



High risk health insurance plans: Past, Present and Future

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Overview

Comprehensive Health Insurance Plans (CHIPs), commonly known as state high risk pools, are special state health insurance programs established by state legislatures. CHIPs, which should not be confused with the children's health insurance plans contained in the Balanced Budget Act of 1997, have been around for over 25 years – the first plans were established by Connecticut and Minnesota in 1975. The National Association of Insurance Commissioners (NAIC) has developed model legislation for states to consider when establishing a high-risk health insurance pool. Most states laws establishing high-risk pools are based on the NAIC model. The current *Model Health Plan For Uninsurable Individuals Act* has been revised and updated to be consistent with the Health Insurance Portability Act (HIPAA).

Risk pools are non-profit entities overseen by appointed diverse boards with consumer, insurance industry, medical, and state insurance department representation. State high risk health insurance pools are designed to serve a small, but very important segment of the individual insurance market – those few individuals who are uninsured and have a high-risk health condition, such as cancer, diabetes, heart disease or other chronic illness that causes them to be turned down when they try to buy insurance. Pools generally serve the self-employed, employees of small businesses that don't offer health insurance, people that formerly were in the employer group market but came into the individual market eligible with portability under HIPAA, young people coming off their family's coverage, and workers who are not a part of a large employer plan. This group is estimated at one to two percent of the uninsured population.

Thirty-three states have created state high-risk health insurance programs which serve as a safety net to guarantee access for the uninsurable population. These plans are providing health insurance to over 181,000 individuals who otherwise would not be able to find coverage in the private, underwritten market. High-risk pools first drew national attention for their role in state implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They recently have attracted attention during debate on health insurance assistance for displaced workers. Landmark provisions in the Trade Act of 2002 provide federal funding assistance for high-risk pools.

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How do these plans work?

Enrollees pay a premium for their health insurance, and these premiums are usually capped so the enrollee has price protection. Since the program is designed to operate at a loss, most states make up the shortfall by assessing the insurance companies (non-ERISA plans) based on the amount of business they do in that state.

Who is eligible for coverage?

Generally speaking, in most states any individual who has been denied coverage in the underwritten health insurance market is eligible for coverage under the high risk pool plan. Some states also specify that an individual who has been offered coverage at a rate higher than that offered by the pool also is eligible for the plan. Structuring eligibility in this way helps protect consumers by discouraging insurance agents from automatically sending an applicant with a health problem to the pool without first attempting to find less expensive coverage for that person in the underwritten market. Most states also limit eligibility to individuals who are not eligible for employer group coverage or coverage through a government program such as Medicaid. In states that have elected to use their plan as an “alternative mechanism” for ensuring group-to-individual portability under HIPAA, individuals who satisfy HIPAA’s eligibility requirements are automatically eligible for coverage.

Why is a state high-risk health plan an attractive policy option?

State high-risk pools serve those that fall through the cracks and can’t buy insurance due to a pre-existing condition, or can only get limited coverage or coverage at extremely high rates in the private market. Risk pools guarantee access to relatively affordable, comprehensive major medical plans. Enrollees pay somewhat higher rates for the coverage, but there is a cap on premiums, and the programs are subsidized. Although the number of persons who fall into this category is fairly small, the cost of covering such individuals is disproportionately high since they have the most serious of medical conditions. The benefits and coverage are generally designed to mirror what is offered in the individual market. Finally, state high-risk pools have played a critical role in stabilization of the individual health insurance market in states electing them as an HIPAA alternative for guaranteed access.

How does risk spreading work in the pools?

High-risk health insurance plans inherently lose money since risk spreading doesn’t work when all participants are in poor health. With premium rates for coverage capped, the plan inevitably will run a deficit, as premiums collected from enrollees will not suffice to pay incurred medical claims. Premiums cover only 40 to 60% of costs incurred. The shortfall typically is covered by an annual assessment on health insurers doing business in the state, which allows the cost of guaranteed access to be spread broadly across both the individual and group health insurance markets. A large portion of the total market for health benefits coverage, however, is missing from this picture: Under ERISA’s federal preemption provisions, self-funded employer health plans are exempt from direct assessment by a state. In any state, such plans typically represent 30 – 40% of the total market for health benefit coverage.

A few states have adopted other ways to spread the cost of guaranteed access—for example, by funding a high-risk pool in whole or in part with revenue from tobacco or other excise taxes, tapping general revenues, or placing a surcharge on hospital services. The last two funding mechanisms spread the cost of coverage much

more broadly by assessing not only insurers that provide primary health insurance coverage, but also those that furnish stop-loss coverage to self-funded employer health plans.

The NAIC model legislation provides the following suggestions for alternative additional revenues (other than premiums):

1. Assessment of health insurers based upon their health insurance premiums written in the state.
2. Assessment of health insurers and reinsurers based upon the number of persons they cover through primary, excess and stop loss insurance in the state. (Note: This method is beginning to come under court challenge as violating ERISA.)
3. Service Charge on Hospital and Surgical Centers.
4. Appropriation of general revenue.

How much does coverage cost?

Premiums for high-risk pool plan coverage can range from 125% to 200%; however they are typically capped at 150% of the average rate for underwritten coverage in the individual health insurance market, as determined by polling the largest individual insurers in the state. Some states have capped premiums at less than 150%. A few permit premiums of up to 200% of standard rates.

Recent Federal Action to help state high-risk pools

Trade Adjustment Assistance Reform Act

On August 6, 2002, President Bush signed the Trade Adjustment Assistance Reform Act (TAA Act). The law provides for two grant programs to assist states with start up funding of new state high risk health insurance pools, and another with operational funding of existing qualified risk pools.

Start-up grant program

Twenty million for fiscal year 2003 was appropriated for high-risk pool start-up grants. Grants of up to \$1 million are available to states for the creation and initial operations of a qualified high-risk pool. To be eligible a state must create a “qualified” high-risk pool that meets the criteria specified in the Trade Act. The criteria for “qualified” risk pool are taken from the Public Health Service Act which requires among other things, that the pool provide coverage to all individuals who are guaranteed coverage through the Health Insurance Portability and Accountability Act (HIPAA).

The deadline for applying for a grant is **March 30, 2004**. Without federal action, **the funding for the start-up grant program expires on September 30, 2004**.

Start-up grant program: Experience to date

Four states have received the maximum award amount of one million dollars. These states are Maryland, New Hampshire, South Dakota and West Virginia. Ohio received a feasibility study grant for \$150,000. Grand total of start-up grant awards is \$4.2 million.

Operational grant program

Eighty million over two years was appropriated to offset a portion of losses incurred by states from operating qualified high-risk pools. Forty million was appropriated for FY 2003 and FY 2004. In order to be a qualified program, the pool must be deemed “qualified” as defined in the Public Health Service Act. Additionally, states that meet the following requirements may receive a grant from the State of up to 50% of the losses incurred by the State in connection with the operation of the pool. The amounts appropriated for a fiscal year and made available to the States are in accordance with a formula based upon the number of uninsured individuals in the States.

Requirements:

- A. Restricts premium to no more than 150% of premium for applicable standard risk rates.
- B. Offers a choice of two or more coverage options through the pool; and
- C. Has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State after the end of FY 2004 in connection with operation of the pool.

Putting the numbers in perspective

The federal grants program provides up to \$40,000,000 to cover up to fifty percent of the losses incurred by the state high-risk pool. Overall enrollment reported as of June, 2004 for thirty-one risk pools in operation was 181,441. Total combined claims reported for 2004 for the 31 risk pools was \$1,258,789,054 (increase of 20.9% from a year earlier). Total combines losses requiring subsidies for all operating state risk pools in 2004 was \$539,802,547 (increase of 15.2% from a year earlier).¹

Operational grant program: Experience to date

Fiscal year 2003, operational grants to offset losses incurred by qualified state high risk pools in 2002 are listed below:

Alabama - \$2,800,000	Kentucky - \$2,297,008
Alaska - \$495,769	Minnesota - \$1,710,789
Arkansas - \$1,764,129	Mississippi - \$1,890,350
Colorado - \$2,945,322	Montana - \$638,228
Connecticut - \$1,460,719	Nebraska - \$719,841
Illinois - \$7,451,658	New Hampshire - \$224,559
Indiana - \$2,889,802	North Dakota - \$310,349
Iowa - \$1,018,945	Oklahoma - \$2,681,597

¹ Comprehensive Health Insurance for High-risk Individuals, A State-by-State Analysis, Eighteenth Edition, 2004/2005, page4.

Kansas - \$1,337,299	Utah - \$52,618
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High-risk pools and the Federal Health Care Tax Credit

The TAA Act provided a federal Health Care Tax Credit (HCTC) to people participating in the Trade Adjustment assistance program, and people age 55 to 64 who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC). Those eligible for assistance receive a HCTC equal to 65% of the premium paid by the individual and qualifying family members for qualified health insurance coverage. The TAA Act specified types of coverage that would automatically qualify for tax credit assistance. Additionally, seven specific types of coverage options were specified in the TAA Act that states can choose to serve as their HCTC acceptance program. Coverage through a state high-risk pool is one option states can use to provide health insurance coverage for individuals eligible for the HCTC.

Over thirty states offer state-qualified options for those eligible for the HCTC under the TAA Act. Sixteen states chose a coverage option through a state high-risk pool. Those states are:

Alaska, Arkansas, Colorado (also uses state continuation), Connecticut (also uses state continuation), Idaho, Illinois, Iowa, Maryland, Minnesota, Montana, New Hampshire (also uses state continuation), North Dakota, South Carolina and Texas (also uses Blue Cross/Blue Shield of Texas).

Federal Risk Pool Legislation in 108th Congress

H.R. 1110, the State High Risk Pool Funding Extension Act of 2003

The bill was introduced on March 6, 2003 by Representative Ed Towns (D-NY). H.R. 1110 is contained in bills addressing the uninsured: The “Health Insurance Certificate Act of 2003”, H.R. 2698 by Representative Mike Bilirakis (R-FL) and the “Fair Care for the Uninsured Act of 2003”, S.1570 by Senator Rick Santorum (R-PA).

S. 2283, the State High Risk Pool Funding Extension Act of 2004

The bill was introduced on April 5, 2004 by Senator Judd Gregg (R-NH) (Chairman of the Senate Health Education, Labor and Pension (HELP) Committee) and Senator Max Baucus (D-MT) (Ranking, Senate Finance Committee). S.2283 extends seed grant funding through FY 2005 and increases the operational funding to \$75 million per year through FY 2009. The legislation was amended establishing a “bonus fund” within the operational grants program. One-third of operational fund money would be available to states to be used to provide supplemental benefits. The program is voluntary and any bonus fund money unspent is redistributed to states for operational offset funding. The Senate HELP Committee unanimously approved the amended bill on September 22, 2004.

H.R. 5341, the State High Risk Pool Funding Extension Act of 2004

The bill was introduced on October 8 by Representative John Shadegg (R-AZ) and Representative George Nethercutt (R-WA). Like S.2283, this bill extends funding for the seed grant funding through FY 2005. Operational grant program is increased to \$50 million and extended for one year, through FY 2005. It increases the allowable premium to 200%, consistent with the NAIC *Model Health Plan for Uninsurable Individuals*. It does not include a “bonus fund.”

The “State High Risk Pool Funding Extension Act” would extend funding for state high risk pools created through the Trade Adjustment Assistance Reform Act (TAA Act). The law amended the Public Health Services Act (PHSA) establishing two federal grant programs to assist states with start up funding of new state high risk health insurance pools, and another with operational funding of existing qualified risk pools. Please refer to the October 12 side-by-side for details.