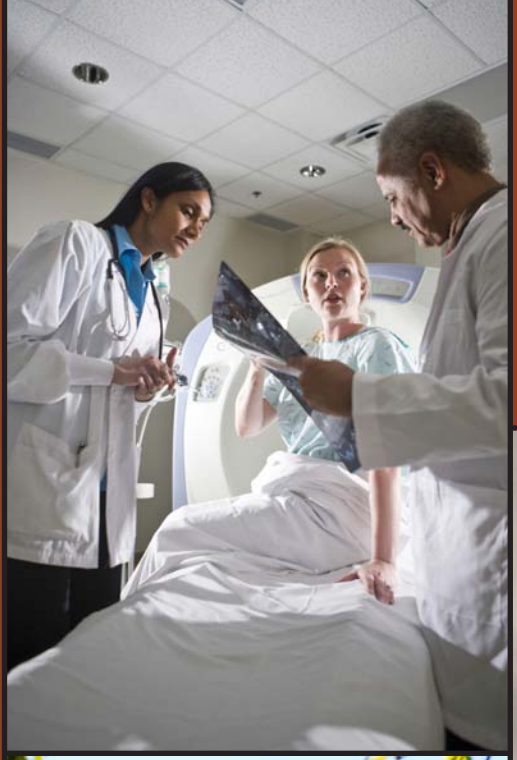

Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis

Twenty-Fifth Edition, 2011/2012

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A State-by-State Analysis

Twenty-Fifth Edition
2011/2012

Information contained herein has been furnished to NASCHIP and is accurate to the best of NASCHIP's knowledge. State-specific information was provided by the pool in each state.

It is not practical to provide all details about the benefits, costs and services of each program. The reader is encouraged to contact individual state programs for specific details, policies and benefit statements. NASCHIP assumes no responsibility for inaccuracies beyond our control.

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The persons portrayed are not known to be participants of any high-risk pool.
Their photo is used for illustrative purposes only.

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Table of Contents

Overview – About NASCHIP

The National Association of State Comprehensive Health Insurance Plans (NASCHIP) is a national nonprofit organization composed of state administered high-risk pools. NASCHIP's purpose is to facilitate information sharing among high-risk pools and to provide educational information about these important programs.

NASCHIP was formed in 1993 as a resource for risk-pools to share information and resources, cutting-edge developments and technical support. It was also created to support the development and implementation of new high-risk pools and to provide information to risk-pool stakeholders including state and federal governments, the insurance industry, health care providers, policymakers and consumer advocates. NASCHIP offers a means to network with program experts and to obtain the latest information about state and federal legislation regarding health coverage issues, and a forum for sharing best practices in managing the high-risk population.

NASCHIP is a 501(c)(6) nonprofit corporation governed by a seven member board of directors elected by its membership. NASCHIP holds an annual conference in various locales throughout the United States for the purpose of education and allowing its members and interested participants and attendees to interact with one another and with representatives of industry and government.

For more information, visit NASCHIP's website at: www.naschip.org

A Message from the NASCHIP Board of Directors

Amie Goldman
2011 NASCHIP Chair

We are pleased to present the 25th edition of Comprehensive Health Insurance for High-Risk Individuals – A State-by-State Analysis, the NASCHIP reference directory of state high-risk pools.

In the ongoing dialogue on how to best provide access to health care for all Americans, we hope that this book will serve as a valuable resource to policymakers, regulators, insurance and health care industry officials, consumer groups and other interested parties. As our country strives to address the issues of the uninsured and uninsurable, the role and value of state high-risk pools is fundamental to health care reform. These programs play a critical role in the ability to provide insurance coverage to high-risk individuals and continue to serve as an integral piece of health care reform. They carry out their mission and purpose by addressing the needs of those most in need of health services.

The information contained in this book was provided by state high-risk pool directors and administrators, the U.S. Centers for Medicare and Medicaid Services, health insurance carriers and national health-related organizations.

Operating statistics for each state are based on year-end 2010, unless otherwise stated. The reader is advised to contact individual states for their most recent legislation, premium rates and other program information.

NASCHIP is thankful for the extensive assistance provided by the many state high-risk pool staff members, staff members at the U.S. Centers for Medicare and Medicaid Services, HHS, and other cooperating agencies. It is proof that working together produces the best results.

Overview – NASCHIP Board of Directors

2011 Chair:	Amie Goldman CEO Wisconsin: Health Insurance Risk-Sharing Plan Authority Term on Board ends in 2011
2012 Chair Elect:	Michael Keough Executive Director North Carolina Health Insurance Risk Pool Term on Board ends in 2012
Treasurer:	Tomi Ossama Executive Director Utah Comprehensive Health Insurance Pool Term on Board ends in 2012
Secretary:	Vacant
Immediate Past Chair:	Vernita Bridges-McMurtrey, Executive Director Missouri Health Insurance Pool Term on Board ends in 2011
Board Member:	Tom Jovick Program Manager Oregon Medical Insurance Pool Term on Board ends in 2011
Board Member:	Debbie Armstrong Executive Director New Mexico Medical Insurance Pool Term on Board ends in 2012
Board Member:	John Harriman Co-General Counsel Arkansas Comprehensive Health Insurance Pool Term on Board ends in 2012

Overview – About High-Risk Pools

Until the Patient Protection and Affordable Care Act (PPACA) of 2010 is fully implemented, the health insurance system in the United States will remain primarily a voluntary system. While there are various health insurance markets available to meet the needs of most people who wish to purchase health insurance, there still remain a few segments of the population that would like to be insured, but do not have access to coverage at all or at prices they can afford.

The health insurance market is comprised of two major components:

- The group market provides health insurance plans to employers. Employers make the plans available to their employees who can choose whether or not to enroll themselves and their families. Employers generally pay a fairly substantial portion of the cost of the coverage, 50% or more. While an employer can set eligibility rules for participation, such as hours worked or employment status, group coverage cannot be denied to an employee or his/her dependents solely because of their health status.
- The individual market provides insurance plans to persons who wish to purchase coverage for themselves or their dependents directly from an insurance company. Persons seeking individual coverage are generally those who work for an employer not providing health insurance coverage, do not meet the eligibility requirements for their employer's plan, are self-employed or are not employed. Because of the voluntary nature of the individual health insurance market, health insurers require medical screening as part of the application process. They reserve the right to reject, rate-up, or impose exclusions for individuals who have pre-existing medical conditions.

PPACA prohibited insurers from using pre-existing condition exclusions for children under age 19 for plan years effective after September 23, 2010. PPACA also established federal high-risk pools in all states for persons with pre-existing conditions who have been uninsured for at least six months. More about the federal pools can be found on page 8. However, a large segment of the population will remain uninsurable until the guarantee issue provisions of PPACA are available to all US Citizens in 2014. This segment of the uninsured population is known as "uninsurable", to distinguish them from persons who have no insurance for reasons other than their health status. Uninsurable individuals have sought coverage, but have been unable to purchase it because they have been rejected or because they have been offered coverage at unaffordable rates. Because of their health conditions, uninsurable individuals are the segment of the uninsured population that most needs health insurance coverage. Their inability to secure coverage puts them and their families at considerable physical and financial risk.

In order to address the problems of uninsurable individuals, thirty-five states have implemented state high-risk health insurance pools. State high-risk pools are nonprofit organizations created by state law to offer comprehensive health insurance to individuals who, in the absence of a statutory requirement for guaranteed access to individual health insurance coverage, would be unable to secure such coverage because of their health status. This approach to covering uninsurable individuals is referred to as a residual market mechanism. In most states, high-risk pools also serve as the mechanism for providing coverage for federally eligible individuals and those eligible for the federal Health Coverage Tax Credit Program.

A high-risk pool is typically an insurance program with its own health benefit plans, rates, administration, and management. Eligibility requirements determine who can enroll in the plan. The benefits are comprehensive and generally comparable to benefits available through medically underwritten individual or employer-based coverage in the state.

Participants pay a premium rate that is established based on a formula included in state law. The premium is generally a multiple of the average individual health insurance rate in the state, with a range that allows some flexibility to those who manage the plan. A typical high-risk pool rate is 125% to 200% of the average medically underwritten individual health insurance market rate, otherwise referred to as the standard risk rate.

Because the premium rates are high, a high-risk pool does not entirely solve the problem of affordability of coverage for uninsurable individuals. It is a valuable mechanism for the portion of the uninsurable population that can afford the premiums, but the high cost of the coverage can present a barrier to others. As a result, many states have adopted discount programs to assist low-income participants. In recent years federal grants have been available to assist states with reduced premium programs.

Because high-risk pool participants are persons with pre-

existing health conditions, premium rates falling within the typical mandated ranges are not adequate to cover the cost of their health care and the administration of the program. As a result, additional funding sources are necessary to cover the costs of the program. States have adopted a wide range of approaches to subsidizing their high-risk pools.

An appointed Board of Directors generally provides the management of high-risk pools. It is common for Board membership to be defined in law to ensure a balanced representation from regulators, legislators, insurance carriers, medical professionals, and consumers. The Board establishes the rules under which the plan operates and enters into contracts for the administration of the plan.

High-risk pools are a common concept across the country. From state to state, they tend to share some similarities, but take on their own unique characteristics based on the insurance market, political climate, demographics, and economic conditions in the state in which they are formed.

NAIC Model Act

The National Association of Insurance Commissioners (NAIC) developed and modified over time a model law for the establishment of high-risk pools. The purpose of model laws is to provide a uniform basis from which all states can deal with regulatory issues. However, the legislation that is ultimately enacted can be customized to fit the needs of individual states. In order to assist states with pool implementation, the NAIC developed the "Model Health Plan for Uninsurable Individuals Act". For additional information about the complete NAIC Model Health Plan For Uninsurable Individuals Act, contact the NAIC at (816) 783-8300.

The formation and operation of high-risk pools is also influenced by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law allows the states to use a qualified high-risk pool as an acceptable alternative mechanism for the guaranteed availability of individual coverage for federally eligible individuals. A qualified high-risk pool is defined as one that provides to all eligible individuals health insurance coverage that does not impose any pre-existing condition exclusion and provides premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Act.

The NAIC Model Act addresses pool supervision, member eligibility, administration, funding, and benefits.

Overview – Federal Participation

State High-Risk Pool Funding Act

History

The federal government has been supportive of state high-risk pools by making substantial grant funds available throughout the years. The Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) is in charge of administering the federal grant programs. Federal risk pool grants are only available to state programs meeting the qualifications of being a state qualified high-risk health insurance pool. Other organizations or institutions are not eligible for the grants. State programs that are awarded federal grant funds must meet terms and conditions of the grant program and must report on a quarterly basis documenting the expenditure and use of the funds. Grant funding has not been guaranteed. It has been made available at various points through the years, for various purposes, using different calculations, and only for the amounts funded by federal appropriations.

The first federal grant program for high-risk pools was established in the Trade Adjustment and Assistance Act of 2002 (TAA). It appropriated $80 million in federal fiscal years 2003 and 2004 for state high-risk pools. Operational losses grants were awarded to twenty-two states and an additional $4 million was awarded in seed grants to six states. Five of the six states that received seed grant money went on to implement qualified high-risk pools.

The State High-Risk Pool Funding Extension Act of 2006 extended the original federal grant program. In addition to $15 million for seed grants to assist states to create and initially fund qualified high-risk pools, the statute authorized up to $75 million for each of federal fiscal years 2006 through 2010 for grants to help fund operational losses and bonus grants for existing qualified state high-risk pools. The grant awards have been subject to appropriation limits over the years.

A Quick Check table showing the 2010 and 2011 grant amounts awarded to each state can be found on page 13. The total appropriation for each year was $55 million.

Additional information about the grant program can be found at: www.cms.hhs.gov/HighRiskPools/.

Medicare Part D

History

Passed by Congress in December 2003 as part of major Medicare reform legislation, the optional Part D program offers Medicare recipients drug coverage which provides a significant catastrophic cost benefit, but also requires significant cost sharing before the catastrophic coverage benefit kicks in. Under the program's basic drug benefit structure, beneficiaries pay a small monthly premium for the coverage offered through participating private plans.

State Pool Responses

In 2006, the implementation of Medicare Part D led to changes for several state health insurance risk pools and their insured members. The majority of state risk pools have not offered health plan coverage to Medicare eligible individuals in the past, because there was a guaranteed access option available to them. However, several state pools did offer Medicare carve-out coverage plans for disabled individuals under age 65, and a few offered Medicare supplement plans. While risk pool coverage is comparatively expensive, those individuals who did take Medicare coverage through a pool often did so because of the pharmacy benefit. The advent of the federal Medicare Part D program significantly improved the affordable options for these people.

The risk pools that have offered Medicare eligible coverage faced the decision in late 2005 and early 2006 of whether to continue offering a health plan to Medicare recipients with the advent of the federally subsidized pharmacy option. After research and analysis by a NASCHIP task force, three of the state programs opted to discontinue offering a Medicare coverage option, concluding that their insured members would have adequate coverage elsewhere through the private market and Medicare Part D.

A Quick Check table showing the states that offer coverage to Medicare eligibles and recent enrollment can be found on page 23.

Federal Health Coverage Tax Credit

History

The Health Coverage Tax Credit (HCTC) was established as part of the Trade Adjustment Assistance (TAA) Reform Act of 2002. The HCTC applies to certain early retirees receiving pension payments from the Pension Benefit Guaranty

Corporation and displaced workers who lost employment because of foreign trade. Those eligible for assistance can receive a tax credit equal to 65% of the health premium paid by the individual and qualifying family members. The tax credit was temporarily increased from 65% to 80% in April 2009. The increase in tax credit expired as of March 2011.

States can choose several options to serve as their Health Care Tax Credit acceptance program. Among the options is coverage through a state high-risk pool. A Quick Check table showing the states that have selected this option and recent enrollment can be found on page 23.

For more information about the HCTC programs, individuals may contact: HCTC Customer Contact Center at (866) 628-4282, or go to the website at www.IRS.gov and enter HCTC for the topic search.

HIPAA

History

The federal Health Insurance Portability and Accountability Act (HIPAA), passed by Congress in 1996, mandates that people who have had group health insurance coverage will have "portability" – access to continued coverage in the group or individual market – if they leave their employer or other source of group coverage and meet certain requirements.

Generally, in the group market under HIPAA, employer groups must accept new employees and family members into their plans and must credit prior "creditable coverage" toward any pre-existing condition exclusion period. If eligible to enter the group, a new employee cannot be turned down for health coverage due to health conditions. Self-funded, non-federal government plans, however, may opt out of some or all of the group market provisions, other than the issuing of certificates of creditable coverage.

To be eligible for group to individual market portability under HIPAA, individuals need to:

- Have previously had 18 months of creditable coverage, the most recent of which was under an employer, government or church group health plan;
- Have had no gaps in coverage of 63 or more full days within or after the 18 months of creditable coverage;
- Have accepted and exhausted all available coverage under COBRA or a similar state program that was offered them;
- Must not be eligible for another group plan, Medicare or Medicaid;
- May not have any other health coverage; and
- May not have had prior coverage canceled for fraud or nonpayment of premium.

State regulations and laws may provide for more liberal access for consumers, but cannot be more restrictive.

State Options

For people who previously have had continuous group coverage and are seeking new coverage in the individual market, state governments have a number of options they can choose from to meet minimum portability standards under HIPAA. For people entering the individual market from group coverage, states can choose to enact and enforce the "federal fallback" portability requirements in the individual market; do nothing and let the federal government enforce the fallback requirements in their state; or implement one of four "alternative mechanisms." Acceptable alternative mechanisms include:

1. A state health insurance risk pool, modeled with respect to premiums and benefits after the National Association of Insurance Commissioners' (NAIC) Model Health Plan for Uninsurable Individuals Act (model state high-risk pool legislation);
2. The NAIC Small Employer and Individual Health Insurance Availability Model Act;
3. The NAIC Individual Health Insurance Portability Model Act;
4. Some "other risk-sharing or risk-spreading mechanism" or mandatory group conversion policies, which, as with the other choices, must meet the minimum access and portability requirements spelled out in the law; or,
5. A mechanism that provides a choice for each eligible individual of all individual health insurance coverage otherwise available.

Any alternative mechanism must offer federally eligible individuals a choice of coverage with no pre-existing condition exclusions.

According to the CMS State Status Chart as of 5/4/10, 33 states have elected to use the state health insurance risk pool as a mechanism for HIPAA portability.

For more information, visit CMS's HIPAA website at: www.cms.hhs.gov/hipaageninfo/.

Overview – Federal Participation

PPACA

Pre-Existing Condition Insurance Plan

The Patient Protection and Affordable Care Act (PPACA) of 2010 provided for an interim national high-risk pool, modeled on the state pools already operating in 35 states. With coverage available in all states in mid to late 2010, the program provides subsidized coverage to uninsured people with pre-existing medical conditions. It is known as the Pre-Existing Condition Insurance Plan (PCIP).

The program is operated either by the states through existing high-risk pools or other non-profit entities, or by the federal government in states that declined to participate. The program is open to citizens and legal residents who have a pre-existing condition. Applicants must have been without creditable coverage for at least six months in order to be eligible.

Benefits offered in PCIP must have an actuarial value of at least 65% and cannot impose any pre-existing condition exclusions. Premium rates may vary only by age, geographic area and tobacco use, and the highest age rate may be no more than four times the lowest. The rates must be set at 100% of the rate that individual insurers in the same state would charge for comparable benefits for a standard population.

Congress allocated $5 billion to fund the program, which is scheduled to be terminated as of December 31, 2013. The funds were initially allocated on a state-by-state basis.

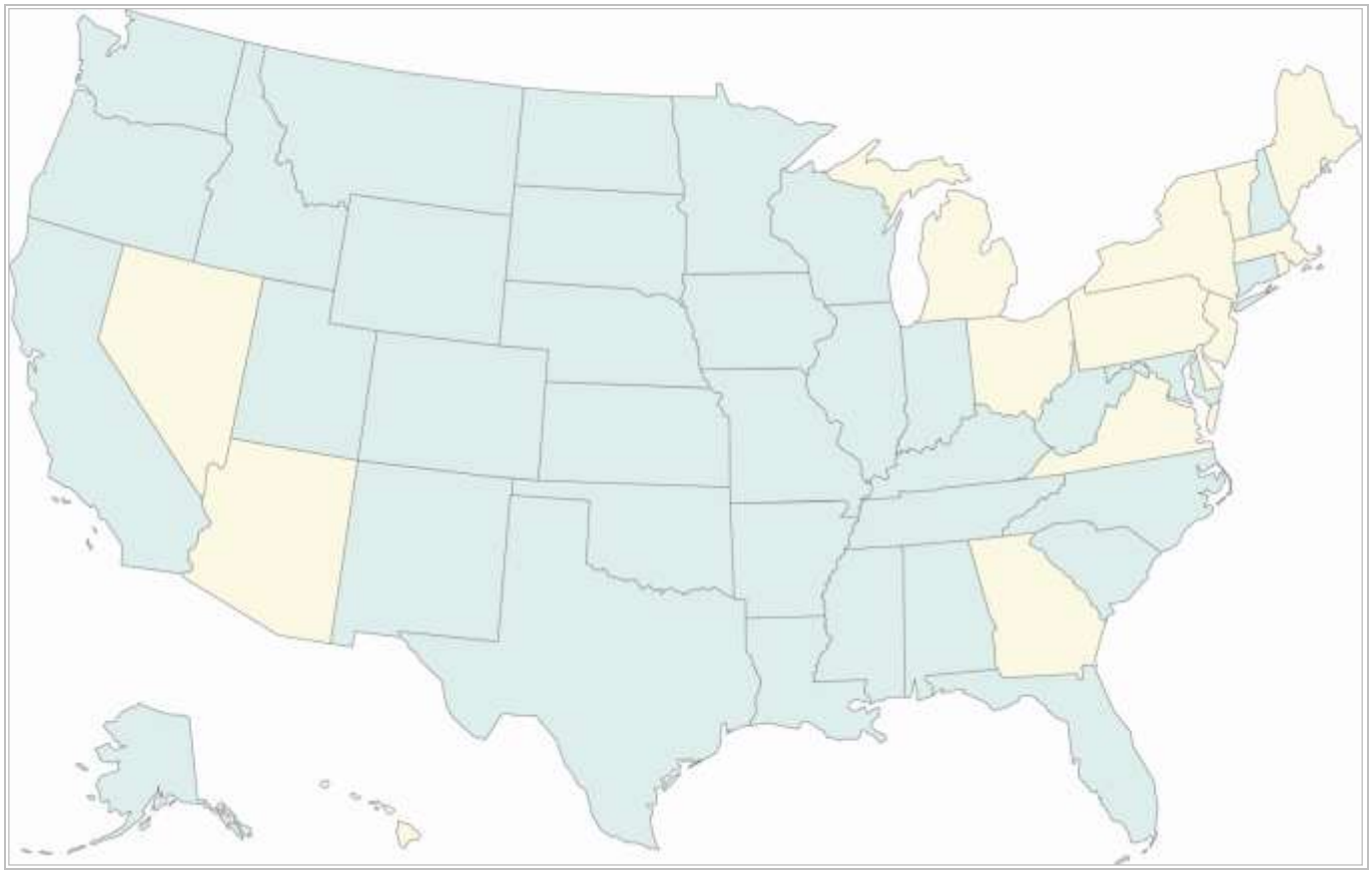
PCIP Enrollment by State as of June 2011

State	Members	Federal or State Run
Alabama	118	Federal
Alaska	38	State
Arizona	639	Federal
Arkansas	254	State
California	2,659	State
Colorado	807	State
Connecticut	57	State
Delaware	73	Federal
District of Columbia	30	Federal
Florida	1,201	Federal
Georgia	822	Federal
Hawaii	45	Federal
Idaho	79	Federal
Illinois	1,491	State
Indiana	273	Federal
Iowa	161	State
Kansas	216	State
Kentucky	140	Federal
Louisiana	166	Federal
Maine	18	State
Maryland	430	State
Massachusetts	1	Federal
Michigan	339	State
Minnesota	66	Federal
Mississippi	105	Federal
Missouri	506	State

State	Members	Federal or State Run
Montana	236	State
Nebraska	79	Federal
Nevada	222	Federal
New Hampshire	183	State
New Jersey	670	State
New Mexico	498	State
New York	1,638	State
North Carolina	1,671	State
North Dakota	13	Federal
Ohio	1,398	Federal
Oklahoma	380	State
Oregon	919	State
Pennsylvania	3,617	State
Rhode Island	125	State
South Carolina	504	Federal
South Dakota	105	State
Tennessee	419	Federal
Texas	2,020	Federal
Utah	395	State
Vermont	0	Federal
Virginia	424	Federal
Washington	446	State
West Virginia	30	Federal
Wisconsin	676	State
Wyoming	87	Federal
Total	27,489	

Source: www.healthcare.gov

Overview - Map



On this map, states shaded dark gray operate a state high-risk pool. Detailed information about each state's pool begins on page 24.

Pool Membership – 2010

State	Membership as of 12/31/2010	2010 Average Membership	Rank based on 12/31/2010 Membership	Year Operational	Rank based on Years
Alabama	2,139	2,212	24	1998	26
Alaska	524	524	34	1993	22
Arkansas	2,865	2,937	21	1996	24
California	6,953	6,971	10	1991	15
Colorado	12,732	11,510	7	1991	15
Connecticut	1,870	1,971	25	1976	1
Florida	238	249	35	1983	6
Idaho	1,565	1,532	29	2001	28
Illinois	18,098	17,065	5	1989	12
Indiana	7,327	7,150	9	1982	4
Iowa	3,154	3,099	19	1987	8
Kansas	1,671	1,659	26	1993	22
Kentucky	4,837	4,718	12	2001	28
Louisiana	1,639	1,502	27	1992	20
Maryland	19,944	19,106	3	2003	31
Minnesota	27,073	27,086	1	1976	1
Mississippi	3,514	3,480	18	1992	20
Missouri	4,046	3,874	15	1991	15
Montana	2,953	2,954	20	1987	8
Nebraska	4,570	4,878	13	1986	7
New Hampshire	1,573	1,424	28	2002	30
New Mexico	8,429	8,175	8	1988	10
North Carolina	4,846	3,738	11	2009	35
North Dakota	1,462	1,442	30	1982	4
Oklahoma	2,175	2,012	23	1996	24
Oregon	13,618	14,029	6	1990	13
South Carolina	2,256	2,281	22	1990	13
South Dakota	645	634	33	2003	31
Tennessee	3,973	3,859	16	2007	34
Texas	26,431	26,600	2	1998	26
Utah	4,158	3,958	14	1991	15
Washington	3,923	3,768	17	1988	10
West Virginia	884	814	31	2005	33
Wisconsin	18,965	17,683	4	1981	3
Wyoming	829	784	32	1991	15
Total	**221,879**	**215,678**			

Quick Checks

Rate Variables

State	Plan Design/ Age/ Family Size	Gender	Smoking Status	Income*	Geography	HIPAA Eligibility	Other
Alabama	X	X	X				
Alaska	X						
Arkansas	X	X	X				
California	X				X		
Colorado	X	X	X	X	X		
Connecticut	X	X		X		X	
Florida	X	X			X		Experience/health
Idaho	X	X	X				
Illinois	X	X	X		X	X	
Indiana	X	X		X	X		
Iowa	X	X	X				
Kansas	X	X	X				
Kentucky	X	X					
Louisiana	X	X	X		X	X	
Maryland	X			X			
Minnesota	X		X				
Mississippi	X	X				X	
Missouri	X	X		X			
Montana	X			X		X	
Nebraska	X	X	X				
New Hampshire	X		X	X			
New Mexico	X	X		X			
North Carolina	X	X	X	X			
North Dakota	X						
Oklahoma	X	X	X				
Oregon	X			X			
South Carolina	X	X					See state page
South Dakota	X	X	X				
Tennessee	X		X	X		X	Weight
Texas	X	X	X		X		
Utah	X			X			
Washington	X		X	X			See state page
West Virginia	X	X		X	X		
Wisconsin	X	X		X			
Wyoming	X	X		X			
Total	**35**	**24**	**17**	**16**	**8**	**6**	**4**

*Includes low-income subsidy programs

Sources of Funding

Percent of 2010 funding by source:

State	Premiums	Assessments	State General Funds	Tax Credits	Grants	Interest	Other
Alabama	75%	20%	0%	0%	5%	0%	0%
Alaska	31%	62%	0%	0%	7%	0%	0%
Arkansas	67%	27%	0%	0%	6%	0%	0%
California	54%	1%	0%	0%	0%	0%	45%
Colorado	42%	25%	0%	5%	2%	1%	25%
Connecticut	65%	35%	0%	0%	0%	0%	0%
Florida	30%	70%	0%	0%	0%	0%	0%
Idaho	52%	0%	0%	0%	11%	3%	34%
Illinois	59%	28%	11%	0%	2%	0%	0%
Indiana	50%	12%	36%	0%	2%	0%	0%
Iowa	45%	53%	0%	0%	2%	0%	0%
Kansas	44%	50%	0%	0%	5%	0%	1%
Kentucky	49%	19%	0%	0%	5%	1%	27%
Louisiana	49%	28%	0%	0%	11%	9%	3%
Maryland	35%	61%	0%	0%	2%	2%	0%
Minnesota	47%	52%	0%	0%	1%	0%	0%
Mississippi	65%	29%	0%	0%	4%	2%	0%
Missouri	65%	31%	0%	0%	3%	1%	0%
Montana	61%	31%	0%	0%	4%	1%	3%
Nebraska	57%	0%	0%	0%	1%	0%	42%
New Hampshire	51%	44%	0%	0%	5%	0%	0%
New Mexico	21%	35%	0%	42%	2%	0%	0%
North Carolina	74%	0%	0%	18%	3%	2%	2%
North Dakota	51%	37%	0%	0%	12%	0%	0%
Oklahoma	39%	57%	0%	0%	4%	0%	0%
Oregon	53%	47%	0%	0%	0%	0%	0%
South Carolina	93%	0%	0%	0%	7%	0%	0%
South Dakota	66%	12%	9%	0%	7%	5%	1%
Tennessee	24%	11%	63%	0%	0%	2%	0%
Texas	67%	30%	0%	0%	3%	0%	0%
Utah	66%	0%	27%	0%	6%	1%	0%
Washington	35%	62%	0%	0%	2%	0%	1%
West Virginia	80%	17%	0%	0%	0%	3%	0%
Wisconsin	54%	21%	0%	0%	2%	1%	22%
Wyoming	43%	15%	21%	14%	5%	2%	0%

*Total may not be 100% due to rounding.

CMS Grants – 2010 and 2011

State	2010 Grant	2011 Grant
Alabama	$897,711	$896,534
Alaska	$873,225	$870,074
Arkansas	$1,372,448	$1,346,166
Colorado	$2,237,857	$2,274,028
Connecticut	$1,174,106	$1,154,158
Florida	$0	$0
Georgia	$0	$0
Idaho	$1,028,031	$1,024,694
Illinois	$3,411,121	$3,434,050
Indiana	$1,878,479	$1,903,947
Iowa	$786,431	$782,164
Kansas	$1,142,865	$1,133,364
Kentucky	$1,604,180	$1,599,518
Louisiana	$1,504,058	$1,445,550
Maryland	$2,800,430	$2,851,970
Minnesota	$3,390,254	$3,240,004
Mississippi	$1,454,057	$1,404,919
Missouri	$1,615,726	$1,790,403
Montana	$1,102,629	$1,082,751
Nebraska	$1,335,629	$1,276,224
New Hampshire	$950,850	$953,075
New Mexico	$1,733,430	$1,721,599
North Carolina	$2,081,586	$2,222,099
North Dakota	$909,569	$900,586
Oklahoma	$1,354,643	$1,346,783
Oregon	$2,458,746	$2,342,102
Rhode Island	$0	$0
South Carolina	$1,464,258	$1,464,175
South Dakota	$857,735	$856,602
Texas	$7,536,033	$7,479,137
Utah	$1,359,908	$1,339,320
Washington	$1,630,823	$1,643,773
Wisconsin	$2,502,217	$2,557,401
Wyoming	$550,965	$552,830
Total	**$55,000,000**	**$54,890,000**

Source: CMS

Assessment Sources

State	Commercial Health Carriers	Stop Loss Carriers	Medicaid Carriers	TPAs	Hospitals	MEWAs & UMPs*
Alabama	X					
Alaska	X	X				
Arkansas	X	X				
California						
Colorado	X	X				
Connecticut	X	X				
Florida	X	X				
Idaho	X	X				
Illinois	X	X				
Indiana	X	X				
Iowa	X					
Kansas	X	X				
Kentucky	X	X				
Louisiana	X	X				
Maryland					X	
Minnesota	X	X				
Mississippi	X	X		X		
Missouri	X	X				
Montana	X					
Nebraska						
New Hampshire	X	X				
New Mexico	X	X	X			
North Carolina						
North Dakota	X					
Oklahoma	X	X	X			
Oregon	X	X				
South Carolina	X	X				
South Dakota	X	X				
Tennessee	X	X	X	X		
Texas	X	X				
Utah						
Washington	X	X	X			X
West Virginia					X	
Wisconsin	X		X			
Wyoming	X	X		X		
Total	**29**	**24**	**5**	**3**	**2**	**1**

*Multiple Employer Welfare Associations & Uniform Medical Plans

Total Revenue by Pool – 2010

State	Premiums*	Assessments	Other	Total Revenue
Alabama	$14,427,956	$3,900,959	$918,339	$19,247,254
Alaska	$4,071,877	$8,046,962	$521,724	$12,640,563
Arkansas	$17,671,629	$7,081,907	$1,696,220	$26,449,756
California	$43,288,524	$0	$37,281,000	$80,569,524
Colorado	$54,033,540	$28,448,711	$36,591,316	$119,073,567
Connecticut	$21,667,596	$11,718,823	$110,471	$33,496,890
Florida	$1,441,565	$1,218,000	$0	$2,659,565
Idaho	$4,803,785	$0	$1,266,832	$6,070,617
Illinois	$120,271,374	$57,163,400	$25,518,220	$202,952,994
Indiana	$57,977,861	$65,499,319	$1,823,964	$125,301,144
Iowa	$18,597,700	$21,998,990	$838,974	$41,435,664
Kansas	$12,547,923	$14,289,411	$1,699,513	$28,536,847
Kentucky	$32,918,810	$11,714,092	$19,652,488	$64,285,390
Louisiana	$7,441,287	$4,256,682	$3,536,586	$15,234,555
Maryland	$72,316,891	$115,500,650	$7,075,983	$194,893,524
Minnesota	$128,741,215	$142,680,989	$1,705,238	$273,127,442
Mississippi	$18,075,559	$8,243,478	$1,692,794	$28,011,831
Missouri	$29,759,731	$14,121,554	$2,136,569	$46,017,854
Montana	$16,519,242	$8,025,890	$1,190,682	$25,735,814
Nebraska	$31,692,009	$0	$22,676,857	$54,368,866
New Hampshire	$8,806,841	$7,553,767	$915,163	$17,275,771
New Mexico	$23,898,664	$84,712,661	$2,272,565	$110,883,890
North Carolina	$23,621,320	$0	$8,129,692	$31,751,012
North Dakota	$7,553,197	$5,500,968	$1,775,609	$14,829,774
Oklahoma	$11,489,601	$16,959,917	$1,354,643	$29,804,161
Oregon	$84,471,671	$80,106,164	$5,841,345	$170,419,180
South Carolina	$25,749,894	$0	$2,078,853	$27,828,747
South Dakota	$4,447,077	$1,223,491	$1,902,412	$7,572,980
Tennessee	$46,338,191	$4,876,652	$0	$51,214,843
Texas	$215,152,762	$97,622,164	$9,694,306	$322,469,232
Utah	$22,717,807	$0	$8,800,648	$31,518,455
Washington	$29,398,559	$53,087,591	$2,123,744	$84,609,894
West Virginia	$4,986,893	$1,056,635	$329,377	$6,372,905
Wisconsin	$88,814,852	$30,955,033	$3,603,584	$123,373,469
Wyoming	$4,942,633	$1,800,000	$2,364,008	$9,106,641
Total	**$1,310,656,036**	**$909,364,860**	**$219,119,719**	**$2,439,140,615**

*Premium reported does not include value of subsidies.

Total Expenses by Pool – 2010

State	Paid Claims	Admin	Total Expenses
Alabama	$20,776,311	$360,000	$21,136,311
Alaska	$11,253,068	$529,761	$11,782,829
Arkansas	$24,323,455	$2,322,283	$26,645,738
California	$58,821,198	$2,308,222	$61,129,420
Colorado	$115,539,266	$5,290,947	$120,830,213
Connecticut	$31,171,224	$2,128,236	$33,299,460
Florida	$2,274,636	$633,216	$2,907,852
Idaho	$11,150,834	$321,366	$11,472,200
Illinois	$183,860,867	$9,848,177	$193,709,044
Indiana	$120,716,332	$4,584,812	$125,301,144
Iowa	$34,185,700	$1,797,285	$35,982,985
Kansas	$25,720,005	$1,114,865	$26,834,870
Kentucky	$60,540,576	$3,729,943	$64,270,519
Louisiana	$15,331,965	$1,845,351	$17,177,316
Maryland	$164,676,841	$15,223,885	$179,900,726
Minnesota	$263,766,918	$9,911,118	$273,678,036
Mississippi	$29,385,521	$1,894,329	$31,279,850
Missouri	$39,390,449	$3,841,673	$43,232,122
Montana	$23,396,658	$1,457,603	$24,854,261
Nebraska	$51,543,839	$2,831,346	$54,375,185
New Hampshire	$12,601,814	$1,097,691	$13,699,505
New Mexico	$105,949,624	$4,934,266	$110,883,890
North Carolina	$23,026,939	$3,350,159	$26,377,098
North Dakota	$12,009,394	$382,710	$12,392,104
Oklahoma	$27,632,812	$1,494,175	$29,126,987
Oregon	$167,065,940	$7,143,923	$174,209,863
South Carolina	$29,331,325	$1,731,341	$31,062,666
South Dakota	$6,196,728	$414,999	$6,611,727
Tennessee	$42,088,319	$693,675	$42,781,994
Texas	$303,795,211	$12,928,661	$316,723,872
Utah	$33,062,286	$1,991,458	$35,053,744
Washington	$79,342,905	$2,938,775	$82,281,680
West Virginia	$4,396,278	$320,346	$4,716,624
Wisconsin	$155,980,610	$6,837,752	$162,818,362
Wyoming	$9,753,088	$140,576	$9,893,664
Total	**$2,300,058,936**	**$118,374,925**	**$2,418,433,861**

Admin includes all costs associated with the Pool not directly paid to health care providers for medical and pharmacy services provided to the members. Admin includes many types of administrative expense such as Pool staff salaries and benefits, office space and systems, marketing, consultants, and fees for claims administration, network access, case management, and disease management.

Claims as a Percent of Premium by Pool – 2010

State	Premiums*	Paid Claims	Claims as a Percent of Premium
Alabama	$14,427,956	$20,776,311	144%
Alaska	$4,071,877	$11,253,068	276%
Arkansas	$17,671,629	$24,323,455	138%
California	$43,288,524	$58,821,198	136%
Colorado	$54,033,540	$115,539,266	214%
Connecticut	$21,667,596	$31,171,224	144%
Florida	$1,441,565	$2,274,636	158%
Idaho	$4,803,785	$11,150,834	232%
Illinois	$120,271,374	$183,860,867	153%
Indiana	$57,977,861	$120,716,332	208%
Iowa	$18,597,700	$34,185,700	184%
Kansas	$12,547,923	$25,720,005	205%
Kentucky	$32,918,810	$60,540,576	184%
Louisiana	$7,441,287	$15,331,965	206%
Maryland	$72,316,891	$164,676,841	228%
Minnesota	$128,741,215	$263,766,918	205%
Mississippi	$18,075,559	$29,385,521	163%
Missouri	$29,759,731	$39,390,449	132%
Montana	$16,519,242	$23,396,658	142%
Nebraska	$31,692,009	$51,543,839	163%
New Hampshire	$8,806,841	$12,601,814	143%
New Mexico	$23,898,664	$105,949,624	443%
North Carolina	$23,621,320	$23,026,939	97%
North Dakota	$7,553,197	$12,009,394	159%
Oklahoma	$11,489,601	$27,632,812	241%
Oregon	$84,471,671	$167,065,940	198%
South Carolina	$25,749,894	$29,331,325	114%
South Dakota	$4,447,077	$6,196,728	139%
Tennessee	$46,338,191	$42,088,319	91%
Texas	$215,152,762	$303,795,211	141%
Utah	$22,717,807	$33,062,286	146%
Washington	$29,398,559	$79,342,905	270%
West Virginia	$4,986,893	$4,396,278	88%
Wisconsin	$88,814,852	$155,980,610	176%
Wyoming	$4,942,633	$9,753,088	197%
Total	**$1,310,656,036**	**$2,300,058,936**	**175%**

*Premium reported does not include value of subsidies.

Distribution of Allowed Cost by Service Type – 2010

State	Inpatient Hospital	Outpatient Hospital	Professional	Pharmacy
Alabama	N/A	N/A	N/A	N/A
Alaska	22%	23%	42%	13%
Arkansas	29%	12%	42%	17%
California	N/A	N/A	N/A	N/A
Colorado	27%	28%	28%	17%
Connecticut	33%	9%	38%	20%
Florida	N/A	N/A	N/A	N/A
Idaho	N/A	N/A	N/A	N/A
Illinois	22%	23%	27%	27%
Indiana	N/A	N/A	N/A	N/A
Iowa	28%	38%	21%	13%
Kansas	35%	35%	17%	13%
Kentucky	25%	17%	22%	36%
Louisiana	30%	17%	35%	18%
Maryland	N/A	N/A	N/A	N/A
Minnesota	28%	25%	28%	19%
Mississippi	N/A	N/A	N/A	N/A
Missouri	N/A	N/A	N/A	N/A
Montana	29%	32%	25%	14%
Nebraska	22%	33%	22%	23%
New Hampshire	26%	44%	16%	14%
New Mexico	16%	33%	24%	26%
North Carolina	21%	8%	23%	48%
North Dakota	44%		34%	22%
Oklahoma	N/A	N/A	N/A	N/A
Oregon	22%	21%	32%	25%
South Carolina	32%	33%	21%	14%
South Dakota	N/A	N/A	N/A	N/A
Tennessee	N/A	N/A	N/A	N/A
Texas	28%	19%	20%	33%
Utah	27%	29%	28%	16%
Washington	22%	47%	11%	20%
West Virginia	28%	17%	24%	30%
Wisconsin	28%	22%	18%	32%
Wyoming	57%		29%	14%

Allowed = Cost after provider contractual discounts. The Allowed amounts are paid for in part by members (via copays, deductible, coinsurance) with the balance paid by the plan.

Distribution of Allowed Cost Payment Responsibility – 2010

State	% paid by Member	% Paid by Plan
Alabama	N/A	N/A
Alaska	15%	85%
Arkansas	18%	82%
California	N/A	N/A
Colorado	21%	79%
Connecticut	16%	84%
Florida	N/A	N/A
Idaho	N/A	N/A
Illinois	20%	80%
Indiana	N/A	N/A
Iowa	15%	85%
Kansas	34%	66%
Kentucky	15%	85%
Louisiana	20%	80%
Maryland	16%	84%
Minnesota	16%	84%
Mississippi	N/A	N/A
Missouri	N/A	N/A
Montana	29%	71%
Nebraska	27%	73%
New Hampshire	24%	76%
New Mexico	16%	84%
North Carolina	29%	71%
North Dakota	12%	88%
Oklahoma	N/A	N/A
Oregon	N/A	N/A
South Carolina	13%	87%
South Dakota	N/A	N/A
Tennessee	N/A	N/A
Texas	22%	78%
Utah	21%	79%
Washington	6%	94%
West Virginia[1]	30%	70%
Wisconsin	31%	69%
Wyoming	N/A	N/A
Total	**20%**	**80%**

[1]Medical expense only (excludes drug benefit)

Allowed = Cost after provider contractual discounts. The Allowed amounts are paid for in part by members (via copays, deductible, coinsurance) with the balance paid by the plan.

Premium Rate Setting Methodology

For more information about standard risk rate methodology, see page 4.

State	Are premiums based on SRR methodology?		Maximum percent of SSR allowed by state law	Average SSR as of 1/1/2011
	Yes	No		
Alabama	X		200%	150%
Alaska	X		150%	130%
Arkansas	X		150%	150%
California		X		
Colorado	X		150%	131%
Connecticut	X		150%	150%
Florida	X		250%	225%
Idaho	X		150%	125%
Illinois	X		150%	131%
Indiana	X		200%	130%
Iowa	X		150%	150%
Kansas	X		150%	129%
Kentucky	X		175%	130%
Louisiana	X		200%	155%
Maryland	X		150%	100%
Minnesota	X		125%	115%
Mississippi	X		175%	150%
Missouri	X		200%	130%
Montana	X		150%	134%
Nebraska	X		145%	145%
New Hampshire	X		150%	125%
New Mexico	X		150%	78%
North Carolina	X		175%	140%
North Dakota		X		
Oklahoma	X		150%	150%
Oregon	X		125%	117%
South Carolina	X		200%	200%
South Dakota	X		150%	150%
Tennessee	X		200%	130%
Texas	X		200%	200%
Utah	X		200%	137%
Washington	X		150%	113%
West Virginia	X		150%	127%
Wisconsin		X		
Wyoming	X		200%	150%

SRR = Standard Risk Rate

Quick Checks

Lifetime Maximums, Popular Plans, Premium Subsidy

State	Maximum Lifetime Benefits	Deductible for Plan with Most Members	Low-Income Premium Subsidy[3]	
			Yes	No
Alabama	$1,000,000	(copay plan) $0		X
Alaska	$3,000,000	$5,000		X
Arkansas	$1,000,000	$1,000	X	
California[1]	$750,000	$500		X
Colorado	$1,000,000	$5,000	X	
Connecticut	$1,500,000	$1,500	X	
Florida[2]	$2,000,000 or $5,000,000	$1,000		X
Idaho[2]	$500,000 or $1,000,000	$3,000		X
Illinois	$5,000,000	$5,000		X
Indiana	None	$500	X	
Iowa	$3,000,000	$2,500		X
Kansas	$2,000,000	$2,500		X
Kentucky[2]	$2,000,000 or None	$1,500		X
Louisiana[1]	$625,000	$5,000		X
Maryland	$2,000,000	$200	X	
Minnesota	$5,000,000	$2,000	X	
Mississippi	$1,000,000	N/A		X
Missouri	$1,000,000	$5,000	X	
Montana[1]	None	$5,000	X	
Nebraska	$1,000,000	$5,000		X
New Hampshire	$2,500,000	$1,000	X	
New Mexico	None	$500	X	
North Carolina	$1,000,000	$5,000	X	
North Dakota	$1,000,000	$500		X
Oklahoma	$1,000,000	N/A		X
Oregon	$2,000,000	$500	X	
South Carolina	$1,000,000	$1,500		X
South Dakota	$2,000,000	$3,000		X
Tennessee[1]	$1,000,000	$1,000	X	
Texas	$3,000,000	$5,000	X	
Utah[1]	$1,500,000	$5,000	X	
Washington	None	$500	X	
West Virginia[1]	$1,000,000	$2,000	X	
Wisconsin	$2,000,000	$2,500	X	
Wyoming[2]	$750,000 or $1,000,000	$1,000	X	

[1]State also has annual maximums for medical services, see specific state info for details.
[2]Lifetime maximums vary based on plan design; see specific state info for details.
[3]More information regarding the low-income subsidies can be found on the state specific pages.

HDHP/HSA Availability

State	Has HDHP/HSA Plan Available in 2011		Specific HDHP/HSA Plan(s)
	Yes	No	
Alabama		X	
Alaska	X		$1,500 PPO & $2,500 PPO
Arkansas	X		$1,250 deductible plan
California		X	
Colorado	X		$2,000 deductible plan
Connecticut		X	
Florida		X	
Idaho	X		HSA Compatible plan
Illinois	X		3-H. 5-H, P-H, T-H ($1,200, $2,000, $5,200)
Indiana	X		Plan 4
Iowa		X	
Kansas	X		$2,500 deductible plan
Kentucky		X	
Louisiana		X	
Maryland	X		$2,600 PPO
Minnesota	X		Federally qualified $3,000 deductible
Mississippi		X	
Missouri	X		Plan V $2,500 deductible
Montana		X	
Nebraska	X		$2,000 HSA
New Hampshire	X		Managed Care Plan H
New Mexico		X	
North Carolina	X		Plan C $5,000 deductible
North Dakota		X	
Oklahoma		X	
Oregon		X	
South Carolina	X		HDHP
South Dakota	X		$3,000 deductible w/ HAS qualifying option
Tennessee	X		Plan Two $3,000 deductible
Texas	X		$3,000 deductible
Utah	X		$5,000 HDHP
Washington	X		$3,000 PPO
West Virginia		X	
Wisconsin	X		HIRSP, HSA
Wyoming	X		Non-Disabled Brown plan
Total	**21**	**14**	

HCTC and Medicare Eligible for Coverage in 2011

For more information about HCTC, see page 6. For more details about Medicare populations covered, see state specific pages.

State	Risk Pool Designated as an HCTC Option		HCTC Enrollment as of 12/31/2010	Coverage Offered to Medicare Eligible Populations		Medicare Population Eligible Enrollment as of 12/31/2010
	Yes	No		Yes	No	
Alabama		X			X	
Alaska	X		2	X		73
Arkansas	X		18		X	
California		X		X		N/A
Colorado	X		33	X		75
Connecticut	X		29	X		5
Florida		X		X		94
Idaho	X		N/A		X	
Illinois	X		282	X		150
Indiana	X		N/A	X		N/A
Iowa	X		19	X		40
Kansas	X		6		X	
Kentucky		X		X		0
Louisiana	X		1		X	
Maryland	X		137		X	
Minnesota	X		162	X		569
Mississippi		X			X	
Missouri	X		N/A		X	
Montana	X		6	X		221
Nebraska	X		10	X		163
New Hampshire	X		N/A		X	
New Mexico		X		X		592
North Carolina	X		265		X	
North Dakota	X		4	X		317
Oklahoma	X		5		X	
Oregon	X		127		X	
South Carolina	X		65	X		286
South Dakota		X			X	
Tennessee		X			X	
Texas	X		44	X		873
Utah		X			X	
Washington		X		X		837
West Virginia	X		8		X	
Wisconsin		X		X		1,019
Wyoming		X		X		397
Total	**23**	**12**	**1,223**	**19**	**16**	**5,711**

Alabama

Alabama Health Insurance Plan ("AHIP")

www.alseib.org

PLAN SUMMARY

Pool Contact: Wynnette Smith, Alabama Health Insurance Plan, c/o State Employees' Insurance Board, P.O. Box 304900, Montgomery, AL 36130-4900, Phone: (334) 263-8311 or (866) 833-3375, Email: wsmith@alseib.org

Contact For Application/Premiums: An information packet may be obtained by calling (866) 833-3375 or (334) 263-8311. This information can also be found on the website.

Plan Administrator: State Employees' Insurance Board

Operational Date: January 1, 1998

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	None	No	No	No	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: No

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, the Executive Director is a State of Alabama employee.

Number Of Staff: 3

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Risk pool funding comes through member premiums and assessments to the insurance industry based on premium volume in the state. Insurance carriers will be provided an offset of the assessments against any premium taxes they pay to the state.

2010 Sources: Premiums: 75%, Grants: 4.7%, Interest Income and Late Fees: 0.1%, Assessments: 20.2%

Assessments:

Are Charged To: Commercial Health Carriers

And Not To: Stop Loss Carriers, Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Assessments are made based on directly written premiums reported to the Department of Insurance by accident and health companies doing business in the State of Alabama. Assessments are based on projected losses and companies are assessed once a year. There are no caps on assessments.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: No

Length Of Wait Period: None

Exceptions: None

AVAILABLE PLAN DESIGNS

HMO or PPO: Yes

Indemnity: Yes

HSA/HDHP: No

Copay Only Plan: Yes, Option A & B

Deductibles Offered: $1,000, $2,500, $4,000

Lifetime Maximum: $1,000,000 on Indemnity Plan

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Alabama

Alabama Health Insurance Plan ("AHIP")

www.alseib.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,653	2,416	2,139
Average # Of Pool Participants	2,515	2,500	2,212
Total Premiums Collected	$16,671,850	$19,405,952	$14,427,956
Total Assessments Required	$4,690,601	$3,828,905	$3,900,959
Total Other Revenue	$175,603	$2,189,185	$918,339
Total Provider Reimbursement Costs For Medical And Rx Claims	$21,580,695	$21,128,931	$20,776,311
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$360,000	$360,000	$360,000

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Blue Cross Blue Shield of Alabama:

$1,000 Deductible Plan:	314
$2,500 Deductible Plan:	877
$4,000 Deductible Plan:	316

Managed Care/Copay Plan:

Option A:	948
Option B: (started 1/1/2011)	0

2010 Utilization

PMPM Expense

Medical:	$603
Rx:	$182
Admin:	$26
Total:	$810

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Members average 2.5 scripts per month. While brand drugs represent only 62% of the count of rx scripts, they are 82% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: The Board can raise rates as they deem appropriate.

Established By: UnitedHealthcare and Blue Cross Blue Shield of Alabama actuaries and the AHIP Board

Rating Methodology:

Brief Description: A yearly study is conducted by AHIP and standard risk rates are determined from data collected. The study is reviewed by the AHIP Board and used by Blue Cross Blue Shield and UnitedHealthcare actuaries to determine acceptable rate increases.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 95% to 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Member's Employer

But Not By: Government Agencies, Special Interest Groups

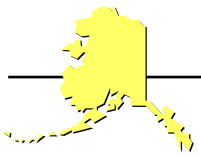
Rate Tables Can Be Found At: www.alseib.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

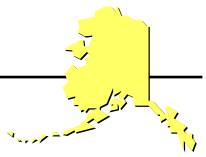
Comments: None



Alaska

Alaska Comprehensive Health Insurance Association

www.achia.com



PLAN SUMMARY

Pool Contact: Cecil D. Bykerk, Executive Director, 9643 Oak Circle, Omaha, NE 68124-2767, Phone: (402) 501-8701, Fax: (402) 393-1645 Alaska Division of Insurance, Robert B. Atwood Building, 550 West 7th Ave., Suite 1560, Anchorage, Alaska 99501-3567, Phone: (907) 269-7900

Contact For Application/Premiums: ACHIA, P.O. Box 1090, Great Bend, KS 67530, Phone: (888) 290-0616 or www.ACHIA.com

Plan Administrator: Benefit Management, Inc., P.O. Box 1090, 2015 16th Street, Great Bend, KS 67530, Toll-free: (888) 290-0616

Operational Date: January 1, 1993

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	62	Yes	Yes	No	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $100

Coverage For Medicare Eligible's: Yes, Medicare Carve-Out for under age 65 and Medicare Supplement A & F for all uninsurable.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, on a contract basis with the Pool

Number Of Staff: 1, the ED

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Policyholder premiums, health carrier assessments and grants

2010 Sources: Premiums: 31.3%, Grants: 6.7%, Interest Income and Late Fees: 0.1%, Assessments: 61.9%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: The Insurance Department supplies a listing of total health premiums received by the Association members in May of the following year. The Insurance Department gathers this data from the NAIC statements from each company. The Board determines when it is necessary to make an assessment. Once the amount has been voted on by the Board, the individual company assessments are calculated by the administrator on a proportional basis and invoiced to the companies for payment. Typically two assessments are made a year. The Board's guiding principle is to maintain a positive equity position.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: HIPAA and TAA eligibles and those termed involuntarily from an individual plan.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $1,500, $2,500, $5,000, $10K, $15K

Lifetime Maximum: $3,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Alaska

Alaska Comprehensive Health Insurance Association

www.achia.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	469	524	524
Average # Of Pool Participants	476	499	524
Total Premiums Collected	$3,356,543	$3,688,758	$4,071,877
Total Assessments Required	$2,499,719	$9,432,996	$8,046,962
Total Other Revenue	$563,679	$1,206,870	$521,724
Total Provider Reimbursement Costs For Medical And Rx Claims	$5,391,566	$11,988,371	$11,253,068
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$514,909	$503,320	$529,761

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 Indemnity:	22
$1,000 PPO:	14
$1,500 PPO:	25
$2,500 PPO:	78
$5,000 PPO:	114
$10,000 PPO:	108
$15,000 PPO:	90
Medicare Carve-Out:	52
Medicare Supplement A:	10
Medicare Supplement I*:	2
Medicare Supplement F:	9

*No longer sold, drug benefits removed

2010 Utilization

PMPM Expense

Medical:	$1,691
Rx:	$167
Admin:	$89
Total:	$1,947

Hospital Utilization / 1,000

Inpatient Admits:	71
Inpatient Days:	273
Outpatient Services:	8

Members average 1.7 scripts per month. While brand drugs represent only 37% of the count of rx scripts, they are 85% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Once a year on January 1, more often if necessary

Established By: An actuary does the basic calculations, but the Board of Directors makes the final determination of where to set the final rates relative to the Standard Risk Rate.

Rating Methodology:

Brief Description: We use the rates of the top five major medical writers in Alaska. Rates for the plans closest to those issued by ACHIA, are adjusted for benefit differences and trend to adjust them to mid-year.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 130% to 140%

Avg SRR% for Non-Medicare Plans: 130%

Premiums Vary By: Age

But Not By: Gender, Smoking Status, Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Special Interest Groups: Ryan White Fund

But Not By: Government Agencies, Member's Employer

Rate Tables Can Be Found At: www.achia.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Arkansas

Arkansas Comprehensive Health Insurance Pool ("CHIP")

www.chiparkansas.org

PLAN SUMMARY

Pool Contact: Arkansas Comprehensive Health Insurance Pool, c/o Mitchell Williams Law Firm, 425 West Capitol Ave, Suite 1800, Little Rock, AR 72201, Phone: Chuck Cliett: (501) 370-4279, John Harriman: (501) 370-4233

Contact For Application/Premiums: BlueAdvantage, Phone: (800) 285-6477

Plan Administrator: BlueAdvantage Administrators of Arkansas

Operational Date: July 28, 1996

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Both	None	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: There are three eligibility categories: Federally Eligible Individual, Resident Eligible Person, and Health Coverage Tax Credit ("HCTC").

Special Populations Covered: None

Agent Compensation: $100

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Premiums, Federal Grant for past year's deficit (if available), health insurance company assessments.

2010 Sources: Premiums: 66.81%, Grants: 6.39%, Interest Income and Late Fees: 0.03%, Assessments: 26.77%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers, all insurers writing health insurance premium in Arkansas, including excess or stop loss coverage (does not include short term coverage)

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Each insurer's assessment is determined by multiplying the total assessment by a fraction. The numerator is the insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year. The denominator is the total of all health insurance premiums for all insurers in that year.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Individuals coming from another pool and those eligible for and purchasing the Pre-Ex waiver, under Arkansas statute.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $1,250 (HSA), $5,000, $10,000

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Arkansas

Arkansas Comprehensive Health Insurance Pool ("CHIP")

www.chiparkansas.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	3,061	3,055	2,865
Average # Of Pool Participants	3,043	3,110	2,937
Total Premiums Collected	$16,658,055	$17,582,699	$17,671,629
Total Assessments Required	$5,613,424	$7,593,366	$7,081,907
Total Other Revenue	$732,873	$327,356	$1,696,220
Total Provider Reimbursement Costs For Medical And Rx Claims	$21,583,796	$22,864,621	$24,323,455
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$2,246,255	$2,327,673	$2,322,283

2010 PLAN MEMBERSHIP

(At Calendar Year End)

HIPAA eligible total:	1,425
$1,000 deductible:	1,000
$1,250 deductible:	119
$5,000 deductible:	182
$10,000 deductible:	124
Resident eligible total:	1,449
$1,000 deductible:	956
$1,250 deductible:	82
$5,000 deductible:	278
$10,000 deductible:	133
HCTC eligible total:	18
$1,000 deductible:	15
$1,250 deductible:	2
$5,000 deductible:	0
$10,000 deductible:	1

2010 Utilization

PMPM Expense

Medical:	$545
Rx:	$149
Admin:	$66
Total:	$760

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Members average 2.0 scripts per month. While brand drugs represent only 30% of the count of rx scripts, they are 45% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: As needed; typically reviewed on a biennial basis

Established By: Insurance Commissioner and CHIP Board act on actuarial recommendation

Rating Methodology:

Brief Description: Consideration of premium rates charged by other insurers offering health insurance coverage to individuals in Arkansas; SRR established using reasonable actuarial techniques and reflects anticipated experience and expenses for coverage.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Plan Design, Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Prior Continuous Coverage, Length of Time in Pool

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.chiparkansas.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
200% FPL	12%	28%	N/A	$408,605	No

How is the Subsidy Funded? CMS Federal Grant

Comments: None

California

Major Risk Medical Insurance Program

www.mrmib.ca.gov

PLAN SUMMARY

Pool Contact: Jeanie Esajian, Deputy Director for Health Policy, Legislation and External Affairs, Managed Risk Medical Insurance Board, 1000 G Street, Suite 450, Sacramento, CA 95814, Phone: (916) 324-0571, jesajian@mrmib.ca.gov

Contact For Application/Premiums: (800) 289-6574 or go to www.MRMIB.ca.gov/MRMIB/MRMIP.shtml

Plan Administrator: Anthem Blue Cross provides eligibility, enrollment and premium collection services for the program. Phone: (800) 289-6574

Operational Date: January 1, 1991

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	No	Yes	No	Yes	Yes	No

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $50 per successful application

Coverage For Medicare Eligibles: Yes, for those who are eligible due to end-stage renal disease.

HIPAA Alternative Mechanism: No

Accepts HCTC Payments: No

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, Jeanette Casillas

Number Of Staff: 5

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	N	Financial Statements:	Y	Accounts Payable:	N

FUNDING

Pool Funding: MRMIP subscribers pay monthly premiums at rates between 125% and 137.5% of standard market rates, which cover over 60% of the total cost of the program. The remainder of the program's cost is subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99).

2010 Sources: Premiums: 54%, Assessments: 1%, Other: 45% (State Cigarette and Tobacco Surtax Revenues)

Assessments:

Are Charged To: None

And Not To: N/A

Calculation: N/A

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 3 months

Exceptions: Yes, contact pool for details

AVAILABLE PLAN DESIGNS

HMO and PPO:	Yes
Indemnity:	No
HSA/HDHP:	No
Copay Only Plan:	No
Deductibles Offered:	$500
Annual Maximum:	$75,000
Lifetime Maximum:	$750,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

California

Major Risk Medical Insurance Program

www.mrmib.ca.gov

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	7,036	6,830	6,953
Average # Of Pool Participants	7,313	6,866	6,971
Total Premiums Collected	$39,987,507	$40,428,563	$43,288,524
Total Assessments Required	$0	$0	$0
Total Other Revenue	$48,938,000	$35,626,000	$37,281,000
Total Provider Reimbursement Costs For Medical And Rx Claims	$57,677,837	$58,740,776	$58,821,198
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$2,486,027	$2,296,203	$2,308,222

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Anthem Blue Cross:	2,637
Kaiser South:	2,684
Kaiser North:	1,601
Contra Costa:	31

2010 Utilization

PMPM Expense

Medical:	$653
Rx:	$241
Admin:	$24
Total:	$981

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Notes:

PMPM = Per Member Per Month

/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: The plans propose premiums, which are reviewed and approved by the MRMIB after consultation with an independent actuary.

Rating Methodology:

Brief Description: MRMIP carriers establish the premiums for their specific offering and are allowed to charge 125% of their company specific normal market rates on a benefit equivalent design. Current law states that subscribers who select plans with higher than average loss ratios can be required to pay up to 10% more, not to exceed 137.5% of normal market rates.

Use SRR Calculation: No

Premiums Vary By: Age, Geography, Plan Selected, Family Size

But Not By: Gender, Smoking Status, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage, Subscriber and Dependent

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer or Special Interest Groups. Nothing in state law prohibits contributions by other persons or organizations.

But Not By: None

Rate Tables Can Be Found At: www.mrmib.ca.gov/mrmip

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Colorado

CoverColorado

www.covercolorado.org

PLAN SUMMARY

Pool Contact: Suzanne Bragg-Gamble, Executive Director, CoverColorado, 425 S. Cherry #160, Glendale, CO, 80246, Phone: (720) 941-2538, Email: sbgamble@covercolorado.org

Contact For Application/Premiums: See the website at www.covercolorado.org.

Plan Administrator: Rocky Mountain Health Plans, P.O. Box 3559, Englewood, CO 80155

Operational Date: April 1991

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Citizen	34	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $25

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, we have an Executive Director who is employed by the Pool.

Number Of Staff: 8

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: By legislation passed in 2008, funding starting in 2009 is 25% from Unclaimed Property Fund, 25% from carrier assessments, and 50% from member premiums, carrier tax credits and possible grants.

2010 Sources: Premiums: 42%, Grants: 2%, Tax Credits: 5%, Interest Income and Late Fees: 1%, Assessments: 25%, Other: 25% (Colorado Unclaimed Property Fund)

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: CoverColorado is required to project funding requirements and provide notice to carriers of the amount of assessment for the next calendar year by September 1st of each year. In 2010, the assessments are paid quarterly.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Those with qualifying previous coverage which was terminated within 90 days prior to coverage.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO and HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $1,500 $2,000, $3,000, $5,000, $7,500, $10,000

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Colorado

CoverColorado

www.covercolorado.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	8,543	10,439	12,732
Average # Of Pool Participants	7,848	9,465	11,510
Total Premiums Collected	$32,909,410	$41,209,166	$54,033,540
Total Assessments Required	$24,602	$23,843,654	$28,448,711
Total Other Revenue	$40,465,444	$32,137,363	$36,591,316
Total Provider Reimbursement Costs For Medical And Rx Claims	$59,972,477	$79,454,014	$115,539,266
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$5,301,591	$5,814,445	$5,290,947

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 deductible:	2,159
$1,500 deductible:	588
$2,000 deductible:	2,073
$2,000 deductible HSA:	2,210
$3,000 deductible:	1,616
$5,000 deductible:	2,385
$7,500 deductible:	607
$10,000 deductible:	1,010
Medicare COB:	75

2010 Utilization

PMPM Expense

Medical:	$703
Rx:	$119
Admin:	$38
Total:	$860

Hospital Utilization / 1,000

Inpatient Admits:	154
Inpatient Days:	851
Outpatient Services:	1,953

Members average 2.0 scripts per month. While brand drugs represent only 31% of the count of rx scripts, they are 71% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Rates are currently changed annually, but were changed semi-annually prior to 2009.

Established By: Our independent actuary with CoverColorado Board and Colorado Division of Insurance approval.

Rating Methodology:

Brief Description: The Standard Risk Rate (SRR) is defined as the weighted average of the largest five carriers' rates in the individual market, adjusted for plan design differences.

Use SRR Calculation: Yes
Weighted Or Simple Average: Weighted
Max SRR % Allowed By State Law: 150%
Range Of SRR % Currently In Place: 100% to 140%
Avg SRR% for Non-Medicare Plans: 131%

Premiums Vary By: Age, Gender, Smoking Status, Income, Geography
But Not By: Experience/Health, HIPAA Eligibility, Prior Continuous Coverage, Length of Time in Pool

Premiums May Be Paid By: Member, Direct Family Member
But Not By: Government Agencies, Member's Employer, Special Interest Groups, Providers

Rate Tables Can Be Found At: www.covercolorado.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
$50,000	25%	27%	70%	$3,492,455	No

How is the Subsidy Funded? CMS Federal Grants to the extent available, Carrier Assessments and the Colorado Unclaimed Property Fund

Comments: Subsidies vary based on income being under $40k or $50k.

Connecticut

Connecticut Health Reinsurance Association

www.hract.org

PLAN SUMMARY

Pool Contact: Karl Ideman, Pool Administrators Inc., 628 Hebron Avenue, Suite 212, Glastonbury, CT 06033

Contact For Application/Premiums: Phone: (800) 842-0004, HRA website: www.hract.org

Plan Administrator: Pool Administrators, Inc.

Operational Date: 1976

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	No	No	No	No	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: A more affordable Low-Income Plan that reimburses providers at 75% of the Medicare Reimbursement Rate is offered to residents below 300% of the Federal Poverty Level. A Group Conversion Option only requires 12 months of prior creditable coverage and insurers can choose to have HRA assume responsibility for their group conversion obligations.

Agent Compensation: Referral fee of $50 per application

Coverage For Medicare Eligibles: Yes, HIPAA eligible members may continue if they are enrolled prior to age 65.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: 5

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Association member insurers are assessed for net losses. This funding mechanism has been in place since the inception of the plan.

2010 Sources: Premiums: 64.8%, Assessments: 35.2%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Net losses, including premium, incurred claims and expenses, are assessed annually by the Administrator to all participating member insurers. Each insurer's assessment is based on its respective market share of total health insurance premium earned for the year that coincides with the year of the net loss. Typically two assessments are made a year. The Board's guiding principle is to maintain a positive equity position.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: Yes, contact the pool for details.

AVAILABLE PLAN DESIGNS

HMO or PPO: PPO

Indemnity: Yes - Managed

HSA/HDHP: No

Copay Only Plan: No

Lifetime Maximum: $1,500,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Connecticut

Connecticut Health Reinsurance Association

www.hract.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,336	2,177	1,870
Average # Of Pool Participants	2,493	2,206	1,971
Total Premiums Collected	$21,525,891	$21,036,607	$21,667,596
Total Assessments Required	$13,500,500	$8,062,806	$11,718,823
Total Other Revenue	$15	$5	$110,471
Total Provider Reimbursement Costs For Medical And Rx Claims	$33,208,879	$31,083,703	$31,171,224
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,605,298	$1,671,732	$2,128,236

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Special Health Care Plan:	325
HMO Plan:	556
PPO Plan:	989

2010 Utilization

PMPM Expense

Medical:	$1,243
Rx:	$319
Admin:	$30
Total:	$1,592

Hospital Utilization / 1,000

Inpatient Admits:	171
Inpatient Days:	1,115
Outpatient Services:	6,802

Members average 2.3 scripts per month. While brand drugs represent only 46% of the count of rx scripts, they are 90% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually, effective on January 1st.

Established By: An actuary develops the rates, which are reviewed by the actuarial committee. The rates are then recommended to the board. The Board's approved rates are then filed with the DOI for their review of the actuarial rating methodology.

Rating Methodology:

Brief Description: The SRR is the statewide average standard market rate for a group of ten employees.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: The rates are set at 150% but the insurance law allows the range of 125% to 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Income (but only for low income qualified applicants), HIPAA Eligibility

But Not By: Smoking Status Geography, Income, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer, Special Interest Groups

But Not By: None

Rate Tables Can Be Found At: www.hract.org

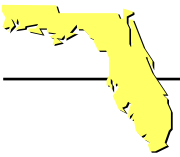
LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	17%	5%	5%	N/A	Yes

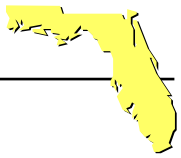
How is the Subsidy Funded? CMS Federal Grant

Comments: Members currently receiving this subsidy are enrolled in a Low-Income Plan that is more affordable and reimburses providers at 75% of the Medical Reimbursement Rate.



Florida

Florida Comprehensive Health Association (FCHA)



PLAN SUMMARY

Pool Contact: Jerome (Jerry) Ashford, Executive Director, Florida Comprehensive Health Association, 2928 Wellington Circle, Suite 101, Tallahassee, Fl 32309, Phone: (850) 309-1200

Contact For Application/Premiums: N/A - closed to new enrollment.

Plan Administrator: Covenant Administrators, 1745 North Brown Road, Lawrenceville, GA 30043, (800) 680-8728

Operational Date: State Comprehensive Health Association: October 1983 - September 1989, Florida Comprehensive Health Association: October 1989 - Present

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	3	Yes	No	No	No	No

Other Eligibility Comments: None

Special Populations Covered: FCHA serves Medicaid beneficiaries whose conditions are not covered by Medicaid and provides wrap-around coverage to policyholders with Medicare.

Agent Compensation: N/A - closed to new enrollment

Coverage For Medicare Eligibles: Yes, all Medicare eligibles

HIPAA Alternative Mechanism: No

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? Yes

Executive Director: Yes

Number Of Staff: 3

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	N
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: FCHA is funded through member premiums and insurance industry assessments.

2010 Sources: Premiums: 30%, Assessments: 70%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: FCHA issues an assessment for each calendar year based on the audited operating loss for the FCHA and the earned premiums of participating insurers. (FCHA has the ability to issue an interim assessment if necessary.) Each insurer's portion of the assessment is determined by multiplying FCHA's operating loss by a fraction, the numerator of which equals the insurer's assessable earned premium and the denominator of which equals the total of all assessable earned premiums. The assessment may not exceed one percent of an insurer's health insurance premium.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: N/A

Length Of Wait Period: N/A

Exceptions: N/A

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA or Copay Only Plan: No

Deductibles Offered: $1,000, $1,500 $2,000, $5,000, $10,000

Lifetime Maximum: $2M (Basic) $5M (Standard)

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Florida

Florida Comprehensive Health Association (FCHA)

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	300	265	238
Average # Of Pool Participants	312	285	249
Total Premiums Collected	$1,681,150	$1,609,860	$1,441,565
Total Assessments Required	$1,483,000	$0	$1,218,000
Total Other Revenue	$0	$0	$0
Total Provider Reimbursement Costs For Medical And Rx Claims	$2,483,801	$2,384,709	$2,274,636
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$475,968	$660,981	$633,216

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Non-Medicare	Basic/Standard
$1,000:	10/30
$1,500:	3/10
$2,000:	5/31
$5,000:	2/21
$10,000:	3/9

Medicare	Basic/Standard
$1,000:	7/71
$1,500:	1/3
$2,000:	2/10

Standard $5,000:	5
Basic $10,000:	1

2010 Utilization

PMPM Expense

Unable to provide expense information at this time.

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Notes:

PMPM = Per Member Per Month

/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Rates are changed annually

Established By: The rates are calculated by FCHA using a statutorily established formula and approved by the Office of Insurance Regulation.

Rating Methodology:

Brief Description: Survey of 80% of the individual market (by enrollment)

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 250%

Range Of SRR % Currently In Place: 200%, 225%, 250%

Avg SRR% for Non-Medicare Plans: 225%

Premiums Vary By: Age, Gender, Geography, Experience/Health

But Not By: Smoking Status Income, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Trust Funds and Asset Managers

But Not By: Government Agencies, Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: N/A

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Idaho

Idaho Individual High Risk Reinsurance Pool

www.doi.idaho.gov

PLAN SUMMARY

Pool Contact: Joan Krosch, Health Insurance Specialist, Idaho Dept. of Insurance, 700 West State Street, Third Floor, Boise, Idaho 83720-0043, Phone: (208) 334-4300, Joan.Krosch@doi.idaho.gov

Contact For Application/Premiums: Contact carriers serving the individual market in Idaho. For a list of the current Idaho individual carriers, go to www.doi.idaho.gov, then select "consumer affairs" and "health insurance".

Plan Administrator: AmeriBen Solutions, 3449 East Copper Point Drive, Meridian, Idaho 83642
Phone: (208) 344-7900

Operational Date: January 1, 2001

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	No	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: This is the Idaho HIPAA alternative mechanism, guaranteed issue coverage.

Agent Compensation: 5%

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? Yes

Executive Director: No

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: The Idaho Individual High Risk Reinsurance pool is funded by carrier reinsurance premium. Additionally, the Pool receives public funding under the Idaho premium tax based on a formula defined in Idaho Code 41-406.

2010 Sources: Premiums: 52%, Grants: 11%, Interest Income and Late Fees: 3%, Other: 34% (Premium Tax Revenue)

Assessments:

Are Charged To: Disability Health Carriers, Stop Loss Carriers; No assessments required for program at this time

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Assessment is based on prior year losses. Total premium earned by the carrier is divided by total premium earned by all carriers to determine each carrier's individual ratio of the loss. This calculation is done annually in June (if the program has a prior year loss) by AmeriBen Solutions, the administrator.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6/12 months

Exceptions: "Federally eligible individuals" if coverage within 63 days of termination of prior creditable coverage.

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity and HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $2,000, $3,000, $5,000

Lifetime Maximum: $500K (Basic) or $1M (Others)

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Idaho

Idaho Individual High Risk Reinsurance Pool

www.doi.idaho.gov

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	1,338	1,424	1,565
Average # Of Pool Participants	1,383	1,402	1,532
Total Premiums Collected	$2,589,287	$3,228,661	$4,803,785
Total Assessments Required	$0	$0	$0
Total Other Revenue	$1,852,383	$1,775,967	$1,266,832
Total Provider Reimbursement Costs For Medical And Rx Claims	$10,285,908	$9,374,951	$11,150,834
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$298,592	$308,909	$321,366

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Basic:	24
Standard:	134
Catastrophic A:	189
Catastrophic B:	587
HSA:	631

2010 Utilization

PMPM Expense

Unable to provide expense information at this time.

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Notes:

PMPM = Per Member Per Month

/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Premiums are drafted by an independent actuary, presented to the Board of Directors and either approved or recommendations are made for changes. If there are any recommended changes, amended rates are presented to the Board for approval.

Rating Methodology:

Brief Description: Standard risk rate is established by using the average rates that individual standard risks in the state are charged by at least five of the largest health carriers, based on similar plan design.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 125%

Avg SRR% for Non-Medicare Plans: 125%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Income, Experience/Health HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies

But Not By: Members Employer

Rate Tables Can Be Found At: www.doi.idaho.gov

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Illinois

Illinois Comprehensive Health Insurance Plan (ICHIP)

www.chip.state.il.us

PLAN SUMMARY

Pool Contact: Timothy C. Sullivan, Illinois Comprehensive Health Insurance Plan, 320 W. Washington, Suite 700, Springfield, IL 62701-1150, Phone: (217) 782-6333, director@chip.state.il.us

Contact For Application/Premiums: www.chip.state.il.us or by contacting the administrator or the Board office

Plan Administrator: ICHIP Administrative Unit, BCBS of Illinois, Phone: (800) 367-6410, TTY: (800) 545-2455

Operational Date: May 1989

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	31	Yes	No	Yes	No	Yes

Other Eligibility Comments: HCTC

Special Populations Covered: Plan 2 of the Traditional Pool covers persons under 65 who are eligible for Medicare A and B and are suffering from renal disease or otherwise disabled. Plans P, T, Y and Z of the HIPAA Pool cover persons who are eligible for the HCTC.

Agent Compensation: $50

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 30

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The Traditional pool is funded by participants' premiums and an appropriation from the State's General Revenue Fund; the HIPAA pool by participants' premiums, an assessment on health insurers, and federal grants, when available.

2010 Sources: Premiums: 59%, Grants: 2%, Assessments: 28%, State General Fund: 11%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: The Board, with advice from an independent actuary and an actuarial advisory committee, determines the anticipated deficit for the HIPAA pool which is the basis for assessment. An insurer's portion is determined by taking that insurer's direct Illinois premiums during the preceding calendar year divided by the total of all insurers' direct Illinois premiums, and multiplying the result by the total assessment.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Waived if application is made within 90 days of losing coverage due to an insolvent individual issuer of coverage.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO and HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $1,200, $1,500, $2,000, $2,500, $5,000, $5,200

Lifetime Maximum: $5,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Illinois

Illinois Comprehensive Health Insurance Plan (ICHIP)

www.chip.state.il.us

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	15,682	16,085	18,098
Average # Of Pool Participants	16,126	15,794	17,065
Total Premiums Collected	$115,344,689	$113,900,274	$120,271,374
Total Assessments Required	$19,815,000	$47,823,800	$57,163,400
Total Other Revenue	$28,046,879	$35,225,106	$25,518,220
Total Provider Reimbursement Costs For Medical And Rx Claims	$162,850,191	$168,702,566	$183,860,867
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$8,879,106	$9,094,883	$9,848,177

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Traditional pool - Plan 2: 150
Traditional pool - Plan 3: 3,918
Traditional pool - Plan HDHP: 514

HIPAA pool - Plan 5: 11,573
HIPAA pool - Plan 5 HDHP: 1,661
HIPAA pool - HCTC Plans: 282

2010 Utilization

PMPM Expense

Medical:	$668
Rx:	$230
Admin:	$48
Total:	$946

Hospital Utilization / 1,000

Inpatient Admits:	180
Inpatient Days:	1,055
Outpatient Services:	4,036

Members average 2.5 scripts per month. While brand drugs represent only 43% of the count of rx scripts, they are 90% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Twice annually on February 1 and August 1

Established By: The Board, with help from an independent actuary.

Rating Methodology:

Brief Description: Based on average rates charged for individual policies in Illinois providing comparable coverage, and adjusted for differences in coverage. Premiums to be between 125% and 150% of applicable market.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: Traditional pool: 150%, HIPAA pool: 125%

Avg SRR% for Non-Medicare Plans: 131%

Premiums Vary By: Age, Gender, Smoking Status, Geography, HIPAA Eligibility, ICHIP Plan (2, 3, and 5) Deductible

But Not By: Income, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct or Distant Family Member, Domestic Partner, Special Interest Group, Employer of Member, Spouse, or Parent

But Not By: Government Agencies or Health Care Providers (Traditional pool)

Rate Tables Can Be Found At: www.chip.state.il.us

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Indiana

Indiana Comprehensive Health Insurance Association (ICHIA)

www.ichia.org

PLAN SUMMARY

Pool Contact: Douglas Stratton, 9465 Counselors Row, Suite 200, Indianapolis, IN 46240, Phone: (317) 877-5376

Contact For Application/Premiums: Contact the administrator for an application packet by calling customer service at (317) 614-2133 or (800) 552-7921 or www.ichia.org

Plan Administrator: ACS

Operational Date: July 1982

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	No	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: Trade Adjustment Assistance program

Special Populations Covered: HIV/AIDS, Hemophilia, Medicare Disabled, Healthy Indiana Participants

Agent Compensation: None

Coverage For Medicare Eligibles: Yes, under age 65 disabled, with Part B benefits, ICHIA becomes secondary.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, employed by the pool

Number Of Staff: 1

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: The Association is funded by premiums earned, investment income, grants, State assessment, and member assessments.

2010 Sources: Premiums: 50%, Grants: 2%, Assessments: 12%, State General Fund: 36%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Twenty-five percent (25%) of the net loss is assessed to health insurance carriers in proportion to their respective share of total health insurance premiums as reported to the Indiana Department of Insurance. Seventy-five percent (75%) of any net loss shall be paid by the State of Indiana.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 3 months

Exceptions: None

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $1,500, $2,500, $5,000

Lifetime Maximum: None

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Indiana

Indiana Comprehensive Health Insurance Association (ICHIA)

www.ichia.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	6,561	6,715	7,327
Average # Of Pool Participants	6,755	6,669	7,150
Total Premiums Collected	$50,381,943	$49,387,721	$57,977,861
Total Assessments Required	$48,846,408	$67,212,553	$65,499,319
Total Other Revenue	$2,012,437	$2,020,167	$1,823,964
Total Provider Reimbursement Costs For Medical And Rx Claims	$96,909,880	$114,319,439	$120,716,332
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$4,330,908	$4,301,002	$4,584,812

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Plan 1 $500 Deductible:	2,891
Plan 2 $1,000 Deductible:	600
Plan 3 $1,500 Deductible:	1,701
Plan 4 $2,500 Deductible:	2,155
Plan 5 $5,000 Deductible*	0

*Plan 5 is new as of 1/1/2011

2010 Utilization

PMPM Expense

Medical:	$773
Rx:	$647
Admin:	$54
Total:	$1,474

Hospital Utilization / 1,000

Inpatient Admits:	299
Inpatient Days:	313
Outpatient Services:	542

Members average 1.6 scripts per month. While brand drugs represent only 40% of the count of rx scripts, they are 60% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Typically reviewed annually

Established By: Rates are determined by an independent actuary and approved by the ICHIA Board and the Indiana Department of Insurance.

Rating Methodology:

Brief Description: 150% of the average of the top 5 commercial carriers' rates

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 200% of FPL

Range Of SRR % Currently In Place: 151% to 200%

Avg SRR% for Non-Medicare Plans: 130%

Premiums Vary By: Age, Gender, Geography, Medicare Part D, Income

But Not By: Smoking Status, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.ichia.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
200% FPL	10%	40%	45%	$750,000	No

How is the Subsidy Funded? CMS Federal Grant

Comments: None

Iowa

Health Insurance Plan of Iowa (HIPIowa)

www.hipiowa.com

PLAN SUMMARY

Pool Contact: Rod Turner, Representing American Republic Insurance, 8049 Heather Bow Court, Johnston, IA 50131, Phone: (202) 497-0751, and Cecil Bykerk, ED, 9643 Oak Circle, Omaha, NE 68124-2767, Phone: (402) 501-8701, Toll-Free: (866) 590-6662, Fax: (402) 393-1645

Contact For Application/Premiums: HIPIOWA, P.O. Box 1090, Great Bend, KS 67530, Phone: (877) 793-6880 or www.hipiowa.com

Plan Administrator: Benefit Management, Inc., P.O. Box 1090 & 2015 16th St, Great Bend, KS 67530, Phone: (877) 793-6880

Operational Date: July 1987

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	42	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $200

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, on a contract basis with the Pool

Number Of Staff: 1, the ED

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: The pool is funded through premiums from the policyholders, investment income, grants and health insurance carrier assessments

2010 Sources: Premiums: 44.9%, Grants: 1.9%, Interest Income and Late Fees: 0.1%, Assessments: 53.1%

Assessments:

Are Charged To: Commercial Health Carriers

And Not To: Medicaid Carriers, Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Typically an annual projection is made early in the calendar year to determine the estimated shortfall for the year. The necessary amount is then voted on at the annual meeting in April and the assessment is allocated across the health insurance premium earned in the previous year by the member companies.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: TAA eligibles and individuals terminated from individual policies.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $1,000, $1,500, $2,500, $5,000 $10,000

Lifetime Maximum: $3,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Iowa

Health Insurance Plan of Iowa (HIPIowa)

www.hipiowa.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,732	2,991	3,154
Average # Of Pool Participants	2,752	2,864	3,099
Total Premiums Collected	$15,431,358	$15,906,831	$18,597,700
Total Assessments Required	$10,500,000	$28,180,221	$21,998,990
Total Other Revenue	$963,732	$1,107,479	$838,974
Total Provider Reimbursement Costs For Medical And Rx Claims	$31,322,845	$33,508,802	$34,185,700
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,662,432	$1,590,053	$1,797,285

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 PPO:	672
$1,500 PPO:	528
$2,500 PPO:	1,189
$5,000 PPO:	573
$10,000 PPO:	152
Medicare Carve-Out*:	11
Medicare Carve-Out II**:	29

*Includes drug benefits but not currently for sale

**Excludes drug benefits

2010 Utilization

PMPM Expense

Medical:	$705
Rx:	$236
Admin:	$48
Total:	$989

Hospital Utilization / 1,000

Inpatient Admits:	513
Inpatient Days:	2,172
Outpatient Services:	1,006

Members average 2.9 scripts per month. While brand drugs represent only 34% of the count of rx scripts, they are 89% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: As needed; typically reviewed on an annual basis

Established By: An independent actuary does the basic calculations but the Board of Directors makes the final determination of relativity to the Standard Risk Rate.

Rating Methodology:

Brief Description: We use the rates of the top five major medical writers in Iowa. Rates for the plans closest to those issued by HIPIowa, are adjusted for benefit differences and trend to adjust them to mid-year.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member

But Not By: Government Agencies, Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.hipiowa.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Kansas

Kansas Health Insurance Association

www.KHIAstatepool.com

PLAN SUMMARY

Pool Contact: Kansas Insurance Department, Attn: Julie Holmes, 420 S.W. 9th Street, Topeka, KS 66612 Phone: (785) 296-7850

Contact For Application/Premiums: KHIA, P.O. Box 1090, Great Bend, KS 67530, Phone: (800) 362-9290 or www.khiastatepool.com

Plan Administrator: Benefit Management, Inc., 2015 16th Street, P.O. Box 1090, Great Bend, KS 67530 Phone: (800) 362-9290

Operational Date: May 1, 1993

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	None	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $100

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: KHIA is funded with premiums from enrollees, assessments to insurance carriers in Kansas, indirectly by the state with offsets against premium revenue for carriers, and in recent years with funds from a federal operating loss grant. Enrollee premiums have been kept at or under 133 percent of the state average of leading carriers' premiums.

2010 Sources: Premiums: 44%, Grants: 5.5%, Interest Income and Late Fees: 0%, Assessments: 50%, Other: 0.5% (Investments)

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: The assessment calculation is based on current data provided by the Kansas Insurance Department. The amount for each carrier is proportional to their total individual premium income. Assessments are set by the Board of Directors one or more times annually.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 3 months

Exceptions: Waived if pre-ex limit was covered under the previous policy

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,500, $2,500, $5,000, $10K

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Kansas

Kansas Health Insurance Association

www.KHIAstatepool.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	1,830	1,754	1,671
Average # Of Pool Participants	N/A	1,742	1,659
Total Premiums Collected	$11,878,647	$11,962,930	$12,547,923
Total Assessments Required	$10,385,231	$11,028,518	$14,289,411
Total Other Revenue	$1,574,126	$1,400,804	$1,699,513
Total Provider Reimbursement Costs For Medical And Rx Claims	$22,264,200	$22,671,417	$25,720,005
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,136,567	$1,202,781	$1,114,865

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Old Block	
$500 deductible:	22
$1,000 deductible:	47
$1,500 deductible:	143
$2,500 deductible:	121
$5,000 deductible:	198
$7,500 deductible:	90
$10,000 deductible:	50
New Block	
$1,500 deductible:	280
$2,500 deductible:	396
$5,000 deductible:	169
$10,000 deductible:	155

2010 Utilization

PMPM Expense	
Medical:	$1,148
Rx:	$173
Admin:	$62
Total:	$1,383
Hospital Utilization / 1,000	
Inpatient Admits:	191
Inpatient Days:	1,299
Outpatient Services:	4,248

Members average 2.5 scripts per month. While brand drugs represent only 30% of the count of rx scripts, they are 81% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: The Board decides on rates based on recommendations by an actuary. The rates are reviewed and approved by the Commissioner of the Kansas Insurance Department.

Rating Methodology:

Brief Description: Rates are based on average rates of the five largest individual insurers in the state. Rates are actuarially adjusted for benefits, age, gender, and tobacco use.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 129%

Avg SRR% for Non-Medicare Plans: 129%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer, Special Interest Groups

But Not By: None

Rate Tables Can Be Found At: www.KHIAstatepool.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Kentucky

Kentucky Access

www.kentuckyaccess.com

PLAN SUMMARY

Pool Contact: DJ Wasson, Acting Director, Kentucky Access Program, P.O. Box 1380, 46 Mill Creek Park, Frankfort, Kentucky 40602-1380, Phone: (502) 573-1026

Contact For Application/Premiums: Contact (866) 405-6145 toll-free or download information from www.kentuckyaccess.com

Plan Administrator: Anthem Health Plans of Kentucky, Inc. Please direct inquiries to: Bonnie Walker, Account Rep, ACS Healthcare Solutions, 4550 Victory Lane, Indianapolis, IN 46203, Phone: (866) 405-6145

Operational Date: January 1, 2001

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	35	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $50

Coverage For Medicare Eligibles: Yes. If a member becomes Medicare eligible after they are already enrolled in Kentucky Access, they may stay in the program unless they are enrolled in Medicare Parts A, B and D.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* No
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 4.5

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Enrollee premiums, Master Tobacco Settlement receipts, annual assessments on insurers and stop loss carriers, and federal grant funds, when available.

2010 Sources: Premiums: 49%, Grants: 5%, Interest Income and Late Fees: 1%, Assessments: 19%, Other: 27% (Master Tobacco Settlement)

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: KRS 304.17B-021, the KY DOI shall assess each calendar year: (1) stop loss carriers $2 for each $100 of health insurance stop loss premiums, and (2) insurers based on health premiums earned during the prior period and paid by all who receive health premiums on which the annual assessment is based. This may be done twice a year, but can't exceed 1% of the total assessable premiums earned during the prior period.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: HIPAA and federally eligible individuals.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $400, $750, $1,000, $1,500

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Kentucky

Kentucky Access

www.kentuckyaccess.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	4,458	4,535	4,837
Average # Of Pool Participants	4,343	4,503	4,718
Total Premiums Collected	$26,556,178	$29,650,984	$32,918,810
Total Assessments Required	$11,693,783	$12,029,828	$11,714,092
Total Other Revenue	$30,090,113	$31,156,690	$19,652,488
Total Provider Reimbursement Costs For Medical And Rx Claims	$54,311,491	$56,877,566	$60,540,576
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$4,382,510	$4,082,985	$3,729,943

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Traditional Access	
$400 Deductible:	117
Premier Access	
$400 Deductible:	895
$1,000 Deductible:	716
$1,500 Deductible:	2,543
Preferred Access	
$750 Deductible:	119
$1,500 Deductible:	450

2010 Utilization

PMPM Expense	
Medical:	$730
Rx:	$339
Admin:	$66
Total:	$1,135
Hospital Utilization / 1,000	
Inpatient Admits:	159
Inpatient Days:	1,054
Outpatient Services:	68,676

Members average 3.3 scripts per month. While brand drugs represent only 41% of the count of rx scripts, they are 90% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes:	Annually
Established By:	The KY Department of Insurance
Rating Methodology:	
Brief Description:	Rates from at least two commercial carriers using both PPO and Indemnity plans are considered in the calculation.
Use SRR Calculation:	Yes
Weighted Or Simple Average:	Weighted
Max SRR % Allowed By State Law:	175%
Range Of SRR % Currently In Place:	130%
Avg SRR% for Non-Medicare Plans:	130%
Premiums Vary By:	Age, Gender
But Not By:	Smoking Status, Geography, Income, HIPAA Eligibility, Experience/Health, Length of Time in Pool, Prior Continuous Coverage
Premiums May Be Paid By:	Member, or Member's Parent, Grandparent, Spouse, Child, Grandchild, Stepchild, Father-In-Law, Mother-In-Law, Son-In-Law, Daughter-In-Law, Brother-In-Law, Sister-In-Law, Sibling, Guardian, or Court-Appointed Payer.
But Not By:	All Others
Rate Tables Can Be Found At:	www.kentuckyaccess.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Louisiana

Louisiana Health Plan (LHP)

www.lahealthplan.org

PLAN SUMMARY

Pool Contact: Leah Barron, Chief Executive Officer, Louisiana Health Plan, P.O. Drawer 83880, Baton Rouge, LA 70884-3880, Phone: (225) 926-6245, Toll-free: (800) 736-0947, Fax: (225) 927-3873, Email: lhp@lahealthplan.org

Contact For Application/Premiums: Louisiana Health Plan (Information above)

Plan Administrator: Covenant Administrators, Inc., P.O. Box 105738, Atlanta, GA 30348-5738, Phone: (800) 680-8728, Fax: (678) 258-8299

Operational Date: October 1992

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	None	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $100 for both the HIPAA Pool and the High Risk Pool

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 8

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: General revenue: With regard to the 2010 High Risk Pool, in addition to premiums, Louisiana received $1,657,623 in federal grants. There was no state appropriation. In addition, each patient (except as covered by the State Employees Group Benefits program, a program directly subsidized by the federal government or one covered by an insolvent insurer) admitted to a hospital shall be assessed a service charge of $2 per day for inpatient admissions and $1 for outpatient procedures.

2010 Sources: Premiums: 49%, Grants: 11%, Interest Income and Late Fees: 9%, Assessments: 28%, State General Fund: 0%, Other: 3% (Mandated Service Charge)

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers, HMOs

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Assessment is based upon a proportionate share of assessable premium.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Those eligible for statutory coverage in the high-risk pool or transferring from another state pool.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $1,000, $2,000, $3,500, $5,000

Annual Maximum: $125,000

Lifetime Maximum: $625,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Louisiana

Louisiana Health Plan (LHP)

www.lahealthplan.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	1,110	1,322	1,639
Average # Of Pool Participants	1,121	1,235	1,502
Total Premiums Collected	$7,556,672	$7,187,839	$7,441,287
Total Assessments Required	$1,645,273	$4,304,737	$4,256,682
Total Other Revenue	$6,309,588	$4,424,885	$3,536,586
Total Provider Reimbursement Costs For Medical And Rx Claims	$9,136,351	$10,918,536	$15,331,965
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,522,790	$1,622,965	$1,845,351

2010 PLAN MEMBERSHIP

(At Calendar Year End)

High Risk Pool:	617
HIPAA Plan:	1,022
$1,000 Deductible:	295
$2,000 Deductible:	476
$3,500 Deductible:	184
$5,000 Deductible:	684

2010 Utilization

PMPM Expense

Medical:	$718
Rx:	$133
Admin:	$35
Total:	$886

Hospital Utilization / 1,000

Inpatient Admits:	218
Inpatient Days:	989
Outpatient Services:	839

Members average 2.3 scripts per month. While brand drugs represent only 36% of the count of rx scripts, they are 89% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Independent actuary

Rating Methodology:

Brief Description: 5 top individual carriers

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 110% to 200%

Avg SRR% for Non-Medicare Plans: 155%

Premiums Vary By: Age, Gender, Smoking Status, Geography, HIPAA Eligibility. LHP maintains two separate pools (High Risk Pool and HIPAA Pool) and rates are based on eligibility in each pool.

But Not By: Income, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies: Ryan White Act

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.lahealthplan.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Maryland

Maryland Health Insurance Plan (MHIP)

www.marylandhealthinsuranceplan.state.md.us

PLAN SUMMARY

Pool Contact: Kent McKinney, Executive Director, Maryland Health Insurance Plan, 201 E. Baltimore Street, Suite 630, Baltimore, MD 21202, Phone: (410) 576-2053

Contact For Application/Premiums: MHIP, 10455 Mill Run Circle, Owings Mills, MD 21117-9685, Telephone: (888) 444-9016 www.marylandhealthinsuranceplan.state.md.us

Plan Administrator: CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., 10455 Mill Run Road, Owings Mills, MD 21117-9685, Phone: (888) 444-9016

Operational Date: July 1, 2003

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	68	Yes	Yes	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $100

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 10

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	N	Grievances:	N
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: MHIP is funded by premiums paid by members and by an annual assessment on Maryland hospitals.

2010 Sources: Premiums: 35.2%, Grants: 1.7%, Interest Income and Late Fees: 1.7%, Assessments: 61.5%

Assessments:

Are Charged To: Hospitals

And Not To: Commercial Health Carriers, Medicaid Carriers, Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: On or before May 1 of each year, the Maryland Health Services Cost Review Commission is required to determine the amount of funding to allocate to MHIP by multiplying 1.0% times the value of the total net patient revenues received in the immediately preceding State fiscal year by all hospitals for which rates were approved by the Commission. Hospitals are required to pay the amount determined in monthly installments of one-twelfth of the amount.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Applicants having prior health coverage within 63 days of applying, the wait period will be reduced.

AVAILABLE PLAN DESIGNS

HMO and PPO: Yes

Indemnity: No

HSA/HDHP: Yes

Copay Only Plan: Yes

Deductibles Offered: PPO: $200, $500, $1,000, $2,600, HMO: $200

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Maryland

Maryland Health Insurance Plan (MHIP)

www.marylandhealthinsuranceplan.state.md.us

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	15,180	17,658	19,944
Average # Of Pool Participants	14,458	16,551	19,106
Total Premiums Collected	$48,127,130	$58,996,154	$72,316,891
Total Assessments Required	$94,957,440	$110,990,730	$115,500,650
Total Other Revenue	$11,544,015	$8,024,466	$7,075,983
Total Provider Reimbursement Costs For Medical And Rx Claims	$120,372,521	$147,813,928	$164,676,841
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$10,178,242	$9,793,761	$15,223,885

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$200 Deductible PPO:	4,636
$500 Deductible PPO:	4,395
$1,000 Deductible PPO:	3,732
$2,600 Deductible PPO:	4,560
HMO:	1,723

2010 Utilization

PMPM Expense

Medical:	$555
Rx:	$234
Admin:	$46
Total:	$835

Hospital Utilization / 1,000

Inpatient Admits:	243
Inpatient Days:	588
Outpatient Services:	8,774

Members average 1.5 scripts per month. While brand drugs represent only 37% of the count of rx scripts, they are 90% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: As needed; typically reviewed on an annual basis

Established By: The Board for MHIP establishes premiums with the advice of an actuary. The rates are reviewed and approved by the Maryland Insurance Commissioner.

Rating Methodology:

Brief Description: The Board determines a standard risk rate by considering the premium rate charged by carriers in the State for coverage comparable to that of MHIP.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 55% to 135%

Avg SRR% for Non-Medicare Plans: 100%

Premiums Vary By: Age, Income, Family Composition and Benefit Package Delivery System

But Not By: Gender, Smoking Status, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer, Special Interest Group, Hospital

But Not By: None

Rate Tables Can Be Found At: www.marylandhealthinsuranceplan.state.md.us

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	31%	40%	70%	N/A	Yes

How is the Subsidy Funded? Hospital Assessments

Comments: Reductions in deductibles and coinsurance are also available.

Minnesota

Minnesota Comprehensive Health Association

www.mchamn.com

PLAN SUMMARY

Pool Contact: Peggy Zimmerman-Belbeck, Director of Operations, Minnesota Comprehensive Health Association, 5775 Wayzata Blvd. Suite 910, St. Louis Park, MN 55416, Phone: (952) 593-9609, Email: Peggy@mchamn.com

Contact For Application/Premiums: Available online at www.MCHAMN.com

Plan Administrator: Medica, 401 Carlson Parkway, CP 265, Minnetonka, MN 55305-5387, Contact: Anton Dmytrenko (952) 992-3704

Operational Date: June 1976

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	44	Yes	No	No	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $50

Coverage For Medicare Eligibles: Yes

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 3

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: MCHA is funded through member premiums and by assessments on all insurers that sell health and accident insurance in Minnesota.

2010 Sources: Premiums: 47%, Grants: 0.5%, Interest Income and Late Fees: 0%, Assessments: 52.3%, Other: 0.2%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Member companies pay their share of the assessment in direct proportion to their total share of health insurance premium written in the state of Minnesota.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Yes, refer to MCHA application for info on specific exceptions.

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $2,000, $3,000, $5,000, $10K

Lifetime Maximum: $5,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Minnesota

Minnesota Comprehensive Health Association

www.mchamn.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	27,386	27,187	27,073
Average # Of Pool Participants	29,188	27,396	27,086
Total Premiums Collected	$116,264,157	$122,038,917	$128,741,215
Total Assessments Required	$136,548,740	$125,306,804	$142,680,989
Total Other Revenue	$2,458,607	$657,863	$1,705,238
Total Provider Reimbursement Costs For Medical And Rx Claims	$245,773,335	$241,370,823	$263,766,918
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$11,694,466	$9,810,653	$9,911,118

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Medicare Supplement Plans:	569
$500 deductible plan:	2,154
$1,000 deductible plan:	4,595
$2,000 deductible plan:	8,150
$3,000 deductible plan*:	3,791
$5,000 deductible plan:	4,600
$10,000 deductible plan:	3,214

*HDHP

2010 Utilization

PMPM Expense

Medical:	$737
Rx:	$175
Admin:	$22
Total:	$934

Hospital Utilization / 1,000

Inpatient Admits:	155
Inpatient Days:	769
Outpatient Services:	3,512

Members average 2.0 scripts per month. While brand drugs represent only 29% of the count of rx scripts, they are 86% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Independent actuarial consultant, recommended by the Board of Directors and approved or modified by the Commissioner of Commerce.

Rating Methodology:

Brief Description: MCHA rates are set as a percent of the average individual market rates and calculated as a weighted average of rates for compatible plans.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 125%

Range Of SRR % Currently In Place: 101% to 125%

Avg SRR% for Non-Medicare Plans: 115%

Premiums Vary By: Age, Smoking Status

But Not By: Gender, Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer if group coverage isn't available, Special Interest Groups

But Not By: Member's Employer if group coverage is available

Rate Tables Can Be Found At: www.mchamn.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
220% FPL	9%	N/A	N/A	$1,674,608	Yes

How is the Subsidy Funded? Total funding is provided by the bonus funds from Federal Grants to States for High Risk Pools. Qualified individuals receive a one-time check each year the Low Income Subsidy is offered.

Comments: None

Mississippi

Comprehensive Health Insurance Risk Pool Association

www.mississippihealthpool.org

PLAN SUMMARY

Pool Contact: L.M. Craft, EDr, Comprehensive Health Insurance Risk Pool Association., P.O. Box 13748, Jackson, MS 39236, Phone: (601) 899-9967, Toll-free: (888) 820-9400, Email: craft@mississippihealthpool.org

Contact For Application/Premiums: Information and applications may be obtained by calling or writing to the Association. This information and an online application may also be obtained on the Association's website.

Plan Administrator: CoreSource, Inc.

Operational Date: January 1992

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	88	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: One time $100 finder's fee

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 2

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The Association is funded by premiums and assessments paid by Association member insurers. No public funds are used. Quarterly assessments are based on the number of Covered Persons (individual policies/group certificates) each member insurer has as of the first of each month of the calendar quarter. The statutory maximum rate of assessment is $3.00 per Covered Person per month, but the current assessment is $1.50.

2010 Sources: Premiums: 64.5%, Grants: 4.2%, Interest Income and Late Fees: 1.9%, Assessments: 29.4%

Assessments:

Are Charged To: Commercial Health Carriers, Stop loss carriers, TPAs, Reinsurers, HMOs

And Not To: Medicaid Carriers, Hospitals, Other Medical Providers

Calculation: The rate of assessment is determined through actuarial analysis, which attempts to predict future funding

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes, 12 months

Length Of Wait Period: 6 months Rx, 9 months pregnancy

Exceptions: Persons eligible under HIPAA

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA or Copay Only Plan: No

Deductibles Offered: $1,000, $2,000, $3,000, $5,000, $10,000

Annual Maximum: $100,000 (for Rx)

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Mississippi

Comprehensive Health Insurance Risk Pool Association

www.mississippihealthpool.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	3,464	3,446	3,514
Average # Of Pool Participants	3,547	3,455	3,480
Total Premiums Collected	$18,234,496	$17,783,526	$18,075,559
Total Assessments Required	$8,437,165	$8,381,939	$8,243,478
Total Other Revenue	$1,901,123	$2,485,249	$1,692,794
Total Provider Reimbursement Costs For Medical And Rx Claims	$22,548,274	$24,882,117	$29,385,521
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,597,069	$1,941,202	$1,894,329

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Membership by Plan is not available due to change in TPA, however:

As of 1/1/2010:	3,446
As of 1/1/2011:	3,514

2010 Utilization

PMPM Expense

Medical:	$555
Rx:	$208
Admin:	$30
Total:	$793

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Members average 4.5 scripts per month.

Notes:

PMPM = Per Member Per Month

/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Independent consulting actuary

Rating Methodology:

Brief Description: The calculation is based on rates and benefits of health insurers licensed in Mississippi. Blue Cross and Blue Shield of Mississippi has the predominant share of the health market. As a result, Blue Cross rates have a significant impact on calculation of the Association's rates.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 175%

Range Of SRR % Currently In Place: 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, HIPAA Eligibility, Deductible

But Not By: Smoking Status, Geography, Income, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Member's Employer, Church

But Not By: Government Agencies, Special Interest Groups

Rate Tables Can Be Found At: www.mississippihealthpool.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Missouri

Missouri Health Insurance Pool

www.mhip.org

PLAN SUMMARY

Pool Contact: Vernita McMurtrey, Executive Director, MHIP, 832 Weathered Rock Ct, P.O. Box 104538, Jefferson City, MO 65110, Phone: (573) 526-2349, Toll-free: (800) 821-2231

Contact For Application/Premiums: www.mhip.org and (800) 821-2231

Plan Administrator: BCBS of Kansas City, One Pershing Sq, 2301 Main, Kansas City, MO 64108, Toll-free: (888) 989-8842, Anthem BCBS, 1831 Chestnut St, Saint Louis, MO 63103, Phone: (314)923-4444, Toll-free: (800) 843-6447

Operational Date: November 1991

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	None	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $150 flat fee for Missouri brokers

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 3

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Funded by assessments and premiums paid by enrollees.

2010 Sources: Premiums: 64.7%, Grants: 3.5%, Interest Income and Late Fees: 1.1%, Assessments: 30.7%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Statute requires a survey of the 5 largest individual health carriers in the state completed on an annual basis. The projection includes future losses in relation to paid claims, loss trends, operational expense projections, etc.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: Contact MHIP for more details

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $2,500, $5,000

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Missouri

Missouri Health Insurance Pool

www.mhip.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,999	3,613	4,046
Average # Of Pool Participants	2,899	3,353	3,874
Total Premiums Collected	$21.220.788	$24,138,706	$29,759,731
Total Assessments Required	$3,262,207	$10,462,791	$14,121,554
Total Other Revenue	$1,047,808	$2,264,890	$2,136,569
Total Provider Reimbursement Costs For Medical And Rx Claims	$24,743,496	$31,139,448	$39,390,449
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$2,745,928	$3,299,016	$3,841,673

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$500 deductible:	381
$1,000 deductible:	602
$2,500 deductible:	1,108
$2,500 HDHP:	191
$5,000 deductible:	1,764

2010 Utilization

PMPM Expense

Medical:	$559
Rx:	$288
Admin:	$83
Total:	$930

Hospital Utilization / 1,000

Inpatient Admits:	362
Inpatient Days:	2,448
Outpatient Services:	6,015

While brand drugs represent only 31% of the count of rx scripts, they are 64% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Through actuarial justification, premium changes are recommended by the Board of Directors and approved by the Department of Insurance.

Rating Methodology:

Brief Description: Calculations include a summary of the 5 largest individual health carriers in the state.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 130%

Avg SRR% for Non-Medicare Plans: 130%

Premiums Vary By: Age, Gender, Income

But Not By: Smoking Status, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Members Employer, Special Interest Groups, Any Other Source

But Not By: None

Rate Tables Can Be Found At: www.mhip.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	12%	$150	$150	$762,795	No

How is the Subsidy Funded? CMS Federal Grant

Comments: None

Montana

Montana Comprehensive Health Association

www.mthealth.org

PLAN SUMMARY

Pool Contact: Linda Price, Specialist, MCHA, c/o BCBS of Montana, 560 N. Park Avenue, P.O. Box 4309, Helena, MT 59604 Phone: (406) 437-6048 or (800) 447-7828 x6048
Cecil D. Bykerk, Executive Director, Phone: (402) 501-8701, Fax: (402) 393-1645
Carol Roy, Montana Department of Insurance, Phone: (406) 444-3917

Contact For Application/Premiums: Visit our website or call Blue Cross Blue Shield of Montana at (800) 447-7828, ext. 2128.

Plan Administrator: Blue Cross and Blue Shield of Montana

Operational Date: July 1987

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	71	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $100 (at discretion of Board and approval of Insurance Commissioner)

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, contracted on a part time basis

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Premiums, assessments, grants

2010 Sources: Premiums: 60.7%, Grants: 4.4%, Interest Income and Late Fees: 0.7%, Assessments: 31.2%, Other: 3.6% (State Monies-Tobacco Settlement Fund Interest)

Assessments:

Are Charged To: Commercial Health Carriers

And Not To: Medicaid Carriers, Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: The assessment calculation is statutorily based. MCHA may assess an amount up to 1% of the assessable premium written in the state. The MCHA Board projects financial performance and assesses once per year based on the needs of the plans. The Insurance Commissioner providers the premium data for calculation of the assessment through an annual survey of carriers.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: Yes, with continuous involuntarily termed coverage

AVAILABLE PLAN DESIGNS

HMO: No

PPO and Indemnity: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $1,000, $2,500, $5k, $7.5k, $10k

Annual Maximum: $750,000

Lifetime Maximum: None

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Montana

Montana Comprehensive Health Association

www.mthealth.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,995	2,926	2,953
Average # Of Pool Participants	3,026	2,963	2,954
Total Premiums Collected	$17,104,119	$16,823,480	$16,519,242
Total Assessments Required	$7,692,509	$7,979,426	$8,025,890
Total Other Revenue	$1,249,023	$1,464,315	$1,190,682
Total Provider Reimbursement Costs For Medical And Rx Claims	$26,045,651	$26,267,221	$23,396,658
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,399,318	$1,458,105	$1,457,603

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Traditional/Portability Plans

$1,000 Indemnity:	25/26
$1,000 PPO:	90/87
$2,500 PPO:	129/559
$5,000 PPO:	589/292
$7,500 PPO:	113/157
$10,000 PPO:	144/303
Medicare Carve-Out:	181/0

Premium Assistance Plan

$1,000 deductible (PPO):	227
Medicare Carve-Out:	40

2010 Utilization

PMPM Expense

Medical:	$516
Rx:	$144
Admin:	$34
Total:	$694

Hospital Utilization / 1,000

Inpatient Admits:	52
Inpatient Days:	238
Outpatient Services:	1,373

Members average 2.4 scripts per month. While brand drugs represent only 28% of the count of rx scripts, they are 70% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: The Board with consultation of an actuary. Rates must also be approved by the Insurance Commissioner.

Rating Methodology:

Brief Description: The commissioner provides a list annually of the five insurers with the largest premium amount of individual plans of major medical insurance in force in the state. MCHA's actuary requests additional info and adjusts for plan differences to develop the average market rate.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple for 2011, weighted for 2012

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 129% to 141%

Avg SRR% for Non-Medicare Plans: 134%

Premiums Vary By: Age, Income, HIPAA Eligibility

But Not By: Gender, Smoking Status, Geography, Experience/Health, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Special Interest Groups

But Not By: Member's Employer

Rate Tables Can Be Found At: www.mthealth.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
150% FPL	9%	45%	45%	$935,223	No

How is the Subsidy Funded? State Tobacco Settlement

Comments: None

Nebraska

Nebraska Comprehensive Health Insurance Pool (NECHIP)

www.nechip.com

PLAN SUMMARY

Pool Contact: Adam Steffen, Manager NECHIP, Blue Cross and Blue Shield of Nebraska, P.O. Box 3248 Omaha, NE 68180-0001, Phone: (402) 982-6593, Fax: (402) 398-3640 Email: adam.steffen@bcbsne.com

Contact For Application/Premiums: (402) 343-3574 and (877) 348-4304

Plan Administrator: Blue Cross Blue Shield of Nebraska

Operational Date: November 1986

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	56	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $25

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: The Board shall make periodic estimates of the amount needed from the Fund for payment of losses resulting from claims, including a reasonable administrative reserve, and administrative, organizational and interim operating expenses and shall notify the Director of Insurance of such estimates. The Director is required to approve all withdrawals from the Fund to assure the continuing financial stability of the Fund.

2010 Sources: Premiums: 57%, Grants: 1%, Other: 42% (CHIP Distributive Fund)

Assessments:

Are Charged To: None

And Not To: Commercial Health Carriers, Stop Loss Carriers, Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: N/A

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Prior Medicaid, Medically Handicapped Child Program, or Medicare due to transplant, involuntary termination of prior coverage, HIPAA eligible

AVAILABLE PLAN DESIGNS

HMO, Indemnity, Copay: No

PPO and HSA/HDHP: Yes

Deductibles Offered: $500, $1,000, $1,500, $2,000, $3,000, $4,000, $5,000, $7,500, $10,000

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Nebraska

Nebraska Comprehensive Health Insurance Pool (NECHIP)

www.nechip.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	5,089	5,081	4,570
Average # Of Pool Participants	5,126	5,160	4,878
Total Premiums Collected	$30,892,348	$29,252,909	$31,692,009
Total Assessments Required	$0	$0	$0
Total Other Revenue	$27,322,962	$25,034,972	$22,676,857
Total Provider Reimbursement Costs For Medical And Rx Claims	$54,558,979	$51,385,519	$51,543,839
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$3,656,331	$2,902,362	$2,831,346

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$500 Deductible:	272
$1,000 Deductible:	510
$1,500 Deductible:	214
$2,000 Deductible:	744
$3,000 Deductible:	411
$4,000 Deductible:	565
$5,000 Deductible:	800
$7,500 Deductible:	173
$10,000 Deductible:	580
$2,000 HSA:	301

2010 Utilization

PMPM Expense

Medical:	$646
Rx:	$252
Admin:	$48
Total:	$946

Hospital Utilization / 1,000

Inpatient Admits:	181
Inpatient Days:	911
Outpatient Services:	5,333

Members average 3.0 scripts per month. While brand drugs represent only 37% of the count of rx scripts, they are 87% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Per statute, calculated by an independent actuary, subject to approval by the Board and DOI.

Rating Methodology:

Brief Description: As of calendar year 2010, the SRR is determined by calculating the average individual rate charged by the ten insurers writing the largest amount of individual health insurance coverage in the state, actuarially adjusted to be comparable with the pool coverage.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 145% and will increase to 150% in 2012

Range Of SRR % Currently In Place: 145%

Avg SRR% for Non-Medicare Plans: 145%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies: Ryan White

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.nechip.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

New Hampshire

New Hampshire Health Plan (NHHP)

www.nhhp.org

PLAN SUMMARY

Pool Contact: J. Michael Degnan, Executive Director, Helms & Company, Inc , One Pillsbury Street, Suite 200, Concord, NH 03301-3570, Phone: (603) 225-6633, Fax: (603) 225-4739

Contact For Application/Premiums: Visit www.nhhp.org or contact Benefit Management, Inc. at (877) 888-6447 for premium rates and policy forms.

Plan Administrator: Helms & Company, Inc., One Pillsbury Street, Suite 200, Concord, NH 03301-3570

Operational Date: Summer of 2002

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	16	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: NHHP offers a Low Income Premium Subsidy Program (LIPS) to persons whose income is 400% of FPL or less.

Agent Compensation: $200 one time

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 0, but pool has hired Helms and Company to perform executive management functions

Responsibilities Of Helms:

Eligibility Determination:	N	Customer Service:	N	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Premiums and a broad-based assessment of insurance carriers based on a "per covered lives" basis. Stop loss insurer's are among those to be assessed. In addition to its regular assessment, NHHP may establish a special assessment if its funds might otherwise become insufficient. Special assessments may be passed through to insureds.

2010 Sources: Premiums: 51%, Grants: 5.1%, Interest Income and Late Fees: .2%, Assessments: 43.7%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Based on an actuarial projection of the calculated subsidy with consideration of prior year shortfalls or overages. The assessment is calculated as the number of covered lives times a specified amount which is fixed through the calendar year and determined by the Board.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes, for indemnity and managed care plans

Length Of Wait Period: 9 months

Exceptions: None

AVAILABLE PLAN DESIGNS

HMO or Copay Only Plan: No

PPO and Indemnity: Yes

HSA/HDHP: Yes

Deductibles Offered: $1,000, $2,000, $2,500, $3,500, $5,000, $5,950, $10,000

Lifetime Maximum: $2,500,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

New Hampshire

New Hampshire Health Plan (NHHP)

www.nhhp.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	1,094	1,275	1,573
Average # Of Pool Participants	1,103	1,181	1,424
Total Premiums Collected	$6,129,185	$6,855,304	$8,806,841
Total Assessments Required	$6,302,291	$67,236	$7,553,767
Total Other Revenue	$866,635	$1,110,726	$915,163
Total Provider Reimbursement Costs For Medical And Rx Claims	$12,183,418	$11,879,897	$12,601,814
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$843,929	$843,124	$1,097,691

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Indemnity Plan A:	64
Indemnity Plan B:	21
Managed Care Plan A:	416
Managed Care Plan B:	271
Managed Care Plan C:	339
Managed Care Plan D:	268
Managed Care Plan H:	194

2010 Utilization

PMPM Expense

Medical:	$670
Rx:	$81
Admin:	$64
Total:	$815

Hospital Utilization / 1,000

Inpatient Admits:	42
Inpatient Days:	183
Outpatient Services:	51

Members average 1.7 scripts per month. While brand drugs represent only 29% of the count of rx scripts, they are 77% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: NHHP rates are set on January 1 and July 1.

Established By: An independent actuary recommends the premiums, which are then approved by the Board of Directors and the Commissioner of Insurance.

Rating Methodology:

Brief Description: All companies offering individual comprehensive major medical in the state (5 companies currently).

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 125%

Avg SRR% for Non-Medicare Plans: 125%

Premiums Vary By: Age, Smoking Status, Income

But Not By: Gender, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage.

Premiums May Be Paid By: Member, Direct Family Member, Member's Employer

But Not By: Government Agencies, Special Interest Groups

Rate Tables Can Be Found At: www.nhhp.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
400% FPL	11%	18%	20%	$211,579	No

How is the Subsidy Funded? CMS Federal Grant

Comments: None

New Mexico

New Mexico Medical Insurance Pool (Pool)

www.nmmip.org

PLAN SUMMARY

Pool Contact: Deborah Armstrong, Executive Director, P.O. Box 6726, Santa Fe, NM 87502, Phone: (505) 424-7105, Fax: (505) 424-7107, Email: darmstrong@nmmip.org

Contact For Application/Premiums: www.nmmip.org, (505) 424-7105, or toll-free at (866)622-4711

Plan Administrator: Blue Cross and Blue Shield of New Mexico, Leslie Malek-Chavez, NMMIP Administrator, P.O. Box 27630, Albuquerque, NM 87125-7630, Phone: (505) 816-4248, Fax: (505) 816-5671 Toll-free: (800) 432-0750

Operational Date: 1988

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	53	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: Children's Medical Services, HIV/AIDS, Hemophilia

Agent Compensation: $100 one time payment after receipt of first month's premium

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, the Executive Director and staff are on a contract basis with the pool

Number Of Staff: 0 employed by the pool, Executive Director's contract includes 5 staff

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Premiums, Federal grant, assessments to carriers, 50% premium tax credit on regular and low-income program (LIPP) and a 75% premium tax credit on losses for publicly sponsored members.

2010 Sources: Premiums: 21%, Grants: 2%, Tax Credits: 42%, Assessments: 35%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers, Medicaid Carriers

And Not To: Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Formula based on market share premium

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Yes, for prior continuous coverage.

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $2,500, $5,000, $7,500, $10K

Lifetime Maximum: None

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

New Mexico

New Mexico Medical Insurance Pool (Pool)

www.nmmip.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	6,020	7,684	8,429
Average # Of Pool Participants	5,456	7,044	8,175
Total Premiums Collected	$15,687,401	$19,566,284	$23,898,664
Total Assessments Required	$49,028,813	$65,892,146	$84,712,661
Total Other Revenue	$1,262,689	$4,585,277	$2,272,565
Total Provider Reimbursement Costs For Medical And Rx Claims	$60,740,483	$89,077,166	$105,949,624
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$3,430,418	$4,421,316	$4,934,266

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$500 Deductible:	5,154
$1,000 Deductible:	876
$2,000 Deductible:	897
$5,000 Deductible:	683
$7,500 Deductible:	87
$10,000 Deductible:	135
Medicare Carve-Out:	592
Senior Pharmacy:	5
Medbank:	9

2010 Utilization

PMPM Expense

Medical:	$842
Rx:	$223
Admin:	$51
Total:	$1,116

Hospital Utilization / 1,000

Inpatient Admits:	261
Inpatient Days:	766
Outpatient Services:	7,791

Members average 2.3 scripts per month. While brand drugs represent only 32% of the count of rx scripts, they are 67% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: January 1 and July 1

Established By: An actuary calculates the semi-annual changes in the Standard Risk Rate. Changes in Pool rates are recommended by the Board and the DOI has final say.

Rating Methodology:

Brief Description: The SRR is the actuarial value of the rate that would be charged for an individual policy with Pool benefits. It is based on the average of the actuarially adjusted rates of the largest individual carriers in the state.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 28% to 112%

Avg SRR% for Non-Medicare Plans: 78%

Premiums Vary By: Age, Gender, Income

But Not By: Smoking Status, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, Member's Employer, Special Interest Groups

But Not By: None

Rate Tables Can Be Found At: www.nmmip.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
400% FPL	49%	64%	75%	$12,455,057	No

How is the Subsidy Funded? Insurer Assessments, CMS Federal Grant

Comments: None

North Carolina

North Carolina Health Insurance Pool

www.inclusivehealth.org

PLAN SUMMARY

Pool Contact: Michael Keough, Executive Director, North Carolina Health Insurance Risk Pool dba Inclusive Health, 3739 National Drive, Suite 228, Raleigh, NC 27612, Phone: (919) 783-5766 Fax:(919) 783-5767, Email: Michael.Keough@inclusivehealth.org

Contact For Application/Premiums: Contact the Administrator

Plan Administrator: CoreSource, Inc., 5200 77 Center Drive, Suite 400, Charlotte, NC 28217-0718

Operational Date: January 2009

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	66	Yes	Yes	Yes	Yes*	Yes

Other Eligibility Comments: *Dependents are only covered if primary is TAA eligible

Special Populations Covered: None

Agent Compensation: $150 to $200

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? No
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 2

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Premiums from enrolled individuals, the annual transfer of state premium tax collections (a portion of revenue growth on existing taxes), and an annual payment from the NC State Health Plan.

2010 Sources: Premiums: 74%, Tax Credits: 18%, Interest Income and Late Fees: 2%, Grants: 3%, Other: 2% (State Employees and Teachers Health Plan)

Assessments:

Are Charged To: None

And Not To: Commercial Health Carriers, Medicaid Carriers, Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: N/A

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Federally defined HIPAA and TAA

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $2,500, $3,500, $5,000

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

North Carolina

North Carolina Health Insurance Pool

www.inclusivehealth.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	0	2,365	4,846
Average # Of Pool Participants	0	1,318	3,738
Total Premiums Collected	$0	$8,769,395	$23,621,320
Total Assessments Required	$0	$0	$0
Total Other Revenue	$0	$14,163,294	$8,129,692
Total Provider Reimbursement Costs For Medical And Rx Claims	$0	$8,049,472	$23,026,939
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$0	$2,153,696	$3,350,159

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 Deductible:	596
$2,500 Deductible:	1,155
$3,500 Deductible:	1,380
$5,000 Deductible:	1,502

2010 Utilization

PMPM Expense

Medical:	$294
Rx:	$231
Admin:	$44
Total:	$569

Hospital Utilization / 1,000

Inpatient Admits:	143
Inpatient Days:	880
Outpatient Services:	N/A

Members average 2.8 scripts per month.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: An independent actuary recommends the premiums, which are then approved by the Board of Directors and the Insurance Commissioner.

Rating Methodology:

Brief Description: The SRR is based on the average of the premium rates for the largest individual insurers based on market share in North Carolina. It is then adjusted by a multiplier.

Use SRR Calculation: Yes
Weighted Or Simple Average: Simple
Max SRR % Allowed By State Law: 175%
Range Of SRR % Currently In Place: 135% to 175%
Avg SRR% for Non-Medicare Plans: 140%

Premiums Vary By: Age, Gender, Income, Smoking Status
But Not By: Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member
But Not By: Government Agencies, Member's Employer, Health Care Providers

Rate Tables Can Be Found At: www.inclusivehealth.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	15%	31%	43%	$1,500,006	No

How is the Subsidy Funded? CMS Federal Grant

Comments: The subsidy program became effective in January 2010.

North Dakota

Comprehensive Health Association of North Dakota (CHAND)

www.chand.org

PLAN SUMMARY

Pool Contact: Administrative and Board of Directors:, Kathy Robley, Blue Cross Blue Shield of North Dakota, 4510 13th Avenue South, Fargo, ND 58121-0001, Phone: (701) 282-1235

Contact For Application/Premiums: Reference the chand.org website

Plan Administrator: Lead Carrier Services provided by Blue Cross Blue Shield of North Dakota

Operational Date: 1982

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	18	Yes	Yes	Yes	Yes	Yes

Other Eligibility Comments: TAARA (Trade Adjustment Assistance Reform Act)

Special Populations Covered: None

Agent Compensation: $25

Coverage For Medicare Eligibles: Yes, for those over age 65 and under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: Allocated lead carrier staff

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Pool is funded through premiums, grants and assessments

2010 Sources: Premiums: 50.9%, Grants: 11.9%, Interest Income and Late Fees: 0.1%, Assessments: 37.1%

Assessments:

Are Charged To: Health Insurance Carriers, Medicare Supplement Carriers

And Not To: Medicaid carriers, TPAs, Hospitals, Other Medical Providers; Federal Employees Health Benefits Plans; Medicare Part C Plans; Accidental or Disability Plans, Supplemental Liability, Limited Dental or Vision, Long-Term Care, Nursing Home Care, Home Health, Community-Based, or Limited Benefits; Specified HIPAA; Specified Disease or Illness; Hospital Indemnity

Calculation: Assessments are calculated to fulfill any projected losses. The amount is calculated by the Lead Carrier and approved by CHAND's Board. This is typically completed on an annual basis, but can be done more or less often as needed.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: TAARA's and at discretion of Board based on legislative authority.

AVAILABLE PLAN DESIGNS

HMO:	No
PPO:	No
Indemnity:	Yes
HSA/HDHP:	No
Copay Only Plan:	No
Deductibles Offered:	$500, $1,000
Lifetime Maximum:	$1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

North Dakota

Comprehensive Health Association of North Dakota (CHAND)

www.chand.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	1,463	1,422	1,462
Average # Of Pool Participants	1,470	1,435	1,442
Total Premiums Collected	$7,398,137	$7,178,374	$7,553,197
Total Assessments Required	$4,000,000	$5,000,000	$5,500,968
Total Other Revenue	$446,292	$431,366	$1,775,609
Total Provider Reimbursement Costs For Medical And Rx Claims	$10,342,768	$13,464,299	$12,009,394
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$378,983	$429,806	$382,710

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Traditional/HIPAA/TAARA benefit plans:

$500 deductible w/o chiro:	448
$500 deductible w/ chiro:	310
$1,000 deductible w/o chiro:	275
$1,000 deductible w/ chiro:	112
Standard/Basic Supplement for age 65 / disabled:	317

2010 Utilization

PMPM Expense

Medical:	$511
Rx:	$159
Admin:	$22
Total:	$692

Hospital Utilization / 1,000

Inpatient Admits:	320
Inpatient Days:	1,460
Outpatient Services:	4,648
Other (SNF & Swing Bed, Home Health, etc.)	339
Professional:	58,977

Members average 2.6 scripts per month. CHAND Rx reimbursement is not based on brand or generic.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually as established by the CHAND Board

Established By: The Lead Carrier establishes the rates CHAND's Board approves the rates, and then they are filed with the Insurance Department for informational purposes.

Rating Methodology:

Brief Description: The Lead Carrier establishes the premiums based on North Dakota Century Code at 135% of the rates for similar coverage within North Dakota.

Use SRR Calculation: No

Weighted Or Simple Average: N/A

Max SRR % Allowed By State Law: 135%

Range Of SRR % Currently In Place: 135%

Avg SRR% for Non-Medicare Plans: 135%

Premiums Vary By: Age

But Not By: Gender, Smoking Status, Income, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member

But Not By: Government Agencies, Member's Employer, Special Interest Groups, Health Care Provider, Nonprofit Charitable Organization

Rate Tables Can Be Found At: www.chand.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Oklahoma

Oklahoma Health Insurance High Risk Pool

www.bcbsok.com/ohrp

PLAN SUMMARY

Pool Contact: Frazier Farley, Oklahoma High-Risk Pool, P.O. Box 50429, Midwest City, OK 73140-5429
Phone: (405) 741-8434

Contact For Application/Premiums: Contact the plan administrator (OHRP-BCBSOK) at (877) 885-3717 for premium rates and policy forms.

Plan Administrator: OHRP-BCBSOK, P.O. Box 3283, Tulsa, OK 74102-3283, Phone: (877) 885-3717

Operational Date: July 1, 1996

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	54	Yes	Yes	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: OHRP covers any health condition of otherwise eligible individuals.

Agent Compensation: $100

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: The pool employs a manager

Number Of Staff: 1

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Premiums and assessments

2010 Sources: Premiums: 39%, Grants: 4%, Assessments: 57%

Assessments:

Are Charged To: Commercial Health Carriers, Medicaid Carriers, Stop Loss Carriers

And Not To: Hospitals, Other Medical Providers

Calculation: Assessments are based on a member company's net assessable premium.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: Yes, for the federally eligible

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $1,500, $2,000, $5,000, $7,500

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Oklahoma

Oklahoma Health Insurance High Risk Pool

www.bcbsok.com/ohrp

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,098	1,896	2,175
Average # Of Pool Participants	2,144	1,965	2,012
Total Premiums Collected	$13,349,958	$12,182,648	$11,489,601
Total Assessments Required	$10,007,042	$10,116,041	$16,959,917
Total Other Revenue	$1,392,608	$2,008,785	$1,354,643
Total Provider Reimbursement Costs For Medical And Rx Claims	$21,862,706	$23,519,195	$27,632,812
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,322,223	$1,320,187	$1,494,175

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Original Plan:	1,948
Alternate Plan:	222
HCTC Plan:	5

2010 Utilization

PMPM Expense

Medical:	$750
Rx:	$394
Admin:	$62
Total:	$1,206

Hospital Utilization / 1,000

Unable to provide hospital utilization at this time.

Members average 3.3 scripts per month. While brand drugs represent only 39% of the count of rx scripts, they are 85% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: This depends on the timing the Board believes is necessary.

Established By: Independent actuary

Rating Methodology:

Brief Description: The average standard risk rate is derived from the top five companies doing business in Oklahoma (and adjusted for variations).

Use SRR Calculation: Yes
Weighted Or Simple Average: Simple
Max SRR % Allowed By State Law: 150%
Range Of SRR % Currently In Place: 125% to 150%
Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Smoker/Non-Smoker
But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies
But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.bcbsok.com/ohrp

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Oregon

Oregon Medical Insurance Pool (OMIP)

www.omip.state.or.us

PLAN SUMMARY

Pool Contact: Tom Jovick, Oregon Medical Insurance Pool, 250 Church St. SE Ste 200, Salem, OR 97301, Phone: (503) 373-1692, Fax: (503) 378-8365

Contact For Application/Premiums: Regence BlueCross BlueShield of Oregon at (503) 225-6620 or (800) 848-7280, or access through the Internet at www.omip.state.or.us.

Plan Administrator: Regence Blue Cross Blue Shield of Oregon

Operational Date: July 1990

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Citizen	82	Yes	No	No	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: Members enrolled in CAREAssist Program

Agent Compensation: $75 paid after the enrollee has paid the first month's premium

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 5 to 6

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The pool is funded by member premiums, assessments on insurers and reinsurers, and interest earned on money held in reserve.

2010 Sources: Premiums: 53%, Assessments: 47%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, Hospitals, Other Medical Providers

Calculation: The assessment is calculated by Fiscal Services staff with input and review by various data analysts, actuaries and the Oregon Insurance Division. The assessment model uses historical paid claims, premiums and enrollment data to project losses in the 6 month periods of January through June and July through December. Various adjustments are made for trend, enrollment, seasonality, etc. The projected assessment amount is divided by the estimated number of covered lives in Oregon as of March 31 to yield a per-covered-life assessment.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Credit for prior coverage applies towards wait period.

AVAILABLE PLAN DESIGNS

HMO: No

PPO: Yes

Indemnity: No

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $500, $750, $1,000, $1,500

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Oregon

Oregon Medical Insurance Pool (OMIP)

www.omip.state.or.us

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	15,320	14,517	13,618
Average # Of Pool Participants	16,596	14,683	14,029
Total Premiums Collected	$81,907,382	$79,742,276	$84,471,671
Total Assessments Required	$79,049,187	$90,366,148	$80,106,164
Total Other Revenue	$3,053,246	$2,381,432	$5,841,345
Total Provider Reimbursement Costs For Medical And Rx Claims	$163,029,078	$155,934,942	$167,065,940
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$7,981,842	$6,628,727	$7,143,923

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Plan 500:	6,128
Plan 750:	2,178
Plan 1000:	1,770
Plan 1500:	3,542

2010 Utilization

PMPM Expense

Medical:	$751
Rx:	$251
Admin:	$129
Total:	$1,131

Hospital Utilization / 1,000

Inpatient Admits:	758
Inpatient Days:	N/A
Outpatient Services:	N/A

Members average 2.7 scripts per month. While brand drugs represent only 25% of the count of rx scripts, they are 82% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: OMIP staff calculates the rates, with input from the actuaries for the Third Party Administrator and the Oregon Insurance Division. The Board approves the final rates.

Rating Methodology:

Brief Description: OMIP surveys in the Individual market and the Portability market premiums for benefit plans that are similar to those offered by OMIP to develop weighted average market premiums for the coming year.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 125%

Range Of SRR % Currently In Place: 117%

Avg SRR% for Non-Medicare Plans: 117%

Premiums Vary By: Age, Tier (Single, 2-Party, Family), Income

But Not By: Gender, Smoking Status, Geography, HIPAA Eligibility, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.omip.state.or.us

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
200%	10%	95%	95%	N/A	No

How is the Subsidy Funded? N/A

Comments: Details about the Family Health Insurance Assistance Program (FHAP) can be found at www.omip.state.or.us

South Carolina

South Carolina Health Insurance Pool

www.doi.sc.gov

PLAN SUMMARY

Pool Contact: Blue Cross Blue Shield of South Carolina, P.O. Box 61173, Columbia, SC 29260-1173
Toll-free: (800) 868-2500 ext. 46401, Phone: (803) 788-0500 ext. 46401

Contact For Application/Premiums: Contact the administrator at (800) 868-2500 ext. 46401, for premium rates and policy forms.

Plan Administrator: Blue Cross Blue Shield of South Carolina

Operational Date: February 1990

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	0	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: None

Coverage For Medicare Eligible's: Yes, under age 65 and covered under Medicare Parts A and B for reasons other than age.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: 0

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	N	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Premiums and member assessments. Insurers are assessed for the net losses of the Pool in proportion to their share of total health insurance premiums. Assessments are offset against state premium or income taxes, with total tax credits limited to $10 million in any one year for all members combined.

2010 Sources: Premiums: 92.5%, Grants: 7.4%, Interest Income and Late Fees: 0.1%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, Hospitals, Other Medical Providers

Calculation: Assessments occur at year end with interims as necessary. It is determined by multiplying the net loss of pool operations by a fraction. The numerator is the insurer's health insurance premiums written in SC during the preceding calendar year, and the denominator is the total of all health insurance premiums written by all insurers in SC during the same period.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Credit for prior coverage

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, HDHP: $1,500, Medicare Plans A and C

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

South Carolina

South Carolina Health Insurance Pool

www.doi.sc.gov

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	2,328	2,255	2,256
Average # Of Pool Participants	2,319	2,292	2,281
Total Premiums Collected	$25,120,853	$24,982,468	$25,749,894
Total Assessments Required	$4,199,337	$0	$0
Total Other Revenue	$398,799	$1,521,304	$2,078,853
Total Provider Reimbursement Costs For Medical And Rx Claims	$26,630,046	$26,341,078	$29,331,325
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,803,306	$1,747,420	$1,731,341

2010 PLAN MEMBERSHIP

(At Calendar Year End)

80/80 Network Option:	88
80/60 Network Option:	385
HDHP:	1,497
Medicare Supplement:	286

2010 Utilization

PMPM Expense

Medical:	$929
Rx:	$143
Admin:	$63
Total:	$1,135

Hospital Utilization / 1,000

Inpatient Admits:	282
Inpatient Days:	1,561
Outpatient Services:	N/A

Members average 1.7 scripts per month. While brand drugs represent only 40% of the count of rx scripts, they are 85% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Upon approval by the Director of Insurance and 31 days notice

Established By: Independent actuary

Rating Methodology:

Brief Description: The SRR is takes into account the rates of the five largest insurers offering individual coverage in SC.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 200%

Avg SRR% for Non-Medicare Plans: 200%

Premiums Vary By: Age, Gender; Those eligible due to premiums which exceed 150% of pool premiums must pay an additional 25% for the first six months during which pre-existing condition exclusions are waived.

But Not By: Smoking Status, Geography, Income, HIPAA Eligibility, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies, An Insurable Interest

But Not By: Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.doi.sc.gov

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

South Dakota

South Dakota Risk Pool

http://riskpool.sd.gov

PLAN SUMMARY

Pool Contact: Larry Kucker, Risk Pool Program Manager, c/o Bureau of Personnel, State of South Dakota, 500 East Capitol Avenue, Pierre, SD 57501, Phone: (605) 773-3148, Fax: (605) 773-6840 Email: riskpool@state.sd.us

Contact For Application/Premiums: Phone (605) 773-3148 or email riskpool@state.sd.us, visit http://riskpool.sd.gov, or see a licensed health insurance agent.

Plan Administrator: South Dakota Bureau of Personnel, Phone: (605) 773-3148, Email: riskpool@state.sd.us

Operational Date: August 1, 2003

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	No	No	No	No	No	Yes

Other Eligibility Comments: None

Special Populations Covered: No

Agent Compensation: Three percent of premium

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* No
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 2

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The South Dakota Risk Pool is funded by a combination of: premiums paid by individual members; state general revenue funding of $700,000 and $1.5 million reserve; assessments to health insurance carriers providing coverage in the state, including stop loss and excess loss carriers; and an initial start-up grant from the U.S. Centers for Medicaid and Medicare Services risk pool grant program of $1,000,000.

2010 Sources: Premiums: 66%, Grants: 7%, Interest Income and Late Fees: 5%, Assessments: 12%, State General Fund: 9%, Other: 1% (refunds)

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, Hospitals, Other Medical Providers

Calculation: Per legislation, the assessment to health insurance carriers on a per covered lives basis is not to exceed $0.35 per person per month.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: No

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $3,000, $10,000

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

South Dakota

South Dakota Risk Pool

http://riskpool.sd.gov

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	653	642	645
Average # Of Pool Participants	668	652	634
Total Premiums Collected	$4,653,097	$4,378,338	$4,447,077
Total Assessments Required	$860,722	$845,459	$1,223,491
Total Other Revenue	$1,568,280	$1,718,041	$1,902,412
Total Provider Reimbursement Costs For Medical And Rx Claims	$5,949,604	$7,296,451	$6,196,728
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$323,201	$410,420	$414,999

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 deductible:	206
$2,000 deductible:	21
$3,000 deductible:	233
$5,000 deductible:	35
$7,500 deductible:	4
$10,000 deductible:	86
$3,000 HSA:	60

2010 Utilization

PMPM Expense

Medical:	$565
Rx:	$262
Admin:	$54
Total:	$881

Hospital Utilization / 1,000

Inpatient Admits:	160
Inpatient Days:	801
Outpatient Services:	2,771

Members average 3.1 scripts per month. While brand drugs represent only 33% of the count of rx scripts, they are 88% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually (July 1)

Established By: Independent actuary

Rating Methodology:

Brief Description: Premium rates shall be 150% of the average in force premium or payment rate for that classification charged by at least three carriers with the largest number of individual health benefit plans in the state during the preceding calendar year.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 150%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Smoking Status

But Not By: Geography, Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Country Assistant Program

But Not By: Government Agencies, Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: http://riskpool.sd.gov

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? No

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?

Comments: None

Tennessee

Access Tennessee (Access TN)

www.AccessTN.gov

PLAN SUMMARY

Pool Contact: Bo Irvin, Director, (615) 741-9750, Bo.Irvin@tn.gov, Krista Lee, Assistant Director, (615) 253-9942, Krista.m.lee@tn.gov or access.tn@tn.gov, c/o Tennessee Division of Health Care Finance and Admin, 26th Floor, WRS Tennessee Tower, 312 Rosa L. Parks Ave, Nashville, TN 37243-1700

Contact For Application/Premiums: Call toll-free (866) CoverTN or (866) 268-3786

Plan Administrator: BCBS of Tennessee, 1 Cameron Hill, Chattanooga, TN 37402, Toll-free: (866) 636-0080

Operational Date: April 2007

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	55	Yes	Yes	No	No	Yes

Other Eligibility Comments: Non-Citizens limited to qualified legal aliens who meet federally defined exceptions contained in 8 U.S.C § 1622(b)

Special Populations Covered: No

Agent Compensation: None

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: No

Accepts HCTC Payments: No

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: Full-time Director plus State staff as needed to perform supervision and vendor oversight.

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: AccessTN is funded by premiums, state funds and, if necessary to cover losses, assessments.

2010 Sources: Premiums: 24.4%, Interest Income and Late Fees: 1.7%, Assessments: 11.1%, State General Fund: 62.8%

Assessments:

Are Charged To: Commercial Health Carriers, Medicaid Carriers (HMOs-only, but not currently included in assessment), Stop Loss Carriers, TPAs

And Not To: Hospitals, Other Medical Providers

Calculation: Assessments are to cover losses. The assessments will be based on covered lives and are limited to the amount of the state appropriation to fund AccessTN.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 3 months

Exceptions: Exhausting COBRA, adults completing TennCare, or children aging out of SCHIP/CoverKids or a parent's plan.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $3,000, $5,000

Annual Maximum: varies by plan

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Tennessee

Access Tennessee (Access TN)

www.AccessTN.gov

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	4,516	3,785	3,973
Average # Of Pool Participants	3,909	4,060	3,859
Total Premiums Collected	$31,384,560	$32,523,261	$46,338,191
Total Assessments Required	$4,090,548	$4,100,574	$4,876,652
Total Other Revenue	$2,374,574	$0	$0
Total Provider Reimbursement Costs For Medical And Rx Claims	$36,868,842	$41,505,113	$42,088,319
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$2,813,797	$1,705,414	$693,675

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Plan One* ($1,000 ded):	3,430
Plan Two ($3,000 ded):	226
Plan Three ($5,000 ded):	317

* Premium assistance eligible

2010 Utilization

PMPM Expense

Medical:	$1,200
Rx:	$568
Admin:	$24
Total:	$1,792

Hospital Utilization / 1,000

Inpatient Admits:	269
Inpatient Days:	320
Outpatient Services:	510

Members average 3.2 scripts per month. While brand drugs represent only 21% of the count of rx scripts, they are 75% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: As needed, but usually on an annual basis.

Established By: The Board based on actuarial recommendations.

Rating Methodology:

Brief Description: The SRR is based on the average rates collected through a survey of the largest individual carriers in Tennessee. The SRR is adjusted to account for benefit variations.

Use SRR Calculation: Yes

Weighted Or Simple Average: Simple

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 130%

Avg SRR% for Non-Medicare Plans: 130%

Premiums Vary By: Age, Smoking Status, HIPAA Eligibility, Weight, Income

But Not By: Gender, Geography, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Special Interest Groups, Other Individuals, Disease Support Group, or foundations may pay premium if disclosed to pool and if no conflict of interest exists.

But Not By: Government Agencies, Member's Employer, Medical Providers

Rate Tables Can Be Found At: www.AccessTN.gov

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes, but only to members who are currently enrolled and continue to meet eligibility criteria.

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
350% FPL	86%	72%	80%	N/A	No

How is the Subsidy Funded? State General Fund and Assessments

Comments: Percent of subsidy is tiered based on FPL. The lower the FPL, the higher the discount. New members are currently not eligible for premium assistance.

Texas

Texas Health Insurance Pool

www.txhealthpool.org

PLAN SUMMARY

Pool Contact: Steven Browning, ED, Texas Health Insurance Pool, 1701 Directors Blvd. #120, Austin, TX 78744, Phone: (512) 441-7665, Fax: (512) 441-7690, Email: poolinfo@txhealthpool.org

Contact For Application/Premiums: Toll-free: (888) 398-3927; Hearing impaired: (800) 735-2989;
Email: texashealthpool@bcbstx.com; Website: www.txhealthpool.org

Plan Administrator: Blue Cross Blue Shield of Texas, Inc., P.O. Box 660819, Dallas, TX 75266
Phone: (888) 398-3927

Operational Date: 1998

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Citizen	56	Yes	Yes	No	Yes	Yes

Other Eligibility Comments: Agent certification allowed

Special Populations Covered: No

Agent Compensation: $50 referral fee for each issued policy

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 4

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The Texas Pool is largely funded by covered members' premiums and assessments on insurers.

2010 Sources: Premiums: 66.7%, Grants: 3%, Assessments: 30.3%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers

And Not To: Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: The Texas Pool Board determines the amount to be assessed each year based upon actuarial projections of net losses for the upcoming 12-month period. The assessment amount is first allocated between fully-insured and stop-loss carriers based upon their relative share of assessable covered lives. The share allocated to fully-insured carriers is distributed based upon premium market share. The share allocated to stop-loss carriers is distributed based upon covered lives market share.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: Up to 12 months

Exceptions: Credit given for creditable coverage prior to enrollment.

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $2,500, $3,000, $5,000, $7,500

Lifetime Maximum: $3,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Texas

Texas Health Insurance Pool

www.txhealthpool.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	26,908	26,556	26,431
Average # Of Pool Participants	27,346	26,708	26,600
Total Premiums Collected	$195,428,416	$198,620,458	$215,152,762
Total Assessments Required	$76,471,627	$87,126,554	$97,622,164
Total Other Revenue	$5,081,065	$6,329,044	$9,694,306
Total Provider Reimbursement Costs For Medical And Rx Claims	$264,866,598	$273,347,726	$303,795,211
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$13,715,133	$12,822,580	$12,928,661

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$1,000 deductible:	2,965
$2,500 deductible:	8,937
$3,000 HSA:	563
$5,000 deductible:	9,695
$7,500 deductible:	4,271

2010 Utilization

PMPM Expense

Medical:	$670
Rx:	$299
Admin:	$40
Total:	$1,009

Hospital Utilization / 1,000

Inpatient Admits:	182
Inpatient Days:	1,238
Outpatient Services:	4,890

Members average 2.8 scripts per month. While brand drugs represent only 37% of the count of rx scripts, they are 83% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: The Pool Board reviews premium rates twice a year.

Established By: Premium rates are developed by the actuary and approved by the Board and Insurance Commissioner.

Rating Methodology:

Brief Description: The SRR is the average of the commercial carriers' adjusted composite rates. The 5 carriers currently included in the calculation have the largest blocks of open individual health insurance business in Texas.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 200%

Avg SRR% for Non-Medicare Plans: 200%

Premiums Vary By: Age, Gender, Smoking Status, Geography (zip code), Deductible Plan

But Not By: Income, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Friend, Family Member, Special Interest Groups

But Not By: Government Agencies, Member's Employer, Medical Provider

Rate Tables Can Be Found At: www.txhealthpool.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	11%	$300/mo	50%	$0	No

How is the Subsidy Funded? A portion of the penalties paid by insurers and HMOs to medical providers for clean claims paid late.

Comments: Subsidies began January 2011.

Utah

Utah Comprehensive Health Insurance Pool (HIPUtah)

www.selecthealth.org/hiputah

PLAN SUMMARY

Pool Contact: Tomi Ossana, Executive Director, Phone: (801) 485-2830, Email: tjossana@xmission.com
Elizabeth Hunter, Chair, Phone: (801) 595-5394, Email: lhunter@stmarkscathedral-ut.org

Contact For Application/Premiums: Contact the administrator at (801) 442-6660 or (800) 705-9173.

Plan Administrator: SelectHealth, Jim Murray, Director Government Programs, Phone: (801) 442-7499
Toll-free: (800) 705-9173, Fax: (801) 442-6969, Email: jim.murray@selecthealth.org

Operational Date: September 1991

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Both	Yes	No	No	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: Individuals under the Ryan White Act

Agent Compensation: $50

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates: *Use Commercially Contracted Rates?* Yes
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes, on a contractual basis

Number Of Staff: Done by Administrator and State

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: Funding is provided by the Comprehensive Health Insurance Pool Enterprise Fund. The fund is credited with all premiums, appropriations from the state's general fund, and interest and dividends earned on fund assets.

2010 Sources: Premiums: 66%, Grants: 6%, Interest Income and Late Fees: 1%, State General Fund: 27%

Assessments:

Are Charged To: None

And Not To: Commercial Health Carriers, Stop Loss Carriers, Medicaid Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: N/A

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: Loss of coverage and new residents who were on a similar plan in previous states.

AVAILABLE PLAN DESIGNS

HMO: Yes

PPO or Indemnity: No

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $2,500, $5,000

Annual Maximum: $400,000

Lifetime Maximum: $1,500,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Utah

Utah Comprehensive Health Insurance Pool (HIPUtah)

www.selecthealth.org/hiputah

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	3,715	3,924	4,158
Average # Of Pool Participants	3,614	3,729	3,958
Total Premiums Collected	$19,554,792	$20,452,889	$22,717,807
Total Assessments Required	$0	$0	$0
Total Other Revenue	$10,800,000	$10,300,869	$8,800,648
Total Provider Reimbursement Costs For Medical And Rx Claims	$27,314,491	$28,458,861	$33,062,286
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$1,849,045	$1,816,523	$1,991,458

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$500 deductible:	939
$1,000 deductible:	615
$2,500 deductible:	758
$5,000 HDHP:	1,808

2010 Utilization

PMPM Expense

Medical:	$585
Rx:	$111
Admin:	$42
Total:	$738

Hospital Utilization / 1,000

Inpatient Admits:	162
Inpatient Days:	656
Outpatient Services:	1,051

Members average 2.3 scripts per month. While brand drugs represent only 26% of the count of rx scripts, they are 75% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Rates are adjusted biannually.

Established By: An actuary recommends premiums and the HIPUtah Board and Insurance Department provide the approval.

Rating Methodology:

Brief Description: HIPUtah uses the index rate as defined in Utah Code Title 31A Chapter 30. Individual carriers are required to file conversion rates that do not exceed 135% of the index rate. These rates for $1,000 deductible plans are compared to the HIPUtah $1,000 plan.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 137%

Avg SRR% for Non-Medicare Plans: 137%

Premiums Vary By: Age, Income

But Not By: Gender, Smoking Status, Geography, HIPPA Eligibility, Experience/Health, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member, Government Agencies (Ryan White Fund)

But Not By: Member's Employer

Rate Tables Can Be Found At: www.selecthealth.org/hiputah

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	28%	38%	50%	$2,040,583	No

How is the Subsidy Funded? CMS Federal Grant

Comments: None

Washington

Washington State Health Insurance Pool (WSHIP)

www.wship.org

PLAN SUMMARY

Pool Contact: Kären Larson, Executive Director, P.O. Box 329, Bow, WA 98232-0329
Phone: (360) 766-6336

Contact For Application/Premiums: Benefit Management, Inc., Toll-free: (800) 877-5187, www.wship.org

Plan Administrator: Benefit Management, Inc., P.O. Box 1090, Great Bend, KS 67530, Toll-free: (800) 877-5187

Operational Date: July 1988

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	0	Yes	Yes	Yes	Yes	Yes

Other Eligibility Comments: Dependents of eligibles are limited to children.

Special Populations Covered: Individuals eligible under the Ryan White Act, some individuals with kidney disease

Agent Compensation: $100

Coverage For Medicare Eligibles: Yes, for all Medicare eligibles.

HIPAA Alternative Mechanism: No

Accepts HCTC Payments: No

Provider Reimbursement Rates:
Use Commercially Contracted Rates? Yes
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: 4

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	N	Grievances:	N
Marketing/Outreach:	Y	Financial Statements:	N	Accounts Payable:	N

FUNDING

Pool Funding: Funding is primarily from premiums and assessments.

2010 Sources: Premiums: 34.8%, Grants: 1.9%, Interest Income and Late Fees: 0.0%, Assessments: 62.7%, State General Fund: 0.0%, Other: 0.6%

Assessments:

Are Charged To: Commercial Health Carriers, Medicaid Carriers, Stop Loss Carriers, Insured Multiple Employer Welfare Associations, Uniform Medical Plan

And Not To: TPAs, Hospitals, Other Medical Providers

Calculation: Assessments on carriers are on a covered lives basis. Stop loss carriers and the state employee's uniform medical plan are assessed based on insured lives divided by ten. There is no premium tax offset. Carriers must remit profits in excess of 74% to 77% (percentage depends on declination rates). Assessments are done 3 times a year and calculated to maintain a minimum of 3 weeks of claims at all times.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: If 18 months of prior continuous coverage.

AVAILABLE PLAN DESIGNS

HMO: No

PPO and Indemnity: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $500, $1,000, $1,500, $2,500, $3,000, $5,000

Lifetime Maximum: None

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Washington

Washington State Health Insurance Pool (WSHIP)

www.wship.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	3,397	3,618	3,923
Average # Of Pool Participants	3,336	3,460	3,768
Total Premiums Collected	$19,604,248	$24,408,153	$29,398,559
Total Assessments Required	$40,700,000	$44,558,900	$53,087,591
Total Other Revenue	$1,899,320	$2,731,518	$2,123,744
Total Provider Reimbursement Costs For Medical And Rx Claims	$55,207,849	$67,609,809	$79,342,905
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$3,567,380	$3,468,600	$2,938,775

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Standard $500 deductible:	122
Standard $1,000 deductible:	21
Standard $1,500 deductible:	124
PPO $500 deductible:	1,678
PPO $1,000 deductible:	224
PPO $2,500 deductible:	540
PPO $3,000 deductible*:	104
PPO $5,000 deductible:	257
PPO Ltd A $1,500 deductible:	7
PPO Ltd B $1,500 deductible:	9
Medicare A & B Wrap:	332
Medicare A, B & D Wrap:	505

*HSA Qualified

2010 Utilization

PMPM Expense

Medical:	$939
Rx:	$809
Admin:	$65
Total:	$1,813

Hospital Utilization / 1,000

Inpatient Admits:	178
Inpatient Days:	1,206
Outpatient Services:	294

Members average 2.9 scripts per month. While brand drugs represent only 43% of the count of rx scripts, they are 91% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes:	Annually
Established By:	Independent actuary
Rating Methodology:	
Brief Description:	For non-Medicare products the SRR is calculated using the average individual rates charged for comparable pool coverage by the 5 largest individual carriers. Medicare products SRR is determined by calculating the average Med Supp rates charged for Plan F by the five largest Medicare Supplement carriers.
Use SRR Calculation:	Yes
Weighted Or Simple Average:	Weighted
Max SRR % Allowed By State Law:	150%
Range Of SRR % Currently In Place:	110% to 150%
Avg SRR% for Non-Medicare Plans:	113%
Premiums Vary By:	Age, Smoking Status, Income, Length of Time in Pool, Prior Continuous Coverage
But Not By:	Gender, Geography, Experience/ Health, HIPAA Eligibility
Premiums May Be Paid By:	Member, Direct Family Member, Government Agencies, Member's Employer, Special Interest Groups
But Not By:	None
Rate Tables Can Be Found At:	www.wship.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
300% FPL	1%	20%	52%	$64,837	No

How is the Subsidy Funded? Assessments

Comments: Subsidy may not result in premium below 110% of Standard Risk Rate.

West Virginia

AccessWV

www.AccessWV.org

PLAN SUMMARY

Pool Contact: Nancy Malecek, Executive Director, AccessWV (Acting), P.O. Box 50540, Charleston, WV 25305-0540, Phone: (304) 558-8279 x1175, Toll-free: (866) 445-8491
Fax: (304) 558-8362, Email: nancy.malecek@wvinsurance.gov

Contact For Application/Premiums: Contact AccessWV at (866) 445-8491 or consult the website at www.AccessWV.org

Plan Administrator: WV Public Employees Insurance Agency

Operational Date: July 2005

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	47	Yes	No	Yes	Yes	Yes

Other Eligibility Comments: None

Special Populations Covered: None

Agent Compensation: $50

Coverage For Medicare Eligibles: No

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: Yes

Provider Reimbursement Rates:
Use Commercially Contracted Rates? No
Use Statutory Rates? No
Do Any Other Discounts Apply? No

Executive Director: Yes

Number Of Staff: One plus acting director

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	N

FUNDING

Pool Funding: Premiums and hospital assessments

2010 Sources: Premiums: 80%, Interest Income and Late Fees: 3%, Assessments: 17%

Assessments:

Are Charged To: Hospitals

And Not To: Commercial Health Carriers, Medicaid Carriers, Stop Loss Carriers, TPAs, Other Medical Providers

Calculation: Hospital gross revenue is assessed a maximum of 0.025%; as of 7/1/10 the rate was reduced by half to 0.0125%.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: HIPAA and HCTC eligibles, and persons who lose coverage

AVAILABLE PLAN DESIGNS

HMO or Indemnity: No

PPO: Yes

HSA/HDHP: No

Copay Only Plan: No

Deductibles Offered: $400, $800, $2,000, $4,000

Annual Maximum: $200k (medical)

Lifetime Maximum: $1,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

West Virginia

AccessWV

www.AccessWV.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	653	734	884
Average # Of Pool Participants	574	651	814
Total Premiums Collected	$3,520,000	$4,287,737	$4,986,893
Total Assessments Required	$2,070,000	$1,034,772	$1,056,635
Total Other Revenue	$330,000	$39,260	$329,377
Total Provider Reimbursement Costs For Medical And Rx Claims	$2,810,000	$3,564,063	$4,396,278
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$500,000	$340,686	$320,346

2010 PLAN MEMBERSHIP

(At Calendar Year End)

$400 deductible Plan A:	139
$800 deductible Plan B:	163
$2,000 deductible Plan C:	372
$4,000 deductible Plan D:	210

2010 Utilization

PMPM Expense

Medical:	$275
Rx:	$117
Admin:	$29
Total:	$421

Hospital Utilization / 1,000

Inpatient Admits:	257
Inpatient Days:	1,742
Outpatient Services:	4,542

Members average 2.2 scripts per month. While brand drugs represent only 25% of the count of rx scripts, they are 85% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually (generally)

Established By: The premiums are established by the Board and approved by the WV Offices of the Ins. Commissioner.

Rating Methodology:

Brief Description: AccessWV's risk rate is developed based on a comparison of the actuarial values of its plans to the individual marketplace. The methodology recognizes benefit differentials, but not reimbursement differentials.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 150%

Range Of SRR % Currently In Place: 125% to 150%

Avg SRR% for Non-Medicare Plans: 127%

Premiums Vary By: Age, Gender, Geography, Tier (single or family), Income

But Not By: Smoking Status, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member

But Not By: Government Agencies, Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.AccessWV.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
400% FPL	15%	N/A	N/A	$58,490	No

How is the Subsidy Funded? Fund Balance – Premiums and Hospital Assessments

Comments: The subsidy program began 7/1/2010. The number indicated in 'Total Subsidy Funding in 2010' is for July-December.

Wisconsin

Health Insurance Risk Sharing Plan (HIRSP)

www.hirsp.org

PLAN SUMMARY

Pool Contact: Amie Goldman, HIRSP Authority, 33 E. Main Street, Suite 230, Madison, WI 53703, Phone: (608) 441-5777

Contact For Application/Premiums: Contact the administrator at (800) 828-4777 for premium rates and policy forms or check the HIRSP website at: www.hirsp.org

Plan Administrator: WPS Health Insurance, Toll-free (800) 828-4777

Operational Date: June 1981

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	HIV/AIDS	Yes	Yes	Yes	No	Yes

Other Eligibility Comments: None

Special Populations Covered: Wisconsin residents who are eligible for Medicare due to a disability are eligible for HIRSP

Agent Compensation: $40 not HIRSP certified, $100 if HIRSP certified

Coverage For Medicare Eligibles: Yes, under age 65 disabled, members may remain after age 65 if enrolled prior to age 65.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates:
Use Commercially Contracted Rates? No
Use Statutory Rates? Yes
Do Any Other Discounts Apply? Yes

Executive Director: Yes, a CEO employed by the pool

Number Of Staff: 4

Responsibilities Of Staff:

Eligibility Determination:	N	Customer Service:	Y	Grievances/Appeals:	N/Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: HIRSP is funded 60% by premiums and 20% by both insurer assessments and provider discounts. The low-income subsidy program is funded first by any available federal grants and then 50% by insurers and 50% by providers.

2010 Sources: Premiums: 54.7%, Grants: 2.4%, Interest Income and Late Fees: 1%, Assessments: 20.7%, Other: 22.1% (Provider Contribution)

Assessments:

Are Charged To: Commercial Health Carriers, Medicaid Carriers

And Not To: Stop Loss Carriers, TPAs, Hospitals, Other Medical Providers

Calculation: Assessments are levied in proportion to the ratio of the insurer's health care coverage premium for residents of Wisconsin during the preceding calendar year to the aggregate health care coverage premium of all participating insurers for residents of Wisconsin during the preceding calendar year. Annual assessments can be paid in installments.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 6 months

Exceptions: HIPAA eligibles, those from BadgerCare, Medicaid, Medicare, Farmers Health Co-Op, other risk pools, and Rx

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1,000, $2,500, $3,500, $5,000

Lifetime Maximum: $2,000,000

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Wisconsin

Health Insurance Risk Sharing Plan (HIRSP)

www.hirsp.org

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	16,284	16,458	18,965
Average # Of Pool Participants	16,374	16,416	17,683
Total Premiums Collected	$96,105,543	$91,013,992	$88,814,852
Total Assessments Required	$39,291,498	$27,514,892	$30,955,033
Total Other Revenue	$1,340,574	$2,818,299	$3,603,584
Total Provider Reimbursement Costs For Medical And Rx Claims	$150,990,732	$141,132,161	$155,980,610
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$6,529,839	$6,696,399	$6,837,752

2010 PLAN MEMBERSHIP

(At Calendar Year End)

HIRSP 1,000:	1,632
HIRSP 2,500:	8,408
Medicare Supplement:	1,019
HSA 2,500:	421
HSA 3,500:	800
HIRSP 5,000:	6,685

2010 Utilization

PMPM Expense

Medical:	$560
Rx:	$185
Admin:	$32
Total:	$777

Hospital Utilization / 1,000

Inpatient Admits:	133
Inpatient Days:	803
Outpatient Services:	3,052

Members average 2.7 scripts per month. While brand drugs represent only 28% of the count of rx scripts, they are 84% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: An actuary in conjunction with preparation of an annual operating budget for the upcoming fiscal year.

Rating Methodology:

Brief Description: SRR is calculated as an analytical tool but is not used as the basis for setting HIRSP premiums. HIRSP subsidized premium rates are discounted off of the HIRSP standard rates based on the policyholder's household income, currently up to $33,999.99.

Use SRR Calculation: Yes, but not for basis of rates.

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: 200%

Range Of SRR % Currently In Place: 91% to 150%

Avg SRR% for Non-Medicare Plans: 98%

Premiums Vary By: Age, Gender, Income, Plan Type

But Not By: Smoking Status, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Anyone except as prohibited by Wisconsin law

But Not By: Federal, State, County, or Municipal Government or Agency

Rate Tables Can Be Found At: www.hirsp.org

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
$33,999.99	27%	32%	43%	$8,936,065	Yes

How is the Subsidy Funded? The low-income subsidy program is funded first by any available federal grants and then 50% by insurers and 50% by providers.

Comments: None

Wyoming

Wyoming Health Insurance Pool

www.WHIPCoverage.com

PLAN SUMMARY

Pool Contact: Peter Greff, Wyoming Insurance Department, 106 East 6th Avenue, Cheyenne, WY 82002-0440, Phone: (307) 777-7401

Contact For Application/Premiums: Contact the administrator at (888) 557-2519

Plan Administrator: Blue Cross Blue Shield of Wyoming

Operational Date: January 1991

Eligibility Info:

Resident vs. Citizen	Qualifying Medical Conditions	Rejection Letter	Exclusionary Rider	Qualifying Rate	Dependents of Eligible Individual	HIPAA
Resident	67	Yes	Yes	No	No	Yes

Other Eligibility Comments: Presumptive declination for Medicare under 65 population based on disability condition.

Special Populations Covered: None

Agent Compensation: $100

Coverage For Medicare Eligibles: Yes, for those under age 65 who are disabled.

HIPAA Alternative Mechanism: Yes

Accepts HCTC Payments: No

Provider Reimbursement Rates:
Use Commercially Contracted Rates? No
Use Statutory Rates? Yes
Do Any Other Discounts Apply? No

Executive Director: No

Number Of Staff: 3 full-time equivalents

Responsibilities Of Staff:

Eligibility Determination:	Y	Customer Service:	Y	Grievances:	Y
Marketing/Outreach:	Y	Financial Statements:	Y	Accounts Payable:	Y

FUNDING

Pool Funding: The Wyoming Health Insurance Pool is funded by member premiums, general fund appropriation and assessments to insurance carriers licensed to do business in Wyoming.

2010 Sources: Premiums: 43%, Grants: 5%, Tax Credits: 14%, Interest Income and Late Fees: 2%, Assessments: 15%, State General Fund: 21%

Assessments:

Are Charged To: Commercial Health Carriers, Stop Loss Carriers, TPAs

And Not To: Medicaid Carriers, Other Medical Providers

Calculation: Assessments are based on a combination of historical losses and projected future losses. There is a statutory annual cap of $6 million. Assessments are allocated to carriers based on annual data collected by the Wyoming Insurance Department including total premiums written.

PRE-EX AND WAIT PERIODS

Pre-Ex For Non-HIPAAs: Yes

Length Of Wait Period: 12 months

Exceptions: Waived if continuous credible coverage.

AVAILABLE PLAN DESIGNS

HMO or PPO: No

Indemnity: Yes

HSA/HDHP: Yes

Copay Only Plan: No

Deductibles Offered: $1k, $5k, $25k

Lifetime Maximum: Gold Plan: $1,000,000
Others: $750k

MORE INFORMATION

The information provided on these pages pertains only to the State Pools.
More information regarding vendors and disease management programs can be found at: www.naschip.org.

Wyoming

Wyoming Health Insurance Pool

www.WHIPCoverage.com

OPERATIONAL DATA

	2008	2009	2010
# Of Pool Participants At Year End	687	732	829
Average # Of Pool Participants	689	720	784
Total Premiums Collected	$4,361,813	$4,747,981	$4,942,633
Total Assessments Required	$2,000,000	$4,000,000	$1,800,000
Total Other Revenue (State General Fund)	$885,298	$1,823,415	$2,364,008
Total Provider Reimbursement Costs For Medical And Rx Claims	$8,171,029	$8,866,026	$9,753,088
Total Other Costs (TPA Fees, Pool Admin, Etc.)	$82,360	$133,741	$140,576

2010 PLAN MEMBERSHIP

(At Calendar Year End)

Non-Disabled Brown Plan:	171
Non-Disabled Gold Plan:	249
Catastrophic Plan:	12
Disabled Brown Plan:	34
Disabled Gold Plan:	363

2010 Utilization

PMPM Expense

Medical:	$894
Rx:	$145
Admin:	$15
Total:	$1,054

Hospital Utilization / 1,000

Inpatient Admits:	379
Inpatient Days:	1,711
Outpatient Services:	5,310

Members average 1.5 scripts per month. While brand drugs represent only 40% of the count of rx scripts, they are 89% of the cost of rx scripts.

Notes:
PMPM = Per Member Per Month
/1000 = Per 1000 Members Per Year

PREMIUMS

Frequency Of Changes: Annually

Established By: Wyoming Health Insurance Pool premiums are established by the WHIP Board of Directors and approved by the Wyoming Insurance Commissioner.

Rating Methodology:

Brief Description: Statutorily, the Wyoming Health Insurance Pool SRR is based on the average individual standard rate charged by the five largest insurers in the state offering comparable coverages.

Use SRR Calculation: Yes

Weighted Or Simple Average: Weighted

Max SRR % Allowed By State Law: Level 1: 200%, Level 2: 135%

Range Of SRR % Currently In Place: Level 1: 150% to 200%, Level 2: 100% to 135%

Avg SRR% for Non-Medicare Plans: 150%

Premiums Vary By: Age, Gender, Income

But Not By: Smoking Status, Geography, Experience/Health, HIPAA Eligibility, Length of Time in Pool, Prior Continuous Coverage

Premiums May Be Paid By: Member, Direct Family Member

But Not By: Government Agencies, Member's Employer, Special Interest Groups

Rate Tables Can Be Found At: www.WHIPCoverage.com

LOW-INCOME PREMIUM SUBSIDIES

Subsidy Offered in 2011? Yes

Maximum Income for Subsidy	% of Members Subsidized	Average Discount	Maximum Discount	Total Subsidy Funding in 2010	Unique Plan Design?
250% FPL	47%	32%	32%	$1,147,516	No

How is the Subsidy Funded? N/A

Comments: None

Other States

Arizona
www.id.state.az.us

Arizona does not have a state high-risk pool. Under federal law insurers are required to guarantee issue to groups as small as two, but Arizona does not extend guaranteed issue to individuals generally. However, if an employee leaves a job where he/she was covered under a fully insured group plan, in most cases that person would be eligible to buy a conversion policy from the insurer. The state enforces the federal fallback portability requirements for HIPAA.

In March 2009 the Arizona Chamber of Commerce and Industry released a white paper about the issues of the uninsured in Arizona. One of their recommendations was for Arizona to create a risk pool.

The full report can be found at:
http://www.azchamber.com/policy/policy-briefs

CONTACT INFO
For more information, contact the Arizona Department of Insurance at (602) 364-2499 or (602) 364-2393.

Website: www.id.state.az.us

Delaware
www.delawareinsurance.gov

Delaware does not have a state high-risk pool. Under federal law, insurers are required to guarantee issue to groups as small as two, but Delaware does not extend guaranteed issue to individuals generally. However, if an employee leaves a job where he was covered under a fully insured group plan, in most cases, that person would be eligible to buy a conversion policy from the insurer. The state enforces the federal fallback portability requirements for HIPAA.

CONTACT INFO
For more information, contact the Delaware Department of Insurance at (302) 674-7300 or (800) 282-8611.

Website: www.delawareinsurance.gov

Georgia
www.GAinsurance.org

Georgia does not currently have a state high-risk pool. Other than the federal high risk pool, there are no programs or regulations to provide guaranteed access in the individual market. Under HIPAA, conversion plans are mandated for individuals coming from true group plans. The individual carriers use an assignment system for individuals coming from self-funded plans.

Since its inception in 2005, the Georgia High Risk Insurance Commission has held several hearings and researched proposals for establishing a high-risk pool. In February 2007, SB 109 would have authorized the Commission to re-open the study of risk pools. The bill was withdrawn in April 2007.

In September 2007, Georgia was awarded a grant from CMS in the amount of $150,000 for purposes of a feasibility study. Milliman, Inc. was contracted by the Georgia Department of Insurance in late 2008 to perform the feasibility study and the feasibility study was published in March 2010.

CONTACT INFO

For more information, contact the Georgia Insurance Department Consumer Services Division at (800) 656-2298 or (404) 656-2070.

Website: www.GAinsurance.org

Hawaii
www.hawaii.gov/dcca/areas/ins

Hawaii does not have a state high-risk pool. All employers in Hawaii are required to offer health coverage to most employees who work at least 20 hours per week. While most other states cannot require employers to offer health coverage or dictate the terms of employer-provided health plan coverage, Hawaii has a unique ERISA exemption for its Prepaid Health Care Act that allows it to do so. Under federal law, insurers are required to guarantee issue to groups as small as two, but Hawaii does not extend guaranteed issue to groups of one or two individuals. The state enforces the federal fallback portability requirements for HIPAA.

CONTACT INFO

For more information, contact the State of Hawaii Insurance Division at (808) 586-2790 or (808) 586-2799.

Website: www.hawaii.gov/dcca/areas/ins

Maine
www.maine.gov/pfr/insurance

Guaranteed issue is required for all plans in the individual market. This is continuous and year-round and uses a modified community rating methodology. Rating adjustments are allowed for age, industry and geographic area, limited to 20 percent above or below the community rate. Further rating adjustments are allowed for family composition and smoking status. A 12-month waiting period is allowed for pre-existing conditions for applicants with no prior coverage in the past 90 days. For those with prior coverage, the waiting period is waived to the extent benefits would have been paid under the old policy.

CONTACT INFO
For more information, contact Maine Bureau of Insurance, (800) 300-5000 or (207) 624-8475.

Website: www.maine.gov/pfr/insurance/

Massachusetts
www.mahealthconnector.org

Massachusetts does not have a state high-risk pool.

The Massachusetts health care insurance reform law, enacted in 2006, mandates that nearly every resident of Massachusetts obtain a state-government-regulated minimum level of healthcare insurance coverage and provides free health care insurance for residents earning less than 150% of the federal poverty level who are not eligible for Mass Health (Medicaid). The law also partially-subsidizes health care insurance for those earning up to 300% of the FPL.

The law established an independent public authority, the Commonwealth Health Insurance Connector Authority, also known as the Health Connector. Among other roles, the Connector acts as an insurance broker to offer private insurance plans to residents.

The reform legislation also included tax penalties for failing to obtain an insurance plan. Massachusetts tax filers who failed to enroll in a health insurance plan which was deemed affordable for them lost the $219 personal exemption on their income tax. Beginning in 2008, penalties increased by monthly increments.

CONTACT INFO
For more information about Massachusetts, contact (617) 521-7777.

Website: www.mass.gov/DOI or www.mahealthconnector.org

Other States

Michigan
www.michigan.gov/cis

Michigan does not have a state high-risk pool.

Blue Cross Blue Shield of Michigan, a nonprofit organization, serves as carrier of last resort. Enrollment is open year-round. Plans have some limitations in benefits, including limits on prescription drugs. One non-group enrollment plan does include an outpatient prescription drug benefit. It has a 50 percent copayment and a $2,500 annual maximum benefit. Also, HMOs in Michigan are required by statute, after their first two years of operation, to offer individual health insurance coverage with a 30-day open enrollment period each year.

CONTACT INFO
For more information, contact the Michigan Office of Financial and Insurance Securities at (877) 999-6442 or (517) 373-0220.

Website: www.michigan.gov/cis then select "Financial & Insurance Services".

Nevada
www.doi.state.nv.us

Nevada does not have a state high-risk pool. There is no program or regulation to provide guaranteed access in the individual market. Under federal law, insurers are required to guarantee issue to groups as small as two, but Nevada does not extend guaranteed issue to groups of one or two individuals. A state-sponsored voluntary reinsurance program exists for participating carriers to cede lives in the individual and small group markets.

CONTACT INFO
For more information, contact the Nevada Division of Insurance at (775) 687-4270.

Website: www.doi.state.nv.us

New Jersey
www.state.nj.us/dobi

New Jersey does not have a state high-risk pool. Guaranteed issue is required for all plans in the individual market. Full community rating is used for all plans, except for a limited benefits plan, which may be rated based on age, gender and geography up to a 3.5:1 ratio. A 12-month pre-existing condition exclusion period is allowed for coverage of pre-existing conditions, with a six-month look back. Credit is applied for prior creditable coverage whether or not the person is HIPAA-eligible. The state has a risk adjustment mechanism available to carriers in the individual market that experience a loss ratio above 115 percent.

CONTACT INFO
For more information, contact the New Jersey Department of Banking and Insurance, Individual Health Coverage Program Board at (609) 633-1882.

Website: www.state.nj.us/dobi

New York
www.ins.state.ny.us

New York does not have a state high-risk pool. Guaranteed issue is required for all plans in the individual market. Coverage is community rated and open continuously, year-round. A 12-month waiting period is allowed for coverage of pre-existing conditions with a 6-month look back. The waiting period is waived for prior creditable coverage. No waiting period is required for HIPAA eligibles. State law requires all HMOs to offer a standard point-of-service plan and a standard managed care plan, with standard benefits fixed by statute. Blue Cross Blue Shield plans participate in the individual market through their HMO line of business.

New York received $150,000 in a seed grant from CMS in October 2006. This grant was provided to perform a pool funding methodology study.

CONTACT INFO
For more information, contact the New York Department of Insurance at (800) 342-3736.

Website: www.ins.state.ny.us

Other States

Ohio
www.ohioinsurance.gov

Ohio does not have a state high-risk pool. Instead, the state uses an open enrollment system to make coverage available to uninsurable individuals.

Under the Ohio open enrollment system, health insurance companies, multiple employer welfare arrangements (MEWAs), and health insuring corporations (HICs or HMOs) are required to accept individuals during an open enrollment period.

The open enrollment ends when the insurer has accepted the number of open enrollment applicants required by law. If all insurers have reached their limits of federally eligible individuals, a new open enrollment period will begin.

Insurers may reinsure coverage of any individual or nonemployer group with the Open Enrollment Reinsurance Program. The open enrollment program is funded through premiums and assessments. The assessments are apportioned among all insurers participating in the reinsurance program. The assessment of any insurer is limited to three percent of its Ohio premiums for health plans covering individuals.

In 2005, the Ohio Department of Insurance secured a federal grant to perform a high-risk pool feasibility study. A copy of the study can be found at www.insurance.ohio.gov.

CONTACT INFO
For more information, contact the Ohio Department of Insurance at (614) 644-2658.

Website: www.insurance.ohio.gov

Pennsylvania
www.ins.state.pa.us

Pennsylvania does not have a state high-risk pool. Open enrollment is offered by the four Blue Cross and Blue Shield plans in Pennsylvania. Enrollment is open continuously and the coverage is community rated. A 12-month waiting period is allowed for pre-existing conditions for applicants who are not eligible for portability under HIPAA. Individuals with previous Blue Cross and Blue Shield coverage may have their waiting period reduced for prior creditable coverage.

CONTACT INFO
For further information, contact the Pennsylvania Department of Insurance Consumer Services division at (717) 787-2317.

Website: www.ins.state.pa.us

Rhode Island
www.dbr.state.ri.us/divisions/healthinsurance

Rhode Island does not have a state high-risk pool. Open enrollment is offered by Blue Cross and Blue Shield of Rhode Island, during a limited annual open enrollment period. R.I.G.L - S 27-19.2-10 requires nonprofit hospital and/or medical service corporations (such as Blue Cross) to offer at least one 30-day open enrollment period every 12 months. A waiting period of 7 months is allowed for pre-existing conditions, other than for individuals who have 12 months of prior coverage and who have no waiting period.

In September 2007, Rhode Island was awarded a federal grant to perform a high-risk pool feasibility study. A copy of the study can be found at:
http://www.ohic.ri.gov/2009%20HRP%20study%20report.php

CONTACT INFO
For more information, contact the Rhode Island Department of Business Regulation Insurance Division at (401) 462-9520.

Website: www.dbr.state.ri.us/divisions/healthinsurance

Vermont
www.bishca.state.vt.us

Vermont does not have a state high-risk pool. Guaranteed issue is required for all plans in the individual and small group markets. It is continuous and open year-round. Rating adjustments are allowed for age, but are limited to 20 percent. Blue Cross Blue Shield of Vermont does not deviate rates by age. A 12-month waiting period is allowed for pre-existing conditions, with a 12-month lookback. The waiting period must be waived for individuals and dependents who have nine months of prior continuous health benefit coverage.

Act 191 of 2006, as implemented by the Vermont legislature, established among a variety of health care reforms a "Non-group Market Security Trust" for the purpose of reducing premiums in the individual market by a minimum of 5%, and perhaps as much as 15%.

Because of this reform, Vermont was awarded a $1,000,000 federal seed grant in October 2006 for start-up expenses of the trust, but matching state funds were required. Unfortunately, state funds were not appropriated for this purpose during the 2007 legislative session. As such, the federal grant was returned and no progress was made to lower the costs for Vermonters enrolled in individual products. Act 203 of 2008 required the state to study the merger of the nongroup, small group, and association markets by calendar year 2011.

CONTACT INFO
For more information, contact the Vermont Department of Banking, Insurance, Securities and Health Care Administration's Consumer Services Division at (802) 828-2900.

Website: www.bishca.state.vt.us

Virginia
www.scc.virginia.gov/division/boi

Virginia does not have a state high-risk pool. Blue Cross and Blue Shield plans offer open enrollment year-round, as required by statute. A 12-month pre-existing condition waiting period is allowed, except for HIPAA eligibles who have no waiting period. Individuals can apply for the standard plan offered. If after underwriting they are considered to be of higher risk, a higher premium rate can be charge. There are four premium levels.

CONTACT INFO
For more information, contact the Virginia Bureau of Insurance at (804) 371-9741.

Website: www.scc.virginia.gov/division/boi