

**Funding High-Risk Pools:
Changes, Trends and Policy Concerns**

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Funding High-Risk Pools: Changes, Trends and Policy Concerns

Part I. Survey Highlights: Role of Risk Pools

High-risk pool administrators in 32 states expressed their views of the role of the pools and their impact on the private insurance market and consumers through a survey and structured interviews.¹

- Survey respondents found that high-risk pools stabilize the individual market while also making insurance more affordable for others.
- A majority of those with a preference agreed that guaranteed issue requirements in the individual market should be replaced with high-risk pools.

The administrator of Kentucky's pool "wholeheartedly agreed" that the market had stabilized. "We went from two to eight insurers in the individual market in three years,"² following the creation of the pool. A Maryland official observed that, "If pools cover losses for higher-risk individuals, then healthier people in individual plans generate lower costs which should equal lower premiums."³

Risk pool managers were also asked what they thought the Federal role should be in funding for risk pools.

- A large majority agreed that the Federal government should subsidize excess losses in high-risk pools

A number of respondents emphasized that recent Federal policies have invited individuals who were previously covered in ERISA self-funded plans to enroll in the risk pools. As a result, pools are serving people from groups that are not subject to pool assessment. Federal support would compensate by broadening the funding base beyond insured small employers and individuals, who currently bear the brunt of the assessment.

- State leaders were nearly unanimous in their rejection of the suggestion that any entity or person who is willing to pay the premium should be able to buy into a high-risk pool.

Some respondents said that their pools were already struggling to find financing for their current members and expected growth and, thus, feared the possibility of expansions to additional eligibility groups.

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Part II. Survey Results: Funding Nuts and Bolts

Introduction

Almost 30 years ago, a handful of states pioneered a new kind of safety net to assure that anyone who could afford insurance could buy it, regardless of health status. Today, more than 30 states have followed suit. State high-risk health insurance pools (sometimes called “comprehensive health insurance associations”) serve people who: (1) were denied coverage in the private market due to preexisting medical conditions; (2) were only offered private coverage at rates higher than offered by the pool; or (3) are afflicted with a medical condition that confers automatic acceptance into the pool. In most states, the pools are non-profit associations, usually closely tied to the insurance department. In a few states they are public entities.

High-risk pools guarantee that individuals can buy coverage, regardless of their health status. Premiums are capped (typically limited by statute to 150 percent of the standard rate for someone of similar age) and the difference between income from premiums and the cost of claims is bridged through a variety of funding mechanisms. This paper presents the findings of a major survey on how high-risk pools are funded. It examines trends in financing, the policy discussion around various approaches, recent state and national policy changes that affect pool funding, state efforts to better manage spending, and emerging concerns.

The Project

Researchers at the National Conference of State Legislatures surveyed medical high-risk pool administrators in 33 states in order to learn how policy makers perceive current state policy and proposals related to risk pool funding, and how funding is being affected by the changing state and Federal fiscal and policy environments. To provide a more nuanced understanding of the national results, case studies were conducted in six states (Colorado, Illinois, Indiana, Kentucky, Minnesota and South Dakota) selected for their varied histories, concerns and pool memberships. These involved historical and background research, document review and structured interviews with a wider selection of individuals in the case study states, including experts in the insurance, provider and consumer communities.⁴ Background on the pools is drawn from the literature. Analysis of trends is based on data contained in annual reports on risk pools produced by Communicating for Agriculture, Inc.

Historical Overview

Membership in the pools and sources of revenue to support them have steadily evolved since 1976. Risk pool premiums have historically been the primary revenue source, with other funding streams making up losses. Currently, in most states an assessment on insurers is used to fund a portion of losses. States participate financially in a number of ways, including direct appropriations and grants to offset losses, administrative support, and premium support for low-income participants. While most pools are quasi-public entities, a few are operated by state agencies (i.e., AL, CA until this year, KY).

The first pool, Connecticut, began with a broader mission than that of other states, and allows a number of different paths to eligibility. However, most pools have specialized in insuring individuals who have been denied or face difficulty obtaining coverage in the private market as a result of preexisting medical conditions. Pool applicants demonstrate this by documenting rejection by one or two carriers, depending on the state. Alternatively, presumptive eligibility is granted people with certain medical conditions. Another common eligibility standard allows individuals to join if they are offered nongroup coverage at rates that are higher than what is available in the pool. Recently, several Federally-defined categories of individuals moving out of group coverage have been allowed to enter without demonstrating rejection or medical conditions (e.g., HIPAA-eligibles).

- ***ERISA and Market Changes Impact Funding***

High-risk pools that rely on premiums and insurer assessments have seen their base diminish as the self-funded market has expanded and the insured market has contracted. In the early days of the risk pools, most health coverage was provided by regulated health insurance carriers and insurance assessments fell on a broad portion of a state's population. State ability to assess insurers has steadily fallen as a result of the Employee Retirement and Income Security Act of 1974 (ERISA). ERISA preempts state regulation of benefits, including assessment of self-funded employer plans. Although most employers continued to purchase insured products immediately following the passage of ERISA, during the 1980s and early 1990s there was rapid growth in the number of employers self-funding, effectively removing their insurance business—and their contributions—from the funding base.

ERISA led to two classes of employer-based coverage: those who assumed risk for coverage and are self-funded, and thus are exempt from state regulation, including premium taxes; and those who continued to purchase coverage from insurance companies that are subject to state rules. States could not assess coverage offered by self-funded companies in the same way that they can assess regulated insurance carriers.

- ***Impact of Federal Policies on Risk Pools***

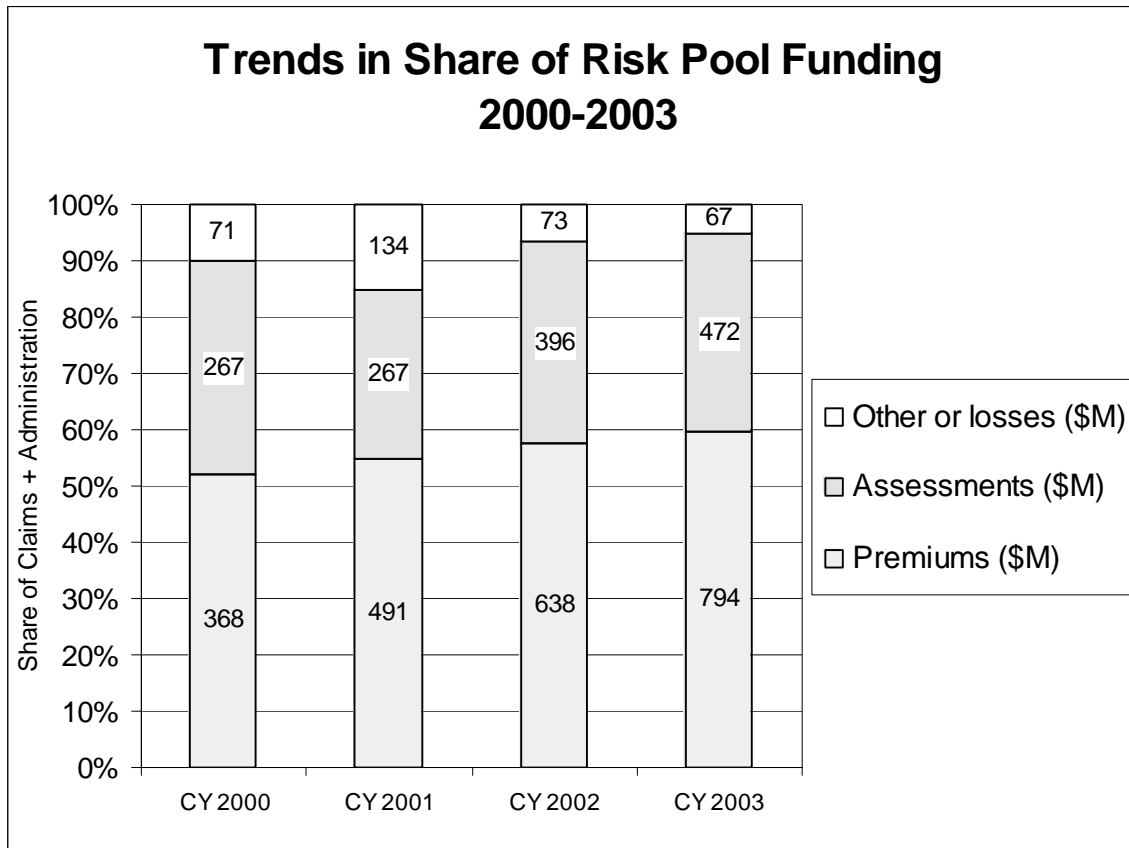
As a result of ERISA, which prevents states from taxing self-funded plans, the insurance that is subject to assessments for the high-risk pools is mostly purchased by small employers and individuals. Recently, however, states have expanded pools to include Federally-defined categories of individuals who become eligible after leaving self-funded plans. These new groups swell enrollment in the pools and put pressure on the states to find new ways to pay for losses above the premiums. Many respondents commented that Federal funding to broaden the funding base should be made available to reflect the broadened enrollment categories.⁵

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to guarantee issue coverage with no preexisting condition exclusion period for individuals leaving group coverage who meet certain eligibility criteria. A state may opt-out of the Federal individual portability requirements, which preempt less restrictive state laws, by adopting an acceptable “alternative mechanism”. High-risk pools are one option. Over time, 28 states have chosen to use their risk pools as the alternative mechanism to cover HIPAA-eligible individuals, thus avoiding Federal preemption.

The Trade Adjustment Assistance Act of 2002 (TAA) created additional opportunities for pool eligibility, and offered grants to states to supplement implementation and operating costs. Four states used these seed grants to create pools (MD, NH, SD, WV); one (UT) obtained a grant to modify its pool to meet the Federal standards; and another (OH) is using a grant to conduct a feasibility study.⁶ In addition, \$80 million was provided over two years to offset operating losses in pools that met the Act’s requirements (e.g., a cap on premiums of no more than 150 percent of the applicable standard rates; a choice of coverage options; being open to all HIPAA eligible individuals).

Another, and unrelated, provision in the TAA offers an advanceable or refundable health care tax credit (HCTC) equal to 65 percent of the cost of a “qualified health insurance plan” to certain individuals. As one of a number of alternatives, the TAA allows states to designate their pools as a “qualified health insurance plan,” to which eligible displaced workers can apply the HCTC. By February 2005, 17 states had chosen their high-risk pools as one of their HCTC options.

Table 1: Shifting Proportion of Funding by Sources



Source: Communicating for Agriculture, 2001, 2002, 2003, 2004

Approaches to Funding

This section examines different financing strategies in more detail. A look at total premiums, claims and assessments across all operating pools shows some interesting recent trends. In the last four years for which data are available, from 2000 to 2003, premiums have risen from 52 percent to 60 percent of total pool costs (claims plus administration). The portion funded through assessments has fluctuated up and down around 35 percent, while other sources, including both state and Federal appropriations, have accounted for a dwindling share of the pie, falling from 10 percent to five percent.

This shift is likely due to a number of factors. Premiums are tied to standard rates, which rise with inflation. Other funding sources make up the gap between premiums and payments, which fluctuate at different rates depending on the phase of the insurance cycle. Public funding can be cyclical as well. In some states hard hit by the recent fiscal crisis, broad-based state financial support may be increasingly difficult to come by. For example, pass-through tax credits for insurers, which indirectly fund the pool through general revenues, may become increasingly limited. A good historical perspective is provided by Minnesota,

which initially financed its pool losses through an assessment offset by an insurance premium tax credit, but the credit was eliminated during a fiscal crisis in 1987.

The growing proportion of risk pool claims funded through premiums on pool participants may also reflect changes in the pools themselves: an aging pool in which older members vary less from the general trend than younger members; improved cost containment within the pools; or slower growth in health care utilization among high-risk pool members compared with the general population

Table 2: Growth of Premiums 2000-2003

	CY 2000	CY 2001	CY 2002	CY 2003
Participants	127,406	153,351	172,845	181,441
Premiums (\$M)	\$ 368.00	\$ 490.79	\$ 638.13	\$ 793.55

Source: Communicating for Agriculture, 2001, 2002, 2003, 2004

- **Premiums**

Pool participants must have some income or resources, and are generally employed—often self-employed or in very small businesses.⁷ In 2004, risk pools collected over \$793 million in premiums—almost 60 percent of operating costs. Premiums in all pools combined grew more than 24 percent from the previous year. Enrollment grew five percent in that period, and health cost increases contributed to a 21 percent growth in claims.

Risk pool premiums are based on a fixed percentage above the standard premium charged by private health plans for individual coverage in the state,⁸ and setting them is an annual exercise which ultimately drives all other funding decisions. The 1996 NAIC model calls for initial premiums at 125 -150 percent, rising no higher than 200 percent of the standard rate.

Currently, 12 states set a statutory maximum premium rate of 150 percent, making it the most frequently chosen cap. In three other states rates are capped at between 125 – 150 percent, while six states have lower maximum premium rates. In the remaining 11 risk pool states, premiums may rise up to 175 – 200 percent. (see Appendix Table 3) Even at the highest cap of 200 percent, risk pool participants are receiving a significant subsidy.

Some states have made other adjustments to premium rates. For example, Indiana recently added language that allows the pool to decrease its rates if its cost trend is less than the trend in the state. This has allowed the pool to bring premiums down from the maximum allowable cap of 150 percent of standard, and in 2005 it was able to offer its members no rate increase as a result of successful cost decreases. The pool is also authorized to raise premiums for members with incomes over 350 percent of the poverty level.

This survey uncovered an important fact related to pool premiums: at least 13 states set actual rates below the maximum allowed by statute. In a few states, carriers have pushed for the premiums to fully fund their allowed share before assessments are levied. In some states, board members representing industry, providers and consumers have worked to maximize affordability. A handful of pool administrators said that going to the maximum allowed could result in some individuals dropping coverage, often with no alternatives.⁹

- **Premium Subsidies Based on Income**

A growing number of state risk pools (CO, CT, MT, NM, OR, WA and WI) offer additional premium subsidies for certain individuals based on income. Typically, the subsidy lowers the premium closer to the standard rate, in proportion to income. Maryland authorized a subsidy in 2004 but it had not been implemented at the time of this survey.

Washington's subsidy is narrowly targeted to individuals between 50 and 64 with incomes below 251 percent of the federal poverty level. Montana's program has been funded through a special Federal grant which preceded TAA¹⁰ and continued with a state general fund appropriation. In Oregon, an existing low-income premium assistance program available for the general population may be extended to include pool participants.

Income subsidies can be controversial. Several respondents deplored policies that tried to simultaneously address insurability and affordability through additional subsidies. One concern we heard voiced was that the group covered by the pool is not necessarily low-income, and should be treated differently from groups that need help to buy any coverage at all. We also heard that individuals in the pool were already highly subsidized through publicly collected funds which offset the pool's losses.

A Blue Cross and Blue Shield of Minnesota executive talked about the need to think through the relationship between who is served and how a pool is funded. Minnesota has an array of subsidized coverage for lower income residents.

"[MCHA] was not originally set up to be a subsidy program for low-income people,, but rather as a place to get coverage for those unable to purchase in the private market. But, as costs increase, there is more and more pressure for the risk pool to implement a subsidy program. Minnesota risk pool rates are capped at 125 percent of the market. There are other state subsidy programs--GAMC, MNCare, PMAP-- that give coverage along the income continuum. To subsidize low-income people in the pool changes the original purpose of the pool. If it becomes a low-income subsidy program, then we must decide who subsidizes it, and more importantly, would the enrollees be better off in a different program.

That's the most important thing. Where and how are the enrollees best served?"¹¹

- **Payment by Third Parties**

Who pays the premium has become an issue in many states, and almost all now have language prohibiting payments by certain third parties. To avoid becoming a dumping ground for people with group coverage who become ill, risk pool administrators carefully monitor where premiums come from. Many of the individuals we interviewed expressed their conviction that dumping was a common practice, whether done by employers encouraging their workers to buy outside a group plan, or brokers recommending a portfolio of individual policies as a replacement for a group. Several reported receiving payments emanating from a single address as a tip-off.

Another source of dumping that pool administrators pointed out is done by providers. Hospitals and health centers allegedly enrolled uninsured individuals with catastrophic costs, such as transplant recipients, in order to reduce their losses. Drug companies were also mentioned as paying premiums for people who were high users of their charitable programs. Even more troubling, according to some of the interviewees, Medicaid and local health programs (e.g., AIDS/HIV programs), purchased high-risk pool coverage for some of their beneficiaries.

This activity has the effect of using private insurance assessments and premiums to subsidize a group that would ordinarily be covered with state general fund and Federal matching grants. However, many states do allow people who become eligible for other public programs after they enter the pool to remain, and there are a variety of arrangements with Ryan White Care Act (ADAP) participants. Kentucky's experience with dumping and steering, which took place when it operated in a guaranteed issue environment, caused state officials to put prohibitions in place to prevent this from recurring when it shifted to a pool in 2000.

"When we operated under guaranteed issue, we became aware of situations where third parties began directing high-risk individuals to our plan, and apparently paid the premiums for those people. We could tell because we were sending an unusually large number of premium invoices to identical addresses, including those of health care providers. The legislature learned the same information and made provisions within the high-risk pool statutes to prohibit third parties from paying premiums of enrollees within KY Access."¹²

Table 3 : Trends in Risk Pool Participants, Revenues and Costs

	CY 2000	CY 2001	CY 2002	CY 2003
Participants	127,406	153,351	172,845	181,441
Premiums (\$M)	\$ 368.00	\$ 490.79	\$ 638.13	\$ 793.55
Assessments (\$M)	\$ 266.64	\$ 267.23	\$ 395.83	\$ 471.85
Other Revenues or Losses ¹³ (\$M)	\$ 71.43	\$ 134.47	\$ 72.69	\$ 66.61
Administrative Costs (\$M)	\$ 40.07	\$ 51.78	\$ 65.22	\$ 73.22
Claims (\$M)	\$ 666.00	\$ 840.71	\$ 1,041.43	\$ 1,258.79
Total Costs ¹⁴	\$ 706.07	\$ 892.49	\$ 1,106.65	\$ 1,332.01

Source: Communicating for Agriculture, 2001, 2002, 2003, 2004

- **Carrier Assessments**

As of the end of 2003, 27 pools had collected a total of over \$471 million in assessments from insurance carriers—an average of just over \$2,600 per covered life--to cover losses due to pool operations.¹⁵ (see Appendix Table 1: Premium and Assessment). States typically require that carriers be members of a risk pool organization, subject to assessment. In some states it is a levy determined by the insurance department. Assessments may be prospective, with funds held in reserve and investments producing some of the revenue to operate the pool, or they may be assessed during the year to cover losses. In the latter case, one of the participating plans (or the third party administrator (TPA) that serves as a vendor that provides the pool coverage) may assure that claims are paid until the assessment is collected. The assessment is an “add-on” to the premiums paid by individuals and small employers and sometimes actually appears as an item on the premium bill.

Carrier assessments can be simple and straightforward. When they are conducted by a non-governmental risk pool organization, they are outside the state appropriation process and can be managed by rules defined by the risk pool organization in accordance with state law. If pools incur unexpected costs, carriers may levy an interim assessment on themselves quickly and easily as compared with, for example, appropriating additional funds. When insurers manage the cash flow, they are able to assure prompt payment of provider claims.

While assessments are the most prevalent method of funding, they are not without controversy. Describing how the funding base changed over three decades, an executive from Blue Cross and Blue Shield of Minnesota remarked, “In 1976, the market didn’t look like it does now. The assessment was spread across a larger base. Less than half the market now pays the assessment.”¹⁶ Eight of the state pool administrators (AK, IA, MN, NE, NM, TX, WA, WI) commented on recent debates over assessment approaches, most often about the need to create a funding base that included more of the market.

- **Assessment with Tax Offsets**

In 11 states, assessments are offset, at least in part, through state tax offsets on premium taxes, income taxes, sales taxes or other fees paid by insurance carriers. As recently as 2001, nine states with tax offsets allowed assessments to be fully credited. While some states still allow all assessments to be offset (AL, MO, MT¹⁷, ND), most do not. Instead, they limit the proportion of taxes owed that may be offset (KS), the share of the assessment (IA¹⁸, KS, NM) or cap the total budget for credits (WY, SC.) These offsets make estimates of the relative size of state and industry contribution difficult to estimate; our data do not include the offsetting credits.

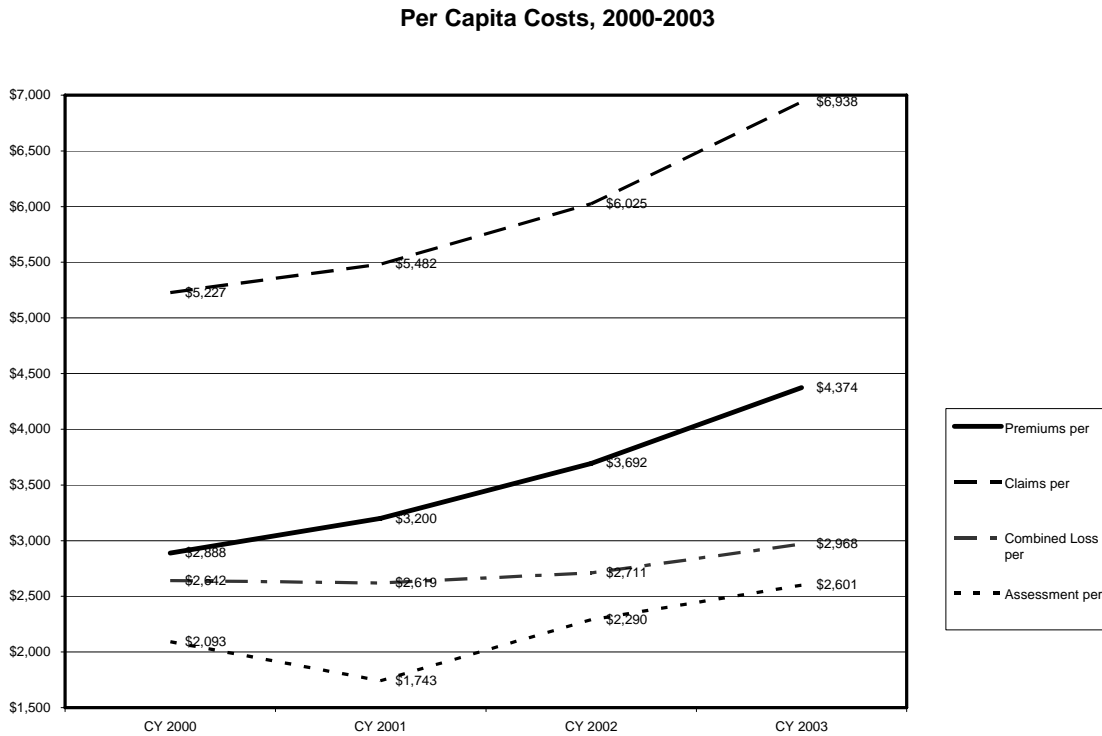
Carriers that have been unprofitable and certain exempt entities¹⁹ do not owe taxes that can be offset. In Indiana, which no longer offers offsets, plans were allowed to carry over their credit from year to year. Nonetheless, low margins left some plans with assessments that they could not recoup through the credit.

At least two states, Oregon and Washington, take into account carriers' market practices as reflected by percentage of rejected applicants and loss ratios in calculating their assessments. Carriers whose loss ratio falls below 72 percent must remit the excess to the Washington State Health Insurance Plan.

Missouri's practice illustrates how complex the assessment process can become when combined with tax offsets. Carriers are assessed in proportion to their share of insurance premiums collected, with assessments offset against premium taxes in the same year. Companies that do not pay premium taxes can offset against sales and use taxes. Assessment on HMOs is limited to no more than one percent of their nongroup premium income.

Tax offsets constitute indirect state funding for the pools. Indiana restructured the financing of its pool and eliminated the credit in 2004. In its place will be state funding for 75 percent of pool losses combined with assessments, no longer to be offset, for the remaining 25 percent. The proportions were determined based on the amount of assessment that carriers were not offsetting at the time of the change.

Table 4: Per Capita Trends



Source: Based on Communicating for Agriculture, 2001, 2002, 2003, 2004

One reason Indiana moved to direct financing of the program was that the tax credit led to pool funding with little accountability. The total tax expenditure due to the program was not tracked for state budgeting purposes, as it was an entry on a corporate tax return and consequently there was no mechanism to ask for increased program accountability. Direct funding is transparent and, thus, encourages improved management and accountability.

- **Alternative Assessment Approaches**

The major drawback to assessments is their relatively narrow base. An estimated 50 percent of private sector coverage is provided through self-funded plans, which cannot be assessed due to ERISA preemption.²⁰ Health insurers that participate in pools are increasingly concerned about the inequity of requiring insured small employers and individuals to subsidize persons who leave self-funded and unassessable groups and end up in a pool²¹. This issue is more prominent with pools opened to groups explicitly defined on the basis of previous group coverage under Federal HIPAA and HCTC provisions.

Minnesota addressed this issue by choosing to assess insurers for a share of losses based on their share of total accident and health insurance premiums received from or on behalf of Minnesota residents. One State Senator explained

the dilemma faced by legislators dealing with budget problems as they debate over what constitutes a fair assessment.

“Because it is like a premium tax, ERISA plans are exempt [from the assessment]...We have seen a continued erosion of the insured market in Minnesota. Smaller and smaller companies are going to self-insurance, even though we point out it could be a bad idea because of the potential impact of a catastrophic illness. The [assessed insurance companies] feel it is a disproportionate burden, especially as it serves self-funded groups as well. So there is constant debate about whether the state should take over a portion.

“ In this political environment, we are struggling to pay for what we already have so it is hard to talk about taking over anything more... We need to find a fair funding base across the system and need a commitment to do that. There are ways of structuring a private funding mechanism... Everyone who is eligible should be paying into this—it is the only fair thing to do.”²²

Between concerns about the dwindling funding base, and the rationale of Federally-defined pool participants coming out of ERISA plans, a number of states levy an assessment based on the number of lives covered by a carrier, implicitly encouraging them to pass the fee to their customers. Based on our survey and supporting documents, states that used this methodology in late 2004 included MS, NH, OR, SD and WA.

States are especially interested in the per-covered-life approach because it assesses reinsurance or stop loss insurance sold to back-stop self-funded plans on a more even footing with fully insured plans. Some very large self-funded companies that keep all financing in-house would still not be assessed under this approach. But, partially self-funded plans that rely on reinsurance to reduce their own risk assume a larger share of the collective state risk when this strategy is employed.

This approach to financing pools is evolving rapidly. Courts have generally upheld these assessments, although the law must be carefully structured to avoid falling afoul of ERISA. There are actually two components: assessing stop loss carriers on a premium basis; and assessing various vendors on a per-life basis. For example, Kentucky assesses on a premium basis. Oregon’s program established that states could tax on a per-life basis as long as there was a requirement for the reinsurer, rather than the self-funded plan, to report the number of lives. While it appears possible to assess insurers in various ways, whether states can levy charges on other related functions such as third party administration is still being determined in the courts.

At least nine states (CO, IN, LA, MS²³, NH, OR, KS, SD, WA) have assessed stop loss carriers on a per-life basis at some point, although not all do so now. Some pools are authorized to use this approach but have opted for other funding strategies (e.g. New Mexico). Based on our survey and supporting documents, states that used this methodology in late 2004 included MS, NH, OR, SD and WA. Mississippi uses a unique variant, assessing each insurer or third party administrator (TPA) a monthly amount (up to \$3) per individual policy or covered employee.

Just how big a share is appropriate for stop loss companies to pay has been a matter of dispute. In Washington, all carriers are assessed on a per-covered-life basis, but stop loss carriers and the state employee plan are assessed at 10 percent of the rate for other carriers.

Colorado also tried this approach as a stopgap following abrupt increases in pool losses. According to the CoverColorado Administrator, the per-covered-life assessment on stop loss carriers was not controversial at first. But eventually, a large stop loss and excess loss carrier sued over the methodology and the state moved to find other ways to fund losses.²⁴ Moving from a premium-based assessment to a per-covered life assessment caused a leap in rates that these carriers had to pass through to their customers.

In Indiana, the experiment with a per-covered-life assessment was followed by a blended assessment using a combination of premium and per-life bases for assessing plans' shares. In Colorado, the assessment on stop loss carriers may have helped mobilize the business community to make the case for state funding of pool losses, after carriers displayed it as a separate line in their bills.

- ***State Appropriations***

Premiums and assessments provide the lion's share of revenue for the pools nationally, but some states rely on other resources. (see Appendix Table 2: State and Federal Contribution.) A few pools receive direct state funding, either from general funds or a variety of dedicated revenues including insurance trust funds, unclaimed property funds, tobacco settlement funds or taxes, and general fund appropriations.

Some states have different funding streams for the traditional pool and the pool of HIPAA eligibles (i.e., IL, LA). General revenue is a direct source of financing for the traditional high-risk pool, in contrast with the so-called HIPAA pool, which is funded by an assessment in both states. Subsidized and reduced premiums, such as Washington's reduced rates for individuals aged 50-64, are typically supported using state appropriations.

The total share of pool losses paid from non-premium, non-assessment sources has fallen since 2000, despite an infusion of Federal funds. Both state

appropriations and the Federal funds are included in the “other revenues or losses” category, so for 2003, direct state funding is likely even lower than Table 5 suggests.²⁵ Although direct state funding is a diminishing portion of risk pool financing, the number of states that allocate some state revenues for pools has remained at about one-third. These data understate the amount of state appropriations that support pools, however, since the value of tax credits applied against assessments, which constitute indirect general fund support, is not available.

Table 5: Other Revenue Sources

	CY 2000	CY 2001	CY 2002	CY 2003
Participants	127,406	153,351	172,845	181,441
Premiums (\$M)	\$ 368.00	\$ 490.79	\$ 638.13	\$ 793.55
Assessments (\$M)	\$ 266.64	\$ 267.23	\$ 395.83	\$ 471.85
Other Revenues or Losses²⁶ (\$M)	\$ 71.43	\$ 134.47	\$ 72.69	\$ 66.61
Total Costs ²⁷	\$ 706.07	\$ 892.49	\$ 1,106.65	\$ 1,332.01

Source: Communicating for Agriculture, 2001, 2002, 2003, 2004

- ***Unpredictable Funding***

Unlike premiums or per capita assessments, the flow of state funds tends to be uneven. This reflects political uncertainties and diverse sources of this funding. One-time settlements related to the health, insurance systems or tobacco claims, have all been used in one state or another. Start-up money was appropriated for reserves for new pools, even before TAA start-up grants became available to provide assistance from the Federal treasury.

Further adding to unevenness of state funding, pressure on state revenues over the last few years has forced downward budget revisions and a scramble for revenue in nearly every state. State appropriations to the pools have reportedly been reprogrammed for purposes as narrow as smoking prevention and as broad as increasing general funds available to balance the budget.

While broad-based funding is desirable, recent years have shown reliance on general fund appropriations can be stymied by fiscal pressures. The ramp-up of risk pools as HIPAA was implemented coincided with down-turning state revenues and rising health care costs. After a few rounds of sharply higher assessments, or fearing such increases, some pool boards and administrators have looked for alternative funding options, as discussed below.

- ***Dedicated Revenue***

As a general matter, legislators dislike—and may not honor restrictions on—dedicated revenues, since they limit their ability to revise priorities. Nonetheless, to replace reduced general fund appropriations, some pools have sought dedicated revenue sources. For example, some state pools have been authorized to collect revenues with a connection to the operation of the insurance industry or even the pool (e.g., funds generated by insurance-related trust funds (AR, IA); grants and donations (MD); investment income generated by the pools (IL, OR, UT). In the past, lotteries were a funding source in Louisiana, but no states now use that device.

Often proposed, although not commonly implemented, are revenues with a direct health connection. Aside from provider taxes, which are discussed below, tobacco settlement funds (KY, MN, MT) and tobacco taxes (CA) are a popular source of revenue for pools. Tobacco-related funding is often dedicated to health-related programs, but pools must then compete with a number of other needs and funding levels may be volatile. The Minnesota pool reported a potential one-time infusion of funds from Blue Cross and Blue Shield’s tobacco settlement, while Kentucky is concerned that the promised funding from that source may be redirected to cover state budget shortfalls.

- ***Provider Assessment or Discount***

Provider assessments or discounted rates are used in several states and have been discussed in others. The rationale for this approach is that hospitals, in particular, benefit from risk pools because they care for chronically ill patients whose large medical bills might otherwise be written off as bad debt or charity care.

Maryland uses a hospital assessment designed to replace a discount that hospitals gave certain insurers before the pool was created. The 2004 statute that created the West Virginia pool allows hospital assessments. Minnesota’s pool received a one-time appropriation from the state’s Health Care Access Fund, which is funded through a tax on provider charges. Louisiana has been considering whether to impose service charges on hospital admissions and outpatient surgeries to fund its high-risk pool. Implementation of this approach was jeopardized after a local court ruled such a charge could not apply to people covered in ERISA plans.

While several pool administrators commented that some sort of provider assessment could be a more equitable approach to funding pools in the future, there may be some obstacles to expanding this avenue. Provider assessments historically have been used to assist groups with limited ability to pay for care. Provider taxes used to fund expansions of coverage for the uninsured have sometimes been attacked as a “sick tax.”

Instead of a broad assessment on providers, several states have negotiated targeted discounts or rebates from providers serving people covered in the pool. This has the virtue of tying the reduction specifically to the providers from whom these individuals seek care. Wisconsin, Indiana and South Dakota each have relied on provider discounts to help finance their risk pools.

Pool Operations

It is difficult to draw a dividing line between how pools are financed and features of their operation that affect the financial soundness of the product. We looked at how and why pools were using managed care techniques. In addition, several respondents made other observations about some features of pool operations that seemed likely to have implications for the financial soundness of the pool. These include the timing of payments and the location of the pool.

A longstanding concern has been that pools provide indemnity coverage and have not kept pace with cost containment measures prevalent in the private market. However true that has been in the past, recent price spikes have driven pools to improve cost management. Almost every pool now uses managed care techniques such as limited provider networks and disease management programs for their chronically ill members.

Most pools now offer or require that participants use PPOs, which have different cost sharing in and out of the network. Many of the pools share networks with major public purchasers such as state employees, with the dominant carrier in the pool, or with the writing carrier or administrator of the pool—often the local Blue Cross and Blue Shield Plan. As of the end of 2004, provider networks were reportedly used in every state except Oklahoma.²⁸

Capitated plans such as conventional HMOs are less likely to contract with a pool (although HMO options are available in CA and CT). Another concern that affected the use of managed care was the need to allow people in the pool to seek care outside the state. This did not necessarily work against the use of managed care, however, since several pools indicated they referred members to a national network of centers of excellence.

Disease management and negotiated contracts for pharmaceuticals are also important cost management techniques because of the relatively high volume of services and drugs used by risk pool participants. At least 18 pools have active disease management programs.²⁹ At the end of 2003, a study of the pools identified 15 disease management contractors, 22 external case or utilization management contractors, and 15 separate pharmacy benefit managers. Five states (AR, CO, KS, OK, WA) are collaborating on an “advanced care management” demonstration and evaluation that seeks to quantify the value of

the intervention. In conjunction with contracted disease management for other conditions, Indiana has developed a targeted disease management program for hemophilia that it administers in-house.

- ***Timing and Independence***

Timing of funding is critical to the operation of the pools, since the use of funds for investments and cash flow affects profitability. Some states use a line of credit and assess carriers retrospectively based on actual costs.³⁰ The practices may vary with the degree of independence from state government; reserves held within a state agency are in jeopardy at the time of budgetary downturns. But separation does not guarantee immunity from state budget problems if the pool depends on state appropriations. The Illinois pool, which once maintained reserves similar to an insurance carrier, no longer bankrolls its own cash flow using state appropriations. After the state determined that its practices should be more consistent with other state-supported programs, it went three years without an additional appropriation.³¹ According to one Illinois State Representative, who preferred the earlier policy,

*If you establish a pool, make it a priority to be sure the Bureau of Budget understands reserves are how you receive payment savings. Paying on time keeps you more solvent. Small general revenue fund infusions could have kept [the Illinois pool's looming solvency crisis] from happening. But temptations are there when reserves are there.*³²

Most risk pools are quasi-governmental entities. Depending on how it is structured, a quasigovernmental entity may have more flexibility in assessing and retaining funds during tight state budget times than an entity that is within state government. At one extreme, a fully independent private entity voluntarily assessing itself would fall outside of tax caps. In the case of a state agency, with all pool employees in the state civil service system, a pool's reserves might be vulnerable to recapture and reprogramming during fiscal crises.

CoverColorado's Executive Director described their pool as being, in effect, self-funded:

"We are an 'OWA'—other weird arrangement. We function like an insurance company, but because we are fully self-funded we are not regulated by the Division of Insurance although we work closely with them every day and they assess us. The Insurance Department can't regulate fully self-funded plans. Every claim paid by CoverColorado is paid with CoverColorado dollars, there's no reinsurance company in back. But we're not an ERISA plan. Our money is held separately. It is our own money in our own bank, outside the state. Money that comes to us from the state will be managed and held by the Treasury, then when distributed to us it

goes to the CoverColorado bank account and CoverColorado investment.”³³

Although most pools are superficially alike in how they fund losses, there is a great deal of discussion of alternative approaches in addition to premiums and assessments on carriers. Among the newer strategies under consideration are assessments on stop loss carriers, tobacco taxes, and provider assessments. In addition, pool growth due to new Federal eligibility groups has stimulated a quest for a broader base, as well as a call for a greater Federal role in subsidizing pool losses.

Funding High-Risk Pools: Changes, Trends and Policy Concerns

Part III: Case Studies – Evolution in Funding Strategy

To provide a more nuanced understanding of the national results of our survey, case studies were conducted in six states (Colorado, Illinois, Indiana, Kentucky, Minnesota and South Dakota) selected for their varied histories, concerns and pool memberships. The case studies involved historical and background research, document review and structured interviews with a wider selection of individuals in the relevant states, including experts in the insurance, provider and consumer communities.³⁴

Colorado

In recent years, Colorado’s risk pool has had many ups and downs as a result of a statewide limitation on taxes and spending.³⁵ Colorado was selected for this project in part because of their experience with a wide range of approaches to funding in the quest for one that was both stable and independent of an annual appropriation process.

CoverColorado was created in 1990 as the Colorado Uninsurable Health Insurance Plan, and was initially funded by an income tax surcharge. Over the course of the next decade, it successively received support from the state Business Association Unclaimed Property Fund; other unclaimed property funds; interest proceeds from the Unclaimed Property Trust Fund; a carrier assessment on a per-covered-life basis; and half of a fund (called CAPCO) that was formerly used for economic development and now supports up to \$5 million per year in tax credits to offset donations to CoverColorado. The risk pool depends heavily on premiums, which are estimated to have contributed 78 percent of revenue in 2004.

Figure 1: CoverColorado History of Financing Methodologies

Period	Methodology
1990-1993	Income tax surcharge
1993-2002	Appropriations: three unclaimed property funds
2001-present	Appropriations: interest from unclaimed property trust fund
2001-present	Authority to assess carriers
2003-2004	Per-covered-life assessments collected
2005-present	Unclaimed property funds excess available as needed
2005-2014	CAPCO economic development fund tax credit for donations

Source: NCSL case study interviews, Cover Colorado Special Analysis, September 30, 2004

The recent history of CoverColorado funding has been challenging. Enrollment and expenses rose sharply between 2000 and 2002, with the advent of HIPAA eligibility in the pool and the departure of some carriers from the market. Rising demand³⁶ met the obstacle of state budgetary shortfalls. In 2001, the three funds that had supported CoverColorado were replaced by a combined Unclaimed Property Trust Fund (UPF), with income from the fund's assets dedicated to CoverColorado. However, eight months after this was set in law, the legislature appropriated almost all the monies from the fund to fill a steep budget shortfall, leaving few assets to produce interest.

The legality of depleting the fund balance was challenged by the state Treasurer on grounds that by failing to maintain sufficient reserves to pay potential claims, the state was failing to meet normal accounting standards. CoverColorado's claim on the fund has since been restored. The current rule is that CoverColorado may apply for anything beyond what the Unclaimed Property Fund needs for operations and claims. The pool Administrator expects to draw \$15 - \$16 million annually from this source. Although the pool assessed \$29.8 million for operations from May 2004 through May 2005 and beyond, the administrator does not anticipate another assessment for some time.³⁷

In 2001, CoverColorado became the state "alternative mechanism" and began covering HIPPA-eligible individuals, thus removing these individuals from the private guaranteed issue market. In exchange, an assessment was placed on health carriers. As the drama around the Unclaimed Property Fund unfurled, the assessment mechanism evolved from a backstop to the main source to cover pool losses. CoverColorado assessed all carriers on a per-covered-life basis, modeled on Oregon's program. This approach, which was not controversial at first, was designed to bring the many stop loss policies associated with partially self-funded plans into the funding base. All of the carriers, with the exception of Great West Life, agreed to the per covered life methodology. In a case still pending as of April, 2005, Great West Life sued over the per capita methodology, as well as on the grounds that the assessment was an illegal tax, prohibited under TABOR.³⁸

In anticipation of escalating losses from a rapidly growing pool, the assessment was increased three times in quick succession, tripling from \$9.8 million in 2003 to \$29.8 in 2004. Small businesses received a notice from insurers that their premiums were being increased to defray the cost of operating the high-risk pool. The politically potent small business community aggressively lobbied their legislators to change the funding scheme. The backlash may have helped persuade the legislature to secure the escheat (unclaimed property) funds, which had been first assigned and then withdrawn, for the pool.³⁹ According to a business leader,

"From the employer perspective, we wanted a [funding] source that didn't shift costs. We don't know what the future will hold, and resisted putting

business groups of one into the pool because of fears of a cost shift. It's a societal problem and should be fixed by government rather than an imposition on employers."⁴⁰

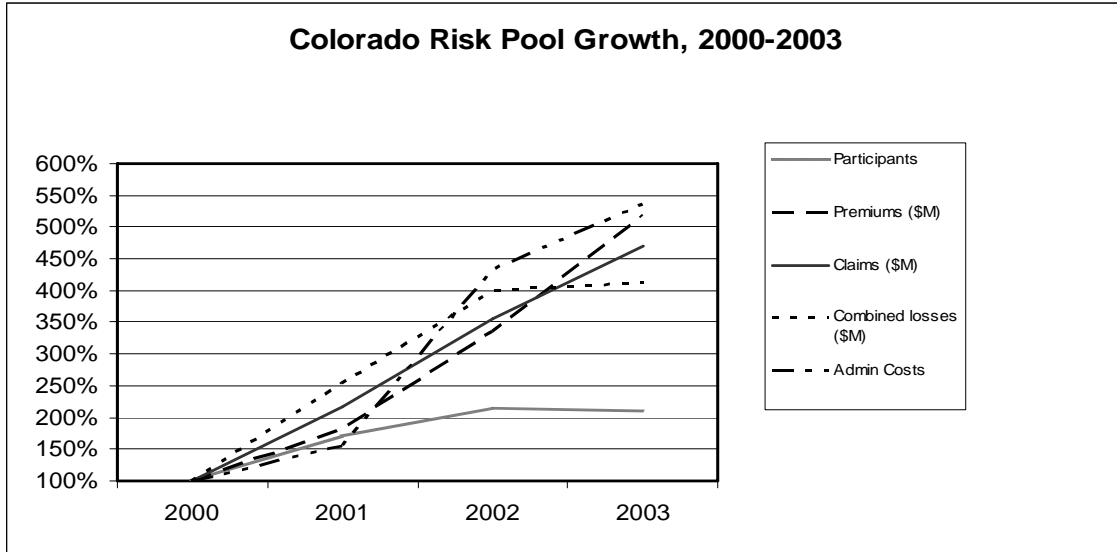
In 2004, the legislature dedicated another source of funds to CoverColorado by recycling an underused fund designed to encourage capital investment by insurers, the Certified Capital Companies Program (CAPCO). The fund had previously been used to provide tax credits for insurance company investments in local economic development. The legislature ended the CAPCO program and earmarked up to five million dollars of its appropriation for premium tax credits to carriers who made donations to CoverColorado. The initial year of CAPCO premium tax credit funding was disappointing. Only one carrier, Anthem Blue Cross and Blue Shield, chose to participate. Uncertainties about the timing of the credit, complexity, and the possibility that non-participating plans would benefit without committing funds were all mentioned as reasons for low participation by other plans.

Changes enacted in the 2005 legislative session are expected to alleviate these concerns.⁴¹ According to an insurance official, HB 05-1060 greatly simplified the process for a carrier to contribute tax monies to CoverColorado. Under the new law, the carrier simply checks off the amount they would like to contribute to CoverColorado on their quarterly premium tax returns submitted to the Colorado Division of Insurance (DOI). The DOI then posts on its Web site whether the full amount of tax credits authorized for that year have been allocated. The removal of administrative paperwork, complexity, and difficult timeframes is anticipated to encourage more carriers to participate in the tax credit program and hopefully will grant CoverColorado the full \$5 million annually that is authorized.⁴²

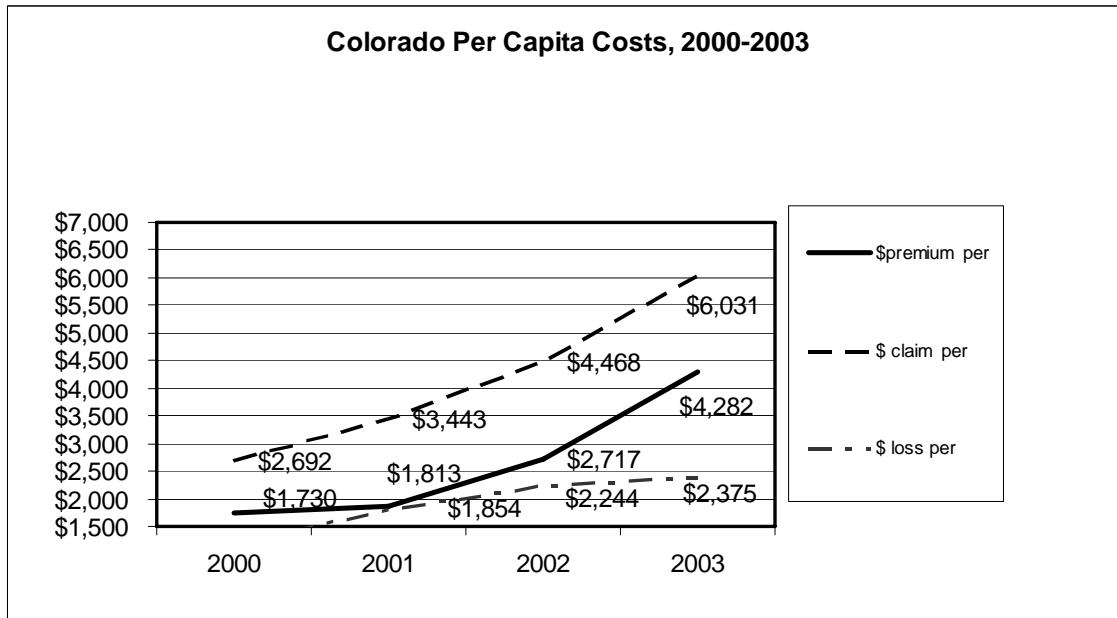
The volatility in funding sources affected pool premium levels as well. Originally capped at 135 percent of standard rate, the cap rose to 150 percent although actual premiums remained near the 135 percent level. However, when the carrier assessment was adopted in 2001, the law stipulated that carriers not be assessed until premiums were at 150 percent.

For all the funding challenges, CoverColorado has strong bipartisan support, is recognized by business as playing an essential role in keeping coverage affordable, and is preferred by insurers. The complex approaches the legislature has taken to fund the program reflect the restrictions imposed by TABOR and the severity of competing demands in a down budget cycle.

Looking to the future, the pool's Executive Director emphasized the dilemma risk pools face if they accept Federally-defined eligibles from ERISA plans that states are unable to assess: "The single greatest funding source will have to become Federal because they are the ones who are creating these populations."⁴³ In the short-term, her preference would be to seek passage of a referendum to allow CoverColorado to breach TABOR in order to establish a hospital bed tax.⁴⁴



Source: Communicating for Agriculture 2001, 2002, 2003, 2004



Source: Communicating for Agriculture 2001, 2002, 2003, 2004

Illinois

The Illinois Comprehensive Health Insurance Plan (ICHIP) was created in 1989. It was selected for study because it is a large, mature pool that continues to expand—recently successfully enrolling more TAA- eligible displaced workers than most states. It is a bifurcated program with: (1) a traditional high-risk pool that is size-limited and is fully state-funded for losses (ICHIP); and (2) a HIPAA portability pool that is funded through insurance assessments (HIPAA-CHIP). Premiums may and do differ between the pools—143 percent and 135 percent of the standard rate, respectively, as of late 2004.

The funding of the traditional pool stems from a compromise reached in the enabling statute. To assure legislators that it would not become a “runaway entitlement,” the law allows the risk pool board to limit the number of participants to whatever funds are appropriated each year. This appropriation is based on actuarial estimates of likely incurred claims, funded on a prospective basis. If claims exceed the estimate, enrollment is capped.⁴⁵

The pool had accumulated large reserves under a former Executive Director. Today the pool is operating close to the margin. In 2005, the funding priorities involve finding a mechanism that will ensure stability and smooth operations.⁴⁶ One State Representative expressed concern that reserves be sufficient to enable the pool to maintain discounts it now gets through its provider network.⁴⁷ To avoid future funding crises, state policymakers whom we interviewed were searching for a stable source of funding that would not require annual appropriations.

The original impetus for creating the pool came from the state’s Attorney General, who was concerned about availability of coverage for the disabled. Enrollment was originally capped at 4,000 medically uninsurable Illinoisans, and has been raised periodically as waiting lists developed; it is now capped at 5,950. Roughly 1,000 members of the traditional pool are under-65 Medicare recipients who primarily use it to pay for prescription drugs.⁴⁸ The traditional pool is funded through a state appropriation.

Beginning in 1997, a parallel program for Federally-eligible groups was implemented. Unlike the traditional pool, this pool is not capped and there is not a waiting list. Additional assessments can be levied on insurers doing business in Illinois to cover any deficits expected or incurred by the HIPAA-CHIP. In addition to HIPAA-eligibles, the pool began to enroll TAA-eligibles in June 2003. Premiums for all of these participants are capped at 150 percent of the standard rate.

According to the current pool Executive Director, funding additional groups such as the TAA groups has not been controversial. “The real battle (in 1986-1989) was to get startup funding appropriated. Compared to that, add-ons have been

pretty painless.”⁴⁹ The pool has strong, bipartisan support in the legislature. The former pool Executive Director pointed out that there are enrollees in every legislative district, and they have been very effective at informing their representatives about the program. He characterized the insurance industry as being vigilant rather than adversarial towards the assessment. “They keep track; they pay for it.”⁵⁰

A competitive market is credited with keeping premiums low – and the pool is credited with keeping the market competitive. Furthermore, according to survey respondents, the assessment has been very low because Illinois continues to have a large insurance base, which includes stop loss insurance carriers.⁵¹

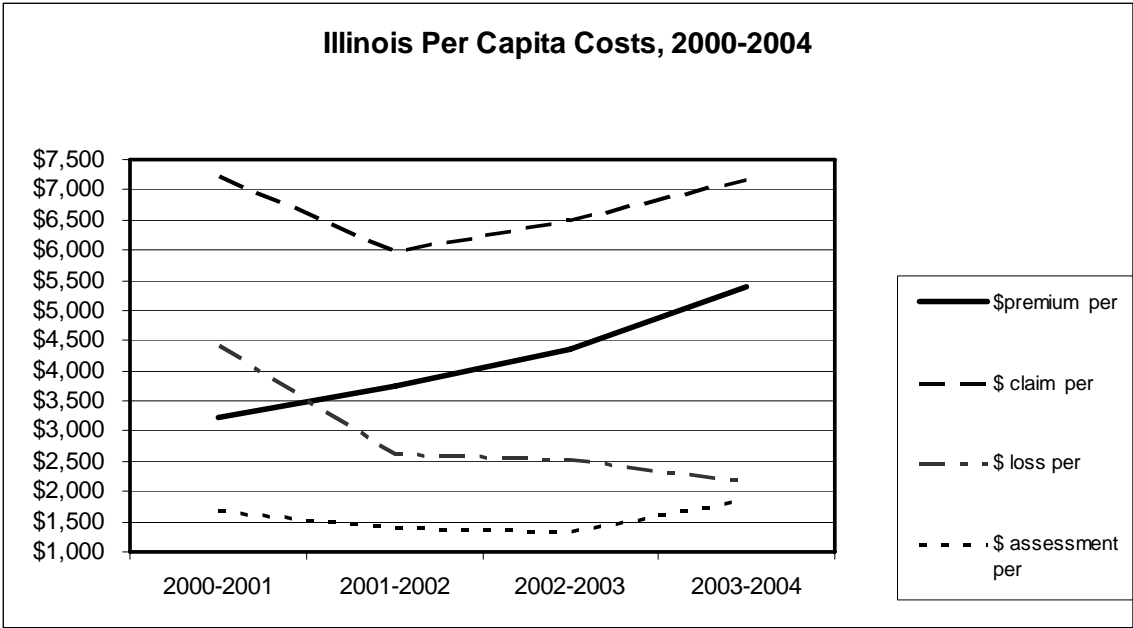
Illinois captured a large share of TAA operating grants in the first year, \$7.4 million. It allocated the grant across premium relief and assessments: 72 percent went to premium relief for the HIPAA-CHIP (resulting in a 6.6 percent reduction in rates, or about \$500/member/year) for a net premium increase in 2005 of only 1.1 percent.⁵² The remaining 28 percent of grant monies served to abate the assessment on carriers. According to a press release, Illinois was one of only two states to use the grant for premium relief.

Stop loss carriers are currently assessed, like other carriers, based on their total premiums.⁵³ An assessment may take place up to five times a year but typically is only done annually, based on the board’s estimate of the shortfall for the upcoming year. The timing of the program—it coincided with a general fund fiscal crisis—made it easier to get an assessment approved. The state has considered using per capita methodology; the insurance industry maintains that while ERISA plans do not contribute, some of their members end up in the pool. A shift to per covered lives would require a supplement to annual statements with this information, including a report from TPAs.

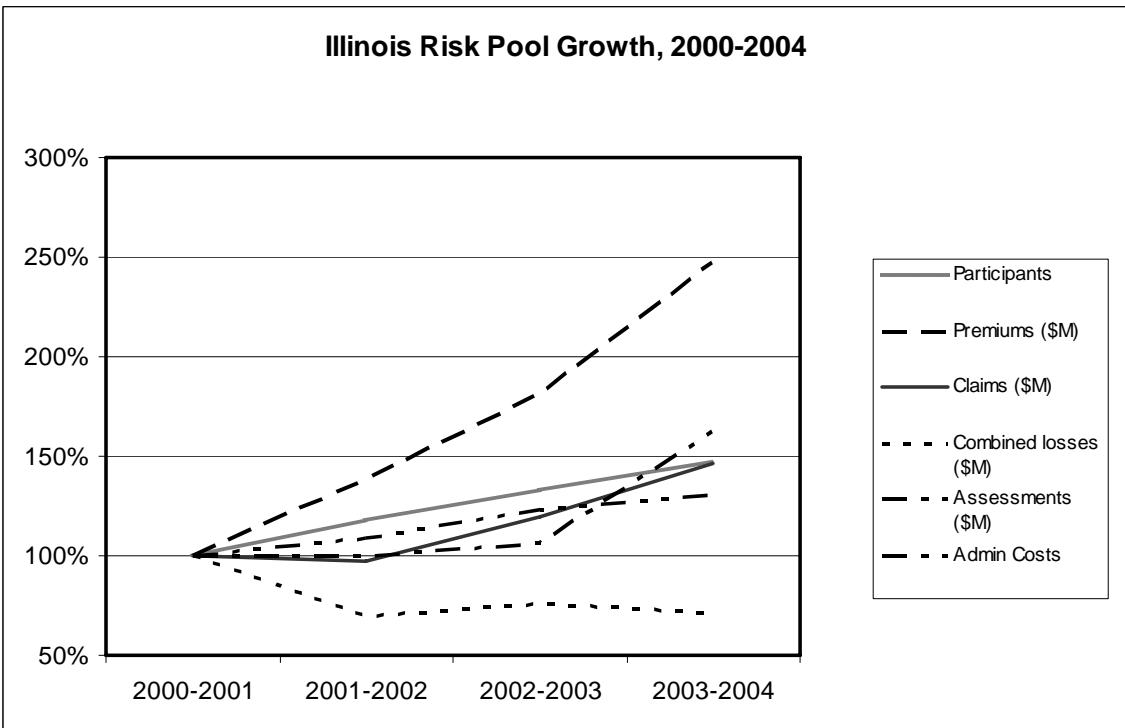
According to the current pool Executive Director, costs within the pool are rising slower than standard rates, although premiums—which are pegged to standard rates—continue to rise with the general market.⁵⁴ The claims experience within the pool mirrors the market as a whole. In any given year, at least half the members fail to meet the deductible, and a small percentage of members –an ICHIP board analysis found 3-4 percent -- account for most of the claims.

The Illinois risk pool has been doing disease management since 2002. Both individual and family policies are offered, with five levels of deductibles, ranging from \$500/\$1,000 to \$5,000/\$10,000. Out-of-pocket maximums on the policies are \$1,500 above the deductible for individuals and \$3,000 for families.

In addition, the pool requires prior approval for many high-cost procedures and preadmission hospital review. Except for the Medicare group, all pool members are now in PPOs—a decision taken after pool officials found that a large portion of the fee-for-service care was being given by the same providers.



Source: Communicating for Agriculture 2001, 2002, 2003, 2004



Source: Communicating for Agriculture 2001, 2002, 2003, 2004

Indiana

The Indiana Comprehensive Health Insurance Association (ICHIA), founded in 1981, has cycled through several different financing strategies in an effort to find a broad, stable funding base for its risk pool. Its experience may prove instructive for other states.

Indiana pool members pay a relatively low proportion of total costs through premiums—about 45 percent in 2003.⁵⁵ This may reflect ICHIA's close relationship with publicly funded programs in Indiana. In the early to mid 1990s, the legislature opened the pool to individuals in some public programs. Some high cost Medicaid recipients and certain other Health Department beneficiaries such as Ryan White (HIV/AIDS) and Hemophilia Foundation members were enrolled in the pool, with their premiums paid through public programs.⁵⁶ Costs of hemophilia patients, as high as \$1 million/year, have dominated the program. Most states, in contrast, explicitly ban premium payment by such third party payers on behalf of recipients, though many allow people to remain in the pool after they become eligible for other programs. Unlike Indiana's program, almost all impose lifetime maximums.⁵⁷

Budget shortfalls, pool losses and rising health care costs⁵⁸ have driven recent changes in how the pool is financed. Due to expensive third party cases and the addition of new Federally-eligible members, pool losses almost doubled, rising from \$35 million to \$62 million between 2000 and 2001.⁵⁹ This sharp jump in pool losses caught the attention of legislators since the assessment, which was passed through to the general fund as a tax expenditure, led to an unexpected dip in revenues that had a significant impact on the state budget.

The pool had initially been financed through an assessment on health carriers (including some stop loss carriers) based on their proportion of premium share. This assessment was offset through a state tax credit. However, in 2001, Indiana changed to a per-capita assessment system in an effort to address concerns about the assessment burden raised by carriers for whom the assessment had grown faster than the tax obligation (e.g., state-based HMOs). Because stop loss carriers faced steep increases as a result, they fought the change in policy and refused to pay, according to an executive with the Blue Cross and Blue Shield Plan.⁶⁰

In response, the risk pool board modified the method to a blended assessment, 50 percent based on premiums and 50 percent per covered life, effective July 2003. HMOs, many of which had not been able to take advantage of the tax credit to offset the assessment either because of low profitability or tax-exempt status, then sued to restore the per capita approach. The pool successfully won cases brought against its per capita assessment methodology,⁶¹ but fears that the entire pool might be lost brought all parties to the table where a consensus arrangement was reached and implemented through statute.

The key players agreed in 2004 to a revised method that changed the roles of insurers, the state and even providers in funding the high-risk pool. The state returned to a premium-based assessment for all carriers, but limited it to 25 percent of the pool's losses, eliminated the tax credit offset, and assumed the responsibility to fund the remaining 75 percent of losses through general appropriations. In addition, providers agreed to accept a reduced reimbursement rate and to not balance bill risk pool participants for the difference between their billed charges and the pool's fee schedule.⁶² The table below summarizes these changes.

Figure 2: ICHIA History of Assessment Methodologies

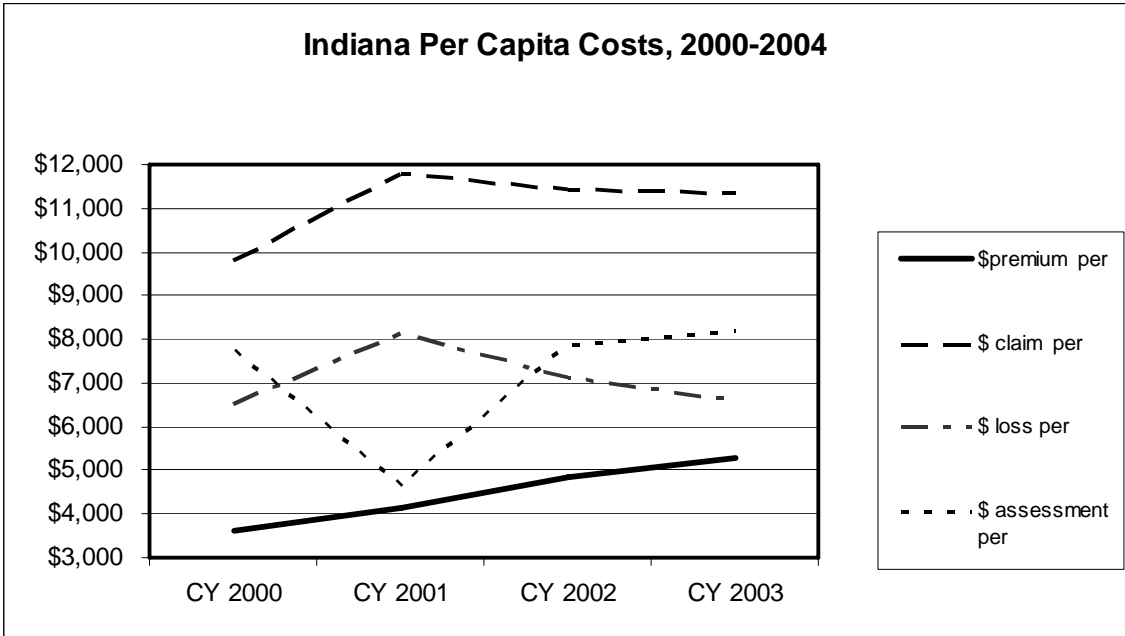
Period	Methodology	Tax credits allowed
1981-2001	Percentage of premium	Yes
1/2002-7/2003	Covered lives ("head count")	Yes
7/2003-12/2004	50% premium/ 50% covered lives	Yes
1/2005	75% appropriation from state of Indiana 25% assessment to member carriers based on their share of total health insurance premiums	No

Source: ICHIA administrator, January/2005.

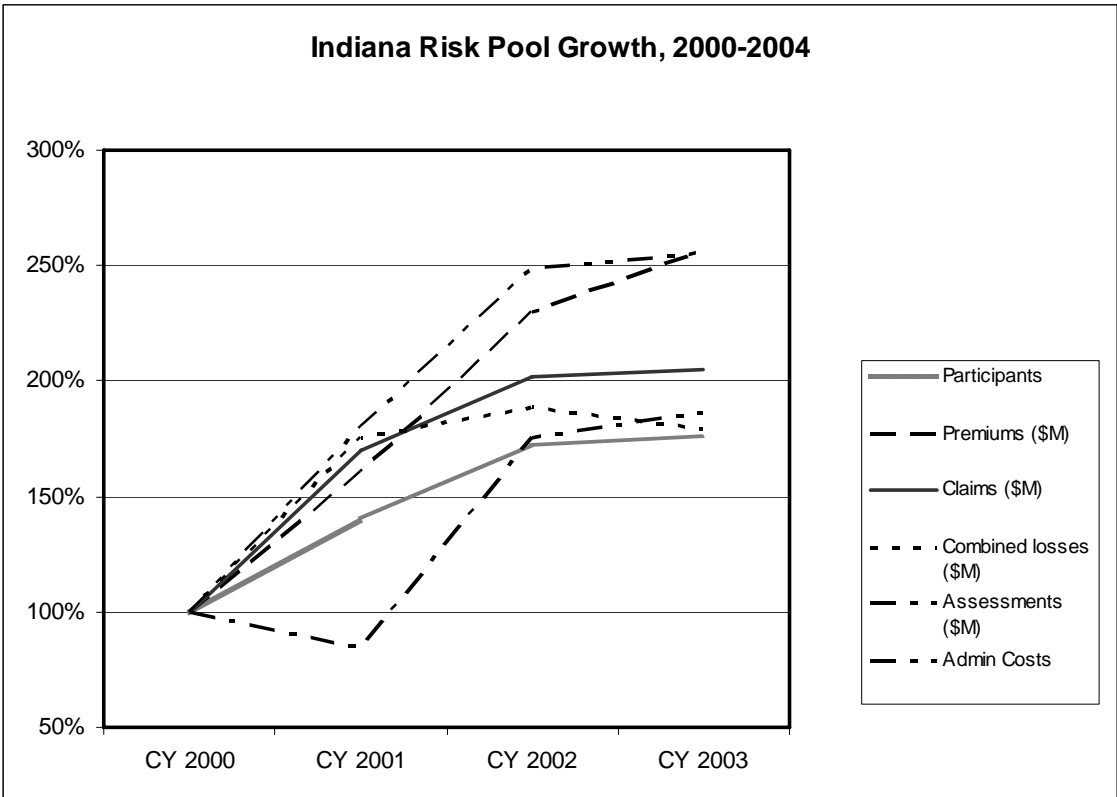
Prior to 2005, assessments were made prospectively, then reconciled against experience at year's end. Assessments are now set by the program's actuarial service, and offset against premiums and/or state income taxes. According to the program's Executive Director, one major shift is that now the state, rather than the industry, covers the majority of the cash flow for the program.

In addition to rates that vary by family income, Indiana pool premiums may be adjusted up or down 10 percent, based on its performance compared to national health cost trends. According to the pool's Executive Director, "If we have substantially better control over medical costs, program participants should share in the benefits of the savings."⁶³ This provision—and the Executive Director's vigorous pursuit of savings opportunities--translated into premiums that held flat for the pool in 2005.

Finally, ICHIA has experienced a turn-around in costs as a result of several other reforms. Legislation effective in 2003 and 2004 enabled it to exclude people who had resided in the state for less than one year, identify and move eligible individuals back to Medicaid and related programs,⁶⁴ and initiate strong utilization and disease management programs, leading to over a \$30 million reduction in medical expenses in 2004.⁶⁵ A board member who was also a consumer took a very proactive role in pushing for improved cost containment and making the case with other consumers that it was important for the continuation of the pool.⁶⁶



Source: Communicating for Agriculture 2001, 2002, 2003, 2004 ICHIA financial statement and PMPM data 2000-2003



Source: Communicating for Agriculture 2001, 2002, 2003, 2004; ICHIA financial statement and PMPM data 2000-2003

Kentucky

The Kentucky Access high-risk pool became operational in January 2001. The pool was adopted under contentious circumstances after aborted health reforms beginning in 1994 were followed by carrier flight.⁶⁷ Its adoption in 2000 followed complex and repeatedly modified insurance reform, including guaranteed issue and community rating requirements that had been successively delayed, diluted, partially implemented, and repealed.⁶⁸ This state was selected for a case study because it is often cited as a prime example of a crisis in the individual market caused by market regulation and alleviated by creation of a risk pool. The case study deals with current Kentucky risk pool financing and not the previous reform efforts, which are outside the scope of this project and have been well documented and much debated elsewhere.

According to an Anthem Blue Cross and Blue Shield executive, the pool came out of “Five years in a flawed guaranteed issue system. We weren’t forced into a pool, we evolved. It was a matter of lessons learned. [When Kentucky passed reforms] we didn’t expect guaranteed issue to have to stand on its own. Anthem was the only one writing in the nongroup market, and rate inflexibility drove costs up for the young and healthy. We saw them leaving the market and as they left it drove up rates for everyone else.”⁶⁹

Kentucky Access funding comes from several sources including premiums paid by program participants, appropriations from the state’s share of the Tobacco Master Settlement Agreement, and an assessment on health plan premiums . According to both an Insurance Department official and Anthem Blue Cross and Blue Shield, an advantage of the assessment mechanism over guaranteed issue is that it broadens the funding base to include group as well as individual carriers.⁷⁰ Insurance policies for fully insured businesses are assessed up to ½ of one percent of premiums, while stop-loss assessments are capped at two percent of premiums. A second annual assessment is allowed but has never been taken.⁷¹

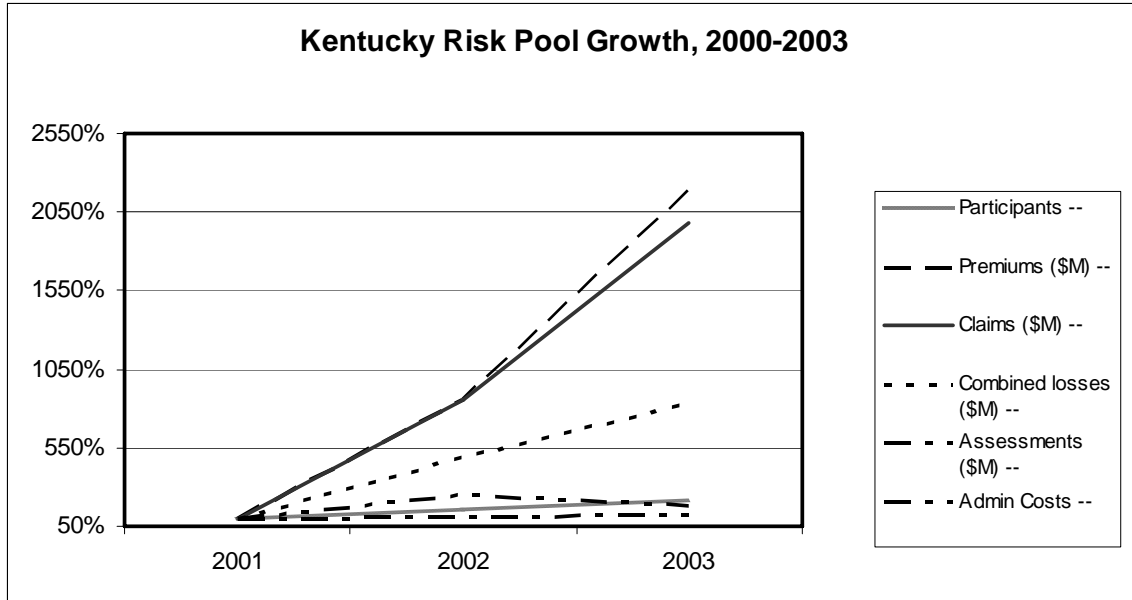
Kentucky Access is permitted to charge as high as 175 percent of standard risk rates. As of April 2005, the program’s premiums were approximately 132 percent of standard rates. The premium paid by each individual is guaranteed not to change for at least a twelve-month period. Third party payment is not allowed except by spouse, parent, adult child or guardian of HIPAA-eligible members.

The pool clearly achieved its objective of reinvigorating the individual market. Carriers returned to Kentucky, bringing the number of companies up to eight in 2004, compared to a low of one in 1997. The pool Administrator agreed that the program had stabilized the individual market, created a positive climate for insurers to return and was preferable to Kentucky’s experience with guaranteed issue in the individual market.⁷² One Insurance Department official we surveyed

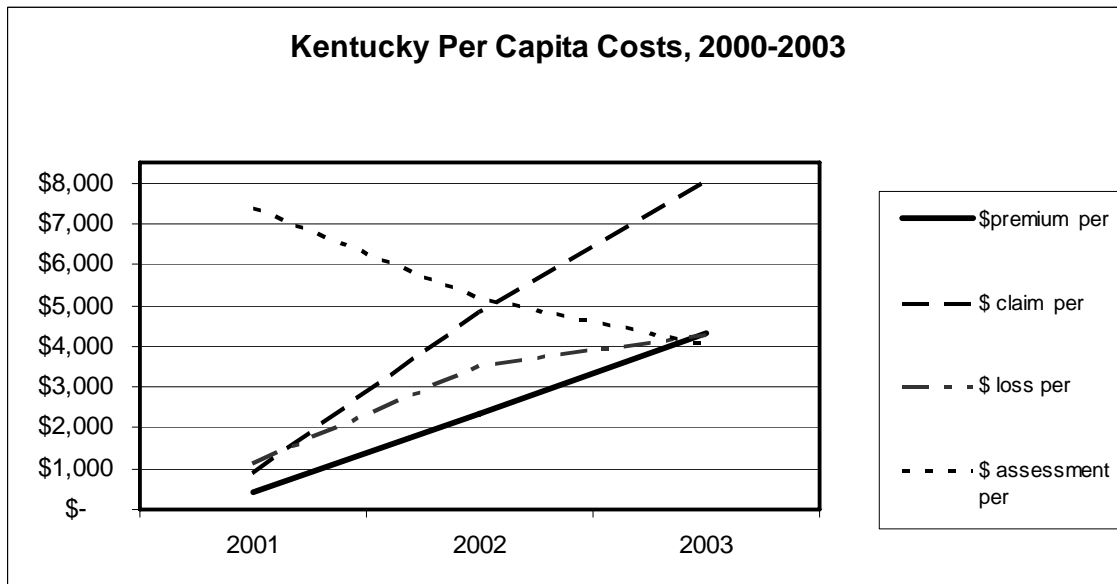
remarked that it was hard to tell what changes were due to Kentucky Access and which to changes nationwide in the individual market.⁷³

The funding of the pool continues to face challenges. Tobacco funds set aside for Kentucky Access have been lost at least twice during the budget process when they were shifted back to the General Fund to provide funding for other programs. Although they were secured by the end of the regular 2005 legislative session, this could happen again. The start-up period, during which reserves needed to be accumulated in expectation of future claims, coincided with an economic downturn. That likely made the funds a tempting target. Unlike most states, the pool in Kentucky is a state entity. This puts its reserves in reach of state appropriators, who opted to reprogram some of the funds that the pool accumulated during its start up period.

The pool utilizes four provider networks, each of which is the largest of its kind in the state. By leasing these networks, Kentucky minimizes balance billing of consumers and enjoys provider discounts. The Insurance Department exercises close oversight of the TPA that operates the pool, auditing it to make sure rules are followed and only eligible people are enrolled in the pool's products.



Source: Communicating for Agriculture 2001, 2002, 2003, 2004



Source: Communicating for Agriculture 2001, 2002, 2003, 2004

Minnesota

The Minnesota Comprehensive Health Association (MCHA), begun in 1976, is the largest and second oldest pool, serving about six percent of Minnesota's individually insured.⁷⁴ We are focusing on it because it is the original template from which most other programs evolved. The pool has been stable and successful over almost thirty years. Minnesota has a large insurance base, relatively few uninsured citizens, and several public health access programs for low-income residents. Despite its long-standing and stable reliance on assessments to cover losses, in the last eight years the state has made two appropriations from two different sources and attempted to tap a third, hinting that this method of financing could be approaching its limit.

Minnesota's insurer assessments, allocated in proportion to their share of residents' total accident and health insurance premiums in the state, were fully offset by income or premium tax credits until 1987. At that time, non-profit insurers, which did not pay premiums taxes, were added to the assessment pool. Today, MCHA member companies include insurance carriers, HMOs and other sorts of plans.

Constrained by ERISA and responding to small businesses, who were feeling increasingly burdened by the insurance assessment,⁷⁵ the legislature has appropriated additional funds for the pool in recent years. For example, during 1998 and 1999 the pool received \$30 million from a surplus in the state's existing Health Care Access Fund, which is funded by a provider assessment.⁷⁶ A one-time \$15 million appropriation to help fund pool losses came from a 2001 surplus in the state's Workers Compensation Assigned Risk Plan.⁷⁷ In 2002, Blue Cross and Blue Shield of Minnesota designated \$70 million of its tobacco settlement to reduce assessments for the pool. This earmark is on hold, pending resolution of a lawsuit filed by Blue Cross and Blue Shield of Minnesota policyholders.⁷⁸

A legislator mused on the difficulty the state was having with finding agreement on changes in how the pool is funded: "It may be easier to get consensus for something new than for changing something you've had for a long time."⁷⁹ The MCHA president agreed and pointed out that the current funding is stable, and that they have "searched for 10 years for a better broad-based funding methodology."⁸⁰

A legislator noted another problem that could accompany a shift from assessments to appropriations. "MCHA is a privately run program with state regulation. If the state takes over the funding or does general funding, the state needs to be in a position to have more say over daily operation of the program. I don't think the state can afford to take over another health care program. MCHA doesn't just provide insurance to low-moderate income people; [through MCHA] we are subsidizing wealthier people than our other [state health coverage] programs do today."⁸¹

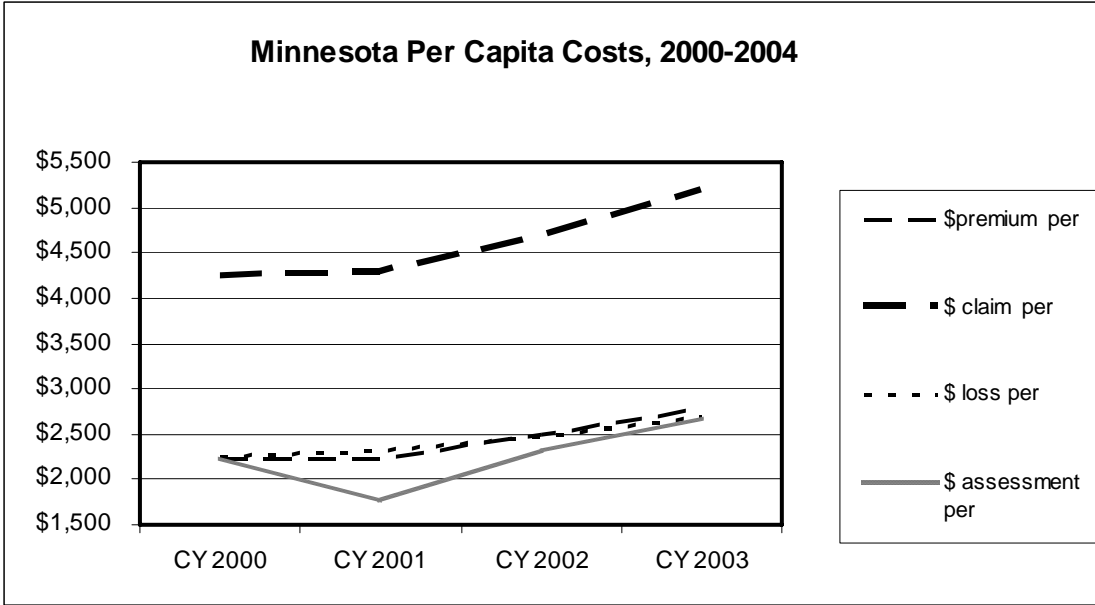
Despite these concerns, during 2005 the legislature considered eliminating the MCHA assessment in favor of a substantial cigarette tax increase and a subsequent biennial appropriation to MCHA. According to a legislator, a cigarette tax, although superficially appealing, could become inadequate over time because it is not related to the base that drives the pool's costs in the way that provider and premium taxes are.⁸²

Although recent changes have created some uncertainty in the pool funding, they have also elevated the pool's profile as an important part of the state's health care safety net. According to the pool's President, it would be more equitable if the Federal government had a greater role in funding the pools. "States can't go it alone, and all the new groups are coming from the feds."⁸³ The state received a grant for operations under the TAA that was quite small—particularly in proportion to the size of MCHA—because the allotment is based on a state's uninsured rate, which is very low in Minnesota.

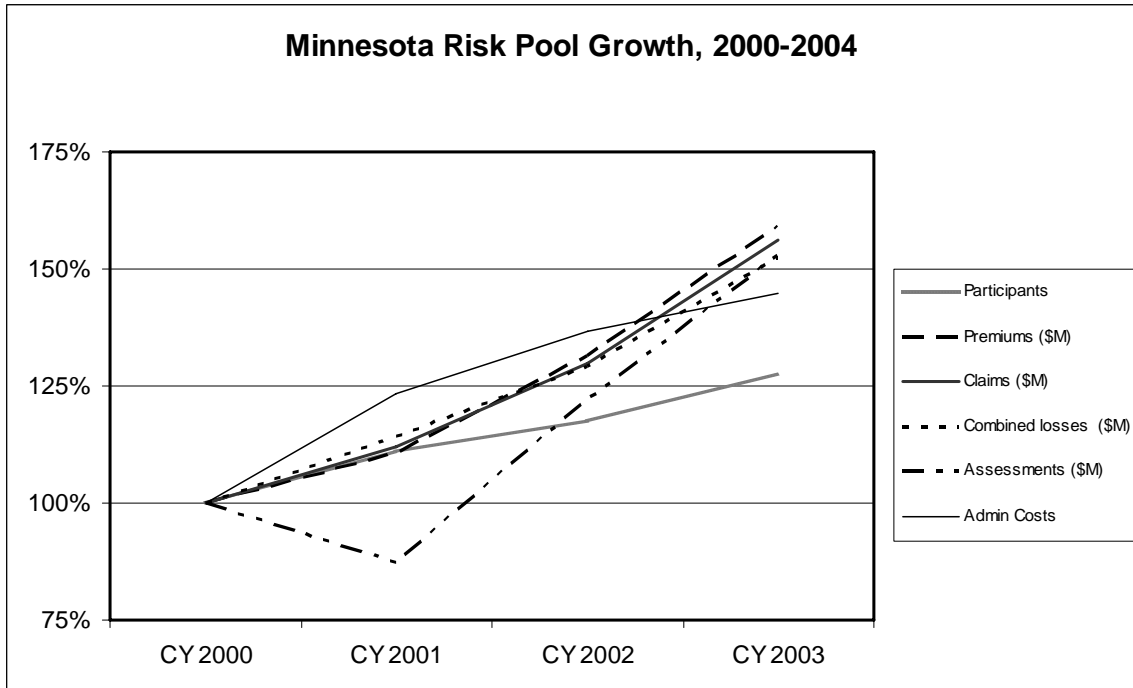
Unlike the national trend and other states we looked at, Minnesota pool premiums and losses have grown at almost exactly the same rate, perhaps reflecting stability and a more varied mix of risks due to its size. Premiums, claims and losses have grown at slower rates than in other states, as well. The statutory range for premiums—101 percent to 125 percent of the standard rate—is lower than other states; and medical costs in the state—the standard from which these are calculated—also tend to be lower than elsewhere, resulting in moderate premium prices. Pool premiums are currently set below the cap at 112 percent. According to a former consumer member of the MCHA board, setting premiums is always a balancing act to "keep the plan affordable to policy holders while not making it so low it undercuts the industry."⁸⁴

Assessments on insurers are made on an annual and interim basis. The pool President estimated that they never have more than \$10 million in reserve. "We would not be appreciated if we over-assessed. When we assess we make sure it is exactly what we need so assessed companies don't give up what they need for their operation."⁸⁵

Although Minnesota has been a national leader in managed care, its risk pool has been late in offering a managed care product. Pressure to keep an indemnity product is strong. Some pool members are "snowbirds" who spend part of the year out of state, and others cherish the ability to get care at various centers of excellence around the country.⁸⁶ MCHA does offer a disease management program through its Administrator and its disease management partners. As of February 2005, 4,200 MHA members were participating in these programs, which were offered for 30 chronic diseases and 14 disease states (stages of chronic diseases). MCHA officials point out that many enrollees are in rural areas where managed care may not be available.⁸⁷



Source: Communicating for Agriculture 2001, 2002, 2003, 2004



Source: Communicating for Agriculture 2001, 2002, 2003, 2004

South Dakota

South Dakota was selected for a case study because it has a relatively new pool. We hoped that it would show the politics and process of start-up (especially in a tight budget period) and spotlight new funding opportunities. The early story of the transition to the pool is surprisingly complex for such a small pool, and its multiple funding sources contrasts with most older pools.

The law creating the South Dakota risk pool was enacted in June of 2003 during a special session of the state legislature convened by Governor M. Michael Rounds.⁸⁸ Created as a Federal HIPAA-compliant mechanism for the state, it replaced guaranteed issue as the portability product in the individual market for newly eligible individuals. However, high-risk individuals who are currently uninsured and do not meet HIPAA's requirements, and the roughly 1,055 "old guaranteed issue" individuals who were already covered when the pool opened, are not eligible to participate.

Before the creation of the risk pool, South Dakota required carriers in the individual market to issue policies for individuals with 12 months of prior creditable coverage. Each carrier in the market was required to accept individuals in this category, up to a set proportion of their business. Unfortunately, the proportion—which began at two percent--rose in increments to six percent, a level and trajectory that may have been increasingly unacceptable for the many carriers that left the market. In addition, there was concern that the risk spreading mechanism employed by the guaranteed issue law was not adequate to help insurers manage their exposure to high claims.

Eight carriers, comprising half the individual market, left between 2000 and 2003. A task force appointed by the Governor considered this issue in 2002 and recommended the creation of a risk pool, but agreement was not reached. By mid-2003, Mutual of Omaha had declared it would be pulling out of the state altogether, while American Family Insurance announced that it would stop offering individual policies as of August of that year. The only large carriers that remained were Fortis Health and Wellmark Blue Cross and Blue Shield. With the individual market down to three carriers and the deadline on applying for \$1 million in Federal start-up funds fast approaching, the legislature created a high-risk pool as an alternative mechanism, while leaving current customers in existing guaranteed issue products.⁸⁹

The pool's statute established a three-way partnership, with the state, the insurance industry and the provider community each responsible for covering approximately one-third of the pool's losses. It is striking that the parity is achieved through three divergent assessment methodologies: (1) a lump sum contribution from the state; (2) a per capita assessment on all health insurance subscribers in the state; and (3) discounted charges by providers. It will be interesting to see how and whether equal sharing is maintained over time.

The legislature agreed to an annual appropriation of \$500,000 for the pool. All licensed health carriers in the state, including stop loss, must pay a \$3 per capita annual assessment. An Insurance Department official pointed out that this broad assessment base was critical in a state as small as South Dakota. Physicians and hospitals agreed to accept rates of 115 percent of Medicaid reimbursement levels for providing services to high-risk patients. Insurance agents also receive a lower commission (3 percent rather than the standard 10 percent) for referring individuals to the pool. Pool premiums are set at 150 percent of the standard rate.

A reserve fund of \$1.5 million dollars was established with the initial state funds. South Dakota was awarded a Federal TAA start-up grant of \$1 million in 2003. As of the end of 2004, the pool had not yet used any of its \$1.5 million reserve. Risk pool officials are not quite certain why that is the case, although it is likely due to lower than expected enrollment. Many have attributed it to the relative infancy of the pool. The legislature adjourned for 2005 without a formal analysis of pool funding.

Some officials have noted that the medical community's contribution has been higher than was anticipated. Doctors and providers have asked that their reimbursement levels be increased, perhaps to approximately 130 percent of the Medicaid level, arguing that current pool reimbursement levels are not sufficient to cover their costs. During the 2005 session the legislature enacted SB 29, which gives the risk pool board the authority to enter into contracts with out-of-state providers.

People who had coverage before the pool began are also looking for relief. Under the South Dakota law, because they were already covered, they are not eligible for the pool unless their coverage is cancelled by the insurer, even though they would be if they were newly seeking coverage. For people who have been covered under guaranteed issue by carriers who stayed in the market premiums cannot rise above 250 percent of the carrier's base rate. The cap is set at 185 percent of the base for people who are in the underwritten business of these carriers, or covered by carriers that no longer market in the state. There is some skepticism as to whether the guaranteed issue group will be allowed to join the pool, because an actuarial study found that admitting them would cost the pool \$4.1 million more than what it would bring in. One possibility that has been floated is for the state to cap both "old guaranteed issue" cohorts at 185 percent, with the state making up the difference between that and the current 250 percent.

In addition to multi-partnered funding, the state hopes to keep the pool affordable by using strong benefits and care management. The risk pool product uses the same techniques as the State Employee Health Plan to control costs: disease management and tight utilization management. It is administered through the state Bureau of Personnel.

From a carrier's perspective, the Blue Plan executive noted, knowing that they would no longer be required to accept guaranteed issue seemed to be enough to persuade carriers to remain in the market. Many have credited the risk pool for creating a positive climate in which carriers want to remain in or return to the state.

NOTE: Because this is a new pool, there are no graphs of trend data.

Funding High-Risk Pools: Changes, Trends and Policy Concerns

Part IV: Looking Ahead

State Financing Policies Must Co-Exist with Budget Limits

The convergence of an economic downturn and pool expansions from 2001 – 2004 has left states looking for new funding sources. Although some states are not inclined to move from a carrier-based assessment to a general fund tax base in the face of budget shortfalls, many have at least considered how to make assessments more equitable because they are now disproportionately borne by the nongroup and small group market. The guiding rule seems to be *qui bono* – or who benefits from the pools’ existence. Table 6 lists reasons pool administrators identified for considering funding changes.

Table 6: **Rationale for Funding Change**

Reasons	# states
Funding base too narrow	10
State budget shortfall	9
Exit of insurers from market	8
New Federal opportunities	7
Pool shortfall/recoup losses	6
Court decision/ERISA	6
Interest group pressure	6
New eligibility groups added	5
Other states’ experience	5
Waiting list/increased demand	4
Rising uninsured	4
Federal restrictions	4
Rising health care costs	4
Pool program change	3
Changed political environment	3
Model legislation	3

source: NCSL Survey of Risk Pools, 2004 Table
Note: Count based on responses from 16 states; some respondents gave multiple answers

One theme in the interviews was the need to level the playing field by assessing all players, whether self-funded or not, because HIPAA and TAA eligibles frequently come from self-funded plans that have not participated in funding the risk pool. As described previously, to achieve more equitable financing, states have experimented with assessing reinsurers and third party administrators (TPAs) on a per-covered-life basis. Versions of this requirement continue to be tried and challenged on ERISA grounds.

A few states have begun to look beyond insurance assessments and have legislated an assessment on health care providers. Currently, the Maryland and West Virginia high-risk pools are funded, in part, through an assessment on hospitals.⁹⁰ Some states have also noted the fact that rebounding prices in the last few years have left many hospitals with

healthy bottom lines at a time when other revenue sources are looking wan. In

Wisconsin, Indiana and South Dakota, providers were at the table recently when pool financing policies were made, and accepted negotiated discounts to spread the pain.

Interest in risk pools is likely to grow if the Bush administration and Congress continue to explore tax-incentivized individual alternatives to employer-based group coverage, including tax credits, new purchasing arrangements, and high cost-sharing in conjunction with health savings accounts.

Legislation pending in Congress in June 2005 would extend Federal funding for operation of state high-risk pools. S. 288 would promote qualified high-risk pools through three mechanisms: (1) seed grants to states who wish to create pools; (2) grants for operational losses; and (3) bonus grants for consumer benefits (e.g., premium subsidies for low-income enrollees). This measure would appropriate \$15 million for seed grants over FY 2005 and 2006, and \$75 million for each of FY 2005 through 2009 of which two-thirds would be earmarked to offset the cost of running the pools, with the remainder available for enhanced consumer benefits.

Bibliography

Abbe, Bruce. Vice President of Public Affairs, Communicating for Agriculture. Telephone Interview. January 31, 2005.

Abbe, Bruce. "Using Tax Credits and State High-Risk Pools to Expand Health Insurance Coverage." Health Affairs: October 23, 2002.

Bartling, Julie. State Senator, South Dakota. Telephone Interview. January 6, 2005.

Berglin, Linda. State Senator, Minnesota. Telephone Interview. January 18, 2005.

Blumberg, Linda & Len Nichols. "First, Do No Harm: Developing Health Insurance Market Reform Packages." Health Affairs: Fall 1996.

Brett, Barbara. Executive Director, CoverColorado. Telephone Interview. January 12, 2005.

Brown, Lawrence & Michael Sparer. "Window Shopping: State Health Reform Politics in the 1990s." Health Affairs: Vol. 20, Number 1.

Carlson, Rick. Former Executive Director, Illinois Comprehensive Health Insurance Plan. Telephone Interview. January 12, 2005.

Center for Health System Change. Issue Brief. "The Individual Health Insurance Market." No. 58, December 2002.

Chollet, Deborah. "Consumers, Insurers, and Market Behavior." Journal of Health Politics, Policy and Law: 25.1, (2000).

Chollet, Deborah. "Assessing the Individual Health Insurance Market in the Post-HIPPA Era: A Review of the Literature." US Dept of Health and Human Services. June 2001.

Communicating for Agriculture & the Self-Employed, Inc. Comprehensive Health Insurance for High-risk Individuals. Fergus Falls, MN: Communicating for Agriculture, 2001.

Communicating for Agriculture & the Self-Employed, Inc. Comprehensive Health Insurance for High-risk Individuals. Fergus Falls, MN: Communicating for Agriculture, 2002.

Communicating for Agriculture & the Self-Employed, Inc. Comprehensive Health Insurance for High-risk Individuals. Fergus Falls, MN: Communicating for Agriculture, 2003.

Communicating for Agriculture & the Self-Employed, Inc. Comprehensive Health Insurance for High-risk Individuals. Fergus Falls, MN: Communicating for Agriculture, 2004.

Feldman, R, C Escribano & L Pellise. "The Role of Government in Health Insurance Markets with Adverse Selection." Health Economics: 7, (1998).

Ford, Lawrence. Director, Government Relations, Anthem Blue Cross and Blue Shield of Kentucky. Telephone Interview. January 18, 2005.

Freedman, Greg. Legislative Staffer, Kentucky Legislature. Telephone Interview. January 10, 2005.

Fritts, Kelli. Associate State Director, AARP Colorado. Telephone Interview. January 11, 2005.

Fuchs, Beth. "Expanding the Individual Health Insurance Market: Lessons from the state reforms of the 1990s." The Robert Wood Johnson Foundation, Research Synthesis Report No. 4. June 2004.

Gambrill, Susan. Deputy Commissioner, Division of Insurance, State of Colorado. Telephone Interview. January 5, 2005.

Government Accounting Office. Implementation of HIPAA: State-Designing Mechanisms for Group-to-Individual Portability. May 20, 1998.

Griffin, Janet. Vice President, Public Policy & Government Relations, Wellmark Blue Cross and Blue Shield of Iowa. Telephone Interview. January 11, 2005.

Gross, John. Director, Health Care Policy, Commerce Department, State of Minnesota. Telephone Interview. January 12, 2005.

Gruber, Lynn. President, Minnesota Comprehensive Health Association. Telephone Interview. January 31, 2005.

Harrington, Scott & Tom Miller. "Competitive Markets for Individual Health Insurance." Health Affairs: October 23, 2002.

Jerkovitz, Thomas. Executive Director, Illinois Comprehensive Health Insurance Plan. Telephone Interview, March 30, 2005.

Kennedy, Tim. Counsel, Indiana Hospital Association. Telephone Interview. January 25 2005.

Ladenheim, Kala and Stella Chiang. "National Conference of State Legislatures Survey of State High-Risk Pools." National Conference of State Legislatures, 2004-2005.

Lindsay, Bill. Insurance Broker, Colorado. Telephone Interview. January 10, 2005.

Madson, Deborah. Vice President, Public Programs, Blue Cross and Blue Shield of Minnesota. Telephone Interview. January 5, 2005.

Maginn, Marjorie. Indiana Regional Director, Anthem Blue Cross and Blue Shield of Indiana. Telephone Interview. January 10, 2005.

Mautino, Frank. State Representative, Illinois. Telephone Interview. January 10, 2005.

McKittrick, Lonnie. Insurance agent, Fischer Rounds and Associates. Telephone Interview. January 10, 2005.

Meier, Conrad. “Extending Affordable Health Insurance to the Uninsurable.” Heartland Policy Study No. 91. August 27, 1999.

Miller, Carl. Director, Government Relations, Anthem Blue Cross and Blue Shield of Colorado. Telephone Interview. January 7, 2005.

Mitchell, Jill. Manager, Health Care Financing, Kentucky Department of Insurance. Telephone Interview. January 25, 2005.

Mock, Kathy. Vice President, Blue Cross and Blue Shield of Minnesota. Telephone Interview. January 5, 2005.

Mollner, Carol. Director, Development, Headwaters Foundation. Telephone Interview. January 19, 2005.

Morrison, Marcy. Mayor, Manitou Springs, Colorado. Telephone Interview. January 31, 2005.

Moses, Randy. Assistant Director of Regulation, Division of Insurance, State of South Dakota. Telephone Interview. January 14, 2005.

Patel, Vip & Mark Pauly. “Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets.” Health Affairs: August 28, 2002.

Pauly, Mark & Len Nichols. “The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes.” Health Affairs: October 13, 2002.

Pollitz, Karen & Deborah Chollet. “Thinking about the Individual Health Insurance Market in a Post-HIPAA Era.” U.S. Department of Health and Human Services. June 2001.

Pollitz, Karen, Richard Sorian & Kathy Thomas. “How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?” Henry J. Kaiser Family Foundation. June 2001.

Pollock, Ralph. Board Member, Colorado Chamber of Commerce. Telephone Interview. January 10, 2005.

Rice, Michelle. Executive Director, Hemophilia of Indiana. Telephone Interview. January 19, 2005.

Robbins, Kathy. Senior Manager, Illinois Comprehensive Health Insurance Plan Administration, Blue Cross and Blue Shield of Illinois. Telephone Interview. January 6, 2005.

Stratton, Doug. Executive Director, Indiana Comprehensive Health Insurance Association. Telephone Interview. January 12, 2005.

Sutton, Duane. State Senator, South Dakota. Telephone Interview. January 7, 2005.

Wilson, Sam. Associate State Director for Advocacy, AARP. Telephone Interview. January 10, 2005.

Witwer, John. State Representative, Colorado. Telephone Interview. January 31, 2005.

Young, Daniel & Thomas Wildsmith. "Expanding Coverage: Maintain a Role for the Individual Market." Health Affairs: October 23, 2002.

State Case Study Resources

Colorado

Brett, Barbara. Executive Director, CoverColorado. Telephone Interview. January 12, 2005.

CoverColorado. Special Analysis. September 30, 2004.

CoverColorado. Financial Statements. 2001-2003.

Gambrill, Susan. Deputy Commissioner, Division of Insurance, State of Colorado. Telephone Interview. January 5, 2005.

Joint Budget Committee Staff. "Budget Briefing on CoverColorado." State of Colorado. December 16, 2002.

Joint Budget Committee Staff. "Budget Briefing on CoverColorado." State of Colorado. December 15, 2003.

Leif Associates. "Actuarial Study: The Impact of Small Employer Carriers Ceding Certain Business Groups of One to CoverColorado." February 2004.

Lindsay, Bill. Insurance Broker, Colorado. Telephone Interview. January 10, 2005.

Miller, Carl. Director, Government Relations, Anthem Blue Cross and Blue Shield of Colorado. Telephone Interview. January 7, 2005.

Morrison, Marcy. Mayor, Manitou Springs, Colorado. Telephone Interview. January 31, 2005.

Pollock, Ralph. Board Member, Colorado Chamber of Commerce. Telephone Interview. January 10, 2005.

Witwer, John. State Representative, Colorado. Telephone Interview. January 31, 2005.

Illinois

Carlson, Rick. Former Executive Director, Illinois Comprehensive Health Insurance Plan. Telephone Interview. January 12, 2005.

Illinois Comprehensive Health Insurance Plan. 2003 Annual Report.

Illinois Comprehensive Health Insurance Plan. Website. www.chip.state.il.us

Jerkovitz, Thomas. Executive Director, Illinois Comprehensive Health Insurance Plan. Telephone Interview. March 30, 2005.

Mautino, Frank. State Representative, Illinois. Telephone Interview. January 10, 2005.

Meier, Conrad. Extending Affordable Health Insurance to the Uninsured. Heartland Institute. August 27, 1999.

Robbins, Kathy. Senior Manager, Illinois Comprehensive Health Insurance Plan Administration, Blue Cross and Blue Shield of Illinois. Telephone Interview. January 6, 2005.

Indiana

Indiana Comprehensive Health Insurance Association. Financial Statements. September 2004.

Indiana Comprehensive Health Insurance Association. Enrollment Data. September 2004.

Indiana Comprehensive Health Insurance Association. Claims Data. November 2004.

Indiana Comprehensive Health Insurance Association. Resource Guide and Program Update. December 2004.

Indiana Comprehensive Health Insurance Association. Website.
<http://www.onlinehealthplan.com>

Indiana Legislative Services Agency. Final Report of the Interim Study Committee on the Indiana Comprehensive Health Insurance Association. October 2000.

Kennedy, Tim. Counsel, Indiana Hospital Association. Telephone Interview. January 25 2005.

Maginn, Marjorie. Indiana Regional Director, Anthem Blue Cross and Blue Shield of Indiana. Telephone Interview. January 10, 2005.

Rice, Michelle. Executive Director, Hemophilia of Indiana. Telephone Interview. January 19, 2005.

Stratton, Doug. Executive Director, Indiana Comprehensive Health Insurance Association. Telephone Interview. January 12, 2005.

Kentucky

Ford, Lawrence. Director, Government Relations, Anthem Blue Cross and Blue Shield. Telephone Interview. January 18, 2005.

Freedman, Greg. Legislative Staffer, Kentucky Legislature. Telephone Interview. January 10, 2005.

Kentucky Access. Report of the Kentucky Access to the Legislative Research Commission. November 2001.

Kentucky Access. Report of the Kentucky Access to the Legislative Research Commission. November 2003.

Mitchell, Jill. Manager, Health Care Financing, Kentucky Department of Insurance. Telephone Interview. January 25, 2005.

Minnesota

Abbe, Bruce. Vice President of Public Affairs, Communicating for Agriculture. Telephone Interview. January 31, 2005.

Berglin, Linda. State Senator, Minnesota. Telephone Interview. January 18, 2005.

Chollet, Deborah and Lori Achman. "Approaching Universal Coverage: Minnesota's Health Insurance Programs." Field Report, Commonwealth Fund. February 2003. p. 18-22.

Gross, John. Director, Health Care Policy, Commerce Department, State of Minnesota. Telephone Interview. January 12, 2005.

Gruber, Lynn. President, Minnesota Comprehensive Health Association. Telephone Interview. January 31, 2005.

Health Economic Program. "Health Care Coverage and Financing in Minnesota: Public Sector Programs." Health Policy and Systems Compliance Division, Minnesota Department of Health. March 1999.

Madson, Deborah. Vice President, Public Programs, Blue Cross and Blue Shield of Minnesota. Telephone Interview. January 5, 2005.

Minnesota Comprehensive Health Association. Annual Report 2002.

Minnesota Comprehensive Health Association. Website. www.mchamn.com

Mock, Kathy. Vice President, Blue Cross and Blue Shield of Minnesota. Telephone Interview. January 5, 2005.

Mollner, Carol. Director, Development, Headwaters Foundation. Telephone Interview. January 19, 2005.

Wolfe, Warren. "For Some, A Painful Cut." Star Tribune. January 31, 2005.

South Dakota

Bartling, Julie. State Senator, South Dakota. Telephone Interview. January 6, 2005.

McKittrick, Lonnie. Insurance agent, Fischer Rounds and Associates. Telephone Interview. January 10, 2005.

Moses, Randy. Assistant Director of Regulation, Division of Insurance, State of South Dakota. Telephone Interview. January 14, 2005.

South Dakota Risk Pool. 2004 Annual Report to the South Dakota Legislature.

South Dakota Risk Pool. Financial Statements. July-November 2004.

South Dakota Risk Pool. Website.

<http://www.state.sd.us/bop/RiskPool.htm>

Sutton, Duane. Senator, South Dakota Legislature. Telephone Interview. January 7, 2005.

Wilson, Sam. Associate State Director for Advocacy, AARP. Telephone Interview. January 10, 2005.

Appendices

Appendix Table 1: Premium and Assessment

Risk Pool Financing, 2003-2004

STATES	DATA SOURCE	PREMIUMS EARNED	ASSESSMENT	Basis	detail	Tax credit
AL	(1)	\$ 18,820,989.00	\$ 9,736,765.00	T		Y
AK	(2)	\$ 2,555,828.00	\$ 4,551,599.00	T		N
AR	(3)	\$ 12,211,539.00		T	All insurers, as a condition of doing business in the state	F
CA	(1)	\$ 69,285,147.00	NA			(na)
CO	(4)	\$ 16,285,737.00	\$ 10,614,910.00	P	not currently	(na)
CT	(1)	\$ 16,014,394.00	\$ 7,971,862.00	M	include self-insured	N
FL	(1)	\$ 2,178,595.00	\$ 2,744,115.00	T	not to exceed 1% of insurer's health insurance premium	N
ID	(1)	\$ 1,707,956.00	NA	C	carriers	NA
IL (traditional)	(2) & (1)	\$ 31,554,211.00	NA			NA
IL (HIPAA)	(2) & (1)	\$ 51,646,702.00	\$ 1,960,000.00	T		N
IN	(1)	\$ 50,713,360.00	\$ 78,424,200.00	T & P	Fifty percent based on relative premiums and fifty percent based on per-covered life (excluding Medicaid); As of 1/05, only premiums	N
IA	(1)	\$ 1,188,026.00	\$ 2,990,544.00	T		P
KS	(1)	\$ 9,919,663.00	\$ 3,045,981.00	M	"and other insurance arrangements"	P
KY	(1)	\$ 12,289,119.00	\$ 11,487,604.00	P		N
LA	(1)	\$ 8,706,948.00	\$ 5,400,000.00	T	Assessment for HIPAA only, mandated service charge for traditionally high-risk patients.	N
MD				O	Hospital	(na)
MN	(1)	\$ 93,435,724.00	\$ 90,091,014.00	M	include self insured insofar as allowed	N
MS	(1)	\$ 16,329,578.00	\$ 5,510,233.00	P	Currently \$1 per covered life per month	N
MO	(1)	\$ 12,484,083.00	\$ 6,157,206.00	M	"and other insurance arrangements"	N
MI (traditional)	(2)	\$ 4,254,711.00	\$ 3,420,279.00	T	up to 1% of premiums	P
MI (HIPAA)	(2)	\$ 6,493,365.00	\$ 1,787,312.00	T		P
MI (low-income)	(2)	\$ 251,067.00	\$ 79,721.00	T		P
NE	(2)	\$ 31,617,569.00	NA	O	premium tax	(na)
NH	(5)	\$ 487,115.00	\$ 4,239,247.00	P		N
NM	(3)	\$ 5,222,971.00	\$ 4,699,272.00	T	including MCO for Medicaid beneficiaries	P
ND	(5)	\$ 6,050,021.00	\$ 3,000,000.00	T	with > \$100,000 in premiums	F
OK	(1)	\$ 16,595,130.00	\$ 11,091,379.00	M	including NFP HMOs and state health plan	N
OR	(3)	\$ 44,267,501.00	\$ 21,223,055.00	P		N
SC	(5)	\$ 13,775,512.00	\$ 3,138,905.00	T		P
SD				P		N
TX	(1)	\$ 124,145,230.00	\$ 62,688,185.00	T		N
UT	(3)	\$ 12,262,206.00	NA			(na)
WA	(2)	\$ 12,829,025.00	\$ 18,732,850.00	P	Stop loss carriers and WA State Uniform Medical Plan are assessed at a rate one-tenth the rate of other insurers.	N
WI	(2)	\$ 77,565,293.00	\$ 26,934,890.00	T,O		(na)
WV	(6)			O	Adjustment to provider payment rates	(na)
WY	(1)	\$ 3,205,134.00	\$ 1,250,000.00	T		P

(1) CA (2004-2005)
(2) 2003 Annual Report
(3) 2004 Financial Report
(4) 2004 Annual Report
(5) 2003 Financial Report
(6) Legislation

P=per covered life/stop loss
T=total book of business
O=other
M=more than just insurers

N=no
P=partial
F=full
Y=yes, not specified
(na)=no answer

Appendix Table 2: State and Federal Contribution

Risk Pool Financing, 2003-2004

STATE	source	STATE FUNDS	Source	Detail	CLAIMS	ADMINISTRATION	FEDERAL TAX GRANT RECEIVED?
AL	(1)				\$ 23,748,679.00	\$ 249,968.00	Y
AK	(2)				\$ 6,593,811.00	\$ 323,630.00	Y
AR	(3)		O	In case of pool deficit, monies may be taken from the state Insurance Department Trust Fund and Trade Act of 2002 grants.	\$ 13,162,191.00	\$ 1,614,555.00	Y
CA	(1)	\$ 40,000,000.00	S	cigarette and tobacco products surtax fund	\$ 97,564,821.00	\$ 4,850,396.00	Y
CO	(4)	\$ 836,007.00	A, O	Interest from unclaimed property (Escheat) and CAPCO credit for donations	\$ 26,897,478.00	\$ 2,701,245.00	Y
CT	(1)				\$ 23,006,930.00	\$ 1,888,227.00	Y
FL	(1)				\$ 4,370,809.00	\$ 551,901.00	(na)
ID	(1)	\$ 5,190,000.00	A		\$ 3,056,168.00	\$ 142,655.00	
IL (traditional)	(2) & (1)	\$ -	A		\$ 48,345,813.00	\$ 2,334,233.00	Y
IL (HIPAA)	(2) & (1)				\$ 68,671,861.00	\$ 3,897,357.00	Y
IN	(1)				\$ 109,046,237.00	\$ 5,133,274.00	
IA	(1)		O	Health Insurance Trust Fund	\$ 1,519,829.00	\$ 367,499.00	Y
KS	(1)				\$ 13,138,557.00	\$ 451,424.00	Y
KY	(1)	\$ 19,405,200.00	O	state tobacco settlement (2003 figure)	\$ 22,800,666.00	\$ 1,571,040.00	(na)
LA	(1)	\$ 2,000,000.00	A		\$ 12,864,113.00	\$ 1,083,805.00	(na)
MD							Y
MN	(1)				\$ 175,049,430.00	\$ 9,078,824.00	Y
MS	(1)				\$ 23,327,829.00	\$ 1,371,445.00	Y
MO	(1)				\$ 18,413,476.00	\$ 449,781.00	(na)
MI (traditional)	(2)				\$ 4,588,985.00	\$ 466,037.00	(na)
MI (HIPAA)	(2)				\$ 8,896,732.00	\$ 661,150.00	(na)
MI (low-income)	(2)				\$ 599,437.00	\$ 69,720.00	(na)
NE	(2)	\$ 17,225,362.00	O	Department of Insurance Fund, premium and retaliatory tax	\$ 45,915,218.00	\$ 2,984,488.00	Y
NH	(5)				\$ 1,559,156.00	\$ 365,791.00	Y
NM	(3)				\$ 9,365,999.00	\$ 1,463,865.00	(na)
ND	(5)				\$ 8,089,662.00	\$ 280,593.00	Y
OK	(1)				\$ 23,500,077.00	\$ 1,495,488.00	Y
OR	(3)				\$ 65,947,214.00	\$ 3,780,405.00	(na)
SC	(5)				\$ 18,973,039.00	\$ 1,679,425.00	(na)
SD			A				Y
TX	(1)				\$ 171,777,880.00	\$ 13,400,319.00	(na)
UT	(3)	\$ 6,916,200.00	A		\$ 21,313,468.00	\$ 1,609,535.00	(na)
WA	(2)		A	Legislature funds discounts for low-income enrollees.	\$ 35,486,334.00	\$ 1,746,160.00	(na)
WI	(2)		A		\$ 126,187,327.00	\$ 5,148,407.00	(na)
WV	(6)						(na)
WY	(1)				\$ 4,205,286.00	\$ 63,707.00	(na)

- (1) CA (2004-2005) A=appropriation
- (2) 2003 Annual Report S=sin tax
- (3) 2004 Financial Report O=other
- (4) 2004 Annual Report
- (5) 2003 Financial Report
- (6) Legislation

Appendix Table 3: Premiums as % of Standard: Maximum allowed, actual, variation by group

	Statutory Maximum (%)	Actual or Initial Rate	Less than Statutory Maximum?
AL	200		(na)
AK	150	125 to 140	Y
AR	150	135	Y
CA	125-137.5		(na)
CO	150		N
CT	150	125	N
FL	200-250 depending on risk		(na)
IA	150		N
ID	125-150	currently at 125	Y
IL	125-150	MU 143 HI 135 standard	Y
IN	150	Board may increase based on income	Y
KS	150		Y
KY	175	132	Y
LA	200	at least 125	Y
MD	110-200	115-130 depending on age range	N
MN	125	112	Y
MO	200	175	Y
MS	175	150	(na)
MT	150 – MU, 200 HI	=150	Y
ND	135		N
NE	135		N
NH	125, no higher than 150	140	Y
NM	150	125	(na)
OK	150		(na)
OR	125 (100 for HI)	100 for HI	Y
SC	200		N
SD	150		N
TX	200	165 in March 2004 (SCI)	N
UT	150		(na)
WA	150	125 for managed care plan	(na)
WI	200	150	(na)
WV		150	(na)
WY	200	150	(na)

source: NCSL survey of high risk pools, 2004-2005; Communicating for Agriculture, 2004; TX actual SCI State Coverage Matrix, updated March 2004

End Notes

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- ¹ To learn whether they agreed with some “conventional wisdom” about pools, we asked whether they agreed or disagreed with a series of statements about pools
- ² Kentucky survey response
- ³ Maryland survey response
- ⁴ The project included two components; one on financing, funded by the Blue Cross and Blue Shield Association (this paper) and a separate paper focused on programmatic and eligibility changes for AARP.
- ⁵ NCSL survey responses, 2004-2005
- ⁶ \$4.2M of \$20M available to start new pools was used, and \$15.8 M reverted to the U.S. Treasury.
- ⁷ Communicating for Agriculture, an organization that has long promoted these entities, originally promoted them as a source of coverage for farmers.
- ⁸ Actual premiums will vary according to such things as plan type, allowable factors such as age, and deductibles.
- ⁹ Affordability or impact on members were cited as one reason for decision on rates according to survey responses from Alaska, Arkansas, Idaho, Minnesota, Montana.
- ¹⁰ It may have served as a prototype for some of TAA’s elements.
- ¹¹ Mock and Madson Interview
- ¹² Ford Interview
- ¹³ Other revenues or losses = total costs –(premiums + assessments)
- ¹⁴ Total costs = claims + administrative costs
- ¹⁵ Some states set assessments prospectively and in others they are set retrospectively. This total is for the calendar year in which the assessments were collected.
- ¹⁶ Mock and Madson interview
- ¹⁷ traditional policies only
- ¹⁸ Fully offset in 2005 –Personal communication, Bykerk, May 2005
- ¹⁹ Historically, certain not-for-profit HMOs and carriers that offered coverage on a guaranteed issue basis were exempt from taxes.
- ²⁰ This varies a great deal from state to state, rising over 60 percent in many states.
- ²¹ Mock and Madson Interview
- ²² Berglin interview
- ²³ Assessment applies to all insurance arrangements within the constraints of ERISA.
- ²⁴ As of April 2005, the lawsuit was still pending.
- ²⁵ As reported for 2003 in CA annual summary. The year represented—calendar or fiscal, prospective or retrospective, varies across the states but is the same year-to-year for each state, allowing comparison of trends.
- ²⁶ Other revenues or losses = total costs –(premiums + assessments)
- ²⁷ Total costs = claims + administrative costs
- ²⁸ CA 2004, personal communication with B. Abbe, NCSL survey.
- ²⁹ CA 2004, personal communication with B. Abbe, NCSL survey.
- ³⁰ The timing of Colorado’s new CAPCO refund, or at least uncertainty about timing, may have contributed to slow uptake by carriers other than Anthem Blue Cross and Blue Shield of Colorado according to the pool administrator.
- ³¹ Robbins, Jerkovitz interview
- ³² Mautino interview
- ³³ Brett interview
- ³⁴ The project included two components; one on financing, funded by the Blue Cross and Blue Shield Association (this paper) and a second paper focused on programmatic and eligibility changes, for AARP.
- ³⁵ TABOR—“Taxpayers’ Bill of Rights” is a set of constitutional provisions adopted by referendum in 1993 that limit state and local revenue growth. The provisions seemed satisfactory during the expansive economy of the 1990s, but have been problematic during the recent economic downturn. The impact of the program has been exacerbated by a ratchet effect that reduced the base during the recession and Amendment 23, passed in 2000, which mandates spending growth for grades k-12. As a result of the cap and the expansion, k-12 is now 40% of the Colorado general fund budget. For more on TABOR, see NCSL’s talking point on TABOR <http://www.ncsl.org/programs/fiscal/taborpts.htm>
- ³⁶ Enrollment rose 80% in 2002.

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- ³⁷ Personnel Communication, Barbara Brett, April 2005
- ³⁸ TABOR—“Taxpayers’ Bill of Rights” is a set of constitutional provisions adopted by referendum in 1993 that limit state and local revenue growth. The provisions seemed satisfactory during the expansive economy of the 1990s, but have been problematic during the recent economic downturn. The impact of the program has been exacerbated by a ratchet effect that reduced the base during the recession and Amendment 23, passed in 2000, which mandates spending growth for grades k-12. As a result of the cap and the expansion, k-12 is now 40% of the Colorado general fund budget. For more on TABOR, see NCSL’s talking point on TABOR <http://www.ncsl.org/programs/fiscal/taborpts.htm> .
- ³⁹ Brett interview
- ⁴⁰ Pollock interview
- ⁴¹ Brett interview
- ⁴² Rebecca Weiss correspondence
- ⁴³ Brett survey
- ⁴⁴ Brett Interview
- ⁴⁵ Interview—Rick Carlson, former executive director of ICHIP.
- ⁴⁶ Jerkovitz interview
- ⁴⁷ State Rep. Frank Mautino, continues the role of his father, who created the pool.
- ⁴⁸ Waiting lists rarely extend more than a few months. Due to movement in and out of other programs there were under 5,000 enrolled as of 10/28/04
- ⁴⁹ Jerkovitz interview
- ⁵⁰ Carlson interview
- ⁵¹ Illinois survey
- ⁵² According to a10/5/2004 press release, Illinois was one of only two states to use the grant for premium relief. <http://www.idfpr.com/newsrelease/CHIPInsurancePremiumRelief.pdf>
- ⁵³ Less Medicare and FEHBP premiums.
- ⁵⁴ Jerkovitz interview
- ⁵⁵ Stratton interview
- ⁵⁶ Although many states allow individuals to remain in pools after they become eligible for other programs, as far as we could ascertain Indiana was unique in allowing Medicaid to explicitly enroll people in the pool.
- ⁵⁷ Except New Mexico and Kentucky. Until very recently the program (also uniquely) allowed employees eligible for group coverage to enroll in the pool. According to ICHIA, their premiums were frequently paid by their employers.
- ⁵⁸ Stratton interview
- ⁵⁹ Maginn interview
- ⁶⁰ Maginn interview
- ⁶¹ Five separate lawsuits were brought by carriers challenging the assessment methodology, and the program and the Insurance Commissioner’s exercise of authority in relation to the assessment. *ICHIA Resource Guide and Program Update*, December 2004
- ⁶² Tim Kennedy, Counsel, Indiana Hospital association. According to Stratton, from July 1, 2003 until March 15 2004, providers were reimbursed on the basis of Medicare plus 10 percent. Beginning in March 16, 2004, the ICHIA returned to a rented PPO network and providers were compensated based on network rates.
- ⁶³ Stratton interview
- ⁶⁴ Medworks, the Indiana TWIIA program. However, Ryan White HIV/AIDS program and hemophilia patients not eligible for Medicaid remain in ICHIA.
- ⁶⁵ Stratton update, April 2005
- ⁶⁶ Rice Interview
- ⁶⁷ Almost fifty companies left the individual market following passage of HB250, although most were very small. Anthem, which had dominated the market, was left virtually alone in it.
- ⁶⁸ Freedman interview
- ⁶⁹ Ford interview
- ⁷⁰ Mitchell interview
- ⁷¹ Ford interview
- ⁷² Survey, Parsons
- ⁷³ Mitchell interview
- ⁷⁴ Chollet, Deborah and Lori Achman. “Approaching Universal Coverage: Minnesota’s Health Insurance Programs.” Field Report, Commonwealth Fund. February 2003. p. 18-22.

⁷⁵ Questionnaire, Gruber

⁷⁶ Courts have upheld the assessment, which may be passed to payers, against an ERISA challenge.

⁷⁷ A lawsuit challenging this appropriation was decided in favor of the state and the pool.

⁷⁸ Gross interview. The state of Minnesota and Blue Cross and Blue Shield of Minnesota sued tobacco companies and received a large out of court settlement. BCBS received \$400-\$500 million. This put them over their state-regulated reserve corridor. Under prior existing MN law, if they were above this corridor, they had to file a plan of action with the state detailing what they were going to do to get back within the corridor. Commerce Commissioner Jim Bernstein approved the plan of action submitted by BCBS which designated \$70 million of their surplus to offset the MCHA deficit. A subsequent lawsuit filed by BCBS subscribers is still pending. Therefore, MCHA has not been able to use this money.

⁷⁹ Berglin interview

⁸⁰ Gruber interview

⁸¹ Berglin interview

⁸² *ibid*

⁸³ Gruber interview

⁸⁴ Mollner interview

⁸⁵ Gruber interview

⁸⁶ *ibid*

⁸⁷ Chollet and Achman, *op.cit.*

⁸⁸ Interviews and news articles commented on the Governor's personal history as an insurance professional with an ongoing financial interest in the industry.

⁸⁹ Interestingly this was not South Dakota's first risk pool enactment. One was created in 1994 but never funded, because lottery revenues that were to support it were never directed to it. The risk pool was repealed in 1995, a year before HIPAA was enacted.

⁹⁰ In the case of Maryland this reflects the origin of the pool as a replacement to a program that was funded through such an assessment.