

## North Carolina High-Risk Insurance Pools

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*Imagine this: You are a 58-year-old man. You have worked all your life, paid taxes, and helped support your family. Two years ago you had a mild heart attack. Your wife has diabetes and high blood pressure. Luckily, you had health insurance through your job that helped you pay for the hospitalization, doctor's visits, and necessary medications for you and your wife. With a new diet, exercise, and the medications, you both are doing well managing your health problems. A little over a year ago, you lost your insurance when your company downsized. You found another job, but your current employer doesn't offer insurance. Your wife also works, but she works for a small employer that does not offer coverage. So, you pay approximately \$600/month for continuation coverage (COBRA) for your wife and yourself through your former employer. Last month, you found out your COBRA coverage is about to end. You want to continue to buy insurance coverage, but you were told that purchasing a comprehensive policy with a \$1,000 deductible (70% coinsurance) that covers your needed medications would cost more than \$4,000/month for your wife and yourself.*

All of us know people with health problems; these are the people who most need health insurance. But, have you ever stopped to think about how difficult or expensive it is to buy health insurance if you have pre-existing conditions? As a health and life insurance underwriter (independent insurance agent), I frequently work with families who want to buy health insurance, but have problems because of their past health history or ongoing health problems.

State and federal laws provide some protections for people who have health problems if they work for an employer who

offers coverage. Under these laws, people with employer-based coverage cannot be charged higher premiums or excluded from coverage because of their pre-existing health problems. However, these same protections don't generally apply to individuals who want to purchase health insurance in the non-group market. There is currently only one insurer in North Carolina—Blue Cross and Blue Shield of North Carolina (BCBSNC)—that will cover anyone, regardless of their health status. However, the premiums charged are high, because people with pre-existing health problems typically incur greater than average healthcare costs. The premiums charged to people with the most serious health problems may be seven times higher than the premiums charged to a healthy individual. This premium is unaffordable to most families.

Thirty-three other states have established high-risk pools to offer comprehensive health insurance coverage to people with pre-existing health problems. These high-risk pools are similar to high-risk auto insurance. In North Carolina, individuals with poor driving records can purchase automobile insurance—at a higher rate—through the state's high-risk automobile pool. The pool is financed through premiums and an assessment on all of the automobile insurers in the state.

The states that offer high-risk health insurance typically cap the premium charged to families to make the coverage more affordable. Generally, the premium can be no more than 1.5 times (or 150%) of the standard rate charged to comparable healthy individuals.<sup>a</sup> However, because these premiums do not cover the full costs of the healthcare services that the insured high-risk individuals use, states pay for the deficits through assessments on insurance companies, state appropriations, or other means.<sup>b,1</sup> For the last five years, the North Carolina Health Underwriters Association has advocated that North

a Most states cap the premium at 150% of the standard rate; however, a few states allow premiums to be up to 200% of the standard rate. Health plans typically vary insurance premiums based on the person's age, gender, and geographic location. In a high-risk pool, the 150% cap would be based on a healthy person with a similar age and gender and living in the same geographic area of the state.

b Twenty-seven states finance the losses in their high-risk pool through an assessment on insurers. Of these, 11 states provide full or partial tax credits to offset the assessment, effectively shifting the costs back to the state. Seven states have a broad assessment on insurers, including commercial insurance carriers, stop-loss or reinsurance carriers, third-party administrators on a per-person/per-month basis. Two states pay for the losses through a surcharge on hospital bills, and five states use general revenues to fund their losses.<sup>1</sup>

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Carolina join the majority of other states and create a high-risk pool to provide affordable coverage to the people with pre-existing health problems.

Two bills have been introduced in the North Carolina General Assembly that would create a high-risk pool: HB 1895 (introduced by Representatives Insko, England, Nye, and Wright, with 28 other co-sponsors) and SB 1681 (introduced by Senator Purcell). The House Select Committee on Health and the North Carolina Institute of Medicine's Task Force on Covering the Uninsured supports similar legislation. While these bills may change as the legislation is debated in the General Assembly, the proposed legislation accomplishes the goal of providing more affordable health insurance to people with pre-existing health problems.

Under the introduced legislation, people with pre-existing health problems would be eligible for the pool if they had been turned down by two insurers due to pre-existing health problems, charged premiums by two insurers with higher rates than offered through the high-risk pool, or offered a health plan by two insurers with conditional riders that exclude coverage for the pre-existing health conditions. Individuals could also qualify if they have specific health problems that were identified by the plan administrators as eligible for coverage, such as HIV/AIDS. Certain other people who do not have pre-existing health problems can also purchase health insurance through the pool if they are unable to find better health insurance coverage in the private market. These include individuals who are guaranteed coverage in the non-group market under the federal Health Insurance Portability and Accountability Act (HIPAA) laws (described previously), or people who lost their insurance when their employer downsized or closed due to the Trade Adjustment Act.

Like most other states, the current legislation caps the premium at 150% of the standard rate charged by other insurers offering health insurance to individuals. Rates can be adjusted by age, sex, and geographic variation in claims cost in accordance with established actuary and underwriting practices. In addition, the bills that were introduced would also provide an additional premium subsidy for lower- or moderate-income families to help them afford their health insurance premiums.

The pool would offer several different plans, including Preferred Provider Organization (PPO) plans with different deductibles and cost-sharing levels and at least one high-deductible Health Savings Account plan (HSA).<sup>c</sup> The plans must include at least a \$1 million lifetime limit and sliding-fee scale annual limit on out-of-pocket expenses of \$2,000-\$5,000 based on family income.

This is not the first time that high-risk pool legislation has been introduced in the North Carolina General Assembly.

Similar legislation to either establish or study the need for a high-risk pool has been introduced at various times dating back to the 1980s. Historically, the major stumbling block has been the mechanism to finance the uncovered claims costs (e.g., the healthcare costs that are in excess of the premiums collected). Insurance companies have opposed past attempts to finance the uncovered costs through assessments on covered lives. They were concerned that an assessment focused solely on commercial insurance companies, like Blue Cross and Blue Shield of North Carolina, United Healthcare, Cigna, Wellpath, Fortis, and all other providers of health insurance products in North Carolina, would raise the costs of their premiums, leading more employer groups to self-insure in order to avoid paying the assessment. Provider groups similarly opposed any attempts to cover losses through a provider assessment, arguing that the assessment was nothing more than a "sick-tax" (e.g., tax on sick people). The General Assembly has never been willing to appropriate state funds to finance a high-risk pool.

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This year, the legislation is structured differently. Instead of singling out any one group to bear the burden of financing the losses, the legislation spreads the burden across multiple groups. The bill limits provider reimbursement to the Medicare rates, which is lower than what is typically paid through commercial insurance plans. By accepting this lower reimbursement, providers help by lowering overall healthcare costs and therefore, the amount of financial loss to the plan. The proposed legislation also assesses insurers to help pay for the losses. However, unlike past attempts that focused the assessment on commercially insured plans, this legislation calls for a broader-based assessment on commercially insured plans, multiple employer welfare arrangements (MEWAs), third-party administrators (TPAs), administrative service organizations (ASOs), and reinsurers. This helps spread the costs to employer groups that purchase health insurance through commercial insurers, and indirectly, to those who self-insure (by assessing third-party administrators or reinsurers). The legislation also calls for a general appropriation to help subsidize the costs of insurance coverage for lower-income or moderate-income individuals. Congress also appropriated \$75 million annually through 2010 to help states offset some of the losses incurred in high-risk pools, and another \$15 million to provide

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<sup>c</sup> A Health Savings Account is a high-deductible health plan combined with a pretax savings account. Both employers and employees can contribute to the savings account with pretax dollars. Individuals can withdraw funds from the savings account to pay for healthcare expenses up to the deductible amount.

grants of up to \$1 million to help states, like North Carolina, establish a high-risk pool.<sup>2</sup>

Making health insurance coverage affordable to people with pre-existing health problems is not only the “right thing to do,” it is also a smart investment. People who have chronic illnesses or other serious health problems (such as cancer) are more likely than healthier people to need healthcare services. Many of these individuals want to buy health insurance, but can’t afford the policies that currently exist. So instead of creating a health insurance product that captures the premium dollars these people are able to afford, we force many people to go without insurance coverage. Without insurance, they are more likely to forgo the care they need to manage their health problems, and their health suffers as a result. Many end up in the hospital with

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problems that could have been prevented, with no way to pay for the outstanding hospital bills. Large outstanding healthcare bills (often caused by lack of insurance coverage) is one of the primary reasons that people go into bankruptcy.<sup>3</sup> This affects not only the individual family and specific healthcare providers, but other creditors as well. Further, all of us who have health insurance pay higher premiums to help cover the costs of services provided to the uninsured. Thus,

by creating an affordable insurance product for those with prior health problems, we both make it easier for these individuals to obtain needed health services in a timely way in an appropriate—and hopefully less costly—setting, but also help capture the funds these individuals can afford to pay for needed healthcare services. **NCMedJ**

## REFERENCES

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- 3 Himmelstein DU, Warren E, Thorne D, et al. Outstanding healthcare bills and health problems are major contributors to nearly half of personal bankruptcies. MarketWatch: Illness and Injury as Contributors to Bankruptcy. Health Affairs Web Exclusive 2005;W5:63-73. Available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>. Accessed May 20, 2006.



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## Advocating for Healthcare

In 1983, I began a journey that taught me the inadequacies of the health insurance industry. My daughter was born with a birth defect known as microtia. Within 18 months of her birth, my husband became unemployed, and as a result, we lost our health insurance coverage. My husband found employment in North Carolina, and we moved in 1985. During this time, I spent countless hours researching microtia and seeking medical care for my daughter.

In 1989, I finally found doctors who could care for my daughter, and I thought our troubles were over. However, we were quickly denied coverage because she wasn't born on the health insurance plan that we were now under. The reality was that the insurance plan included a clause that exempted all claims for a child with a birth defect unless the child was born under the plan. This was not a pre-existing clause that would give coverage after a period of time, but a clause that prohibited payment at any time for that defect. We chose to fight the claim denial since we had not been able to secure a proper diagnosis for our daughter previously, and the surgery that she needed was not usually done prior to the age of seven years. With the help of our daughter's doctors, we advocated for her care and won our case. Once again, we believed our troubles were over since our daughter was going to receive her much needed medical care. We hoped that this chapter of our life was closing, and life would move on.

As life would have it, in the next few years my husband was laid off from his job again. In a funny coincidence the company he was working for (a small business with less than ten employees) was denied health insurance coverage. One week after his lay-off, the company secured health insurance coverage. Tired of living through unemployment at life's twists and turns, we decided to open our own business. We thought that we had taken control of our own fate, but now we became our own small group seeking health insurance coverage.

This presented a challenge all its own without having the additional difficulty of a child with a congenital defect.

During the ten years we owned our business, we were never able to obtain health insurance for two main reasons:

- The cost was prohibitive—in the mid-1990s, I received quotes for health insurance for our family that were between \$800-\$1,000 per month.
- We were asked to sign a waiver that stated we would not seek coverage for anything related to our daughter's birth defect.

After our previous experience with insurance claims, we were not comfortable signing an agreement that gave up our daughter's right to coverage for her medical condition, and as a result, we weren't insurable. In the end, we resolved the situation by closing our business. Our overwhelming concerns for our family's health lead us to seek employment with large employers where our daughter's condition would not be a factor in health insurance coverage. We knew we had an overwhelming obligation to our entire family and how devastating a medical emergency could be financially. We went through a difficult transition as we adjusted to less monthly income, but we felt more secure knowing that our children were now protected by a health insurance plan.

Today, we are glad that our situation has been resolved. However, I continue to be greatly concerned about healthcare in the United States and the countless others who are not able to find alternate employment to reconcile issues such as these. Everyday, I hear the concerns of others who are struggling with insurance issues and finding it increasingly difficult to maintain their families' financial and physical health.

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