

Medically Eligible

Most state high-risk pool enrollees are medically eligible for coverage. Typically, people are considered medically eligible or uninsurable if they have been turned down or charged substantially higher premiums for coverage, or have been offered private coverage that does not cover services for pre-existing conditions. People who are offered an insurance policy in the individual market that costs more than what is available for a similar level of coverage in the high-risk pool are also usually eligible for coverage.

Health Insurance Portability and Accountability Act Eligible (HIPAA)

HIPAA guarantees the right for individuals to purchase individual coverage with no pre-existing condition exclusions when they leave group health coverage. To be HIPAA-eligible, a person must have at least 18 months of prior coverage, not interrupted by a gap of more than 63 days in a row, and the last day of prior coverage must have been in a group health plan. They also must elect and exhaust COBRA coverage. Twenty-eight states use high-risk pools to comply with HIPAA requirements. Other states comply with

HIPAA requirements by guaranteeing coverage in the individual market or with the individual's prior group coverage insurance carrier. According to the Government Accountability Office, 28 percent of high-risk pool enrollees were HIPAA-eligible in 2008.⁵

State Snapshot

High-risk pools in **20 states** are open to all three of the following eligibility categories: Medically- Eligible, HIPAA-Eligible, and Health Coverage Tax Credit-Eligible.³

California, Tennessee, and Washington: State high-risk pools are only open to people who are medically eligible for coverage.⁴

Health Coverage Tax Credit Eligible (HCTC)

In order to be eligible for the Health Coverage Tax Credit (HCTC), people must receive Trade Readjustment Allowance benefits⁶, will receive these benefits once unemployment benefits are exhausted, or are age 55 and older and receive benefits from the Pension Benefit Guarantee Corporation. The HCTC program helps pay for nearly two-thirds of eligible individuals' health plan premiums. Twenty-one states currently designate their high-risk pool for their HCTC program. Only 0.3 percent of high-risk pool enrollees were HCTC-eligible in 2008.⁷

Specified Medical Conditions

Having certain health conditions, such as HIV/AIDS, cancer, or diabetes, may qualify people for state high-risk pools. In states that allow people with specified medical conditions to obtain high-risk pool coverage, the number of qualifying conditions in 2008 ranged from three to 88 conditions.⁸ However, only half of state high-risk pools have this eligibility category.

What benefits do people receive through state high-risk pools?

The benefits provided through state high-risk pool insurance plans are typically comprehensive and comparable to benefits provided under private health insurance. Most plans include inpatient and outpatient services and prescription drugs. HIPAA also contains requirements regarding the comprehensiveness of health plans offered to HIPAA-eligibles.

Pre-Existing Condition Exclusions and Waiting periods

Thirty state high-risk pools have waiting periods before pre-existing medical conditions can be covered. This waiting period ranges from two to 12 months, and is typically six or 12 months. However, health plans that provide coverage to HIPAA-eligible individuals cannot impose pre-existing condition exclusions on those individuals. Pre-existing condition exclusions and waiting periods create a major barrier to receiving needed health care services. The primary reason

people seek coverage through a state high-risk pool is because they cannot obtain affordable coverage for their pre-existing condition in the individual market. For people with serious chronic conditions, going without care for a period of time can be detrimental to their health.

Benefit Limitations

While most of the state high-risk pools do not have an annual limit on covered benefits, almost all high-risk pools impose lifetime limits on coverage. Five states—**California, Louisiana, Tennessee, Utah, and West Virginia**-- have annual medical maximums that range from \$75,000/year in **California** to \$300,000/year in **Utah**.⁹ The lifetime benefit maximum ranges from \$625,000 in **Louisiana** to \$5 million in **Minnesota** and in some plans in **Florida**. In twelve states the lifetime maximum benefit is \$1 million.¹⁰ For people with high health care needs, the benefits they receive could easily exceed the maximum benefit level in some states.

Some pools have an annual maximum on specific health care services, such as radiology and chemotherapy. According to the Government Accountability Office, approximately 18 percent of enrollees in the 34 most popular high-risk pools plans in 2008 had coverage that did not cover maternity care. Additionally, three percent of enrollees were in plans that did not cover mental health services.¹¹

How much do people in state high-risk pools pay for coverage?

Premium Costs

Premium costs for coverage in state high-risk pools vary by state and health plan (Table 1). Almost all states base premium costs on the standard cost for underwritten individual market health insurance plans (referred to as the standard market rate). Coverage typically costs between 125 and 200 percent of the standard market rate for health insurance. Premium rates also vary by different personal characteristics. Most states allow variation in rates by age and gender, and some states permit rate variation based on smoking status, geography, income, length of time in the high-risk pool, prior continuous coverage, and health status.

State Snapshot

California, Minnesota & Oregon: Premium costs are capped at 125% of the standard market rate for coverage.¹²

In thirteen states, premium costs are capped at 200% of the standard market rate for coverage.

Premium costs for plans purchased through state high-risk pools have been increasing over time. From 2002 to 2010, monthly premiums increased by at least 50 percent in 15 states. As of January 2010, state high-risk pool premiums ranged from an average of less than \$550/month (\$6,600/year) in four states to over \$1,200/month (14,400/year) in two states.¹³

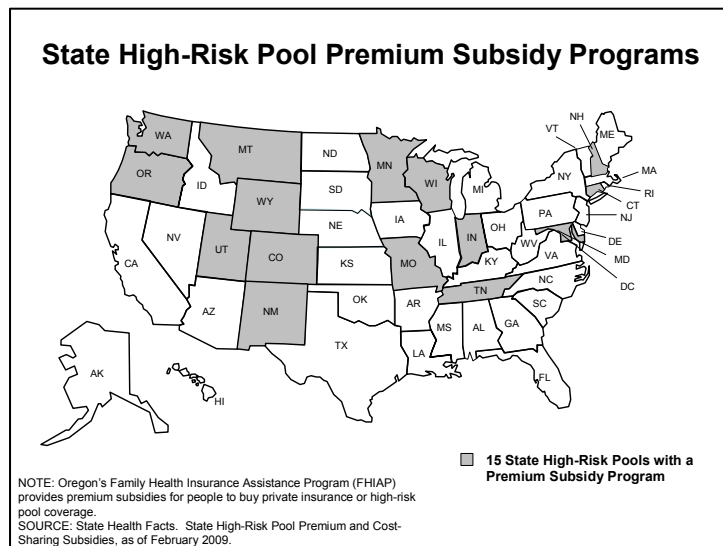
Annual Deductible and Out-of-Pocket Costs

State high-risk pools typically offer four to eight health plans through contracts with private health insurers. The annual deductible ranges based on the benefit design, but as of January 2010, the lowest annual deductible option is at least \$1,000 in 18 states.¹⁴ In 2008, the average deductible for the most popular plan in each state was \$1,593. According to the Government Accountability Office, over half of all high-risk pool enrollees had annual deductibles between \$1,000 and \$3,000, and eighteen percent of enrollees had annual deductibles of \$5,000 or greater.¹⁵

The deductible helps determine the out-of-pocket costs that enrollees are required to pay in addition to the premium, but these costs can be difficult to measure. According to the Government Accountability Office, over two-thirds of enrollees in the most popular plan in each state had annual out-of-pocket spending limits that ranged from \$2,000 to \$7,000 in 2008. Nearly 7 percent of enrollees in the most popular plans had out-of-pocket limits of \$7,000 to \$10,000.¹⁶

Do subsidy programs exist to help low-income individuals afford state high-risk pool coverage?

High-risk pools in 15 states offer premium subsidies for low-income individuals (Table 1). However, eligibility for subsidy programs varies by state, which impacts state enrollment. In **New Mexico**, premium discounts of 75 percent are given to people with income below 200 percent FPL, a 50 percent discount is given to people with income between 200 and 300 percent FPL, and a 25 percent discount is given to people with income between 300 and 400 percent FPL.¹⁷ According to the Government Accountability Office, over 40 percent of all **New Mexico** high-risk pool enrollees were in the low-income premium discount program in 2008.¹⁸



Colorado offers one level of premium subsidies to people with incomes below \$40,000 and another premium subsidy for those with income between \$40,000 and \$50,000.¹⁹ In 2008, nearly 40 percent of **Colorado** high-risk pool enrollees received premium subsidies.²⁰ In **Washington**, premium discounts of up to 30 percent are provided to people with income at or below 250 percent FPL and a 15 percent discount is given to people with income between 251 and 300 percent FPL.²¹ Less than one percent of **Washington** high-risk pool enrollees were in the premium discount program in 2008.²² High-risk pools in three states (Connecticut, Maryland, and Wisconsin) provide cost-sharing subsidies.

Table 1.
34 State High-Risk Pools

	Enrollment (as of 12/31/08)	Pre-Existing Condition Exclusion Period	Statutory Premium Cap as % of Standard Rates	Pool Offers Premium Subsidies ^b	Percent of Total Cost Paid by Premiums
United States	199,020	n/a	n/a	15	n/a
Alabama	2,653	0 months ^c	200%		76%
Alaska	469	6 months	150%		57%
Arkansas	3,061	6 months	150%		70%
California	7,036	3 months	125%		96%
Colorado	8,543	6 months	150%	x	50%
Connecticut	2,336	12 months	150%	x	62%
Florida	300	n/a	250%		57%
Illinois	15,682	6 months	150%		67%
Indiana	6,561	3 months	200%/150% ^h	x	50%
Iowa	2,732	6 months	150%		47%
Kansas	1,830	3 months	150%		51%
Kentucky	4,458	12 months	175%		45%
Louisiana	1,110	6 months	200%		71%
Maryland	15,180	2 months	200%	x	37%
Minnesota	27,386	6 months	125%	x	45%
Mississippi	3,464	12 months ^d	175%		76%
Missouri	2,999	12 months	150%	x	77%
Montana	2,995	12 months	200%/150 ⁱ	x	67%
Nebraska	5,089	6 months	140%		53%
New Hampshire	1,094	9 months	150%	x	47%
New Mexico	6,020	6 months	150%	x	24%
North Carolina ^a	n/a	12 months ^e	200%		n/a
North Dakota	1,463	6 months ^f	135%		69%
Oklahoma	2,098	12 months	150%		58%
Oregon	15,320	6 months	125%/100% ⁱ	x ^k	48%
South Carolina	2,328	6 months	200%		88%
South Dakota	653	0 months ^c	150%		74%
Tennessee	4,516	6 months ^g	200%	x	79%
Texas	26,908	12 months	200%		70%
Utah	3,715	6 months	200%	x	67%
Washington	3,397	6 months	150%	x	33%
West Virginia	653	6 months	150%		106%
Wisconsin	16,284	6 months	200%	x	61%
Wyoming	687	12 months	200%/135% ^l	x	53%

SOURCE: Kaiser Family Foundation: State Health Facts. Statehealthfacts.org
 Enrollment: State High-Risk Pools Programs and Enrollment, December 2008.
 Pre-Existing Condition Exclusion Period: State High-Risk Pool Pre-Existing Condition Exclusion and Look-Back Periods, January 2009.
 Statutory Premium Cap as Percent of Standard Rate: State High-Risk Pool Rating Rules, January 2010.
 Pool Offers Premium Subsidies: State High-Risk Pool Premium Subsidies, December 2008.
 Percent of Total Cost Paid by Premiums: State High-Risk Pool Costs, December 2008.
 Additional notes related to this table can be found in the endnotes section.²²

HIGH-RISK POOL ADMINISTRATION

How are state high-risk pools governed and how much do they cost to operate?

High-risk pools are governed by an appointed board of directors, representing various stakeholders including legislators, health insurers, health care providers, and consumers. Board members may be appointed by the state insurance commissioner, the governor, or another public official. The size of the board ranges from three members in **Florida** to 15 members in **Kentucky**.²⁴

State high-risk pools are costly to operate, primarily because they serve a high health-risk population that utilizes a greater number of services. In 2008, over \$2.01 billion was spent on 199,020 high-risk pool enrollees nationwide.²⁵ According to NASCHIP, the average health care claim cost per risk-pool participant was approximately \$8,650 per year (\$720/month) in 2007.²⁶ According to the Government Accountability Office, the average claim cost per enrollee was \$9,437 in 2008.²⁷ These average claim costs exceed the 2006 Medicare per enrollee claim cost of \$8,304.²⁸ Unlike in other insurance markets, premiums paid by enrollees do not come close to covering all of the costs of state high-risk pools (Table 1). In 2008, the premiums that were collected covered at least 50 percent of total program costs in 23 states.²⁹ However, it ranged from 24 percent of total costs in **New Mexico** to 106 percent in **West Virginia**.³⁰

State Snapshot					
Percent of Total High-Risk Pool Cost Paid By Premiums, 2008					
<u>New Mexico</u>	<u>New Hampshire</u>	<u>Nebraska</u>	<u>Illinois</u>	<u>Alabama</u>	<u>West Virginia</u>
24%	47%	53%	67%	76%	106%

Because premiums do not cover all of the operating costs, states must raise additional funds from other sources. These funding sources vary by state but generally include assessments on insurance companies, general revenues, and designated funds. Twenty-seven high-risk pools assess health insurers and Health Maintenance Organizations for at least a portion of their funding.³¹ Some states fund their high-risk pool using income taxes, premium taxes, or state tobacco settlement funds. Two states, **Maryland** and **West Virginia**, have an assessment on hospitals.³²

Do states receive federal funding for state high-risk pools?

The first federal grant program for state high-risk pools was established in the Trade Adjustment and Assistance Act of 2002. In February 2006, former President Bush extended and expanded this program by signing the State High-Risk Pool Funding Extension Act of 2006. The legislation authorized \$75 million for fiscal year 2006 through fiscal year 2010. Of this total funding, \$50 million is divided among high-risk pools based on a distribution formula. A portion of the funding is distributed equally among the high-risk pool programs, and the remaining funding is allocated based on state rankings of the number of uninsured people per state and the number of enrollees that were in each state high-risk pool during the previous year.³³ The remaining \$25 million is used as bonus grants for states to support various program components including: expanding eligibility, reducing premiums and cost-sharing, and for premium subsidy programs for the low-income population. In order to be eligible for a CMS grant, state high-risk pools must follow one of the two models in the NAIC Model Health Plan for Uninsurable Individuals Act.³⁴ The program is administered by the Centers for Medicare and Medicaid Services (CMS) Center for Medicaid and State Operations.

BENEFITS OF STATE HIGH-RISK POOLS

The existence of state high-risk pools can be extremely valuable for individuals, especially for those with chronic conditions and high health care costs. State high-risk pools provide a safety net of coverage for people who cannot obtain affordable coverage in the individual market. State high-risk pools can also serve as a source of transitional coverage or to fill gaps in coverage for people who for various reasons, including loss of employment, are between group and individual coverage. Some of these high-risk pool plans provide comprehensive benefits that truly help people with chronic conditions obtain and afford health care services. Additionally, because high-risk pools plans have premium caps, premium costs for those with high health care needs may be lower than what they would otherwise pay in the individual market.

HIGH-RISK POOL CHALLENGES

Enrollment in state high-risk pools has been extremely low. Nearly 200,000 individuals are enrolled in the 34 programs across the country, representing a very small percentage of the total insured population. Low enrollment in high-risk pools is primarily attributable to the high cost of coverage. Coverage typically costs between 125 and 200 percent of the standard market rate and out-of-pocket costs can be substantial. Many individuals may not be able to afford to purchase coverage through high-risk pools. Additionally, because premiums can vary based on demographic characteristics, some people, including women and those who are older, may pay even higher premiums.

High-risk pools are also extremely expensive for states to operate. Because most states do not have sufficient funding to cover everyone who needs coverage, states are forced to implement enrollment caps and strict eligibility requirements, purposely limiting enrollment. Although the **California** high-risk pool does not currently have a wait list, it had a wait list for most of its existence because state funding comes from tobacco taxes. Enrollment is currently capped at 7,100 enrollees. **Illinois** also had a wait list in 2004 and 2005 and **Florida's** high-risk pool has been closed to new enrollment since 2001. Nationally, the Government Accountability Office estimates that 3.97 million people may be eligible for state high-risk pools based on their uninsured status and pre-existing health conditions.³⁵

HIGH-RISK POOLS AND HEALTH REFORM

Health reform legislation passed in the House of Representatives on November 7, 2009 and in the Senate on December 24, 2009, creates new avenues for providing health coverage in the United States. However, many of the major coverage provisions in the bills would be implemented in 2013 or 2014. In order to help people obtain coverage prior to the implementation of coverage reforms, the bills establish temporary high-risk pool programs to provide immediate health coverage to certain people and their dependents. However, the structure and eligibility requirements for the temporary high-risk pools vary between the bills (Table 2). In establishing high-risk pools, the legislation seeks to address some of the challenges state high-risk pools currently face.

Affordable Health Care for America Act (H.R. 3962)³⁶

The bill passed by the House of Representatives would establish a national temporary high-risk pool as a mechanism for providing coverage to the uninsured and to those with pre-existing medical conditions. Eligibility for the national high-risk pool would be relatively broad and would include U.S. citizens and legal immigrants who have been denied coverage; offered

unaffordable coverage; offered coverage that does not cover a pre-existing condition; have an eligible medical condition; are in the Medicare waiting period; have retiree coverage and the annual premium increase exceeds a percentage set by the Secretary; are not eligible for public programs or have not had employer-sponsored insurance for at least six months.

To make coverage for this population more affordable, the bill sets premiums at no higher than 125% of the prevailing rate for comparable coverage in the state, premiums can vary by no more than 2 to 1 due to age, and are adjusted for geographic variation in costs. Annual deductibles would be limited to \$1,500 for an individual, cost-sharing would be limited to \$5,000 for individuals and \$10,000 for families, and there would be no annual or lifetime limits on benefits. The plan would prohibit the exclusion of pre-existing conditions and the benefits provided in the high-risk pool would be consistent with the basic categories in the essential benefits package that would be required in all health plans.

The temporary national high-risk pool would be administered by the Secretary of the U.S. Department of Health and Human Services, most likely through contracts with state high-risk pools, other state programs, or private health plans, provided that they meet the requirements outlined in the bill. State high-risk pools that were in effect as of July 1, 2009, but no longer operate after the temporary high-risk pool is established, are required to maintain payments equivalent to what they were previously paying toward their state high-risk pool. In state-high risk pools that currently require health insurance issuers to contribute to the funding of their high-risk pool, the state will maintain this contribution arrangement with the issuers. The legislation appropriates \$5 billion to pay for health care claims and administrative costs that exceed the premiums collected for the high-risk pool. This national high-risk pool is scheduled to go into effect on January 1, 2010 and terminate when the National Health Insurance Exchange is established in 2013.

Patient Protection and Affordable Care Act (H.R. 3590)³⁷

The bill passed by the Senate on December 24, 2009, would also create a temporary national high-risk pool, but eligibility would be limited to those with pre-existing health conditions. U.S. citizens and legal immigrants who have not had creditable coverage for the previous six months and have a pre-existing health condition would be eligible for coverage.

The bill sets premiums at the prevailing rate for comparable coverage, allows premiums to vary by age (4 to 1), geographic area, family composition, and tobacco use. Health plans must have an actuarial value of at least 65% and limit out-of-pocket spending to \$5,950 for individuals and \$11,900 for families. The plan would not exclude coverage of pre-existing conditions. However, the bill does not include any information on the level of benefits that would be provided.

The temporary high-risk pool would be administered by the Secretary of the U.S. Department of Health and Human Services, most likely through contracts with states, including existing state high-risk pools, or non-profit entities. States with existing high-risk pools that contract to offer the temporary high-risk pool must maintain current payments. The standards established under the bill would supersede any state law or regulation (except for state licensing laws and state laws related to plan solvency). The Secretary would have the authority to stop accepting applications for enrollment in the high-risk pool program if costs exceed available funding. The legislation appropriates \$5 billion to pay for health care claims and administrative costs that exceed the premiums collected for the high-risk pool. This high-risk pool program is scheduled to go into effect 90 days following the enactment of the bill and terminate on January 1, 2014 when the state-based American Health Benefit Exchanges are established.

**Table 2.
High-Risk Pool Provisions Under Health Reform Legislation**

	House Bill	Senate Bill
Eligibility	U.S. citizens and legal immigrants who have been denied coverage; offered unaffordable coverage; offered coverage that does not cover a pre-existing condition; have an eligible medical condition; are in the Medicare waiting period; are not eligible for public programs; have retiree coverage and the premium increase exceeds a percentage set by the Secretary; or have not had employer coverage for at least 6 months.	U.S. citizens and legal immigrants who have not had creditable coverage for the previous six months and who have a pre-existing medical condition.
Benefits	The Secretary of HHS determines the benefits, but they must be consistent with the essential benefits package, which requires an actuarial value of 70%.	The Secretary of HHS determines the benefits that must be included. Require health plans to have an actuarial value of at least 65%.
Premiums and Cost-Sharing	Set premiums at no more than 125% of the prevailing rate for coverage. Allow premiums to vary by age (2:1) and geographic variation. Limit annual deductibles to \$1,500 for an individual. Limit out-of-pocket spending to \$5,000 for individuals and \$10,000 for families.	Set premiums at the prevailing rate for comparable coverage. Allow premiums to vary by age (4:1), geographic area, family composition, and tobacco use. Limit out-of-pocket spending to \$5,950 for individuals and \$11,900 for families.
Funding	\$5 billion	\$5 billion
Timeline	Effective January 1, 2010. Terminates when the National Health Insurance Exchange is established in 2013.	Effective 90 days after the bill is enacted. Terminates on January 1, 2014 when the American Health Benefit Exchanges are established.

Impact of Reform on Future Coverage for Current and Temporary State High-Risk Pool Enrollees

People who currently obtain coverage through state high-risk pools would maintain their existing coverage. In both bills, the temporary high-risk pool program would terminate when the health insurance Exchanges are implemented. Both current state high-risk pool enrollees and temporary high-risk pool enrollees would transition into the new Exchanges. Procedures would be developed to help transition enrollees to ensure that there are no lapses in health coverage. Given that the Exchanges would prohibit health plans from denying people coverage or charging them more based on health status and would limit cost-sharing, in addition to providing premium and cost-sharing subsidies, current state high-risk pool enrollees may receive more affordable coverage in the Exchanges than they currently do.

CONCLUSION

State high-risk pools are currently a source of coverage for 200,000 people nationwide. Although this is a small share of the insured population, high-risk pools can be an important source of coverage and the only coverage option for people with pre-existing medical conditions who do not have access to employer coverage. National health reform legislation creates temporary high-risk pools to address the health care needs of people with high-cost medical conditions by providing them with immediate health coverage before other health reform provisions are implemented. Temporary high-risk pools would serve as a bridge between now and the implementation of broader coverage provisions designed to address the challenges faced by those with medical conditions in a more systematic way.

¹ This number does not include Idaho, which operates a high-risk reinsurance plan. This number does include Florida, whose high-risk pool has been closed to new enrollment since 1991.

² Bangit E. and Pollitz, K. "State High-Risk Pool Programs and Enrollment, December 2008." Statehealthfacts.org.

³ Bangit E. and Pollitz, K. "State High-Risk Pool Eligibility Requirements, January 2010." Statehealthfacts.org.

⁴ Ibid. NOTE: Generally, Washington's high-risk pool is only open to medically eligibles. However, any Washington resident, including those who are HIPAA eligible, may apply if they live in a county where individual insurance is not marketed to the general public.

⁵ Government Accountability Office, 2009. "Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools."

⁶ Trade Readjustment Allowance benefits are given to people who have exhausted unemployment compensation and who have lost their job due to an increase in foreign imports.

⁷ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

⁸ National Association of State Comprehensive Health Insurance Plans (NASCHIP). "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis. 22nd Ed., 2008/2009. Accessed at www.naschip.org. Analysis of state profiles.

⁹ Bangit E. and Pollitz, K. "State High-Risk Pool Annual and Lifetime Benefit Maximum, 2010." Statehealthfacts.org

¹⁰ Ibid.

¹¹ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

¹² In Oregon, premium costs are capped at 125% for standard high-risk pool enrollees and 100% for high-risk pool enrollees who are HIPAA-eligible.

¹³ Bangit E. and Pollitz, K. "State High-Risk Pool Premium History 2002-2010." Statehealthfacts.org. NOTE: Premium history is based on a 50-year old, male, non-smoker, meeting the target weight, located in the largest city and includes all riders except maternity. Rates do not include HMO plans.

¹⁴ Bangit E. and Pollitz, K. "State High-Risk Pool Plan Options and Premiums, January 2010." Statehealthfacts.org

¹⁵ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

¹⁶ Ibid.

¹⁷ New Mexico Medical Insurance Pool. Accessed January 21, 2010 at: <http://www.nmmip.org/2009/premiumast.htm>.

¹⁸ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

¹⁹ NASCHIP, 22nd Ed., 2008/2009.

²⁰ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

²¹ NASCHIP, 22nd Ed., 2008/2009.

²² Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

²³ Table Notes- Bangit E. and Pollitz, K. Statehealthfacts.org.

(a) North Carolina's high-risk pool did not become operational until January 2009. (b) Connecticut, Maryland, and Wisconsin also provide cost-sharing subsidies. (c) Alabama and South Dakota high-risk pools only accept HIPAA-eligibles, and therefore no pre-existing condition exclusions are imposed. (d) The pre-existing exclusion period for pharmacy benefits is 6 months; 9 months for pregnancy. (e) In North Carolina, the pre-existing condition exclusion increased from six months to 12 months for policies that took effect after July 1, 2009 or later. (f) In North Dakota, the pre-existing exclusion period for maternity benefits is 270 days. (g) During this time, claims will be paid at 50% of the Maximum Allowable Charge in Tennessee. (h) The statutory premium cap as a percent of the standard rate is 200% for individuals with incomes above 350% FPL and 150% for individuals with incomes below 350% FPL. (i) In Montana and Oregon, the statutory premium cap as a percent of the standard rate for standard high-risk pool enrollees differs from the statutory premium cap for HIPAA-eligibles. Montana: 200% for high-risk pool enrollees and 150% for HIPAA-eligibles. Oregon: 125% for high-risk pool enrollees and 100% for HIPAA-eligibles. (j) The statutory premium cap as a percent of the standard rate is 200% for individuals with incomes equal to or greater than 250% FPL and 135% for individuals with incomes below 250% FPL. (k) The Family Health Insurance Assistance Program (FHIAP) in Oregon helps eligible families pay the monthly premium for private health insurance plans. FHIAP pays from 50 percent to 95 percent of the premium for families who are uninsured and meet income and other guidelines. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans—such as Oregon Medical Insurance Pool coverage—if insurance is not available through an employer.

²⁴ Bangit E. and Pollitz, K. "State High-Risk Pool Governing Boards, February 2009." Statehealthfacts.org.

²⁵ Bangit E. and Pollitz, K. "State High-Risk Pool Costs, December 2008." Statehealthfacts.org. Note: Includes claims and administrative costs.

²⁶ NASCHIP, Overview-Claim Costs, 22nd Ed., 2008/2009.

²⁷ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

²⁸ The Dartmouth Atlas Project at the Dartmouth Institute for Health Policy and Clinical Practice. 2009.

²⁹ Bangit E. and Pollitz, K. "State High-Risk Pool Costs, December 2008." Calculated using Premiums Collected and Total Claim Costs.

³⁰ Bangit E. and Pollitz, K. "State High-Risk Pool Costs, December 2008."

³¹ Bangit E. and Pollitz, K. "State High-Risk Pool Financing Arrangements, December 2007."

³² Bangit E. and Pollitz, K. "State High-Risk Pool Financing Mechanisms, December 2007."

³³ Centers for Medicare and Medicaid Services Presentation, 2008.

³⁴ NASCHIP, 22nd Ed., 2008/2009.

³⁵ Government Accountability Office, July 2009. "State High-Risk Health Insurance Pools."

³⁶ Affordable Health Care for America Act (H.R. 3962)

³⁷ Patient Protection and Affordable Care Act (H.R. 3590)

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