



Issue Brief

Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?

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ABSTRACT: To help people whose health conditions make it difficult for them to obtain insurance coverage, the Trade Act of 2002 initiated federal matching payments to support state high-risk pools and promote coverage expansion through them. Some 30 states already had high-risk pools, but enrollment was very limited, largely because of high premiums, exclusion of coverage for preexisting conditions, and high cost-sharing. In interviewing officials from high-risk pools that received grants in the program's first year, the authors found that most states did not use grant funds to make their pools more accessible or affordable; instead, 18 of 19 states used some or all funds to refinance existing programs. Only one state used its entire grant award to reduce enrollee premiums, expand covered benefits, or otherwise enact changes to promote enrollment. Policymakers may need to strengthen grant requirements and/or financial incentives to promote expansion of coverage via state high-risk pools.

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BACKGROUND

Thirty-two states have established high-risk pools as an alternative source of coverage for residents whose health conditions make it difficult to buy coverage on the individual market. In most states, individual health insurance is "medically underwritten," which means applicants can be turned down, their premiums can be surcharged, or their covered benefits can be limited based on their health status. According to one insurance industry survey, approximately 25 percent of applicants for medically underwritten individual coverage are turned down, charged more than other applicants, or offered policies with riders that limit coverage.¹ While the need for such coverage may be substantial, actual enrollment in high-risk pools is quite limited. Enrollment in state high-risk pools constitutes less than 2 percent of individual market participants, on average. Combined enrollment in all state high-risk

pools was approximately 178,000 people in 2003, compared with the nearly 11 million residents of high-risk pool states covered by individual health insurance that year ([see the Appendix on page 11](#)).

The average per capita annual cost for high-risk pool enrollees, including claims and administrative expenses, exceeded \$7,500 in 2003. Enrollee premiums typically cover about half of these costs.² The remaining costs are publicly financed. Most states assess health insurers to cover pool losses, and several rely on hospital assessments or general revenue financing in an effort to spread program costs over a broader funding base.³

To minimize losses requiring public subsidy, states have incorporated various features that, in effect, serve to limit the protection that high-risk pools offer residents. All states set high-risk pool premiums at above-market rates, usually 125 percent to 200 percent of prevailing individual market premiums. All but three high-risk pools temporarily exclude coverage of preexisting conditions for at least some enrollees. Many pools impose high cost-sharing for covered services, such as annual deductibles of \$1,000 or more. Some limit coverage for prescription drugs, maternity care, and other health services.⁴ Several states restrict eligibility or have waiting lists.

Such features have the effect of limiting enrollment in state high-risk pools. A study of the experiences of 344 diabetics who required individual coverage and lived in high-risk pool states found that only seven had successfully enrolled in high-risk pools. High premiums and preexisting condition exclusions were the leading factors discouraging the rest of the diabetes patients from obtaining high-risk pool coverage.⁵

Another study estimated that only 8 percent of the target uninsured population is able to enroll in high-risk pools, due primarily to high premiums. The study authors estimated that federal financial assistance, in the amount of \$105 million, could subsidize premiums sufficiently to allow 11 percent of otherwise uninsurable residents to enroll in high-

risk pools. They noted that “while this increase may be modest, this is a population most in need of coverage and likely to rely on substantial amounts of high-cost emergency care if uninsured.”⁶

Another study of high-risk pools concluded:

[F]unding . . . is the key issue faced by states considering establishing a new risk pool, for states with existing programs, and for any efforts to enhance coverage Federal shared funding will be important . . . if [pools] are to be open and providing affordable coverage for the uninsurable population.⁷

This issue brief explores the effects of the Trade Act of 2002, which initiated federal matching payments to support state high-risk pools and promote coverage expansion through them. It draws on a 2004 survey of officials from the high-risk pools in the 19 states that received such grants in federal fiscal year 2003.

FEDERAL GRANTS TO HIGH-RISK POOLS

The 2002 Trade Act created new federal financial assistance to state high-risk pools. A seed grant program promised states up to \$1 million to offset the cost of establishing new high-risk pools. In addition, a matching grant program was created to assist states with high-risk pool operating costs.⁸ Congress specified that matching grants should go only to programs meeting minimum qualifications (Table 1).⁹ Eligible states could apply for grants for up to 50 percent of pool losses. The Trade Act authorized and appropriated \$40 million per year for high-risk pool operations grants for each of federal fiscal years 2003 and 2004. (In October 2005, Congress agreed to extend the high-risk pool grant program through fiscal year 2010; this legislation is discussed in detail below.)

Eligibility Standards

To be eligible for matching grants, state pools have to meet four standards. During the first year of the grant program, all of the pools that met these standards applied for and received funding.

Table 1. State High-Risk Pool Eligibility for FFY 2003 Federal Operations Grants

State	Grantee in FFY 2003	Pool open to all HIPAA eligible	Premium set at or below 150% of standard risk rates	Had losses in 2002
Alabama	✓	✓	✓*	✓
Alaska	✓	✓	✓	✓
Arkansas	✓	✓	✓	✓
California	no	no	✓	✓
Colorado	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓
Florida	no	no	no	✓
Illinois	✓	✓	✓	✓
Indiana	✓	✓	✓	✓
Iowa	✓	✓	✓	✓
Kansas	✓	✓	✓	✓
Kentucky	✓	✓	✓	✓
Louisiana	no	✓	no	✓
Maryland	no	✓	✓	no
Minnesota	✓	✓	✓	✓
Mississippi	✓	✓	✓*	✓
Missouri	no	no	no	✓
Montana	✓	✓	✓*	✓
Nebraska	✓	✓	✓	✓
New Hampshire	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓
North Dakota	✓	✓	✓	✓
Oklahoma	✓	✓	✓	✓
Oregon	no	no**	✓	✓
South Carolina	no	✓	no	✓
South Dakota	no	✓	✓	no
Texas	no	✓	no	✓
Utah	no	✓	no	✓
Washington	no	no**	✓	✓
West Virginia	no	✓	✓	no
Wisconsin	✓	✓	✓*	✓
Wyoming	no	✓	no	✓

* Statutory premium caps for AL, MS, MT, and WI are set above 150 percent of standard market rates, but actual pool premiums are at or below 150 percent of standard rates.

** Oregon and Washington pools are HIPAA-qualified but some HIPAA-eligible residents are required to seek coverage from the pool while others are assigned to the private individual insurance market.

Source: Authors' survey of state insurance statutes and high-risk pool officials, 2004.

HIPAA-qualified pool. To be eligible, high-risk pools must be designated as a state's Health Insurance Portability and Accountability Act (HIPAA) coverage mechanism and meet the requirements for HIPAA-qualified high-risk pools.¹⁰ As of 2003, two states (Oregon and Washington) had designated the high-risk pool as a coverage option for only some HIPAA-eligible residents and two other states (California and

Missouri) had not designated their pools as HIPAA-qualified coverage at all.

HIPAA also requires qualified high-risk pools to provide coverage consistent with standards included in the Model Health Plan for Uninsurable Individuals Act developed by the National Association of Insurance Commissioners (NAIC).¹¹

Premiums at or below 150 percent of private market rates. Federal grant eligibility rules specify

that high-risk pool premiums must not exceed 150 percent of prevailing individual market rates. A number of states set statutory limits on high-risk pool premiums but give directors authority to establish premiums below that limit. States with premium caps above 150 percent of standard rates may be eligible for operations grants if actual premiums are at or below 150 percent of standard rates. One state, Wisconsin, reduced high-risk pool premiums in order to meet this program eligibility standard.

Ongoing financing mechanism. To be eligible, states also must demonstrate a mechanism independent of federal grants to fund high-risk pool losses after the federal grant program sunsets.

Losses in prior fiscal year. Finally, state high-risk pools applying for federal operations grants must have incurred losses in the prior year. Federal grants were authorized for two federal fiscal years; states could apply for one grant per year. To accommodate state fiscal years that do not coincide with the federal calendar, each federal grant year was conducted in two phases and states were given flexibility in timing their application.

Allocation Formula

The law requires grant funds to be allocated among eligible applicant states based on the number of uninsured residents in each state. Under the formula, the Centers for Medicare and Medicaid Services (CMS) sums the number of uninsured residents in all eligible applicant states and awards each state a share of grant funds equal to its share of uninsured residents. For example, if a state had 100,000 uninsured, representing 10 percent of all uninsured in the grantee pool, then they would get 10 percent of grant funds. State awards are capped at 50 percent of high-risk pool losses reported for the prior year. Although a few states reached the 50 percent funding limit under this formula in federal fiscal year 2003 (FFY 2003), most did not. The \$40 million pool of federal grant funds for that year compared with more than \$400 million in losses experienced by all state high-risk pools in 2002.¹²

FEDERAL GRANT AWARDS AND STATE USES OF FUNDS

Nineteen state high-risk pools were awarded federal grants under the first year of the program, FFY 2003. In December 2003, CMS awarded \$30 million in operations grant funds to 16 states. In October, 2004, three additional states (Alaska, New Mexico, and Wisconsin) were awarded a total of \$7 million, and remaining FFY 2003 funds were dispersed as supplemental grants to the first 16 states (Table 2). FFY 2004 grants will be awarded in the fall of 2005.

State Uses of Grant Funds

A key purpose of the federal grants is to expand coverage for the uninsured. This goal was emphasized by the former Secretary of Health and Human Services, Tommy G. Thompson, in the news release announcing the program:

These grants will make it more affordable for states to expand access to health care through high-risk pools for the uninsured These new grants for high-risk pools will help get coverage to people who otherwise would not have access to health care.

The release went on to call the grants “part of the Bush Administration’s broad strategy for expanding access to health care for the more than 40 million Americans without health insurance.”¹³

The formula for allocating grant funds is based on states’ uninsured population. Nevertheless, the Trade Act does not specify that grant funds be used to increase health coverage under high-risk pools. Absent such explicit direction, states are able to use grant funds solely to refinance the cost of existing high-risk pool programs.

In 2004, we surveyed the 19 states that received FFY 2003 awards to assess the impact of federal grants on their programs. We asked officials of the high-risk pools a standard set of questions about their programs and use of grant funds. We found that only a few grantee states opted to use all or a portion of federal funds to directly benefit

Table 2. High-Risk Pool Operations Grant Awards, FFY 2003

State	2003 grant (thousands)	Percent of losses subsidized	Pool enrollment	Grant per pool enrollee
Alabama	\$ 2,825.6	34%	3,924	\$ 720
Alaska	541.9	17%	469	1,155
Arkansas	1,928.2	28%	3,619	533
Colorado	3,219.3	38%	3,722	865
Connecticut	1,596.6	23%	2,338	683
Illinois	8,144.8	49%	13,123	621
Indiana	3,266.1	5%	9,794	333
Iowa	1,106.9	50%	165	6,708
Kansas	1,461.7	31%	1,775	823
Kentucky	2,510.7	32%	1,356	1,852
Minnesota	1,984.2	2%	33,705	59
Mississippi	2,066.2	28%	4,124	501
Montana	697.6	14%	2,635	265
Nebraska	894.4	5%	6,008	149
New Hampshire	224.6	50%	63	3,565
New Mexico	2,047.9	37%	1,200	1,707
North Dakota	329.4	11%	1,800	183
Oklahoma	2,931.0	29%	2,987	981
Wisconsin	2,222.0	4%	17,447	127
Total	\$40,000.0	Avg 12%	110,254	Avg \$ 363

Note: Alabama, New Mexico, and Wisconsin grants based on state fiscal year 2003; all others based on state fiscal year 2002.

Source: CMS and authors' survey of state high-risk pool officials.

Table 3. Uses of Federal Grant Funds, FFY 2003

State	Grant (thousands)	Average monthly premium	Grant per enrollee	Uses of grant funds			
				Pay claims	Reduce premiums	Expand covered benefits	Other uses
AL	\$2,826	\$368	\$ 720	X			
AK	542	410	1,155	X			
AR	1,928	385	533	X			
CO	3,219	574	865	X			
CT	1,597	472	683	X			
IL	8,145	458	621	X	X		
IN	3,266	617	333	X			
IA	1,107	436	6,708	X			
KS	1,462	235	823	X	X	X	X
KY	2,511	302	1,852	X			
MN	1,984	321	59		X		X
MS	2,066	350	501	X		X	
MT	698	433	265	X			
NE	894	462	149	X			
NH	225	412	3,565	X	X		
NM	2,048	279	1,707	X	X		
ND	329	521	183	X			
OK	2,931	419	981	X	X		
WI	2,223	368	127	X			

Source: Authors' survey of high-risk pool officials.

enrollees. Most states used federal grant awards to pay claims, thereby reducing pool losses requiring external subsidy (Table 3). In effect these states passed federal grant funds through as tax cuts to the insurance industry (in states where insurer assessments finance high-risk pool costs) or as state fiscal relief (in states that rely on general revenue financing).

Some high-risk pool officials felt constrained to use grant funds to pay claims either because their state laws cap insurer assessments that finance pool losses or specify that insurers should be assessed only as a last resort. Others were reluctant to use limited federal assistance to undertake changes that would permanently expand pool enrollment at potentially substantial added state costs, especially since grant funds were authorized for only two years. Still others reasoned that using grant funds to limit or reduce taxes on health insurers would help reduce pressure on rising health insurance premiums throughout their state, thereby promoting coverage expansion generally.

Reduce/subsidize premiums. Grantee states reported that their enrollees paid average monthly premiums ranging from \$235 to \$617 per month for single coverage in 2002. Only eight states offer premium subsidies for low-income enrollees, including six of the FFY 2003 grantee states. In Montana, a premium subsidy program was initiated in 2001 upon receipt of a special federal appropriation for this purpose, although enrollment in the program was later suspended because of lack of funds. Montana did not use its FFY 2003 high-risk pool grant to revive the premium subsidy program. According to program staff, the insurance industry assessment that finances high-risk pool losses is capped by state law. Grant funds therefore had to be used to help pay claims to minimize premium increases for enrollees.

Five states applied a portion of their FFY 2003 grant awards to reduce premiums. Oklahoma and Kansas gave enrollees a one-month “premium holiday.” Illinois spent nearly 70 percent of its grant award to reduce temporarily a scheduled premium increase for all enrollees; rates will return

to the regular schedule when federal funds run out. Minnesota and New Hampshire instituted across-the-board premium reductions for all members. Minnesota also used a portion of grant funds to conduct a survey of high-risk pool enrollees that found that most enrollees had incomes well below the state median income.¹⁴ Based on this finding, Minnesota is developing a new premium subsidy program for its low-income enrollees. New Hampshire officials also report that they are considering a premium subsidy program. Wisconsin, which used its entire FFY 2003 grant award to pay claims, had previously reduced enrollee premiums from 163 percent to 150 percent of standard rates in 2002, and then to 140 percent of standard rates in 2003.¹⁵

Beyond the amount of federal grants, other factors influenced state decisions on premium relief. Wisconsin’s two premium cuts predate enactment of the Trade Act. Minnesota’s grant will offset the cost of administering a low-income subsidy program, but state funds will finance the subsidy itself. These states operated two of the largest state pools in the nation prior to the Trade Act grants and appear inclined to continue to promote enrollment growth, regardless of federal grant assistance. States receiving the highest per-enrollee grant awards did little or nothing in the way of premium relief, even though some of the grants were large enough to have done so.

Enhance covered benefits. In nearly all state high-risk pools, covered benefits are comparable to those offered in the individual insurance market, despite the fact that the NAIC specifies that high-risk pools should have standards similar to those in large employer group plans.¹⁶ Compared with employer-sponsored group plans, individual market plans typically offer less comprehensive coverage and impose higher cost-sharing for covered benefits.¹⁷ For example, in eight FFY 2003 grantee states, the lowest annual deductible option offered is \$1,000. By contrast, the most recent national data indicate that for PPOs, the average single-coverage deductible for in-network services is \$323.¹⁸

Maximum annual out-of-pocket limits on cost-sharing for covered services under most large employer plans are less than \$2,500.¹⁹ In several FFY 2003 grantee states, however, high-risk pool enrollees face greater liability for cost-sharing, depending on plan choice—as high as \$5,000 in Colorado, Montana, and Nebraska; \$10,000 in Alaska and New Mexico; and up to \$40,000 in Arkansas. Virtually all large employer health plans offer comprehensive prescription drug benefits. By contrast, Kentucky’s high-risk pool basic benefit package does not cover prescription drugs. Instead, enrollees must purchase these benefits separately for an added premium. The Mississippi pool covers no prescription drug expenses during the first six months of enrollment. The Connecticut high-risk pool covers prescription drugs for enrollees paying the full premium, but offers no drug coverage for low-income enrollees in its premium subsidy program.

Two states spent a portion of FFY 2003 grant funds to enhance covered benefits under their high-risk pools. Kansas lowered cost-sharing on prescription drugs and expanded coverage for preventive care benefits. Mississippi financed new disease management services with its matching grant.

Reduce insurer assessments. All but two FFY 2003 grantee states reported using some or all of their grant funds to pay claims, thereby reducing the need to assess the insurance industry to cover program costs. Many program officials said it made sense to use grant funds in this way in order to reduce health insurance premiums for all residents in the private market. Assuming insurers reduced premiums by the entire amount of federal grant funds received, the federal operations grant program would have yielded individual health insurance premium savings of approximately 83 cents per month (Table 4).

Table 4. Per Capital Federal Grant Amounts, FFY 2003

State	FY 2003 federal grant amount (thousands)	State individual market participants in 2002* (thousands)	Federal grant amount per individual market participant	
			Per year	Per month
Alabama	\$2,826	207	\$13.65	\$1.14
Alaska	542	29	18.69	1.56
Arkansas	1,928	195	9.89	0.82
Colorado	3,219	315	10.22	0.85
Connecticut	1,597	172	9.28	0.77
Illinois	8,145	642	12.69	1.06
Indiana	3,266	335	9.75	0.81
Iowa	1,107	302	3.67	0.31
Kansas	1,462	190	7.69	0.64
Kentucky	2,511	247	10.17	0.85
Minnesota	1,984	305	6.50	0.54
Mississippi	2,066	136	15.19	1.27
Montana	698	100	6.98	0.58
Nebraska	894	142	5.07	0.42
New Hampshire	225	54	6.30	0.52
New Mexico	2,048	62	33.03	2.75
North Dakota	329	68	4.84	0.40
Oklahoma	2,931	216	13.57	1.13
Wisconsin	2,223	304	7.35	0.61
Weighted average			\$9.93	\$0.83

* Source: U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State—People Under 65: 1987 to 2004, available at <http://www.census.gov/hhes/www/hlthins/historic/hihistt6.html>.

Distribution of Grant Funds

The FFY 2003 grant allocation formula allocated funds based on a state's uninsured population, without regard to the numbers enrolled in a state's high-risk pool. Therefore, the resulting distribution of grant awards on a per-enrollee basis, in absolute dollars and as a proportion of high-risk pool program costs, was uneven. New Hampshire—the newest and smallest program in 2002 with only 63 enrollees—received federal funds in the amount of \$3,565 per pool enrollee, while Minnesota—the oldest and largest program in the nation with almost 34,000 enrollees that year—received \$59 per pool enrollee. Had the distribution formula not capped awards at 50 percent of state operating costs, New Hampshire would have received an even larger grant to subsidize even more of its start-up costs. Iowa received more than \$6,700 for each of its 165 enrollees in 2002.²⁰

The grant formula also yielded uneven proportional subsidies for state programs. Minnesota's grant of \$1.9 million constituted only a 2 percent subsidy for its program covering 34,000 enrollees. New Hampshire and Iowa received 50 percent subsidies, and \$1.3 million in combined awards, to cover just over 200 people.²¹

The uneven distribution of grant relief could be viewed as undermining the program's goal to promote coverage through high-risk pools. The allocation formula did not take into account the size of a state's high-risk pool in relation to its uninsured population, and therefore did not reward states based on their relative success at expanding coverage through pools. In fact, concerns over the allocation formula led Congress to examine alternative formulas in reauthorization legislation.

REAUTHORIZATION

Federal grant programs for state high-risk pools expired at the end of fiscal year 2004 and the 108th Congress. Legislation to reauthorize the program was considered in both the House and the Senate during the 109th Congress. In October

2005, agreement between House and Senate negotiators was reached. A reauthorization bill passed the Senate unanimously on October 19 and awaits final action in the House. The compromise bill, H.R. 3204, extended the grant program through fiscal year 2010 and increased funding to \$75 million annually. Other key changes to the grant program include:

Bonus grants. H.R. 3204 sets aside one-third of total grant funds for bonus grants. This portion of funding would be awarded to states acting to reduce barriers to high-risk pool enrollment by lowering premiums, eliminating waiting lists, enhancing covered benefits, or other efforts. No single state may receive more than 10 percent of the total bonus pool in a year. Any unclaimed bonus grant funds in a year will be reallocated to all grantee states under the allocation formula described below.

Relaxing eligibility standards. H.R. 3204 allows state pools with premiums as high as 200 percent of standard individual insurance market rates to qualify for grants. However, pools with premiums in excess of 150 percent of standard rates would be required to spend at least half of their grant awards on premium relief. The bill also includes a provision that would allow Oregon and Washington pools to qualify for matching grants, even though their high-risk pools are not designated as the HIPAA-qualified coverage option for all HIPAA-eligible residents.

Allocation formula change. The reauthorization bill changed the grant allocation formula to take into account state high-risk pool enrollment and to guarantee a minimum grant amount to all eligible states. Under the new formula, 40 percent of grant funds (other than bonus grant funds) would be distributed evenly among all eligible states that apply; 30 percent would be distributed according to the original formula based on the uninsured; and 30 percent would be distributed according to the size of state high-risk pools.

End “matching” feature of grants. State grants are no longer capped at 50 percent of actual pool losses. Under H.R. 3204, it would be possible for very small high-risk pools, such as New Hampshire, to receive grants equal to or greater than 100 percent of the cost of their pool programs.

DISCUSSION

The early experience with federal financial assistance to state high-risk pools is noteworthy in several respects.

The precedent for federal aid to state high-risk pools has been established. New federal grants helped 19 states finance their high-risk pool programs. Federal subsidies overall were modest, averaging 12 percent of operating costs in grantee states. However, in a few states federal subsidies reached 50 percent of operating costs. State fiscal pressures are such that the need for federal grants is likely to continue and grow. Congressional health policy leaders have acted to extend federal grants and increase funding for the program to \$75 million annually. State pressure to further increase federal financial assistance may continue.

Congress enhanced minimum standards for consumer protection in state high-risk pools. The Trade Act did not make all high-risk pools eligible for federal matching grants. Instead, it specified that high-risk pool premiums must not exceed 150 percent of prevailing individual market rates. Reauthorization language relaxed this eligibility standard, but required the most expensive state pools to spend at least half of grant funds on premium relief. This compromise suggests that the legislation strives to strike a balance between state fiscal relief and coverage expansion.

Promoting health coverage expansion via high-risk pools met with limited success. Some grant funds were spent on premium relief and enhanced covered benefits—actions that could help make high-risk pool coverage somewhat more accessible to the uninsured. In light of the

relatively small federal grant awards, however, it is unknown whether a discernable increase in the rate of pool enrollment growth will result in these states. The availability of even limited federal grant funds did prompt action in some states. A few, such as Illinois and Oklahoma, likely would not have undertaken premium relief without federal financial assistance and, indeed, will not maintain changes if federal grants are discontinued. Other states probably would have acted to promote high-risk pool enrollment on their own. The cost of Minnesota’s new low-income premium subsidy program will far exceed its grant award, and Minnesota’s 25-year tradition of promoting high-risk pool coverage pre-dates federal financial assistance. Wisconsin lowered pool premiums twice before the federal grant program began, then declined to use its matching grant for further premium relief.

Most federal grant funds were used to replace, or “crowd out,” extant high-risk pool financing. Most states did not use grants to modify features that currently prevent the uninsured from enrolling in high-risk pools. Instead, the bulk of federal grant funds were used to pay claims, thereby reducing pool losses otherwise financed by insurance industry assessments and state general revenue. Congress responded by setting aside a portion of “bonus” grant funds to encourage changes that promote high-risk pool enrollment. However, the bonus grants are constrained by two conditions. First, any one state’s bonus grant is capped at \$2.5 million per year, even though the cost of initiatives such as premium cuts (and the enrollment growth that could ensue) could well exceed this amount. Second, any unused bonus grant funds in a year are returned to the main grant pool and distributed. This balancing of concerns for coverage expansion against fiscal relief to states and tax cuts for the insurance industry leaves open the question of how (or whether) state high-risk pools will expand to cover more of the sick uninsured.

Finally, although Congress nearly doubled funding for high-risk pool grants, federal financial assistance is still extremely modest relative to the cost of these programs. Unless states are willing to devote significant new resources of their own, prospects for expanding health insurance coverage through high-risk pools seem more rhetorical than real.

NOTES

- ¹ L. Tooman, “Real People, Real Coverage,” Council for Affordable Health Insurance, Issues and Answers No. 103, May 2002. Available at <http://www.cahi.org>.
- ² B. Abbe, “Overview—State High Risk Health Insurance Pools Today,” June 2003. Available at <http://www.selfemployedcountry.org/riskpools/overview.html>.
- ³ Many states offset insurer assessments with a tax credit so that general revenues indirectly fund high-risk pool costs.
- ⁴ L. Achman and D. Chollet, “Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools,” The Commonwealth Fund, August 2001. Available at http://www.cmwf.org/publications/publications_show.htm?doc_id=221291.
- ⁵ K. Pollitz et al., “Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes,” American Diabetes Association and Georgetown University, February 2005. Available at <http://www.diabetes.org/advocacy-and-legalresources/healthcare/insurance.jsp>.
- ⁶ A. Frakt et al., “High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects,” *Health Care Financing Review* 26 (Winter 2004–2005).
- ⁷ Abbe, “Overview,” 2003.
- ⁸ Public Health Service Act, Section 2745. The law established another seed grant program, providing up to \$1 million each to states that did not yet have high-risk pool programs.
- ⁹ 45 CFR Part 148.310.
- ¹⁰ HIPAA-qualified high-risk pools must offer all HIPAA-eligible individuals coverage that does not impose preexisting condition exclusion periods. In addition, HIPAA-eligible individuals must be offered a choice of at least two plan options and may not be subject to enrollment waiting lists.
- ¹¹ Public Health Service Act, Section 2744 (c)(2).
- ¹² Communicating for Agriculture and the Self-Employed, Comprehensive Health Insurance for High-Risk Individuals, 17th ed. Fergus Falls, Minnesota (2002).
- ¹³ “HHS Awards Nearly \$30 Million to States to Offset Costs of Insurance for Residents Too Sick for Conventional Coverage,” U.S. Department of Health and Human Services news release, December 17, 2003, available at <http://www.hhs.gov/news/press/2003pres/20031217a.html>.
- ¹⁴ “MCHA Member Survey Report,” January 2005.
- ¹⁵ Wisconsin’s action did not result in an absolute reduction in high-risk pool premiums, but did slow the annual rate of premium growth from what it otherwise would have been.
- ¹⁶ B. Abbe, “State Health Insurance Pools for the High-Risk Population: 25 Years of Proven Service in Guaranteeing Access to Coverage,” Available at <http://www.selfemployedcountry.org/riskpools/commonwealth.html>.
- ¹⁷ J. Gabel et al., “Individual Insurance: How Much Financial Protection Does It Provide?” *Health Affairs* Web Exclusive (April 17, 2002). Available at http://www.cmwf.org/publications/publications_show.htm?doc_id=221493.
- ¹⁸ J. Gabel et al., “Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode,” *Health Affairs* 24 (September/October 2005).
- ¹⁹ Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits 2004 Annual Survey.” Available at <http://www.kff.org/insurance/7148/index.cfm>.
- ²⁰ Iowa has since changed eligibility rules for its high-risk pool (previously, pool enrollment was limited to 12 months, after which enrollees were sent to the private market to seek guaranteed issue coverage) and expects significant enrollment growth beginning in 2005.
- ²¹ Illinois’s grant of \$8 million also constituted a nearly 50 percent subsidy. However, Illinois artificially divides its program into two pools and its grant award was based only on HIPAA-eligible enrollment. Medically uninsurable residents make up roughly one-third of total State Children’s Health Insurance Program enrollment and one-half of total operating costs in the state.

Appendix. High-Risk Pool Enrollment as Percentage of Individual Market Participants

State	Pool enrollment in 2003*	State individual market participants under age 65 in 2003**	Pool as % of individual market
Alabama	3,464	207,000	1.7
Alaska	484	29,000	1.7
Arkansas	3,296	134,000	2.5
California	8,570	2,601,000	0.3
Colorado	4,801	325,000	1.5
Connecticut	2,290	143,000	1.6
Florida	520	1,173,000	0.04
Idaho	1,330	106,000	1.3
Illinois	16,055	741,000	2.2
Indiana	9,309	362,000	2.6
Iowa	130	214,000	0.1
Kansas	1,703	197,000	0.9
Kentucky	2,457	213,000	1.2
Louisiana	1,368	259,000	0.5
Maryland	6,137	251,000	2.4
Minnesota	33,705	424,000	7.9
Mississippi	4,240	138,000	3.1
Missouri	2,440	294,000	0.8
Montana	3,556	70,000	5.1
Nebraska	6,087	176,000	3.5
New Hampshire	158	48,000	0.3
New Mexico	1,200	62,000	1.9
North Dakota	1,806	61,000	3.0
Oklahoma	2,845	167,000	1.7
Oregon	9,885	232,000	4.3
South Carolina	1,798	247,000	0.7
South Dakota	386	67,000	0.6
Texas	24,675	879,000	2.8
Utah	3,000	181,000	1.7
Washington	2,652	485,000	0.5
Wisconsin	17,447	304,000	5.7
Wyoming	657	40,000	1.6
Total	178,451	10,830,000	1.6

* Source: Communicating for Agriculture and the Self-Employed, Comprehensive Health Insurance for High-Risk Individuals, 18th ed. Fergus Falls, Minnesota (2004).

** Source: U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2003, available at http://pubdb3.census.gov/macro/032004/health/h05_000.htm.

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