

INSURING MEDICALLY UNINSURABLE INDIVIDUALS

AN EXAMINATION OF DIFFERENT STATE APPROACHES

Catherine Chou*

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INTRODUCTION

The burden of providing health insurance to unhealthy, high-cost medical consumers in the United States is a major social issue. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)¹ requires states to provide state-guaranteed coverage for individuals unable to secure coverage in the private health insurance market. In response, states have used four different approaches to finance health care for medically uninsurable individuals. This article analyzes these four approaches and their effects.

Studies show that one in four men and one in five women will develop cancer, have a heart attack, or suffer a stroke before age 65.² In most cases, having one of these three medical conditions disqualifies an individual from being able to obtain health insurance in the private market. These conditions also are on most state lists of “qualified preexisting conditions” that qualify an individual as “medically uninsurable,” as states assume that individuals with these conditions will be unable to obtain private health insurance coverage. Furthermore, even if an individual with one of these medical conditions is able to secure coverage, that person’s premiums are significantly higher than premiums for a healthy individual of the same age.

A study published in February of 2005 reported findings of an investigation of 1,771 personal bankruptcy filers in five federal courts and 931 in-depth interviews. Approximately half of these bankruptcy filers cited medical cases as a reason for their bankruptcy: between 1.9 and 2.2 million Americans (filers plus dependents).³ The study also reported that 75.7% of the group driven to

* J.D., Brigham Young University, 2006. Address correspondence to Ms. Chou at catherine.chou@gmail.com.

¹ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 110 Stat. 1936 (1996).

² David Himmelstein et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS, Feb. 2, 2005, at W5-69 available at <http://content.healthaffairs.org> (Quick Search “Himmelstein”).

³ *Id.*

bankruptcy had employer-sponsored health insurance when they first became ill. Medical bankruptcies had increased by a factor of 23 between 1981 and 2001 and continue to increase.⁴

In response to the rapidly rising demand and need for health care for medical uninsurables, Congress created a federal obligation that requires states to provide affordable coverage for their unhealthy citizens.⁵ HIPAA set federal standards for preexisting condition clauses; by 1995, 36 states had enacted some form of HIPAA-equivalent state reform.⁶ As of 1999, 28 state governments had chartered nonprofit health insurance plans to accomplish the social goal of assuring access to necessary, quality medical care without the disruptions and negative side effects common to the private health insurance industry.⁷ Currently, as a result of HIPAA, every state provides some type of guaranteed coverage for residents who cannot get coverage either because they have a preexisting condition which prevents them from getting coverage in the private market or because they are very poor to the extent that they are unable to afford the premium for health insurance.

This article addresses the following questions: What is HIPAA-eligibility and how does it apply to the medically uninsurable? What four methods have states utilized to provide health insurance to medical uninsurables? What results have states reported as a result of utilizing these methods to provide subsidized health care to medical uninsurables? Finally, which method is the most economically efficient and least socially damaging way to provide care to medical uninsurables?

I. THE HIPAA MANDATE AND STATE RESPONSES

HIPAA requires that all individuals who meet seven federally specified requirements be provided with state-provided, affordable coverage.⁸ All 50 states and the District of Columbia have established programs in line with this federal mandate. All but 10 states have gone one step further and also provide coverage for unhealthy individuals who are not HIPAA-eligible.

⁴ *Id.*

⁵ UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, ADMINISTRATIVE SIMPLIFICATION UNDER HIPAA: NATIONAL STANDARDS FOR TRANSACTIONS, PRIVACY AND SECURITY (2003), available at <http://www.hhs.gov/news/press/2002pres/hipaa.html> (last visited Apr. 17, 2006).

⁶ Gail A. Jensen & Michael A. Morrisey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, MILBANK Q., 77 No. 4 (1999), available at <http://www.milbank.org/quarterly/7704feat.html>.

⁷ Conrad Meier, *Extending Affordable Health Insurance to the Uninsured*, HEARTLAND INST., Aug. 27, 1999, at <http://www.heartland.org/Article.cfm?artId=12610>.

⁸ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 110 Stat. 1936 (1996).

States have instituted risk pools, open enrollment periods, guaranteed issue insurance, and guaranteed issue community-rated insurance to provide health care coverage to otherwise medically uninsurable individuals.

For the purposes of this article, medical uninsurables are divided into two groups—HIPAA-eligibles and non-HIPAA-eligibles. To begin, it is necessary to establish a basic understanding of the federal regulations that make an individual “HIPAA-eligible.”

A. HIPAA-Eligible Individuals

To be HIPAA-eligible, an individual must meet seven of the following eligibility requirements at the time the individual applies for health care coverage. To be eligible, an applicant must: have at least 18 months of continuous creditable coverage without any breaks of 63 days or more; have had most recent coverage under a group health plan; not be eligible for coverage under another group health plan; not have had the most recent health coverage cancelled for nonpayment of premiums or because of committing fraud; not be eligible for Medicare or Medicaid; if offered COBRA,⁹ Temporary Continuation of Coverage (TCC),¹⁰ or State continuation coverage, have purchased and exhausted the coverage; and not have accepted a conversion policy or a short-term limited duration policy.¹¹

If an individual is deemed HIPAA-eligible and applies for individual coverage within 63 days after the day group health coverage or continuation coverage ends, that person is guaranteed individual coverage with no exclusions for preexisting conditions. The insurer cannot exclude payments for medical conditions that predated the start of insurance coverage.¹²

HIPAA-eligible individuals are provided health insurance through four mechanisms. These are state risk pools, open enrollment periods, guaranteed

⁹ COBRA insurance provides for the temporary continuation of group health care coverage that would otherwise be terminated because of retirement, termination, or reduced hours at work. COBRA insurance covers former employees, retirees, spouses and dependent children. *See* COBRA Insurance.com, [http://cobrainurance.com/COBRA Legal Text.htm](http://cobrainurance.com/COBRA%20Legal%20Text.htm) (last visited May 17, 2006). COBRA insurance was created in the health care benefit section of the Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272 (1986).

¹⁰ Temporary Continuation of Coverage is a program under the Federal Employees Health Benefits Act that enables former employees and their families to continue coverage after it has been terminated. *See* UNITED STATES OFFICE OF PERSONNEL MANAGEMENT, WHAT IS TEMPORARY CONTINUATION COVERAGE (TCC)?, at <http://www.opm.gov/insure/health/tcc/02.asp> (last visited May 17, 2006).

¹¹ UNITED STATES DEPARTMENT OF LABOR, HEALTH COVERAGE PORTABILITY, 2004, at 28, available at <http://www.dol.gov/ebsa/pdf/consumerhipaa.pdf>.

¹² *Id.* at 8.

issue community-rated policies, and guaranteed issue non-community rated policies.

1. State Risk Pools

The first and most common of these four methods is insurance provided through state risk pools. State risk pools (also called “high-risk pools”) started in 1976 as a “state-created, nonprofit association that—in most states—does not require tax dollars for its operational purposes to provide insurance coverage for individuals who are denied health insurance for medical reasons.”¹³

However, risk pools are not created to serve the indigent who cannot afford health insurance. The indigent have other options available, which include state medical assistance, Medicaid, or similar programs.¹⁴ State risk pools provide insurance to those who have the financial resources to pay for insurance but are unable to qualify for coverage in the private health insurance market because of a medical condition.

Since 1976, new states have added risk pools each year. Most recently, West Virginia became the 33rd state to approve the creation of a high-risk health insurance risk pool program, which became operational in January of 2005.¹⁵ Generally, high-risk pools serve as a “risk-spreading mechanism whereby the few high-risk, high-cost persons in a market are guaranteed a source from which to purchase insurance, and the added costs are spread broadly throughout the insurance industry or the public through government funding.”¹⁶ The burden, therefore, is not left to the healthy insureds in the state to fully subsidize the costs of the medically uninsurables. Instead, the government instituted programs subsidize the cost of health care to these unhealthy persons and remove the burden from the healthy citizens.

More than 250,000 individuals have received state-guaranteed coverage from a state risk pool or its equivalent.¹⁷ Use of state risk pools has increased over the years, as evidenced by the growth in all areas of use from 2002 to 2003 as shown in Table 1 (following page).

All high-risk pools necessarily lose money, because their only paying customers are those considered medically uninsurable. Premiums generally

¹³ HealthInsurance.org, *Risk Pools—Affordable Health Insurance for Medically Uninsurable Individuals*, at <http://www.healthinsurance.org/riskpoolinfo.html> (last visited Apr. 17, 2006).

¹⁴ SelfEmployedCountry.org, *What Is a Risk Pool?*, at <http://www.selfemployedcountry.org/riskpools/whatis.html> (last visited Apr. 17, 2006).

¹⁵ *Risk Pools*, *supra* note 13.

¹⁶ Bruce Abbe, *Using Tax Credits and State High-Risk Pools to Expand Health Insurance Coverage*, HEALTH AFFAIRS, Oct. 23, 2002, at W347, available at <http://content.healthaffairs.org> (Quick Search “Abbe”).

¹⁷ *Risk Pools*, *supra* note 13.

TABLE 1: Statistics for 2003 for All State Risk Pools¹⁸

	Total <u>Enrollment</u>	Total <u>Claims</u>	Total <u>Premiums</u>	Total Reported Administration <u>Costs</u>	Total Combined <u>Deficit</u>
2003	181,411	\$1.26 million	\$793.5 million	\$74.6 million	\$539.8 million
% Increase from 2002	NA	+20.9%	+24.3%	+14.3%	+15.2%

cover only 40% to 60% of the necessary operating funds.¹⁹ According to National Association of Insurance Commissioners (NAIC)²⁰ model legislation, premiums paid by the individuals in these risk pools are between 125% and 200% of the average cost of an individual policy premium.²¹

Given the potential of insuring extremely unhealthy citizens with high health care costs, it is no wonder that state risk pool managers often use the highest average they can justify, so that increased funds premiums will offset the high cost of operating the risk pool.²² Table 2 compares individual

TABLE 2: Representative Samples of Risk Pool Premiums Versus Traditional Policy Premiums

State	Risk Pool Premium and Deductible	Traditional Policy Monthly Premium
Alaska	\$486/month with \$1,000 deductible ²³	\$192/month with \$1,000 deductible ²⁴
New Hampshire	\$235/month with \$1,000 deductible ²⁵	\$163/month with \$1,000 deductible ²⁶
Texas	\$364/month with \$1,000 deductible ²⁷	\$117/month with \$1,500 deductible ²⁸
Washington	\$384/month with \$1,000 deductible ²⁹	\$146/month with \$750 deductible ³⁰

¹⁸ *Id.*

¹⁹ Wayne Nelson, Communicating for Agriculture Announces Support for Self-Employed Health Care Affordability Act, at <http://www.selfemployedcountry.org/testimony/20030430healthcare.html> (last visited Apr. 17, 2006).

²⁰ The NAIC is an organization of insurance regulators organized to provide a forum for the development of uniform policy. See www.naic.org (last visited Apr. 17, 2006).

²¹ Bruce Abbe, *Overview—State High Risk Health Insurance Pools*, at <http://www.selfemployedcountry.org/riskpools/overview.html> (last visited Apr. 17, 2006).

²² PAUL ZANE PILZER, *THE NEW HEALTH INSURANCE SOLUTION* 129 (2005).

²³ Alaska Comprehensive Health Insurance Association, Rates—Applications—Inquiries, at <http://www.achia.com/apply/> (last visited Apr. 17, 2006).

²⁴ eHealthInsurance.com, Celtic Managed Indemnity 80/20 Plan; Single Applicant (M/35) from Juneau AK 99601, at <http://www.ehealthinsurance.com> (last visited Apr. 17, 2006).

²⁵ New Hampshire Health Plan, Managed Care Plan Option A; Single Applicant (M/35), at <http://www.nhhealthplan.org/downloads/Brochure.pdf>.

²⁶ eHealthInsurance.com, Anthem Blue Direct \$1,000/\$2,000 Single Applicant (M/35) from Concord, NH 03301, at <http://www.ehealthinsurance.com> (last visited Apr. 17, 2006).

²⁷ Texas Health Insurance Risk Pool, at <http://www.txhealthpool.org> (5 Oct. 2005) (Plan II \$1,000 Deductible Area 2; Single Applicant (M/35) from Austin, TX 78701).

²⁸ eHealthInsurance.com, Blue Cross Blue Shield of Texas, PPO Select Choice, Single Applicant (M/35) from Austin, TX 83301, at <http://www.ehealthinsurance.com> (last visited Apr. 17, 2006).

²⁹ Washington State Health Insurance Pool, Plan 3 Network Plan \$1,000 Deductible Plan Choice; Single Applicant (35), at <http://www.wship.org/summary.asp> (last visited Apr. 17, 2006).

³⁰ eHealthInsurance.com, Regence Blue Shield Selections Comprehensive Plan 1000, Single Applicant (M/35), from Olympia, WA 98501, at <http://www.ehealthinsurance.com> (last visited Apr. 17, 2006).

states' risk pool premiums against comparable traditional premiums available to citizens of the same state.

In each state, after factoring in additional charges assessed for unhealthy individuals' increased health care costs, risk pool premiums exceed traditional policy premiums charged by the private health insurance market. However, consumption of health care by those in the risk pool far exceeds consumption by individuals who are able to secure private health insurance coverage. Generally, state risk pool subscribers consume between \$10,000 and \$100,000 in annual medical expenses; for these subscribers, however, the monthly premiums are low.³¹

To illustrate, one study estimated that, for specific types of cancer during 1999 to 2000, mean monthly health care costs ranged from \$2,187 for prostate cancer to \$7,617 for pancreatic cancer.³² That multiplies into annual health care costs of \$26,244 to \$91,404, respectively. States have widely varying monthly premiums for unhealthy coverage. Georgia charges its HIPAA-eligible applicants only \$172 per month (\$2,064 per year) with an annual deductible of \$2,000,³³ while North Carolina charges its HIPAA-eligible applicants \$1,389 per month (\$16,668 per year) with an annual deductible of \$1,200 for a guaranteed issue policy³⁴ without medical underwriting.³⁵

To offset operating costs, state risk pools generally are funded through four main sources of revenue: charging insurance carriers a premium-based fee on health insurance policies sold in the state; allocating tobacco and other revenue taxes to fund the pool; federal grants; or matching federal funds.³⁶ As of 2002, 26 of the state risk pools used some kind of assessment on the industry to subsidize risk pool costs. Twelve of those 26 provided for state funding by granting a premium tax credit back to insurance carriers. Other states use general revenue appropriations, tobacco tax revenue, or other state funding for pool subsidies.³⁷ Seed grants provided by the federal government through the Centers for Medicare and Medicaid Services (CMS) are available

³¹ PILZER, *supra* note 22, at 130.

³² Stella Chang et al., *Eliminating the Cost of Cancer: Results on the Basis of Claims Data Analyses for Cancer Patients Diagnosed with Seven Types of Cancer During 1999 to 2000*, 22 J. CLIN. ONC. 3524, available at <http://www.jco.org/cgi/content/full/22/17/3524>.

³³ Interview with Insurance Commission Official, GA Assignment Program (May 12, 2005) (Single Applicant (M/35)). Georgia has a pool of providers that are required to provide health insurance to medically uninsurables with state government subsidies.

³⁴ Interview with Blue Cross/Blue Shield of NC Official (May 11, 2005) (Single Applicant (M/35)).

³⁵ Medical underwriting is the process in which an insurance agent or company assesses the health risk of an individual and charges a premium based on probable frequency and size of claims.

³⁶ Robert Wood Johnson Foundation, *State Coverage Initiatives*, at <http://www.statecoverage.net/pdf/coverage.pdf>.

³⁷ Abbe, *supra* note 21.

to states for qualified high-risk pools.³⁸ In 2004, legislation was introduced to expand a new federal grant program that provides \$80 million in matching funds to help finance state high-risk insurance pools.³⁹

States use different approaches to determine how these assessments or revenue subsidies will be contributed. For example, California relies primarily on government revenues to fund its state risk pool. The state draws from an established Major Risk Medical Insurance Fund established in the California State Treasury that is funded by cigarette and tobacco tax revenues.⁴⁰ Kentucky similarly uses tobacco settlement funds to fund its risk pool; in addition to government revenues, however, Kentucky also funds its pool by charging all insurers an assessment on health benefit premiums.⁴¹ South Dakota funds its Health Insurance Pool by charging a \$3 per year assessment to all health insurance subscribers in the state.⁴²

Eligibility requirements for admittance into state risk pools differ across states. Generally, states view risk pool coverage as a last resort for providing health care coverage to the medically uninsurable. The information contained in this article is available to the general public; however, because most state-sponsored programs operate at a loss, states do not choose to advertise this guaranteed coverage.

Typically, only individuals unable to secure alternate coverage are accepted into a state's risk pool. However, some states, such as West Virginia, allow dependents of those eligible for the pool to also be covered by the West Virginia Risk Pool (AccessWV).⁴³ In addition, some states illogically allow unhealthy individuals unable to secure coverage in the private health insurance market to add their families to the state risk pool plan for a lower cost than they would face in the private health insurance market. For example, Maryland's state risk pool is losing money by charging a potentially medically uninsurable person and family (including a spouse and two children) a premium⁴⁴ that is lower than the market premium for a healthy individual and family.⁴⁵

³⁸ Federal Grants Wire, *Seed Grants to States for Qualified High Risk Pools*, at http://www.federalgrantswire.com/seed_grants_to_states_for_qualified_highrisk_pools.html (last visited Apr. 17, 2006).

³⁹ Karen Pollitz, *Federal Grants to State High-Risk Pools: Tracking State Efforts to Strengthen Coverage*, Commonwealth Fund: Programs & Grants, at http://www.cmwf.org/grants/grants_show.htm?doc_id=23104 (last visited Apr. 17, 2006).

⁴⁰ Robert Wood Johnson Foundation, *supra* note 36.

⁴¹ *Id.*

⁴² *Id.*

⁴³ Access West Virginia, at <http://www.wvinsurance.gov/accesswv/faqs.htm> (last visited Apr. 17, 2006).

⁴⁴ Maryland Health Insurance Plan, MHIP \$1,000 PPO Plan, Subscriber and Family, at www.marylandhealthinsuranceplan.state.md.us (last visited Apr. 19, 2006).

⁴⁵ eHealthInsurance.com, Golden Rule Single/Family HSA Saver, Single Applicant (M/35), Family Applicant (M/35), Spouse (F/35), Children (F/8, M/5) from Annapolis, MD 21401, at <http://www.ehealthinsurance.com> (last visited Apr. 19, 2006).

Risk pool policy benefits also vary widely among states. Generally, however, “insurance benefits vary, but risk pools typically offer benefits that are comparable to basic private market plans—80/20 major medical and outpatient coverage, a choice of deductible and co-payments.”⁴⁶ Benefits specific to each of the existing 33 state risk pools can be found by visiting the Department of Insurance or Risk Pool Web site of each state.

The United States Department of Labor defines a preexisting condition as a “medical condition present before your enrollment date in any new group health plan.”⁴⁷ Under HIPAA, preexisting condition exclusions cannot be applied to pregnancy or HIPAA-eligible individuals. Those individuals can immediately obtain coverage for preexisting conditions. They are exempt from the typical six-month to twelve-month waiting period during which individuals without previous health coverage are not covered for medical expenses resulting from a preexisting condition.⁴⁸

States without a risk pool are required to provide some type of substitute or equivalent state-guaranteed coverage for their unhealthy, HIPAA-eligible citizens. There are three alternatives to state risk pools.

2. Open Enrollment Policies

One alternative to state risk pools is for states to offer open enrollment policies to their medically uninsurables. Certain states mandate that health insurance carriers offer all residents a period of open enrollment during which all applicants are accepted regardless of health status. Ohio is the only state that utilizes this system exclusively to fulfill the federal requirement to provide HIPAA-eligibles with state guaranteed coverage. Other states have periods of open enrollment in addition to risk pools or other methods to insure HIPAA-eligibles. Federally eligible applicants in Ohio are guaranteed the right to purchase insurance from individual health insurance providers at any time during the year.⁴⁹

If a state were to require only one carrier to offer open enrollment policies, the costs to that carrier would increase significantly, as it would have to bear the burden of all the medically uninsurables aware of open enrollment. Given a high enough number of medically uninsurables, the carrier required to provide open enrollment would be driven from the market. States that require

⁴⁶ *What Is a Risk Pool?*, *supra* note 14.

⁴⁷ UNITED STATES DEPARTMENT OF LABOR, FREQUENTLY ASKED QUESTIONS ABOUT PORTABILITY OF HEALTH COVERAGE AND HIPAA (2006), available at http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html (last visited Apr. 19, 2006).

⁴⁸ *Id.*

⁴⁹ American Diabetes Association, Ohio—Health Insurance, at www.diabetes.org/advocacy-and-legalresources/insurance/ohio.jsp (last visited May 17, 2006).

all carriers to offer open enrollment policies to HIPAA-eligible individuals are able to spread the cost across all of those insurance carriers. These costs, however, are borne fully by the insurers, without state or federal subsidies to defray their increased costs arising from allowing open enrollment to unhealthy individuals.

If possible, the cost is then transferred to healthy health insurance consumers, increasing the cost of coverage in the state. If the insurer is unable to shift the cost to the health consumers, it is required to either cross-subsidize from other, more profitable areas of its business or exit the market and leave the state if the operating costs increase and make providing health insurance an unprofitable business. Such exit would further drive up the costs of health insurance in the state, because the number of substitutes and health insurance providers would decrease.

3. *Guaranteed Issue, Non-Community-Rated Coverage*

Other states offer guaranteed issue, non-community-rated coverage for HIPAA-eligible individuals in lieu of a state risk pool or an open enrollment period. For example, legislation in North Carolina requires insurers to designate either their two most popular individual market policies for federally eligible individuals or two “representative” policies similar to those offered in the individual market.⁵⁰ These policies must be offered without preexisting condition exclusions, but there is no limit on the premiums that may be charged.⁵¹ To illustrate, BC/BS of North Carolina charges a \$1,389 monthly premium for a policy without medical underwriting, which allows it to fulfill the HIPAA requirement but still cover its costs.

Similarly, Pennsylvania guarantees HIPAA-eligible applicants a state-approved policy. However, Pennsylvania requires only one carrier—BC/BS—to provide guaranteed issue policies.⁵² While the Pennsylvania legislature does limit the premium that may be charged, BC/BS increased premiums to compensate for the HIPAA-eligibles it is required to insure. Monthly premiums increased from \$325 in May of 2005 to \$441 in October of 2005.⁵³ The

⁵⁰ Kaiser Family Foundation, North Carolina, Non-Group Coverage Rules for HIPAA Eligible Individuals, at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi> (follow “North Carolina,” then “Managed Care & Health Insurance,” then “HIPAA Rules” links) (last visited Apr. 19, 2006).

⁵¹ *Id.*

⁵² Kaiser Family Foundation, Pennsylvania: Non-Group Coverage Rules for HIPAA Eligible Individuals, at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi> (follow “Pennsylvania,” then “Managed Care & Health Insurance” then “HIPAA Rules” links) (last visited Apr. 19, 2006).

⁵³ Capital Blue Cross, Comprehensive 1500, Single Applicant (M/35), at <http://www.capbluecross.com/Products/ForIndividuals/HIPAAComprehensive/Rates.htm> (last visited Apr. 19, 2006) (this information on the Web site has been updated and is no longer available).

relative fluidity of BC/BS premiums allows the company to offer these HIPAA policies.

4. *Guaranteed Issue, Community-Rated Coverage*

The fourth and final alternative that states have utilized to provide health insurance coverage to medically uninsurables is guaranteed issue, community-rated coverage. Five states (New York, New Jersey, Massachusetts, Maine, and Vermont) provide all residents with state-guaranteed coverage that is both guaranteed issue⁵⁴ and community rated.⁵⁵

These states have effectively created one giant state risk pool without any government subsidy for the unhealthy.⁵⁶ Individuals in these states pay significantly higher premiums, because healthy individuals share the burden of the health care costs of the unhealthy individuals. The following chart reports the results of 82,000 policies sold to single individuals by eHealthInsurance.com during 2004 (the eHealth Study).⁵⁷ Included in Table 3 are the three highest populated states in the United States.

State	Population	Average Monthly Premium
California	34,705,060	\$140
Texas	21,266,000	\$133
New Jersey*	8,521,890	\$340
New York*	19,027,190	\$295

* Guaranteed Issue, Community-Rated States

⁵⁴ Guaranteed issue means that health insurance providers “cannot turn applicants down based on health or risk status.” See Kaiser Family Foundation, Small Group Health Insurance Market Guaranteed Issue, at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi> (follow “Managed Care & Health Insurance,” then “Small Group Guaranteed Issue” links) (last visited Apr. 19, 2006).

⁵⁵ Community rating is the process of “setting health insurance premiums at the same level for all individuals or groups in a defined community.” Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, Coverage Matters: Insurance and Health Care, at <http://books.nap.edu/html/coveragematters/appE.html> (last visited Apr. 19, 2006).

⁵⁶ PILZER, *supra* note 22, at 131.

⁵⁷ eHealthInsurance Services, Inc., The Cost and Benefits of Individual Health Insurance Plans, at <http://image.ehealthinsurance.com/ehealthinsurance/expertcenterNew/CostBenefitReportFinal101204.pdf> (last visited Apr. 19, 2006).

⁵⁸ *Id.*

On average, guaranteed issue, community-rated states' residents pay about 150% of the state risk pool premium and 300%-400% of the private health individual rate.⁵⁹

Normally, health insurers choose to accept only the 80% of applicants who are healthy and most likely to stay that way at their normal, non-uprated premium. In this group, actual health costs are close to \$1,000 a year.⁶⁰ By comparison, a cancer patient with no other major health expenditures could be spending more than \$91,404 a year.⁶¹ In a guaranteed issue, community-rated state where all residents face the same health insurance premium regardless of individual health status, healthy individuals face much higher health care costs, because their premiums subsidize high-cost residents of their state.

Only individuals with very high medical care costs—the older, unhealthy individuals—benefit from these systems. For instance, for a healthy individual who lives in Mount Holly, New Jersey, a move 25 miles west into Philadelphia, Pennsylvania would result in a decrease in the approximate average monthly health insurance premium from \$340 to \$138.⁶² This equates to a difference in annual health insurance premium of \$2,424 for a single individual caused by a move into a non-guaranteed issue, community-rated state.

Guaranteed issue, community-rated health insurance is based on the premise that all individuals with adequate financial resources should have equal access to health insurance. The Kentucky legislature adopted guaranteed issue and modified community rating in 1994 under the basic assumption that health insurance would be more affordable, and health care more accessible, for the state's residents.⁶³ As a result, "healthy Kentuckians generally sought out policies with premium rates frozen at lower levels, while the unhealthy population was forced to choose between more expensive community-rated plans, Kentucky Kare (the insurer for the uninsured not eligible for Medicaid), or Medicaid."⁶⁴

The Heartland Institute published an article summarizing the resulting turmoil that overcame the insurance market in Kentucky. It noted,

by December 1996, 45 insurance companies had pulled out from the state's individual insurance market . . . ; Anthem BC/BS—for years the state's largest insurer in the individual market and by 1996 virtually the only insurer in the market—reported an underwriting loss of \$60 million; and Kentucky Kare reported a \$30 million underwriting loss over the previous 20 months and increased premiums 28 percent for 1996.⁶⁵

⁵⁹ PILZER, *supra* note 22, at 131.

⁶⁰ *Id.* at 29.

⁶¹ Chang et al., *supra* note 32, at 3529.

⁶² eHealthInsurance Services, *supra* note 57.

⁶³ Conrad F. Meier, *Kentucky Gov. Fletcher Seeks Insurance Reform*, HEARTLAND INST. HEALTH CARE NEWS, May 1, 2004, at <http://www.heartland.org/Article.cfm?artId=14790> (last visited Apr. 19, 2006).

⁶⁴ *Id.*

⁶⁵ *Id.*

In addition, out of pocket expenses increased, average premiums jumped between 36% and 165%, and the number of uninsured in Kentucky actually increased from 12.5% in 1993 to 15.6% in 1996.⁶⁶ By 1996, the legislature realized that the state had become a magnet for unhealthy people from other states. Policymakers, therefore, imposed a one-year residency requirement for enrollment in Kentucky Kare and allowed the range of rates private insurers could charge to increase. In 1997, the legislature pushed the premium of the state's near-monopolist private insurer up by 50%. By 2000, the legislature had established a high-risk pool, eliminated the guaranteed-issue mandate, and broadened the rate range.⁶⁷ Four years after these legislative changes, Kentucky's monthly premium rates had dropped drastically, to \$25 below the national health insurance premium average.⁶⁸

The basic theory behind state laws requiring health insurance to be guaranteed issue and community-rated has a weakness. Specifically, the principle of adverse selection dictates that only unhealthy individuals will choose to purchase health insurance when the price is four times that of comparable coverage in other states.⁶⁹ As a result, health insurers are forced to operate unprofitably or increase their premiums significantly if they are unable to choose the individuals they insure and adequately control their costs.

B. Non-HIPAA-Eligible Individuals

In aggregate, 40 states and the District of Columbia offer some type of state-guaranteed coverage to their unhealthy residents whether or not they are HIPAA-eligible, though HIPAA-eligible individuals may be offered better coverage or reduced premiums.⁷⁰ These states offer coverage through the same four alternatives available to HIPAA-eligibles.

I. State Risk Pool

Non-HIPAA-eligibles are offered entrance into the risk pools of certain states if they meet specific requirements. Common eligibility requirements include the individual seeking coverage being a resident of the state, not being eligible to participate in an employer's health benefits plan, not being eligible to receive COBRA benefits, and satisfying at least one of the following three conditions: being denied coverage by a private health insurance carrier for

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ eHealthInsurance Services, *supra* note 57.

⁶⁹ PILZER, *supra* note 22, at 132.

⁷⁰ Ten states have no health insurance options available for medically uninsurables who are not HIPAA-eligible. These are Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Nevada, Rhode Island, South Dakota, and Tennessee.

health reasons; being offered coverage with an exclusion for a preexisting condition; or being offered coverage for an uprated premium.⁷¹

Benefits offered to non-HIPAA-eligible applicants are the same as those offered to HIPAA-eligibles. However, for applicants who are not HIPAA-eligible, state risk pools typically have preexisting condition exclusions. State risk pools, whether insuring HIPAA-eligibles or non-HIPAA-eligible individuals, entail the same costs and subsidy schemes.

2. Open Enrollment

Certain states allow non-HIPAA eligibles who are medically uninsurable to obtain coverage through open enrollment periods. Open enrollment ends, however, when the “new members are one-half of one percent of a company’s total enrollment”; applicants are received on a first come, first served basis.⁷² After each insurance company meets its limit for open enrollment, waiting lists begin to develop for those individuals who are not HIPAA-eligible who are unable to obtain coverage during open enrollment periods.

3. Guaranteed Issue, Non-Community-Rated Coverage

Guaranteed issue, non-community-rated coverage is offered by certain states including North Carolina, Virginia, and Pennsylvania, to individuals who are not HIPAA-eligible. In addition, Washington, D.C. offers applicants who are not HIPAA-eligible access to an individual health policy on a guaranteed issue basis through CareFirst Blue Cross/Blue Shield, if the applicant lives in the covered area, is at least 18 years of age, and is not currently enrolled in another insurance plan. The premium charged is based on the applicant’s health status.⁷³

Data show that this guaranteed issue, non-community-rated coverage does not significantly increase the premiums charged by insurance providers in the private market. In aggregate, the four mentioned states that offer this type of coverage have an average monthly premium of \$153.75, with a range from \$130 to \$193, while the average over all states surveyed is \$150.⁷⁴

⁷¹ Insurance companies may charge uprated premiums if an applicant presents a moderate health risk. The insurance company may accept the application with a typical 15% to 200% rate increase over the normal monthly premium charged to a healthy individual in the same age group. See PILZER, *supra* note 22, at 27-28.

⁷² Ohio Department of Insurance, Ohio Shopper’s Guide Series—Health Insurance Guide, at <http://www.ohioinsurance.gov/ConsumServ/Ocs/CompleteGuides/CompleteHealthGuide.pdf> (last visited Apr. 19, 2006).

⁷³ Interview with Care First Blue Cross/Blue Shield official (May 17, 2005) (regarding eligibility requirements for open enrollment).

⁷⁴ eHealthInsurance Services, *supra* note 57.

4. Guaranteed Issue, Community-Rated Policies

In guaranteed issue, community-rated states, non-HIPAA-eligible individuals who are unhealthy pay the same predetermined rate that all residents of the state pay. The burden of individuals with high health care costs is spread among all insured residents of the state, without any state or federal subsidy, thereby increasing costs for all residents.

CONCLUSION

Risk pools, though continuously operating at a loss, are usually supported by member premiums and additionally are subsidized primarily by insurance company assessments and government revenues. Alternatively, because open enrollment policies allow states to spread the risk of high medical costs among different insurance companies, the costs are shared equally and companies are not driven from the market. However, once enrollment caps are met and private insurers are no longer required to accept individuals with costly medical conditions, those individuals are unable to obtain health insurance.

Guaranteed issue policies allow medically uninsurable individuals access to health care. However, the designation of only one company as the sole guaranteed issue insurer puts a burden on that company and increases its costs, forcing it to shift costs and cross-subsidize. Guaranteed issue, community-rated policies force all residents of a state to pay the same insurance premium regardless of health status or health risk. The only individuals who gain from this system are older, unhealthy individuals. As a result, unprofitable insurance companies that are forced to charge high premiums without being able to recover their costs are driven from the market. This increases the health care costs of all residents who face a decreased supply of health care insurers.

Risk pools have continued to evolve since their creation in 1976. They place the bulk of the burden caused by medically uninsurables upon the state and federal governments. Without a government subsidy, open enrollment and guaranteed issue policies result in the burden being carried by private insurance companies. Guaranteed issue, community-rated policies place the burden directly on the residents of the state and encourage the immigration of unhealthy individuals.

States with adequate resources, therefore, should follow the growing trend and create risk pools as a flexible, functional method to insure their unhealthy residents. In the unlikely event that states are incapable of obtaining federal subsidies or themselves subsidizing the cost of risk pools, open enrollment and guaranteed issue policies should be carefully crafted as an alternative. In no case should a state keep a guaranteed issue, community-rated policy intact. This is because the burden of such policies is borne by

the residents of the state, and the market for health insurance is stifled by the overwhelming burden of healthy insureds and insurance companies completely subsidizing the unhealthy, aging population.

The Council for Affordable Health Insurance (CAHI) published a study reporting that the individual insurance market cannot fund the medically uninsurables without assistance from other sources.⁷⁵ The burden of medically uninsurables should not be covered by the insured through guaranteed issue, community-rated plans, where most residents face significantly higher health care costs. Only older residents with costly medical conditions benefit from states with this policy. On the macro level, healthy individuals are deterred from getting health coverage at such an inflated price, while unhealthy individuals are driven to these guaranteed issue, community-rated states.

High-risk pools are the most effective, efficient option. The Heartland Institute proposes that state governments play a positive role, by chartering nonprofit, high-risk health insurance plans such as high risk pools. When these plans are financed by small assessments on the premiums paid to private group insurers, these risk pools spread the cost of covering uninsurables across a much larger base of insureds.⁷⁶ The result is “accomplishing the social goal of assuring access to quality medical care for those who need it, without the disruptions and negative side effects caused by heavy-handed regulation of the insurance industry.”⁷⁷

The Cato Institute’s study on rising health care costs makes a similar finding. It concludes:

States with well-structured and adequately financed high-risk pools are more successful in keeping the individual health insurance markets competitive and insurance rates affordable. Such pools allow the individual insurance market to operate efficiently, while carving out for the special treatment of high-cost individuals who are beyond the capacity of the individual market to handle on an unsubsidized basis.⁷⁸

Furthermore, a study done in June of 2005 by the state of Ohio reported the impact of high-risk pools on uninsured rates. The report concluded:

⁷⁵ Council for Affordable Health Insurance, *CAHI Policy Brief: Understanding the Individual Health Insurance Market* (Vol. 3, No. 3, Apr. 1, 1999) at http://www.cahi.org/cahi_contents/resources/pdf/040199.pdf (last visited Apr. 19, 2006).

⁷⁶ Conrad Meier, *High Risk Pools Insure the Uninsurable*, HEARTLAND INSTITUTE HEALTH CARE NEWS, Mar. 1, 2002, at <http://www.heartland.org/Article.cfm?artId=10456> (last visited Apr. 19, 2006).

⁷⁷ *Id.*

⁷⁸ CATO Institute, *Statement by Tom Miller: Rising Health Care Costs: The New Role for Consumer Empowerment, Greater Cost Medical Savings Accounts, and Two-Tiered Defined Contribution Health Plans*, at <http://www.cato.org/testimony/ct-tm081302.html> (last visited Apr. 19, 2006).

A high-risk pool has economic benefits for the health care system by bringing high-risk people into the ranks of the uninsured so their care can be managed, and medical providers are directly paid for their services. Properly managed care often reduces overall health care expenses, and direct payment of medical providers reduces the cost shifting that can occur with regard to uncompensated care.⁷⁹

The most effective, efficient way of handling medically uninsurables is through state risk pools. Thirty-three states already have opted to use this method. Although risk pools operate at a loss, the funding options for high-risk pools are varied. States therefore can tailor the funding for their pools according to the needs of the state.⁸⁰ The flexibility and functionality of state risk pools make them the best choice for states to insure their medically uninsurables.

⁷⁹ LEIF ASSOCIATES, INC. STATE OF OHIO HIGH-RISK POOL FEASIBILITY STUDY, *available at* <http://www.ohioinsurance.gov/Legal/Reports/OhioRiskPoolFeasibilityStudyFinal.pdf> (Apr. 19, 2006).

⁸⁰ NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, OVERVIEW OF HIGH-RISK POOL FUNDING OPTIONS, *at* <http://www.nahu.org/legislative/HRPs/index.cfm> (last visited Apr. 19, 2006).