



## State High-Risk Health Insurance Pools

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People turn to the individual insurance market when they do not have access to job-based health benefits nor qualify for public programs. Over a three-year period, as many as one in four adults seek individual health insurance coverage.<sup>1</sup> In most states, however, those with expensive health conditions, such as diabetes, cancer, heart disease or pregnancy, will be considered “uninsurable.”

Two principal options have been discussed to ensure that high-risk people have access to individual health insurance. One is to require guaranteed issue and community rating so as to pool risk across all participants. Critics say that, in the absence of an individual mandate, this option invites adverse selection and raises premiums prohibitively for everyone else in the pool. A second option is to create and strengthen public programs that offer health insurance to people who do not have viable options in the private market. In theory, these high-risk pools can help stabilize private markets by removing the most costly participants and financing their coverage through taxes or other broad-based funding.

Thirty-five states have established high-risk pools, with mixed success. In this essay, I describe the current status of these high-risk pools and comment on how they might be improved and their potential place in future health reform efforts.

### High-Risk Pool Enrollment

Approximately 25 percent of individual health insurance applicants receive adverse underwriting responses, and so might be considered eligible for high-risk pools.<sup>2</sup> If all of them found their way to a high-risk pool, enrollment would be about one-third as large as the population covered through the individual market. In reality, however, enrollment in all state high-risk pools was approximately 200,000 people in 2007, or

### Figure 1. Overview of States with High-Risk Pools

35 States with High-Risk Pools: AL, AK, AR, CA, CO, CT, FL\*, ID, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, NC, ND, OK, OR, SC, SD, TN, TX, UT, WA, WV, WI, WY

Program Characteristics Limiting Enrollment	Number of States	Percent of Total Pools
<b>Availability</b>		
Enrollment caps	2	6%
Exclusion period for COBRA eligibility	2	6%
HIPAA-eligible only	2	6%
Requires proof of 2 denials	6	17%
<b>Affordability</b>		
Pool charges above-market premiums	35	100%
No premium subsidy for low-income persons	21	60%
<b>Adequacy</b>		
Exclusion period for pre-existing conditions	33	100%**
Cap on prescription drug coverage	5	14%
Limitations on maternity care	10	29%
Lifetime benefit cap of less than \$1 million	5	14%

\*The pool in FL has been closed to new enrollment since 1991.

\*\* AL and SD excluded from calculation because their pools enroll only HIPAA-eligible individuals and, by federal law, may not impose pre-existing condition exclusions.

only about two percent of the nearly 10 million residents covered by individual health insurance in those states.<sup>3</sup> Pool enrollment may be discouraged by various features of state programs that limit the availability, affordability and adequacy of high-risk pool coverage (Figure 1).

### Availability

Eligibility requirements can limit the availability of coverage for some applicants. For example, of the 35 states with high-risk pools, two have enrollment caps, two do not permit a person to apply until any potential COBRA benefit period has expired, and two restrict enrollment to HIPAA-eligible individuals only. Complex application and enrollment procedures may also deter enrollment – for example, in six states, proof of “uninsurability” requires denials by two insurers. Further, few states engage in extensive advertising or outreach to attract participants,<sup>4</sup> nor do high-risk pool programs benefit from the

same degree of marketing by insurance agents. While commercial insurers may pay agents commissions of 15 to 20 percent of the first year’s premium for each individual policy they sell, high-risk pools usually pay commissions of \$100 or less.<sup>5</sup>

### Affordability

All states set their pool premiums at above-market rates, usually 125 to 200 percent of prevailing individual market premiums. All pools also adjust premiums for age – enrollees in their early sixties can pay three to six times higher premiums than enrollees in their early twenties, for example.

Many states offer a choice of plans with deductibles ranging from \$500 to \$10,000.<sup>5</sup> While higher deductibles are usually associated with lower premiums, the up-front savings may not offset the higher cost sharing. In the Arkansas pool, for example, a 50-year-old

woman would pay \$6,036 per year for a \$1,000 deductible option. Adding \$9,000 in cost sharing by moving to a \$10,000 deductible would reduce her annual premium by only \$2,400.<sup>6</sup>

One study estimated only eight percent of the target uninsurable population is able to enroll in high-risk pools, due primarily to high premiums.<sup>7</sup> Some experts have recommended that premium subsidies might be needed for enrollees with incomes up to 400 percent of the federal poverty level if high-risk pools are to be a viable safety net.<sup>8</sup> To date, only 14 state pools offer premium subsidies to low-income enrollees, with discounts ranging from around 30 percent to 75 percent.<sup>5</sup>

### Adequacy

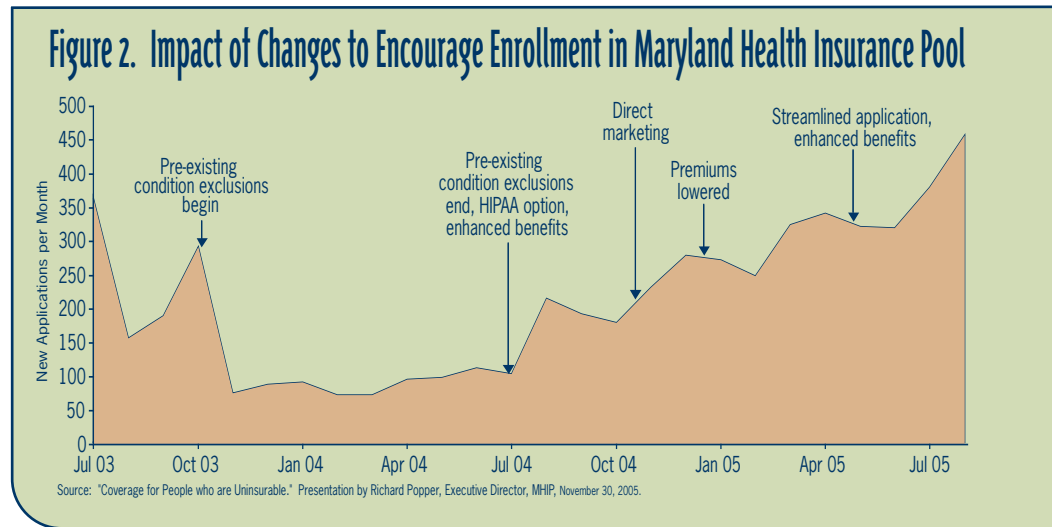
Inadequate financial protection against medical bills may be another feature that limits high-risk pool enrollment. All pools impose pre-existing condition exclusion periods, typically lasting from six to 12 months. Claims related to the excluded condition(s) are not covered during this time. These exclusions are a very strong deterrent to enrollment; for example, they have been found to be a leading reason why some cancer patients do not enroll.<sup>9</sup>

States also limit the benefits covered through their pool plans. Five programs cap prescription drug coverage or require an additional premium for the benefit. Ten pools exclude, limit or surcharge coverage for maternity care. Five pools limit lifetime covered benefits to less than \$1 million.<sup>5</sup>

### Financing

High-risk pool expenses will always exceed revenue from premiums because claims costs cannot be spread across low-risk individuals. On average, the per-capita annual cost of high-risk pool enrollees exceeded \$9,000 in 2007. While enrollee premiums financed almost 60 percent of these expenses, states had to find other funds to cover the remainder – amounting to well over \$700 million across all high-risk pools. Most states assess health insurers or hospitals to cover program losses; some rely on general revenue financing in an effort to spread program costs over a broader base.<sup>5</sup>

In addition, a small federal grant program provides some support for state high-risk pools. Initially authorized at \$40 million in 2002, funding was increased to \$75 million annually in 2005. Though this amount accounts for only about 10 percent of total high-risk pool losses nationwide, the grants can provide significant fiscal support to smaller state pools.



Most states initially used grant funds to refinance pool losses rather than to make program changes to facilitate enrollment.<sup>10</sup> Accordingly, in 2005 Congress set aside one-third of program funds for "bonus grants" to states making efforts to improve coverage. In 2006, 25 states received bonus grants, ranging from \$55,000 to \$2 million, and used these funds for purposes such as low-income premium subsidies.<sup>5</sup> No grant funding was provided in 2007, but \$49 million was awarded to states in 2008.<sup>11</sup>

### Strengthening High-Risk Pools

States can expand enrollment by making their high-risk pools more available, affordable and adequate. Between 2004 and 2005, the Maryland pool eliminated pre-existing condition exclusions, expanded eligibility, lowered cost sharing, pursued more targeted outreach to uninsurable residents, cut premiums, and streamlined the application process. The number of new applicants grew substantially in response (Figure 2),<sup>12</sup> and pool enrollment had more than doubled by mid 2007. These improvements came at a cost, however. Net losses rose from \$35 million in 2005 to \$51 million in 2007, and program budget cuts soon forced Maryland to reverse most of these changes. Enrollment growth came to a halt by mid 2008.<sup>13</sup>

### Future of High-Risk Pools?

National health reform policies are still under development, and it is unclear what role high-risk pools might have in any reform legislation. As these plans evolve, policymakers considering the future of high-risk pools must recognize the cost of a separate safety net program to guarantee coverage for people with expensive health care needs. The Congressional Budget Office

has estimated the cost of a national high-risk pool at \$16 billion over the next 10 years<sup>14</sup> and the actual cost could be even higher. Assuring meaningful coverage to these populations through high-risk pools will require far more resources than have been appropriated to date. Until then, the promised protection of high-risk pools may not always be realized in practice. ■

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- 13 Persichetti T. Letter to Don Brandenburg, Actuary, Maryland Insurance Administration regarding MHIP Enrollment and Rates, January 29, 2009.
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