



U.S. Department of Health and Human Services

REPORT TO CONGRESS ON THE
HIGH RISK POOL GRANT PROGRAM
FOR FISCAL YEARS 2006 AND 2007

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Executive Summary

The State High Risk Pool Extension of Funding Act of 2006 (Extension Act), Public Law 109-172, amended section 2545 of the Public Health Service Act and states that the Secretary shall submit to Congress an annual report on grants provided under this section. Each report shall include information on the distribution of such grants among States and the use of grant funds by States. This report is submitted pursuant to section 2745(f) of the PHS Act.

States establish “high risk pools” for individuals who cannot afford or are unable to enroll in private health insurance programs due to complex or pre-existing health conditions. The benefit packages and premiums for enrollment into these pools vary across States.

The Trade Adjustment Assistance Reform Act of 2002, the Deficit Reduction Act of 2005 and the State High Risk Pool Funding Extension Act of 2006 (Extension Act) provided and extended funding to States for this effort to broaden health care to the uninsured. The latter two statutes provided authorization and appropriations for \$75 million for operational grants and \$15 million for seed grants under Section 2745 of the Public Health Service Act (PHS Act).

The Centers for Medicare & Medicaid Services (CMS) awarded 35 high risk pool grants in Federal fiscal years 2006 and 2007, resulting in comprehensive healthcare coverage for individuals unable to obtain health insurance due to their health history.

Most State High Risk Pools have utilized the CMS grant funds to sustain existing programs by offsetting operational losses, but also to offer expanded consumer benefits, disease management services, and income-sensitive premium subsidies. At least one new pool has been created by the State of North Carolina, with several other States utilizing the findings of their high risk pool feasibility studies to inform their legislature of options for improving access to health care coverage.

Many of the pools have adopted creative strategies to maximize quality of care delivery systems and to control costs where possible. Overall, high risk pool benefit packages are tailored to those with chronic and/or severe conditions and include a strong emphasis on case management, utilization review and disease management programs.

However, growing health care costs and lack of access to Federal discounted drug programs have impeded the pools from lowering their premium rates, which could otherwise significantly stimulate enrollment. Despite the low-income premium subsidies, the high risk pools are often still unaffordable to those in need of comprehensive health insurance coverage in the individual market.

CMS management of the high risk pool grant program has sought to ensure the continuation and dissemination of these innovations through technical assistance to individual States and grant performance oversight.

I. Overview of High Risk Pools

High Risk Pools offer comprehensive health insurance benefits to individuals who are “medically uninsurable” due to a pre-existing medical condition¹. Individuals who would otherwise be uninsured are eligible for high risk pool participation. Many States use their high risk pools to comply with the individual market guaranteed availability provisions of title XXVII of the PHS Act, as added by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191). For eligible individuals moving from the group to the individual market, section 2741 of the PHS Act requires state-licensed health insurers to make coverage available to such individuals, and in general prohibits exclusion of coverage for pre-existing conditions.²

The High Risk Pools are typically State-established nonprofit organizations. However, a few remain as State entities (ex. Oregon and Wisconsin) whereby the pools contract with private insurance companies to handle day-to-day operations and to access their Statewide provider networks. Although their 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 125 percent and 200 percent of market rates, per State statute, and pools often are subsidized through insurer assessments and other funding mechanisms.

For more detailed information about the general characteristics of State High Risk Pools, please refer to CRS Report to Congress #RL31745, titled “Health Insurance: State High Risk Pools” (updated 5/9/2008).

II. Authorization and Appropriation of Grant Funding

The Deficit Reduction Act of 2005 (DRA)³ and the State High Risk Pool Funding Extension Act of 2006⁴ (Extension Act) authorized grants for continued support to States for high risk pools through 2010. Ninety million dollars were appropriated for fiscal year 2006, with \$75 million for grants to help fund existing qualified State High Risk Pools and \$15 million for seed grants to assist States to create and initially fund qualified high risk pools. The Centers for Medicare & Medicaid Services (CMS) administers the Federal grant program.

See Appendix B for a table of historical CMS grant awards to State High Risk Pools from 2003-2007.

¹ In general, a medical condition for which treatment was recommended or received, or medical advice was sought, prior to enrollment.

² To comply with these provisions, States may either enforce the individual market guarantees described in section 2741 of the PHS Act (known as the “Federal fallback”), or establish an “acceptable alternative State mechanism,” under section 2744 of the Act, such as a high risk health insurance pool. Currently 30 States use their High Risk Pool as a State Alternative Mechanism.

³ PUBLIC LAW 109-171—FEB. 8, 2006

⁴ PUBLIC LAW 109-172—FEB. 10, 2006

III. CMS Grant Eligibility Criteria

A qualified State High Risk Pool, as defined in sections 2744(c)(2) and 2745(g) of the Public Health Service Act, is a risk pool that (a) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, except that it may provide for enrollment of eligible individuals through an acceptable alternative mechanism (as defined for purposes of section 2744) that includes a high risk pool as a component; and (b) provides for premium rates and covered benefits for such coverage consistent with standards included in the National Association of Insurance Commissioners (NAIC) Model Health Plan for Uninsurable Individuals Act that was in effect at the time of the enactment of the Health Insurance Portability and Accountability Act of 1996 (August 21, 1996).

CMS provides three kinds of grants to State High Risk Insurance Pools:

1. The first grant type is known as seed grants which States can use to either a) conduct a feasibility study about the possible implementation of a high risk pool or b) create and implement a high risk insurance pool, if the requisite State legislation has been passed.
2. The second grant type is to offset operational losses. As non-profits with significant premium reduction programs for lower-income members, the pools generally operate at a loss. CMS grants can be used to offset the operational losses incurred during the prior fiscal year.
3. The third grant type is bonus grants. States that have established a qualified high risk pool and are receiving grants for operational losses are eligible to apply for a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk insurance pools. States may utilize bonus funds to extend consumer benefits, such as reducing waiting lists, expanding covered services, or implementing chronic disease management programs.

To be eligible for an operational losses grant, a State must have an established qualified high risk pool that has incurred losses and (1) restricts premium charged under the pool to no more than 200 percent of the premium for applicable standard risk rates; (2) offers a choice of two or more coverage options through the pool; and (3) has in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the State in connection with operations of the pool after the end of the last fiscal year for which a grant is provided.

IV. FY06 Grant Funding Distribution Formula & Mechanism

The State High Risk Pool Funding Extension Act dictated several rules for the distribution of operational and seed grant funding. Seed grants of up to \$1 million could be awarded to States that had not created a qualified high risk insurance pool by the date of the law's enactment, for the creation and initial operation of the high risk insurance pool.

Operational grants were to be awarded following a distribution formula for qualified high risk insurance pools applying for funding:

- Forty percent of the appropriated amount for the fiscal year shall be allotted in equal amounts to the District of Columbia and each qualifying State that applies for a grant.
- Thirty percent of the appropriated amount for the fiscal year shall be allotted among qualifying States that apply for a grant so that the amount allotted to a State bears the same ratio to such appropriated amount as the number of uninsured individuals in the State bears to the total number of uninsured individuals (as determined by the Secretary) in all qualifying States that apply for a grant.
- Thirty percent of the appropriated amount for the fiscal year shall be allotted among qualifying States that apply for a grant so that the amount allotted to a State bears the same ratio to such appropriated amount as the number of individuals enrolled in health care coverage through the qualified high risk pool of the State bears to the total number of individuals so enrolled through qualified high risk pools (as determined by the Secretary) in all qualifying States that apply for a grant.

For States operating qualified high risk pools, the Extension Act enacted in February 2006 modified the eligibility requirements to include 1) an increase in the allowable percentage over the standard risk rate that may be charged from 150 percent to 200 percent and 2) extended the definition of a qualified high pool to an acceptable alternative mechanism that includes a high risk pool as a component. The modifications to the eligibility requirements enabled an additional seven States to apply for operational losses.

The States with premium rates greater than 150 percent were Louisiana, Missouri, South Carolina and Texas. The statute requires that those States with premiums greater than 150 percent must apply at least 50 percent of their Federal Grant fund to the reduction in premiums.

V. CMS FY06 High Risk Insurance Pool Grant Awards

CMS issued a competitive solicitation and a State Medicaid Director Letter (See Appendix A) in April 2006. Operational loss award amounts were based solely on the statutory formula. State uninsured data was based on U.S. Census Bureau Current Population Survey Annual Social and Economic Supplement, Uninsured Three Year Average 2002-2004 reported in March 2006.⁵ Participant data reported in the State's grant application was used for the number of participants

⁵ <http://www.census.gov/hhes/www/hlthins/hlthin04/hi04t11.pdf>

in the pool. CMS conducted an analysis for reasonableness against Kaiser Family Foundation's data and the publication: 2005/2006 Comprehensive Health Insurance for High Risk Individuals-A State-by-State Analysis.⁶

CMS oversight of the State High Risk Pool grant program includes requiring quarterly financial and performance narrative reporting, and then final financial and performance narrative reports at the end of the grant period. Technical assistance is provided by CMS to the high risk pool grantees to disseminate best practices and lessons learned. Communication is channeled both directly to the individual grantees and through the National Association of State Comprehensive Health Insurance Plans (NASCHIP).

A. FY06 Operational Losses Grants

Grants were awarded on September 30, 2006 to 31 States to offset losses incurred in the operation of qualified high risk pools during fiscal year 2005 and to 25 States for bonus grants for supplemental consumer benefits.

Table A: FY06 High Risk Pool Operational and Bonus Funds Grantees

State	Operational Losses	Bonus Grant	Total	Bonus Grant Statutory Category
Alabama	\$1,442,972	-	\$1,442,972	n/a
Alaska	\$1,253,047	\$895,640	\$1,308,947	Increased Consumer Benefits
Arkansas	\$1,253,047	\$55,900	\$1,308,947	Disease Management
Colorado	\$1,658,396	\$1,478,373	\$3,136,769	Disease Management
Connecticut	\$1,147,452	\$700,000	\$1,847,452	Premium Reduction
Idaho	\$960,424	-	\$960,424	n/a
Illinois	\$2,939,767	\$1,250,000	\$4,189,767	Premium Reduction
Indiana	\$1,926,155	\$942,000	\$2,868,155	Disease Management and Low Income Subsidy
Iowa	\$994,341	-	\$994,341	n/a
Kansas	\$1,031,608	\$295,000	\$1,326,608	Disease Management
Kentucky	\$1,406,506	\$975,000	\$2,381,506	Disease Management
Louisiana	\$1,354,951	\$992,713	\$2,347,664	Disease Management and Pool Expansion
Maryland	\$1,797,813	\$1,200,000	\$2,997,813	Low Income Premium Subsidy
Massachusetts	\$414,569	-	\$414,569	n/a
Minnesota	\$3,664,879	\$2,000,000	\$5,664,879	Low Income Premium Subsidy
Mississippi	\$1,392,593	\$449,202	\$1,841,795	Disease Management
Missouri	\$1,409,440	\$1,000,000	\$2,409,440	Low Income Premium Subsidy
Montana	\$1,074,800	\$729,875	\$1,804,675	Premium Subsidy and Disease Management
Nebraska	\$1,273,440	\$934,097	\$2,207,537	Disease Management
New Hampshire	\$826,355	\$782,644	\$1,608,999	Pool Expansion, Disease Management and Premium Reduction
New Mexico	\$1,121,553	\$950,000	\$2,071,553	Pool Expansion
North Dakota	\$867,573	-	\$867,573	n/a
Oklahoma	\$1,388,788	\$1,000,000	\$2,388,788	Disease Management and Premium Subsidy

⁶ Published annually by the National Association of State Comprehensive Health Insurance Plans. www.naschip.org

State	Operational Losses	Bonus Grant	Total	Bonus Grant Statutory Category
Oregon	\$2,375,581	\$1,500,000	\$3,875,581	Reduction in Cost Sharing
South Carolina	\$1,278,624	\$700,000	\$1,978,624	Premium Reduction
South Dakota	\$785,577	\$312,851	\$1,098,428	Pool Expansion
Texas	\$7,237,175	\$2,000,000	\$9,237,175	Premium Reduction
Utah	\$1,162,603	\$1,250,000	\$2,412,603	Low Income Premium Subsidy
Washington	\$1,575,759	\$856,705	\$2,432,464	Premium Reduction
Wisconsin	\$2,672,935	\$1,750,000	\$4,422,935	Low Income Premium Subsidy
Wyoming	\$773,843	-	\$773,843	n/a
TOTAL	\$50,000,000	\$25,000,000	\$75,000,000	

The States awarded grants for operational losses⁷ reported \$560,583,907 in operational losses during fiscal year 2005. For fiscal year 2006, CMS grant funding for operational losses offset less than 9 percent of operational losses.

B. FY06 Seed Grants

On September 30, 2006, CMS awarded \$2,450,000 in seed grants to five States.

Table B. FY06 High Risk Pool Seed Grantees

State	FY06 Seed Grant Award	Purpose
California	\$150,000	Feasibility Study
New York	\$150,000	Pool Funding Methodology Study
North Carolina	\$150,000	Feasibility Study
Tennessee	\$1,000,000	Creation and Implementation
Vermont	\$1,000,000	Creation and Implementation
Total	\$2,450,000	

C. FY06 Bonus Grants

Per statute, if a State has a qualified high risk insurance pool and is receiving an operational losses grant, a bonus grant may be allotted to the State to provide supplemental consumer benefits to enrollees or potential enrollees (or defined subsets of such enrollees or potential enrollees) in qualified high risk pools. States are permitted to use their bonus grant funds to provide one or more of the following benefits:

- Low-income premium subsidies. States choose to set guidelines based upon Federal poverty levels and offer subsidies to qualifying enrollees to offset premium costs. For example, several high risk insurance pools offer tiered premium discounts based upon the enrollee's income (New Mexico, Missouri, Indiana, Maryland, Alabama, Utah, Wisconsin) using allotted Federal grant funds.

⁷ Operational losses are defined as premiums collected minus claims payments and operational expenses. This definition does not take into account other income sources (State funds, insurance carrier assessments, etc.)

- A reduction in premium trends, actual premiums, or other cost-sharing requirements. Some high risk insurance pools have used their grant funds to: reduce overall premiums, offer premium holidays (Illinois, Oklahoma, Texas, Washington, S. Carolina, Louisiana), and/or reduce enrollee co-payments for medications (Oregon), or to offer important chronic disease screening tests (Mississippi).
- An expansion or broadening of the pool of individuals eligible for coverage through eliminating waiting lists, increasing enrollment caps, or providing flexibility in enrollment rules. Some high risk insurance pools have increased their lifetime maximum coverage amount (New Hampshire), implemented marketing campaigns (Alaska, Louisiana, New Hampshire, Connecticut) to expand pool enrollment, and/or expanded their eligibility criteria to include individuals whose individual coverage will reach its lifetime maximum within 90 days (Idaho).
- Less stringent rules, or additional waiver authority, with respect to coverage of pre-existing conditions. For example, high risk pools may shorten the waiting period for State residency, or shorten the waiting period for coverage of pre-existing conditions.
- Increased benefits. Some high risk insurance pools have offered increased benefits such as influenza vaccinations and cancer screenings at no-cost to the enrollees (Louisiana, S. Dakota, or increased prescription drug benefits (Oregon).
- The establishment of disease management programs. In order to reduce rising healthcare costs while improving enrollee health outcomes, particularly for chronic conditions, more than a third of the qualified high risk insurance pools have disease management programs that target enrollees with particular conditions such as diabetes, coronary artery disease, depression, HIV, hemophilia, asthma, etc. Disease management program approaches can vary to include face-to-face encounters, remote monitoring, telephonic contacts, health coaching, enrollee rewards and enrollee education. CMS encourages the grantees to utilize HEDIS⁸ measures to track the outcomes of enrollees in their disease management program (see Section VIII for additional disease management details).

CMS evaluated State bonus grant funding requests using the following criteria: (1) the type of program requested was identified in the statute; (2) the estimated number of people that would be served by the supplemental consumer benefit program; (3) the program demonstrated promising practice as a model; and (4) the maximum availability of funds. The maximum any State could be awarded was ten percent of the total \$25 million of the appropriated bonus grant funding or \$2.5 million based upon the statute. Eight States were funded at 100 percent of their requested amount. Seventeen States were funded between 40 percent and 80 percent of their requested amount. Six States did not apply for bonus grants.

⁸ Healthcare Effectiveness Data and Information Set (HEDIS). <http://www.ncqa.org/tabid/59/Default.aspx>

D. FY07 Seed Grants

The remaining \$12,550,000 in seed grant funding was carried over into fiscal year 2007, and CMS issued a second seed grant solicitation. CMS awarded \$1,450,000 to the five States who applied for a grant.

Table C. FY07 High Risk Pool Seed Grantees

State	FY07 Seed Grant Award	Purpose
District of Columbia	\$150,000	Feasibility Study
Florida	\$150,000	Feasibility Study
Georgia	\$150,000	Feasibility Study
North Carolina	\$850,000	Creation and Implementation
Rhode Island	\$150,000	Feasibility Study
Total	\$1,450,000	

The sixth seed grant request from the State of Ohio was not approved because the State did not pass enabling legislation for the implementation of a high risk pool. The remaining un-awarded seed grant funds were returned to the U.S. Treasury.

VI. FY06 Operational, Bonus & Seed Grant Timelines and Status

The 36 States receiving a fiscal year 2006 operational or seed grant were awarded funds from September 30, 2006 through March 31, 2008. The States of California and Vermont did not use any of their seed grant funding (totaling \$1,150,000) and returned the full amount. The State of Tennessee utilized its seed grant to create a new State High Risk Pool.

As of March 2008, twenty-one of the fiscal year 2006 grants were closed out. In the case of nine States (Indiana, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, Oklahoma, Oregon, Utah) with remaining unspent bonus or seed grant funds and a reasonable justification, a 90 day no-cost extension (essentially extending the deadline for the grant, but awarding no further funds) was granted through June 30, 2008. The State of New York was granted a no-cost extension through March 31, 2009 in order to complete its feasibility study.

Please see the Section VIII for further details about the outcomes of the FY06 bonus grants.

VII. FY07 Seed Grant Timelines and Status

The five States awarded seed grants as of September 30, 2007 were awarded a budget period through March 31, 2009.

- Of these, North Carolina was the only seed grantee that fully created and implemented a high risk pool. By North Carolina statute, the pool was required to open for enrollment by January 2009 and has already begun accepting applications. It has also received approval from CMS as an acceptable alternative mechanism for qualified individuals under section 2744 of the PHS Act.

- Florida has completed its feasibility study and delivered Executive Summaries of the completed report to significant stakeholders in the Florida Legislature and other segments of the public and private sectors in preparation for the January 2009 legislative session.
- Rhode Island completed Phase One of its feasibility study of merging the non-group market with the small group market to create a larger, more stable pool for cross-subsidization. After having completed an environmental scan of challenges and beneficial characteristics of the non-group market, the study will proceed to identify and assess alternative risk spreading models. This assessment will result in a recommended risk-spreading model for the non-group market and is likely to be completed within the regular grant cycle.
- Georgia has issued a Request for Proposals for an entity to conduct their feasibility study and is likely to request that CMS grant the State a no-cost extension to complete the project.
- The District of Columbia has not yet implemented its seed grant for a feasibility study, having pursued other safety-net coverage options. It is likely that the District will request that CMS grant them a no-cost extension to complete the study, as the District's economic environment has caused the other coverage efforts to be put on hold indefinitely.

VIII. Trends & Outcomes

Data reported to CMS by the FY06 High Risk Pool grantees has provided insight into the successes and challenges sustained by the pools, particularly in the areas of enrollment, premium costs relative to accessibility, drug costs, and optimal management of chronic conditions through disease management services.

A. Enrollment, Cost Drivers and Low-Income Premium Subsidies

As of December 31, 2007, there were 183,954 individuals enrolled in the 30 high risk pools qualified for CMS grants⁹. Overall enrollment among all high risk pools remained fairly level from 2005 through 2007¹⁰. However medical and pharmaceutical claims costs have grown, resulting in most high risk pools increasing their premiums (as the standard risk rates in their States have also increased). In general, inpatient hospital stays and pharmaceuticals represent a greater proportion of high risk pool claims than for a typical insured population that includes healthier enrollees, thus, cost trends are generally higher for high risk pool claims compared with standard industry statistics.

One of the biggest cost drivers for high risk pools, as with other payers of healthcare, is pharmaceutical costs. The State of Washington High Risk Pool reported that 42 percent (nearly

⁹ This figure does not include the high risk pools for West Virginia or Tennessee, who, while qualified for CMS grants, did not apply for funds under the FFY08 solicitation, therefore their 2007 enrollment data is not available to CMS.

¹⁰ Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis 20th and 21st Editions

\$24 million) of its overall claims were from drug claims in 2007. Thirty-eight percent of their pool's total drug expenses were for HIV/AIDS medications. Although the State High Risk Pools are Federal grantees and provide a safety-net for the medically uninsurable, they are not considered "covered entities" and therefore not able to access the 340B Drug Pricing Program for outpatient medications that help those entities to decrease losses and improve their ability to expand enrollment.¹¹ Given high retail drug prices, State High Risk Pools, lacking the designation of 340B covered entities, must pay significantly higher drug costs, which contribute to their annual operational losses and their ability to expand enrollment by lowering premiums and the enrollees' cost-share.

In order to address the enrollment barrier presented by high premium costs, seven of the fiscal year 2006 High Risk Insurance Pool grantees (Indiana, Maryland, Minnesota, Missouri, New Mexico, Utah, Wisconsin) implemented low-income premium subsidy programs¹² to encourage enrollment for individuals meeting the eligibility criteria, but for whom the high premiums made the pool otherwise unaffordable. While this did result in pool expansion among individuals with lower incomes in those States, there is concern that when a low-income premium subsidy program is entirely funded through the CMS Federal grant, it is vulnerable to discontinuation when the grant funds are expended. For example, the State of Missouri experienced a four-month funding gap between the end of their fiscal year 2006 grant and beginning of the fiscal year 2008 grant. As a result, the Missouri pool was not able to sustain the premium subsidy program, and the majority of individuals previously receiving the subsidy disenrolled from the pool and became uninsured. A minority of pools has sufficient additional funding sources to complement their Federal grants, therefore, gaps between Federal grant disbursements sometimes prevent pools from accepting new enrollees for their low-income subsidy programs. (e.g. Maryland, Wisconsin); however, they did not need to eliminate the subsidies during that time.

Several States, including Alaska and Louisiana, have implemented marketing campaigns to increase awareness of the existence of their high risk pools. However, the barrier of high premium rates which are approximately \$5,300 per year on average, prohibits the expansion of the high-risk pools to offset the large number of uninsured Americans with pre-existing medical conditions.

Wisconsin Health Insurance Risk-Sharing Authority (HIRSP) has a statutory mandate to provide subsidy assistance to policyholders who have less than \$25,000 of annual household income. During FY2007, they allowed total subsidies of \$6,142,811 as offsets to costs paid by low-income plan participants. The subsidies included premium subsidies of \$5,118,161, benefit coverage deductible subsidies of \$662,171, and coinsurance out-of-pocket maximum payment subsidies of \$362,171. The entire \$4,422,935 in total funds provided by the CMS high risk pool grant was applied to partially offset premium subsidy funding, and equaled 72 percent of the aggregate low-income policyholder subsidies that were allowed in FY2007. As of June 30, 2007, the HIRSP Authority had 3,009 subsidized participants, who represented 17.1 percent of the total HIRSP Authority enrollment membership.

¹¹ Congress established the 340B program in 1992 under Section 602 of the Veterans Health Care Act. It is called the 340B program because it is governed under Section 340B of the Public Health Service Act. The program provides for significant discounts on drugs purchased by eligible providers for outpatient use.

¹² As of October 2008, this has grown to 14 high risk pools offering subsidies or lower out-of-pocket costs for low-income individuals.

B. Disease Management

Disease management (DM) is an approach to improve participants' ability to self-manage their chronic conditions, improve overall health outcomes, and therefore serves as a means to control rising healthcare costs. High Risk Pools can use external disease management vendors that are independent or a third-party administrator contractor. Vendors provide this service utilizing enrollee assessments and claims data to stratify individuals into low, moderate and high risk categories. It should be noted that some High Risk Pools offer both case management and disease management, while others only offer case management to their enrollees.

The most commonly covered conditions in High Risk Pools' disease management programs have been identified to be diabetes, asthma, coronary artery disease and congestive heart failure. However, some pools cover additional conditions in their DM programs such as HIV/AIDS, hemophilia, obesity, depression and lower-back pain. In addition, many pools have demonstrated cost savings to justify inclusion of rare, but high-cost conditions such as hemophilia, cystic fibrosis or multiple sclerosis in their disease management programs.

CoverColorado's Care Management Program utilized predictive modeling software and direct communication with enrollees' clinical providers to offer over 7,800 of their High Risk Pool enrollees individualized care in FY2006. During that year, the program showed replacement of 595 acute care inpatient days with Skilled Nursing Inpatient Facility Days; 323 acute care inpatient days were replaced by Long Term Care acute days, and 18 referrals were made to hospice (as compared to one referral the prior year). Direct cost savings were applied to the pool with more appropriate care settings identified for the enrollees.

The size of the pool can determine the scope of a DM program. Larger pools have shown larger prevalence of certain conditions, which can justify coverage of selected conditions in the DM programs. Smaller pools may have to be more selective in conditions that are covered in order to reduce costs and maximize their investment.

High Risk Pool approaches to disease management can include but are not limited to:

- Educational materials, both individualized and general for certain conditions
- 24/7 Nurse Access and Support Helplines
- Individualized telephone contacts with varying periodicity
- Face-to-face visits, either at home or while hospitalized
- Physician coordination
- Pharmacist-delivered medication therapy management
- Individualized health coaching
- Biometric monitoring
- Depression screening

- “Quality of Life” surveys
- Websites with clinical educational content
- Newsletters
- Medication Adherence tools (such as pillboxes)
- Financial incentives (such as waiving deductibles for Hemoglobin A1c tests)
- Financial rewards (such as gift cards for enrollees meeting or exceeding their annual DM goals)

Disease management services are staffed by multiple types of providers ranging from general practice nurses, nurses with specialty training (i.e. cardiac, diabetes, or geriatric), social workers, and other allied health professionals.

Quality outcomes are tracked using clinical measures for the specific disease conditions, often HEDIS measures or those by other national clinical standards-setting bodies. For example, DM vendors are likely to track adherence to asthma controller treatments for individuals with asthma. For enrollees with diabetes, DM vendors would monitor annual eye and foot exams and the frequency of Hemoglobin A1c and lipid testing. Screening and monitoring results for co-morbidities is very common, such as monitoring for depression, obesity and high blood pressure concurrently.

Return on investment or cost savings measures often include monitoring inpatient stays, repeat hospitalizations, emergency department visits, outpatient surgical visits, medication adherence, and laboratory and radiology tests. One example is Washington’s High Risk Pool which reported medical claim net cost savings of \$2.1 million through utilization management, case management, disease management, and specialty review programs in 2007.

In 2007, Minnesota’s High Risk Pool reported the following DM results:

- A 32.6% reduction in the rate of emergency room visits among participating enrollees A reduction in hospital admissions from 42/1000 to 25/1000
- An increase in participants with Coronary Artery Disease (CAD) who 1) had annual lipid screening, 2) who were on a beta blocker, and 3) who taking aspirin as prescribed
- An increase in participants with COPD not receiving corticosteroids and an increase in COPD participants on a bronchodilator
- An increase in Heart Failure participants on a beta blocker
- An increase in the percentage of Hypertensive participants with controlled blood pressure levels

To date, the high risk pools report varying cost savings outcomes from their disease management programs. A minority of medical conditions have been most frequently observed to allow for concrete measurement of return on investment or immediate improvements in care from disease management interventions. As the average period that an individual was observed in a high risk pool was 30 months, that short time frame is often inadequate to effectively measure either objective. Other obstacles identified for effective evaluation include the lack of a comparison group and the lack of baseline data from the members prior to their enrollment in the high risk pool. Pools also noted that effective DM can sometimes increase costs as with depression, and

prevention efforts for flu shots. That observation is consistent with findings from the CMS Medicare Coordinated Care Demonstration Evaluation.¹³

The primary methodologies identified for calculating disease management cost savings in high risk pools are; 1) by calculating “services avoided,” such as avoided or prevented hospital admissions; and 2) by comparing baseline cost trends to actual costs during program implementation for the chronic population.

All high risk pools have conducted utilization reviews using claims data, but have yet to report on measuring clinical outcomes. Some cases with particularly severe conditions such as hemophilia, HIV/AIDS, high-risk prenatal and coronary artery bypass, pools have reported cost savings. For example, the improvement of a member not compliant with their HIV/AIDS medication regime to being fully compliant was estimated by one pool to save \$26,000 per patient per year (Wisconsin). Similarly, one pool that focuses on targeted DM for members with post-coronary artery bypass has calculated a significant reduction in hospital readmission, resulting in both cost savings for the program and improved quality of life for the members (Colorado).

Many high risk pools look for innovative ways to improve care for enrollees with complex health needs and to incentivize them to improve self-management of their conditions. The Mississippi High Risk Pool offers its diabetic enrollees a certain number of primary care visits per year and Hemoglobin A1c screenings at no cost, outside of deductibles. Other pools are looking at similar cost-sharing incentives or rewards programs for enrollees with chronic and/or high-cost conditions.

Highlight: HIV/AIDS

For individuals with HIV/AIDS, many State High Risk Pools collaborate with their State’s Ryan White-funded HIV/AIDS programs. States receiving HRSA-funded Ryan White grants may use their funding to pay for the premiums and deductibles for Ryan White-eligible members of High Risk Pools. The Ryan White Program benefits by having individual’s healthcare costs covered by the High Risk Pool. Individuals benefit through receipt of comprehensive health care benefits including healthcare needs beyond their HIV/AIDS disease. The State can benefit by covering individuals whose non-HIV/AIDS related healthcare costs would otherwise be lacking in insurance coverage and would most likely result in uncompensated care with poorer health outcomes.

¹³ Third Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration *January 3, 2008*

The Indiana Comprehensive Health Insurance Association (ICHIA) has implemented an AIDS / HIV Disease Management Program through its CMS high risk pool bonus grant, which involves 115 randomly selected HIV-positive patients. An additional 345 HIV-positive patients are being followed as a control group.

The program has been developed in conjunction with clinical experts, experienced providers, and organizations that care for and treat those with HIV/AIDS. ICHIA is working in direct association with the Regenstrief Institute Inc., and has also involved the Indiana State Department of Health and the State Medicaid program to help coordinate the implementation of the program.

The primary objective is to use intensive, individualized one-on-one relationship building and incentives, by non-clinical “health facilitators” to try to improve adherence to medical instructions and enhance the participants’ outcomes.

As a critical part of the Program, selected medical providers will act as a Steering Committee to assist in the development of a comprehensive care management concept for this population. Pharmaceutical considerations (implementing 340B drug pricing), social needs, and general quality of life has likewise been factored into the design of the program.

The guiding philosophy is that it is worth the long term investment and use of resources is to find the best practices and outcomes for HIV/AIDS treatment adherence. Progress will be measured on the basis of specific standard, HIV/AIDS treatment metrics as well as Viral Load and CD4 counts.

Highlight: Hemophilia

Research has shown that the mortality for individuals with hemophilia who are receiving care outside of a comprehensive Hemophilia Treatment Center increases by 70 percent and there is a 40 percent higher hospitalization rate, even while in the care of a hematologist.¹⁴ In addition, as High Risk Pools are not eligible entities for 340B Drug Pricing, the cost of the pharmaceutical treatments for bleeding disorders can be extremely high.

To address the quality of care and cost issues, many High Risk Pools (Utah, Indiana, Oregon, New Hampshire, Washington, Illinois) partner with local Hemophilia Treatment Centers to assure optimal management of this rare but debilitating and expensive condition. Indiana has reported cost savings through accessing lower cost clotting factor concentrate through the Indiana Hemophilia Treatment Center, and has additionally contained costs through the decreased total amount of replacement product utilized and through a decrease in utilization of other medical services (emergency room visits and inpatient hospital days). The decrease in emergency room visits and number of inpatient days are also reported measurements of the quality of care the patients have received. The experiences of the Indiana and Utah high risk pools are noted as typical for State High Risk Pools partnering with local Hemophilia Treatment Centers for comprehensive care and for access to clotting factor at 340B pricing.

¹⁴ Soucie JM, Symons J 4th, Evatt B, Brettler D, Huszti H, Linden J and the Hemophilia Surveillance System Project Investigators. (2001) "Home-based factor infusion therapy and hospitalization for bleeding complications among males with haemophilia." *Haemophilia* Mar; 7(2): 198-206.

In April 2005, Utah University Hospital entered into an agreement with the Utah Comprehensive Health Insurance Pool (HIPUtah) to provide hemophilia clotting factors to HIPUtah enrollees at the 340B cost plus a nominal service fee.

Several advantages to patients and HIPUtah were identified for this program. They include:

1. A lower charge to the plan
2. A lower patient co-pay when a co-pay is a per cent of the charge
3. Lower charges to HIPUtah result in a longer time to reach yearly or lifetime caps
4. Inclusion of all medical supplies necessary for factor administration
5. No delivery charge
6. Provision of a local provider

The 340B program has several noted restrictions. One that most affects HIPUtah enrollees is the requirement that drugs purchased under the program can only be used for patients who are being treated by physicians of the “covered entity.” This means that only those prescriptions written by physicians who are on staff at University Hospital or one of its clinics are eligible to receive 340B prices. Since most hemophilia patients in Utah are patients of the Mountain States Hemophilia Center whose physicians are all on staff at University Hospital, all patients of the Treatment Center qualify. Any patients who do not qualify and who wish to obtain their clotting factors from University Hospital may do so, but the prices will have to be prevailing rates to the general public by law.

University Hospital will provide this service to HIPUtah enrollees through University Hospital Home Infusion Services (UHI), a division of University Hospital Department of Pharmacy Services. UHI has many years of experience in providing service to hemophilia patients and has been nationally recognized for its sole source program with Utah Medicaid, the only program of its kind in the country.

High Risk Pool disease management programs offer an opportunity to provide innovative and evidence-based medical management to a concentrated population of predominately ill individuals. High risk pools are committed to offering disease management services as an important benefit for participants with difficult medical conditions. There is a wide variety of approaches currently utilized by the pools, however, there are not yet enough data to currently demonstrate efficacy.

IX. High Risk Pool Federal Regulations

On April 25, 2008, the Department of Health and Human Services (HHS) published a Final Rule, 73 Fed. Reg. 222281,¹⁵ which finalized the interim final rule published on July 27, 2007 regarding extended funding for seed and operational grants for State High Risk Pools under the Public Health Service Act. The final rule was effective May 27, 2008 and updated HHS regulations at 45 CFR Part 148, Subpart E, Grants to States for Operation of Qualified High Risk Pools, to implement the changes made by the Deficit Reduction Act of 2005 and the State High Risk Pool Extension Act of 2006. CMS did not receive any public comments on the July 27, 2007 interim final rule with comment period. Therefore, the final rule implemented the provisions of the interim final rule without change.

¹⁵ 22281-22287 [E8-9066] http://www.access.gpo.gov/su_docs/fedreg/a080425c.html

X. Conclusion

The Deficit Reduction Act of 2005 provided \$90 million in grant funding to support State High Risk Pools. CMS awarded 35 grants in Federal fiscal years 2006 and 2007 that totaled \$78,900,001. The grant funds supported operations for 31 existing pools, created two new high risk pools (Tennessee, N. Carolina) and provided funding to several others to conduct studies regarding the feasibility of creating a high risk pool in their State.

As part of the Consolidated Appropriations Act of 2008 (P.L. 110-161), Congress made additional funding available for grants to State high risk pools. CMS awarded \$49,126,500 for operational grants (two-thirds of the appropriated amount) and bonus grants (remaining one-third) to 30 States, effective July 1, 2008.

Appendix A

2006 State Medicaid Director Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SHO #06-001

March 31, 2006

Dear State Medicaid Director:

The purpose of this letter is to provide you with information regarding the extension of grant funds for State high risk pools and the availability of additional grant funding related to high risk pool activities. The funding for the grants is authorized by the Deficit Reduction Act of 2005 (DRA) and the State High Risk Pool Funding Extension Act of 2006 (Extension Act). Section 6202 of the DRA entitled “State High Risk Health Insurance Pool Funding” extends funding of grants under 2745 of the Public Health Service Act through the fiscal year (FY) 2006 by authorizing and appropriating \$75 million for grants to help fund existing qualified State high risk pools and \$15 million for seed grants to assist States to create and initially fund qualified high risk pools. The Extension Act, enacted February 10, 2006, also modifies eligibility requirements and the funding formula, beginning with the 2006 appropriation, and authorizes \$75 million for each of fiscal years 2007 through 2010.

The Extension Act amends section 2745 of the Public Health Service Act to establish: (1) the availability of seed grants through FY 2006 to States for the creation and initial operation of a qualified high-risk pool for those States that do not have one, and (2) significantly modify the statutory provisions relating to grants to States, with high risk pools that have incurred losses. These modifications include a broader definition of a “qualified high risk pool,” beyond its current definition to include an acceptable alternative mechanism such as a health insurance coverage pool, guaranteed issue plans of individual insurance health coverage, open enrollment by health insurance issuers or a combination.

Grant Opportunities Announcement:

This letter gives general information about the grant opportunities. More specific requirements and instructions will be announced on or about May 1, 2006, on the Web at www.grants.gov. Letters of Intent for seed grants are desired by May 31, 2006. Grant applications for seed grants and operational grants will be due on June 30, 2006, and grant awards will be announced on or by September 30, 2006.

Seed Grants - A State that has not created a qualified high risk pool as of February 10, 2006, may apply for grant funding for the State’s costs of creation and initial operation of a high risk pool. The terms of the grant program will be detailed in the grant opportunities announcement.

Grants for Operational Losses and Bonus Grants - States that have established a qualified high risk pool which has incurred losses and meet the terms of the grant program may apply for

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funding. The terms of the grant program are significantly different than those that applied for FY 2002 through 2004 and will be detailed in the grant opportunities announcement.

Allocation of Grant Amounts for the Operational Losses Grants - The amount of dollars available for the operational grants is based on the following funding methodology. Two-thirds of the total appropriation will be available for the operational losses grants. This amount will be divided among the States that apply and are awarded grants according to the allotment rules that generally provide that: 40 percent will be equally divided among those States; 30 percent will be divided among states and territories based on their number of uninsured residents in the State during the specified year as compared to all states that apply and; 30 percent will be divided among states and territories based on the number of people in State high risk pools during the specified year as compared to all states that apply.

The Extension Act also modifies the definition of “qualified high risk pool” to include state alternative mechanisms as described in section 2744 of the Public Health Service Act and allows a state to qualify for a grant as long as the premiums it charges under the risk pool are no more than 200 percent of the premium for applicable standard risk rates. (The previous limitation was 150 percent). However, if a State’s qualified high-risk pool program charges premiums that exceed 150 percent of the premium for applicable standard risks, the State must use at least 50 percent of the amount of the grant award to reduce premiums for enrollees.

Limitations for Territories – The aggregate amount allotted and made available to Territories for operational grants will not exceed \$1,000,000.

Bonus Grants for Supplemental Consumer Benefits - One-third of the total appropriation is set aside to be used for grants for supplemental consumer benefits. If a State has an established qualified high risk pool and is receiving a grant for operational losses, it may apply for a grant to be used to provide supplemental consumer benefits to enrollees or potential enrollees of its high risk pool. The benefits to be funded with this grant shall include one or more of the following: (a) low income premium subsidies; (b) reduction in premium trends, actual premium or other cost-sharing requirements; (c) an expansion or broadening of the pool of individuals eligible for coverage, such as through eliminating waiting lists, increasing enrollment caps, or providing flexibility in enrolment rules; (d) less stringent rules, or additional waiver authority with respect to coverage of pre-existing conditions; (e) increased benefits; and (f) the establishment of disease management programs.

The availability of these grants along with flexibility provided by other DRA provisions, may create opportunities for states to promote greater options and strategies for the uninsured. For example, a State may want to take advantage of new benefit flexibility options under Medicaid to leverage the purchase of insurance coverage for a broader pool of individuals through Medicaid, SCHIP, and the risk pool. We encourage you to use this flexibility to find better ways to provide access to affordable and economical insurance products for the citizens of your State.

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The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children's Health Program Group. She may be reached at 410-786-5647. Please do not hesitate to contact us if you have any additional questions.

Sincerely,

\s\

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

Governors
State Insurance Commissioners

Appendix B

CMS High Risk Pool Funding 2003-2007

State	Seed	2003	2004	2005	2006 Seed	2006 Op	2006 Bonus	2007 Seed	Total
AL	\$0	\$2,825,618	\$0	\$1,419,134	\$0	\$1,442,972	\$0	\$0	\$7,071,156
AK	\$0	\$541,883	\$483,555	\$1,670,364	\$0	\$790,482	\$895,640	\$0	\$5,068,351
AR	\$0	\$1,928,221	\$1,892,658	\$1,287,604	\$0	\$1,253,047	\$55,900	\$0	\$7,341,373
CA	\$0	\$0	\$0	\$0	\$150,000	\$0	\$0	\$0	\$150,000
CO	\$0	\$3,219,285	\$3,096,266	\$3,110,375	\$0	\$1,658,396	\$1,478,373	\$0	\$14,373,274
CT	\$0	\$1,596,590	\$1,502,721	\$1,827,412	\$0	\$1,147,452	\$700,000	\$0	\$7,953,693
DC	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000	\$150,000
ID	\$0	\$0	\$0	\$942,736	\$0	\$960,424	\$0	\$0	\$2,870,108
IL	\$0	\$8,144,784	\$7,472,921	\$4,146,168	\$0	\$2,939,767	\$1,250,000	\$0	\$26,951,336
IN	\$0	\$3,266,148	\$3,358,254	\$2,840,277	\$0	\$1,926,155	\$942,000	\$0	\$14,039,329
IO	\$0	\$1,106,939	\$367,670	\$975,627	\$0	\$994,341	\$0	\$0	\$4,157,835
FL	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000	\$150,000
GA	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000	\$150,000
KS	\$0	\$0	\$1,461,689	\$1,297,042	\$0	\$1,031,608	\$295,000	\$0	\$5,170,963
KY	\$0	\$2,510,667	\$2,291,952	\$2,358,210	\$0	\$1,406,506	\$975,000	\$0	\$11,230,610
LA	\$0	\$0		\$2,320,009	\$0	\$1,354,951	\$992,713	\$0	\$6,104,767
MD	\$1,000,000	\$0	\$3,175,868	\$2,971,167	\$0	\$1,797,813	\$1,200,000	\$0	\$12,446,081
MA	\$0	\$0	\$132,271	\$1,157,575	\$0	\$414,569	\$0	\$0	\$1,704,415
MN	\$0	\$1,984,248	\$1,971,749	\$5,643,559	\$0	\$3,664,879	\$2,000,000	\$0	\$18,706,436
MS	\$0	\$2,066,184	\$2,037,628	\$1,819,818	\$0	\$1,392,593	\$449,202	\$0	\$9,180,233
MO	\$0	\$0	\$0	\$2,384,658	\$0	\$1,409,440	\$1,000,000	\$0	\$6,285,438
MT	\$0	\$697,594	\$621,040	\$1,788,115	\$0	\$1,074,800	\$729,875	\$0	\$5,965,497
NE	\$0	\$894,351	\$751,032	\$2,190,538	\$0	\$867,573		\$0	\$5,898,997
NH	\$1,000,000	\$224,599	\$531,515	\$1,592,929	\$0	\$1,273,440	\$934,097	\$0	\$6,438,832
NM	\$0	\$2,047,889	\$1,738,727	\$2,051,069	\$0	\$826,355	\$782,644	\$0	\$8,887,613
NY	\$0	\$0	\$0	\$0	\$150,000	\$1,121,553	\$950,000	\$0	\$2,221,553
NC	\$0	\$0	\$0	\$0	\$150,000	\$0	\$0	\$850,000	\$1,000,000
ND	\$0	\$329,379	\$292,703	\$852,596	\$0	\$0	\$0	\$0	\$2,205,209
OH	\$150,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000
OK	\$0	\$2,931,029	\$2,730,738	\$2,363,926	\$0	\$1,388,788	\$1,000,000	\$0	\$11,807,089
OR	\$0	\$0	\$0	\$3,852,114	\$0	\$2,375,581	\$1,500,000	\$0	\$10,408,345
RI	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000	\$150,000
SC	\$0	\$0	\$0	\$1,955,426	\$0	\$1,278,624	\$700,000	\$0	\$5,378,780
SD	\$1,000,000	\$0	\$0	\$1,083,134	\$0	\$785,577	\$312,851	\$0	\$3,906,171
TN	\$0	\$0	\$0	\$0	\$1,000,000	\$0	\$0	\$0	\$1,000,000
TX	\$0	\$0	\$0	\$9,131,446	\$0	\$7,237,175	\$2,000,000	\$0	\$24,644,684
UT	\$52,618	\$0	\$1,395,360	\$2,393,529	\$0	\$1,162,603	\$1,250,000	\$0	\$7,647,439
VT	\$0	\$0	\$0	\$0	\$1,000,000	\$0	\$0	\$0	\$1,000,000
WA	\$0	\$0	\$0	\$2,404,268	\$0	\$1,575,759	\$856,705	\$0	\$6,453,990
WV	\$1,000,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,000,000
WI	\$0	\$2,222,903	\$2,500,578	\$4,399,531	\$0	\$2,672,935	\$1,750,000	\$0	\$16,107,116
WY	\$0	\$0	\$357,751	\$758,735	\$0	\$773,843	\$0	\$0	\$2,394,454
Total	\$4,202,618	\$38,540,314	\$40,166,650	\$74,991,096	\$2,450,000	\$50,000,001	\$25,000,000	\$1,450,000	\$285,927,179