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Health Insurance: State High Risk Pools

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Summary

In an effort to expand the options for health coverage, 34 states have established high risk health insurance pools. These programs target individuals who cannot obtain or afford health insurance in the private market, primarily because of pre-existing health conditions. Also, many states use their high risk pools to comply with the portability and guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).

In general, high risk pools tend to be small and enroll a small percentage of the uninsured. As of the end of 2006, 190,462 individuals were enrolled in these pools. State-established nonprofit organizations typically run these pools, with private insurance companies handling day-to-day operations. Although benefit packages vary across states and plans, they generally reflect health benefits that are available in the private insurance market. The majority of high risk pools cap premiums between 125% to 200% of market rates, and pools are subsidized through insurer assessments and other funding mechanisms.

Congress has acted in recent years to fund the expansion and operation of state high risk pools. The Trade Act of 2002 (P.L. 107-210) appropriated a total of $100 million for FY2003-FY2004. With the expiration of authorizing legislation for federal funding of state pools, the 109th Congress took up this issue. The House passed H.R. 4519, the State High Risk Pool Funding Extension Act of 2006, on December 17, 2005. H.R. 4519 reauthorized federal grants to state high risk pools through FY2010, and changed the funding formula used for such grants. The Act authorized the following amounts for FY2006: $15 million for seed grants and $75 million for operational and bonus grants. The Senate passed H.R. 4519 without amendment on February 1, 2006, and President Bush signed it into law (P.L. 109-172) on February 10, 2006.

As part of the budget reconciliation process, the Senate passed S. 1932, the Deficit Reduction Act of 2005 (DRA) conference agreement, which provided appropriations for the grants authorized under H.R. 4519. The measure also included conforming language on enactment of H.R. 4519. The House agreed to the Senate-amended DRA bill on February 1, 2006, and President Bush signed it into law (P.L. 109-171) on February 8, 2006. The Centers for Medicare and Medicaid Services (CMS) awarded grants to 31 states that experienced operational losses in 2005. Of those 31 states, 25 also received bonus grants. In 2006, CMS awarded seed grants to five states, and to another five states in 2007.

The 110th Congress took up the issue of extending the federal grant program by making funding available pursuant to the Consolidated Appropriations Act of 2008 (P.L. 110-161). The grant funding totaled $49,127,000. In July 2008, CMS announced that 30 states received operational and bonus grants totaling $49,126,500.

This report will be updated periodically.

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Health Insurance: State High Risk Pools

Introduction

In an effort to expand the options for health coverage and reduce the number of uninsured, a majority of states have established high risk health insurance pools.[1] These programs target individuals who cannot obtain or afford health insurance in the private market. High risk pools generally cover people who have sought health coverage in the individual (nongroup) market, but have been denied coverage, received quotes from insurers that are higher than the premiums offered by the high risk pools, or received offers from insurers that permanently exclude coverage of pre-existing health conditions.[2]

Many states also use their high risk pools to comply with the portability and guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). For eligible individuals moving from the group to nongroup market, HIPAA requires state-licensed health insurers to make coverage available to such individuals, and prohibits exclusion of coverage for pre-existing conditions. Of the 34 states currently operating high risk pools, 28 states use their pools to comply with HIPAA's portability and guaranteed availability provisions.[3]

In general, state high risk pools tend to be small and enroll a small percentage of the uninsured. At the end of 2006, 190,462 individuals were enrolled in these pools,[4] compared with over 31 million people who were uninsured in states with high

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[1] National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis, Twentieth Edition, 2006/2007*, 2006. (Hereafter cited as *Comprehensive Health Insurance*.) For online information about state high risk pools, see State Coverage Initiatives, "High-Risk Pools," at [http://www.statecoverage.net/matrix/highriskpools.htm].

[2] A medical condition for which treatment was recommended or received, or medical advice was sought, prior to enrollment.

[3] To comply with these provisions, states may either enforce the HIPAA individual market guarantees ("federal fallback"), or establish an "acceptable alternative state mechanism," such as a high risk health insurance pool. For more information about HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, and Stephen Redhead. (Hereafter cited as CRS Report RL31634.)

[4] Enrollment for Idaho's pool is from the end of June 2006. Since Tennessee's pool was established in 2007, there is no enrollment data for the state.

risk pools operating that year.[5] However, such limited enrollment reflects, in part, the narrow focus of these pools: individuals with costly health conditions who seek coverage in the private market.

Health Insurance Context

High risk pools fill a niche in the health insurance system — a patchwork system of private markets and public programs designed to meet the needs of different types of health care consumers.[6] In the private health insurance market, most people get health coverage through the group market. This market provides health benefits to groups of people that are drawn together by an employer or other organization, such as a trade union. Such groups are generally formed for some purpose other than obtaining insurance, like employment.

While most Americans receive their health coverage through the workplace — as a current employee, a dependent of an employee, or a retiree — some individuals do not have access to employer-sponsored insurance (ESI). They may be workers who do not qualify for an offer of health benefits from their employer (e.g., because the workers have part-time or seasonal employment status), or they may work for a company that does not provide health insurance at all, or they may be unemployed. Public programs also are a source of health coverage, but individuals and families must meet eligibility requirements in order to qualify for benefits. Individuals who cannot access ESI and are not eligible for public programs may seek health insurance in the nongroup (individual) market.

Applicants to the individual insurance market must go through robust medical underwriting — the process by which an insurer considers information about an applicant and determines (1) whether to offer an insurance policy in the first place, and (2) the terms of that policy (e.g., the monthly premium). The information that a health insurer considers may include personal characteristics, such as an individual's health conditions, family medical history, and other relevant factors. Though uncommon, the insurance carrier may ask an applicant to undergo a physical exam, or provide specimens. In the group market, insurers forgo underwriting in the traditional sense, that is, reviewing *each* person's demographics and medical history. Instead, an insurer would consider the overall characteristics of the group, and calculate a premium for a set of benefits that would be charged to each person in the group, regardless of their individual health status. (For very small groups, insurers may individually underwrite policies, if permitted by law.)

Federal and state laws restrict somewhat insurers' ability to reject applications or design coverage based on health factors in the nongroup market. Nonetheless, some applicants are rejected from the individual market altogether, others may receive insurance offers with riders that exclude coverage for a specific health condition or body part, or others may be charged premiums that are higher than those

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[5] CRS calculation of uninsured in states with high risk pools. Data source: Current Population Survey (CPS), CPS Table Creator, at [http://www.census.gov].

[6] For a general discussion about health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

in the group market for similar coverage.[7] Rigorous underwriting results in an enrollee population in the individual market that is fairly healthy (three out of four enrollees report that their health is excellent or very good[8]), thereby excluding persons with moderate to severe health conditions from this private market. High risk pools were designed to assist such individuals who — because of their health conditions — have very few options for private health coverage.

Health Policy Context

High risk pools appeal to policymakers who prefer an incremental approach to coverage expansion and reliance on current state oversight of health insurance.[9] Supporters of high risk pools contend that states can use their existing regulatory infrastructure, as well as their knowledge of health care markets, to efficiently insure previously uninsurable individuals. Supporters also contend that the private, nongroup market will benefit. They reason that by removing high risk persons from the individual market and placing them in publicly-subsidized insurance pools, coverage in the individual market will become more affordable. They argue that better risk spreading helps to stabilize the market, promote competition, and retain insurance carriers — earning the support of such organizations.[10] Moreover, high risk pools function as a safety net for the nongroup market by assuring that individuals have access to health insurance as long as they are able and willing to pay for it.

Others contend that high risk pools are generally too small and underfunded to meet the needs of the majority of persons who cannot access health insurance in the private market. By design, high risk pools experience losses, but federal attempts to subsidize these losses have been limited. Waiting lists for enrollment are common, and premiums combined with other cost-sharing requirements can often make the coverage offered by these pools unaffordable. As a result, some researchers remain skeptical that high risk pools will be able to substantially reduce the number of

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[7] M. Pauly and A. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy and Law*, February 2000.

[8] General Accounting Office, "Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs," November 1996.

[9] For example, see National Governors Association, Policy Position, "Private Sector Health Care Reform Policy," December 14, 2000. Also, see examples from advisory groups and academia, such as the National Association of Insurance Commissioners, News Release," NAIC Applauds Extension of Federal Funding for High-Risk Pools," July 27, 2005, and M. Pauly, "How Private Health Insurance Pools Risk," National Bureau of Economic Research, Research Summary, Summer 2005.

[10] For example, see the National Association of Health Underwriters' position on high risk pools at [http://www.nahu.org/government/issues/Risk_Pools/High_Risk_Pools.htm], and the Council for Affordable Health Insurance's issue brief on high risk pools at [http://www.cahi.org/cahi_contents/issues/article.asp?id=489].

uninsured, particularly among those with serious medical conditions.[11] With respect to reducing the number of people without health coverage, consumer groups generally advocate for expansion of the federal role in providing coverage, whether through existing public programs or broader health care reform.[12]

While high risk pools have existed since the mid-1970s, only recently has Congress acted to support the expansion and operation of high risk pools across the country. The enactment of HIPAA during the 104th Congress specified state high risk pools as acceptable mechanisms for complying with the group-to-individual market requirements. The 107th Congress passed the Trade Act of 2002 (P.L. 107-210), which authorized a new federal program to provide grants to state high risk pools and made appropriations for FY2003 and FY2004. With expiration of the authorizing legislation for the grant program to states, the 109th Congress reauthorized the program through FY2010 and made appropriations for FY2006. The 110th Congress passed legislation in December 2007 to provide additional appropriations. (See detailed discussion under "Federal Grants to State High Risk Pools" section.)

State High Risk Pools

In 2007, 34 states had high risk health insurance pools. States have a great deal of discretion regarding the establishment and operation of these pools, including covered benefits, eligibility requirements, pre-existing condition exclusion periods, and funding sources.

General Characteristics of State High Risk Pools

Administration. State high risk pools usually are operated through state-established nonprofit organizations. While private insurance companies typically are responsible for daily administrative duties, the pools themselves bear the risk.[13] Boards oversee the management of high risk pools and usually consist of representatives from insurance companies, consumer groups, health care providers, and state agencies.

Premiums and Funding. In order to limit the cost of health coverage for persons with costly medical conditions, all states cap high risk pool premiums.

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[11] For example, see D. Chollet, "Expanding Individual Health Insurance Coverage: Are High-Risk Pools The Answer?," *Health Affairs*, October 23, 2002, and Pollitz, et al., "Health Insurance and Diabetes: The Lack of Available, Affordable, and Adequate Coverage," *Clinical Diabetes*, vol. 23, no. 2, 2005.

[12] For example, see testimony presented by R. Pollack, Families USA, Education and the Workforce Committee Employer-Employee Relations Subcommittee hearing, "Expanding Access to Quality Health Care: Solutions for the Uninsured," July 9, 2002, and American Federation of State, County, and Municipal Employees, "Universal Health Coverage," resolution no. 14, June 26-30, 2000.

[13] A high-risk pool essentially functions as the health plan and is responsible for paying claims. In general, the insurance carrier's role is for administrative purposes only.

Almost all states have caps between 125% and 200% of standard market rates. A majority of states offer coverage at less than 150% of the average. High risk pools generally operate at a loss, "because it isn't feasible to pool a group of individuals known to have major health problems and expect their premium contributions to cover the entire cost."[14] Thus, many state pools tap other sources of funding to cover their operating expenses.

States may augment premium collection with one or more of the following sources: assessments on insurers, in some instances combined with offsetting tax credits; state funds; and other sources.[15] Almost all states with risk pools assess a fee on insurance carriers, although 13 of those states offset those assessments with tax credits. Eleven states use general revenue for additional risk pool funding, while only two states use monies from hospital assessments.

Benefits. Although health benefits provided through risk pools vary across plans and states, they generally reflect coverage that is available in the private market. States usually offer more than one plan from which enrollees may choose. Deductibles and other cost-sharing requirements vary from state to state. Most state pools do not place maximum *annual* limits on benefits, except for California, Idaho, Kansas, Louisiana, Tennessee, Utah, and West Virginia. In contrast, nearly all pools have *lifetime* maximums on benefits, except for Indiana, Kentucky, and New Mexico.[16]

Eligibility. States establish the eligibility criteria for high-risk pools. As noted, many states allow HIPAA-eligible persons to enroll in their high risk pools. HIPAA eligibles are persons who do not have or are losing coverage and seeking it in the individual market.[17] They must meet the following requirements: (1) have at least 18 months of "creditable coverage" (specified in statute) without a significant break in that coverage (63 or more days); (2) most recent coverage must have been through a group health plan; (3) exhausted federal or state continuation coverage; (4) not eligible for Medicaid or Medicare; and (5) not have any other health insurance. For HIPAA eligibles, high risk pools guarantee the availability of health insurance and prohibit exclusion of coverage for pre-existing conditions. Risk pools also are designed to address the insurance needs of non-HIPAA-eligible persons with costly

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[14] Communicating for Agriculture and the Self-Employed, Inc., *Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis, Nineteenth Edition, 2005/2006*, 2005, p. 14.

[15] An assessment is a tax or fee. Some states fund the losses of their risk pools by requiring insurers across the state to pay assessments. Generally, the amount of insurers' assessment is based on their share of the total premiums sold in the state for each year. Some states also provide tax credits to these insurers, thus reducing the insurers' tax liability and enabling them to recover some or all of their expenditures on the assessments. Under the latter of these funding mechanisms, the state assumes part or all of the cost burden for the losses of the risk pools.

[16] In KS, annual maximum applies to certain plans. In FL and KY, no lifetime maximums apply to specified plans.

[17] HIPAA also provides protections to certain people who wish to enroll in the group health insurance market. See the aforementioned CRS Report RL31634 for more details.

medical conditions. A number of states provide for presumptive eligibility, allowing individuals to become automatically eligible for high-risk pools if they have a certain medical condition specified under state law. In addition to HIPAA eligibles and persons with specific conditions, many states allow individuals who have experienced coverage denials, coverage restrictions, or premium increases to enroll in high risk pools.

Enrollment. High risk pool participation varies significantly across states, with enrollment ranging from a high of 29,089 participants in Minnesota to a low of 345 enrollees in West Virginia.[18] Among state high risk pools, the enrollment distribution clusters toward the low end. To illustrate, almost one-third of high risk pools with 2006 enrollment data had pools below 2,000 participants (10 states), and two-thirds of state pools had participation below 4,000 (23 states). In contrast, only six states had more than 10,000 participants. As for new enrollment, all states but Florida are accepting new participants.[19]

Federal Grants to State High Risk Pools

Given that state high risk pools typically operate at a loss (see discussion above), the federal government has provided financial assistance to states during the past several years. Congress established a grant program, administered by the Centers for Medicare and Medicaid Services (CMS), to provide seed grants to states that did not already have high risk pools but wanted to establish them, and operational grants to existing state pools. Once Congress appropriates funding for these grants, CMS announces the funding opportunity and collects and reviews applications. A state may receive up to $1 million in seed grant funding; operational grant amounts are determined by formula. (Not all states with existing high risk pools receive grants.)[20]

107th Congress

With enactment of the Trade Act of 2002 (P.L. 107-210), the federal government provided funding to state high risk health insurance pools for the first time. The Trade Act authorized and appropriated $20 million in the form of seed grants. Each qualifying state could receive up to $1 million to support the creation and implementation of a high risk pool. In 2003, CMS awarded seed grants to six states: Maryland ($1 million), New Hampshire ($1 million), Ohio ($150,000), South Dakota ($1 million), Utah ($52,618), and West Virginia ($1 million).[21]

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[18] The applicable date for enrollment data varies from state to state. For the newest high risk pool, Tennessee, no enrollment data are yet available.

[19] Data sources: Kaiser Family Foundation, "State High Risk Pool Programs and Enrollment, 2007", at [http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7], and *Comprehensive Health Insurance*.

[20] For additional information about the grant program administered by CMS, see High Risk Pool Overview, at [http://www.cms.hhs.gov/HighRiskPools/].

[21] Ohio was awarded a grant to conduct a study on the feasibility of creating a high risk pool.
(continued...)

The Trade Act also authorized and appropriated $80 million to be split evenly over FY2003 and FY2004 to defray some of the operating losses experienced by states with existing high risk pools. Each operational grant could cover up to 50% of a pool's operating losses for the year. To qualify, each state must have established a risk pool that restricts premiums to no more than 150% of the premium for standard risk rates in the state, offers a choice of two or more coverage options, and has in effect a mechanism designed to ensure continued funding of losses incurred after the end of FY2004. However, states may still be able to determine, within federal standards, how much to charge enrollees in out-of-pocket costs, what benefits to include under the plans, how long coverage for pre-existing conditions may be excluded, and whom among otherwise uninsurable individuals will be eligible.

Table 1 shows which states received operational grants for FY2003 and FY2004, and the funding levels. Nineteen states were awarded operational grants in FY2003; 22 states in FY2004.[22]

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[21] (...continued)
Utah was awarded a grant to modify its existing health plan and become a newly "qualified" high risk pool.

[22] The FY2004 grantees include Massachusetts which operates a reinsurance program for the non-group market that differs from traditional high risk pools. Nonetheless, the MA program met the requirements of the federal grant program. For a more detailed discussion about the MA reinsurance program, see *Comprehensive Health Insurance*, p. 261.

Table 1. Operational Grants Awarded to State High Risk Pools, FY2003 and FY2004

State	Grant amount, FY2003 ($, thousands)	Grant amount, FY2004 ($, thousands)
Alabama	2,826	—
Alaska	542	484
Arkansas	1,928	1,893
Colorado	3,219	3,096
Connecticut	1,597	1,503
Illinois	8,144	7,473
Indiana	3,266	3,358
Iowa	1,107	368
Kansas	1,462	1,297
Kentucky	2,511	2,292
Maryland	—	3,176
Massachusetts	—	132
Minnesota	1,984	1,972
Mississippi	2,066	2,038
Montana	698	621
Nebraska	894	751
New Hampshire	225	532
New Mexico	2,048	1,739
North Dakota	329	293
Oklahoma	2,931	2,731
Utah	—	1,395
Wisconsin	2,222	2,501
Wyoming	—	358

Sources: Centers for Medicare and Medicaid Services, "HHS Awards Grants to Twenty-two States to Offset Costs of Insurance for Residents Too Sick for Conventional Coverage," News Release, October 5, 2005; and K. Pollitz and E. Bangit, "Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?" Issue Brief, November 2005.

Note: Grant amounts are rounded to the nearest thousand.

109th Congress

With expiration of authorizing legislation for the grant program, the House passed H.R. 4519, the State High Risk Pool Funding Extension Act of 2006, on December 17, 2005. H.R. 4519 reauthorized federal grants to state high risk pools through FY2010, and changed the funding formula used for such grants. The formula for operational grants was changed to the following: 40% to all qualifying states in equal amounts, 30% based on state proportion of uninsured population among all qualifying states, and 30% based on state proportion of the high risk pool population. H.R. 4519 also allowed operational grants to cover up to 100% of pool losses and authorized the following amounts for FY2006: $15 million for seed grants and $75 million for operational and bonus grants. The Senate passed H.R. 4519 without amendment on February 1, 2006, and President Bush signed it into law (P.L. 109-172) on February 10, 2006.

As part of the budget reconciliation process, the Senate passed S. 1932, the Deficit Reduction Act of 2005 (DRA) conference agreement. DRA included provisions that would provide specific appropriations for the grants authorized under H.R. 4519. Section 6202 of the Senate measure amended the Public Health Service Act to provide $90 million in appropriations for grants to states for FY2006. DRA provided $75 million for operational grants and $15 million for seed grants. The grants are distributed according to existing statutory requirements. This measure also included conforming language on enactment of H.R. 4519. Pursuant to H.Res. 653, the House agreed to the Senate-amended bill on February 1, 2006. On February 8, 2006, President Bush signed DRA into law (P.L. 109-171).

The appropriations provided under DRA were used to extend federal funding for this program. On September 30, 2006, CMS awarded seed grants to five states that wanted either to establish high risk pools or conduct feasibility studies: California ($150,000), New York ($150,000), North Carolina ($150,000), Tennessee ($1 million), and Vermont ($1 million). That same year, CMS awarded grants to 31 states that experienced operational losses in 2005. Of those 31 states, 25 also received bonus grants, exhausting the entire appropriations for operational and bonus grants. **Table 2** shows which states received operational and bonus grants.

Because the funding for seed grants was not exhausted with the 2006 awards, CMS awarded five seed grants in 2007. The states that received these grants were the District of Columbia ($150,000), Florida ($150,000), Georgia ($150,000), North Carolina ($850,000), and Rhode Island ($150,000).

Table 2. Operational and Bonus Grants Awarded to State High Risk Pools, FY2006

State	Operational Grants ($)	Bonus Grants ($)	Total Grant Award ($)
Alabama	1,442,972	0	1,442,972
Alaska	790,482	895,640	1,686,122
Arkansas	1,253,047	55,900	1,308,947
Colorado	1,658,396	1,478,373	3,136,769
Connecticut	1,147,452	700,000	1,847,452
Idaho	960,424	0	960,424
Illinois	2,939,767	1,250,000	4,189,767
Indiana	1,926,155	942,000	2,868,155
Iowa	994,340	0	994,340
Kansas	1,031,608	295,000	1,326,608
Kentucky	1,406,506	975,000	2,381,506
Louisiana	1,354,951	992,713	2,347,664
Maryland	1,797,813	1,200,000	2,997,813
Massachusetts	414,569	0	414,569
Minnesota	3,664,879	2,000,000	5,664,879
Mississippi	1,392,593	449,202	1,841,795
Missouri	1,409,440	1,000,000	2,409,440
Montana	1,074,800	729,875	1,804,675
Nebraska	1,273,440	934,097	2,207,537
New Hampshire	826,355	782,644	1,608,999
New Mexico	1,121,553	950,000	2,071,553
North Dakota	867,573	0	867,573
Oklahoma	1,388,788	1,000,000	2,388,788
Oregon	2,375,581	1,500,000	3,875,581
South Carolina	1,278,624	700,000	1,978,624
South Dakota	785,577	312,851	1,098,428
Texas	7,237,175	2,000,000	9,237,175
Utah	1,162,603	1,250,000	2,412,603
Washington	1,575,759	856,705	2,432,464
Wisconsin	2,672,935	1,750,000	4,422,935
Wyoming	773,843	0	773,843

Sources: Grant data available at [http://www.cms.hhs.gov/HighRiskPools/Downloads/grantawardslist1106.pdf].

110th Congress

Pursuant to the Consolidated Appropriations Act of 2008 (P.L. 110-161), Congress made additional funding available for grants to state high risk pools. CMS issued a grant notification letter to states on May 1, 2008. It stated that a total of $49,127,000 would be split to fund operational grants (two-thirds of the appropriated amount) and bonus grants (remaining one-third).[23] Applications were due by June 9, 2008.

On July 21, 2008, CMS announced that 30 states received grants totaling $49, 126,500. **Table 3** shows which states received grants and the combined grant amounts.

[23] For additional information, see the funding announcement online at [http://www.cms.hhs.gov/HighRiskPools/Downloads/Final_FY08_HRP_announcement.pdf].

Table 3. Combined Operational and Bonus Grants Awarded to State High Risk Pools, FY2008

State	Total Grant Award ($)
Alabama	1,383,432
Alaska	686,427
Arkansas	923,943
Colorado	1,810,579
Connecticut	1,179,518
Idaho	966,948
Illinois	2,997,696
Indiana	1,706,495
Iowa	713,258
Kansas	1,085,624
Kentucky	1,688,275
Louisiana	1,437,094
Maryland	2,301,233
Minnesota	3,442,001
Mississippi	1,414,808
Missouri	1,491,340
Montana	1,054,073
Nebraska	1,195,503
New Hampshire	882,252
New Mexico	1,440,929
North Dakota	703,531
Oklahoma	1,392,608
Oregon	2,680,650
South Carolina	1,444,730
South Dakota	724,609
Texas	6,276,063
Utah	1,393,329
Washington	1,617,258
Wisconsin	2,561,169
Wyoming	504,125
Total	**49,126,500**

Sources: Grant data available at [http://www.cms.hhs.gov/HighRiskPools/Downloads/2008HRPAWARDS.pdf].