Issue BRIEF

May 2006

High-Risk Health Insurance Pools

This issue brief covers the following topics:

- What are high-risk pools?
- Who do high-risk pools help?
- What alternatives do states use to guarantee access to individual insurance?
- How are high-risk pools financed?
- How much do premiums typically cost?
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- Have states done anything to make high-risk pools affordable to low-income consumers?
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What are high-risk pools?[1]

High-risk pools are nonprofit associations that are created by states to provide health insurance for residents with preexisting health conditions. Generally, a board of directors oversees the high-risk pool and contracts with a health insurance company to administer benefits and pay enrollees' claims. Individuals enroll in the high-risk pool by purchasing insurance through the association. By law, premiums are capped: They are somewhat higher than premiums charged to healthy people, but they are not as high as premiums for unhealthy individuals on the open market. The high-risk pool is subsidized in order to keep the premiums within the state's cap. The difference between the money collected from premiums and the cost of enrollees' actual claims (plus administrative expenses) is called the high-risk pool's "loss." The amount of this loss is subsidized, often through assessments charged to insurers, and sometimes from other state or federal funds.

Who do high-risk pools help?

High-risk pools are a way to guarantee access to insurance coverage for a small but important segment of the population—people who are deemed "uninsurable." Uninsurable people do not have coverage through their employers and cannot get coverage in the individual market, either because insurance companies offer them only policies

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with prohibitively high premiums or because insurers simply refuse to sell them policies due to their poor health. Minnesota, which operates the oldest high-risk pool in the nation, insures about 6 percent of its individually insured population through its high-risk pool. A few other states that have been effective in reaching their uninsurable populations cover 2-3 percent of their states' individually insured populations through their high-risk pools.[2]

In most states, high-risk pools provide coverage for middle class people who may be able to afford insurance but who are unhealthy and therefore cannot find insurers willing to sell them policies. In a few states (Colorado, Connecticut, Montana, New Mexico, Oregon, Washington, and Wisconsin), lower-income people receive additional premium subsidies to help them participate in the high-risk pools.

What alternatives do states use to guarantee access to individual insurance?

Under the federal Health Insurance Portability and Accountability Act (HIPAA), states must guarantee access to insurance for certain individuals who are leaving the group market. People who qualify for this federal guarantee are called "HIPAA-eligible," and they must meet the following criteria: a) they were previously insured for 18 months, the last day of which was through a group plan (usually a plan offered by an employer); b) they have used up any rights to continue their health coverage under the federal COBRA law (Consolidated Omnibus Budget Reconciliation Act of 1985)[3] or under similar state laws; c) they are not eligible for Medicare or Medicaid; and d) they have maintained coverage without a gap of more than 63 days.[4] For people previously insured through individual policies or for people who were previously uninsured, there is no federal law that guarantees access to insurance.

Thirty-three states use high-risk pools to guarantee access either to all individuals or to HIPAA-eligible individuals.[5] Other states meet federal HIPAA obligations or provide broader guarantees that insurance policies will be issued to all interested individuals by doing the following:

- requiring all insurers in the individual market to accept HIPAA-eligible applicants;
- requiring all insurers in the individual market to sell policies to all applicants, regardless of their health (called "guaranteed issuance");
- requiring one particular insurer (such as Blue Cross) to accept HIPAA-eligible individuals or to more generally provide an open enrollment period during which it will accept all individuals;
- requiring one particular type of insurer (e.g., all large insurers or all nonprofit insurers or HMOs that sell individual policies) to guarantee issuance to individuals at any time or during an open enrollment period; or
- allowing "uninsurables" to participate in a public program by paying premiums on a sliding fee scale (Tennessee used this approach for several years but has since stopped).[6]

To be effective, public policies that guarantee access to individual insurance must also address the cost of insurance for people with serious health conditions. In states with high-risk pools, capping premiums helps address this issue.[7] Some states also use rate regulation to address costs, either by prohibiting price variation based on health status altogether or by setting limits on how much an insurer can vary premiums based on health status. Since high-risk pool premiums are based on the average costs of premiums for equivalent coverage in the individual market, regulating the rates of *all* individual insurers can help lower the premiums for high-risk pools.

How are high-risk pools financed?

States use several different mechanisms to subsidize the operating costs of their high-risk pools so that premiums will stay within the caps set by law. One challenge that states face is establishing a fair and broad-based funding system that will grow at the same rate as health expenditures. To do this, some states assess all insurance carriers and HMOs. Because this source of revenue is tied to health care costs, it grows along with health expenditures. However, this kind of assessment is not considered broad-based because it reaches only "fully funded" health insurance and does not cover the many employers that "self-fund" health care for their workers.

Large companies often use self-funded insurance. To indirectly reach those employers who self-fund their plans, some states include assessments on stop-loss insurers and reinsurance carriers based on the number of covered lives (that is, the number of people they cover), rather than based on a percentage of premiums collected. (Stop-loss insurance and reinsurance carriers do not collect as many premium dollars as carriers that provide comprehensive coverage because they are only at risk for high-cost claims.) Some states also assess third-party administrators—that is, companies that administer health benefits for an employer who self-funds health insurance. In some states, insurers receive a tax credit for the assessment that they pay, meaning that, in the end, public dollars actually pay for all or part of the high-risk pool subsidy.

"Fully Funded" Health Coverage vs. "Self-Funded" Health Coverage

Employers that "fully fund" health insurance contract with a health insurance company to handle health benefits for their workers. These employers pay premiums to an insurer, and, in exchange, the insurer pays health care claims and bears the risk for claims. In contrast, employers who "self-fund" health insurance directly pay health care claims for their employees, although they may pay a third party administrator to administer health benefits and/or pay a stop-loss insurer to cover a portion of claims that exceed a certain dollar threshold.

States regulate fully funded insurance and can impose taxes or assessments on such health insurers. However, under the federal Employee Retirement Income Security Act (ERISA), states cannot regulate or directly assess employers' self-funded health benefit programs. Self-funded plans cover about 50 percent of people with employer-based coverage and comprise an even higher percentage of the insurance market in some states. So, without a broad base of assessment funding that reaches this portion of the market, the burden of paying for high-risk pool losses falls only on the fully funded insurance plans, which are primarily used by small businesses and individuals.

Hospital or health care provider surcharges are another source of revenue used by some state high-risk pools. This is another source of broad-based funding that may indirectly spread financing among both self-funded and fully funded plans.

Lastly, a number of states use either a special funding source (such as a tobacco tax) or general appropriations to finance high-risk pools. However, these sources may not grow at the same rate as health inflation, so, over time, they may fall short of the amount needed to subsidize premiums.

In addition to state financing mechanisms, high-risk pools may receive federal grants. Federal grants can be used for the following purposes:

- as seed money to start a high-risk pool in a state that does not have one;
- for losses a state incurs by operating a high-risk pool; or
- to provide additional consumer benefits, such as a premium subsidy for low-income enrollees, an overall reduction in premium costs, reduction or elimination of a waiting list for enrollment, reduction of the waiting period before preexisting conditions are covered, an increase in covered benefits, or establishment of a disease management program.

The Centers for Medicare and Medicaid Services (CMS) administers the grant program and announced available funds on May 1, 2006. Information is posted on its Web site at http://www.cms.hhs.gov/HillNotifications/CHN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS062558. Bear in mind that while you may want to encourage states to take advantage of these grants now, there is no guarantee that federal grant money will be available to your state in future years.

How much do premiums typically cost?

Various state laws set premium caps at different levels. Laws in California, Minnesota, and Oregon cap premiums at 125 percent of average premium rates for comparable plans sold to individuals who are not in the high-risk pool. In practice, some of these states have kept premiums even lower than their state laws require. For example, in 2006, high-risk pool premiums in Oregon are set at 111 percent of the average premium rates for individuals not in the high-risk pool. In some years, Oregon's high-risk pool premiums have been as low as 102 percent of average premiums. Further, for people previously covered through an employer (HIPAA-eligibles), Oregon's high-risk pool premiums are just 100 percent of average premiums.

Most states cap their high-risk pool premiums at no more than 150 percent of average premiums. To be eligible for federal grants, high-risk pools must set premium caps below 200 percent of average premium costs.[8] Since high-risk pool premium costs are based on average premium costs for health insurance policies sold to individuals in a state, states with strong rate regulation will also have lower premium charges in their high-risk pools.

To get an idea of what premiums cost in various states, we looked at premiums that would be charged to a 50-year-old woman purchasing a plan with a $500 deductible (the lowest deductible charged) in the states that have enrolled at least 10,000 people in their high-risk pools. For ex-

ample, in 2006, a 50-year-old woman seeking a policy with a $500 deductible would pay monthly premiums of $448 in Minnesota (where premiums are set at between 101-125 percent of the average rate for comparable policies), $506 in Oregon (where premiums are capped at 125 percent), $737 in Texas (where premiums are capped at 200 percent), and $865 in Illinois (where premiums are set at between 125-150 percent).[9] Differences between states may reflect differences in benefit levels among state high-risk pools, as well as differences in overall insurance costs that result both from market forces and from rate regulation and enforcement. In some of these states, low-income people receive additional premium subsidies.

What are typical deductibles?

High-risk pools generally offer policies with a range of deductibles. Typically, the lowest deductible is $500, meaning that consumers pay $500 for medical costs before the insurance policy begins to cover their claims. In high-risk pools around the country, deductibles range from as low as $500 to as high as $10,000 a year. Deductibles often deter low-income people from obtaining routine care—they rely on their insurance only for serious health problems when they require hospital care.[10] Some consumers may choose to establish a tax-free Health Savings Account in hopes of saving enough money to pay for the deductible, co-insurance, and other medical expenses not covered by their plan. However, not surprisingly, few consumers with high-risk health conditions possess the disposable income needed to establish such a savings account. Nationally, about 90 percent of high-deductible plan enrollees do *not* have money saved in a Health Savings Account.[11]

Have states done anything to make high-risk pools affordable to low-income consumers?

As noted earlier, a few states (Colorado, Connecticut, Montana, New Mexico, Oregon, Washington, and Wisconsin) provide additional premium subsidies to lower-income people who participate in high-risk pools. These states use a variety of mechanisms to subsidize low-income enrollees.

- **Oregon**: Subsidies are administered through a separate program called Family Health Insurance Assistance, which helps low-income Oregon residents pay for private insurance premiums if they are former Medicaid beneficiaries or have been uninsured for at least six months. Families with incomes below 185 percent of poverty are eligible. High-risk pool policies are among the policies for which they can use their subsidies. Subsidies pay between 50 and 95 percent of premium costs, depending on the person's income, but they cannot be used to cover deductibles or co-insurance.

  About 60 percent of the enrollees in Oregon's high-risk pool earn less than $35,000 per year. This group includes, for example, people who work for small businesses that do not offer coverage, people with disabilities, people near retirement age, and divorced women who formerly were covered through their spouses. Currently, about 4,600 of the high-risk pool's 15,000 enrollees receive subsidies.[12]

  Oregon's Family Health Insurance Assistance Program is funded in part through a Medicaid waiver, so it uses both state and federal dollars.

In other states, reductions in premium costs for low-income people are offered directly through the high-risk pool.

- **Colorado**: Effective July 2006, premium discounts of 50 percent are provided to people with annual incomes of less than $40,000, and discounts of 40 percent are provided to people with annual incomes between $40,000 and $50,000.

  The high-risk pool is funded through assessments on insurers and through the unclaimed property trust fund.

- **Connecticut**: One particular plan within the high-risk pool—the Special Health Care Plan—provides lower premiums to low-income members and also offers lower deductibles. Providers in that plan are reimbursed at lower rates than in other plans: They agree to accept 75 percent of Medicare payment rates.

  The lower premiums are funded by a combination of provider discounts and the assessments on insurers that fund the high-risk pool generally.

- **Montana:** Federal grant money and a state appropriation have subsidized premiums for low-income people by 45 percent. However, enrollment in the premium assistance program is capped due to funding limitations, so the program is sometimes closed to new members.

- **New Mexico**: Premium reductions based on income are provided by the high-risk pool itself. Premiums are reduced by 75 percent for people with incomes below 200 percent of poverty and by 50 percent for people with incomes between 200 and 400 percent of poverty.

  Assessments and premiums fund the high-risk pool.

- **Washington**: State law requires that enrollees be charged a minimum of 110 percent of the average rate for individual commercial coverage. However, enrollees ages 50-64 with incomes below 300 percent of poverty receive lower rates than other enrollees. (Other enrollees can be charged up to 150 percent of average rates, depending on the policy they purchase.)

  State funds help to support premium discounts.

- **Wisconsin**: Households with incomes below $25,000 pay 133 percent of standard premium rates, and households with incomes below $10,000 pay 100 percent of standard premium rates.

  Assessments on health insurers and provider payment adjustments fund the subsidy.

For more information, see the state high high-risk pool Web sites, available online through www.naschip.org.

What questions should consumers ask when they are considering joining a high-risk pool?

- **Am I able to get insurance on the individual market, through an employer, or through a public program such as Medicaid?** If not, high-risk pools may provide an opportunity to purchase coverage. The Web site of the National Association of State Comprehensive Health Insurance Plans, www.naschip.org, provides contact information for state high-risk pools.
- **What are the residency requirements for coverage through a high-risk pool in my state?** Some state pools will allow people to join immediately upon moving into the state if they intend to stay. Other pools require people to be residents for a period of time before joining. Even in states that require a period of residency for most high-risk pool enrollees, under federal rules, HIPAA-eligibles may be immediately eligible once they demonstrate that they are residents.
- **What do I need to do to prove my eligibility for the high-risk pool?** Am I automatically eligible if I have a certain medical condition, or do I need to apply for individual insurance and show that I have been denied coverage or charged a high rate based on my condition?
- **Is there a waiting period for coverage of preexisting conditions?** If so, what care can I get now, and what treatments will be subject to the waiting period? Most state high-risk pools immediately provide some health coverage to new enrollees, but for new enrollees who were previously uninsured for more than 63 days, high-risk pools commonly exclude coverage of a preexisting health condition for a period of time. These waiting periods for coverage of preexisting conditions are designed to encourage people to sign up for coverage and pay premiums before an illness strikes. It is quite common for high-risk pools to use a six-month waiting period for coverage of a preexisting condition, but some states require waits of as much as 12 months, and other states have shorter waits of three months or no wait at all. States often reduce or eliminate waiting periods for people who had previous health insurance coverage, depending on the length of time they had "creditable" coverage. ("Creditable coverage" includes coverage under a group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state high-risk pool, the Federal Employees Health Benefits Program (FEHBP), the Peace Corps Act, or a public health plan, as long as there was not a break in coverage of more than 63 days.)
- **What will happen if I move?** Be aware that if you are covered by a high-risk pool in one state and then move to another state, you may not automatically have the right to enter the new state's high-risk pool. Some state high-risk pools provide "reciprocity" and guarantee coverage to people who had coverage from a high-risk pool in another state without imposing new waiting periods for coverage of preexisting conditions, while other state high-risk pools do not provide these guarantees.
- **What plan in the high-risk pool is best for me, considering the deductibles, my savings, and the costs that I can and cannot afford to pay out-of-pocket?**

What Can Advocates Do?
A Checklist for Expanding State High-Risk Pools

Find out what your state does to guarantee access to insurance to individuals with health conditions. If your state uses a high-risk pool, here are things your state can do to extend its coverage to more people:[13]

- ✓ Require insurers to inform people about the high-risk pool both when they deny individuals coverage and when they "rate up" consumers (charge them more due to their health status).
- ✓ Require insurance agents to inform people about the high-risk pool.
- ✓ Shorten the waiting period for coverage of previously uninsured enrollees' preexisting conditions. Maryland recently eliminated its waiting period for coverage of preexisting conditions. Other states exclude coverage of preexisting conditions for periods ranging from three months to 12 months. In setting waiting periods, policymakers will have to balance people's needs for immediate coverage, their ability to pay for coverage while treatment of their preexisting condition is excluded, and the need to guard against the financial instability that would result in the high-risk pool if people waited until they urgently needed care to purchase insurance.
- ✓ Lower premium caps to no more than 125 percent of average premiums for comparable policies in the individual market.
- ✓ Institute rate review and rate regulation in the individual market overall so that premiums will be reasonable for both people in the individual market and those who join high-risk pools.
- ✓ Ensure that funding for the high-risk pool is adequate both to keep enrollment open and to limit premium rates. Consider assessing insurers based on the number of covered lives (a system that spreads the financial burden to stop-loss insurers and third party administrators for self-insured employers, who might otherwise be exempt, as well as to other group and individual insurers), and consider other financing mechanisms that will allow revenues to rise along with health care costs.
- ✓ Apply for federal high-risk pool grants.
- ✓ Ensure that the lifetime limit on coverage in the high-risk pool is at least $1 million.
- ✓ Ensure that covered benefits meet the needs of high-risk pool enrollees.
- ✓ Add premium subsidies for low-income people.
- ✓ Provide assistance with deductibles and cost-sharing for low-income people.

Glossary

COBRA: The Consolidated Omnibus Budget and Reconciliation Act of 1985. One provision of this federal law requires that employers with 20 or more workers permit workers leaving employment (and their covered dependents) to remain in the employee health plan for a period of time. It also allows the workers' spouses and dependents to remain in the plan for a period of time after certain life events such as divorce, separation, the end of a child's dependency status, the death of the employee, or the employee leaving the plan upon becoming eligible for Medicare benefits. The person remaining in the plan is responsible for paying the full cost of premiums plus a 2 percent administrative fee.

Creditable coverage: Coverage from one of the following sources is deemed to be "creditable": a group health plan, health insurance purchased either individually or through a group (such as an employer), Medicaid, Medicare A and/or B, CHAMPUS, Indian Health Service, SCHIP, a high-risk pool, or another public health plan. If someone with coverage from such a plan changes insurers, the number of days that person had coverage from one of these sources (without a break in which they were uninsured for 63 days or more) reduces the amount of time that a new insurer can exclude coverage of a preexisting medical condition. Under federal law, this protection applies to people who are "HIPAA-eligible," defined below.

Fully funded health insurance: Health insurance that is purchased from an insurance company or other underwriter that assumes the full risk of medical expenses.

Health Insurance Portability and Accountability Act (HIPAA): A federal law to help workers maintain coverage when they change jobs or leave an employer's policy to buy individual coverage. HIPPA limits the ability of plans to refuse to pay for treatment of preexisting medical conditions. (A different part of the law protects the privacy of medical records, but that is not discussed in this paper.)

HIPAA-eligible: A person who is protected under the federal Health Insurance Portability and Accountability Act. To be protected, the person must be transitioning from:

- one group health plan to another group health plan,
- a group health plan to and individual policy, or
- an individual policy to a new group health plan.

In addition, the person must have had 18 months of continuous creditable coverage; must have used up any COBRA or state continuation coverage; must not be eligible for Medicare or Medicaid; must not have other health insurance; and must apply for individual health insurance within 63 days of losing prior creditable coverage. People who have an individual policy and wish to switch to another individual policy are not protected.

Guaranteed issue: A requirement that an insurer sell a policy to anyone who seeks one.

Preexisting condition exclusion: A policy of excluding people from obtaining insurance or obtaining coverage for specific kinds of medical treatments due to a preexisting medical condition.

Rate review: The practice of reviewing the premiums an insurer plans to charge to determine whether they comply with state laws about fair premium charges and laws designed to guarantee that the health insurer has enough money to pay claims.

Rate regulation: The practice of limiting premiums that an insurer can charge or limiting how much an insurer can vary premiums based on factors such as health status, age, sex, geographical location, type of business, etc.

Reinsurance: A means by which an insurance company (called the reinsured) shares the risk of loss with another insurance company (called the reinsurer). Under such an arrangement, one insurance company essentially buys a policy from another insurance company to assist when particular claims (or the sum of claims) exceed a threshhold amount.

S**elf-funded health plan**: An arrangement in which an employer assumes the financial risk of covering health care costs for its employees, paying medical claims from its own resources.

Stop-loss insurance: A form of health insurance for a health plan or self-funded employer that provides protection from high medical expenses by covering all claims over a certain limit each year.

Endnotes

[1] Throughout this issue brief, the descriptions of existing high-risk pools are drawn from *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis* (Fergus Falls, MN: Communicating for Agriculture and the Self-Employed, Inc. in cooperation with the National Association of State Comprehensive Health Insurance Plans, 2005/2006).

[2] The Minnesota Comprehensive Health Association had the following numbers of participants at the end of the years listed: 31,088 in 2002; 33,705 in 2003, and 32,959 in 2004. Data are from *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, op. cit.

[3] The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is the federal law that allows workers and their families to continue their group health insurance for a period of time when they leave employment, reduce their work hours, or, if they were the spouse or dependent of an employee, when they divorce, legally separate, lose dependency status, or the employee becomes eligible for Medicare or dies. The person must pay the entire premium plus a 2 percent administrative fee. COBRA applies to people working for employers with 20 or more workers. Many states have enacted similar laws to continue health insurance for people who work for employers with fewer than 20 workers.

[4] Under another federal law, the Trade Adjustment Assistance Reform Act (TAARA), states also guarantee coverage to workers and retirees who lost employer-based coverage due to increased imports or trade-related relocation. States may also designate high-risk pools as a way of meeting their obligations to this category of workers and retirees.

[5] The states with high-risk pools in 2006 are as follows: Alabama (only for HIPAA-eligibles), Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Information from the National Association of State Comprehensive Health Insurance Plans, *States That Have Risk Pools*, available online on at http://www.naschip.org/states_pools.htm. Tennessee is considering establishing a high-risk pool now that TennCare, its Medicaid program, has ended coverage for the uninsurable population. In 27 states, high-risk pools are the mechanism through which the state guarantees access to insurance for HIPAA-eligibles and, consequently, all HIPAA-eligibles receive coverage with no waiting period for preexisting conditions. In the other states, not all HIPAA-eligibles can join the high-risk pool. Some states require HIPAA-eligibles to seek coverage in the private individual market first and accept into the high-risk pool only those who have been turned down. Some states cap enrollment in their high-risk pools. Karen Pollitz and Eliza Bangit, *Federal Aid to State High-Risk Pools: Promoting Health Insurance Coverage or Providing Fiscal Relief?* (New York: Commonwealth Fund, November 2005), available online at http://www.cmwf.org/usr_doc/Pollitz_highriskpools_875.pdf.

[6] Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: Commonwealth Fund, August 2001), available online at http://www.cmwf.org/usr_doc/achman_uninsurable_472.pdf.

[7] As noted later, high-risk pools may also be unaffordable unless the premium caps are low, the state regulates the individual insurance rates on which premium caps are based, and low-income enrollees' premiums are further subsidized.

[8] The State High Risk Pool Funding Extension Act of 2006 defines "standard risk rate" as a rate determined by considering premiums charged by other insurers in the individual market and by using reasonable actuarial techniques and reflecting anticipated claims experience. Premiums must be restricted to no more than 200 percent of standard rates, and the state must meet other conditions to get federal grants.

[9] Information is from state high-risk pool Web sites. Wisconsin also has a high-risk pool with more than 10,000 enrollees, but all of its policies have deductibles higher than $500.

[10] Paul Fronstin and Sarah Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans* (Washington: Employee Benefit Research Institute, December 2005), and telephone conversation with Howard "Rocky" King, Administrator, Oregon Medical Insurance Pool, March 29, 2006.

[11] Fronstin and Collins, op. cit. According to this survey, as of October 2005, 1 percent of privately insured, non-elderly adults had high-deductible health plans and health savings accounts, and 9 percent of privately insured non-elderly adults had HSA-eligible high-deductible health plans but had not actually opened health savings accounts.

[12] Telephone conversation with Howard "Rocky" King, Administrator, Oregon Medical Insurance Pool, March 29, 2006. At one time, Oregon's Health Plan—a Medicaid expansion—served low-income, single adults. When that coverage ended, some former beneficiaries entered the state's high-risk pool, but thousands more have been left without insurance, unable to navigate the private insurance system or pay even the subsidized premiums and copayments.

[13] Many of these suggestions are from Deborah Chollet, "Perspective: Expanding Individual Health Insurance: Are High-Risk Pools the Answer?", *Health Affairs*-Web Exclusive, October 23, 2002, available online at http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.349v1.

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