enactment) instituted and administered state high-risk pools (HRPs) as important mechanisms to ensure access to health coverage for Americans facing potentially high-cost health conditions. In the 2008 presidential campaign, Senator John McCain proposed expansion of such state-run HRP coverage, with additional federal funding, as part of a broader reform of the health care system. His opponent, then-Senator Barack Obama, as well as other congressional Democrats, were rather disdainful of this approach during the campaign. The future president's health plan at that time made no room for separate high-risk pools.

When the new Obama administration and its Capitol Hill allies began to develop their health care legislative plans in 2009, they relied instead on mandates and subsidies for private insurance – along with a substantial expansion of Medicaid – to move toward universal insurance coverage. The new health law would include an outright ban on insurers' excluding pre-existing conditions from coverage, and it would prohibit insurers' from requiring people with higher health risks to pay higher premiums (although older plan enrollees and smokers would still pay more than younger and tobacco-free ones in individual market plans; up to a point).

Two cautionary considerations led to a limited revival of the high-risk pool approach during the later stages of the ACA's development. The ACA's reliance on an individual mandate on all Americans to purchase federally required coverage might fall short; for legal, political, or practical reasons. In that case, substantial resistance to retaining or purchasing required coverage

might wreak havoc with the ACA's other complex cross-subsidy schemes through insurance regulation (such as guaranteed issue, modified community rating, and essential health benefits).

Perhaps more important, the new insurance system and expensive taxpayer subsidies to finance it were not scheduled to kick in fully until 2014 (in part, to reduce the initial, visible 10-year budgetary costs of the ACA as a whole). The Obama administration and Capitol Hill supporters of the ACA approach knew they had to offer "something" to voters to address pre-existing condition coverage problems in the interim from 2010 to 2014. Hence, the return of high-risk pools in a newer form, as federally funded mechanisms eventually labeled "Pre-Existing Condition Insurance Plans."

The current administration may not always be effective in solving health policy problems, but it is much quicker and more adept at changing the name of whatever isn't working well and needs a stint in the public policy equivalent of the witness protection program for new identities (see, e.g., "marketplaces" as the 2013 name for unpopular "health exchanges").

The final law required that high-risk pools for people with pre-existing conditions be established within three months of the law's enactment (early July 2010) and operate until January 1, 2014, when the new insurance rules and subsidies would go into effect. These high-risk pool provisions were hastily cobbled together as an afterthought to ACA's other, more sweeping reforms. Their basic structure and the early experience in implementing them remain likely to exacerbate, rather than resolve, the problems faced by states and patients.

For procedural and political reasons, Democratic congressional leaders had to adopt the Senate's sketchy version of high-risk pools included within a bill originally passed in December 2009. The new pools would operate very differently from the high-risk pools already established

in 35 states that were designed to operate with even more limited resources. The new state pools under ACA rules cannot allow any exclusions or waiting periods for coverage of pre-existing conditions. Age-based premium variation must be compressed (no greater than 4:1). Cost-sharing is restricted (though not extremely). Most important, enrollees can only be charged standard rates (even though their likely claims costs are significantly higher). Even the House version of high-risk pools passed in November 2009 (HR 3952) allowed premiums to be as high as 125 percent of the prevailing standard rate in a state's individual market (still the low end of what most existing state pools charged at the time).

Those final rules were a significant departure from the practice of all then-current, state-based HRPs. Insurers in the new risk pools would be required to pay at least 65 percent of the costs of covered medical treatments and procedures (clashing with some states' established practices that required patients to pay for a greater portion of their treatments). In effect, the ACA aimed to impose on the new high-risk pools many of the restrictions it will place on insurance coverage, benefits, and premiums in the health exchanges to be established in 2014 — but starting three and a half years before the latter were fully drafted and implemented.

However, both the earlier Senate and House versions of the health reform law, as well as the final one, tried to limit high-risk pool eligibility to those individuals already uninsured for at least six months. The House bill did establish somewhat better-defined “medically eligible” categories for such subsidized coverage (previously denied private coverage, offered such coverage with condition limits, or offered coverage at rates above those for high-risk pool coverage within the previous six months) than simply the Senate's looser requirement in section 1101(d) of what became the final law's language that an enrollee also must have a pre-existing

condition as determined by the guidance of the Secretary of the U.S. Department of Health and Human Services (HHS).

*Despite Slow Take Up, Underfunded PCIP Operations Run Out of Money*

By most initial estimates, the law also appeared to underfund substantially the PCIPs it requires, authorizing a total of only \$5 billion for three and a half years of operation. The ACA provisions for these high-risk pools tried to get around the law's budget limitations by authorizing the newly mandated pools -- in section 1101(g) (4) -- to "stop taking applications for participation in the program...to comply with the funding limitation" when the money runs out. It also vaguely empowers the HHS secretary -- in section 1101(g) (2) -- to make "such adjustments as are necessary" to eliminate any deficit in the program during any fiscal year. In addition, the law suppresses potential demand for new high-risk pool coverage by limiting eligibility to people who have already been uninsured for six months. Merely having a pre-existing condition, and being turned down for coverage because of it, is not enough to gain access to subsidized coverage in the new pre-existing condition plans. Nor can one gain admission to the new pools if one is already enrolled in an existing state HRP but facing higher premiums with greater cost-sharing. After all, people in these circumstances are not already "uninsured for six months."

In other words, the secretary of HHS was first authorized to determine which pre-existing conditions make a potential enrollee eligible for federal PCIP coverage, and then, if budget funds ran short, the secretary was required to figure out how to avoid actually providing that person with the promised health-care coverage. The results seemed easy to foresee: waiting periods, abruptly closing enrollment, benefit limits, reducing plan options, raising cost sharing, and rationing of care — all the practices for which the ACA's champions attacked the private insurance industry and already-operating state HRPs.

With the announcement by HHS in mid-February of this year that it was suspending acceptance of new enrollment applications in federal and state PCIPs (as of early March 2013) until further notice, we have arrived at this inevitable point; albeit perhaps a little later than first estimated.

In April 2010, the chief actuary of HHS released a cost projection for the new program, predicting that the \$5 billion the law allocated for three-and-a-half years of high-risk pools would in fact be exhausted in the program's first or second year. The actuary estimated that only 375,000 people shut out of insurance elsewhere would obtain health care coverage through the high-risk pools — a number that would fall far short of the potentially targeted population.

However, early experience under the PCIPs turned out quite differently. As of April 30, 2011, enrollment in the program was a little over 20,000. Enrollment gradually rose to 107,139 through January 31, 2013. An earlier estimate as of November 30, 2012 set the total number of people with medical conditions who have received coverage under PCIP at one time (in other words, total enrollment in the program's history, rather than its current enrollment) at 134,708. In any case, enrollment has fallen dramatically short of expectations, even after HHS redesigned its PCIP rules in mid-2011 to lower premiums even more and to make it easier for applicants to document that they had a pre-existing condition (sort of equivalent to a mid-summer "sale" on such coverage).

One might ask whether flawed design and enrollment assumptions for the new, relabeled high-risk pools by the Obama administration and its congressional allies initially reflected reluctance to acknowledge the total cost to fully fund them on the scale that was commensurate with what those same parties claimed was a much larger pre-existing condition problem that justified other provisions of the ACA. Simply funding a potentially robust PCIP solution would

diminish the rationale for controlling even more of the private health insurance market through sweeping regulation, tight premium controls, and complex cross subsidies.

Or did the more limited funding dedicated to PCIPs under the law reflect the tacit acknowledgement that the actual pre-existing condition problem had been greatly exaggerated? For example, HHS suggested in August 2009 that up to 12.6 million Americans recently had been discriminated against by insurers on the basis of their health status. In January 2011, HHS upped the pre-existing condition overestimation ante, with the even extreme claim that up to 129 million people could be denied affordable coverage without ACA-style health reform. The latter report blurred the difference between the many people with some existing medical condition and those actually denied coverage due to their health status,

Most likely, the mismatch between the size of the purported problem and the amount of budgetary resources devoted to solving it represented a combination of both conflicting political impulses, along with the perceived budgetary imperative to suppress demand for such high-risk pool coverage and stretch out the limited taxpayer funding at least until broader coverage expansions under Medicaid and the new exchanges kicked in after the end of 2013.

#### *Reasons behind Low Enrollment*

A July 2011 report by the Government Accountability Office (GAO) suggested that the primary reasons for lower-than-expected enrollment were the statutory requirement that applicants be uninsured for at least six months, lack of awareness of the PCIP program, and affordability concerns (not necessarily in that order of importance).

The requirement that eligible enrollees for PCIP must first meet a 6-month period of being uninsured up to the time of their enrollment application was indeed a fundamentally

flawed condition for such coverage. After all, if someone is suffering from a high-risk/high-cost condition and lacks access to any other insurance coverage, what is the public policy purpose behind then denying that person access to federally subsidized PCIP coverage? The “6-months-as-uninsured” requirement operates as the close equivalent of an initial 6-month waiting period (older state-run HRPs generally utilize waiting periods ranging from 3 months to 12 months).

GAO noted that “the segment of the uninsured population with pre-existing conditions has been difficult to identify and target.” A different observation might be that when you have trouble finding something, it might indicate it’s a smaller problem than first assumed. PCIP administrators at least finally learned by 2011 that it helps to provide financial incentives to insurance agents and brokers to help identify potential high-risk enrollees, rather than to try to bypass those parties as unnecessary and costly middlemen.

The average out-of-pocket premium for enrollees in the PCIP program in 2011 was \$407 per month. Slow enrollment in PCIP further indicates that the primary reason for lack of insurance coverage in the United States as a whole is its unaffordable cost to potential purchasers *in general* (rather than just to those with particular high-risk conditions). Offers of free or very heavily subsidized coverage might encourage more substantial enrollment (leaving aside their budgetary costs), but the broader affordability problem is much greater than the slightly higher surcharges in premiums facing most individuals with pre-existing conditions.

*Exaggerating the Size of the Uninsurable Population, for Political Marketing Purposes?*

The most likely explanation for low enrollment in PCIP is that the estimated size of the population denied coverage due to a pre-existing condition is much smaller in practice than the inexact estimates of various national surveys suggest. Older federal rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the practical economics of selling insurance to more

customers means that there is much more protection against the risk of losing (or failing to gain) coverage due to high-cost conditions than assumed by ACA advocates .

HIPAA made it unlawful for employer-sponsored plans to impose exclusions on pre-existing conditions for workers with sufficient periods of continuous group insurance coverage. This means that if a person stays covered by job-based plans long enough (roughly eighteen months ensures total protection, but lesser intervals still can provide partial protection against shorter pre-existing exclusion periods) with only very short periods of interruption in this continuous coverage, that person can move from one job to another without fear of losing insurance protection, or of having to wait longer than other new hires before gaining coverage for ailments developed before taking a new job. The new employer's plan must provide coverage on the same terms as it is offered to other employees — even if the worker already has developed an expensive medical condition, or demonstrated early indications that it may develop in the near future.

In theory, HIPAA also provided portability rights to people moving from job-based plans to individually owned coverage. The law gave state governments a few options for meeting this mandate: They could establish high-risk pools, which is the approach most states have followed; they could require that all individual-market health insurers within their respective states offer insurance to all eligible individuals, without any limits on coverage of pre-existing medical conditions; or they could use their regulatory powers to create a mix of rules that would have similar results.

Unfortunately, none of these approaches worked well enough. Too many people still risk falling through the cracks. One problem in the pre-ACA world of federal health law stemmed from HIPAA's requirement that a worker first exhaust the right to temporary continuous coverage under the former employer's plan (through a federal program called COBRA, which

lets a worker keep buying into a previous employer's insurance plan, generally for up to 18 months after leaving that job) before entering the individual insurance market without being subject to a pre-existing condition exclusion. Many workers are not aware of this requirement (though their former employers must advise them of it in a written notice). Even if they are, the premiums required to stay in an employer's plan through COBRA are often too high for workers to pay on their own. COBRA premiums must cover both the employer and employee share of costs, and such employer plans generally provide more expensive comprehensive benefits than individual-market alternatives. Unlike premiums paid in employer-based plans, these COBRA premiums do not receive any tax advantage — making them even more expensive to workers between jobs and/or other employer-sponsored coverage. As a result, many workers experience the “sticker shock” of facing this fully loaded price for the first time. They choose not to pay the noticeably higher premiums and take the risk of going without coverage until they can find new jobs (and new coverage). In so doing, they may inadvertently waive their HIPAA rights — leaving themselves vulnerable (under pre-ACA law) to exclusions and high costs for pre-existing conditions when they finally try to buy insurance on their own.

Even if a sick person abides by HIPAA's requirements and remains continuously insured — thereby maintaining protection from pre-existing condition exclusions in the individual market, nothing in current federal law *before* full implementation of the ACA's insurance requirements in 2014 prevents insurers from charging this individual more than they charge healthy people. Insurers are prohibited only from denying coverage altogether for a pre-existing condition; it is quite permissible, however, for insurance providers to charge unaffordable premiums (unless an individual state's laws happen to prevent or restrict the practice), thus producing essentially the same outcome

Pre-ACA law and regulations also provided no premium protections for persons moving between individual insurance policies. A healthy worker who left an employer plan for the individual market might find an affordable plan at first — but if she ever wanted to switch insurers (or was forced to by moving to a new state, for example), she would face the risk of having her premium recalculated based on a new health-risk assessment.

However, the problem of pre-existing condition coverage is limited almost entirely to the individual market. In 2008, at the request of HHS, health economists Mark Pauly, Bradley Herring, and Xue Song examined how people with chronic health conditions, and thus high anticipated health-care expenses, actually fared when seeking insurance in the individual market. Pauly and his co-authors found little, if any, evidence that enrollees in poor health generally paid higher premiums for individual insurance. Nor did they find that the onset of chronic conditions is necessarily associated with increased premiums in subsequent years. Existing “guaranteed renewability” requirements in federal and state law already prevent insurers from continuously reclassifying people (and the premiums they pay) based on health risks. And most private insurers already provided such protection as standard business practice before they were legally required to do so.

Although the risks of facing coverage exclusions and prohibitive premiums caused by pre-existing conditions were not a universal problem in the individual insurance market at the time of ACA’s enactment, they clearly affected many Americans. Reasonable estimates range from 2 to 4 million, out of a total population of about 260 million people under the age of 65. More important than this number alone, however, is how many more Americans know someone who has faced this situation directly, and fear that they could find themselves in the same predicament. The latter perception explains the strong public support for changing the way

insurance companies treat pre-existing conditions. Most people find it unacceptable that other citizens who have tried to act responsibly by staying insured throughout their lives can suddenly find themselves sick, perhaps unemployed as well, and unable to get adequate coverage.

On the other hand, in order to stay financially solvent, insurers clearly need some way to match premiums and likely claims costs. Because the smaller individual market often operates as a last resort for those lacking better insurance options through employers, insurers must plan for the risk that people seeking individual coverage are more likely to do so because they believe they will need substantial medical attention.

Nevertheless, there are both practical limits and basic business incentives that restrain excessive underwriting by insurers. For one thing, individual screening of health risks is expensive. Moreover, if insurers screen too aggressively, they will lose customers whose care would not in fact have been very costly. Insurance companies balance the benefits of screening against these costs in the individual market no less than in others: Indeed, the most extensive research in this area, by Pauly and Herring, has demonstrated that there is already a great deal of pooling of health risks in the individual market. (Pauly and Herring also found that there is *less* pooling than assumed in the employer-group market, due to wage offsets for some types of workers likely to incur significantly higher health care costs.)

But some people clearly have not been able to get covered due to the higher health risks they present to potential insurers.

The last comprehensive survey of the individual insurance market (in 2009) by America's Health Insurance Plans (AHIP) provided mixed findings. On the one hand, it found that 87 percent of applicants undergoing medical underwriting were offered coverage, with 65 percent of them receiving premium quotes at either standard or preferred rates. However, 34 percent of

those individual market applicants were quoted higher than standard rates (a significantly higher percentage than found in previous AHIP individual market surveys). Nevertheless, only 6 percent of all those coverage offers included condition waivers that restricted coverage of a particular health problem.

### *Can High-Risk Pools Handle Most of the Serious Pre-Existing Condition Coverage Problem?*

Before considering whether a high-risk-pool approach can handle most of the pre-existing condition problem, one needs to know how large is the potential population needing such assistance. This remains a far from simple question that is prone to exaggeration on both sides, but several serious attempts to arrive at a reliable set of estimates have been made in recent years.

In a 2001 survey by HHS, respondents were asked if they had “ever been denied health insurance because of poor health.” The data collected indicate that about 2 million people might be eligible for enrollment in high-risk pools.

In a different study, using 2006 data, the Government Accountability Office determined roughly the percentage of uninsured individuals who had at least one chronic health condition, and then applied it to census estimates of the average number of uninsured people in each state with an existing HRP. (The aim was to get a sense of how many more people might be covered by such pools if they were available to all who needed them.) The GAO concluded that as many as 4 million Americans could be covered by more generously funded high-risk pools — 20 times the number then covered by state HRPs.

More recently, University of Pennsylvania health economist Mark Pauly looked at data about the number of people with chronic health conditions whose expected medical expenses are more than twice the national average. He first estimated the total nationwide high-risk group at

around 4 percent of the under-65 population, excluding people receiving Medicaid — a number in the low millions. But Pauly ultimately concluded that the number of people who were both high-risk and looking for coverage in the individual market at any given point was far lower — on the order of tens of thousands.

Regardless of the particular sources or estimating methods, which all have their limitations, it is clear that the demand for premium assistance among those with high expected health costs substantially exceeded the pre-ACA financial capacity of then-operating state HRPs.

#### *Comparing Federal and State Approaches to Pre-Existing Condition Coverage*

Only twenty-seven states elected to administer a PCIP for their residents. Twenty-three other states and the District of Columbia chose to allow HHS to administer such plans. States are said to have some administrative flexibility in establishing their own PCIP program premium rates, insurance benefits, enforcing enrollment and appeals procedures, and determining how eligibility requirements are satisfied. However, all of those state practices must remain consistent with federal guidelines and the concurrence of HHS.

For example, federally run PCIPs do not vary premiums by smoking status or geographic region within a state, whereas 11 state-run PCIPs did the former and 7 state-run programs did the latter in 2011. Until July 2011, federal-run PCIPs did not allow potential enrollees to demonstrate evidence of a pre-existing condition by a letter with a doctor's diagnosis, whereas most state-run PCIPs allowed this option. About 7 state-run PCIPs also allowed evidence of an applicant's receiving a private insurance premium offer that was higher than the premium charged in that state's own PCIP.

Monthly premiums generally are lower in federally run PCIPs. They have been roughly 20 percent higher in state PCIPs since 2011. State-run PCIPs got off to a much better start in

enrolling individuals in 2010, but they now account for about 60 percent of the program's total enrollment. The average per member per month costs do not differ substantially between federal- and state-run PCIPs overall.

Both types of PCIPs have incurred administrative costs that run above the ACA's 10 percent limit for state-run PCIPs (19 percent of costs were administrative in state PCIPs in 2011; they amounted to 16 percent in federal PCIPs that year). Thus far, there has been no move to require rebate payments to enrollees for "excessive" administrative costs.

Among the 27 states operating PCIPs, 20 of them also administer a pre-ACA state HRP. Those states are subject to the ACA's maintenance of effort requirement that they maintain the same pre-ACA level of funding for their state HRPs until January 2014. Arguably, this provision operates as some degree of budgetary disincentive for states to administer PCIPs, because it does not apply if there is a federal PCIP in the state. .

The average PCIP enrollee is roughly three times as costly as an enrollee in a state HRP (\$32,108 per year versus \$11,140; the latter is a 2011 average cost). Note that if these figures are just *taxpayer-subsidized* costs, rather than total health care costs including enrollees' premiums, the latter appears to be out of line with a GAO finding in a 2009 report that *subsidized* costs in state HRPs averaged \$4341 in 2008. State HRPs continue to have much larger enrollment – approximately 223,574 (some states only report 2012, rather than 2013, numbers).

Some analysts excuse the much higher PCIP costs per enrollee, for a smaller population, as due in part to a higher concentration of very expensive enrollees, including those who have lacked insurance coverage and regular access to health care for a longer period of time (due to the requirement that they first be uninsured for at least six months). In addition, as least one-quarter of state HRP enrollees are individuals who have gained portability access to individual

market coverage from recent continuous coverage in the employer group market, and they are arguably less costly to cover (although no official source appears to be estimated how much of a difference this actually makes).

### *Key Takeaway Points*

Pre-existing condition insurance plans represented a poorly designed, half-hearted gesture within the ACA, aimed primarily at minimizing political risks rather than addressing a serious problem more immediately and comprehensively. PCIP coverage served more as a cosmetic patch to cover the consequences of slow implementation of complex coverage provisions scheduled to begin in January 2014 (nearly four years after enactment of the health law).

The PCIP program never received sufficient funding to do its job seriously. That indicates where it stands in the relative level of priorities for the drafters of the law. The relatively small amount of funding and limited attention to the program's structural details appear to conflict with the exaggerated rhetoric of the Obama administration in claiming that the extensive problems of lack of coverage for tens of millions of Americans with pre-existing health conditions were the primary political rationale for enacting the ACA's regulatory, coverage, and financing provisions. Either the funding should have matched the claims of major problems, or the claims should have matched the funding commitment levels.

The political ideology behind the core policies of the ACA (installing guaranteed issue, community rating, mandated coverage, richer standard benefits, and federal regulation of health insurance) trumped targeting the smaller, but significant, problem of several million Americans with limited or no insurance coverage due to serious pre-existing health conditions and addressing it more effectively.

The ACA's PCIP program managed to solve LESS of the problem (fewer enrollees), at a higher per-person cost, while still running out of money. At the same time, it discouraged continuation beyond 2013 of better, tested, state alternative mechanisms (better-funded high-risk pools).

By setting its premiums for all at no more than standard rates --- contrary to better practices of older state HRPs which charge more, and also imposing a 6-month spell as uninsured to qualify for coverage, PCIP only succeeded in mostly enrolling very desperate, high-cost individuals who had no other alternatives for coverage. This may account for a portion of the program's much higher per-enrollee claims costs, but more extensive audits of the plans' administrative operations and care management practices are needed to ascertain causes and effects.

States administering pre-ACA HRPs did a better job by charging enrollees somewhat higher premiums, offering less comprehensive coverage, and focusing on those individuals who presented the most serious and costly medical conditions. However, they, too, still need more robust sources of funding to do their job more thoroughly and effectively.

Simply trying to average (and hide) the same total health care claims costs across a somewhat wider base (the ACA approach) may redistribute them, but it does not reduce them.

If the forthcoming health exchanges are plagued by premium spikes, implementation misfires, limited enrollment, and adverse selection, they may more closely resemble somewhat larger versions of state-level PCIPs than more competitive alternatives to the current private insurance market.

*Policy Lessons and Partial Fixes*

I have written elsewhere about more comprehensive repeal and replacement of most, if not all, ACA provisions, including those involving coverage of pre-existing health conditions. The current political and legislative environment makes enactment of those proposals (continuous coverage incentives, more generous federal assistance to state high-risk pools, better-targeted insurance coverage subsidies) in the near term unlikely. In the meantime, policymakers should consider the following:

- Recognize that health care markets are local, not national. So too are problems for persons with high-cost conditions.
- The rhetoric of delegating administration of sensitive health policy provisions to state governments needs to be matched by the reality of federal officials letting go of tight reins and trusting state officials with more discretion over eligibility, benefits, and appeals issues, within much broader outcome-oriented federal parameters.
- Be very cautious about imprecise estimates (guesses) regarding the scale, scope, and costs of the medically uninsurable and others with inadequate resources to handle very high-cost/high-risk health conditions.
- Commit a generous amount of a series of capped annual appropriations to support continued operations of state HRPs and/or restructured PCIPs, to be revisited upon subsequent evidence of larger enrollment demand or higher (but medically necessary) costs. Avoid early commitments to open-ended entitlement formulas
- Publicly subsidizing the high-cost “tail” of health risks can strengthen the rest of the insurance market. (See previous experience with expansion of Medicare insurance coverage for the disabled).

- Raise unsubsidized premiums charged for most enrollees in high-risk pool plans (to at least 150 percent of standard rates), but then provide income-based subsidies for lower-income persons. Separate the issue of income support from that of protection against losing or lacking coverage solely due to elevated personal health risk.
- Develop better targeted and more intensive care management tools within HRPs or PCIPs for the highest-cost cases.
- Complementary policy reforms can help (better portability from group to individual market with creditable coverage, don't require exhaustion of COBRA benefits, retarget premium subsidies, build information transparency mechanisms that reward better patient choices and provider practices)
- Keep as many older state HRPs as possible in business post-2013, as an "insurance" policy against major problems in exchange implementation and individual mandate enforcement/compliance. Allow such coverage to be considered "qualified insurance" under ACA to minimize post-2013 disruptions in the continuity of coverage and care.
- If the overall costs of health care don't rise more slowly, and individual incomes don't rise more rapidly, in the near future, no amount of subsidized insurance tinkering can keep up with a larger problem. Incentivize better personal health behavior and health care decisions, within a more competitive and accountable health care marketplace.
- Remember that the pre-existing condition issue is still a largely limited, modest problem. Solve it, instead of using it as a political excuse to hijack the REST of the private insurance market.

Thank you again for the opportunity to present this testimony. I look forward to your questions.