Health Insurance: State High Risk Pools

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Summary

In an effort to expand the options for health coverage, 35 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 preexisting 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, state high risk pools tend to enroll a small percentage of the uninsured. In December 2009, approximately 208,000 individuals were enrolled in high risk pools. State-established nonprofit organizations typically run these pools, with private insurance companies handling day-to-day operations, along with plan administrative staff. 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 150% to 200% of market rates, and pools are subsidized through insurer assessments and other funding mechanisms.

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, which reauthorized federal grants to state high risk pools through FY2010, and changed the funding formula used for such grants. The act authorized $15 million for seed grants and $75 million for operational and bonus grants for FY2006. The Senate passed H.R. 4519 without amendment, and it was signed 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, and it was signed 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.

The 111th Congress provided $75 million in appropriations for grants to state high risk pools under the Omnibus Appropriations Act of 2009 (P.L. 111-8). On September 30, 2009, CMS awarded operational grants to 31 states and bonus grants to 28 states. Furthermore, the Consolidated Appropriations Act of 2010 (P.L. 111-117) provided $55 million in additional appropriations for high risk pools.

In addition to state-established high risk pools, the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended, requires the Secretary of Health and Human Services to establish a temporary high risk pool program to provide health insurance coverage for certain uninsured individuals with preexisting health conditions.

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Introduction

In an effort to expand the options for health coverage, 35 states have established high risk health insurance pools.[1] These programs target individuals who cannot obtain or afford health insurance in the private market, primarily due to preexisting health conditions. High risk pools (HRPs) 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 preexisting 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 preexisting conditions. To enforce these rules, states are given a choice. They 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.[3]

In general, state high risk pools tend to enroll a small percentage of the uninsured. For example, approximately 200,000 individuals were enrolled in the 34 high risk pools in operation in 2008.[4] In contrast, the Government Accountability Office (GAO) estimated that nearly 4 million additional persons were potentially eligible for enrollment.[5] However, such limited enrollment reflects, in part, the narrow focus of these pools: individuals with preexisting health conditions, who do not have access to public or group health insurance, and seek coverage in the private, non-group market.

In addition to state-established high risk pools, the 111th Congress passed the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law (P.L. 111-148) on March 23, 2010. PPACA, as amended, requires the Secretary of Health and Human Services to establish a temporary high risk pool program, prior to 2014, to provide health insurance coverage to certain individuals with preexisting health conditions who have been uninsured for six or more months. [6] This report will focus on the original, state-established high risk pools.

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[1] States with existing high risk pools: AL, AK, AR, CA, CO, CT, FL, ID, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, NC, ND, OK, OR, SC, SD, TN, TX, UT, WA, WV, WI, and WY.

[2] National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis*, 2008/2009. (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.

[3] 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 (name redacted) et al. (Hereafter cited to as *HIPAA*.)

[4] The 35th state high risk pool was established by North Carolina, which became operational in 2009.

[5] This statistic is based on estimates of the uninsured population with preexisting health conditions for each relevant state. For additional data concerning state high risk pools, see Government Accountability Office, "Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools," July 22, 2009, available online at http://www.gao.gov/new.items/d09730r.pdf. (Hereafter cited as *GAO*.)

[6] For additional information about the temporary high risk pool program established under health reform, see CRS (continued...)

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.[7] 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 medical 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 in the group market for similar coverage.[8] 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[9]), thereby excluding persons with moderate to severe health conditions from this private market. High risk pools were designed to assist such

(...continued)

Report R41235, *Temporary Federal High Risk Health Insurance Pool Program*, by (name redacted). (Hereafter cited as *Temporary Program*.)

[7] For a general discussion about health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted).

[8] 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.

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

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.[10] Supporters of HRPs 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.[11] Moreover, HRPs 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, HRPs experience losses, but federal attempts to subsidize these losses have been limited. Premiums combined with other cost-sharing requirements can often make the coverage offered by these pools unaffordable. Moreover, most state HRPs exclude coverage for preexisting conditions for six months or more.[12] As a result, some researchers remain skeptical that high risk pools will be able to substantially reduce the number of uninsured, particularly among those with serious medical conditions.[13] 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,[14] not unlike some of the private market reforms included under PPACA.

While state high risk pools have existed since the mid-1970s, congressional support of state pools began in the 1990s. The enactment of HIPAA during the 104th Congress specified state HRPs as acceptable mechanisms for complying with the group-to-individual market requirements. The

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[10] For example, see National Governors Association, Policy Position, "Private Sector Health Care Reform Policy," February 25, 2009. 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.

[11] 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.

[12] Richard Cauchi, National Conference of State Legislatures (NCSL), "States and High Risk Pools," May 17, 2010, http://www.ncsl.org/portals/1/documents/health/HighRiskpoolswebinar51710.pdf. (Hereafter cited as *NCSL*.)

[13] 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.

[14] 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.

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 and the 111th Congress passed legislation in March and December 2009 to provide additional appropriations to state high risk pools. (See detailed discussion under "Federal Grants to State High Risk Pools" section.)

State High Risk Pools

Currently, 35 states have 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 (along with pool administrative staff), traditional high risk pools bear the insurance risk.[15] Boards oversee the governance of HRPs and usually consist of representatives from insurance companies, consumer groups, health care providers, and state agencies.

Premiums and Funding

In order to limit health insurance premiums for persons with costly medical conditions, all states cap high risk pool premiums (most are specified in statute). Almost all states have caps between 150% and 200% of standard risk rates. 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."[16] 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; general revenue; and other state sources.[17] Almost all states with HRPs assess a fee on insurance carriers and health

[15] By bearing risk, a high risk pool essentially functions like an insurance carrier and is responsible for paying claims. In general, the health plan's role is for administrative purposes only. The exception to this is Idaho's pool which was established as a high risk reinsurance pool, in which individual insurance carriers underwrite the insurance offered through the pool, and receive reinsurance should expenses exceed a certain amount specified in the plan design.

[16] 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.

[17] 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.

maintenance organizations; two states place an assessment on hospitals.[18] Many state HRPs also receive grants from the federal government (see discussion under "Federal Grants to State High Risk Pools").

Benefits

Although health benefits provided through high risk pools vary across plans and states, they generally reflect coverage that is available in the private nongroup market. State pools usually offer more than one plan from which enrollees may choose. Deductibles and other cost-sharing requirements vary from state to state. Nearly all state HRPs have at least one plan with *lifetime* maximums on benefits (based on a dollar limit), except for Indiana and New Mexico.[19] In contrast, most pools do *not* apply *annual* maximums on benefits, except for California, Louisiana, Tennessee, Utah, and West Virginia.[20] In addition, most state HRPs exclude coverage for preexisting health conditions for 6-12 months.[21]

Eligibility

States establish the eligibility criteria for high risk pools. As noted, many states allow HIPAA-eligible persons to enroll in their HRPs. HIPAA eligibles are persons who did not have or are losing coverage and seeking it in the individual market.[22] 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 preexisting conditions. High risk pools also are designed to address the insurance needs of non-HIPAA-eligible persons with costly medical conditions. A number of states provide for presumptive eligibility, allowing individuals to become automatically eligible for HRPs 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. Lastly, some states allow persons who receive the Health Coverage Tax Credit to enroll in their high risk pools.[23]

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[18] Kaiser Family Foundation, "State High-Risk Pools: An Overview," January 2010, available online at http://www.kff.org/uninsured/upload/8041.pdf.

[19] NASCHIP, "Lifetime Maximums," http://www.naschip.org/2010/Quick%20Checks/Lifetime%20Maximums.pdf.

[20] Ibid.

[21] See *NCSL*.

[22] HIPAA also provides protections to certain people who wish to enroll in the *group* health insurance market. For more details, see *HIPAA*.

[23] The Health Coverage Tax Credit (HCTC) is a federal income tax credit that covers most of the premium for qualified health insurance for eligible taxpayers and their family members. Eligibility for the HCTC is limited to three groups of taxpayers, two of whom are individuals eligible for Trade Adjustment Assistance allowances because they lost manufacturing, service, or public agency jobs due to foreign trade or shifts in production outside the United States. The third group consists of individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation because of financial difficulties. For additional information about the HCTC, see CRS Report RL32620, *Health Coverage Tax Credit*, by (name redacted).

Enrollment

High risk pool participation varies significantly across states, with average enrollment ranging from a high of 27,187 participants in Minnesota to a low of 265 enrollees in Florida in December 2009. Among state HRPs, the enrollment distribution clusters toward the low end. To illustrate, two-thirds of state pools had participation below 4,000 individuals (23 states). In contrast, only seven states had more than 10,000 participants.[24]

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 and bonus 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 HRPs receive grants.)[25]

107th Congress

With enactment of the Trade Act of 2002 (P.L. 107-210), the federal government provided funding to state high risk 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).[26]

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 high 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 preexisting conditions may be excluded, and whom among otherwise uninsurable individuals will be eligible.

[24] NASCHIP, "Pool Membership – 2009," http://www.naschip.org/2010/Quick%20Checks/2009%20Pool%20Membership.pdf.

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

[26] Ohio was awarded a grant to conduct a study on the feasibility of creating a high risk pool. Utah was awarded a grant to modify its existing health plan and become a newly "qualified" high risk pool.

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.[27]

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.

[27] 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.

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).

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).[28] Applications were due by June 9, 2008.

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

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.

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.

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

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

111th Congress

The Omnibus Appropriations Act of 2009 (P.L. 111-8) provided $75,000,000 for grants to state high risk pools. CMS announced the availability of these grants in May 2009. On September 30, 2009, CMS awarded operational grants to 31 states and bonus grants to 28 states (see **Table 4**).[29] Furthermore, the Consolidated Appropriations Act of 2010 (P.L. 111-117) provided $55,000,000 in additional appropriations for high risk pools.[30]

[29] U.S. Department of Health and Human Services, "Report to Congress on the High Risk Pool Grant Program for Federal Fiscal Years 2008 and 2009," 2010.

[30] To date, no grant awards have been posted by CMS.

Table 4. Operational and Bonus Grants Awarded to State High Risk Pools, FY2009

State	Operational Grants ($)	Bonus Grants ($)	Total Grant Award ($)
Alabama	1,305,753	0	1,305,753
Alaska	764,558	433,684	1,198,242
Arkansas	1,240,960	689,866	1,930,826
Colorado	1,876,773	1,030,186	2,906,959
Connecticut	1,095,579	611,639	1,707,218
Idaho	908,588	511,022	1,419,610
Illinois	3,145,153	1,711,886	4,857,039
Indiana	1,749,210	962,638	2,711,848
Iowa	1,059,056	0	1,059,056
Kansas	1,011,026	566,202	1,577,228
Kentucky	1,409,657	780,200	2,189,857
Louisiana	1,313,112	730,550	2,043,662
Maryland	2,382,726	1,298,566	3,681,292
Minnesota	3,093,491	1,674,622	4,768,113
Mississippi	1,303,254	723,282	2,026,536
Missouri	1,407,332	780,031	2,187,363
Montana	995,050	556,609	1,551,659
Nebraska	1,185,291	658,054	1,843,345
New Hampshire	832,225	469,865	1,302,090
New Mexico	1,436,380	793,190	2,229,570
North Carolina	990,004	510,002	1,500,006
North Dakota	811,220	458,182	1,269,402
Oklahoma	1,291,014	717,771	2,008,785
Oregon	2,278,557	1,242,546	3,521,103
South Carolina	1,323,353	735,099	2,058,452
South Dakota	762,529	432,436	1,194,965
Texas	6,781,948	3,674,808	10,456,756
Utah	1,227,955	682,260	1,910,215
Washington	1,476,637	817,459	2,294,096
Wisconsin	2,288,872	1,247,341	3,536,213
Wyoming	753,819	0	753,819

Sources: U.S. Department of Health and Human Services, "Report to Congress on the High Risk Pool Grant Program for Federal Fiscal Years 2008 and 2009," 2010.

Health Reform

The 111th Congress passed the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law (P.L. 111-148) on March 23, 2010. PPACA, as amended, requires the Secretary of Health and Human Services to establish a temporary high risk pool program, prior to 2014, to provide health insurance coverage to certain individuals with preexisting health conditions who have been uninsured for six or more months. States can run the program or elect to have the Department of Health and Human Services (HHS) operate the program in their states. The majority of states (29 states and DC) contracted to operate their own HRPs. HHS administers the HRPs in 21 states, under the Pre-Existing Condition Insurance Plan (PCIP) name.[31]

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[31] For updated information regarding implementation of this program, see *Temporary Program*.