



News Release

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Policy Options for Design of the Temporary High-Risk Health Coverage Pool

*\$5 Billion for High-Risk Pool Will Fall Far Short of Extending Affordable Coverage
to Millions of Uninsured Americans with Pre-Existing Medical Conditions*

Editor's Note: An advance copy of the embargoed analysis is available by emailing acassil@hschange.org. The analysis will be available online at www.nihcr.org after the embargo lifts at 12:01 a.m. EDT, Thursday, May 27, 2010.

WASHINGTON, D.C.—While 5.6-million to 7-million Americans may qualify for health coverage through the new temporary national high-risk pool program, the \$5 billion allocated until 2014 will cover only a small fraction of those in need, potentially as few as 200,000 people a year, according to a new Policy Analysis from the National Institute for Health Care Reform (NIHCR).

The analysis identifies key policy considerations in designing the temporary high-risk pool program created by the 2010 Patient Protection and Affordable Care Act (PPACA) to provide subsidized health coverage to people who are uninsured because of pre-existing medical conditions. The law includes insurance market reforms and income-based subsidies to make coverage more accessible and affordable, but most of these measures do not take effect until January 2014. To bridge the gap, the law provides for an interim national high-risk pool, modeled on those already operating in 35 states, scheduled to start July 1.

“While the law’s goal is to bridge the gap for people who can’t get affordable private insurance because of pre-existing medical conditions until the full reforms occur in 2014, the limited funding means the administration will have to make hard choices to stretch the dollars as far as possible,” said Paul B. Ginsburg, Ph.D., NIHCR director of research and president of the Center for Studying Health System Change (HSC).

Written by Mark Merlis, M.A., an independent health policy consultant, the NIHCR analysis examines how policy makers might tailor eligibility rules, benefits and premiums to stretch the \$5 billion as far as possible. The new Policy Analysis—*Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool*—is available online at www.nihcr.org.

The analysis points out that, “It is likely that policy makers at both the federal and state level will have to choose between two basic courses. They can simply open the doors to programs that are more generous than most current state pools and allow the programs to reach capacity.... Or they can look for ways to limit entry to the program to those most in need and/or to stretch the dollars to serve more people. How much leeway they have to modify the outlines of the program is uncertain.”

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The U.S. Department of Health and Human Services (HHS) will oversee the temporary high-risk pool program and has asked states to indicate whether or not they want to administer the program in their own state. If a state does nothing, HHS will administer the program. As of May 21, 29 states and the District of Columbia had signaled an interest in operating their own programs, 19 states had declined and two states were undecided.

Generally, the temporary program is open to citizens and legal residents who have a pre-existing condition and who have been uninsured for at least six months. The law does not specify what benefits must be provided, but the pools must cover at least 65 percent of the cost of whatever services are covered. The coverage also must have an out-of-pocket limit—the sum of deductibles, coinsurance or copayments—no greater than the limits established for high-deductible health plans linked to health savings accounts: \$5,950 for an individual and \$11,900 for a family in 2010.

Premium rates may vary only by age, family type (individual vs. family), geographic area and tobacco use. The highest age rate may be no more than four times the lowest. According to the law, rates must “be established at a standard rate for a standard population.” That is, they must be equal to 100 percent of the rate that nongroup insurers in the same area would offer for comparable benefits for a population that did not present high medical risk.

Estimates from the 2007 Medical Expenditure Panel Survey (MEPS) show about 51.6 million nonelderly people were uninsured in December 2007—the most recent available full year of data, according to the analysis. Of these, 43.7 million—85 percent of the total—had been without insurance for six months or more, as required by PPACA. Of that group, nearly 7 million had potentially high-cost medical conditions.

Of the nearly 7 million uninsured with high-cost conditions, 14 percent were offered coverage through their current employment. If those with access to other coverage were excluded—they likely would find subsidized employer coverage more affordable than premiums in the high-risk pool program—approximately 5.6 million people might be eligible for the new high-risk pool program, according to the analysis.

In 2008, existing state high-risk pools’ costs per participant exceeded premiums by \$4,200, according to a 2009 U.S. Government Accountability Office report. If a \$4,200 subsidy was needed to bring premiums down to the typical 125 percent to 150 percent of standard rates used in many state pools, the subsidy needed to bring premiums to 100 percent of standard rates would have been in the range of \$6,000 to \$7,000, according to the NIHCR analysis. If federal subsidies of this size were provided for the full life of the national program, the annual number of people who could be covered would be around 200,000.

Other key considerations include how the new national program will fit with existing state high-risk pools and how to manage the transition of enrollees from high-risk pools to the new health insurance exchanges scheduled to be operational in 2014 to prevent adverse selection and encourage insurer participation, according to the analysis.

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The National Institute for Health Care Reform contracts with the Washington, D.C.-based Center for Studying Health System Change to conduct high-quality, objective research and policy analyses of the organization, financing and delivery of health care in the United States. The nonprofit, nonpartisan Institute was created by the International Union, UAW; Chrysler Group LLC; Ford Motor Company; and General Motors to help inform policy makers and other decision-makers about options to expand access to high-quality, affordable health care to all Americans.

The Center for Studying Health System Change is a nonpartisan policy research organization committed to providing objective and timely research on the nation's changing health system to help inform policy makers and contribute to better health care policy. HSC, based in Washington, D.C., is funded in part by the Robert Wood Johnson Foundation and is affiliated with Mathematica Policy Research.