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# **Insuring the Uninsurable: The Growth in High-Risk Pools**

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# **Insuring the Uninsurable: The Growth of High-Risk Pools**

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## Abstract

This Data Watch studies the growth and affordability of state high-risk pools (also known as comprehensive health insurance associations for high-risk individuals). For a subsidized, yet above-market premium, high-risk pools provide coverage to individuals who do not have access to private health insurance, typically due to pre-existing conditions. While enrollment in most high-risk pools is growing, premiums remain unaffordable to many in the target population. Lowering risk pool premiums in all states to the level currently observed in the most generous states could lead to a modest but significant increase in pool enrollment relative to the numbers of uninsurable individuals.

## Introduction

The current economic downturn has reawakened national concern about the problem of the uninsured. While the proportion of the population without health insurance decreased from 1998 to 2000 (from 16.3 percent to 14 percent),<sup>1</sup> the economic recession of 2001-2002 and associated loss of jobs has exacerbated the problem. Between March and November of 2001, nearly one million individuals lost their jobs and their health care coverage; half of these losses occurred after the terrorist attacks of September 11, 2001.<sup>2</sup> One study reports that the increase in the number of uninsured in 2001 was the largest one-year increase in nearly a decade with 2.2 million losing coverage.<sup>3</sup> By another estimate, up to an additional six million could lose coverage by the end of 2002.<sup>4</sup> With higher unemployment and lower consumer spending, state tax revenues are down and budget surpluses have disappeared. Consequently, Medicaid budgets are tight and program expansions to cover a greater proportion of the uninsured are politically and fiscally impractical.<sup>5</sup>

Among the growing number of uninsured is a class of individuals most in need of insurance: the uninsurable. These are individuals with potentially costly health conditions who pose a high risk to any insurance carrier and who cannot obtain health care coverage due to medical underwriting. In 29 states (as of July, 2002), these high-risk, uninsurable individuals are eligible for coverage under special state programs known as comprehensive health insurance associations for high-risk individuals (high-risk pools). All high-risk pools offer coverage for a subsidized premium that is, nevertheless, above market rate. Though operations vary by state, subsidy financing is generally provided by assessments on private carriers, general state revenue, other public sources (like tobacco-settlement funds), or a combination of these.

High-risk pools have quietly become an important component in the nation's public/private patchwork of health care coverage. The number of high-risk pools has been gradually growing along with enrollment since the first pools began operation in Connecticut and Minnesota in 1976. Recently, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 has encouraged this growth by requiring states to guarantee health insurance portability (i.e., that health insurance is available) to individuals who meet certain requirements. High-risk pools have been designated as one of the acceptable mechanisms for compliance with the portability provisions of HIPAA. Moreover, HIPAA establishes a federal regulatory role over states that do not select an acceptable portability mechanism. Since this federal authority overrides what would otherwise be a state prerogative, HIPAA creates an incentive for states to select an alternative mechanism, thereby strengthening the arguments of high-risk pool advocates.

In this Data Watch, we combine high-risk pool operational data with state demographic and health insurance data to investigate the historical growth in high-risk pools and the affordability of high-risk pool premiums. We also study the potential for enrollment growth if premiums were reduced.

## Data and Methods

We constructed a database consisting of historical high-risk pool operational data linked to historical state demographic data. High-risk pool operational data (number of enrollees, actual premiums charged, statutory premium caps, and other financial and benefits data) for the years 1981-2000 were obtained from the 1995-2001/2002 editions of the Communicating for Agriculture (CFA) publication *Comprehensive Health Insurance for High-Risk Individuals*.<sup>6</sup>

Most state demographic measures (state population, number of uninsured, number of uninsurable, income statistics) were obtained or constructed from the U.S. Census Bureau's 1995-2001 Current Population Survey March Supplement (CPS). To obtain adequate sample sizes for annual state-level descriptive analysis, we employed the standard technique of pooling three years of CPS data. We defined the uninsurable population as individuals who were uninsured and who either could not work, were limited in the type of work they could do, or received any disability or worker's compensation income.<sup>7</sup> The remaining data items, namely per capita Medicare expenditures, were obtained from the Statistical Abstract of the United States.<sup>8</sup>

The resulting dataset consists of 335 observations, each representing a high-risk pool in a single state for a single year. All of these observations include CFA operational data and the 188 observations corresponding to the years 1995-2001 also include Statistical Abstract and CPS data.

## Results

### Pool growth

Three high-risk pools were operating by 1981. The Connecticut and Minnesota pools opened in 1976 and Wisconsin's began operation in 1981. From 1981 to 2000, the number of states with high-risk pools increased nearly every year, as shown in Exhibit 1. The only year in which the number of pools decreased is 1995, when Tennessee folded its high-risk pool into TennCare.<sup>9</sup> Exhibit 1 also shows the number of states that use a high-risk pool as the state alternative mechanism to satisfy the portability requirements of HIPAA. Since the passage of HIPAA in 1996, most states with high-risk pools began offering pool coverage to HIPAA-eligible individuals to satisfy the new portability requirements. Several states created high-risk pools specifically in reaction to and just after the passage of HIPAA (Alabama and Texas) and several new pools have opened more recently (in Kentucky and New Hampshire, both too new to be included in this study). Only four of the 27 pools operating in 2000 were not HIPAA pools (those in California, Florida, Missouri, and Washington).

Corresponding to the growth in the number of high-risk pools, Exhibit 1 shows nearly steady growth in the number of pool enrollees. The only period of decline was from 1994-1997. During this period, Tennessee folded its pool into TennCare, which accounts for part of the decrease in 1995. The period of declining enrollment also immediately follows or coincides with the passage of small- and non-

group insurance reforms in many states.<sup>10</sup> These reforms may have improved access to private insurance and reduced the demand for high-risk pool coverage.

The number of individuals with high-risk pool coverage is very small relative to the number of uninsured, as shown in Exhibit 2. This number is larger, and in some states substantial, relative to the numbers of medically uninsurable (the target population for the pools).<sup>11</sup> Due presumably to its low premiums, Minnesota's pool is the largest in absolute terms (with 25,892 covered in 2000) and relative to the state's uninsured and uninsurable populations (covering 6 percent and 54 percent, respectively). The figures for Minnesota are far above the national averages; high-risk pool enrollment is 0.5 percent of the total uninsured population and 8 percent of the uninsurable population.

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**Exhibit 1**

**Number of High-Risk Pools and Number of Enrollees, 1981-2000**

| Year | Number of Pools | Number of HIPAA Pools | Total Number of Enrollees | Year | Number of Pools | Number of HIPAA Pools | Total Number of Enrollees |
|------|-----------------|-----------------------|---------------------------|------|-----------------|-----------------------|---------------------------|
| 1981 | 3               | 0                     | 6,668                     | 1991 | 17              | 0                     | 77,683                    |
| 1982 | 5               | 0                     | 9,199                     | 1992 | 22              | 0                     | 96,245                    |
| 1983 | 6               | 0                     | 15,448                    | 1993 | 24              | 0                     | 101,623                   |
| 1984 | 6               | 0                     | 19,602                    | 1994 | 24              | 0                     | 95,536                    |
| 1985 | 6               | 0                     | 21,536                    | 1995 | 23              | 0                     | 90,405                    |
| 1986 | 7               | 0                     | 21,833                    | 1996 | 25              | 0                     | 86,723                    |
| 1987 | 10              | 0                     | 24,231                    | 1997 | 25              | 11                    | 86,555                    |
| 1988 | 12              | 0                     | 33,301                    | 1998 | 27              | 22                    | 92,101                    |
| 1989 | 13              | 0                     | 53,458                    | 1999 | 27              | 22                    | 104,918                   |
| 1990 | 15              | 0                     | 68,263                    | 2000 | 27              | 23                    | 115,688                   |

*Sources: Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals," (2001/2002).*

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**Exhibit 2****High-Risk Pool Enrollees by State in Year 2000**

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| <i>State</i>   | <i>High-Risk Pool Enrollees</i> |   |   |
|----------------|---------------------------------|---|---|
|                | <i>Total</i>                    | <i>Relative to Number<br/>Uninsured</i> | <i>Relative to Number<br/>Uninsurable</i> |
| Alabama        | 2,431                           | 0.37%                                   | 5%  |
| Alaska         | 395                             | 0.33%                                   | 4%  |
| Arkansas       | 2,270                           | 0.56%                                   | 7%  |
| California     | 17,343                          | 0.25%                                   | 6%  |
| Colorado       | 1,536                           | 0.25%                                   | 5%  |
| Connecticut    | 1,719                           | 0.51%                                   | 8%  |
| Florida        | 709                             | 0.03%                                   | 1%  |
| Illinois       | 10,120                          | 0.58%                                   | 10%                                       |
| Indiana        | 6,475                           | 0.89%                                   | 11%                                       |
| Iowa           | 271                             | 0.11%                                   | 2%  |
| Kansas         | 1,283                           | 0.43%                                   | 6%  |
| Louisiana      | 1,088                           | 0.13%                                   | 2%  |
| Minnesota      | 25,892                          | 6.14%                                   | 54%                                       |
| Mississippi    | 2,231                           | 0.49%                                   | 7%  |
| Missouri       | 889                             | 0.16%                                   | 3%  |
| Montana        | 1,687                           | 0.99%                                   | 12%                                       |
| Nebraska       | 5,023                           | 3.03%                                   | 35%                                       |
| New Mexico     | 1,063                           | 0.25%                                   | 5%  |
| North Dakota   | 1,307                           | 1.68%                                   | 18%                                       |
| Oklahoma       | 1,922                           | 0.32%                                   | 3%  |
| Oregon         | 5,833                           | 1.22%                                   | 21%                                       |
| South Carolina | 1,451                           | 0.25%                                   | 3%  |
| Texas          | 8,600                           | 0.18%                                   | 4%  |
| Utah           | 1,106                           | 0.37%                                   | 5%  |
| Washington     | 2,333                           | 0.29%                                   | 4%  |
| Wisconsin      | 10,042                          | 1.90%                                   | 21%                                       |
| Wyoming        | 669                             | 0.87%                                   | 11%                                       |
| TOTAL          | 115,688                         | 0.45%                                   | 8%  |

*Sources: Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals," (2001/2002), U.S. Census Bureau, Current Population Survey (1999-2001).*

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## Barriers to enrollment

Of all the possible barriers to high-risk pool enrollment, two stand out as the most significant: enrollment caps or freezes and high premiums. California has an enrollment cap and only sells as many policies as it can finance with revenue from a tobacco tax (17,343 in 2000). There is a waiting list of about 4,000 individuals, each expected to wait about a year before being permitted to enroll in California's pool. Florida has an enrollment freeze. In a political compromise between the insurance industry (which protested the size of assessments for pool subsidy funding) and pool advocates, Florida's pool has been closed to new enrollment since 1990 and enrollment has declined from a high of 7,500 in that year to 709 in 2000. A pool that features enrollment caps or freezes does not comply with HIPAA regulations, so the pools in Florida and California are not HIPAA pools and could not be unless changes were made to enrollment policy.

The most pervasive barrier to enrollment is affordability. In all states, high-risk pool premiums, while subsidized, are above market rates. Only a small number of states offer additional subsidies for low-income individuals (Wisconsin, Connecticut, New Mexico, Oregon, Colorado). Consequently, for most people and in most states, high-risk pool premiums are above the already high non-group market rates, rendering high-risk pool coverage unaffordable for many who cannot obtain coverage in any other way.

To provide a sense of the financial burden imposed by pool premiums, Exhibit 3 lists the percents of all individuals, the uninsured, and the uninsurable, for whom the pool premium is greater than 25 percent and for whom it is less than 10 percent of income. Although there is no standard of affordability, the 25 percent and 10 percent thresholds are intended to serve as rough guides. Exhibit 3 shows, for example, that nationally, high-risk pool premiums are above 25 percent of income (i.e., are unaffordable) for 10 percent of all individuals, 18 percent of the uninsured, and 29 percent of the uninsurable. By these standards, almost a third of the uninsurable are unable to afford high-risk pool coverage, although there are large variations by state with Minnesota's premiums being the most affordable to its population and Kansas' among the least. Note that only 22 of the 27 high-risk pool states are listed in Exhibit 3 because premium data were not available for five states (Connecticut, Florida, Indiana, Louisiana, and Nebraska).

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**Exhibit 3****Percent of Population for Whom Premium Was Either Less Than 10 Percent or More Than 25 Percent of Family Income in Year 2000 for Selected States**

| State                   | Premium <sup>(a)</sup> | All Individuals |      | Uninsured |      | Uninsurable |      |
|-------------------------|------------------------|-----------------|------|-----------|------|-------------|------|
|                         |                        | >25%            | <10% | >25%      | <10% | >25%        | <10% |
| Alabama                 | \$192                  | 9%              | 72%  | 18%       | 54%  | 31%         | 36%  |
| Alaska                  | \$400                  | 14%             | 57%  | 26%       | 35%  | 36%         | 25%  |
| Arkansas                | \$153                  | 6%              | 77%  | 11%       | 61%  | 14%         | 39%  |
| California              | \$280                  | 12%             | 62%  | 19%       | 42%  | 30%         | 36%  |
| Colorado                | \$214                  | 6%              | 79%  | 12%       | 56%  | 22%         | 50%  |
| Illinois                | \$292                  | 11%             | 67%  | 20%       | 46%  | 33%         | 28%  |
| Iowa                    | \$273                  | 9%              | 65%  | 18%       | 35%  | 27%         | 27%  |
| Kansas                  | \$382                  | 18%             | 50%  | 37%       | 24%  | 51%         | 24%  |
| Minnesota               | \$128                  | 2%              | 91%  | 6%        | 82%  | 6%          | 86%  |
| Mississippi             | \$215                  | 11%             | 65%  | 18%       | 46%  | 33%         | 46%  |
| Missouri                | \$267                  | 10%             | 69%  | 16%       | 49%  | 21%         | 50%  |
| Montana                 | \$252                  | 14%             | 58%  | 26%       | 36%  | 34%         | 24%  |
| New Mexico              | \$202                  | 10%             | 66%  | 16%       | 49%  | 23%         | 48%  |
| North Dakota            | \$223                  | 9%              | 65%  | 15%       | 46%  | 26%         | 38%  |
| Oklahoma                | \$224                  | 10%             | 67%  | 15%       | 50%  | 25%         | 40%  |
| Oregon                  | \$232                  | 10%             | 69%  | 20%       | 45%  | 28%         | 26%  |
| South Carolina          | \$268                  | 10%             | 63%  | 20%       | 45%  | 35%         | 29%  |
| Texas                   | \$237                  | 10%             | 67%  | 17%       | 47%  | 24%         | 38%  |
| Utah                    | \$272                  | 7%              | 73%  | 16%       | 52%  | 25%         | 44%  |
| Washington              | \$266                  | 10%             | 69%  | 20%       | 49%  | 28%         | 41%  |
| Wisconsin               | \$196                  | 5%              | 79%  | 16%       | 57%  | 22%         | 55%  |
| Wyoming                 | \$179                  | 6%              | 79%  | 13%       | 63%  | 20%         | 57%  |
| ALL OF THE ABOVE STATES |                        | 10%             | 67%  | 18%       | 46%  | 29%         | 37%  |

<sup>(a)</sup> Premium in 2001 dollars for a 35 year old, non-smoking male at the lowest deductible and no optional features as reported by the states to Communicating for Agriculture. Includes 22 states with high-risk pools and available premium data.

Sources: Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals," (2001/2002), U.S. Census Bureau, Current Population Survey (1999-2001).

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## Implications of lower premiums

Given that affordability is a significant barrier to enrollment, it seems likely that lowering premiums would raise enrollment. To evaluate how much enrollment could grow if premiums were reduced, we conducted a simulation of the impact of lowering all premiums to the level seen in the most generous states.<sup>12</sup>

To conduct the simulation, we first estimated the elasticity of enrollment with respect to premiums using regression methods. The log of enrollment was modeled as a function of the log of high-risk pool premium, the level of benefits, the size and income of the state's uninsured population, and the year. The unit of observation was the state/year. Because actual premium data were missing for many state-years in the CFA data, we used the pool premium as a percent of market premium (set by statute) and per capita Medicare expenditure to create a proxy for this variable.<sup>13</sup> Our preferred specification yielded an elasticity of 1.9.

As Exhibit 4 shows this elasticity estimate implies that if premiums were set to no higher than 125 percent of market rate, enrollment would grow by 33 percent, nationally, reaching 11 percent of the uninsurable (up from 8 percent in 2000—see Exhibit 2). Enrollment growth varies by state, depending on how far current pool premiums are from 125 percent of market rate.

Using premium, claims, and assessment funding figures from CFA, we can calculate a simple approximation of the cost of subsidizing all premiums at 125 percent of market rates. The cost has two components, increased subsidies and increased claims volume. First, the per enrollee average additional premium subsidization is computed in each state as the difference between the current average premium and the new, lower average premium. Second, the per enrollee average annual claim figure is computed for each state. Multiplying these two figures by the total number of enrollees provides the total amount of financing required. From this total, the amount already provided by the state or from premium dollars is subtracted. What remains is the cost of reducing premiums to 125 percent of market.<sup>14</sup>

An order of magnitude estimate of the additional cost of reducing premiums to 125 percent of market rate is about \$105 million nationally, or about \$2,800 per new enrollee. This figure assumes no change in the level of assessment funding currently provided in each state and does not include administrative costs. We acknowledge that a major challenge facing any policy maker wishing to finance high-risk pool expansion is how to do it without displacing current funding (a variant of the crowd-out problem<sup>15</sup>); however, our purpose here is only to develop a first approximation of what might be possible, postponing such implementation issues.

One additional lesson emerges from this simulation. As Exhibit 4 indicates, even when premiums are fixed at approximately the same level relative to the market, states differ dramatically with respect to the proportion of the uninsurable that would be covered. Six states are projected to cover between 20 and 55 percent, eight states are between 10 and 19 percent, and the remaining states are in the low, single digits. These results underscore the fact that considerations other than premium levels have substantial effects on enrollment. Some of these factors could be circumstantial, such as the relative

availability of charity care, and some could reflect characteristics of the high-risk pools, such as the extent of marketing and the attractiveness of benefits.

#### Exhibit 4

#### Predicted Effect of Reduction in Premiums to 125% of Market Rate by State in 2000

| State                       | Premium as Percent of Market | Year 2000 Enrollment | Simulated Enrollment | Simulated Enrollment Relative to |           |             |
|-----------------------------|------------------------------|----------------------|----------------------|----------------------------------|-----------|-------------|
|                             |                              |                      |                      | Actual Enrollment                | Uninsured | Uninsurable |
| Alabama                     | 175%                         | 2,431                | 4,612                | 190%                             | 1%        | 10%         |
| Alaska                      | 200%                         | 395                  | 966                  | 245%                             | 1%        | 11%         |
| Arkansas                    | 150%                         | 2,270                | 3,212                | 141%                             | 1%        | 9%          |
| California <sup>(a,b)</sup> | 125%                         | 17,343               | 17,343               | 100%                             | 0%        | 6%          |
| Colorado <sup>(a)</sup>     | 118%                         | 1,536                | 1,536                | 100%                             | 0%        | 5%          |
| Connecticut                 | 150%                         | 1,719                | 2,432                | 141%                             | 1%        | 12%         |
| Florida <sup>(b)</sup>      | 250%                         | 709                  | 709                  | 100%                             | 0%        | 1%          |
| Illinois                    | 150%                         | 10,120               | 14,318               | 141%                             | 1%        | 14%         |
| Indiana                     | 150%                         | 6,475                | 9,161                | 141%                             | 1%        | 16%         |
| Iowa                        | 150%                         | 271                  | 383                  | 141%                             | 0%        | 3%          |
| Kansas                      | 150%                         | 1,283                | 1,815                | 141%                             | 1%        | 8%          |
| Louisiana                   | 200%                         | 1,088                | 2,662                | 245%                             | 0%        | 5%          |
| Minnesota <sup>(a)</sup>    | 125%                         | 25,892               | 25,892               | 100%                             | 6%        | 54%         |
| Mississippi                 | 175%                         | 2,231                | 4,233                | 190%                             | 1%        | 13%         |
| Missouri                    | 200%                         | 889                  | 2,175                | 245%                             | 0%        | 6%          |
| Montana                     | 150%                         | 1,687                | 2,387                | 141%                             | 1%        | 16%         |
| Nebraska                    | 135%                         | 5,023                | 5,815                | 116%                             | 4%        | 41%         |
| New Mexico <sup>(a)</sup>   | 125%                         | 1,063                | 1,063                | 100%                             | 0%        | 5%          |
| North Dakota                | 135%                         | 1,307                | 1,513                | 116%                             | 2%        | 21%         |
| Oklahoma                    | 140%                         | 1,922                | 2,385                | 124%                             | 0%        | 4%          |
| Oregon <sup>(a)</sup>       | 125%                         | 5,833                | 5,833                | 100%                             | 1%        | 21%         |
| South Carolina              | 200%                         | 1,451                | 3,550                | 245%                             | 1%        | 7%          |
| Texas <sup>(b)</sup>        | 165%                         | 8,600                | 8,600                | 100%                             | 0%        | 4%          |
| Utah                        | 150%                         | 1,106                | 1,565                | 141%                             | 1%        | 7%          |
| Washington                  | 150%                         | 2,333                | 3,301                | 141%                             | 0%        | 6%          |
| Wisconsin                   | 200%                         | 10,042               | 24,567               | 245%                             | 5%        | 51%         |
| Wyoming                     | 200%                         | 669                  | 1,637                | 245%                             | 2%        | 27%         |
| <b>TOTALS</b>               |                              | <b>115,688</b>       | <b>153,666</b>       | <b>133%</b>                      | <b>1%</b> | <b>11%</b>  |

(a) Premiums in these states are already at or below 125 percent of market rates. Therefore, we did not simulate a change in premium in these states and, thus, there is no change in enrollment.

(b) These states were excluded in estimating the elasticity of enrollment with respect to premium: California because enrollment is capped by available funds, Florida because there is an enrollment freeze, and Texas because it is not in equilibrium (enrollment has grown rapidly at start-up).

Sources: *Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals," (1995-2001/2002)*, U.S. Census Bureau, *Statistical Abstract of the United States (1995-2001)*, U.S. Census Bureau, *Current Population Survey (1999-2001)*.

## Policy Discussion

Other than encouraging the establishment of high-risk pools, the influence of federal regulation on access to those pools has been modest to date. Of the two chief barriers to access, enrollment caps or freezes and affordability, HIPAA only addresses the first one, establishing that a high-risk pool must not impose restrictions on the number of enrollees in order to be an acceptable portability mechanism (25 of the 27 high-risk pools in operation in 2000 satisfy this criterion, though only 23 are HIPAA pools).

Most states do not provide additional premium subsidization for low-income pool applicants. Therefore, for much of the high-risk target population (the medically uninsurable) high-risk pool coverage is unaffordable. Federal regulation regarding the degree of affordability of high-risk pools could encourage additional enrollment and lead to an increase in coverage for the uninsurable population.

Of course, the benefits of lower premiums come at a cost. For about \$105 million in additional premium subsidization, high-risk pool enrollment could be expected to grow by about 33 percent and increase coverage of the uninsurable population from 8 percent to 11 percent. 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.

The fact that substantial projected enrollment variation remains among states after adjusting for premium differences suggests that significant enrollment growth could be encouraged even without additional premium subsidies. In the course of their regular reviews of state alternative mechanisms under HIPAA, it would be reasonable for regulators to focus their attention on the operations of pools with relatively low enrollment, controlling for premium. In addition to improving understanding of the factors that explain enrollment variations, it is possible that such a ranking by itself would serve as an effective incentive for state policymakers and pool administrators to seek to minimize barriers to access.

Given the prevailing fiscal climate and the political challenge of simply maintaining the current level of high-risk pool funding, additional funding is unlikely to come from state sources. Federal action, therefore, appears to be the most feasible instrument of expansion in the near future. This study shows that, building on the foundation established by HIPAA, the combination of new federal funding and federal affordability and enrollment guidelines could significantly expand access to health insurance for those currently unable to acquire it.

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<sup>1</sup> U.S. Bureau of the Census, "Chances of Having Health Insurance Increase, Reversing 12-Year Trend, Census Bureau Says," *United States Department of Commerce News* (September 28, 2000); U.S. Bureau of the Census, "More People Have Health Insurance, Census Bureau Reports," *United States Department of Commerce News* (September 28, 2001).

<sup>2</sup> Based on an analysis of Bureau of Labor Statistics and Census Bureau conducted by Families USA (Families USA Media Center, "New Unemployment Number Indicates Over 529,000 Laid-Off Workers Lost Health Coverage from September through November," (December 7, 2001)).

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<sup>3</sup> Covering the Uninsured, “Two Million Americans Lost Their Health Insurance in 2001; Largest One-Year Increase in Nearly a Decade” (Press release prepared by Families USA for a Robert Wood Johnson Foundation-sponsored partnership, Covering the Uninsured, February 12, 2002). Based on Bureau of Labor Statistics data.

<sup>4</sup> National Journal, American Health Line, “Uninsured: New ‘Broad Coalition’ Seeks National Action,” (February 11, 2002).

<sup>5</sup> S. Simon, “Medicaid Ax Is Falling as Recession Saps States,” *Los Angeles Times* (March 5, 2002).

<sup>6</sup> Communicating for Agriculture, Inc., *Comprehensive Health Insurance for High-Risk Individuals*, 9<sup>th</sup>-15<sup>th</sup> editions, (Fergus Falls, MN, 1995-2001/2002).

<sup>7</sup> We are aware of no reliable statistics concerning the number of uninsurable individuals. Our approach suggests that roughly one percent of the total population and six percent of the uninsured population is uninsurable; this is slightly higher than results cited by the State of California, namely that 2.5-5 percent of California’s uninsured are uninsurable due to medical underwriting (S. Hunt, “Individual Health Insurance Options for California,” study by Pricewaterhouse Coopers for the California Managed Risk Medical Insurance Board (September, 2000)).

<sup>8</sup> U.S. Census Bureau, Statistical Abstract of the United States (1995-2001 editions).

<sup>9</sup> TennCare is Tennessee’s health insurance program for the low-income and uninsurable population, including the Medicaid-eligible population. Because the uninsurable population is just a small part of TennCare, it does not operate like a standard high-risk pool and should not be viewed as one.

<sup>10</sup> For an overview of small-group reform by state in the early 1990s see United States General Accounting Office, “Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms,” Fact Sheet for the Chairman, Subcommittee on Employer-Employee Relations, Committee on Economic and Educational Opportunities, House of Representatives (June, 1995).

<sup>11</sup> Since high-risk pool premiums are above market levels and most pools require potential enrollees to demonstrate that private carriers have rejected them, virtually all high-risk pool enrollees would be uninsurable if not enrolled. Consequently, we calculated percents of uninsurable as  $\{\text{pool enrollment}/(\text{pool enrollment} + \text{estimated uninsurable})\} \times 100$ .

<sup>12</sup> Four states (California, Minnesota, New Mexico, and Oregon) set their premiums at 125 percent of the market rate. This is the standard used for the simulation. One state, Colorado, sets premiums at 118 percent of the market rate.

<sup>13</sup> For additional technical details including estimation of an alternative specification based on actual premiums (as opposed to the proxy) see A. Frakt et al., “Technical Appendix to ‘Insuring the Uninsurable: The Growth of High-Risk Pools,’” *HSRE Working Paper*, No. 13, Abt Associates Inc. (May 15, 2002).

<sup>14</sup> This method does not attempt to be precise about the level of subsidy spending in each state for two reasons. First, subsidy spending (including assessments, general revenue, and other sources) does not track claims on an annual basis—under-financed losses in one year are frequently offset by additional revenues in following years. Second, subsidy spending may occur in forms not easily accounted for, for example, in the form of low-income premium subsidies paid from general revenue.

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<sup>15</sup> The term “crowd out” is typically applied to situations where expanded public services (e.g., Medicaid) cause privately financed services to be reduced (see J. Gruber, “Health Insurance and the Labor Market,” in A.J. Culyer, and J.P. Newhouse, eds. *Handbook of Health Economics Vol. 1A*, (Amsterdam: Elsevier Science, 2000)).