LESSONS FROM THE PAST: HIGH-RISK POOLS WILL NOT HELP MOST PEOPLE WITH PRE-EXISTING CONDITIONS LIKE HIV/AIDS

North Carolina's High-Risk Pool at a Glance

- **Plan Name: Inclusive Health**
- **Years of Operation: 2009–2013**
- **Number of People Enrolled in 2012: 6,000 (out of 1.6 million North Carolinians with pre-existing conditions)**
- **Cost per Year: $43.2 million**
- **Average Cost per Enrollee: $6,400 per year**
- **Waiting period for coverage of pre-existing conditions: 12 months**
- **Premium Cost Compared to the Average Premium in Private Health Plans: 200%**
- **Maximum lifetime expenses covered: $1 million**[1]

What are High-Risk Pools?

High-risk pools are special insurance plans for people who cannot get or afford private health insurance because of a pre-existing condition. High-risk pools are set up and run by states. Before Congress passed the Affordable Care Act (ACA), 35 states had high-risk pools.[2] Although they can greatly help people who cannot get insurance anywhere else, they were very expensive and covered very few people.[3]

Problems with State High-Risk Pools

Almost all Republican plans to replace the ACA, including the ACHA, would likely depend on high-risk pools to cover many people with pre-existing conditions. But high-risk pools are nothing new, and state pools that existed before the ACA had many problems. Because of those problems, they were only available and affordable for a tiny fraction of people with pre-existing conditions. A federal high-risk pool, the Pre-existing Condition Insurance Plan ("PCIP") was created by the ACA to provide a bridge to new insurance marketplaces. It was more affordable than many state high-risk pools, but still had low enrollment. Even so, it ran out of money before its planned ending date. Below we explain problems that made state high-risk pools unavailable and ineffective for people with pre-existing conditions like HIV.

1. Underfunding and High Costs

In the years before Congress passed the ACA, many states underfunded their high-risk pools. [4] As a result, many of those pools were forced to freeze people out from enrolling or create waitlists because they did not have enough money to cover all the eligible people who wanted to sign up. These funding problems arose largely because high-risk pools were very expensive to operate. They only covered people with health problems that require expensive treatments and medicines. For example, one nationwide study found that high-risk pools cost around $6,000 per person in 2011.[5] Another study found that it would cost $178 billion per year to properly fund high-risk pools in all 50 states that would adequately cover people with pre-existing conditions. [6]

2. Limited Enrollment and Long Wait Times

Largely because of their limited budgets, high-risk pools enrolled only a tiny fraction of people with pre-existing conditions, restricted eligibility to certain medical conditions, and imposed long waiting periods. Most people qualified them for coverage in North Carolina's high-risk pool had to wait at least twelve months before they could get coverage for those conditions.[7] So many of them had to go months without any way to pay for their medical care. Even the largest state high-risk pools insured only a tiny fraction of their states' populations. Nationwide, just over 225,000 people—0.0007% of America's population in 2011—were enrolled in high-risk pools at their enrollment peak before the ACA was passed.[8] Yet one in three non-elderly adults in the U.S.—about 56 million people—have pre-existing conditions that could interfere with their ability to afford and maintain private health insurance.[9] In fact, one government study found that private insurers denied coverage to 19 percent of people who applied because of pre-existing conditions in the years before the ACA.[10] In NC alone, 1.6 million people—or 27% of all non-elderly adults—could face barriers in affording and maintaining private insurance due to pre-existing conditions.[11]

3. Unaffordable Premiums and Deductibles

Many people were forced to leave or discouraged from enrolling in high-risk pools because plans in those pools charged high premiums and deductibles.[12] For example, in North Carolina's high-risk pool, the average premium cost for a plan with a $1,000 deductible averaged around $500 per month for a 45-year-old non-smoker.[13] Even assuming that premiums would stay at 2013 prices, a single person with income at 150% of the current federal poverty level ($18,090 per year) would have to spend *33% of their gross income just on premiums* in North Carolina's pool. That percentage also does not include any cost sharing or deductibles—deductibles in plans offered in North Carolina's high-risk pool averaged around $3,500 and, unlike the ACA, North Carolina's high-risk pool did not provide any subsidies to help with the high costs of its plans.[14] As a result, North Carolina's high-risk pool largely attracted only higher-income people who could afford those high costs.

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[1] This information was developed using detailed data on high-risk pools collected by the National Association of State Comprehensive Health Insurance Plans (NASCHIP). *See* Coverage of Uninsurable Pre-Existing Conditions: State and Federal High-Risk Pools, NCSL.ORG (last updated Jan. 23, 2017), http://www.ncsl.org/research/health/high-risk-pools-for-health-coverage.aspx.

[2] Karen Pollitz, Henry J, Kaiser Family Found. Issue Br. No. 8903, *High-Risk Pools For Uninsurable Individuals* (July 2016).

[3] *See* note 2.

[4] Drew Altman, Henry J. Kaiser Family Found., *High-Risk Pools as Fallback for High-Cost Patients Require New Rules*, KFF.ORG (Jan. 23, 2017), http://kff.org/health-reform/perspective/high-risk-pools-as-fallback-for-high-cost-patients-require-new-rules/ ("Premiums did not cover costs in the state risk pools, with a combined shortfall of over $1.2 billion in 2011, and some states capped enrollment.").

[5] Pollitz, note 1.

[6] JEAN P. HALL, COMMONWEALTH FUND, WHY A NATIONAL HIGH-RISK INSURANCE POOL IS NOT A WORKABLE ALTERNATIVE TO THE MARKETPLACE 4 (Dec. 2014), available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1792_hall_highrisk_pools.pdf.

[7] *Welcome to Inclusive Health*, INCLUSIVE HEALTH, http://main.nationalmssociety.org/site/DocServer/IH-AWARENESS-FLYER-V5.pdf;jsessionid=00000000.app321a?docID=33504&NONCE_TOKEN=5E68C5B8A7FCB03DFF473A336BC0D198 (last visited Mar. 2, 2017).

[8] *See* note 2.

[9] Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt & Karen Pollitz, Henry J. Kaiser Family Found., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, KFF.ORG (Dec. 12, 2016), http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[10] *See* U.S. GOVERNMENT ACCOUNTING OFFICE, PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS 12, GAO-11-268 (Mar. 16, 2011), available at http://www.gao.gov/products/GAO-11-268.

[11] *See* note 10.

[12] BLUECROSS BLUESHIELD OF N.C., IN THE SPOTLIGHT: HEALTH CARE REFORM AND HIGH RISK POOLS 2 (July 22, 2010), https://www.bcbsnc.com/assets/hcr/pdfs/HCR_HRP.pdf ("State high risk pools' experience has been that their plans—sold at prices above standard market rates—have proven to be unaffordable to many who qualify to purchase their coverage.").

[13] *Inclusive Health*, INTERNET ARCHIVE WAYBACK MACHINE, https://web.archive.org/web/20120626141213/http://www.inclusivehealth.org/? (last visited Mar. 21, 2017).

[14] *See Lifetime Maximums, Popular Plan, Premium Subsidy*, NASCHIP (Sept. 2012), http://naschip.org/2012/Quick%20Checks/Lifetime%20Maximums.pdf.