Approved March 20, 1991
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Represenative Turnquist at
Chairperson

3:30 ~~x~~a.m./p.m. on Tuesday, March 19, 1991, 19__ in room 531 N of the Capitol.

All members were present except:

Tom Sawyer, excused

Committee staff present:

Emalene Correll, Research
Chris Courtright, Research
Bill Edds, Revisor
Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Dick Brock
Bill Sneed

Representative Welshimer moved for the approval of the minutes for March 19, 1991, meeting.. Representative Campbell seconded the motion. Motion carried.

Hearing on HB 2511 - Emalene Correll of Research gave a historical review of the development and operation of state-operated risk pools in the United States. The first one was signed into law by Minnesota in 1976. Premiums for these health pools are not set in dollar amounts but are usually set in percentages with the most common being 150% over average market price. Most set out deductions and coverage and all set maximum life-time benefits. All require that insurees be unable to secure health insurance in the marketplace. Funding sources for such risk pools is found in Attachment 1. At least $30,000,000 is required to start a risk pool. All but one of the risk pools in operation loses money annually. Local Blue Cross and Blue Shield Plans are increasingly becoming the administrator of choice for state risk pools. A comparison between the risk pool charts of 1989 and 1990 was prepared by Greg Scandlen and presented to the committee. See Attachment 2.

Dick Brock of the Insurance Commissioner's Office appeared as a proponent of HB 2511. This bill would require that health insurance be made available to all Kansas residents. It would create the legal entity, define its membership, provide for its governance, require the development of a plan of operation, and provide for some means of funding the amounts by which claims exceed the premium and investment income it receives. (See Attachment 1). The bill is based on the idea of establishing an availability mechanism for a health insurance plan to accommodate a catastrophic illness or accident. The proposal contains no premium limitation since a very high front-end deductible coupled with other characteristics of catastrophic coverage such as exemption from mandated benefits, equality requirements, and non-duplication provisions can conceivably produce a viable availability mechanism on a self-sustaining basis without a premium subsidy.

Concern was raised by the committee that the state should provide basic health care for those individuals who cannot afford it. Mr. Brock indicated that with the passage of this bill, it may open a window to add supplemental coverage.

Bill Sneed, representing HIAA, appeared before the committee as an opponent to HB 2511. The proposed $5,000 deductible clause to the bill will make the policies very expensive as the pool for such insurees is small. Such a policy is usually difficult to sell in the market place. HIAA does not recommend combining such a policy with catastrophic illness but rather using a $1,000 to $2,000 deductible.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 531 N Statehouse, at 3:30 ~~a~~p.m./p.m. on ~~Tuesday, March 19,~~, 19~~9~~1

HCR 5011 - A subcommittee of Representatives Campbell, Neufeld, and Weiland was established to review other states actions and reactions to such a request. (Directing the Insurance Commissioner to establish a health risk pool).

The meeting adjourned at 4:50 p.m.

GUEST LIST

COMMITTEE: Home Insurance DATE: 3/19/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Nancy Zogleman	Topeka	BC/BS of Ks
Bill Sneed	TOPEKA	KIIA
LARRY MAGILL	"	IIAK
Kevin McFarland	Topeka	Ks Homes for the Aging
John Peterson	Topeka	Kaiser Permanente
Lynden Drew	Topeka	KDOA
Art Brown	Ks	Ks Ins Dept
TOM GLEASON	Topeka	KHA
JOE FURJANIC	TOPEKA	KCA
LISA Getz	Wichita	Wichita Hospitals
Dick Brock	Topeka	Ins Dept

Testimony By
Dick Brock, Kansas Insurance Department
Before the House Insurance Committee
on House Bill No. 2511
March 19, 1991

When I testified on House Concurrent Resolution 5011, I discussed the concept of a health risk pool as a means of assuring that Kansans who do not have access to group health insurance and cannot obtain meaningful coverage in the voluntary market will nevertheless have a last resort availability mechanism they can turn to. House Bill No. 2511 is an opportunity to expand that discussion by focusing on the actual composition of such a mechanism. In doing so, I again want to emphasize that the benefit package -- the coverage to be offered -- can be designed in any number of ways but the basic structure of any health risk pool is about the same. That is, as provided by section 4, all insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations, and group funded pools offering health insurance will be members of a nonprofit legal entity. MEWAs, captive insurance companies and any other similar mechanisms could be added if appropriate. That entity, identified as the Kansas Health Insurance Association in the bill before you, is required to assure that health insurance is made available to all Kansas residents. Beyond creating the legal entity and defining its membership, Section 4 provides for its governance and requires the development of a plan of operation which includes certain specified provisions but otherwise allows latitude in establishing a formal system for making health insurance available for eligible persons. Finally, the statutory provisions relating to the establishment of health risk pools will provide for some means of funding the amounts by which claims incurred by the health risk pool exceed the premium and investment income it receives. Subsection (e) of Section 4 does this by providing for an assessment against the insurer members of the health risk pool; however, other methods have been employed in some states. For example, California recoups the difference by a tax on

House Insurance
March 19, 1991
Attachment 1

tobacco products. Maine is doing it by an assessment on hospital revenues. Illinois has a general fund appropriation. Others assess member insurers but allow the amount assessed to be deducted from premium tax obligations. Attached to my testimony is a synopsis of funding mechanisms now in use in the various states as well as some additional options that you might wish to consider. The obvious point is that regardless of the method used, every health risk pool has some means of funding losses and determining how to do it is the most difficult consideration involved.

House Bill No. 2511 attempts to make this decision a little easier because it is based on the idea of establishing an availability mechanism for a health insurance plan to accommodate a catastrophic illness or accident. Because of the catastrophic approach, the proposal contains no premium limitation since a very high front-end deductible coupled with other characteristics of catastrophic coverage such as exemption from mandated benefits, equality requirements and non-duplication provisions can conceivably produce a viable availability mechanism on a self-sustaining basis without a premium subsidy. To be fair, you should also know that at least one state, North Dakota, attempted to have a self-sustaining plan but found that to do so the initial rates had to be 277% of standard rates. North Dakota now has a 135% cap you also need to remember, however, that North Dakota has $500 and $1,000 deductibles. This will obviously make a difference and even if the plan is not totally self-sustaining, any required subsidy would be more modest. Therefore, House Bill No. 2511 does not include provisions for a premium tax offset or other means of subsidization by use of public funds. This, of course, means that under the bill as proposed, any required subsidy would be provided by policyholders in the voluntary market although, as I said, there are other alternatives and some states have gone a different direction.

To some people, a $5,000 deductible is so high that the insurance provided might be considered to be of little or no value. While it is true that $5,000 is a significant amount of money to most people and a seemingly impossible amount to some, few people would see it as totally and forever unobtainable. On the other hand, many persons in comfortable financial circumstances would suffer significant hardship if faced with the expense of a serious and/or long-term illness without insurance protection. In other words, a person facing open heart surgery or a similar medical condition with insurance coverage that would pay all but $5,000 of the expenses would be far better off than the person with no coverage at all.

If a more basic hospital, medical-surgical expense package of benefits is desired, the funding considerations probably change. For example, it would probably be necessary to incorporate some type of premium cap which could, in turn, create the need for other changes. Whether or not the feature contained in House Bill No. 2511 which requires all insurers to offer catastrophic health insurance either by issuing a policy in its own name and retaining the risk the same as they do for voluntary business; issuing the policy in its own name but reinsuring the risk with the association created under Section 4 or by simply referring the risk to the association which will itself provide the coverage would be a viable alternative if the pool policies have a front-end subsidy is a question that can only be answered after the other changes are made.

Even though the method of funding the losses is probably the most difficult decision, the first consideration almost has to be the benefit package. If a catastrophic approach is deemed to have merit, House Bill No. 2511 would seem to be a reasonably good vehicle to build on. It will need some changes. For example, various elements of House Bill 2001 probably need to be merged into it, the exclusion in Section 6 relating to medicaid and medicare is not compatible with other requirements now in effect and the exclusion regarding mandates probably needs to be

updated. However, these are relatively minor adjustments that can be easily developed if the committee wishes to further develop the idea of a health risk pool and if the pool is to provide catastrophic coverage.

If, however, a decision is made to go a different direction, there are at least 20 states with plans in operation and another 8 states with plans in effect but not operational. A couple have been in effect since 1976, a couple became effective in 1982-83 and the others are of more recent vintage. But it is safe to say there are a number of plans available to draw from.

Source: C[illegible]nicating for Agricultur[illegible]
C[illegible]hensive Health Insurar[illegible]or
High Risk Individuals

STATE HEALTH INSURANCE "RISK-SHARING" POOLS

FUNDING MECHANISMS

The following data is provided as it pertains to the funding mechanism of the various state health insurance risk-sharing pools.

California

Major Medical Insurance Fund. No policies are to be issued until $30 million has been deposited in the Fund. Moneys shall come first from the interest accrued on the unspent balances in the Unallocated Account, the Health Services Account, and the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund. If the above is less than $30 million, the balance is to be appropriated from unspent 1988-1989 and 1990-1991 moneys in the three accounts. After June 30, 1991, $30 million is to be deposited annually in the Fund from the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund.

Note: The California legislation passed and was signed into law in 1989. To date, the plan has not yet become operational.

Colorado

Losses associated with operation of the plan are to be paid by a state income tax surcharge. The law states that single filers with adjusted gross income of $15,000 or more will pay a $2 tax when filing their state income tax. Joint filers will be assessed $4 if adjusted gross income is more than $35,000. Colorado is the first state to directly place a tax on the citizens for support of the risk pool.

Note: The legislation passed and was signed into law in May of 1990. The start-up date should be around January 1, 1991. The legislation also included a provision that this funding mechanism is only put in place for a period of three years.

Connecticut

Association members assessed for plan losses based on share of health insurance premium volume in the state. This funding mechanism has been in place since inception of the pool with one exception. Originally, Blue Cross and Blue Shield offered a separate pool for high risks. Because of this, Blue Cross and Blue Shield was not obligated to pay for losses incurred by the state plan. In 1984, Blue Cross and Blue Shield ended the offering of their plan. Between 1984 and 1988, the assessment to Blue Cross and Blue Shield only applied to those policies issued during this period. Since September of 1988 the two pools have merged and assessments for the combined pool include Blue Cross and Blue Shield.

Note: The legislation passed and was signed into law in 1975. The pool has been operational on a continuous basis since 1976.

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Florida

Association members assessed for plan losses based on share of health insurance premium volume in state during the year. From the time of passage of this legislation in 1983 until 1989, these assessments were allowed as a tax credit offset. This credit could be applied towards premium taxes and income taxes payable to the state at the rate of 20% credit per year over a five-year period. 1989 legislation repealed this premium tax offset.

Note: The legislation passed and was signed into law in 1983. The plan has been operational since this time. Legislation passed in 1989 repealed the entire law October 1, 1990, however an extension has been approved.

Georgia

General revenue. The General Assembly is not required to appropriate monies to the plan. The 1990 legislature did not appropriate any monies to fund the losses of the plan, but authorized a $75,000 appropriation to study actuarial data for the plan.

Note: The legislation passed and was signed into law in 1989. The plan is not yet operational.

Illinois

General Revenue. The first state to directly pay the costs of the risk pool through such an appropriation. However, the state placed a cap on the number of participants eligible to participate in the plan at any one time, thereby controlling the amount of dollars to be contributed to the plan. This cap has already been raised once and the state is considering another increase. The appropriation was $12 million in 1989 and $19 million for 1990.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1989 and is still operational.

Indiana

Association members assessed for net losses in proportion to share of total health insurance premiums received in state during the year. Assessments offset against income or premium taxes in year of assessment or following years. Insurers may also include in premium rates an amount to recoup assessments.

Note: The legislation passed and was signed into law in 1981. The plan became operational in 1982 and has operated since this time. No change has occurred in the funding of the plan.

Iowa

Association members assessed for losses in excess of those covered through premiums and the Health Insurance Trust Fund. Assessments allowed as offset against premium taxes or other forms of taxes payable to the state. These offsets are granted at the rate of 20% per year over a five-year period.

Note: The legislation passed and was signed into law in 1986 and the plan became operational in 1987 and has operated since this time. No change has occurred in the funding of the plan.

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Louisiana

Each pati xcept one covered by a program n is directly subsidized by the federal government or one covered by an insolvent insurer, admitted to a hospital for treatment other than psychiatric care or alcohol or substance abuse shall be assessed a service charge of $2 for each day during which the patient is confined as an inpatient in that facility. Facilities operated by the State, United States, Veterans Administration or solely for psychiatric care or treatment of alcohol or substance abuse are not included.

Each patient, except one covered by a program which is directly subsidized by the federal government or one covered by an insolvent insurer, admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of $1 for each admission to that facility.

These service charges are to be paid by the patient's insurer or insurance arrangement. In the event that no payment is made on behalf of the patient for services rendered, the fee is waived.

Note: The legislation passed and was signed into law in June of 1990. The plan has not yet become operational.

Maine

Funding will be taken care of by a Reserve Fund established to pay any expenses and claims above premium income. This reserve shall be funded by an assessment on all revenues of all hospitals in the state. The amount of the assessment shall be determined and adjusted annually and shall not exceed .0015 times hospitals' gross patient services revenues. A unique provision in the legislation states this plan shall cease operation in June of 1991 unless the legislature reauthorizes the plan and recommends a new funding mechanism.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1988 and is still operational.

Minnesota

Health insurers assessed for net losses in proportion to share of total health insurance premium received in the state during the year. Until 1987, insurers were granted a 100% tax offset against assessments paid to the plan. At that time, this tax offset was removed.

Note: The legislation passed and was signed into law in 1976. The plan became operational in 1976 and has operated since that time. Other than removal of the tax offset, no other funding changes have taken place.

Missouri

Association members assessed for net losses in proportion to share of total health insurance premiums received in state during the year. Assessments offset against premium taxes paid to the state in the year such assessments are made.

For those members not paying premium taxes to the state, assessments are still made and such assessment is offset against any sales and use taxes paid to the state. However, no assessment to any member can be in excess of 1% of nongroup premium income, exclusive of Medicare supplement programs, received in the previous year.

Note: The legislation passed and was signed into law in June, 1990. The plan is not yet operational.

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Montana

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1985. The plan became operational in 1987. No change in the funding mechanism has taken place.

Nebraska

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1986 and the plan became operational that year. No change in the funding mechanism has taken place.

New Mexico

All insurers will be assessed for the losses of the pool and no credit on future taxes will be allowed until one member's assessment reaches $75,000 per year. At that time, the member will receive a 30% tax credit for the amount paid over $75,000. New Mexico was the first state to combine both government offsets and an assessment to participating insurers.

Note: The legislation passed and was signed into law in 1988 and became operational that year. No change in the funding mechanism has taken place.

North Dakota

Association members doing more than $100,000 in accident and health insurance business within the state are assessed for net losses of the pool. These members are allowed a direct offset against premium taxes in year of assessment or following years. This funding mechanism was passed into law in 1983. Prior to this, the plan attempted to be a self-supporting one, with premiums adjusted to match total claims paid.

Note: The legislation passed and was signed into law in 1981. The plan became operational in 1982 and has operated since that time. No change in the funding mechanism has taken place since 1983.

Oregon

General fund dollars in the amount of $2 million is authorized for the biennium to help offset costs. However, net losses of the pool in excess of this $2 million will be assessed to association members. These assessments can not exceed $150,000 to any one insurer during the biennium.

Note: The legislation passed and was signed into law in 1987. The plan became operational in May, 1990.

South Carolina

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium or income taxes in year of assessment or following years. This offset is limited to a total statewide offset of five million dollars in any one year. If this cap is reached, premiums of the plan must be raised to keep losses and offset at five million dollars.

Note: The legislation passed and was signed into law in 1989. The plan became operational in 1990.

Tennessee

Until 1990, association members were assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. These assessments were granted as a tax offset to a limit of $3 million. In 1990 the entire funding mechanism has been changed.

New funding has the state appropriating $3 million towards operation of the pool. Association members are to be assessed an amount equal to their share of the number of participants in their health care program as compared to the total number in the state. The total assessments to the members cannot exceed $3 million in any one year. In addition, the association membership was expanded to include HMOs and PPOs. No tax credit is allowed to assessed members.

Note: The legislation passed and was signed into law in 1986. The plan became operational in 1987. The initial cap by the state was $2 million, then raised to $3 million, and in 1990 the entire funding mechanism was restructured.

Texas

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. The members will be granted reimbursement against this assessment, however the manner of the reimbursement has not yet been finalized.

Note: The legislation passed and was signed into law in 1989. The plan is not yet operational.

Utah

Comprehensive Health Insurance Pool Enterprise Fund. This fund will be credited with all pool policy premiums, interest and dividends earned on the fund's assets, and an initial $75,000 appropriation from the state general fund. All losses associated with operation of the Utah plan are to paid from the assets of this fund.

Note: The legislation passed and was signed into law in March of 1990. Issuance of policies is to commence on July 1, 1991 or as soon thereafter as adequate funding for the plan is available. The legislation did not set up any permanent funding mechanism which could delay implementation.

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Washington

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1988. No change in the funding mechanism has taken place since inception of the pool.

Wisconsin

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. No offset of this assessment is allowed, despite several attempts to do so in previous years. However, the state legislature does appropriate a yearly sum of dollars to help reduce the premium charges and deductibles for low-income individuals in the plan.

Note: The legislation passed and was signed into law in 1980. The plan became operational in 1981. Despite several attempts, no change in the funding mechanism has taken place since the pool became operational.

Wyoming

Association members assessed for plan losses based on their share of health insurance premium volume in the state. Also to be assessed are any self insurers not governed by the ERISA law. The state will grant a credit against any premium tax owed to the state towards the assessment paid. However, the total credit allowed by all members cannot exceed $1,000,000 in any one year.

Note: The legislation passed and was signed into law in March, 1990. The plan will take effect on July 1, 1990 and policies are expected to be offered by January 1, 1991. Also included in the legislation is a "sunset" provision which terminates the plan on June 30, 1993.

F DING OPTIO FOR CONSIDERATION

The following options are offered for your consideration in operation of a comprehensive health insurance plan:

GENERAL FUND APPROPRIATION

As is being used in at least one state, the legislature has the right to simply appropriate the funds to cover the losses associated with operation of the pool.

Positives: The state will forego any of the administrative headaches associated with operating the pool. A simple appropriation to cover the losses is all that is required. Many policymakers consider this program to be one of interest to all citizens of the state and feel such funding should therefore be paid with state dollars, spread out over all taxpayers.

Negatives: The state will have no prior knowledge of the amount of dollars required to cover the losses. In addition, with such an appropriation, the state will have no control over attempting to limit the losses. An even bigger concern will be the economic realities of such an appropriation if the state experiences financial difficulty. Should the state experience an economic downturn, where will the dollars come from?

GENERAL FUND APPROPRIATION WITH LIMITATIONS

The state could appropriate the dollars necessary to cover the losses of the pool, but place a cap on these appropriations. In other words, the state would set a cap of, let's say, $3 million to cover the losses for the year of 1990. Several states have, or are, considering this option.

Positives: The state would have control on the amount of state funds to be expended for the program. This allows for future funding projections and yet still removes many of the administrative headaches associated with operation of the pool.

Negatives: In order for this to succeed, the state may have to place a limit on the number of individuals eligible to enter the plan in order to avoid a larger loss. Also to be considered is the possibility of huge, unexpected claims in any one year where the total rises above the cap. Again, the state would be faced with economic conditions of the state.

ASSESSMENT TO THE ASSOCIATION MEMBERS

This option is being used by several states. The members of the association are simply assessed the losses in proportion to the amount of health insurance business they conduct within the state.

Positives: The state is removed from any liability to operate the plan. Insurance carriers are assessed for the clients they would normally turn down for coverage, therefore providing their policyholders lower premiums due to removal of high-risk users. Many policymakers believe because insurance carriers are in the business to provide coverage, they should be assessed if they choose not to insure all applicants due to potentially large claims.

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Negatives: The state is not allowed to assess all insurance carriers within the state. Federal legislation prohibits the state from placing an assessment on self-insured plans. Statistics show nearly half of all insureds are self-insured, therefore the assessment would be an unfair burden on commercial carriers and remove their competitive equality.

ASSESSMENT TO ASSOCIATION MEMBERS WITH A TAX CREDIT

Several states are also using this option to fund the pool. This simply means insurance carriers are assessed for the losses of the pool, but this assessment is offset against premium taxes or income taxes paid to the state.

Positives: Insurance carriers are provided the opportunity to maintain their competitive equality with the self-insureds as they will receive their assessment back from the state. In addition, the state has a source of funds to operate the plan throughout the year. Many policymakers consider this to be a fair way to operate the plan.

Negatives: The bottom line is the state will still be responsible for funding the pool through a tax credit. Again, economic realities could play a role.

COMBINATION OF ASSESSMENT AND TAX CREDIT

Several interpretations of this option are being used. The state could place a cap on the amount of tax credit to be provided in any one year. Any assessments above this cap would have to be paid by the association members with no credit granted. Another way is to not grant any tax credit until a member's assessment in any one year reaches a certain level, say $75,000. Only the amount paid above this total would be allowed as a credit.

Positives: Considered to be a very fair way to operate the plan and pay the losses. The state's funding is limited as are the assessments paid by the members of the pool.

Negatives: The problem again arises concerning the self-insureds, but not as bad. The state is still responsible for a portion of the funding.

RAISE PREMIUMS TO COVER LOSSES

Not considered much of an option. This was attempted in only one state in the early '80s and has since been repealed.

Positives: The losses are paid by the policyholders of the plan. Only those in the plan will pay. The state and insurance carriers are removed from liability.

Negatives: Premiums will become so high that those considered "good risks" will find it too expensive to continue coverage. The "bad risks" will remain, which will increase losses and eventually these individuals will also find it too expensive. The pool will become inoperable.

HOSPITAL TAX ON REVENUES

Being used in one state at this time. However, the plan is designed to sunset within two years unless another funding source can be found. Consideration of placing a tax on doctors has also been discussed when studying this option.

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Positives: Liability is placed on hospitals who will pass along this tax to all users of the health care system. It would include all users of health care, all insurance carriers and self-insureds, private individuals and government.

Negatives: Tax may have to continually be increased to cover losses. Hospitals are not receptive to the idea of being the bearer of additional costs to the consumer.

FIND NEW OPTIONS

The only other options being discussed across the country at this time are 1) raising taxes on cigarettes, alcohol, or some other product with the dollars earmarked to fund the pool; 2) placing a fee on all individuals filing income taxes within the state, again with the dollars earmarked for the pool; and 3) placing a fee on the use of the health care system. The first two are self-explanatory. Here is an example of the third option and how it could work.

A state would have two options when placing a fee on the use of the health care system. The first would mandate all hospitals within the state, and clinics affiliated with these hospitals, to place a $1 fee on every billing sent out. This $1 would only apply to the billing and would not be associated with the length of stay in the hospital or type of care received, and would cover every inpatient and outpatient billing.

Hospitals would have very little administrative expense associated with adding this $1 fee to the bottom of every billing. The hospital would not be responsible for collection of the $1 fee if the entire bill is not paid. In other words, this $1 is the last dollar collected on the bill.

Hospitals would be allowed to deposit this fee in any account they so desire and have the right to the investment income earned on these funds. At a period designated by the state, say every three months, the fees collected would be turned over to the state for funding of the pool.

How much would this fee raise? Using the state of Colorado as an example:

Latest statistics show 385,253 inpatient admissions to Colorado hospitals in 1989. An additional 5,308,723 outpatient visits were conducted. And let's consider 50% of these total visits of 5,693,976 as Medicare/Medicaid/charity cases. This is the approximate usage paid by government entities for health care.

This leaves 2,846,988 visits. Now let's consider 5% of these visits as uncollectable. This leaves us with 2,704,639 total visits paid by individuals, private insurers and self insurers. At $1 per billing, the state would collect $2,704,639 in the first year.

And let's not forget, the hospitals would earn investment income at a rate of approximately 7% on these dollars, for a return to the hospitals of nearly $200,000, more than enough to cover any administrative expense they might incur.

Of course, changing the fee from $1 to $2, or even less, would alter the amount of dollars collected. And if the state feels it should also contribute to the operation of the pool, Medicaid billings could also be assessed a fee which would considerably increase the dollars collected.

The second option to be considered would be to place an assessment of $2 a day on all hospital stays. In Colorado, the total inpatient days in 1988 was 3,366,344.

Again, assuming 50% of these are for Medicare/Medicaid/charity cases funded directly by governmental entities, this leaves 1,683,172 inpatient days to be assessed.

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Assume 5% of these are never collected, this leaves 1,599,014 inpatient days to be charged. At $2 per day, the total raised would be $3,198,028. And you again can add investment income for the hospitals.

The positives of these options far outweigh the negatives. All insurance carriers would have to pay these fees, including self-insurers. This sidesteps the problem with federal law under ERISA. And should the state wish to contribute the fee for Medicaid patients, the dollars would be nearly doubled, as well as government contributing a share of the expenses to operate the pool. All users of the health care system would be paying their share.

When one considers those states with operating pools and their losses, the dollars raised in the state of Colorado during the first two years should provide enough finds to operate the pool for at least five or six years, and maybe longer when one considers the investment income received.

At least one state is considering the option of assessing $2 per day for hospital stays. The insurance industry, the hospital industry, the medical profession, government policymakers and consumers are all in agreement on this funding mechanism.

All in all, an option worth considering.

COMPARISONS BETWEEN THE RISK POOL CHARTS OF 1989 AND 1990

In the past two years the number of states with risk pools has almost doubled. Five states enacted risk pool legislation in 1988 and another four in 1989, bringing the total to nineteen.

Total enrollment has increased by 40%, from the 29,166 reported on last year's chart to 40,958 this year. The average enrollment of the 10 active pools reported last year was 2917, while the average for this year's 13 active pools is 3150. Interestingly the trend is not consistent across the country. CT, IN, MN, and ND held steady, while FL increased from 1611 enrollees to 5200, IA from 276 to 1559 and TN from 790 to 4685. Wisconsin's enrollment actually dropped from 7476 to 6200.

The amount of subsidy (pool losses in excess of premium income) has increased dramatically in all the states. On last year's chart the total subsidy was $20.5 million, this year the total is $47.3 million, more than doubling in a single year. The average subsidy per enrollee has increased from $706 last year to $1156 this year. Some states with particularly large increases in subsidies include: CT which went from $934,575 to $3,755,014; FL from $1.8 million to $9 million, NE from $300,000 to $1,200,000; and MT, from $45,000 to $400,000.

Three states increased their lifetime benefits maximum; both WI and MN went from $250,000 to $500,000 and MT went from $100,000 to $250,000. Both IN and ND increased their minimum deductibles to $500, an amount also adopted by new pools in CA and SC.

Six months has become the standard waiting period for pre-existing conditions with only two states having longer waiting periods (CT and MT).

Financing mechanisms are becoming ever more diverse. IL and GA are both using general revenues to cover pool losses, ME places an assessment on hospital revenues, CA will be using revenue from its tobacco taxes which were enacted by referendum, and OR is attempting to assess both insurers and reinsurers on a per capita basis in an effort to reach the large self-funded employers who would otherwise be exempt from contributing to pool losses due to ERISA. FL's risk pool has been repealed, effective June, 1990 unless the legislature develops a funding mechanism other than an assessment on insurance carriers.

Local Blue Cross and Blue Shield Plans are increasingly becoming the administrator of choice for state risk pools. A year ago Blue Cross and Blue Shield was listed as the administrator of five pools, Mutual of Omaha had eight, and Travelers one. This year Blue Cross and Blue Shield is the administrator of nine pools, Mutual of Omaha has six, and Travelers one.

Greg Scandlen, January 23, 1990

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House Insurance
March 19, 1991
Attachment 2

STATE HEALTH INSURANCE POOLS, January, 1990

	CA	CT	FL	GA	IL	IN	IA	ME	MN
Year Effective	1990	1976	1983	(Note 6)	1988	1982	1987	1988	1976
Maximum Benefits	TBD	$1,000,000	$ 500,000	$ 500,000	$ 500,000	no limit	$ 250,000	$ 500,000	$ 500,000
Deductible	500	400-1,500	1,000-2,000	500-1,500	250-1,000	500-1,500	500-1,000	500	500-1,000
Stoploss(individual)	2,000	2,000	2,500-3,500	none	1,500	1,500-2,500	1,500-2,000	1,500	3,000
Premium cap	125%	150%	200%	150%	135%	150%	150%	150%	125%
Waiting period	6 months	12 months	6 months	6 months	6 months	6 months	6 months	90 days	6 months
Rejected by x carriers	1	0	2	0	1	1	1	1	1
Offset premium tax	(note 2)	No	No	(note 3)	(note 3)	Yes	Part	(note 4)	No
# Enrolled (note 1)	n/a	2037	5900	n/a	3275	2622	1559	119	13,191
Claims Expense	n/a	6,606,554	25,500,000	n/a	n/a	9,640,519	56,725	179,888	27,099,000
Admin. Expense	n/a	412,942	1,000,000	n/a	n/a	500,643	n/a	67,918	1,340,000
Prem. Income	n/a	3,458,891	11,200,000	n/a	n/a	5,607,908	164,995	60,234	14,197,000
$ Subsidy (note 1)	n/a	3,755,014	15,300,000	n/a	n/a	4,500,504	700,000	1,328,916	14,093,000
Per person subsidy	n/a	1843	259	n/a	n/a	1,716	461	1116	1068
Administrator	TBD	Travelers	Mut of Oma	TBD	Mut of Oma	BCBS	Mut of Oma	Mut of Oma	BCBS

Notes:

1. Financial and enrollment numbers are for year end 1988, except the following: MT, 7/1/89; IL, 11/3/89; FL, 12/31/89; and ME, 6/30/89. More recent enrollment figures include the following: CT, 2123, 8/89; IN, 3000, 11/89; NM, 800, 8/89; and TN, 4685, 8/89.
2. California's subsidy will come from a tax on tobacco products.
3. Illinois and Georgia's subsidies are from general revenues.
4. Maine's pool is a demonstration project which is subsidized through an assessment on hospital revenues.
5. Oregon will assess all carriers and reinsurers on a per capita basis.
6. Georgia's pool will begin enrolling people only upon an appropriation by the legislature

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Blue Cross and Blue Shield Association
Washington, D.C.

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Source: Personal interviews

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STATE HEALTH INSURANCE POOLS, January, 1990

	MT	NE	ND	NM	OR	SC	TN	TX	WA
Year Effective	1987	1986	1981	1988	1988	1989	1987	1989	1988
Maximum Benefits	$ 250,000	$ 500,000	$ 250,000	no limit	$1,000,000	$ 250,000	$ 500,000	$ 500,000	$ 500,000
Deductible	1,000	250-1,000	500-1,000	500-1,000	TBD	500	500-2,000	250+	500-1,000
Stoploss(individual)	5,000	5,000	3,000	1,500-3,000	TBD	1500	1,500-2,500	2,000	1,500-2,500
Premium cap	400%	165%	135%	150%	150%	300%	150%	200%	150%
Waiting period	12 months	6 months	6 months	6 months	6 months	6 months	6 months	6 months	6 months
Rejected by x carriers	2	1	1	1	1	1	1	0	1
Offset premium tax	Yes	Yes	Yes	Part	(Note 5)	Yes	Yes	Yes	No
# Enrolled (note 1)	173	1228	1551	358	n/a	n/a	2745	n/a	n/a
Claims Expense	308,374	1,808,813	3,340,442	127,399	n/a	n/a	4,200,000	n/a	n/a
Admih. Expense	17,023	39,097	234,983	72,998	n/a	n/a	258,000	n/a	n/a
Prem. Income	184,120	1,221,792	1,937,904	223,053	n/a	n/a	2,100,000	n/a	n/a
$ Subsidy (note 1)	400,000	1,200,000	2,000,000	159,220	n/a	n/a	2,000,000	n/a	n/a
Per person subsidy	2,312	977	1,290	445	n/a	n/a	725	n/a	n/a
Administrator	BCBS	BCBS	BCBS	BCBS	BCBS	BCBS	BCBS	TBD	Mut of Oma

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STATE HEALTH INSURANCE POOLS, January, 1990

	WI
Year Effective	1981
Maximum Benefits	$ 500,000
Deductible	1,000
Stoploss(individual)	2,000
Premium cap	150%
Waiting period	6 months
Rejected by x carriers	1
Offset premium tax	No
# Enrolled (note 1)	6200
Claims Expense	5,500,000
Admin. Expense	275,104
Premium Income	2,125,061
$ Subsidy (note 1)	1,900,000
Per person subsidy	306
Administrator	Mut of Oma