FOCUS on Health Reform

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ISSUES FOR STRUCTURING INTERIM HIGH-RISK POOLS

One of the first provisions that would be implemented under federal health reform bills in the House and the Senate would establish a national high-risk pool program to offer coverage to otherwise uninsurable individuals during the interim period between enactment and implementation of broader health care reforms.

High-risk pools provide a safety net for people who are denied coverage by private insurers due to their health.[1] Most states that permit insurers to decline applicants for health reasons have high-risk pools today. The House and Senate bills would extend risk pool protection nationally, reduce the costs of risk pool coverage for many participants, and provide $5 billion dollars to subsidize the costs of coverage. The House and Senate provisions are similar, but not identical (see Table 3), and their provisions would need to be reconciled in any final health reform legislation. There also are many decisions left to the discretion of the Secretary of Health and Human Services in how the program would be implemented and operated. This paper examines the role of high-risk pools as a coverage safety net today and reviews key issues involved in implementing a national high-risk pool.

Background

First established in 1976, today there are 35 state high-risk pools.[2] Most were created as a safety net for the individual market. Although only about five percent of the non-elderly population has individual health insurance in any given year, one in four adults will seek individual coverage at some point over a three-year period—typically while they are not eligible for ESI or Medicaid. However, because the individual market is medically underwritten, some people will find it difficult to obtain coverage there. Applicants with expensive health conditions (such as cancer, diabetes, or pregnancy) are typically denied coverage. Even mild health problems (such as hay fever) can trigger an adverse underwriting action, such as a premium surcharge or a rider that restricts coverage.[3] People who encounter such difficulties buying individual health insurance are sometimes described as "uninsurable." In response, states have established high-risk pools as an alternative source of coverage for people who have difficulty buying individual health insurance because of their pre-existing condition.

In 2008, combined enrollment in all state high-risk pools was approximately 200,000 people, or only about two percent of total individual market enrollment in those states[4] (see Table 1). By contrast, insurance industry studies suggest that approximately 25 percent of individual health insurance applicants receive adverse underwriting responses from insurers, resulting in surcharged premiums, benefit restrictions, or denial of coverage.[5] Various high-risk pool program features—including high premiums and the imposition of pre-existing condition exclusion periods—tend to discourage enrollment in state high-risk pools.[6]

Table 1. State High-Risk Pool Enrollment, 2008

State	Enrollment as of 12/31/08
Alabama	2,653
Alaska	469
Arkansas	3,061
California	7,036
Colorado	8,543
Connecticut	2,336
Florida	300
Idaho	1,338
Illinois	15,682
Indiana	6,561

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Table 1. State High-Risk Pool Enrollment, 2008 (continued)

State	Enrollment as of 12/31/08
Iowa	2,732
Kansas	1,830
Kentucky	4,458
Louisiana	1,110
Maryland	15,180
Minnesota	27,386
Mississippi	3,464
Missouri	2,999
Montana	2,995
Nebraska	5,089
New Hampshire	1,094
New Mexico	6,020
North Carolina	0
North Dakota	1,463
Oklahoma	2,098
Oregon	15,320
South Carolina	2,328
South Dakota	653
Tennessee	4,516
Texas	26,908
Utah	3,715
Washington	3,397
West Virginia	653
Wisconsin	16,284
Wyoming	687
TOTAL	200,358

Source: Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis: National Association of State Comprehensive Health Insurance Plans, 23rd Ed. 2009/2010.

Eligibility

Eligibility standards for the transitional national high-risk pool program will determine who is helped by the program. How eligibility is defined will also affect program costs or the rate at which fixed funding for the program is spent. Several eligibility issues will need to be considered as the program is designed and implemented.

Definition of uninsurable. Today, state high-risk pools use two basic methods to identify "uninsurable" individuals: first, people are considered medically eligible for pool coverage if they have recently applied for individual health insurance coverage and received one or more adverse underwriting actions (denial, significant premium surcharge, or exclusion rider limiting coverage for benefits related to a pre-existing condition.) In addition, many state pools develop a list of medically eligible conditions (such as HIV, diabetes, pregnancy) that typically lead to denial of underwritten coverage. Applicants with a listed condition are deemed to be medically eligible. Use of a medical conditions list can expedite the application process for individuals, as it enables people to skip the time consuming step of applying for private coverage and being denied. Because some insurers also require applicants to submit the first month premium with the application, a medical conditions list can also reduce cash flow burdens on individuals who seek help from the pool. State pools typically do not require re-determination of medical eligibility once individuals enroll. So, for example, if a pregnant woman is denied private coverage and enrolls in the high-risk

pool, she would not be required to leave pool coverage after the baby is born. High-risk pool coverage is guaranteed renewable in all states as long as enrollees remain state residents and pay their premiums.

Other eligibility categories. In most states today, high-risk pools are also open to people who are HIPAA-eligible or eligible for the federal Health Coverage Tax Credit (HCTC.) For these individuals, federal law guarantees eligibility for non-group coverage on a guaranteed issue basis. States have flexibility to determine how to guarantee access for such individuals and in most states, the high-risk pool is the designated coverage option. To the extent a national high-risk pool program replaces or builds on existing state high-risk pools, HIPAA-eligible and HCTC-eligible individuals should be allowed to enroll in the national program. Otherwise, existing state pools would need to be maintained to continue federally guaranteed protections under HIPAA and HCTC prior to the full implementation of health care reform.

In addition, a number of state high-risk pools today offer the option of dependent coverage. An individual who is eligible for the pool by virtue of a pre-existing condition may enroll in family coverage along with a spouse or children who may be healthy. In other states, each family member must demonstrate eligibility to enroll. Research indicates that participation, or "take-up" by individuals eligible for coverage may increase when family members are also eligible to enroll.[7]

Avoiding crowd out. Because funding for the new national high-risk pool will be limited, one priority will be to target assistance as efficiently as possible and avoid "crowd out" or replacement of other coverage that individuals may have. This is a concern for current state high-risk pools, as well. Today, all states require their high-risk pool to be a coverage-of-last-resort, and, in particular, that applicants not be eligible for job-based coverage. The coverage-of-last-resort requirement also avoids creating an incentive for employers to steer sick enrollees into the pool. Such steering would be illegal in any case under current HIPAA nondiscrimination rules. By asking about an applicant's employment status and eligibility for health benefits, the high-risk pool can collect and verify information about the availability of other job-based coverage.

States define eligibility for job-based coverage somewhat differently. For example, a newly hired employee of a firm that offers health benefits may be subject to a waiting period, or probationary period before she can enroll in the group health plan. In some states, that person's eventual eligibility for job-based coverage would make her ineligible to join the high-risk pool. Other states would allow the individual to join the high-risk pool at least during the waiting period. The House health reform bill specifies that a person who is in a waiting period is not considered to have job-based coverage. If the purpose of a national pool is to provide immediate relief to uninsurable individuals who seek coverage, eligibility rules should take into account other coverage that is immediately available to applicants.

Some states also measure the comparability of other coverage available to applicants. For example, an applicant who suffers from depression might have a private policy that does not cover mental health treatment. In theory, the availability of a safety net public program might encourage private insurers to cut back on coverage for certain types of benefits. On the other hand, a high-risk pool program with limited enrollment capacity might not provide sufficient incentive for insurers to re-design their policies significantly.

State high-risk pools today will usually accept applicants who have access to other individual coverage. For example, a person with a pre-existing condition might be able to buy individual health insurance, but will have her premium surcharged at issue or renewal based on health status. If her premium is more expensive than that charged by the high-risk pool, she can be admitted to the pool in most states.

Because the incidence of many "uninsurable" health conditions increases with age, it is not surprising that the typical state high-risk pool enrollees are older, averaging about 50 years old.[8] Consequently, how a pool adjusts premiums for age could affect the relative cost of pool coverage compared to private plan coverage, and could potentially affect the level of pool enrollment. According to AHIP, rate tables used by private carriers typically reflect age climbs at 5:1 to 7:1.[9] However, the premiums of most state high-risk pools today do not appear to have been established with the intent of discouraging enrollment by older individuals who would face unaffordable private market premiums based solely on age.

In 8 of the 33 state high-risk pools today, the age climb is less than 3:1, in 10 states it is less than 4:1, and in 10 states is it less than 5:1 (see Table 2). There is no evidence that high-risk pools face a problem of "over-enrollment" by older individuals seeking to avoid the full impact of age rating by private carriers; in fact, there is some evidence that over-enrollment is not a problem. Unpublished data from the Maryland high-risk pool, which limits age-adjustments to 2:1, indicates that only six percent of pool enrollees had other individual coverage when they enrolled, of those, about 1/3 dropped existing coverage because it had an exclusion rider related to their health condition.[10]

Table 2. State High-Risk Pool Premiums, 2009

State	Age rating adjustment (age 64 compared to 24)	Monthly premium for 50-year-old, 2009
Alabama	3.3:1	$653
Alaska	4:1	$1,305
Arkansas	5.4:1	$475
California	2.5:1	$420-$840
Colorado	5.2:1	$556
Connecticut	4.3:1	$844
Florida	Unknown	Unknown
Idaho	Unknown	Unknown
Illinois	4.2:1	$840
Indiana	3.7:1	$705
Iowa	3.5:1	$483
Kansas	4.4:1	$568
Kentucky	4:1	$701
Louisiana	4.6:1	$674
Maryland	2:1	$377
Minnesota	2.9:1	$498
Mississippi	2.8:1	$517
Missouri	4.3:1	$763
Montana	3.1:1	$723
Nebraska	5.6:1	$626
New Hampshire	3.9:1	$608
New Mexico	3.1:1	$363
North Carolina	4.7:1	$676
North Dakota	2.6:1	$460
Oklahoma	4.9:1	$848
Oregon	2.2:1	$508
South Carolina	3.8:1	$808
South Dakota	5.1:1	$692
Tennessee	2:1	$688
Texas	3:1	$881
Utah	2.6:1	$555
Washington	3.6:1	$1,362
West Virginia	4.8:1	$571
Wisconsin	3.8:1	$759
Wyoming	5.4:1	$979

Source: Henry J. Kaiser Family Foundation State Health Facts.

Other protections against crowd out are also possible. The House health reform bill includes an "anti-dumping" provision that requires the Secretary to investigate whether new enrollees who had prior individual coverage were steered inappropriately to the pool by carriers. For example, an insurer with a closed block consisting of mostly sick individuals might discontinue a policy or exit the market, knowing its sick enrollees will be covered by the high-risk pool, instead. Minnesota is one state that has responded to this problem by assessing carriers for the claims cost of enrollees they "dump" into the high-risk pool. A national high-risk pool could adopt similar protections.

A different approach to deterring crowd out could be to require that enrollees in the national high-risk pool must have had a prior spell of uninsurance. This requirement is included in the Senate health reform bill. Such a rule poses an incentive for individuals to remain in current coverage if at all possible. However, it also presents a barrier to coverage continuity for sick individuals who lose coverage involuntarily—for example, due to job loss or because they are too sick to work.

Covered Benefits and Premiums

What a national high-risk pool offers in terms of covered benefits and what it charges for such coverage will also affect the level of assistance the program offers and what it will cost.

Pool premiums vs. "standard rates". Currently state high-risk pools set premiums at a multiple of standard rates, ranging from 125% to 200%. As a result, pool coverage is often unaffordable for individuals. Today in most state pools, it would cost a 50-year-old more than $7,000 per year to enroll in single coverage with a $1,000 deductible. One study estimated only eight percent of the target uninsurable population is able to enroll in state high-risk pools, due primarily to high premiums.[11] To the extent a national pool can set premiums at or nearer to standard rates, more eligible individuals will be able to enroll.

The calculation of standard rates will be a key factor determining the cost of high-risk pool coverage. States today determine "standard" rates based on the average premium charged by some or all private carriers for similar coverage. In general, the "standard rate" benchmark is used so that high-risk pool premiums will be reasonably competitive with private coverage. This method, however, entails some imprecision. For example, calculating standard rates based on premiums charged by the largest five vs. three carriers might produce different results. In addition, the content of private policies varies enormously, so measuring the comparability of coverage requires estimation. Pool rating methodology might be adjusted to minimize pool rates and enhance affordability for enrollees. Or it could be adjusted to produce higher rates in order to limit program costs. Over time, state high-risk pool premiums have accounted for an increasing share of program financing. Ten years ago, on average, enrollee premiums financed slightly less than 50 percent of high-risk pool costs; today the share is 60 percent.[12]

If a national high-risk pool program builds upon current state high-risk pools, it will be important to review rating methodologies used in each state and reconcile differences in order to set premiums for a nationwide program consistently.

Premium subsidies. Today 14 state high-risk pools offer premium subsidies or discounts for low-income applicants. Health reform legislation does not specifically address whether a national pool could offer low-income subsidies. Because funding for a national program is capped, low-income subsidies may or may not be offered. However, if they are not, it may be possible to tap other, external subsidy sources. For example, some state high-risk pools permit third parties to pay premiums on behalf of enrollees. In such states, community health centers, hospitals, or pharmaceutical companies may subsidize premiums for enrollees who would otherwise be uninsured and generate uncompensated care. A national program could permit similar third-party premium assistance. A national program might also permit states to subsidize high-risk pool premiums on behalf of residents, including through existing state high-risk pool subsidy programs. External premium subsidies will have the effect of increasing pool enrollment, which in turn, will increase pool costs. On the other hand, the uninsured overwhelmingly have low incomes; to the extent the new program seeks to target the uninsured, most will need help paying premiums.

Covered benefits and cost sharing. Coverage adequacy is another key issue for a program designed to help people with uninsurable health conditions. Many state high-risk pools currently limit coverage of some or all benefits in order to limit program costs, but this strategy can also leave enrollees underinsured. There is some evidence that high cost sharing, annual and lifetime caps on coverage, and other benefit limits leave high-risk pool enrollees facing medical debt and barriers to care.[13] House and Senate health care reform bills indicate that coverage under a national interim high-risk pool program should be similar to that guaranteed to all Americans once reform takes effect. This means covered benefits would include at least those specified in health care reform bills (hospitalization, outpatient medical care, maternity care, prescription drugs, rehab, mental health care, etc.) with no annual or lifetime limits.[14] Further, a comprehensive limit on annual cost sharing for covered services would be applied. Like state pools today, a national high-risk pool program might offer coverage options, for example, with different annual deductibles.

Other Consumer Protections

The interim national high-risk pool might also adopt other consumer protections that will eventually be required for all Americans under health reform. These include prompt payment of claims, grievance and appeals protections, network adequacy standards, notice requirements, and the development of clear and understandable plan materials. The national high-risk pool program could also provide for a consumer ombudsman office to assist with enrollee and applicant problems and inquiries. States can help the federal government identify existing consumer protections, such as state external appeals programs, that may appropriately be applied for high-risk pool consumers. For some protections, new programs and procedures may need to be developed, although in such cases investments will likely prove useful in the larger health care implementation effort.

Administration

Expedited implementation will be another key issue facing a national high-risk pool program that is intended to provide immediate relief to uninsured, uninsurable individuals. The National Association of State Comprehensive Health Insurance Programs (NASCHIP) has urged that existing state programs are "shovel-ready" and so should be a vehicle for implementing a national program. Existing pools would likely need to be modified to meet national program standards for eligibility, premiums, covered benefits, and so on. However, states have indicated they would support and quickly adopt such changes to participate in a national program.[15]

Roughly one-third of states do not currently operate high-risk pools, although some of these operate other public programs for the uninsured—Healthy New York, the Dirigo Health Program in Maine, the Catamount Health Program in Vermont, the Commonwealth Care plans in Massachusetts, the Adult Basic program in Pennsylvania, and the Health Care Alliance in the District of Columbia. The federal government could contract with such other existing state programs to provide comparable coverage options. In states that already prohibit medical underwriting in the individual market, modified eligibility rules might be adopted. For example, enrollment priority might be given to residents diagnosed with eligible medical conditions.

In other states, that do not currently have high-risk pools or other significant public programs for the uninsured, yet other options might be fashioned.[16] The federal government could work with each state to develop new, state-specific programs. However, creating entirely new coverage programs in an expedited time frame may be a challenge. In particular, it takes time to develop a robust provider network, the availability of which will be essential to provide meaningful coverage for a high-risk population.

Alternatively, the federal government might develop one or more fallback options that could be used in any state. The Medicare program is one such option. It has the advantage of having a broad network of participating providers in every state. Another advantage would be that use of Medicare rates could help to limit program costs and extend coverage to more individuals. On the other hand, doctors and hospitals may raise objections to expanded use of Medicare payment rates, which tend to be lower than those paid by commercial insurers. It is possible that objections might not be as great in the context of a temporary program to cover uninsured individuals whose care would otherwise have been largely uncompensated anyway. The Wisconsin high-risk pool, for example, limits provider reimbursement

in order to partially finance program costs. If providers do object to the use of Medicare rates under a national program, Medicare could still be used as the coverage vehicle with provider payments enhanced for high-risk pool enrollees. As yet another alternative, the federal government might contract with another private carrier(s), such as BCBS-FEHBP, to ensure a plan with a robust provider network is available in every state.

Funding Limitations

Congressional health reform bills would establish a National High-Risk Pool Trust Fund and appropriate $5 billion to support the program over the duration of the reform implementation period. Over the reform implementation period, this would mean an average of $1.25 to $1.67 billion in program funding would be available per year.

By contrast, in 2008, states with high-risk pools collectively spent roughly $900 million to subsidize excess losses for some 200,000 enrollees. Taking into account health care inflation and the cost of other changes state pools would need to adopt to meet federal standards, it is doubtful that federal funding provided under health reform bills would support substantial pool enrollment growth.

Both House and Senate bills provide for a state maintenance of effort so that new federal funding does not displace current state high-risk pool expenditures. Under House bill, the federal government would also calculate a comparable contribution for States that do not currently have a high-risk pool.

Funding for an existing federal grant program for state high-risk pools, currently authorized at $75 million per year, could also be redirected to support the new national program. In addition, other economies might be explored to stretch program dollars. For example, currently about one-third of state high-risk pool claims costs are for prescription drugs. State pools are administered by private insurers, and so pay the same rate for pharmaceuticals as other commercial payers. If, on the other hand, a national high-risk pool program were given access to the Section 340(b) prescription drug rebate program, considerable cost savings could be realized. Ceiling prices under the 340(b) program are approximately 50 percent of average wholesale prices for outpatient prescription drugs.

Both the Senate and House bills stipulate that if funding is not sufficient to support a national pool throughout the transition period, the Secretary of HHS would have authority to make adjustments, including suspension of new enrollment, premium increases, or reductions in covered benefits. Inadequate funding has long been a problem facing state high-risk pools. In response, all have adopted features, such as premium increases and limited benefits, to control costs. Such features also discourage enrollment, eliminating the need for enrollment caps as a way to control program costs. However, it could be argued that such "hidden" enrollment caps generate complacency about the effectiveness of safety net programs, while more visible enrollment caps and waiting lists could motivate public support for increasing program resources. Recent Congressional action to provide emergency extension of unemployment benefits, or state action in Pennsylvania to increase funding for the Adult Basic program in order to trim its waiting list, are case examples.

A Learning Opportunity

The design and implementation of a national high-risk pool program offers important opportunities to collect data to assist in the development of later health reform initiatives. The experience of the national high-risk pool program, its enrollees and providers, and its administrative partners, could be monitored to identify successes and issues with federal implementation. Successful design features may offer models for other reforms while problematic features can be modified to immediately benefit pool enrollees and to inform future policy endeavors.

In particular, as health reform is implemented, it will be important to track the experiences of vulnerable populations to ensure coverage is available, affordable, and adequate and that they are protected from insurance discrimination. National high-risk pool administrators and staff should meet regularly with officials engaged in other reform implementation tasks to share information and best practices.

For example, Maryland requires quarterly reporting by insurers of applications for individual health insurance and adverse underwriting actions. This provides policymakers with a rough baseline estimate of the number of residents who might need and be eligible for high-risk pool coverage. Similar reporting requirements could be applied to all carriers to determine how effectively the national high-risk pool enrolls its target population.

Baseline data on private health insurance premiums can also be gathered in the course of calculating standard market rates for the national high-risk pool. These data could be useful for developing rate review systems and for monitoring the experience of so-called grandfathered plans.

High-risk pool claims data can be analyzed to learn more about billed and allowed charges for medical care. Data about use of non-network providers by enrollees could inform the development of network adequacy standards. Utilization patterns and out-of-pocket medical care spending by enrollees could be studied to track medical debt or other measures of cost burden that will be important to coverage effectiveness. Enrollee satisfaction surveys can identify other types of program strengths and weaknesses. Enrollee assistance or ombudsman programs should also collect encounter data to teach policymakers about the types of problems enrollees have and how problems can be effectively resolved.

Table 3: Temporary High-Risk Pools: House-Passed Bill and Senate-Passed Bill

	House-Passed Bill	Senate-Passed Bill
When effective:	Begin January 1, 2010 and continue until date on which the Health Insurance Exchange is established.	Begin not later than 90 days of enactment of Act and continue until January 1, 2014.
Administration:	Secretary will administer the program directly or through State high-risk pools. States without a high-risk pool program, the Secretary may work with the State to coordinate coverage expansions. States that already had operating high-risk pools prior to July 1, 2009 must demonstrate maintenance of effort. In addition, states that required health insurers to contribute to the high-risk pool must continue the requirement. The Secretary will monitor insurers and group health plans to determine if plans are discouraging individuals from retaining coverage due to health status, and plans may be responsible for costs for people that were encouraged to disenroll.	Secretary will administer the program directly or through contracts with States or nonprofit private entities. To be eligible, a State must agree not to reduce the amount it expended for the operation of its high-risk pool in the preceding year. The Secretary will monitor insurers and group health plans to determine if plans are discouraging individuals from retaining coverage due to health status, and plans may be responsible for costs for people that were encouraged to disenroll.
Coverage:	Benefits determined by the Secretary and must be consistent with essential benefits package. Annual deductibles will be limited to $1,500 for an individual; and maximum cost-sharing will be limited to $5,000 for individuals and $10,000 for a family.	Benefits are determined by the Secretary. Coverage may not limit benefits for preexisting conditions, must have an actuarial value of at least 65%, must have an out-of-pocket limit of no more than allowed for HSA-qualified plans ($5,950/individual and $11,900/family in 2010).
Premiums:	Premiums for the pool will be set no higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age.	Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age.
Who's eligible:	Citizens and legal immigrants and their dependents are eligible if they have not had employment-based health insurance for at least six months **or** if they are medically uninsurable. Individuals are considered medically uninsurable if they were denied coverage due to a preexisting condition, were offered limited coverage due to a preexisting condition, were offered coverage at a premium rate that is more than the high-risk pool premium, have a medical condition deemed eligible by the Secretary, or had an excessive premium increase for retiree coverage after 10/29/09.	Citizens and legal immigrants who have pre-existing conditions **and** who have not been covered by creditable coverage for at least six months are eligible.
Funding:	$5 Billion	$5 Billion
Source:	http://energycommerce.house.gov/Press_111/health_care/hr3962_bill_text.pdf, Division A, Title 1, Sec. 101	http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf, Title 1, Subtitle B, Sec. 1101

ENDNOTES

[1] Schwartz, T, "An Overview of High-Risk Pools," Kaiser Commission on Medicaid and the Uninsured, January 2010.

[2] This count includes Florida, which has been closed to new enrollment since 1991, and Idaho, which requires all individual market health insurers to sell a guaranteed-issue policy, called a "high-risk pool policy" to qualified residents.

[3] Pollitz, K., Sorian, R., and Thomas, K., "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" Henry J. Kaiser Family Foundation, June 2001.

[4] Author's calculation, based on enrollment data from the National Association of State Comprehensive Health Insurance Plans (NASCHIP) and estimates of individual market participants from the Kaiser Family Foundation.

[5] "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits" AHIP Center for Policy Research, December 2007. See also Tooman, L., "Real People, Real Coverage," Council for Affordable Health Insurance, Issues and Answers No. 103, May 2002. Available at www.cahi.org.

[6] Pollitz K., "State High-Risk Health Insurance Pools" National Institute for Health Care Management Foundation, April 2009.

[7] Artiga, S., and Mann, C., "Family Coverage under SCHIP Waivers," Henry J. Kaiser Family Foundation, May 2007.

[8] U.S. Government Accountability Office, "Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools," GAO-09-730R, July 22, 2009.

[9] Norman, J., "Higher Premiums for Older Adults at Issue in Health Care Debate," *CQ Health Beat*, November 12, 2009.

[10] Popper, R., Executive Director, Maryland Health Insurance Plan, personal communication, October 2, 2009.

[11] Frakt A, Pizer S, and Wrobel M. "High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects," *Health Care Financing Review*. 2004; 26(2):73-85.

[12] Comprehensive Health Insurance for High-Risk Individuals, Thirteenth Edition, 1999 and Twenty-third Edition, 2009/2010.

[13] Hall, J. and Moore, J., "Does high-risk pool coverage meet the needs of people at risk for disability?" *Inquiry*, Fall 2008, 45 (3):340-52.

[14] The Senate health reform bill prohibits lifetime and annual dollar limits on covered benefits, but does not prohibit limits on the number of covered services. By contrast, the House health reform bill prohibits all types of annual and lifetime limits on covered benefits.

[15] National Association of State Comprehensive Health Insurance Plans, letter to The Honorable Max Baucus and the Honorable Chuck Grassley, July 1, 2009.

[16] These states would include Arizona, Delaware, Georgia, Hawaii, Michigan, Nevada, New Jersey, Ohio, Rhode Island, and Virginia.

This issue brief was prepared by Karen Pollitz of the Georgetown University Health Policy Institute. Conclusions or opinions expressed in this report are those of the author and do not necessarily reflect the views of the Kaiser Family Foundation.

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