Congress of the United States
House of Representatives
Washington, D.C. 20515

March 4, 2008

The Honorable David M. Walker
Comptroller General
U.S. Government Accountability Office
441 G Street N.W.
Washington, D.C. 20548

Dear Mr. Walker:

The individual market for health insurance coverage is seriously flawed. Many people who need insurance and apply for it are denied coverage in the individual market or are offered insurance coverage that turns out to be inadequate, or it is too expensive, or both. A number of States have tried reform efforts to improve accessibility through requirements such as guaranteed issuance, limits on underwriting, or premium rate bands. These efforts to improve access, however, have been widely opposed by the insurance industry as interfering with the market.

Opponents of these reforms have generally advocated the establishment of high-risk pools by States as a more effective approach to providing coverage to high-risk individuals. Proponents of these pools argue that they can provide subsidized, adequate, and affordable coverage to high-risk individuals while permitting the individual market to operate effectively for healthy individuals, thus saving money for insurers in that market.

As part of the Trade Assistance Act of 2002, Congress authorized a new grant program of $40 million per year, for State high-risk pools, and the program was reauthorized for $75 million annually in 2005. Although the allocation formula for distributing grant funds to States under this program was modified slightly in 2005, it remains very general and vague. Most importantly, there has been no comprehensive assessment of how this taxpayer money has been spent and what it has achieved in terms of expanded coverage, lower premiums, or other potential benefits to potential and actual enrollees in the pools.

Given the significant amount of Federal dollars that have now been contributed to these State high-risk pools, we request that GAO undertake a study to address the questions of the effectiveness of state high-risk pools in meeting the needs of high-risk individuals who are unable to obtain or afford adequate coverage in the individual market, the uses of the Federal grant money, and its effect on the individual market. More specifically, we ask GAO to address the following questions for each State with a high-risk pool:

1. How effective are high-risk pools in providing a safety net for those unable to obtain or afford health insurance in the private market?
    a. What is enrollment by State?

b. What is the average length of enrollment?
c. What is the average age of pool enrollees?
d. How many individual health insurance market applicants in the State are annually rejected by insurers or offered substandard premiums or coverage due to health status or risk?
e. What is the extent to which high-risk pools have waiting lists or other restrictions on enrollment?
f. What kind of efforts do high-risk pools undertake to make people aware of the program and encourage enrollment?
g. What effect have high-risk pools had on the individual market?

2. How are premiums set relative to the "standard rate" that is charged for plans offered in the individual market?
a. What is the definition of "standard rate" and how much does this definition vary among the States? Have individual States redefined the term one or more times since 2000?
b. How often are premiums in the high risk pool increased, and how do those increases compare to increases in the individual market?
c. What is the average monthly premium paid by pool enrollees in each State? How has that amount changed since 2004?
d. How many enrollees receive premium subsidies based on their income? What is the average monthly subsidized premium paid by these enrollees and the average amount of subsidy?

3. How do the benefit packages in high-risk pools compare to benefit packages offered by large employers in the state (the benefit standard specified in the NAIC model act for high-risk pools)?
a. How common are limits on benefits, such as limits on out-patient visits, hospitals days, or prescription drug coverage, compared to typical individual market products?
b. How many pools have annual or lifetime limits on benefits, and how many enrollees reach them?
c. What level of annual deductibles and out-of-pocket maximums are offered? What percentage of pool enrollees have annual deductibles of at least $1,000? At least $2,000? What percentage of pool enrollees have annual out-of-pocket maximums (specify including deductible and coinsurance) of at least $2,000? At least $5,000? In what State programs does the annual out-of-pocket maximum also limit cost-sharing for prescription drugs?
d. How many high-risk pools impose pre-existing restrictions on applicants? Do any States waive the pre-existing restrictions for individuals who have had credible coverage in the past 12 months? Do any states impose pre-existing restrictions that are not offset by previous credible coverage? How many high-risk pool enrollees are subject to pre-existing medical condition restrictions when they enroll so a particular medical condition isn't covered?
e. Do enrollees in high-risk pools have greater out-of-pocket medical care expenses than do a typical enrollee in the individual market?

4. How have the Federal grants for high-risk pools been used?
a. What percentage of the funds has been used to pay claims? Who would have otherwise likely borne this cost? Insurers, beneficiaries, the States?
b. What percentage of the funds has been used to assist beneficiaries directly through benefit increases or premium reductions?
c. In each State that has received a grant, for each year, what percentage of pool net losses have Federal grants comprised?

d. On what basis were Massachusetts, Idaho, and Missouri high-risk pools deemed eligible for high-risk pool grants? (Massachusetts and Idaho do not have high-risk pools; Missouri's high-risk pool was not a HIPAA qualified alternative mechanism before 2007.)
e. Have any State applications for Federal high-risk pool grants been turned down? Which States and on what basis?
f. What process exists within CMS/HHS to make determinations regarding high-risk pool funding eligibility? Who reviews grant applications, who makes decisions, and on what basis?

5. What is the balance of representation on the governing boards of high-risk pools?
   a. How many pools have consumer representatives, and how many such representatives are there?
   b. How many board members have direct connections to the insurance industry?
   c. How many board members have direct connections to the medical provider community?

Thank you for your attention to this matter. If you have any questions, please contact Amy Hall or Bridgett Taylor with the Committee on Energy and Commerce staff at (202) 225-2927.

Sincerely,

John D. Dingell
Chairman
Committee on Energy and Commerce

Henry A. Waxman
Chairman
Committee on Oversight and Government Reform

Frank Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Thomas M. Davis III, Ranking Member
Committee on Oversight and Government Reform

The Honorable Nathan Deal, Ranking Member
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