THE HENRY J. KAISER FAMILY FOUNDATION

Filling the need for trusted information on national health issues…

July 2016 | Issue Brief

High-Risk Pools For Uninsurable Individuals

Karen Pollitz

In the debate over the future of the Affordable Care Act (ACA), proposals have emerged that would repeal or weaken rules prohibiting health insurance discrimination based on health status, instead offering high-risk pools as a source of coverage for people who would be uninsurable due to pre-existing conditions.

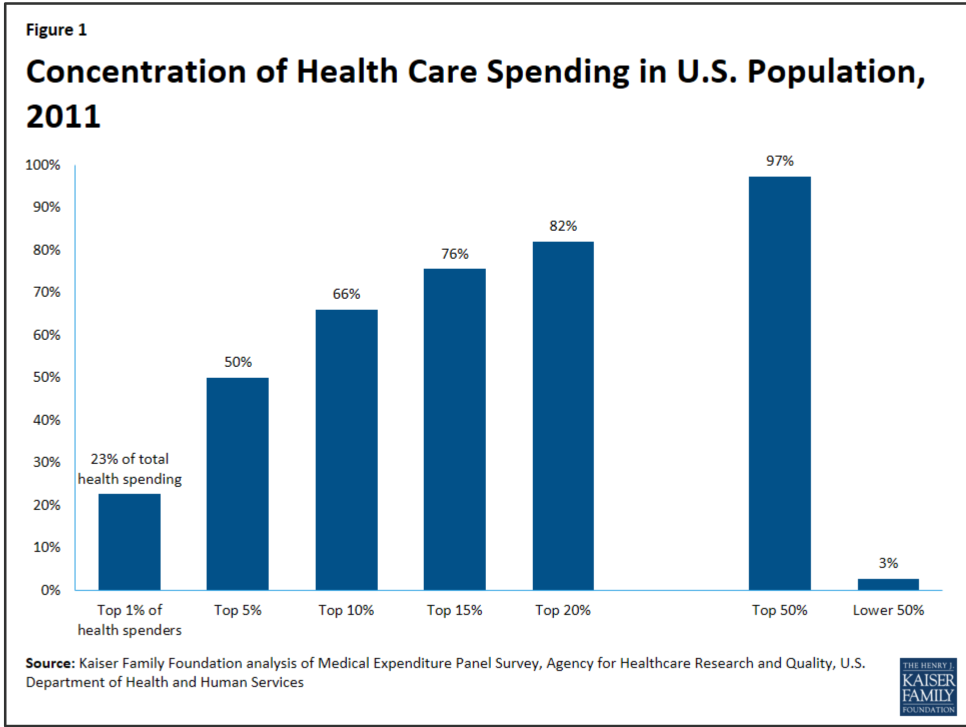
In Congress, HR 2653 was introduced by members of the House Republican Study Committee to repeal the ACA and replace it with other changes, including state high-risk pools. This bill would authorize $50 million for seed grants to help states establish high-risk pools, and $2.5 billion annually for 10 years to help states fund high-risk pools. Recently, House Republicans released their proposal to replace the ACA, entitled A Better Way. This plan would significantly modify ACA insurance market rules to provide a one-time open enrollment opportunity; thereafter, only individuals who maintain continuous coverage would be guaranteed access to insurance without regard to their health status. This plan also would provide $25 billion over 10 years in state grants to help fund high-risk pools. Pools would be required to cap premiums (at unspecified levels) and would be prohibited from imposing waiting lists.

For more than 35 years, many states operated high-risk pool programs to offer non-group health coverage to uninsurable residents. The federal government also operated a temporary high-risk pool program established under the ACA to provide coverage to people with pre-existing conditions in advance of when broader insurance market changes took effect in 2014. This issue brief reviews the history of these programs to provide context for some of the potential benefits and challenges of a high-risk pool.

Distribution and Persistence of Population Health Spending

In the U.S. and other developed nations, population health care spending is highly concentrated: in any given year, the healthiest 50% of the population accounts for less than 3% of total health care expenditures, while the sickest 10% account for nearly two-thirds of population health spending. (Figure 1) Private health insurance pools risks so that premiums paid by most enrollees, who have low claims costs, help pay claims for the small share of enrollees with high costs.

Who is included in the high-cost and low-cost groups changes from year to year. Most people are healthy most of the time, but illness and injury can and do onset unexpectedly for millions of people. Some high-cost conditions, such as hemophilia or HIV, persist and require treatment for extended periods, even a lifetime. Other high-cost conditions may improve or resolve, allowing patients to return to low annual health care spending. In any given year, among the 50% least expensive people in a year, 73% will remain in that group for a second year; similarly, of people who are among the most expensive 10% of the population in one year, only 45% would still be in that group the following year.[1]



Prior to implementation of the ACA, insurers selling individual insurance commonly practiced medical underwriting, excluding people with pre-existing conditions or charging them higher premiums. Medical underwriting effectively excludes a large proportion of total health care spending from the insurance pool. This can permit less expensive policies for healthier individuals, but requires some other mechanism, such as high-risk pools, to help finance costs attributable to the sickest individuals if they are to be covered. Enrollee premiums can finance a portion of the cost of such programs, but by definition, significant additional funding will also be required because the cost of each person covered will be substantial. For example, based on the distribution illustrated in Figure 1, per person costs in the top 10th percentile are more than 100 times, on average, that of people in the bottom 50th percentile.

State High-Risk Pools

Prior to implementation of the ACA, 35 states offered high-risk pools as a source of non-group health insurance for eligible residents. (Figure 2) The first pools were implemented by Minnesota and Connecticut in 1976; North Carolina implemented a high-risk pool in 2009. Pools offered eligibility to people in one or more of the following categories:

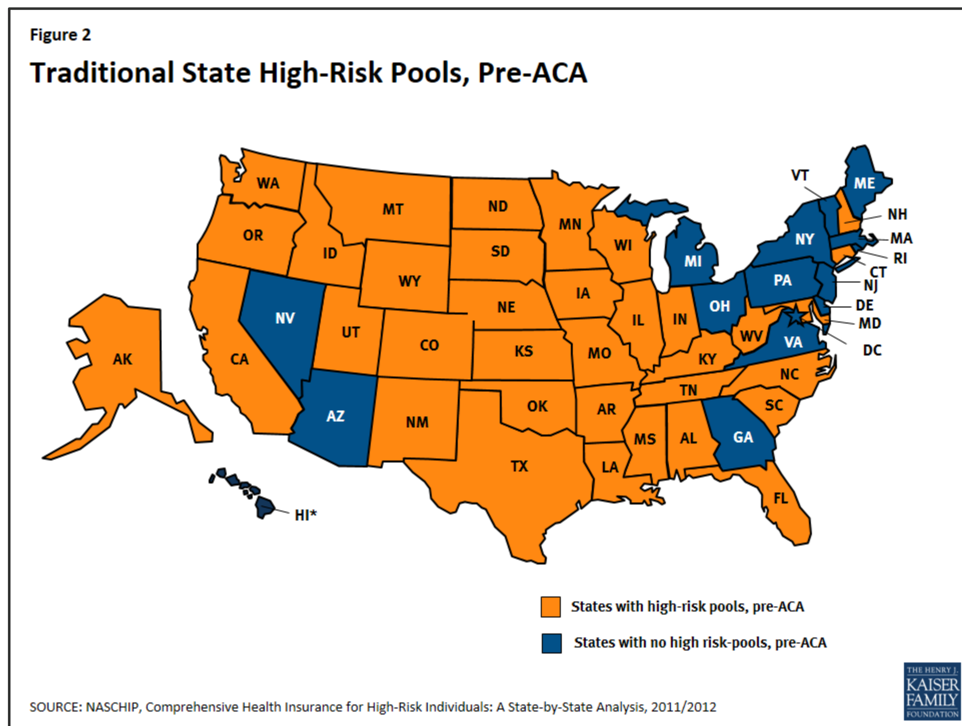
Medically eligible - Originally, high-risk pools were created to offer coverage to state residents with pre-existing conditions that made them uninsurable in the medically underwritten non-group health insurance market. Medically eligible individuals had to demonstrate their application for individual health insurance had been denied or restricted, or – in about two-thirds of state pools with presumptively eligible medical conditions lists – that they had been diagnosed with an eligible condition.[2]

HIPAA eligible - Following enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – a federal law requiring non-group coverage to be available on a guaranteed issue basis with no pre-existing condition exclusions to certain individuals who had lost group health plan coverage – most state high-

risk pools extended eligibility to HIPAA-eligible individuals. One state, Alabama, opened its pool only to HIPAA-eligible individuals.

HCTC eligible - The Trade Act of 2002 established a federal health coverage tax credit (HCTC) to subsidize HIPAA-like coverage for certain eligible individuals with trade-related job loss. Roughly two-third of state pools extended eligibility to HCTC-eligible individuals.

Medicare eligible - Finally, nearly two-thirds of state high-risk pools offered coverage to Medicare-eligible residents who needed supplemental coverage. (Appendix Table 1)



State High-Risk Pool Enrollment, Program Features, and Costs

Before HIPAA was enacted in 1996, there were 25 state high-risk pools with combined enrollment of 91,054.[3] By the end of 2011, combined enrollment in 35 state high-risk pools reached 226,615, or about 2 percent of the number of non-group health insurance market participants in those states that year.[4] (Appendix Table 2)

The potentially medically eligible population in high-risk pool states was likely much larger. For example, a study by the General Accounting Office (GAO) found between 20% and 60% of non-elderly adults have pre-existing conditions that could result in a health insurer restricting coverage. The range of estimates depended on the list of pre-existing conditions included; the most prevalent conditions included hypertension, mental health disorders, diabetes, pulmonary disease and cancer. In a Kaiser Family Foundation national survey, 50% of respondents said they or a member of their household had a pre-existing condition. Another GAO study reported that in 2010, 19% of applicants for non-group health insurance coverage nationwide were denied.[5] A Kaiser Family Foundation study of medical underwriting practices in the individual health insurance market

found applicants with medical conditions as serious as HIV or as mild as seasonal hay fever could have coverage denied or restricted or premiums surcharged when applying for medically underwritten policies.

Although no two traditional state-high risk pools were identical, nearly all adopted certain common features that tended to limit enrollment of eligible individuals.[6] These included:

- *Premiums above standard non-group market rates* – All state high-risk pools set premiums at a multiple of standard (i.e., typical or average) rates for medically underwritten coverage in the non-group market, usually 150%-200%. Fifteen pools provided low-income premium subsidies that varied in comprehensiveness. The Oregon pool, for example, discounted premiums 95% for enrollees with income up to 185% of the poverty level, while the New Hampshire pool provided a 20% premium discount for enrollees with income below 200% FPL. Other pools required people to pay the full premium, regardless of income.

- *Pre-existing condition exclusions* – Nearly all state high-risk pools excluded coverage of pre-existing conditions for medically eligible enrollees, usually for 6-12 months. This made coverage less attractive for people who needed coverage specifically for their pre-existing conditions.

- *Lifetime and annual limits* – Thirty-three pools imposed lifetime dollar limits on covered services, most ranging from $1 million to $2 million. In addition, six pools imposed annual dollar limits on all covered services while 13 others imposed annual dollar limits on specific benefits such as prescription drugs, mental health treatment, or rehabilitation.

- *High deductibles* – Most pools offered a choice of plan options with different deductibles; in 25 programs, the plan option with the highest enrollment had a deductible of $1,000 or higher. (Appendix Table 3)

A small number of states capped or closed enrollment to limit program costs, though enrollment caps were not allowed for HIPAA-eligible individuals. Limiting enrollment, directly or indirectly, was a key strategy to limit the cost of high-risk pools to states. By design, all state high-risk pools experienced net losses – that is, expenses greater than premium revenue. In 2011, net losses for 35 state high-risk pools combined were over $1.2 billion, or $5,510 per enrollee, on average. (Appendix Table 4) Most states financed net losses through an assessment on private non-group health insurance premiums; however, nearly all state high-risk pool assessments were offset by tax credits so that, in effect, general state revenue funding applied. A few states used other revenue sources – tobacco taxes and hospital assessments – to fund high-risk pool losses. In addition, in 2003-2010 federal grants were available intermittently, subject to appropriations, to help fund qualified state-high risk pools that met certain criteria. For the first two fiscal years (2003-2004) $80 million per year was appropriated; $75 million in grants was next awarded in 2006, followed by $49 million in 2008, $73.5 million in 2009, and $55 million in each of 2010 and 2011. In some years, a portion of federal grant funds was reserved for states that adopted supplemental consumer benefits such as low-income premium subsidies. Federal grants comprised between 2% and 12% of program expenses in states that received them.[7]

Federal Pre-existing Condition Insurance Program (PCIP)

The ACA established a temporary, national high-risk pool program, implemented in 2010, to offer coverage for uninsured individuals with pre-existing conditions until 2014, when private non-group policies would be available under new market rules prohibiting insurance discrimination based on health status. The law

required PCIP enrollees to pay premiums and appropriated $5 billion to fund expected net losses during the program's duration. Twenty-seven states opted to administer PCIP for their residents; the federal government operated PCIP for 23 states and D.C.

PCIP Enrollment, Program Features, and Costs

Program features under PCIP varied from state high-risk pools in several significant respects. Under the law, PCIP premiums were set at 100% of the standard risk rate for non-group health insurance in each state, meaning rates varied by age but were otherwise equivalent to what a typical person without a pre-existing condition would pay. Low income premium subsidies were not offered. PCIP did not impose annual or lifetime dollar limits on covered benefits. Annual out-of-pocket-cost sharing was capped at the level set for tax-favored high-deductible health plans ($6,050 in 2012) and a minimum actuarial value of 65% was established for program coverage (meaning patients were expected to pay, on average, 35% of their health expenses). In 42 states, the lowest deductible option offered in 2012 was at least $1,000.[8]

PCIP did not impose pre-existing condition exclusions. However, to prevent "crowd out" from existing state pools and other private insurance, PCIP eligibility was limited to individuals who had been uninsured for at least 6 months immediately prior to enrolling.

PCIP was operational in all 50 states by the fall of 2010. By late 2012, just over 100,000 individuals were enrolled and program expenses had consumed nearly half of the $5 billion appropriation. For the final 12-month period for which PCIP expense data were reported, net losses for the program were over $2 billion. (Table 1)

Table 1. PCIP Enrollment and Net Expenses, 2011–2013

Date	Enrollment as of date	Cumulative expenditures net of premiums	Quarterly increase in net expenditures
May 31, 2011	24,712	$0.180 billion	--
Sep. 30, 2011	37,624	$0.386 billion	$207 million
Dec.31, 2011	48,879	$0.618 billion	$232 million
Mar. 31, 2012	61,619	$0.963 billion	$334 million
June 30, 2012	77,877	$1.401 billion	$439 million
Sep. 30, 2012	90,347	$1.861 billion	$460 million
Dec. 31, 2012	103,160	$2.406 billion	$545 million
Mar. 31,2013	114,959	$2.978 billion	$571 million
June 30, 2013	104,966	$3.602 billion	$625 million
Sep. 30, 2013	89,438	$3.956 billion	$354 million

Source: PCIP quarterly data reports, 2011-2013.

In 2012, average per enrollee claims costs for PCIP were $32,108, or more than 2.5 times higher than average per enrollee claims costs ($12,471) under traditional state high-risk pools, all of which continued to operate that year.[9] Compared to traditional state high-risk pool enrollees, PCIP enrollees tended to have more immediate and intensive health care needs, including higher hospital admissions, likely due to the six-month prior uninsurance requirement and lack of pre-existing condition exclusions.[10] By contrast, many traditional state pool enrollees were HIPAA-eligible, meaning they had to have been continuously covered and were less likely to have put off needed treatment prior to joining the pool. Pre-existing condition exclusions would have limited traditional pool coverage of initial treatment costs of (or enrollment by) other non-HIPAA eligible individuals.[11]

In addition, PCIP premiums were based on standard rates for underwritten non-group coverage, while under traditional state pools, premiums were set at 150%-200% of standard market rates. As a result, enrollees under traditional state pools paid a greater share of their claims costs compared to PCIP enrollees. This meant that the loss ratio – the ratio of claims costs to premiums – would naturally be higher in PCIP compared to the traditional state pools. In 2011, claims under traditional state high-risk pools averaged 181% of pool premiums; that year, PCIP claims averaged 417% of premiums. By late 2013, the PCIP loss ratio had reached 600%.[12]

In the face of growing expenses, PCIP adopted a series of changes to limit program costs. In 2012 federally-administered programs switched to a less expensive provider network and negotiated additional discounts with targeted hospitals that treated large numbers of PCIP enrollees. State-run programs were required to achieve similar cost savings or transition to federal administration; 17 state programs transitioned in mid-2013. The federal PCIP program also consolidated plan options for 2013, eliminating those offering the lowest patient cost sharing. Even with these changes, program expenses were still projected to exceed appropriated funds before the end of 2013. In March 2013, new PCIP enrollment was suspended to ensure sufficient funds to pay claims for people already enrolled.[13] PCIP enrollment peaked at nearly 115,000 in March 2013, then declined below 90,000 six months later.

Discussion

Nearly four decades of experience with high-risk pools suggests they have the potential to provide health coverage to a substantial number of people with pre-existing conditions. State high-risk pools that existed prior to passage of the ACA covered over 200,000 people at their peak, and the temporary PCIP pool created as part of the ACA covered over 100,000 individuals.

These high-risk pools likely covered just a fraction of the number of people with pre-existing conditions who lacked insurance, due in part to design features that limited enrollment. State pools typically excluded coverage of services associated with pre-existing conditions for a period of time and charged premiums substantially in excess of what a typical person would pay in the non-group market. PCIP had fewer barriers to enrollment – charging standard premiums with no pre-existing condition exclusions – but it did restrict signups to people who had been uninsured for a least six months.

Even with these limitations, the government subsidies required to cover losses in these high-risk pools were substantial – over $1 billion per year in the state pools and about $2 billion in the final year of PCIP. A high-risk pool that had minimal barriers to enrollment could cost substantially more.

Appendix Tables

Appendix Table 1. State High-Risk Pool Eligibility Categories, 2011				
State	Uninsurable	HIPAA-Eligible	HCTC-Eligible	Medicare Eligible
Alabama		X		
Alaska	X	X	X	X
Arkansas	X	X	X	
California	X	X		X
Colorado	X	X	X	X
Connecticut	X	X	X	X
Florida	X			X
Idaho	X	X	X	
Illinois	X	X	X	X
Indiana	X	X	X	X
Iowa	X	X	X	X
Kansas	X	X	X	
Kentucky	X	X		X
Louisiana	X	X	X	
Maryland	X	X	X	
Minnesota	X	X	X	X
Mississippi	X	X		
Missouri	X	X	X	
Montana	X	X	X	X
Nebraska	X	X	X	X
Nevada	X	X	X	
New Hampshire	X	X	X	X
New Mexico	X	X	X	
North Carolina	X	X	X	X
North Dakota	X	X	X	
Oklahoma	X	X	X	
Oregon	X	X	X	X
South Carolina	X	X		
South Dakota	X	X		
Tennessee	X	X	X	X
Texas	X	X		
Utah	X	X		X
Washington	X	X	X	
West Virginia	X	X		X
Wisconsin	X	X		X
Wyoming	X	X	X	X
Total	**34**	**34**	**24**	**19**

Source: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012

Appendix Table 2. State High-Risk Pool Enrollment, 2011			
State	Enrollment as of December 31, 2011	Non-group market participants, 2011	Pool enrollment as percent of non-group market
Alabama	2,133	216,884	0.1%
Alaska	525	20,940	2.5%
Arkansas	2,801	116,501	2.4%
California	6,334	2,203,043	0.2%
Colorado	13,859	396,950	3.5%
Connecticut	1,603	158,581	1%
Florida	208	914,604	0.02%
Idaho	1,658	123,742	1.3%
Illinois	19,998	589,454	3.4%
Indiana	7,502	190,011	3.9%
Iowa	3,268	185,988	1.8%
Kansas	1,528	149,443	1%
Kentucky	4,798	170,835	2.8%
Louisiana	1,728	161,923	1%
Maryland	20,646	271,473	7.6%
Minnesota	26,859	264,370	10.2%
Mississippi	3,328	135,913	2.4%
Missouri	4,009	345,408	1.2%
Montana	2,878	82,021	3.5%
Nebraska	4,021	139,251	2.9%
New Hampshire	2,586	68,940	3.8%
New Mexico	8,442	84,667	9.9%
North Carolina	8,160	408,557	2%
North Dakota	1,446	61,539	2.3%
Oklahoma	2,422	154,818	1.6%
Oregon	12,152	240,724	5%
South Carolina	1,799	189,469	1%
South Dakota	645	61,672	1%
Tennessee	3,265	320,607	1%
Texas	24,792	955,857	2.6%
Utah	3,946	158,000	2.5%
Washington	3,862	357,130	1.1%
West Virginia	1,152	26,466	4.4%
Wisconsin	21,317	313,149	6.8%
Wyoming	945	28,191	3.4%
Total	**226,615**	**10,266,121**	**2.2%**

Sources: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012; U.S. Census Bureau, 2011 Current Population Survey.

Appendix Table 3. State–High Risk Pool Program Features, 2011						
State	Premium cap as percent of standard rate	Pre-ex exclusion period	Deductible in most-enrolled plan	Lifetime benefit maximum	Annual benefit maximum	Low-income subsidies
Alabama	200%	n/a[1]	$2,500	$1 million	$10,000[6]	X
Alaska	150%	6 months	$5,000	$2 million	none	
Arkansas	150%	6 months	$1,000	$1 million	$4,000[7]	X
California	125-137.5%	3 months	$500	$750,000	$75,000	
Colorado	150%	6 months	$1,000	$1 million	$3,000[8]	X
Connecticut	150%	12 months	$1,500	$1.5 million	none	
Florida	250%	n/a[2]	$1,000	$5 million	none	
Idaho	150%	12 months	$5,000	$1 million	multiple[9]	
Illinois	150%	6 months	$500	$2 million	none	
Indiana	200%	3 months	$500	none	$50,000[10]	
Iowa	150%	6 months	$2,500	$3 million	none	
Kansas	150%	3 months	$5,000	$2 million	$100,000	
Kentucky	175%	6 months	$1,500	none	none	
Louisiana	200%	6 months	$5,000	$625,000	$125,000	
Maryland	200%	6 months	$500	$2 million	none	X
Minnesota	125%	6 months	$2,000	$5 million	none	X
Mississippi	175%	6-12 months[3]	$3,000	$1 million	$100,000[11]	
Missouri	200%	12 months	$5,000	$1 million	none	X
Montana	200%	12 months	$5,000	$2 million	multiple[12]	X
Nebraska	135%	6 months	$2,000	$1 million	none	
New Hampshire	150%	9 months	$1,000	$2.5 million	multiple[13]	X
New Mexico	150%	6 months	$500	none	none	X
North Carolina	200%	12 months	$5,000	$1 million	$100,000[14]	
North Dakota	135%	6-9 months[4]	$500	$1 million	$6,000[15]	
Oklahoma	150%	12 months	$2,000	$1 million	$4,000[16]	
Oregon	125%	6 months	$500	$2 million	none	X
South Carolina	200%	6 months	$1,500	$1 million	none	
South Dakota	150%	6 months	$1,000	$2 million	multiple[17]	
Tennessee	200%	6-9 months[5]	$1,000	$1 million	$200,000[18]	X
Texas	200%	12 months	$2,500	$2 million	multiple[19]	
Utah	200%	6 months	$500	$1.5 million	$300,000	X
Washington	150%	6 months	$500	$2 million	none	X
West Virginia	150%	6 months	$2,000	$1 million	$200,000	
Wisconsin	200%	6 months	$2,500	$1 million	none	X
Wyoming	200%	12 months	$1,000	$750,000	none	X

Source: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012
Notes: Pre-existing condition exclusions:
[1]Alabama pool open only to HIPAA-eligible individuals, no pre-ex imposed.
[2]Florida pool closed to new enrollment in 1991, pre-ex not applicable.
[3]Mississippi pool imposed separate 6-month pre-ex exclusion period for pharmacy benefits, 9 months for pregnancy related benefits, 12 months for physician and hospital services for all other conditions.
[4]North Dakota imposed separate 9-month pre-ex exclusion for pregnancy related benefits.
[5]In lieu of pre-ex exclusion, Tennessee pool reduced benefits 50% for most outpatient services for pre-existing conditions, imposed 12-month waiting period for maternity-related services.
Annual maximums:
[6]AL: $10,000 for pharmacy benefit; [7]AR: $4,000 for mental health/substance abuse benefit; [8]CO: $3,000 for DME benefit; [9]ID: $2,000 for rehab benefit, $5,000 for hospice benefit; $10,000 for DME benefit; [10]IN: $50,000 for mental health/substance abuse, Plan 3 only; [11]MS: $100,000 for pharmacy benefit; [12]MT: $5,000 applies to DME, $4,000 applies to rehab benefit; [13]NH: $10,000 applies to pharmacy, $5,000 applies to DME, $3,000 applies to mental health/substance abuse, various day limits apply to skilled nursing, rehab, home health; [14]NC: $100,000 applies to injectable drugs; various day limits apply to skilled nursing, rehab; [15]ND: $6,000 applies to DME benefit; [16]OK: $4,000 applies to mental health and chemical dependency combined; [17]SD: $2,000 applies to substance abuse, $900 applies to mental health treatments for non-biologically based conditions, $8,000 applies to DME benefit; [18]TN: annual limit increased by $100,000 for organ transplant; [19]TX: $2,000 applies to rehab, $5,000 applies to home health, $10,000 applies to hospice, various day limits apply to skilled nursing care and mental health care.

Appendix Table 4. State High-Risk Pool Expenses Per Enrollee, 2011				
State	**Premiums ($ millions)**	**Expenses ($ millions)**	**Net Losses ($ millions)**	**Per-Enrollee Net Losses**
Alabama	$15.1	$21.8	$6.7	$3,147
Alaska	$3.7	$14.3	$10.6	$20,255
Arkansas	$18.0	$26.4	$8.4	$2,999
California	$47.6	$70.3	$22.7	$3,579
Colorado	$67.3	$127.2	$60.1	$4,322
Connecticut	$19.4	$29.0	$9.6	$5,993
Florida	$1.3	$3.6	$2.3	$10,894
Idaho	$6.1	$11.4	$5.3	$3,197
Illinois	$118.9	$224.0	$105.1	$5,255
Indiana	$64.2	$134.2	$70	$9,335
Iowa	$20.2	$42.1	$21.9	$6,690
Kansas	$13.2	$27.9	$14.7	$9,626
Kentucky	$34.6	$67.9	$33.2	$6,926
Louisiana	$9.0	$20.8	$11.8	$6,808
Maryland	$97.9	$203.8	$106	$5,133
Minnesota	$133.3	$294.8	$161.5	$6,008
Mississippi	$18.0	$36.3	$18.3	$5,501
Missouri	$33.9	$49.2	$15.4	$3,852
Montana	$17.6	$29.5	$11.9	$4,128
Nebraska	$32.0	$59.2	$27.2	$6,774
New Hampshire	$13.3	$21.3	$8	$3,102
New Mexico	$27.1	$123.0	$95.9	$11,358
North Carolina	$38.3	$48.3	$10	$1,225
North Dakota	$8.5	$13.6	$5.1	$3,499
Oklahoma	$11.9	$36.5	$24.6	$10,165
Oregon	$87.3	$170	$82.6	$6,799
South Carolina	$25.3	$27.7	$2.4	$1,329
South Dakota	$4.6	$8.0	$3.4	$5,313
Tennessee	$31.7	$43.4	$11.7	$3,586
Texas	$207.4	$322.7	$115.3	$4,649
Utah	$23.0	$38.3	$15.4	$3,897
Washington	$31.0	$95.8	$64.8	$16,753
West Virginia	$5.3	$7.1	$1.8	$1,562
Wisconsin	$104.2	$186.2	$82	$3,847
Wyoming	$5.5	$8.9	$3.4	$3,611
Total	**$1,395.7**	**$2,644.5**	**$1,248.7**	**$5,510**

Source: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012

Endnotes

[1] S Cohen and W Yu, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the US Population, 2008-2009. AHRQ Statistical Brief #354, January 2012.

[2] In the Maryland pool, for example, the list of eligible conditions included behavioral health conditions (bipolar disorder, chemical dependency, dementia, psychotic disorders); blood disorders (aplastic anemia, hemochromatosis, hemophilia, sickle cell disease); cardiovascular conditions (angina pectoris, cardiomyopathy, congestive heart failure, coronary artery disease, coronary insufficiency, coronary occlusion); endocrine disorders (Addison's disease, cystic fibrosis, diabetes, porphyria, Wilson's disease); gastrointestinal disorders (ascites, Banti's disease, cirrhosis of the liver, Chron's disease, esophageal varices, hepatitis B and C, ulcerative colitis); infectious diseases (HIV/AIDS); musculoskeletal/connective disorders (ankylosing spondylitis, lupus, rheumatoid arthritis, scleroderma); pulmonary disorders (chronic obstructive pulmonary disease, emphysema); neoplasm (cancer treated or diagnosed within 5 years, Hodgkin's disease, leukemia, multiple myeloma, non-Hodgkin's lymphoma, Wilm's tumor); neurologic conditions (Alzheimer's disease, ALS, Friedreich's Ataxia, Guillain-Barre syndrome, Huntington's disease, hydrocephalus, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, palsy, paraplegia, Parkinson's disease, quadriplegia, stroke, Tay-Sachs disease); also major organ transplant and pregnancy.

[3] Communicating for Agriculture, Comprehensive Health Insurance for High-Risk Individuals, 1996.

[4] All but eight traditional state high-risk pools have since suspended new enrollment.

[5] The total number of applications included those made in states, such as New York, which required non-group coverage to be offered on a guaranteed issue basis.

[6] K Schwartz, G Claxton, K Martin, and C Schmidt, "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System," Kaiser Family Foundation, 2009. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7851.pdf

[7] NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012.

[8] J Hall and J Moore, The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform, September 2012, available at http://www.commonwealthfund.org/publications/issue-briefs/2012/sep/preexisting-condition-insurance-plan

[9] PCIP Annual Report, 2012 available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip-report.pdf, and PCIP Annual Report, 2013 available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_report_01312013.pdf.

[10] For example, in Colorado, enrollees in the state PCIP experienced 562 hospital admissions per 1,000 and used 5,174 inpatient days per 1,000, while enrollees in Colorado's traditional high-risk pool experienced 137 hospital admissions per 1,000 and used 735 inpatient days per 1,000. See PCIP Annual Report, 2012.

[11] PCIP Annual Report, 2013.

[12] PCIP Annual Report, 2012 and 2013.

[13] PCIP Annual Report, 2013. The report notes that various cost containment measures had been adopted prior to enrollment suspension, including switching to a more competitively priced provider networks, negotiating special discounts with hospitals treating a disproportionate share of PCIP enrollees, and requiring use of cost effective preferred pharmacies for specialty drugs. See also PCIP Data Report, March 2013, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/pcip-expenditures-3-31-2013.pdf