



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

April 2, 2010

Dear Governor:

As you are aware, on March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Public Law 111-148). As the Department of Health and Human Services (HHS) begins the monumental task of implementing this historic legislation, I look forward to working in partnership with you as we transform the nation's health care system. I would like to draw your attention to one of the immediate changes that will be implemented this year. Section 1101 of the new law establishes a "temporary high risk health insurance pool program" to provide health insurance coverage to currently uninsured individuals with pre-existing conditions. The law directs HHS to carry out the program directly or through contracts with states or private, non-profit entities.

We are interested in building upon existing state programs in this important initiative to provide expanded access to health coverage for individuals who cannot otherwise obtain health insurance. **To that end, I am writing you today to request an expression of your state's interest in participating in this temporary high risk pool program, consistent with one of the implementation options described below.** We understand that final decisions in this regard may be subject to the availability of additional details, approval from your state legislature, and other factors. HHS will engage individually with each state that indicates its intent in response to this letter, both in the preparation of its potential application and during the application review process, as appropriate.

The new statute establishes some specific requirements surrounding the eligibility, benefits, and funding for the new high risk pool program. Specific statutory requirements include but are not limited to:

Eligible Individuals Must:

- Be a citizen or national of the United States or lawfully present in the United States;
- Not have been covered under creditable coverage (as defined in Section 2701(c)(1) of the Public Health Service Act) for the previous 6 months before applying for coverage; and
- Have a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

Benefits/Coverage Must Have:

- An actuarial value of at least equal 65 percent of total allowed costs;
- An out-of-pocket limit no greater than the applicable amount for high-deductible health plans linked to health savings accounts, described in section 223(c)(2) of the Internal Revenue Code of 1986 (that is, \$5,950 for an individual); and
- No pre-existing condition exclusions.

Premiums Must:

- Be established at a standard rate for a standard population (that is, not exceed 100 percent of the standard non-group rate); and
- Not have age rating greater than 4 to 1.

Beyond the minimum statutory requirements, HHS's goal is to grant the flexibility needed to permit successful and expeditious implementation of the program by interested states. For example, we recognize that there are different avenues for states to carry out the statutory requirements for a high risk pool program. A state could consider the following options:

- Operate a new high risk pool alongside a current state high risk pool;
- Establish a new high risk pool (in a state that does not currently have a high risk pool);
- Build upon other existing coverage programs designed to cover high risk individuals;
- Contract with a current HIPAA carrier of last resort or other carrier, to provide subsidized coverage for the eligible population; or
- Do nothing, in which case HHS would carry out a coverage program in the state.

In reviewing the existing state high risk pools, there is much common ground in the benefits currently provided. Since HHS is considering establishing a floor set of benefits that all the new high risk pool programs must cover, we anticipate that these benefit requirements would take into account benefit lists currently used by existing state high risk pools. Similarly, states would have the option to follow pre-existing condition criteria for determining eligibility established by the Secretary, or propose their own, subject to Secretarial approval. We are committed to working with states to identify other areas where flexibility is appropriate.

The law appropriates \$5 billion of federal funds to support the new high risk pool program. It will be available beginning on July 1, the start of many state fiscal years, until the program ends on January 1, 2014. HHS anticipates allocating these funds to states based on population as well as state costs (similar to the allocation method used for the Children's Health Insurance Program), with a reallocation of unused funds after 2 years. More details regarding the potential funding available to states will be made available prior to the deadline for applications. HHS will also hold a conference call in mid-April to provide a forum for learning additional details about the anticipated structure of the program and the anticipated application requirements, as well as to respond to any questions you may have regarding this program. We ask that your state's primary contact for the high risk pool program participate in this call.

To begin the process of implementing this program, HHS is asking that each state do the following:

1. Submit the name of a primary contact person to [highriskpools@cms.hhs.gov](mailto:highriskpools@cms.hhs.gov) by April 9, 2010. We also strongly encourage the advance submission of questions that you may have to the same mailbox, to facilitate a productive exchange of information during the conference call.
2. Submit a letter of intent by April 30, 2010, that indicates whether you intend to submit an application to contract with HHS to operate a high risk pool program under the new law. This letter should include the anticipated timing for establishment of the program, as well

as information on any State legislative decisions that would be needed in order to participate in the new high risk pool program. This information should be submitted to the same email box, with the subject line, "Notice of intent."

In addition, we would particularly appreciate an advance indication of which of the potential implementation options appears to be most likely for states to use to carry out their program, including available additional details (such as outlines of programs, or other ideas about potential mechanisms of providing coverage under the new law).

In order to determine the extent to which we will carry out our obligations directly, or under contracts with States or other entities, it is critical that HHS receive States' indication of intent to participate and requested preliminary information by April 30, 2010. I appreciate your assistance in ensuring that your state provides this information by the specified deadlines. This information will be critical in helping successfully implement the high risk health insurance pool program. HHS intends on establishing an option for eligible individuals in States that do not indicate their intent to participate. A State that indicates its intent but does not follow through with a successful application could be delaying assistance for its residents.

We look forward to working with you to bring affordable health care to individuals in your State through the new high risk pool program.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathleen Sebelius". The signature is written in a cursive, flowing style with a large initial "K".

Kathleen Sebelius



Comparison of State High Risk Pool to  
(what is known about) Federal High Risk Pool

	<b>MRMIP</b>	<b>Interim Federal High Risk Pool Product</b>
	<ul style="list-style-type: none"> <li>❖ NA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Secretary to establish Interim High Risk Pool 90 days after enactment of federal health care reform June 22. She may contract with states or non-profits to provide the coverage.</li> <li>❖ Secretary has requested that Governors inform her by the end of April if they intend to contract with DHSS for this purpose.</li> <li>❖ States choosing to contract with DHSS are subject to a maintenance of effort requirement to spend the same amount on medically uninsurable persons as the state spent in the year prior to the contract</li> </ul>
Eligibility	<ul style="list-style-type: none"> <li>❖ Resident of state</li> <li>❖ Demonstrate               <ul style="list-style-type: none"> <li>○ Rejection from a carrier in the last 12 months, or</li> <li>○ An offer of coverage whose premiums are equal to or exceed MRMIP premiums, or</li> <li>○ Termination by a carrier for reasons other than fraud or non-payment of premium</li> </ul> </li> <li>❖ Ineligible for Medicare (except if solely for end</li> </ul>	<ul style="list-style-type: none"> <li>❖ Be a citizen or national of the US or lawfully present</li> <li>❖ Have had no creditable coverage in the last 6 months, and</li> <li>❖ Have a pre-existing condition as determined by the Secretary of DHSS or as proposed by a state and approved by the Secretary.</li> </ul>

	<ul style="list-style-type: none"> <li>❖ stage renal disease), and</li> <li>❖ Ineligible for (or has exhausted) COBRA and Cal-COBRA</li> </ul>	
Pre-existing condition exclusions/waiting periods	<ul style="list-style-type: none"> <li>❖ If enrolled in the PPO product, a 3 months pre-existing condition exclusion</li> <li>❖ If enrolled in HMO product, a three month post-enrollment waiting period during which no benefits are provided. Subscriber does not pay premiums during this period.</li> </ul>	Pre-existing condition exclusions not permitted
Benefits	<ul style="list-style-type: none"> <li>❖ Comprehensive benefits with an annual \$500 household deductible. Preventive services excluded from deductible.</li> </ul>	<ul style="list-style-type: none"> <li>❖ To be defined by Secretary of DHSS. The subscriber's share of the cost of benefits cannot be higher than 35 percent.</li> </ul>
Subscriber Out-of-Pocket (OOP) Expenses	<ul style="list-style-type: none"> <li>❖ Limit of \$2,500/year for an individual and \$4,000 for household</li> <li>❖ See Attachment A for OOP charges by plan</li> </ul>	<ul style="list-style-type: none"> <li>❖ OOP maximums equal to those for HSA products; \$5,950 /individual and \$11,900 for family</li> </ul>
Benefit Maximums	<ul style="list-style-type: none"> <li>❖ \$75,000/year</li> <li>❖ \$750,000 over the course of a lifetime</li> </ul>	<ul style="list-style-type: none"> <li>❖ As noted above, Secretary of HHS to define benefits.</li> <li>❖ Provisions that will apply to insurance products in the market bar lifetime caps and "unreasonable" annual caps.</li> </ul>
Subscriber Premiums	<ul style="list-style-type: none"> <li>❖ 125-137% of the standard rate that a carrier would charge for MRMIP benefits (including annual benefit maximum) in the commercial market</li> <li>❖ Rate variance: Six geographic regions with no limits on amount of variation; 12 ages with no limit on amount of</li> </ul>	<ul style="list-style-type: none"> <li>❖ 100% of the standard rate for the benefits in the commercial market</li> <li>❖ Rate variance: Rates may vary only by the following factors: age (maximum variation of 4 to 1), whether the plan covers an individual</li> </ul>

	<p>variation; 3 possible family sizes (subscriber, subscriber plus one dependent, subscriber plus 2 dependents</p> <p>❖ See Attachment A for premiums</p>	<p>or a family, region, and tobacco use (maximum variation of 1.5 to 1). Secretary determines regions. At least one region per state</p>
Subsidy Funds	<p>\$37 million in Proposition 99 funds. \$10-\$15 million of these funds are spent for persons enrolled in a guaranteed issue pilot project. The remainder is spent on subsidies in the MRMIP program.</p>	<p>\$ 5 billion to cover costs of the pool through 2013. Statute does not indicate how funds will be allocated to states. Decision of Secretary of DHHS.</p>
Enrollment Cap	<p>MRMIB sets enrollment cap semi-annually based on available funding.</p> <p>Presently cap is 7,100 slots.</p>	<p>If funding inadequate, Secretary can set a cap or seek additional funds.</p>

Attachment A. Handbook:

Available at [www.mrmib.ca.gov/mrmip](http://www.mrmib.ca.gov/mrmip) tab. Hyperlink to application at bottom of page.





## Implementing Health Reform: Temporary High-Risk Pool

Prepared by: Adam Dougherty and Mike Sloyan

March 26, 2010

### Introduction

The health reform law contains immediate access to insurance for uninsured individuals with pre-existing conditions through temporary high-risk pool funding. A recent CMS study estimates that up to 6% of the uninsured population is uninsurable, defining this population as individuals who were uninsured and who either could not work, were limited in the type of work they could do, or received any disability or worker's compensation income.<sup>1</sup> A PricewaterhouseCoopers study estimates that between 2.5% and 5% of individuals are medically uninsurable on the individual market due to medical underwriting.<sup>2</sup> Based on these estimates, the Managed Risk Medical Insurance Board (MRMIB), the governing body of the Major Risk Medical Insurance Program (MRMIP), finds that between 165,000 and 396,000 Californians may be uninsurable and in need of coverage.<sup>3</sup> In the following analysis, we summarize the provisions related to the program, review the current high-risk pool in California, and make recommendations regarding next steps.

### Sec. 1101 of HR 3950: Temporary High-Risk Pool Program

The pool will be established no later than 90 days after the bill was signed into law (on or before June 22, 2010) and will continue through January 1, 2014 when these individuals will transition to the Exchange. The law allocates \$5 billion over the course of the program, without fiscal year limitation. Based on our state's share of the nation's uninsured, California should be eligible for at least 14% of the federal funds, providing over \$700 million for the state. To qualify for the federal funds, a state or non-profit high-risk pool must adhere to the following new federal standards:

- No pre-existing condition exclusions
- Coverage requirements
  - Standard rates for a standard population
  - Minimum 65% actuarial value
  - Age rating no more than 4:1
  - Annual out-of-pocket maximum of \$5,000/\$10,000 for individual/family
- Eligibility for individuals
  - Has been uninsured for 6 months<sup>4</sup>
  - Has a pre-existing condition

The California Major Medical Risk Insurance Program (MRMIP) is the existing program dedicated to those individuals who cannot obtain insurance on the individual market, and is a logical choice for expansion with these funds.

### Overview of MRMIP

#### Eligibility

1. Must be a resident of the state (present with intent to remain). A person absent from the state for a period longer than 210 consecutive days is not considered a resident.

2. Must not be eligible for Medicare **both** Part A **and** Part B, unless eligible solely because of end-stage renal disease.
3. Not eligible for COBRA (the MRMIP program allows COBRA beneficiaries to apply for deferred enrollment in the MRMIP if COBRA coverage will soon expire)
4. Must be unable to secure adequate coverage within the previous year.

### How the Program Works

#### *General*

Health plans (Anthem Blue Cross PPO, Kaiser Permanente, and Contra Costa Health Plan) are contracted to provide and coordinate services. The annual deductible is \$500 and annual subscriber out of pocket max costs are \$2,500 for an individual and \$4,000 for a family. MRMIP's benefit limits are \$75,000 per year and \$750,000 in a lifetime. Californians qualifying for the program participate in the cost of their coverage by paying premiums (called subscriber contributions) equal to 125% of the cost of equivalent individual coverage. The State of California supplements those premiums to cover the cost of care in MRMIP. Tobacco tax funds currently subsidize the MRMIP.

#### *Applying*

The potential subscriber completes and submits the application along with the first month's contribution. The applicant is then either enrolled or placed on a waiting list if the MRMIP is at maximum enrollment (7,100). Dependents may be covered up to age 23; unmarried dependents above age 23 may be covered if that dependent is incapable of self-support due to physical or mental disability. For those wishing to enroll in a PPO plan (Anthem Blue Cross), there is a 3-month exclusion period on coverage for pre-existing conditions. For those enrolling in an HMO plan (KP or CCHC), there is a 3-month post-enrollment waiting period where the MRMIP will not provide any benefits or services. No subscriber contributions are paid during this time. After the waiting period is up, the first-month payment provided with the application will be applied. The subscriber may be eligible to waive all or part of the exclusion/waiting period if:

1. The subscriber has been on the MRMIP waiting list for 180 days or more. The exclusion/waiting period will be waived entirely.
2. The subscriber was previously insured and the application to the MRMIP was submitted within 63 days of the termination of the previous coverage. If the subscriber was enrolled in previous coverage for at least 3 months, the entire exclusion/waiting period will be waived. If the subscriber was covered less than 3 months, the subscriber will get credit for either 1 or 2 months toward the exclusion/waiting period depending on the length of coverage.
3. The subscriber was enrolled in employer-sponsored coverage that was terminated and the application to the MRMIP was received within 180 days of termination of coverage. The subscriber may be eligible for a waiver up to 3 months.
4. The subscriber was enrolled in a similar program in another state within the last 12 months. In this case the exclusion/waiting period will be completely waived.

### *Waiting list*

If the MRMIP is at max enrollment, a waiting list begins from the date the completed application was received. There are two types of enrollees on the waiting list, those due to closed enrollment and those due to deferred enrollment. Currently there are 84 on the MRMIP waiting list due to closed enrollment and 43 waiting due to deferred enrollment for a total of 143.

### Declined enrollment

MRMIP surveys individuals who did not accept their enrollment offers after being admitted off the waiting list<sup>5</sup>. The vast majority of survey responders (33 out of 49) had obtained other health coverage. Eight out of the 49 could not afford their contribution cost. These reasons are consistent when comparing to the various reasons why individuals are disenrolled from the MRMIP during the Annual Disenrollment Survey.

### **Recommendations**

In regard to the Major Risk Medical Insurance Program and the new federal funding opportunities, MRMIB should be in close contact with HHS to assure qualification for federal funds. Certain policies, such as the current three-month pre-existing condition exclusion period and the annual and lifetime benefit limits, will need to be changed.

Federal guidelines stating that the high risk individual be uninsured for the previous 6 months may pose a challenge unless a potential enrollee has been on the wait list without coverage for a period longer than 6 months. Further, if this federal stipulation isn't modified or unless there is an alternative agreement made between federal and state officials, federal high-risk dollars might not be available to fund upgraded coverage for current MRMIP subscribers unless they disenroll for 6 months.

With a substantial increase in funding, it is essential that the dollars be used effectively in order to enroll as many of the medically uninsurable uninsured as possible. Existing programs such as the Genetically Handicapped Persons Program (GHPP) may be able to increase capacity through new MRMIP contracts. An increase in enrollment applications can also be expected in anticipation of the program's expansion. A greater administrative capacity should parallel the increased volume as needed. There may be an opportunity to expand benefits within the high-risk program as needed (improving the actuarial value, cost sharing, benefits package, etc.); contracting plans may seek rate increases from MRMIP; non-contracting plans may increase their medical underwriting rejections with the expectation that MRMIP will cover those they reject. In our view, the priority should be covering as many of the medically uninsurable as possible within federal fiscal constraints without opening the floodgates to a cascade of new rejections and stiffer underwriting exclusions from some plans.

It is the intention of the federal dollars to (1) provide a coverage option for those who are unable to find appropriate insurance elsewhere and (2) smooth the transition of these populations into the health exchange beginning in 2014. California's MRMIP already satisfies the first point but only for those able to pay the elevated cost. The main reason

why people are disenrolled from and decline enrollment offers through the MRMIP is because the subscriber contributions are too costly.

California may wish to increase the number of private and public health plans offered through the MRMIP. Additional safety net plans, such as Local Initiatives, and County Operated Health Systems (COHS) may wish to consider offering coverage.

MRMIP may wish to offer benefit options similar to the bronze, silver, and gold levels stipulated for the Exchange in 2014 under the new federal law. This could provide a choice of more affordable coverage options for high-risk populations, but it may be far too complex for what is a very small pool of high-risk enrollees. This approach could pre-test elements of an exchange in California and work out some of the inescapable “bugs”, thereby dramatically smoothing this particular population’s transition into the health insurance exchange in 2014. The federal law stipulates a 65% actuarial value, which would be lower than a bronze plan offered through the exchange.

Current state dollars for MRMIP (\$40 million in tobacco tax funding) could be realigned to lower the subscriber contribution for moderate-income Californians who qualify for MRMIP but can’t participate due to the high cost of the current subscriber contributions. There is a federal maintenance of effort (MOE) requirement so the new federal funds cannot simply be used by the state to plug its budget deficit.

The changes that will take place will need to balance the availability of new federal funds and subscriber contributions while maintaining a keen eye on the limit on total federal funds available. Under one possible future, California may be stuck in a ‘Cash for Clunkers’ scenario where a significant federal funding increase would be exhausted in an unexpectedly short period of time, once again stranding “medically uninsurable” Californians without insurance until 2014. Under another, Californians could debate, delay and squander a valuable opportunity for California to demonstrate how a well-planned implementation effort of federal health reform law could be executed.

Whatever changes will take place to enhance MRMIP should be done swiftly. Options involving a prolonged state legislative debate or an expansion with lengthy timelines are not recommended. From the beginning, the KISS (Keep it Simple, Stupid) rule should apply with modifications phased in later.

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<sup>1</sup> Frakt, A.; Pizer, S.; and Wrobel, M.; High Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects: Winter 2004-2005, Health Care Financing Review; Volume 26, Number 2; page 74.

<sup>2</sup> Hunt, S.: Individual Health Insurance Options for California; September 2000 (Report presented to the Managed Risk Medical

Insurance Board by PricewaterhouseCoopers, the Board’s contract actuary.)

<sup>3</sup> Managed Risk Medical Insurance Board, California Major Risk Medical Insurance Program 2006 Fact Book, March 2006

<sup>4</sup> Health plans that dump individuals based on health status prior to risk-pool enrollment will be responsible for any medical expenses incurred to the program (what does this mean?)

<sup>5</sup> Major Risk Medical Insurance Program, 2010 MRMIP Survey Individuals on the Waiting List Declining Enrollment Offers



A Private Foundation Working Toward a High Performance Health System

## Expanding Coverage: HHS Faces a Tight Timetable in Setting Up High-Risk Pools

By Rebecca Adams, CQ Staff

April 5, 2010 -- From day one, President Obama and other proponents of a health care overhaul promised to help people with pre-existing health conditions who find it difficult, if not impossible, to get insurance coverage.

So it is not surprising that providing such coverage is one of the first parts of the new law to take effect — and it's required to happen within the next three months.

It's a daunting timetable, and the pressure is even more intense given the expectations associated with the new law. A slight delay or isolated snafus for some patients could give critics ammunition to paint the entire endeavor as a failure.

Among the problems experts foresee: How will the new federal program square with existing high-risk pools at the state level? Is there enough money to cover as many as 2 million new enrollees? Will the program be up and running by its deadline?

Building a new network of providers throughout the country from scratch — not to mention setting payment rates and signing contracts — is virtually impossible within the next 90 days. For that reason, Health and Human Services (HHS) secretary, Kathleen Sebelius announced April 2 that she would seek to build on existing state programs and where necessary, contract with not-for-profit insurance carriers as a temporary solution until 2014 when insurance companies will have to take all comers.

Yet even piggybacking on existing programs could prove difficult.

"I can't imagine how they'll push all this out in this short turnaround," said Joy Johnson Wilson, director of health policy for the National Conference of State Legislatures, predicting that HHS officials will miss at least some of the first-year deadlines in this and other programs.

Sebelius, however, discounted the difficulties, saying she had written governors and state insurance commissioners asking whether they would participate and on what basis. If they do not, she said, HHS would set up the programs.

Currently, 35 states run pools for people who have trouble buying insurance because of pre-existing conditions, although not all of the programs are accepting new patients. Coverage costs vary significantly from state to state, with 2009 premiums for a 50-year-old ranging from a low of \$377 per month in Maryland to a high of \$1,362 in Washington, according to the Kaiser Family Foundation, a nonprofit research organization.

But the premiums in the state pools can be much more expensive for people who are very sick — so expensive that in a nation of about 47 million uninsured people, only about 200,000 get coverage through the pools. Premiums are likely to be lower in the federal program because they would be subsidized.

Sebelius may also contract with not-for-profit insurance carriers, particularly in states without a high-risk pool. One option would be working with the plans that belong to the Blue Cross and Blue Shield Association.

However, neither Blue Cross, nor officials in the National Association of State Comprehensive Health Insurance Plans (NASCHIP), which represents administrators of the state high-risk pools, say they know how the agency will proceed. Neither does America's Health Insurance Plans, the insurers' trade group.

"We need specifics as to what the final enrollment criteria would be and what coverage options would be desired, as well as how the funding would be distributed," said Vernita Bridges-McMurtrey, executive director for the Missouri Health Insurance Pool and the chairwoman of the national group's board of directors. "I don't think any of that has been determined yet."

One of the first issues that HHS must address is whether it will require high-risk pools in every state. Six states already prohibit denial of coverage based on pre-existing conditions — a policy known as "guaranteed coverage." Another seven states have some insurance regulations that help give people with pre-existing conditions access to insurance, according to the Kaiser Foundation.

Blue Cross officials question whether Sebelius needs to create programs in states that already require insurers to offer coverage to all comers.

"The real problem is that if you're sick and uninsured and you have to buy coverage on the individual market, in [a small number of] states, there's no place to get the coverage that you need. That should be the priority," said Alissa Fox, the association's senior vice president for policy and representation.

Consumer advocates agree, saying the most important thing is whether coverage is affordable, not where people get it.

"There are a number of states that use mechanisms other than high-risk pools to guarantee coverage to people who would otherwise be uninsurable," said Cheryl Fish-Parcham, deputy director of health policy for Families USA. "Those systems are underfunded and need to be able to use federal money to stabilize premiums and keep them affordable."

Sebelius will have to decide quickly how much flexibility to give state officials. One issue that has come up is whether the new law allows expansion of existing state pools, or whether it requires states to create a second pool.

Some believe a second pool may be necessary because federal law requires applicants to have been uninsured for at least six months. However, people in the existing high-risk pools have insurance. That means they may be ineligible for the new program, which is likely to charge lower premiums, according to state officials who have raised the issue with HHS.

"We are concerned that the population in those programs who have done the right thing in buying insurance, regardless of how high the premiums they had to pay were, may very well feel penalized because they bit the bullet and paid the high rates, and then the federal program is more attractive and they don't have access to it," said Bridges-McMurtrey.

Jeanne Lambrew, deputy director of the White House Office of Health Reform, said it was "premature" to say how the issue might be resolved, but that the administration's goal was to be as flexible as possible to get people enrolled quickly.

Another question is whether the federal government is setting aside enough money to cover the program's costs. The law provides \$5 billion to be spent from this year until the new exchanges are running in 2014. But according to the Kaiser Family Foundation, states with high-risk pools collectively spent roughly \$900 million to subsidize excess losses for the 200,000 enrollees in 2008. Health experts say the new pools could attract as many as 2 million people.

The authors of the law gave the agency the right to stop enrolling people if funds run out. But if HHS exercises that power, the administration will face a political backlash.

Hanging over all of these issues is the time pressure. State officials say they are already besieged by calls from citizens seeking information on how to access the new program.

"It honestly is an extremely short window to establish a brand new program when you consider the pieces that have to be in place," said Bridges-McMurtrey. "A lot of work remains to be done."

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