How to Cover Pre-existing Conditions

James C. Capretta and Tom Miller

The health-care legislation enacted this spring followed more than a year of heated, rancorous debate. But rather than subdue the public’s passions, the bill’s passage has only stoked them. Opposition to the new law remains very high, and Republicans have made clear their intention to push for its repeal if they gain control of Congress and the White House in 2010 and 2012.

For their part, President Obama and other champions of the legislation insist that public attitudes will soon change. More Americans will come to appreciate the law, they argue, once people have a better grasp of its benefits. And foremost among these benefits is the law’s prohibition of “pre-existing condition” exclusions in health insurance — which would prevent insurance companies from denying coverage to customers with serious medical problems.

Like most of the health-care bill’s major provisions, this ban will not take full effect until 2014. But the mere prospect of finally addressing the “pre-existing condition problem” is held up as an enormous selling point of the law. At long last, the bill’s advocates claim, America has a solution to a profound failing of our current system — a solution that will eliminate a source of worry for millions, and that opponents would not dare undo. Indeed, while describing the plight of a young woman in the audience at a rally he attended in April, Obama told the crowd: “If [opponents of the law] want to look at Lauren Gallagher in the eye and tell her they plan to take away her father’s ability to get health insurance… they can run on that platform.”

The president’s dramatic talents notwithstanding, the choice he presents is a false one. We do not face an either-or showdown between

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cruelly denying sick people treatment and a massive new federal health-insurance entitlement. The problem of covering Americans with pre-existing conditions is certainly real, but the notion that the only way to solve it is through a massive transformation of America’s health-care system—one that will increase costs, raise taxes, displace millions of the happily insured, create a new entitlement, and undermine our private insurance sector—is simply wrong.

The case for repealing the newly enacted law, then, is not that there are no problems to solve in American health care. Rather, it is that there are far better solutions available.

**THE PRE-EXISTING DILEMMA**

The challenge of covering people with pre-existing conditions is a function of the way our health-insurance system has evolved over many years—and especially of the fact that it is largely employer-based, voluntary, and distorted by complex subsidies and regulations that favor some insurance purchasers over others.

Since most working Americans get health insurance as a benefit of employment, losing or changing jobs often means losing or changing insurance coverage. As a result, most people are not continuously covered by the same plan throughout their lives. If they move directly from one employer-sponsored health plan to another, the disruption is usually not a problem (for reasons laid out below). But whenever someone, by choice or necessity, leaves employer-sponsored insurance to purchase health insurance on his own, the switch in coverage can present several challenges.

In a voluntary individual insurance market, insurers must have some means of preventing large mismatches between the premiums they take in and the claims they will likely need to pay out. The classic form of such a mismatch is the case of a consumer who waits until he is sick to purchase or enroll in an individual insurance plan. If an insurer offers coverage to such a person without pricing the expected costs of the enrollee’s illness into the premium, the expense of paying out medical claims will almost certainly exceed the premiums collected. The practice will also encourage other people not to buy insurance until they need to draw on it—a problem known as “adverse selection.” Why pay for insurance when you’re healthy if you can buy it for the same price when you get sick? It would be the equivalent of purchasing auto
insurance only after you’ve totaled your car — and insurers would obviously go bankrupt if this were their business model.

Insurers selling directly to individual consumers use two practices to prevent widespread adverse selection. First, they try to take into account the health status of prospective customers when determining their premiums (a process called “underwriting,” by which they consider an applicant’s age and other demographic factors and, in certain cases, medical history). Second, in some instances, they deny coverage of pre-existing conditions for a set period of time after a customer enrolls, so that if he buys insurance (or changes insurers) only after he has already been diagnosed with a costly condition, he cannot immediately use the new coverage to pay for medical claims associated with his existing ailment. Taken together, these two practices have led to the pre-existing condition problem: People who are sick can find themselves without health-care coverage, and without the ability to secure coverage at an affordable price, sometimes through no fault of their own.

From the rhetoric of some politicians, one might think this dilemma lies at the very core of America’s health-care crisis. But in fact, the problem is relatively contained. Senior citizens can get health-care coverage through Medicare; the poor have Medicaid; and most Americans who have employer-based coverage do not run across the “pre-existing condition problem.” It primarily affects a subgroup of sick, working-age Americans — those who do not receive health coverage from their employers, do not qualify for Medicaid, and are not able to buy coverage in the individual market because their health conditions make their premiums too high (or cause insurers to reject them altogether).

Pre-existing conditions are not much of an issue in the (vastly larger) employer-based insurance market for several reasons. First, job-based plans are implicitly “community rated” products — meaning that everyone who is covered by the same plan is charged more or less the same price. Underwriting of individual patients is therefore minimal, as insurers sell group plans to firms based on the risk profile of the entire work force. (The high costs of caring for some workers with diabetes, for instance, are balanced by the relatively low costs associated with their more healthy co-workers.) Risk levels in employer plans are also somewhat contained by the plans’ very nature, in that only relatively healthy people are likely to show up to work regularly, stay employed, and gain access to job-related insurance benefits.
Of course, these techniques for spreading risk do not always work perfectly. Some smaller firms may have fewer workers across whom an occasional high-cost risk might be spread; in some industries—like automobile manufacturing or coal mining—the balance between new “healthy” workers and older “unhealthy” ones may be unfavorably tipped by demographic and economic factors. Even within larger firms, there is evidence that employers sometimes reduce cash wages to adjust for the cost of insuring some workers (particularly older and more obese ones) whose actual health-care expenses are likely to be much higher than average. Still, on the whole, the sick and the healthy pay roughly the same premiums in job-based plans. And insurers see it as a sustainable business practice, because selling to a group allows for the balancing of high and low risks.

Moreover, in 1996, Congress provided an important protection to workers by making it unlawful for employer-sponsored plans to impose exclusions on pre-existing conditions for workers in continuous group insurance coverage. This means that if a person stays covered by job-based plans long enough (usually six months), he 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 he may have developed. If a new hire maintained insurance in his old job, his new employer’s plan must cover him—even if the worker has developed an expensive medical condition.

In theory, this law—called the Health Insurance Portability and Accountability Act (or 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, as discussed below, is the approach most states have followed); they could require that all individual-market health insurers within their 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. But unfortunately, none of these approaches has worked well enough, and today many people still end up falling through the cracks.

The problem starts with HIPAA’s requirement that a worker first exhaust his right to temporary continuous coverage under his former employer’s plan (through a federal program called COBRA, which lets workers keep buying into their employers’ insurance plans, generally for
up to 18 months after leaving their jobs) before he can enter the individual insurance market without a pre-existing condition exclusion. Many workers are not aware of this requirement (though 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 them to pay. This is because COBRA premiums must cover both the employer and employee share of costs, and generally provide more expensive comprehensive benefits than individual-market alternatives. And unlike premiums paid in employer-based plans, these COBRA premiums do not receive any tax advantage—making them more expensive still. As a result, many workers facing this fully loaded “sticker shock” price choose not to pay the premiums, simply hoping for the best until they can find new jobs (and new coverage). In so doing, they inadvertently waive their HIPAA rights—leaving themselves vulnerable to exclusions and high costs for pre-existing conditions when they try to buy insurance on their own.

But even if a sick person abides by HIPAA’s requirements and remains continuously insured—thereby protecting himself from pre-existing condition exclusions in the individual market—nothing in current federal law prevents insurers from charging him more than they charge healthy people. Insurers are prohibited only from denying coverage for a pre-existing condition altogether; 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 achieving essentially the same outcome.

Likewise, current law and regulations provide no premium protections for persons moving between individual insurance policies. A healthy worker who leaves an employer plan for the individual market might find an affordable plan at first—but if he ever wanted to switch insurers (or was forced to by, say, moving to a new state), he would face the risk of having his premium recalculated based on a new assessment of his health.

Of course, the fact that the problem of pre-existing condition coverage is limited almost entirely to the individual market does not mean that it pervades that market. In 2008, at the request of the U.S. Department of Health and Human Services, health economists Mark Pauly and Bradley Herring 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 Herring 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.

But even if the exclusions and prohibitive premiums caused by pre-existing conditions are not a universal problem in the individual insurance market, they clearly affect many Americans. 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 the sheer number, however, is the fact that many Americans know someone who has faced this situation directly, and fear that they could find themselves in the same boat—which explains the strong public support for changing the way insurance companies treat pre-existing conditions.

Most people find it unacceptable that responsible fellow citizens who have tried to stay insured throughout their lives can suddenly find themselves sick and unable to get adequate coverage. On the other hand, insurers clearly need some way of aligning premiums and risks in order to stay financially solvent. And because the smaller individual market now 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 doing so because they believe they will need substantial medical attention.

Of course, insurers have incentives to avoid excessive underwriting. For one thing, screening is expensive. For another, 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. But some people clearly still cannot get covered.

The question is what should be done for them. The most effective solution would be not heavy-handed regulation, but rather a new insurance marketplace built around truly portable, individually owned insurance. If households, not firms, chose and controlled their own insurance plans, people would no longer face the risks that
come with changing coverage based on new employment arrangements. By carrying the same insurance plan from one job to the next (or even through periods with no job at all), individuals would keep their coverage even as their health status changed. Moreover, insurers would have strong incentives to do what they could to keep their enrollees healthy, knowing full well that some of them could be enrolled for many years. That is how health insurance is supposed to work.

But moving to true insurance portability will not be easy. It will require fundamental reform of the tax treatment of health insurance in order to level the playing field between plans owned by employers and those owned by individuals, as well as a reworking of some current insurance regulations. For now, both reforms face long political odds. And even if these changes were to happen, we would still need some way of covering people who already suffer from costly health conditions (and so could not easily buy their own portable insurance, even once a new system got up and running).

Short of such a transformation, then, what can be done to help people shut out by the current system? Some states have attempted to address the problem by imposing price controls on health-insurance premiums—requiring insurers to sell to all comers, regardless of their health status (a rule called “guaranteed issue”) and at standard rates (“community rating”). But this has only caused insurers to increase the premiums they charge everyone else—even young, healthy customers—in order to make up for the losses associated with the enrollment of these more expensive cases at below-cost premiums. And when premiums rise for younger and healthier customers in a voluntary marketplace, a significant number of these people—weighing the low risk of an expensive illness against the high cost of buying health insurance—will drop out of coverage altogether. The pool of enrollees thus becomes older and less healthy, further driving up premium costs for the enrollees who remain. The resulting vicious cycle triggered by excessive regulation can cause so many consumers and insurers to flee that the entire market can collapse. This is what happened in Washington state and Kentucky when such reforms were tried in the 1990s, before they had to be “repealed and replaced.”

The new federal health-care legislation, meanwhile, aims to solve the “pre-existing” problem by dramatically transforming our entire health-care system—even though most insured Americans are quite happy
with the coverage they have — and by creating an enormous and expensive system of regulations and entitlements. Obamacare thus creates an even greater risk of system collapse — in this case, with taxpayers picking up the pieces.

As so often happens, though, the model for a promising national solution has begun to emerge from the states. Across the country, state policymakers have turned to an approach that does not require a fundamental transformation of the insurance marketplace: the creation of high-risk pools. Unfortunately, these state-level efforts have not been sufficiently ambitious or adequately funded; they would also be badly undermined by the new federal health-care law. But if that law is in fact repealed, reformers concerned about the problem of pre-existing conditions should champion a system of robust, well-funded high-risk pools as a smart and effective solution.

Promise and Shortcomings

High-risk pools are basically a policy mechanism for bridging the gap between the high cost of providing insurance to patients with predictably expensive pre-existing health conditions and the comparatively low premiums those patients can afford. In most states that have established such programs, the pool is a highly regulated, independent non-profit entity that functions as an insurance program, offering a selection of health-benefit plans. The work of managing benefits and interacting with customers (such as the collection of premiums and the payment of claims) is usually contracted out to participating private insurance companies. In other states, the risk-pool program is run more directly by the state health or insurance department (which, again, contracts out most key management functions to private insurers).

People who try to get insurance and are denied, or who receive only unaffordable coverage offers, may apply to participate in the high-risk pool program; the program’s administrators then determine each applicant’s eligibility. Common eligibility criteria in the states include one or more of the following: having been rejected for coverage, based on health reasons, by private insurers; having been refused coverage except at rates exceeding the subsidized premium offered in the high-risk pool; having received private coverage offers, but only with restrictive riders or pre-existing condition limitations; the existence of particular medical conditions (like HIV/AIDS, cancer, or diabetes) presumed to result in
rejection by health insurers; or being a dependent of a person eligible for high-risk pool coverage. The pools also often cover people who, having maintained continuous coverage under HIPAA rules, need to find new insurance arrangements in the individual market.

Because everyone in the pool has, by definition, a high-risk profile, average claim costs are necessarily quite high. But eligible individuals’ premiums are capped at various levels above standard rates; beyond those caps, premium payments are fully subsidized from various public revenue sources. The idea is that people will pay only the premiums they can afford, and the difference between those payments and the real cost of insurance will be made up by taxpayers.

In theory, such pools should not only help provide coverage for people with pre-existing conditions, but should also help lower premium costs in the rest of the insurance marketplace. This is because the uncertainty involved in covering the least healthy consumers would be removed from the cost structure financed by normal premium payments. When that is done, premiums go down and become more attractive for lower-risk customers, thus further expanding the pool of premium payers (and again lowering costs for everyone else).

The first high-risk pools were instituted in Minnesota and Connecticut back in 1976; today, 35 states operate some version of the plans. In 2008, approximately 200,000 people were enrolled in state high-risk pools; the average length of enrollment was three years (about 20 to 25% of enrollees leave each year), and the average age of those enrolled was 49. The premium costs that enrollees in these high-risk pools must pay are generally capped at levels between 125% and 150% of standard market rates (although some states—like Texas and South Carolina—go up to 200% or higher, while others—like Minnesota—cap them even below 125% for some categories of beneficiaries).

Premium revenue contributed by enrollees amounted to just over half (54%) of total high-risk pool funding in 2008; the rest came from a combination of assessments on private insurance carriers (23.2%), state general revenues (5%), state tobacco taxes (2.2%), and federal grants (1.7%). (A total of about $286 million has been awarded to states to establish new high-risk pools or subsidize existing ones under a federal program in operation since 2002.) The less transparent categories of “other assessments” (7.4%) and “other” (6.3%) comprised the rest of the funding sources.
Although high-risk pools have helped hundreds of thousands of Americans, they have nonetheless fallen far short of meeting the needs they are meant to address. In addition to the large differences among the state plans in terms of eligibility rules, benefit design, premium prices, subsidies, and financing, there are also huge discrepancies when it comes to effectiveness.

The pools’ main shortcoming in every instance, though, is the large mismatch between the number of people who need them and the amount of money made available to subsidize them. Just how many people might face pre-existing condition exclusions and might benefit from high-risk pools is not a simple question, but several serious attempts have been made in recent years to arrive at a reliable figure.

In a 2001 survey by the Department of Health and Human Services, 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 high-risk pool. (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 now covered.

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% 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, however, it is clear that the demand for premium assistance among those with high expected health costs far exceeds the state high-risk pools’ current financial capacity.
Assuming that the higher ranges of these estimates are correct, what would it cost to use high-risk pools to cover between 2 and 4 million people? For an initial assessment, it might be best to start with the 2008 average subsidized cost of $4,341 per pool enrollee—the amount states contributed to their programs beyond the premiums paid by enrollees. If we assume that as many as 4 million more people might need (and seek) high-risk pool coverage, the annual cost of public subsidies could be as high as $17 billion. Other variables might include whether the new enrollees are likely to be somewhat less costly than current ones (since their situations might be less dire); whether benefits and cost-sharing levels are more or less generous than under current high-risk pool coverage; and whether additional income-based subsidies for enrollees are included. All of this suggests a rough estimate of between $15 and $20 billion per year for a comprehensive set of high-risk pool programs.

Given that cost, and the fiscal stresses most state governments are feeling these days, it is not surprising that state-based pools have been underfunded and closed off to many potential beneficiaries. Indeed, the most common complaint about high-risk pools has been that their coverage remains too expensive and too limited. Most state pools offer comprehensive insurance benefits (of the sort that most people in employer-based coverage receive), generally with 20% co-insurance, although they tend to impose higher deductibles (and some have lower lifetime-coverage limits) than private insurers. Furthermore, to control costs, all current state high-risk pools actually impose pre-existing condition exclusion periods—ranging from two months to one year—for enrollees who forfeited (or never accrued) portability rights under HIPAA. Facing fiscal pressures, many states are also not particularly aggressive in trying to boost high-risk pool enrollment through advertising and outreach to potential enrollees; nor have they been eager to pay commissions as generous as those paid by private insurers to insurance agents who bring in customers.

In short, the lack of adequate financing still leaves millions of potential high-risk beneficiaries with inferior options—and sometimes no options—for health-care coverage. So while high-risk pools offer a plausible and promising conceptual model for covering people with pre-existing conditions, their real-life implementation has (at least to date) left much room for improvement.

Champions of pro-market health-care reform should therefore urge states to properly design and operate high-risk pools, and should call on
the federal government to properly fund them. Such pools would offer an effective, yet far less expensive and intrusive, approach to the problem of covering pre-existing conditions than the tack taken by the new health-care law. And very soon — well before its most important provisions take effect in 2014 — that law will put pre-existing conditions and risk pools front and center in our national health-care debate.

**Obamacare’s Shallow Pools**

High-risk pools have tended not to be popular with liberal health-care reformers, who would prefer instead deep government involvement in the inner workings of the insurance system. The health-care plan Barack Obama offered when he ran for president in 2008 therefore made no room for the pools, and Obama-campaign surrogates were critical, if not dismissive, of Senator John McCain’s proposal to use such pools as part of a broader reform of the health-care system.

President Obama and congressional Democrats remained disdainful of high-risk pools when they began to develop their health-care legislation last year, relying instead on mandates and subsidies for private insurance — along with a substantial expansion of Medicaid — to move toward universal insurance coverage. Unfortunately, their approach to addressing the needs of people with pre-existing conditions is modeled on one that has failed in several state efforts in recent decades: The new law includes an outright ban on insurers’ excluding pre-existing conditions from coverage, and on insurers’ requiring people with higher health risks to pay higher premiums (older enrollees would still pay more than younger ones, up to a point).

But the new federal law does differ from previous state efforts in one important way: Starting in 2014, health-insurance coverage will no longer be voluntary; every American must either carry insurance or pay a fine. In theory, mandating insurance enrollment should prevent the young and healthy from fleeing the marketplace when their premiums are increased to cover higher-cost cases (thus preventing any regulation-induced meltdown of private insurance markets). But many industry experts argue that the insurance mandate — which charges a penalty of less than $1,000 for failing to purchase insurance that could cost several times that much — will not work as planned, because too many young and healthy people will choose to stay out of the system. For them, it will still make financial sense to go without coverage. The Obama plan
could therefore bring about the same cycle that eventually doomed state initiatives in the past.

Furthermore, as part of a legislative ploy to mask Obamacare’s full cost and to keep the 10-year Congressional Budget Office score below $1 trillion, the new insurance system will not go into effect until 2014. But to sell the bill to the public, Democrats knew they had to offer something on the pre-existing condition front in the interim. To fill the gap, they turned to the very mechanism they had long derided: high-risk pools. The bill requires that high-risk pools for people with pre-existing conditions be established within three months of the law’s enactment (meaning they must begin by the end of June), and operate until January 1, 2014, when the new insurance rules and subsidies would go into effect.

It is clear from the language of the legislation that these high-risk pool provisions were crudely cobbled together as an afterthought to Obamacare’s other, more sweeping reforms. Little press or public attention was paid to them either before or after the bill passed. As a result, these provisions are likely to exacerbate the problems faced by states and patients, rather than resolve them.

To begin with, the notion that the new high-risk pools can be up and running effectively within a mere 90 days is sheer fantasy. Although the secretary of Health and Human Services has the authority to contract with existing state-based pools, the requirements for their eligibility as federal partners under the new law will be difficult to meet. As many as 20 states object to participating in the new law’s high-risk pool program, including a dozen states already operating their own high-risk pools (which would be required to undergo significant changes). But the alternative — setting up one or more entirely separate, federally managed high-risk pools that would exist for less than four years — would be unnecessarily costly and redundant (even if it could be done quickly and competently, which is a pretty big “if”).

Moreover, the law prohibits the high-risk pools from imposing any pre-existing condition exclusions from coverage. Eligible individuals cannot be charged premiums that exceed the standard non-group insurance rate in each state — a significant departure from the practice of all current state-based high-risk pools (which, to one degree or another, charge higher-than-standard rates). Age-based premium rating will be more constrained than it is under state high-risk plans today, and insurers in the new risk pools will be required to pay at least 65% of the
costs of covered medical treatments and procedures (clashing with some states’ established practices, which require patients to pay for a greater portion of their own treatments). In effect, the new law would impose on the high-risk pools many of the restrictions it will place on insurance coverage, benefits, and premiums in the new health exchanges to be established in 2014—but three and a half years before the latter are fully drafted and implemented.

The law also grossly underfunds the high-risk pools it requires, authorizing a total of only $5 billion for three and a half years of operation. The bill tries to get around its own tight purse strings by authorizing the newly mandated risk pools 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 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, will not suffice. Nor can one gain admission to the new pools if one is already enrolled in an existing state high-risk pool but facing higher premiums with greater cost-sharing. After all, people in these circumstances are not “uninsured.”

In other words, then, the secretary of Health and Human Services is first authorized to determine which pre-existing conditions make a potential enrollee eligible for federal high-risk pool coverage—and then, as budget funds run short, is required to figure out how to avoid actually providing that person with the promised health-care coverage. The results are easy to foresee: waiting periods, benefit limits, and rationing of care—all the practices for which the new law’s champions like to attack the private insurance industry.

The administration’s own cost estimates reflect the degree to which optimistic promises are out of step with harsh reality. In April, the chief actuary of the Department of Health and Human Services released a cost projection for the new program, predicting that the $5 billion the law allocates for three and a half years of high-risk pools will in fact be exhausted in the program’s first or second year. The actuary estimates that only 375,000 people shut out of insurance elsewhere will obtain health-care coverage through the high-risk pools—a number that falls
far short of the 2 to 4 million people in the targeted population. One can therefore expect that, soon after the program is launched, it will be short of funds and forced to turn applicants away.

This coming failure of Obamacare’s high-risk pool component will put the question of pre-existing conditions at the heart of the continuing health-care debate. For opponents of the new law, it will be crucial to show the public that the failure of the temporary high-risk pool is a function of its careless design, but not an indictment of the fundamental concept. They must show the public that the solution to our enduring “pre-existing” problem is a well-designed and well-funded system of state high-risk pools—not the new law’s massive and misguided transformation of American health care.

**The Real Solution**

What would a well-designed system of high-risk pools look like? Its guiding principle is straightforward enough: Americans who stay in continuous insurance coverage should not be penalized for developing costly health conditions. Any system capable of upholding this principle would need to incorporate several key components.

First, it would require Congress to fix several of the flaws in HIPAA noted above. Workers leaving job-based plans for the individual market should be able to do so without being penalized for failing to exhaust their COBRA rights. If a worker moves directly from an employer-provided plan to an individual policy, he should not be denied coverage based on a pre-existing condition.

Second, there should be limits (imposed by states, based on broader federal guidelines) on underwriting for people who move from the employer-based market to the individual market. This could be achieved by, for instance, capping the premiums charged to high-risk customers at some fixed level above their standard rates, regardless of income, and then having the government provide supplemental subsidies to the poor on a sliding scale. Another option is to take income as well as risk into account when setting the premium caps—so that if two people have the same risk level, the wealthier of the two will pay higher premiums. The aim of both ideas is to allow insurers to take higher health risks into account when calculating premiums, while also ensuring that people with expensive health conditions are not completely priced out of the market. (Identifying people at very high risks could also help insurers
to better tailor health-care interventions in order to encourage these customers to change their behavior and lower their risks over time.)

Of course, limiting premiums this way will mean that the gap between a customer’s contribution and the actual cost of insuring him must be bridged with taxpayer dollars through high-risk pool programs in the states. If these programs are to function properly, they must therefore be well funded—somewhere in the range of $15 to $20 billion per year. This funding should come in the form of a capped annual appropriation to the states from Congress. Making high-risk pools an open-ended entitlement—like, say, Medicaid—would create the same problems of runaway costs that are likely to plague the whole of the Democrats’ health-reform plan. It is therefore better to set initially generous, but still firmly limited, annual appropriations; only after the program has undergone the necessary trial and error of implementation and practice—thus providing a better sense of the pools’ actual needs and costs—should lawmakers re-examine the funding commitments.

Third, the risk pools themselves must be structured properly to prevent participating private insurers from dumping unwanted (but not truly high-risk) customers into the public-subsidy system. If an insurer believes that an applicant’s health status argues for charging him a premium higher than, say, 1.5 times the standard rate, the insurer should be allowed to direct the customer to the high-risk pool program in his state. The job of determining eligibility for the subsidy should be contracted out by the state to a neutral third party with experience in medical-insurance underwriting, with private insurers collaborating to determine in advance the criteria for high-risk selection. If the third party finds no basis for designating the applicant an unusually high risk, the insurer seeking the evaluation would be required to take the applicant at no more than the maximum rate of (in this example) 1.5 times the standard premium. (And if the insurer makes failed claims too often, it would pay additional penalty fees to the state—thus discouraging so-called “risk dumping.”) But if the insurer’s application is deemed valid, the state would subsidize the individual’s high premium in its high-risk pool program, taking into account the enrollee’s income and other resources.

Fourth, insurers participating in the individual market would need to offer coverage without a new risk assessment to anyone who has maintained an individual policy for some minimum period when he applies for a new one. This would mean that market entrants would
face a risk evaluation only once; they would then have the right to renew their policies at the same rate class from any licensed insurer.

Finally, when these reforms are first implemented, there will need to be a one-time open-season enrollment period to allow people who have fallen through the cracks over the years to re-establish their rights by maintaining continuous coverage. Those who have forfeited their coverage would get just one chance to become insured under the new rules (though perhaps at higher rates than those who had not forfeited their rights); once the enrollment window closed, everyone would know that people who remain continuously insured are protected, and that those who choose not to become insured have taken a risk.

**A BETTER WAY**

This approach to covering pre-existing conditions would not be inexpensive, of course. But its price tag would be tiny compared to the recent health-care bill’s. And using high-risk pools to cover people who are uninsured because of pre-existing medical conditions would not cede all power over our health-care system to bureaucrats in Washington. Nor would it disrupt insurance arrangements that are working well for the vast majority of Americans. It would leave in place the many protections already available to people in the much larger employer-based insurance market. Indeed, it would likely ease cost pressures on many Americans who are currently insured — by properly funding high-risk individuals who are now pushing insurance premiums up for everyone.

The many advantages of high-risk pools create an opening for opponents of Obama’s approach. Critics should seize the chance to present a coherent case to the public for replacing the deeply flawed new law — advancing in its place a series of targeted, incremental solutions to the specific problems plaguing our health-care system.

The challenge of covering Americans with pre-existing conditions offers the earliest, and perhaps best, proving ground for their case. It is a challenge that those who oppose Obamacare’s overreach should embrace — not a vulnerability that should scare them away from the cause of repeal.