NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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The Temporary High Risk Pool Program: An Opportunity for Insurance Coverage for Mental Health and Addiction Benefits

Health Care Reform Implementation Series: Updated 4/19/10

Changing the High-Risk Pool Landscape

The Patient Protection and Affordable Care Act, the comprehensive health care reform law enacted on March 23, 2010, establishes a temporary high-risk health insurance pool program for individuals who cannot obtain coverage in the private insurance market because of pre-existing medical conditions, which include mental health and substance use disorders. The program, which must begin within 90 days of the enactment of the law, will provide health insurance for eligible individuals through January 1, 2014, when participants will transition to the new American Health Benefit Exchanges* or Medicaid. Under the law, the secretary of the Department of Health and Human Services will administer the program directly or through contracts with states or non-profit private entities that operate qualified high-risk pools.

The Patient Protection and Affordable Care Act

General Requirements

The law:

Establishes a temporary high-risk health insurance pool program, which must begin within 90 days of enactment and operate through January 1, 2014, for individuals who have pre-existing medical conditions and cannot obtain coverage in the private market; and

Requires the HHS secretary to administer the program directly or through contracts with states or non-profit private entities that operate qualified high-risk pools.

Currently, more than 30 states have high-risk pools, which are private, self-funded health plans designed to serve individuals who attempt to obtain health insurance in the individual market but are denied because of pre-existing medical conditions or cannot afford the quoted premiums. In most states, high-risk pools operate as independent entities governed by their own boards and administrators, but in some states, they function as part of the department of insurance. State high-risk pools in 2008 had a combined enrollment of only about 200,000 individuals, or about 2% of the total individual health insurance market in states that had pools, in part because certain factors, such as high premiums and exclusion periods for pre-existing medical conditions, discourage enrollment.[1]

Implementation of the national program will pose a number of challenges—such as the development of eligibility requirements, the determination of premiums and benefits, funding issues, and administrative concerns—but also will offer an **opportunity to address some of the factors that have limited enrollment in state pools and help ensure that individuals with pre-existing mental health and substance use disorders have access to adequate and affordable coverage for treatment**.

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*The health care reform law requires each state by January 1, 2014, to establish an American Health Benefit Exchange for individuals and a Small Business Health Options Program Exchange for small businesses that have 50 to 100 employees. The exchanges will market qualified health plans that provide an essential benefits package, adhere to mental health parity rules, and meet other requirements. For more information on the exchanges, please review the National Council fact sheet on provisions in the law.

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Ensuring Eligibility

The national high-risk pool program will have to establish eligibility requirements as part of the implementation process, and these criteria will help determine who can participate in the program. Under the health care reform law, U.S. citizens and legal residents who have a pre-existing medical condition, cannot obtain health insurance in the private market, and have lacked coverage for at least six months qualify for the national program. The law requires the HHS secretary to establish the criteria used to determine whether an individual has a pre-existing medical condition, and through the development of these guidelines, an **opportunity exists to ensure that individuals with mental health and substance use disorders, many of whom do not qualify for state high-risk pools, qualify for the national program**.

The Patient Protection and Affordable Care Act

Eligibility Requirements

The law:

Requires the HHS secretary to establish the criteria used to determine whether an individual has a pre-existing condition; and

Requires the secretary to monitor health insurers and group health plans to determine whether they encourage individuals to leave prior coverage because of their health status, and when this occurs, allows the secretary to require insurers to pay the associated costs.

Currently, eligibility requirements for state pools vary, but the most common criteria include either (1) denial of health insurance in the individual market because of pre-existing medical conditions or (2) receipt of coverage with a premium rate that exceeds the rate offered by the pool and (3) residency in the state in which the pool operates. About half of state pools provide automatic eligibility for individuals with certain medical conditions, such as HIV. A few state pools provide automatic eligibility for limited, specific mental health disorders. In addition to these criteria, most state pools accept individuals who qualify under the 1996 Health Insurance Portability and Accountability Act.

Avoiding Crowd Out

Related to eligibility requirements, the national high-risk pool program faces potential concerns with "crowd out," a problem experienced by some state high-risk pools. Crowd out occurs when individuals who have other forms of health insurance replace that coverage with benefits obtained through state pools. In an effort to prevent crowd out, the health care reform law requires that individuals lack health insurance for at least six months before they can participate in the national program. This requirement provides an incentive for individuals to retain their current health insurance when possible.

In addition, the HHS secretary will monitor health insurers and group health plans to determine whether they encourage individuals to leave prior coverage because of their health status. For example, health insurers might offer sick individuals payments or other financial considerations to leave their plans or might decide to discontinue policies or exit markets that include mostly sick individuals because of the availability of the national program. Under the law, health insurers that engage in these types of activities might have to pay the costs associated with individuals who decide to leave their plans.

Addressing Issues with Premiums and Benefits

In addition to eligibility requirements, the national high-risk pool program will have to set premiums and benefits as part of the implementation process, and these factors will help determine whether individuals can afford to participate in the program and the level of coverage provided.

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Avoiding High Premiums

The health care reform law includes a number of provisions to help address high premiums that have discouraged enrollment in state high-risk pools. In dollars, state pools have average annual premiums of $5,355, and these premiums range from about $1,700 in Idaho to $9,160 in South Carolina.[2] Deductibles for state pools generally range between $500 and $1,000 but can exceed $10,000 in some states, such as Arkansas, Alaska, and Florida.[3] In most state pools, a 50-year-old individual would have an annual premium of more than $7,000 and a deductible of $1,000.[4]

The Patient Protection and Affordable Care Act

Premiums and Benefits

The law:

Requires the national high-risk pool program to establish premiums at a standard rate for a standard population;

Limits adjustment of premium rates based on the age of participants to a ratio of no more than 4:1 in the national program;

Requires the national program to pay at least 65% of the cost of covered services and caps out-of-pocket costs for participants at $5,950 per individual and $11,900 per family; and

Allows the HHS secretary to determine which services the national program will cover.

Under the law, the national high-risk pool program must establish premiums at a standard rate for a standard population; most state pools establish premiums at different standard rates that range from 125% to 200% of the rates charged by private health insurers, and as a result, many individuals cannot afford to participate.[5] The law also limits the adjustment of premium rates based on the age of participants to a ratio of no more than 4:1 in the national program; only 18 state pools adjust their premium rates based on age at this level or lower.[6] In addition, the law requires the national program to pay at least 65% of the cost of covered services and caps out-of-pocket costs for participants at $5,950 per individual and $11,900 per family; some state pools limit out-of-pocket costs for low-income participants.

The law does not address whether the national program will offer premium subsidies, but because of the limit on available funding, the program might not have the ability to provide them. However, similar to some state pools, the national program might allow third parties—such as hospitals, community health centers, and community behavioral health organizations—to pay premiums on behalf of participants who otherwise would not have health insurance and likely would increase the amount of uncompensated care provided by these facilities. The national program also might allow states to offer premium subsidies to residents; 14 state pools currently provide this assistance.[7]

Ensuring Appropriate Benefits

In terms of benefits, the health care reform law allows the HHS secretary to determine which services the national program will cover, and these benefits might include hospitalization, outpatient care, maternity care, prescription drugs, rehabilitation, and mental health care, among others, with no annual or lifetime limits. **An opportunity exists to ensure that the national program covers treatments for mental health and substance use disorders at an appropriate level**, which often has not occurred in state high-risk pools. State pools generally provide coverage for similar services as traditional health plans, but many pools limit coverage of some or all services to reduce costs. In addition, although most state pools offer coverage for some treatments for mental health and substance use disorders, they generally impose stricter limits and require higher co-payments for these benefits than for other services.

Other Challenges

The health care reform law appropriates a total of $5 billion, or $1.25 to $1.67 billion annually, for the national high-risk pool program. In 2008, states with high-risk pools spent a combined $900 million to subsidize excess losses for participants.[8] After accounting for expected increases in health care costs and the costs of changes state high-risk pools would need to make to meet federal requirements, the $5 billion likely will not support a significant increase in enrollment in the pools. In response to potential funding challenges, the health care reform law requires that states not reduce the amount they spent on high-risk pools in the previous year to ensure funding for the national program does not replace state funding. The law also allows the HHS secretary to suspend enrollment, increase premium rates, reduce benefits, and take other actions to address funding issues in the national program.

The law does not include funding for outreach to individuals who might qualify for the national program. In contracts with states or other entities that operate qualified high-risk pools, the HHS secretary could require them to engage in certain outreach activities to help ensure access to the national program for eligible individuals. In addition, **health care providers could offer information about the national program and direct individuals who might qualify to places where they can apply or distribute applications themselves**.

The national program also will face a number of administrative concerns as the implementation process begins, with state pools that seek to participate in the program likely to require significant changes to meet federal standards for eligibility requirements, premiums, and benefits. In addition, about one-third of states do not have high-risk pools. In these cases, the national program might contract with state programs that provide coverage for residents who lack health insurance, help states develop pools, contract with private health insurers to offer coverage, or provide coverage through Medicare.

Conclusion

The establishment of the national high-risk pool program to address immediately the lack of access to health insurance for individuals who have pre-existing medical conditions serves as positive step that will help bridge the gap in coverage until the exchanges begin in 2014. In addition, the implementation of the program **offers a number of opportunities for us to advocate at the federal and state levels for fair inclusion of individuals with mental health and substance use disorders**. You also can **contact high-risk pools that currently operate in your state to ask about their plans for the transition to the national program**.

For additional information, please visit the links below:
http://www.hhs.gov/news/press/2010pres/04/20100402b.html
http://www.kff.org/healthreform/upload/8040.pdf
http://www.kff.org/uninsured/upload/8041.pdf

For more information on the national high-risk pool program, please contact Chuck Ingoglia, MSW, Vice President of Public Policy, National Council for Community Behavioral Healthcare, at chucki@thenationalcouncil.org or 202-684-7457 ext. 249.

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1. Kaiser Family Foundation, "Issues for Structuring Interim High-Risk Pools," Jan. 2010
2. National Council for Community Behavioral Health Care, "Issue Brief: High-Risk Pools," 2007
3. Ibid.
4. KFF
5. National Council
6. KFF
7. Ibid.
8. Ibid.