

# Overview of State High Risk Insurance Pools and Catastrophic Health Insurance Plans

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## Health Insurance Pools

Roughly 37 million Americans under the age of 65 do not have adequate health insurance. This problem affects different groups of people for varying reasons. Many people find themselves without health insurance because their employers do not offer coverage, their health insurance plans drop them when they become unemployed, they lose dependent coverage through a spouse, or they fall between the cracks of government plans such as Medicaid and Medicare due to eligibility limitations. Some are offered only partial coverage and are not able to obtain supplemental policies to make their health coverage complete, while still others are plagued with pre-existing, long-term illnesses and are, therefore, categorized as “high-risk” individuals and considered virtually uninsurable by commercial insurance plans.

Currently in Federal and State legislatures there is action to establish health insurance pools for underinsured and uninsurable persons. These programs would provide an opportunity for the hard to insure population to purchase health insurance regardless of circumstance or physical condition, although at a rate considerably higher than those of commercial plans. While it is important to create these opportunities for assistance in purchasing health coverage, the pools are not the solution to the overall problem of insurance coverage for the uninsured and underinsured. Due to the high cost of participation in these health insurance pools, they will not benefit those who cannot afford to purchase health insurance.

Although the plans vary from State to State, the basic pattern is that persons who have been turned down by commercial insurers are eligible for participation. Those receiving government assistance are usually disqualified from participation; ten plans will not accept Medicaid recipients and six plans will not accept Medicare recipients. Seven of the fifteen States, however, have a special supplement plan for beneficiaries of Medicare. A choice of deductibles is usually offered, ranging from \$150 to \$2,000 with correspondingly differing premiums, and a 20-percent coinsurance charge required for all covered expenses. For example, in Connecticut a 35-year-old woman pays quarterly premium rates of \$310.44 for a policy with a 20-percent coinsurance and a \$1,000 deductible.

Typically, all health insurance companies within the State organize and elect one company to administer the plan under regulations established by State law. Even with high premium rates, the premiums are generally insufficient to cover the costs of the claims. Most States cover losses by assessing the health insurance companies in proportion to each company’s share of the State health insurance market, the companies, then, deduct these payments from premium and income taxes. Two exceptions are Illinois and Maine who use general revenue funds and tax hospital patient services revenue, respectively, to cover pool losses.

A major point of contention regarding this legislation is that increasing numbers of employers are opting to insure their employees through employee benefit programs; that is, they are using self-insured plans in lieu of operating through a commercial insurance firm. A group health plan offered by an insurance company is subject to State regulations, while self-insured plans, those which are financed and run by an employer without using an insurance company, have been determined by the U.S. Supreme Court in 1981 to be exempt from State insurance regulations and are, instead, governed by the Employee Retirement Income Security Act (ERISA). ERISA establishes Federal guidelines for employee benefit plans and preempts all State laws that relate to such plans. Self-insured plans, then, are subject to almost no regulations, including State requirements to contribute to the health insurance pool when losses are incurred. Insurance companies claim that this gives employers an incentive to fund their own plans, thereby avoiding State insurance regulatory requirements as well as escaping mandatory participation in health insurance pools. The insurance industry is willing to implement the health insurance pool plan and, in fact, supports the idea, but only if self-insured plans are subject to the same regulations regarding contributions to the pool association. The insurance industry wants Congress to amend ERISA so that self-insured plans are included. Self-insured plans want to maintain the law as it stands now, arguing that the problem of paying for health care for uninsured people is not an employer’s concern but rather one for which society should be responsible.

Legislation has been introduced at the Federal level that would provide incentives for employers to participate in health insurance pools by mandating certain penalty taxes to be applicable to both self-insured plans and commercial plans if either fails to comply with health pool regulations. Senators Dave Durenburger and Donald Reigle are among the leading legislators on this issue, persistently proposing legislation to promote the establishment of health insurance pools. Table B-1 provides a brief synopsis of the major legislative attempts of the 100th Congress regarding health insurance pools. As it is early in the legislative session, more proposals are promised to surface in the following months. Fifteen States have already established health insurance pools. The first programs were established in Connecticut in 1975 and in Minnesota in 1976, followed by Wisconsin and North Dakota in 1981, then Indiana in 1982 and Florida in 1983; plans in Iowa, Montana, and Tennessee began operation in 1987 while the plans in Illinois, Washington, New Mexico, Maine, and Oregon plan to be functioning by 1988. Table B-2 provides a comparison of these plans. Descriptions of each of the State health insurance plans are provided below. Unless otherwise indicated, each plan's benefits include hos-

pital services, professional diagnostic and treatment services (other than dental), skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental of durable medical equipment.

## Connecticut

The Connecticut Comprehensive Health Care Plan was created in 1975 to help meet medical costs of non-occupational injuries and diseases.

## Eligibility

Any State resident, including Medicare recipients under 65 but excluding those eligible for Medicare solely because of age, is eligible for pool membership. There is no waiver of the 12-month waiting period required for an existing medical condition or one treated within 6 months prior to coverage unless the applicant is converting directly from a Connecticut-issued group contract. The group contract must remain in effect and the applicant must have been insured by the group plan for at least a year. Eligibility for the plan differs somewhat from other State plans in that there

**Table B-1.—Congressional Bills on High-Risk Insurance Pools (1987)**

S. 1634: Sen. Durenburger; The Access to Insurance for the Medically Uninsurable Act of 1987

Encourages States to setup pooling mechanisms through a \$10 million grant program. States will receive funds based on their proportionate share of the national population to be used toward establishing health insurance risk pools. The States themselves would be responsible for financing, design, and subsidization of the pools.

S. 177: Sen. Reigle; Health Care for the Uninsured Act of 1987 Permits States to establish health care pools to provide health care services to all uninsured individuals and share among all hospitals in the State the costs of uncompensated care. Requires the implementation of the health care pool at the Federal level where a State does not establish such a program or receive a waiver from the Secretary of Health and Human Services. Uninsured individuals wishing to secure health coverage through the pool will pay a premium for such coverage based on the individual's family income.

S. 1139: Sen. Chafee; MedAmerica Act of 1987

Amends the Social Security Act to give States the option of extending coverage to individuals whose family income does not exceed an income level established by the State at or below 200 percent of the Federal poverty level, who are unable to obtain health insurance coverage from another source by reason of a preexisting medical condition, have exhausted some or all benefits under their health insurance policy, and whose employer employs no more than

25 individuals and is unable to provide adequate health insurance coverage for such individuals at a reasonable cost. Also offers provision to those with catastrophic health expenses who have exhausted private insurance coverage or who have a preexisting condition and are therefore denied by private insurers, by allowing them to purchase Medicaid coverage at full premium with no income adjustment.

H.R. 406: Rep. Roe; National Catastrophic Illness Protection Act of 1987

Establishes a national catastrophic illness insurance program under which the Federal government, State insurance authorities, and the private insurance industry cooperate to make available adequate health protection to all Americans at reasonable cost. State-wide plans providing extended health insurance will be provided and the Federal government will reinsure insurers and pools of insurers who offer such insurance.

H.R. 1182: Rep. Regula; Health Services Act of 1987

Amends Title XIX of the Social Security Act to establish a public/private program providing health services to the medically uninsured. Provides benefits to residents of a State where there exists a Statewide Pooling Corp. and establishes a Federal Health Trust Fund to pay direct grants to such corporations. Employers who are not members of the corporation will be taxed, the revenues going to the trust fund.

**Table B-2.—State High-Risk Insurance Pools Summary of Plans**

State	Enactment date	Plan administrator	Maximum lifetime benefits	Deductibles <sup>a</sup>	Premium caps	Stop/loss	Medicare supplement plan	1986 enrollment	Pool funding
Connecticut	1975	The Travelers	\$1,000,000	\$400 \$1,000 \$1,500	125%, 150%	\$2,000/Individual \$4,000/Family	No	3,101	Insurers assessed, no tax credit
Florida	1983	Mutual of Omaha	\$500,000	\$1,000 \$1,500 \$2,000	200%	Regular \$2,500/Individual; \$5,000/Family \$3,000/Individual; \$6,000/Family \$3,500/Individual; \$7,000/Family Medicare \$1,500/Individual; \$4,000/Family \$2,000/Individual; \$4,500/Family \$1,500/Individual; \$5,000/Family \$1,500/Individual; \$3,000/Family \$500/Medicare recipient	Yes	865	Insurers assessed with tax credit
Illinois	1988	Not awarded	\$500,000	\$250/500/1,000/Individual \$500/1,000/1,500/Family	135%		No	—	General revenues
Indiana	1982	Mutual of Omaha	Plan I—no limit Plan II—\$50,000	\$200 \$500 \$1,000	150%	Plan I \$1,000/Individual; \$2,000/Family Plan II \$1,000/Individual; \$2,000/Family \$1,500/Individual; \$3,000/Family \$2,000/Individual; \$4,000/Family A. \$1,500/Individual; \$3,000/Family B. \$2,000/Individual; \$4,000/Family	No	3,229	Insurers assessed with tax credit
Iowa	1987	Mutual of Omaha	\$250,000	\$500 \$1,000 Others designated by the board	150%		Yes	—	Insurers assessed with tax credit
Maine	1988	Not awarded	\$500,000	Between \$500 & \$1,000	150%	No more than \$1,500/Individual \$3,000/Family	No	—	Tax on hospital patient services revenue
Minnesota	1976	Blue Cross/ Blue Shield	Regular plan \$250,000 Medicare plan \$100,000	\$500 \$1,000	125%	Regular plan—\$3,000/Individual Medicare supplement— \$1,000/Individual	Yes	10,439	Insurers assessed, no tax credit
Montana	1987	Blue Cross/ Blue Shield	\$250,000	Not to exceed \$1,000	150%, 400%	\$5,000/Individual	No	—	Insurers assessed with tax credit
Nebraska	1987	Blue Cross/ Blue Shield	\$500,000	\$250 \$500 \$1,000	135%, 165%	\$5,000	No	67	Insurers assessed with tax credit
New Mexico	1988	Not awarded	None	\$500 \$1,000	150%	\$500 Deductible \$1,500/Individual; \$2,500/Family \$1,000 Deductible \$2,000/Individual; \$3,000/Family	No	—	Insurers assessed, partial tax credit
North Dakota	1981	Blue Cross/ Blue Shield	\$250,000	\$150 \$500 \$1,000	135%	\$3,000/Individual	Yes	1,131	Insurers assessed with tax credit
Oregon	1988	Not awarded	\$1,000,000	Not yet determined	150%	Not yet determined	No	—	Partial insurer assessment
Tennessee	1987	Mutual of Omaha	\$500,000	\$500 \$2,000 Others designated by the board	150%	A. \$1,500/Individual; \$2,500/Family B. \$2,500/Individual; \$3,500/Family	Yes	—	Insurers assessed with tax credit
Washington	1988	Not awarded	\$500,000	\$500 \$1,000	150%	\$500 Deductible \$1,500/Individual; \$3,000/Family \$1,000 Deductible \$2,500/Individual \$5,000/Family Medicare supplement \$1,000	Yes	—	Insurers assessed with tax credit
Wisconsin	1981	Mutual of Omaha	\$500,000	\$500 (Medicare Part A) \$1,000	150%	Plan I \$2,000/Individual; \$4,000/Family Plan II (Medicare) \$500	Yes	1,964	Insurers assessed, no tax credit (subsidy from general revenues)

<sup>a</sup>All plans also have a 40% coinsurance requirement (excepting Nebraska where the coinsurance payment is 10%).

SOURCE: Office of Technology Assessment, 1988.

is no requirement that one must be rejected by a commercial plan prior to applying for membership in the pool. Because of this, the plan attracts many good risks such as those between jobs, recent school graduates not yet employed, and group conversions.

### Payments and Benefits

There is a 20-percent coinsurance required for all covered expenses and deductibles of \$400, \$1,000, and \$1,500 are offered. The maximum lifetime benefit is \$1,000,000. The premium cap is no less than 125 percent initial and no more than 150 percent of the average group premium rate offered for comparable coverage. Stop loss/out-of-pocket expenses are limited to \$2,000 for an individual and \$4,000 for a family. There is no Medicare Supplement Plan, as Medicare beneficiaries are ineligible to participate.

### Administration

The pool is governed by a board of seven individuals selected by participating pool members. The Travelers Insurance Company administers the plan, and there are special provisions for Blue Cross/Blue Shield (BC/BS). In the past, BC/BS operated an identical plan and was not required to pay assessments on the State operated plan. In 1984, however, BC/BS became mutualized and, although it continues to cover its existing policyholders of over 25,000 individuals, it now refers uninsurable to the State pool. All health insurance carriers, including health care service plans, health maintenance organizations authorized to issue insurance in the State, and self-insured employer health benefit plans established in the State after 1976 (however, self-insurers can no longer be obligated to join), are required to be members of the pool and are assessed in proportion to their share of the State insurance market. The enrollment dropped from 4,399 in 1983 to 3,101 as of August 1, 1986. In calendar year 1985, the members shared an estimated loss of \$1,333,000.

### Florida

The 1983 Florida Comprehensive Health Insurance Plan is designed to provide adequate health insurance coverage to those unable to procure coverage in the private market due to their mental or physical condition.

#### Eligibility

To be eligible, an individual must be a Florida resident ineligible for Medicaid who has been rejected by at least two health insurers for similar coverage, or

who has received notice of benefit reduction, condition exclusion, or premium increase exceeding the rate for pool coverage. There is no waiver of the 6-month waiting period for any illness diagnosed or treated within 6-months of policy date.

### Payments and Benefits

Deductibles of \$1,000, \$1,500, and \$2,000 are available, accompanied by a 20-percent coinsurance requirement. There is a \$5,000,000 maximum lifetime benefit and a premium cap of 200 percent of the average plan for comparable coverage. Stop loss/out of pocket expenses can vary from \$2,500 to \$3,500 for an individual and from \$5,000 to \$7,000 for a family. Benefits include limited mental health services and the option to purchase durable medical equipment, but do not include home health care services or oral surgical services. A Medicare Supplement Plan is included.

### Administration

The plan is administered by Mutual of Omaha as of 1986, and is governed by a seven-member board. The board is composed of three members appointed by the Insurance Commissioner (one from the general public, one from medical providers, and one from health insurance agents) and four members appointed by participating insurers (at least one from a nonprofit insurer and one from a domestic insurer). All health insurance carriers, including health care service plans authorized to issue insurance in Florida but excluding health maintenance organizations, are required to participate in the pool. All pool members are assessed in proportion to their share of the State insurance market and can credit their assessments against State premium and income taxes. The number of citizens taking advantage of the pool is low, 1,036 as of December 1986, yet represents a substantial increase from the 49 enrollees in 1983. During the first year of operation the Florida plan was unique in that it recorded no losses. However, by 1985 the 1-year waiting period was changed to 6 months, the enrollment increased and the plan began assessing members for pool losses as do other plans.

### Illinois

The Comprehensive Health Insurance Plan for Illinois was created to provide satisfactory insurance coverage for those unable to purchase traditional health insurance because they are perceived as high-risk persons. The plan passed into law in early 1987 but has postponed the operational date. If appropriations are granted, the plan will open in August 1988.

## Eligibility

All Illinois residents are eligible for pool membership who do not qualify for Medicaid coverage, have been rejected for health insurance coverage for health reasons by an insurance company, or were offered coverage at a rate exceeding the plan's rate. Additionally, those suffering from a condition listed by the plan automatically satisfy eligibility requirements. A waiting period of 6 months is required for pre-existing conditions manifested or treated within 6 months prior to the effective date of coverage. An additional premium of up to 10 percent of the annual premium (to be effective for the life of the contract) can be chosen. This coverage would exclude charges or expenses incurred during the first 2 months of coverage date for any condition manifested or treated within 2 months preceding coverage effectiveness. A group of 10 or less is eligible for membership if one or more of the group meets the above pool criteria.

## Payments and Benefits

A 20-percent coinsurance payment is required in addition to the deductible charge which can be \$250, \$500 or \$1,000 for an individual and **\$500, \$1,000 or \$1,500** for a family. The maximum lifetime benefit is limited to **\$500,000** and the premium is capped at 135 percent. Stop-loss/out-of-pocket expenses are set at \$1,500 for an individual, \$3,000 for a family and \$500 for Medicare recipients. Benefits include hospice care, physical, speech and occupational therapy, and some outpatient mental health coverage. No Medicare Supplement Plan is offered.

## Administration

The plan administrator has not yet been named. A board of 11 people will oversee the plan including representatives from participating insurers, public members, the Illinois Health Care Cost Containment Council, the Office of the Attorney General and members of the General Assembly (nonvoting). Costs of the plan are to be paid from the premiums. If, however, costs exceed the premiums received, the deficit will be paid out of the general revenues of the State.

## Indiana

The Indiana Comprehensive Health Insurance Association was enacted in **1982** to offer health insurance for those residents who find it difficult to obtain or keep health insurance due to a medical condition.

## Eligibility

Any Indiana resident not eligible for Medicare who has been rejected by two health insurers for similar health coverage or who has received notice of benefit reduction, condition exclusion, or premium increase exceeding the rate of pool coverage is eligible for pool participation. There is a 6-month waiting period for a pre-existing condition treated 6 months prior to the policy date, which can be waived on request (for a 25 percent premium increase) if other health insurance was effective immediately before pool coverage began or if application for pool coverage was within 60 days of becoming eligible. Indiana also includes a provision for any individual suffering from a specified illness (e.g., cancer) listed on the premium rate page which merits automatic eligibility for pool coverage.

## Payments and Benefits

In addition to a 20-percent coinsurance requirement, two deductible plans are offered, one with a \$200 deductible, the other with a choice of a **\$200, \$500, or \$1,000** deductible. There is no maximum benefit limit, however, under plan II there is a **\$50,000** benefit cap for mental and nervous disorders. The premium cap is set at 150 percent. Stop loss/out-of-pocket expenses vary by plan: plan I sets \$1,000 for an individual and \$2,000 for a family, while plan II ranges from \$1,000 to \$2,000 for an individual and from \$2,000 to \$4,000 for a family. Benefits include limited mental health services. There is no Medicare Supplement Plan available as Medicare beneficiaries are ineligible to participate.

## Administration

A board of five to nine people oversees the plan, administered by Mutual of Omaha. All health insurance carriers, including health care service plans, health maintenance organizations authorized to issue insurance in the State, and self-insured employer health benefit plans (self-insurers can no longer be obligated to join), are required to participate in the pool association. All pool members are assessed in proportion to their share of the State insurance market and can credit assessments against State premium and income taxes and can increase rates to offset assessment. The Indiana plan has increased its enrollment to **3,229** in 1986 from the 41 people it served during the first year in operation. Calendar year 1985 showed an estimated loss of **\$3,339,000** for the pool.

## Iowa

The Iowa Comprehensive Health Insurance Association began service in 1987.

### Eligibility

All Iowa residents ineligible for Medicaid who have been rejected by one insurer for similar health insurance coverage, or who were only offered health coverage at a rate exceeding the pool rate, are eligible to participate in the pool.

### Payments and Benefits

Along with 20-percent coinsurance, deductibles of \$500, \$1,000 or any other amount authorized by the board are offered. There is a \$250,000 lifetime maximum benefit and a 150-percent premium cap. Stop loss/out-of-pocket expenses vary between plans, with limits of \$1,500 or \$2,000 for an individual and \$3,000 or \$4,000 for a family under plan I and plan II, respectively. Benefits include limited mental health services. A Medicare Supplement Plan is available and provides coverage of at least 50 percent of the deductible and 80 percent of covered expenses, with Medicare plan premiums to be determined by the board.

### Administration

The plan administrator is Mutual of Omaha. Between five and nine people comprise the board, including one public member selected by the Insurance Commissioner and four to eight selected by the members of the association. All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State, are required to be members of the pool. All pool members are assessed in proportion to their share of the State insurance market and can credit assessments against State premium and income taxes.

## Maine

The Maine High-Risk Insurance Organization will be in effect July 1, 1988 for those persons who are unable to obtain health insurance coverage for medical reasons,

### Eligibility

To be eligible for coverage under the risk pool one must be a resident of the State and either be unable to procure adequate coverage or is being charged higher premium prices by the current carrier than those offered in the pool. Those receiving Medicare and

Medicaid benefits are exempt from risk pool coverage. The pool offers major medical expense coverage to every eligible person up until a 300-person maximum enrollment is reached (unless legislative approval is given to expand). A 90-day waiting period is in effect for any condition which was diagnosed or for which treatment or medical advice was sought during the 90-day period preceding the effective date of coverage. The pre-existing-condition waiting period can be waived if similar exclusion stipulations have been met under previous coverage involuntarily terminated if the pool application is made within 31 days following the involuntary termination and no conversion plan is available at equal or less cost than risk pool costs. Additionally, the waiver is granted if \$3,500 has been paid for uncovered medical expenses (exclusive of the deductible) during the 90-day waiting period in which case the remainder of the waiting period will be waived. Also, any person enrolling in the plan during the first 6 months of operation will not be subject to the pre-existing condition waiting period exclusion.

### Payments and Benefits

Deductibles will be *no less* than \$500 and no more than \$1,000. There is a \$500,000 maximum lifetime benefit and premium cap of 150 percent maximum. Stop loss/out-of-pocket expenses are not to exceed \$1,500 for an individual and \$3,000 for a family. No Medicare Supplement Plan is available as Medicare recipients are not eligible for pool coverage. The pool will also subsidize premiums for individuals denied health insurance due to a health condition and who meet income eligibility requirements set by the board. The subsidy plan will be paid from the General Fund and shall not exceed \$50,000 in costs during the first 2 years of operation. No subsidy will be given to a person if the premium amount, after deducting the subsidy, is less than the premium of any comparable individual health insurance policy currently available to that person in the State.

### Administration

The governing board will consist of seven members including two members representing consumers of health insurance not otherwise affiliated with the provision of health care financing, one member representing domestic commercial insurers, one representing nonprofit hospital and medical service organizations, one representing hospitals and one member being the Superintendent of Insurance or a designee from that office. The Maine pool will be financed through the Reserve Fund established to cover any expenses and claims above premium income. The reserve will be

funded by assessing the revenues of all hospitals in the State. The amount of the assessment is not to exceed .0015 percent of all hospitals' gross patient services revenues and will be adjusted annually by the board. However, under the Maine law enacting the risk pool, the pool will cease enrollments and renewals of participants by June 30, 1991 and if the legislature decide to renew the law, the committee with jurisdiction will consider methods of funding the reserve fund other than by assessing the hospitals.

## Minnesota

The Minnesota Comprehensive Health Association was created in 1976 to make the minimum benefits of hospital and medical-surgical expense coverage available to all State residents.

### Eligibility

An eligible individual must be a State resident who has been rejected by one insurer for similar health insurance coverage, or was offered health coverage with a restrictive rider which decreases benefits, or had a preexisting condition limitation within 6 months prior to enrolling in the pool plan. Individuals who have been treated for certain chronic health conditions within 3 years of pool application are automatically eligible for pool coverage regardless of other requirements.

### Payments and Benefits

Deductibles of \$500 and \$1,000 are available and a 20-percent coinsurance payment for all covered services is required. A Medicare Supplement Plan is available. The maximum lifetime benefit for the Medical-Surgical Plan is \$250,000 and \$100,000 under the Medicare Supplement Plan. There is a premium cap of 125 percent, and the stop loss/ out-of-pocket expenses are \$3,000 per person for the Medical-Surgical plan and \$1,000 per person for the Medicare plan. Benefits include well-baby care and the option to purchase durable medical equipment.

### Administration

Blue Cross/Blue Shield is the plan administrator, and the board consists of seven individuals selected by pool members and two appointees of the Governor. All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State, are required to be members of the pool. Self-insurers were previously required to participate but are now exempt be-

cause of ERISA. All pool members are assessed in proportion to their share of the State insurance market. However, members can no longer credit assessments against State premium taxes as that privilege was repealed as of January 1987. This plan served 10,439 people as of May 1, 1986, an increase from 2,918 in 1981. \$5,507,000 of estimated pool losses were reported in calendar year 1985.

## Montana

The Montana Comprehensive Health Association, operational in July 1987, was created to provide adequate health insurance coverage to all State residents otherwise considered uninsurable.

### Eligibility

All State residents who have been rejected by two health insurers or who have had restrictive rider or pre-existing condition limitations imposed by two insurers within 6 months prior to pool application are eligible for pool participation. There is no waiver for the 12-month waiting period established for any pre-existing condition diagnosed or treated during the past 5 years immediately preceding pool application. An individual who had continuous coverage under a policy during the previous year is exempt from the pre-existing condition clause.

### Payments and Benefits

Deductibles are not to exceed \$1,000 in addition to the 20-percent coinsurance requirement. The lifetime maximum benefit is \$250,000. The premium cap is set at no less than 150 percent and no more than 400 percent, the stop loss/out-of-pocket expense is set at \$5,000 for an individual. Benefits include the option to purchase durable medical equipment but do not include skilled nursing facility services. There is no Medicare Supplement Plan, even though the law does not specifically prohibit participation by Medicare beneficiaries.

### Administration

The plan administrator is Blue Cross/Blue Shield. The board is comprised of eight members, one from each of the seven participating members with the highest annual premium volume of disability insurance or health service contracts, and one member appointed by the Insurance Commissioner to represent the public interest and who serves in an advisory capacity. All health insurance carriers, including health care service plans and health maintenance organizations au-

thorized to issue insurance in the State, are required to be members of the pool. All pool members are assessed in proportion to their share of the State insurance market and can credit assessments against the State premium tax.

## Nebraska

The Nebraska Comprehensive Health Insurance Pool, operational in **1987**, was established to provide health insurance coverage to all State residents regardless of pre-existing medical conditions.

### Eligibility

All persons who have been State residents for at least 6 months, who are ineligible for Medicare, Medicaid, or other medical assistance and who, within 6 months prior to applying to the pool, were rejected by one health insurer or had coverage with a restrictive rider which limits coverage for more than 12 months, and those individuals with coverage at a rate higher than the pool rate, are eligible for coverage. A waiting period of 6 months is required for any condition which manifested itself during the 6-month period preceding the policy date, but a waiver is provided if similar exclusions have been satisfied under prior health insurance coverage (the board may assess an additional premium of up to 10 percent for this waiver).

### Payments and Benefits

Deductibles of \$250, \$500, and \$1,000 are offered, with a 10-percent coinsurance required for all covered expenses. A **\$500,000** maximum lifetime benefit is set. There is a premium cap of no less than 135 percent and no more than 165 percent. Stop loss/out-of-pocket expenses are set at \$5,000. Benefits include limited mental health services and the option to purchase durable medical equipment, but do not include oral surgical services. There is no Medicare Supplement Plan, as Medicare beneficiaries are ineligible to participate.

### Administration

Blue Cross/Blue Shield is the plan administrator, and the board is comprised of nine members, including at least one representative of a domestic insurance company, one representative of a domestic hospital service corporation plan, one representative of a health maintenance organization, and one representative of the general public. All health carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State, are required to be members of the pool. All pool members

are assessed in proportion to their share of the State insurance market and can credit assessment against the State premium tax. During the plan's first year of operation, it served **67** people.

## New Mexico

The New Mexico Comprehensive Health Insurance Pool, scheduled for operation by January **1988**, was created to assist all State residents considered uninsurable or who are denied adequate health insurance.

### Eligibility

Those State residents having received a rejection of health insurance coverage, a rate increase exceeding the pool rates, or a reduction or limitation of coverage (including a restrictive rider), and do not qualify for Medicare or Medicaid benefits are eligible for pool coverage. The plan enforces a 6-month waiting period for those conditions that manifested themselves within 6 months prior to pool coverage or for which medical advice or treatment was sought within 6 months before coverage was effective. Unique to the New Mexico Plan is a conversion provision for those moving to New Mexico from a State where they were covered under the State health insurance pool. If application for pool coverage is completed within 31 days after the termination of the other policy and premiums were paid for the entire coverage period, the effective date of the new coverage will be the termination date of the previous coverage. If waiting period stipulations were satisfied and benefit limitations were not reached under the previous plan then the waiting period under the new plan is waived.

### Payments and Benefits

Deductibles of **\$500** or **\$1,000** are offered unless otherwise approved by the board. There is no maximum lifetime benefit and the premium is capped at **150** percent. The stop loss/out-of-pocket costs are \$1,500 for an individual and \$2,500 for a family under the \$5W deductible plan and \$2,000 or \$3,000 for an individual or family respectively under the \$1,000 deductible plan. No Medicare Supplement Plan is included in the New Mexico Pool. Another unique feature of the New Mexico Plan is the provision stating that employers are authorized to "make a payroll deduction from the compensation of an employee for the portion of the pool policy premium the employee is responsible for, and an employer shall contribute the same dollar amount of the cost of that policy on behalf of the employee that the employer contributes for other similar employees for health insurance."

## Administration

The 10-member board composition will include the Superintendent or his designee, one representative from a nonprofit health care plan, one from an HMO, and two representatives from members of the pool, all 4 of which will be appointed by members of the pool. Additionally, the Superintendent will appoint five members including one representative of Statewide health planning and four citizens not professionally affiliated with an insurer, two of which will be individuals qualifying for coverage under the pool. Pool losses are assessed to all members yet no credit will be given on future taxes until one member's assessment reaches \$75,000 per year at which point the member will receive a 30-percent tax credit for the amount paid over \$75,000.

## North Dakota

In 1981 North Dakota created The Comprehensive Health Association to provide health coverage for those denied health insurance, given only restricted coverage due to health problems, or who were considered to be in a high risk category.

## Eligibility

Any individual who has been a North Dakota resident for at least 6 months and who has written evidence of rejection by one insurer or a restrictive rider or a pre-existing condition limitation from at least one insurer within 6 months prior to the date of enrollment is eligible for pool membership. There is a 6-month waiting period for any condition diagnosed or treated within 90 days prior to the policy date. The waiting period can, however, be waived upon payment of an additional premium or proof of continuous coverage for the 12-month period immediately preceding the contract date.

## Payments and Benefits

Along with the required 20-percent coinsurance, deductibles of \$150, \$500, and \$1,000 are offered. The maximum premium cap is set at 135 percent. The maximum lifetime benefit is **\$250,000**. The stop loss/out-of-pocket expense is limited to **\$3,000** for all deductibles. Benefits include the option to purchase durable medical equipment. A Medicare Supplement Plan is offered.

## Administration

Blue Cross/Blue Shield of North Dakota administers the plan. Ten board members, 1 from each of

the 10 insurers with the highest annual premium volumes, govern the association. All health insurance carriers are required to participate. This includes all health care service plans authorized to issue insurance in the State, although health maintenance organizations are excluded. All pool members are assessed in proportion to their share of the State insurance market and can credit assessment against State premium and income taxes. This plan served 1,131 people as of May, 1986, an increase from the 78 people served during its first full year of operation,

## Oregon

The Oregon Medical Insurance Pool was created to offer health insurance coverage to all State residents denied adequate medical insurance while also avoiding undue financial impact on the State and private insurers. The plan is scheduled to go into effect in the Spring of 1988.

## Eligibility

Those applying for pool coverage must be residents of Oregon ineligible for Medicaid and Medicare and have proof from an insurer of an adverse underwriting decision on medical insurance for health reasons, proof of a history of any medical or health condition on the list adopted by the board (the board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without proving that they were denied medical insurance), or must be a spouse or dependent of a person described under this eligibility. A six-month pre-existing condition waiting period is enforced for any condition for which treatment, care, or medical advice was sought within the six-month period preceding the effective date of pool coverage. The pre-existing condition waiting period can be waived if similar exclusions have been satisfied under prior health insurance involuntarily terminated, provided pool application is made within 60 days following the involuntary termination.

## Payments and Benefits

The deductibles and stop loss/out-of-pocket expenses have not yet been determined by the board although a maximum lifetime benefit of \$1,000,000 and a premium cap of **150 percent initial maximum** have been set. No Medicare Supplement Plan will be offered.

## Administration

The board will be composed of seven members selected by pool members. The commissioner or a designee

nee will serve as the chair of the board. Other members will include at least one representative of a domestic insurance company licensed to transact **health insurance**; **one representative** of a domestic not-for-profit health care service contractor; and one member of the general public not associated with the medical profession, a hospital, or an insurer. The members of the Oregon pool will consist of all insurers issuing medical insurance within the State and, to the extent Federal law allows, self-insurance arrangements either covered or not by ERISA, including governmental and church plans. The plan Administrator has not yet been named. Deficits incurred under the risk pool will be paid by the State. Members of the pool may be assessed for an amount not to exceed \$10,000 to cover initial operating expenses. However, the plan has a built-in protection against losses to the pool. While benefits and premiums will be adjusted annually, pool losses are to be kept at under 1 percent of the total of all medical insurance premiums, subscriber contract charges, and 110 percent of all benefits paid by member self-insurance arrangements. The board can also place a ceiling on the maximum number of persons enrolled.

## Tennessee

The Tennessee Comprehensive Health Insurance Pool, created in 1986 and effective in July 1987, was established to provide health insurance coverage to State residents denied adequate health insurance for any reason.

### Eligibility

All residents not eligible for Medicaid and who have been rejected for similar coverage by one health insurer are eligible for pool coverage. There is no waiver for the 6-month waiting period for any condition which manifested itself *or* was treated within 6 months prior to the policy date.

### Payments and Benefits

Deductibles of \$0, \$2,000, and any other offered by the board will be available, with a 20-percent co-insurance for all covered expenses required. The premium cap is set at 100 percent. The maximum lifetime benefit is **\$100,000**. The stop loss/out-of-pocket expenses range from **\$1,500 to \$2,500** for an individual and from **\$2,500 to \$3,500** for a family, depending on the plan. Benefits include limited mental health services and the option to purchase durable medical equipment. A Medicare Supplement Plan will be offered.

## Administration

Mutual of Omaha administers the plan. The board is composed of nine members, with at least one representative of a domestic insurance company; a foreign insurance company; a domestic non-profit health care service plan; a health maintenance organization; a member from a health-related profession; one member from the general public not associated with the medical profession, a hospital, or an insurer; and one member to represent a group considered to be uninsurable. All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State, are required to participate in the pool association. If premiums do not cover costs, all pool members will be assessed in proportion to their share of the State insurance market and can credit assessments against the State premium tax.

## Washington

The Washington State Health Insurance Pool began operating in January 1988 to assist all State residents denied adequate health insurance.

### Eligibility

Any Washington resident is eligible for pool participation who does not qualify for Medicaid coverage and has proof of rejection for health insurance coverage from at least one insurer or who has insurance with a restrictive rider or a pre-existing condition limitation which reduces the coverage from a standard risk within 6 months of the date of application. There is a 6-month waiting period for any condition for which advice or treatment was sought within 6 months before the effective date of coverage. The pre-existing condition clause can be waived if the individual applies for membership within 30 days of being involuntarily terminated from prior coverage under which similar exclusion stipulations were met.

### Payments and Benefits

Deductibles of \$500 and \$1,000 (or an amount approved by the board) are offered. The maximum lifetime benefit is \$100,000 and the premium cap is set at 100 percent. The stop loss/out-of-pocket expenses are \$1,500 for an individual and \$3,000 for a family for those who choose the \$500 deductible plan, **\$2,500** for an individual and **\$3,000** for a family for those on the \$1,000 deductible plan, and \$1,000 for an individual on the Medicare Supplement Plan.

## Administration

The pool is governed by a nine-member board. A representative of health care providers, health insurance agents, and the general public will be appointed by the commissioner. The remainder of the board is selected by the pool members and includes at least one health care service contractor, one representative of a health maintenance organization, and one representative of commercial insurers providing disability insurance. Self-insurers will be included as soon as Federal law permits their participation. Pool members are assessed for any deficits incurred through the plan for which they will receive full tax credit on future taxes owed to the State.

## Wisconsin

The Wisconsin Health Insurance Risk Sharing Plan was created in 1981 to provide health insurance for those unable to find adequate health insurance coverage due to their mental or physical condition.

### Eligibility

All Wisconsin residents who have been rejected by one health insurer or who have received notice of benefit reduction or a 50 percent or more premium increase are eligible for pool membership. There is no waiver of the 6-month waiting period for any condition diagnosed or treated in the 6 months preceding the plan. Effective April 21, 1988, Medicaid recipients can buy into the pool. This allows pool benefits to act as a supplementary coverage net to the primary assistance provided by Medicaid.

### Payments and Benefits

Two deductible plans are offered, one for \$1,000 and the other for \$500 under Medicare Part A. A 20-percent coinsurance payment is required for all services. There is a 150-percent maximum premium cap and a \$500,000 maximum lifetime benefit. Stop loss/out-of-pocket expenses vary by plan but range from \$500 (Medicare) to \$2,000 for an individual, but is set at \$4,000 for a family. Wisconsin has set aside revenue funds to subsidize premium payments and deductible costs. Policy holders with annual incomes below \$16,000 can apply for subsidies to cover from 17 to 33 percent of premium costs and a reduces deductible of \$500 to \$900, depending on income bracket. Benefits include limited mental health services and the option to purchase durable medical equipment. The Medicare Supplement Plan is for those under 65 and receiving medical assistance.

## Administration

Mutual of Omaha is the plan administrator. The board is composed of nine members, including two participating insurers from nonprofit corporations, two other participating insurers, three public members (two of whom could qualify for coverage in the pool), a health policy council representative, and the Insurance Commissioner or a representative from the commissioner's office. All health care carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State, are required to be pool members (self-insurers can no longer be obligated to join). All pool members are assessed in proportion to their share of the State insurance market but can no longer credit assessment against the State premium tax. Effective January 1988, the State instigated a subsidy to policy holders in the form of \$200,000 in tax relief from general revenues. This is used to moderate deductibles and cost sharing expenses for those in need of pool services yet unable to meet the pool costs. As of May, 1986, this plan assisted 1,964 individuals, an increase from the 309 participants in 1981.

## Catastrophic Health Insurance Plans

Unlike health insurance risk pools, plans established to offer coverage for those unable to procure adequate health care coverage elsewhere, catastrophic plans simply supplement already existing insurance plans. Catastrophic Health Insurance Plans (CHIPS) are operated by State Departments of Human Services and are generally used as a last resort source of funds to help pay for forbiddingly high medical bills. If medical costs financially drain a family to the point where their customary standard of living can no longer be maintained, a catastrophic plan can be purchased. After satisfying a deductible, the CHIP will pay the balance of expenses that private insurance will not cover. Deductibles are determined by a formula sensitive to the income of the applicant; a State may require a deductible of, for example, \$2,500 plus 10 percent of the annual net income. Deductibles are usually set as per family rather than per capita requirements, although there have been exceptions. The costs are pro-rated in that those with no insurance pay much higher deductibles than those with private insurance policies, and Medicare recipients pay the least amount. The deductible screens out a majority of people, and of those remaining with high expenses, many are already covered by Medicare, Medicaid, and private sector health plans. Approximately 10 percent of the population has no coverage, and about half of the people with pri-

vate insurance have catastrophic stop-loss coverage, so these people generally are the ones to take advantage of the catastrophic plans. Also, the non-poor elderly may have high enough expenses not covered by Medicare to qualify for CHIP membership. As for State expenses, when spreading the costs across the residents of the State, per capita costs hover around \$2.00.

CHIP participation has been low; in **1986** the enrollment in Rhode Island was 624 and in Maine was 57. Although a few States have attempted catastrophic plans, only one, Rhode island, has been successfully

maintained. Rhode Island has the model CHIP in that it is the oldest (effective since 1975) and the sole plan able to continue service. Maine, Minnesota, and Alaska each had programs but lost appropriations and folded. The now defunct programs hope to be refunded but none received allocations for fiscal years 1988 and 1989. New Jersey passed a law in early 1988 to establish a Catastrophic Illness in Children Relief Fund. The program is based on the same principles of a CHIP yet is extremely limited in its service in that only children under **18** years of age are eligible for membership.