WYOMING LEGISLATIVE SERVICE OFFICE

Research Memo

05 RM 090

Date: December 9, 2005

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Re: Summary of Wyoming Health Insurance Pool

REQUESTS

1. **Provide a summary of the Wyoming Health Insurance Pool (WHIP), including:**
   a. **General discussion of the operation of WHIP;**
   b. **Level of benefits;**
   c. **Level of premiums/co-pays/deductibles;**
   d. **How WHIP is funded;**
   e. **What constraints and opportunities exist to improve WHIP.**

RESPONSES

1A. BRIEF BACKGROUND

The Wyoming Health Insurance Pool (WHIP) was created in 1990 by W.S. 26-43-101 et seq, and regulated by Chapter 41 of the Wyoming Insurance Department Regulations (Attachment A). The intent of WHIP is to provide health insurance coverage to Wyoming residents who are denied traditional health insurance coverage due to existing medical conditions.[1] Individuals eligible for coverage through WHIP must meet the following criteria:

- must be a Wyoming resident; and
- must provide proof that they have been refused coverage for health reasons by one insurer; or
- have health insurance coverage more restrictive than WHIP's coverage; or
- have health insurance coverage at a rate exceeding WHIP rates; or
- is a federally eligible individual.[2]

[1] The Wyoming Health Insurance Pool Board, consisting of seven members appointed by the insurance commissioner, operates the pool and the Department of Insurance through Blue Cross Blue Shield administers the program.

[2] A federally eligible individual, as defined by Health Insurance Portability and Accountability Act (HIPAA), is an individual who has had at least 18 months of creditable coverage as of the date the individual seeks coverage under the Pool; whose most recent prior creditable coverage was under a group private or public health benefit plan; who is not eligible for coverage und a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or Medicaid, and who does not have other health insurance coverage; whose most recent creditable coverage was not terminated based on nonpayment of premiums or fraud; and who, if offered, elected continuation coverage under a COBRA continuation provision or under a similar state program and exhausted such continuation coverage. Insurance Department staff report that there are few federal eligible individuals in the pool as portability is extended to all applicants if they have creditable coverage, or 90 days has not passed since an applicant had creditable coverage.

1B. BENEFITS

Currently, two plan options are available from WHIP: The Brown Plan and The Gold Plan. Per individual, the lifetime maximum amount for the Brown Plan is $350,000 and $600,000 for the Gold Plan. Both plans offer Type A, Type B, and Type C benefits.

- Type A benefits: high cost expenses such as inpatient hospitalization, outpatient and office surgery, and ambulance services.

- Type B benefits: provides for smaller and less costly items and services, such as outpatient prescriptions and medical care, office calls, and physical therapy.

- Type C benefits: include maternity care (prenatal care, delivery, and postnatal care).

More complete information regarding the provisions of these plans, and WHIP generally, is included as Attachment B.

1C. PREMIUMS AND DEDUCTIBLES

Every year the Wyoming Health Insurance Pool Board surveys five insurance companies to determine current standard market rates within the state in order to adjust and set rates. WHIP rates may be up to 200 percent of standard market rates. According to Department of Insurance staff, premiums for WHIP currently average approximately 165 percent of what a "normal" health insurance premium would cost a Wyoming citizen. Monthly premiums, effective as of July 1, 2005, for WHIP plans are included as Attachment C. Below is a general breakdown of premiums for the Brown and Gold Plans:

The Brown Plan premiums		The Gold Plan premiums	
Single Male:	$301-$1044	Single Male:	$408-$1432
Single Female:	$449-$1044	Single Female:	$615-$1432
Two Adults:	$750-$2088	Two Adults:	$1024-$2864
Each Child:	$194	Each Child:	$263

There are different monthly premiums for Medicare disabled members subscribing to WHIP plans. The plans for Medicare disabled members do not include two adult or child provisions.

The Brown Plan premiums		The Gold Plan premiums	
Single Male:	$58-$199	Single Male:	$78-$273
Single Female:	$87-$199	Single Female:	$116-273

There are also out-of-pocket costs, including deductibles and co-payments. Once the maximum out-of-pocket amount has been met, the plan will pay 100 percent of reasonable and customary charges for services that are included in coverage. The out-of-pocket annual maximums are as follows:

The Brown Plan		The Gold Plan	
Individual:	$4,000	Individual:	$2,000
Adult and Dependent:	$8,000	Adult and Dependent:	$4,000
Two Adults:	$8,000	Two Adults:	$4,000
Family:	$8,000	Family:	$4,000

1D. FUNDING MECHANISMS

According to Department of Insurance staff, there are generally two mechanisms in place to fund WHIP. The first mechanism is the premiums paid by plan subscribers. However, these amounts do not completely cover costs associated with the administration and operation of WHIP. A second funding mechanism is established in W.S. 26-43-105, which provides the authority for the Department of Insurance to perform assessments on health insurance companies participating in WHIP to recoup pool deficits. These assessments are made in proportion to the percentage of a company's participation in WHIP. Associated with these assessments is a premium tax credit for health insurance companies tied to the amount an insurance company is assessed for the pool deficit. According to W.S. 26-43-105(d),

> (d) For the total amount of assessments due from all members in any one (1) calendar year pursuant to this section up to two million five hundred thousand dollars ($2,500,000.00), eighty percent (80%) of each member's proportionate contribution to the first one million two hundred fifty thousand dollars ($1,250,000.00) and fifty percent (50%) of the next one million two hundred fifty thousand dollars ($1,250,000.00) shall be allowed as a credit against any premium tax owed by the member under this code in the year for which the assessment is payable.

There are also federal funds available through the Trade Adjustment Act, which provides federal funds to help keep states' health insurance pools solvent. The Department of Insurance was awarded $357,751 for WHIP for fiscal year 2004. That money will be used to offset claims, according to staff. However, new provisions expected to pass through Congress will require those funds to be used to offset premiums rather than claims, if a state's pool has rates adjusted at more than 150 percent of the standard market rate. Currently, WHIP's premiums are at approximately 165 percent of standard market rate.

1D. CONSTRAINTS AND OPPORTUNITIES FOR IMPROVEMENT

It is unclear whether or not there are constraints to improving WHIP, since it is unknown what improvements may be desired. Naturally, there are likely to be trade-offs associated with making changes to WHIP. If the board increases benefits, they must be funded. To be consistent with current practice, this funding would likely be achieved through increasing premiums or increasing assessments.

Insurance Department staff reports there is no requirement within the statutory language or WHIP regulations that the pool be self-sustaining through premiums. In fact, the purpose of assessments against health insurance companies operating within the state, mentioned previously, are intended to make up any shortfalls the pool experiences. Currently, the program does not receive, nor has it recently requested, General Fund appropriations. In addition, federal funds may be applied for, although there is no guarantee of any award in any given fiscal year.

If you have any further questions please feel free to contact LSO Research at 777-7881.