RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 1

HIGH RISK HEALTH POOLS

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Recorder: ROBERT J. DYMOWSKI

- o Comparison of plans -- examples of current and proposed programs
- o What is working?
- o Experience
- o Public policy considerations

MR. ROBERT J. DYMOWSKI: High risk pools is a broad topic. Currently, about 25 states have these pools, and there are 19 or more states that are in the process of establishing some other form of pool or additional pools. These programs, which usually are designed for people who have been rejected by two or more insurers, only cover perhaps 23,000 people in the United States at present. They raise a number of issues in terms of (a) public versus private roles in the financing of this kind of coverage; (b) the affordability of the coverage for those people who participate in these pools; (c) how the participation in, and the financing of, these programs gets spread over the entire community of insurers and self-insured programs; and (d) the degree of use and anti-selection of benefits by individuals who participate in them. They need to be seen not in a much broader context of the 31-37 million people who are uninsured, since these kinds of pools are certainly one approach that state governments can take, and which may lead to Federal program. We are very pleased to have a panel with a wide range of experience in the subject.

The first speaker will be Don Moran from ICF/Lewin. He joined the organization in 1985 as a Vice President. He holds a bachelor's degree in mathematics from the University of Illinois. He's had extensive experience in analyzing and evaluating public policy in the health care field, and has directed numerous consulting engagements for private clients concerned with health care financing issues. Prior to his work with Lewin, he served as the Executive Associate Director for Budget and Legislation at the Office of Management and Budget, where he directed government-wide policy analysis and budget review, and managed OMB's participation in the Congressional budget and appropriations process. He also had positions with the Director of Human Resources, Veterans and Labor, where he directed policy analysis and budget review for the Department of

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Health and Human Services, the Veterans Administration and other related agencies. He will be addressing the subject in a broad context of how he sees that public policy issues have developed, and the directions that public policy may be taking.

The next speaker will be Glenna Dudley. She is the director of community relations at Indiana University-Purdue University, Indianapolis (IUPUI). She's been there since December 1989. She has degrees from Indiana University and also has a law degree from Indiana University, Indianapolis Law School. Her involvement with this particular subject came from her previous responsibilities during 1986-89, while she was with Blue Cross-Blue Shield of Indiana as part of the Legal Department, as the Plan's Government Affairs counsel. This involved lobbying activities with the Indiana General Assembly and liaison with the Indiana Insurance Department and other government agencies. This led to her involvement with the Indiana Comprehensive Health Insurance Association, and she'll be talking about some of the issues that she experienced there. She will discuss the legislative concerns and objectives and the problems encountered in administrating the program. She also had prior experience with the Indiana state government as a deputy commissioner of the Indiana Department of Revenue.

The third speaker is Gary Massingill. Gary has a degree from the University of California at Davis. He's a member of the health staff of the Seattle office of Milliman & Robertson, Inc. He joined that office in 1984. His work is primarily for HMOs and insurance companies. He has also had an opportunity of working for a number of state governments with regard to Medicaid programs and programs for the uninsured. He is also currently the actuary for the Washington State Health Insurance pool. He will be describing some of the experience of that pool, and some of his experiences with other programs.

MR. DONALD W. MORAN: My challenge, as Bob suggested, is to try and lay out the Washington perspective on the matters at hand, and to try and provide some context for understanding the specifics which my colleagues on the panel will address in terms of existing programs.

In doing so, I think it's fair to say that the politics of all this has changed markedly in the last two to three years. Understanding that is an important precursor for understanding what it is that governments are currently doing and likely to do. I think it's fair to say that, through most of the history of Federal involvement in legislation in the health insurance industry, which has in the private insurance industry been de minimis, there's been an acceptance of the proposition that (a) uninsurability is a fact of life; (b) those high risk individuals who have very bad risk profiles are not likely to be insured in the private insurance market; and (c) whatever obligations are attendant upon that as a social problem are appropriately within the realm of state and federal policy. I'm here to tell you that perception is changing to a certain degree, and that the issue of uninsurability is being thought of in a broader context, where the Federal Government no longer assumes that the private insurance industry ought to be automatically relieved of those responsibilities by voluntary election or selection.

It's likely that within the next two to three years, some form of legislation will be adopted that will have a significant effect on the way in which these risks are distributed

across private insurance carriers. With that said, it's also important to understand that the driving impetus behind this movement is not so much narrowly focused on the issue of uninsurable risks in terms of individual cases, but that it comes out of the politics of the broader issues, which Bob suggested, of insurance as a general phenomenon in society.

The particular concentration in the federal world in the last few years has really been on two phenomena in the insurance market that are being viewed with increasing concern. One is the obvious and historical issue of the availability of private health insurance on a group basis to small businesses. As absolute costs rise. let alone relative costs, this is becoming an issue of increasing concern. Secondly, I think that within the last two to three years, there was a growing perception that employers and other plan sponsors in the market place were withdrawing coverages for dependents, by either reducing contributions or eliminating coverage altogether. The population survey statistics the Washington people follow are beginning to show rising numbers of people who fall into the uninsured category. Boiling that down to its essence, the easiest way to state this is that there's a growing perception in Washington that there is what the industrial organization economists would call a case of classic market failure in the insurance industry.

Whether or not one agrees with the perception -- I have to confess that I don't -- that's the perception on the part of many of the people who make policy. Their argument is that the structure of the private insurance industry itself, in underwriting risk, is increasingly unable to address insurance problems generally for an increasing segment of the population, whether they be high risks or uninsurable in the classic sense, or whether they'd have limited access to insurance through economic reasons or by condition of their places of employment. The attraction is turning now in Washington to trotting out the usual aspects of the Washington policy arsenal to address this. In some sense, this is being viewed as the resurgence of the national health insurance movement of the late 1960s and early 1970s. In my judgment, it will never get that far simply because of the inability of the Federal sector, or any other sector, to pony up the large volume of dollars that would be implied in universalizing insurance coverages. As a result of this, I think there's increasing attention being directed at more limited roles that the Federal government could play in juggling around the structure of the insurance market in order to create what they perceive to be socially desirable effects.

I want to touch on three of those briefly, and give you a few illustrations of the type and character of things that people are saying. I don't go into any depth with respect to specific proposals. If you are interested, you can pursue them or we can discuss them in more detail in the discussion section. They fall roughly into three baskets of options. The first basket of options' characterized by the efforts of Senator Kennedy, Congressman Waxman, and others in recent years, is mandating in the employment sector, rather than creating any new Federal program. This rests on a notion of broadening the risk pool by expanding by regulatory fiat the number of people who are required to receive employer-based coverage. In my view that's an eventual nonstarter, for reasons that have little to do with health insurance, but have a lot to do with low-wage labor market efforts, and the impact which loading in high insurance costs on top of low wages is likely to have in terms of employment in the small business sector. That perception, which I

think is growing in Washington, is raising the interest in the culmination of two other types of proposals which, I think, are important to take fairly seriously at this stage.

The first is being called in Washington the "pay or play" formulation. I'll say a few more things specifically about that in a moment, but the basic notion is that rather than specifically mandating that employers provide coverage, this would offer employers the option of either providing coverage that met minimal federal standards, or paying a tax which would be used to finance a government-sponsored insurance vehicle for those who are unable to receive coverage through employer election. This would apply for the high risk population as well as the low income population.

The third basket, which I think is receiving increasing attention in Washington because of the way the politics are falling down, is the prospect of climbing over the barricades of McCarran-Ferguson, and for the first time, installing some degree of Federal insurance regulation nationwide in the interests of interstate commerce. This would provide for regulating certain aspects of the business of underwriting group coverage in ways that would be historically novel, at least from the perspective of what's gone on in the last 50 years.

Let me say that the recent chain of proposals that's coming out in Washington tends to fall into the "pay or play" world, rather than the Federal insurance regulation world per se. About a year or so ago, a group that called itself the National Leadership Commission on Health Care came out with a proposal that basically purported to offer employers the option of paying up, one way or the other. There are other proposals, such as the recently released report by the Pepper Commission, which was chaired by Senator Rockefeller of West Virginia, which created yet another variant on this theme. Soon to report this summer or fall is a group which is basically the quadrennial Social Security Commission chaired by Deborah Steelman. Also, as he mentioned in the State of the Union address, President Bush has asked the Department of Health and Human Services to come forward with yet another variant; that effort has been given to Connie Horner, the Undersecretary of Health and Human Services, to develop policy options by this summer.

All of these fall within the world of what we could call "pay or play;" the structural issues are important, because depending on how they are configured, these proposals are going to have very important structural effects on the market for group insurance. The basic character is, as I've said, offering employers the choice of paying a tax or providing coverage that meets minimal standards. Interestingly, there is an important policy debate going on in Washington within this camp about how you establish and set that tax. That has important behavioral effects for employer groups which it's important to consider in any discussion at this time. Some of those who really want to use the "pay or play" structure as a proxy for mandating want to set an employer tax rate that is basically an actuarial equivalent trade-off to the type of coverage that people see in the main-stream out in the private insurance market. This would minimize behavioral effects for employers -- basically, dumping people into pools whether because of health insurability problems or simply because of what it adds up to in terms of a percentage of payroll.

Others take the position that it may be okay to induce employer behavioral effects, particularly for medium and small groups. Given the heavy price loads that one experiences on those types of coverages, it might be even better to create a very large government-sponsored pool, and set the financial terms of trade in ways that induce those who have historically not offered coverage to instead pay a tax that's more commensurate with affordability from the employer's perspective, say something like 5 or 6% of covered payroll. This would finance a government-sponsored or government-administered insurance market.

All these variations assume that there's going to be some degree of premium subsidy built into whatever pools are created. Some people talk about regional pools, others talk about state pools, and yet others talk about substate pools, in permutations and combinations of inputs. But the clear message is that a significant component of insurance offering in this market, particularly for the small and medium size group, will be under the aegis of one of these pool structures, if one of these situations is enacted. Some variants on that call for a government, and in this case. state-regulated, market for health insurance, where in effect the pool would be composed of a safe premium subsidy scheme that would permit private insurers to compete for individual coverages. Still other people are talking about an assigned risk structure within a state-operated pool. Still others, and I think the Pepper Commission proposal was typical of this sort of structure, call for a state-administered health insurance pool, which would be, de facto, a state-operated Medicare program for those for whom private coverage is not available, and with a fairly deep set of premium subsidies, financed by taxes raised on employers who don't offer coverage that meets the standards.

All these things have some fairly important effects on the insurance market, as I think everyone can understand. We do a fair amount of modeling and price estimating work for those who are evaluating these options in the Washington policy environment. I can share with you what seems to happen under these simulations. Our current estimate is that something on the order of 179 million lives are presently covered under private health insurance, group and individual, of some form. Mandating options, either de facto or explicit mandating, would tend to drive that coverage rate up somewhere in the range of about 210 million lives. The residual of 40 million would continue to be covered under explicit Federal and state programs, meaning Medicare and Medicaid.

If you look at what happens in terms of the behavioral effects when one of these "pay or play" options is put into place, however, it is that there's a significant transformation of both the distribution of bodies, but also the distribution of risks within the private insurance market. In fact, our estimates of the effect of the Pepper Commission proposal would be to drop the number of lives covered under private insurance from about 179 million down to 165 million, with more than all of the net swing going into the state pools that would be created under the Pepper Commission proposal. As you can probably anticipate (and I think it's somewhat intuitive), the risk structure is not linear in that kind of configuration. What seems to happen is that in terms of migrations both out of individual coverage, which are significant, and migrations out of self-insured, which are smaller, it brings a better quality of risk into the private insurance market. In terms of gross covered health expenditures, we estimate that the population migrating out of

the private insurance market as a result of one of these proposals might drop the actuarial value of private insurance coverage by as much as 5-10%.

If you think about the character of those who are presently uninsured, or those who are buying individual coverages, many of the uninsured tend to have fairly reasonable risk profiles. They tend to be young, working in industries with low wages; this implies people early in their work histories. The implications of all this are that, if one accepts the policy premise that there's a lot of things that seem fairly attractive to folks in Washington about structuring variations of this type, he is inclined to believe that a substantial degree of pooling is going to create substantial and positive public policy results. Those who want to do that on the cheap, therefore, are attracted to the possibility of achieving the same thing by explicit Federal regulation.

There are now being bandied about in Washington proposals to attempt to regulate the private and group employment insurance market in two important ways. First would be to re-create the world of the Blue Cross-Blue Shield system of the early 1950s, which is, at least in some limited portion of the market (perhaps medium and smaller groups), to heavily favor notions of open enrollment and community rating, and adopt Federal regulatory structures that would imply those kinds of systems. In any event, I think the risk of Federal regulation in this area is a serious one that can't be discounted.

The difficulties with all this, I think, are pretty obvious to most of us. It's pretty clear that the ability to successfully wrap public policy objectives around the existing employer insurance industry has less going for it than meets the eye. There are undoubtedly important behavioral effects in terms of the way in which group plans are structured, or groups themselves are structured, that could be manipulated by rational people in order to maximize their financial advantage in any one of these systems currently being considered. I think it's fair to say that the distortions that could arise from what amount to partial Federal regulation of the industry are pretty substantial and can't be ignored. Just consider how a state insurance commission is likely to respond on rating, benefits, and coverage issues when they no longer have, in effect, statutory responsibility for maintaining the comprehensive regulatory scheme designed to assure solvency of insurers in the state. This has important implications for how the world might shake out.

So in all of these issues, I think it's clear that where the world is going in the next few years is going to have important effects on the structure of the insurance market. It will be motivated, in my judgment, more by generic public policy issues rather than a concentration on high risk populations per se. The effects on the distribution of high risks and the underwriting experience of insurers out there in the private market are going to be importantly affected by whatever happens in this scenario for many years to come.

MS. GLENNA G. DUDLEY: My perspective is that of one of the older of the state uninsured risk pools, the Indiana Comprehensive Health Insurance Association (ICHIA). Indiana's program was created by statute in 1981. It is a statutorily-enacted, not-for-profit corporation, of which every insurance company that writes health insurance in Indiana is a member, as is every HMO that provides coverage in Indiana. That means they're also subject to the assessments.

Let me give you a bit of an historical perspective on how Indiana happened to be one of the first states -- I think we were either fifth or sixth. Minnesota and Wisconsin, I believe, came along in 1976, and were somewhat prototypes. In about 1980, Indiana Blue Cross and Blue Shield began to look more closely at how it fit into the whole Blue Cross and Blue Shield system. The Indiana Blue Cross Plan is a mutual insurance company. It does not enjoy the statutory protection that many of the other Plans do in their states. Likewise, along with that absence of protection, is the absence of the requirement that they conduct open enrollments, and take anyone who comes to them with a premium in hand. Blue Cross of Indiana had been doing that, but made a business decision that it was time to stop doing it. At that point, they also recognized that there had to be an alternative for those people who had been purchasing individual Blue Cross coverage through an open enrollment mechanism, but who were not in fact medically insurable, and were not covered by an employer-based plan.

It was at that point that Blue Cross and a couple of other of the major insurance carriers in Indiana began looking at the options. The NAIC at that point had a model law on high risk health pools. The version that was adopted in Indiana was not the NAIC model, but was a hybrid. It was a very benefit-rich plan, and it had a mechanism that provided that each of the three sectors that were involved in the program in fact did pay something. It was, in effect, a public-private partnership. Individual members coming to the risk pool had to bring two rejections from insurance companies for medical reasons. The premium was capped at 150% of a calculated average of a hypothetical policy that was deemed to be identical to the ICHIA plan. Thus, the member was asked to pay more for the opportunity of being covered under a fairly benefit-rich plan. The insurance companies and HMOs, the corporate members of ICHIA, provided a subsidy for the difference between the premiums paid and the claims.

For the first two years it was a profitable venture, but beginning in 1984, the third year of operation, the claims began to exceed the losses. Our 1988 loss ratio was 176%, which put us right in the mean of the six older pools that were examined in an unpublished general accounting office (GAO) study. So the insurance companies paid the excess claims for a period of time. They have the cash flow out to pay the claims for a period -- a year and a half or two years. Under the provisions of our statute, and many others, they are entitled to a tax credit. In Indiana, that tax credit may be against either the premium tax or the gross or adjusted gross income tax, because Indiana still has a domestic preference law on the books. It is conceivable, since this is a carry-forward, nonrefundable credit, that in periods of losses it may be a number of years before that credit is, in fact, recouped. This was a factor in causing the Board of ICHIA to reexamine the law about two years ago and look at some ways that they might begin to bring premiums and claims more closely together. The assessments were beginning to get out of hand, at least from the perspective of the company for which I worked, who happened to be the first and second highest assessments. Blue Cross was the highest assessment because the assessments are pro rata based on the amount of business written in the state. The second highest assessment went to our HMO subsidiary. The third portion of the public-private subsidiary partnership is thus the State of Indiana, which does participate in the program through the tax credit.

I was not around when the original bill was being passed, so I cannot speak specifically as to what was in the minds of the legislature at the time. However, in 1988 the ICHIA board had by that time conducted a study of their own. They had invited the legislature to have an interim study committee and look at the ICHIA law, and they were facing the 1989 legislature with a number of amendments to the law. I was, at that time, the lobbyist for both Blue Cross and Blue Shield, and in a "quasi" capacity, I was the lobbyist for the ICHIA. So I have a great deal of familiarity with the various opinions that were coming from individual members of the legislature, and I think it's important to remember that as we speak of a legislative intent, or legislators' intentions, in Indiana there are 150 of those -- 100 members of the House and 50 members of the Senate. While they tend to group together based on a liberal or conservative lines, there is not always specific clear-cut intent. The contradictions were sometimes extremely evident, especially following a period of time when there might have been an article in a newspaper about the "excessive losses of ICHIA." ICHIA was designed with the expectation that there would be losses because of the fact that, with the premium cap, it was not conceivable that it could be a profitable venture; nor was it even intended to be, in my opinion.

Let me give you a couple of numbers about the size of our pool. The law was passed in 1981, and the risk pool began its operation in 1982. The highest enrollment was in 1984, when the enrollment peaked at about 3,500 people. At that point, the premiums were ranging from $2,000-7,000 a year, and people began to look at their own cash flow. Those people who did not have claims exceeding the amount of their premiums began to drop out of the pool. While this was a very logical approach from the individuals' perspective, it caused the excess of claims over premiums, because the healthy lives were dropping out. The membership has stabilized over the course of the last two or three years at about 2,600. It fluctuates slightly, but not significantly. Prior to the effectiveness of the act, there was the projection, based upon the state's population and some national averages, that there would be 30,000-60,000 eligible people in the state. As I indicated, the premiums are capped at 150% of a defined level, and every year of which I am aware, the calculated premium has been stopped by the cap. The level is defined as the average of premiums of the five largest insurance companies, adjusted for the benefits of the high risk pool. Premiums based on experience of the pool would be higher, so the cap has applied. The premium collections have been running in the range of $6 million, and claims have been running in the range of $11 million. The $5-6 million balance over the years has been paid by the insurers and HMOs in the state.

Our statistics indicate that a disproportionate number of our members are in the 40-64 year age range. Likewise, most of our members are women who are between 60 and 64. Pool eligibility ends when one becomes eligible for Medicare coverage. Until 1989, there were very low deductibles. The deductible was $200. That was increased in the bill that we were able to get passed in 1989. Likewise, the stop loss cap was $1,000. That was also increased. The board was looking for ways where they could be more cost-effective in their management, but the statute prevented them in some instances from doing some of the logical things that a normal insurance company would be able to do.

Our greatest frequency is in small claims. Our statistics from about a year ago indicated that over the life of the pool, we had one member who had collected over $500,000 in

claims. There were another six that exceeded $300,000, but by far the largest number was falling in the smaller claims category.

As I indicated, it's a very rich benefit plan, and that benefit richness was in part responsible for a number of the losses. Likewise, there was no statutory authority for cost containment mechanisms, and that was another aspect which the board was seeking to be able to accomplish through the 1989 legislation. It was interesting to note that legislators looked at that from two perspectives. Keep in mind that Indiana is a relatively conservative state, fiscally. On the one hand, there was the public policy approach that those who were medically uninsurable and those who could not go to the private market place and buy insurance ought to have a place to go where they could get reasonable, accessible and affordable insurance coverage. There was the feeling that ICHIA ought to be that, until we came along with some actuarial numbers and showed them what the cost ultimately was going to be to the state. At that point, they began to get a gleam in their eye, and they began to consider taking away the tax credit. They recognized that, while the subsidy possibly should be provided, perhaps it was up to the insurance companies to provide it because it was their practices in refusing these people that were driving them to the pool.

On the other hand, that was the point at which we began to make our argument that approximately 50% of the people in Indiana who are covered by "insurance" are in fact in self-funded plans. The anomaly is that, while our law is written in such a way that an employer-funded plan becomes a member, and therefore subject to assessment by ICHIA, as soon as the Federal prohibition against that is repealed, they are not currently members. The self-funded plans can drop a member, or carve around a dependent who has excessive claims, thereby making them eligible for ICHIA and throwing them into the pool, without ever contributing to the assessment that's derived from their claims. The lobbying process became one of educating the general assembly that it was a very, very complex issue, that it was not just out of pocket to a member, that it was not just a $5 million tax credit, which in reality didn't come up to quite $5 million. In reality a lot of companies fail to take the credit; perhaps they don't file a tax return in the state if they have a marginal amount of business, and they wait for the revenue department's audit to find them. So while the assessments might have totaled $5 million, the actual tax credit for the year wasn't that high.

There also was an interesting perspective on the part of a lot of the legislators that it would be a good idea to expand the risk pool to include all uninsureds. At this point, the media was making much of the Kennedy proposal, and there was a great deal of discussion about that 37 million people, of whom Indiana was believed to have 2 or 3 million who might be eligible for this pool. At that point, the dollar projections were quite significant, and there was a realization of the potential clash between the ideal public policy approach to what was in fact perceived as a social problem, and the fiscal reality of a state which is constitutionally prohibited from going in debt.

These are the kinds of things that we were facing in the legislature. It was very much an education process. They learned a great deal about ICHIA, including the realization that just because someone carries a card in their pocket that provides medical benefits or third party payment that they are not in fact an insured. The process was an interesting

one. ICHIA still comes under fire. It was just sued a couple of days ago over its premium rates because there is an ambiguity in the law. If the board had perceived the ambiguity, it would have cleared it up at the time we sought the last amendment to the law. In any case, there's a question as to the premiums to which the 150% cap is applied. Another by-product of the legislation and the process of getting it approved was that numerous articles appeared in various newspapers around the state which increased public awareness of ICHIA. One of the objectives of the Board had been to increase ICHIA's membership; from a business perspective, however, if you lose $1,700 per year on each member (which was the amount at the time), why would you want to increase your membership? But this is the dichotomy between the fiscally responsible business aspect and the public service aspect.

Membership did increase after the 1989 bill was passed because the existence of the pool and the eligibility requirement got fairly good publicity throughout the state. The experience was an interesting one, and I'd be happy to answer any questions that I can about the legislative process.

MR. GARY W. MASSINGILL: I'm going to talk specifically about the Washington State health insurance pool, but it's my perception that there's far more similarities than differences in these pools from state to state. I suspect that a lot of my discussion with regard to the Washington pool, in terms of its structure and the experience, would be appropriate or similar to programs in other states.

In 1987, the Washington State legislature passed the Washington State Health Insurance Coverage Access Act, which created the Washington State health insurance pool. The basic purpose of the legislation is to provide access to coverage to persons for whom coverage has either been rejected, or has been limited for health reasons. The pool is set up as a nonprofit entity, and the members are all commercial carriers, health care service contractors, and HMOs that are licensed and operating in the state of Washington. Self-funded plans and employee welfare benefit plans are presently excluded. The first policies were actually issued in July 1988, and at present, the pool covers slightly in excess of 2,000 members.

The pool board consists of nine members. Three of the members are selected by the state insurance commissioner, and are intended to represent health care providers, health insurance agents, and the general public. The other six members are to include at least one representative from each of HMOs, health care service contractors, and insurance carriers. In fact, there are two representatives from each of those types of organizations on the board. The board has the general responsibility of operating the plan, including submission of a plan of operation to the insurance commissioner that assures fair, reasonable, and equitable administration of the pool. It is responsible for handling and accounting of assets; selection of a plan administrator; setting up procedures to determine amounts of assessments; and for programs that publicize the plan, and for establishment of grievance procedures. It also must assure that the rates, benefits, and enrollment procedures are all in compliance with the law. The plan administrator that was selected by the board is Mutual of Omaha; it's my understanding that Mutual of Omaha is presently administering seven of the state high risk pools. Losses are assessed to pool members by the board as needed in order to keep the pool fully funded.

Member assessments are proportional to each member's share of the state health insurance market, and companies are allowed a deduction from their taxable premium for premium tax purposes, so a very modest portion of the cost is actually being paid by the state.

As I said before, the self-funded plans are not now pool members, and therefore, do not share in the pool assessments. The current pool members would love to welcome them into their company. The state law actually specifies that, as soon as Federal law allows, they will immediately be admitted as members, and the board will be expanded to 11 members, including two members representing self-funded plans.

The law requires that insurers, HMOs and health care service contractors that reject or limit coverage must inform the applicant at the time of rejection, or of putting some type of limitation on a policy, that pool coverage is available, and must make them aware of how to make application. Individuals are eligible for the pool coverage if they provide evidence of rejection for either medical reasons or requirement of restrictive riders; a rated-up premium; a pre-existing condition limitation that substantially reduces coverage from that received by a person considered a standard risk; or involuntary termination of health insurance for any reason other than nonpayment of premium. The law specifies a fairly comprehensive package of benefits that must be included in the plan design. Most are typical major medical benefits, but there are a few minor and unusual benefits, such as a diabetes education benefit with a maximum lifetime payment of $250, and some other legislative favorites. The deductibles, the out-of-pocket limits, and the lifetime maximums were specified in the law, and the law actually required that some cost containment features be incorporated into the plan.

At present, two plans are available to individuals that are not covered by Medicare, and one plan is available to Medicare enrollees. The non-Medicare plans offer comprehensive benefits with a choice of a $500 or $1,000 calendar year deductible. Benefits are then paid at 80% of usual, customary, and reasonable charges; after a maximum out-of-pocket cost of $1,500 or $2,500, the benefits are paid at 100%. Both plans include a $500,000 lifetime maximum benefit. The plans do include some modest cost containment features such as preadmission certification, concurrent review, mandatory second surgical opinions on certain types of procedures, and coverage of preadmission testing at 100%. Traditional comprehensive major medical benefits are covered. Maternity is covered for complications only. The plan does cover major organ transplants.

The Medicare plan provides coverage for all of the Medicare co-pays and deductibles, and also pays 80% of amounts in excess of Medicare allowable charges. Prescription drugs are also covered by that plan.

The plan includes a six month pre-existing conditions clause which is waived in cases where prior coverage existed. In some people's minds, the pre-existing clause partially defeated the purpose of the high risk pool, but I think it's really necessary in order to prevent individuals from gaming the system by enrolling after the need for medical care arises. One other rule that's been implemented in an attempt to somewhat limit the amount of gaming is that individuals dropping out of the pool are not permitted back for 12 months.

The law specifies that the pool must determine a "standard risk rate," which is determined by calculating the average rate charged by the five largest members offering coverage in the state comparable to the pool coverage for groups of up to 10 lives. In the event that five members do not offer comparable coverage, the standard risk rate is to be established using "reasonable actuarial techniques," and must reflect anticipated experience and expenses for such coverage. The law does allow rates to vary by age, sex, and geographic area. The pool rates cannot exceed 150% of the standard risk rate, and I think that most states have a maximum rate limitation that ranges from 125-150% of standard rates. It was my belief that we could not find five members that offered comparable coverage in the state. We could have probably found five carriers offering $500 -- or $1,000 -- deductible small group products, but there would have been significant benefit and other differences which would have required adjustments. As a result, we developed a standard risk rate using "reasonable actuarial techniques." We developed expected claims costs for a small group, medically underwritten contract, using our firm's Health Cost Guidelines, and divided the estimated claims cost by .75 to develop standard risk rates or premium rates for a small group product. Then we set pool rates equal to the maximum 150% of the standard risk rates, per instructions from the board.

The Washington State health insurance pool rates could then, therefore, be described or regarded as equal to 150% of typical small group rates for a comparable product. Pool rates vary by age and sex for adults, and the child rates are per child. We did develop rates for two geographic areas within the state that I think could generally be categorized as urban and rural. The rates are increased once per year on all in force policies. The initial rates were developed for July 1988; a trend rate increase was applied to all policies in July 1989, and another will be applied this July. The rate increases are in no way affected by actual pool experience. Consistent with the objective that the rates be equal to 150% of standard carrier rates, we have used trend increases that are in line with carriers' rating trends, as opposed to carriers' experience trends.

The Washington pool is still in a rapid growth phase, from 38 members in July 1988 to just over 2,000 at present. If you look at the demographic analysis page, Table 1, the demographics of the enrolled population are vastly different from standard commercial population demographics. For example, on the nonMedicare plan, we normally expect over 80% of the population to be under age 45. Only about half of the pool enrollees are actually less than age 45. In fact, the two five-year age bands with the greatest enrollment are actually ages 55-59 and 60-64. About 40% of the pool members are over age 50. In the commercial population, I would anticipate this would be about 13%. By cross multiplying the actual and the standard commercial populations by relative cost factors, we calculated an average age-sex factor for the pool of 1.49, relative to a commercial factor of 1.00. In other words, the pool enrollees are about 49% more costly, in terms of morbidity, due to demographics, than a typical commercial population. An observation on the Medicare plan demographics is that 88% of the enrollees are under age 65. In other words, the Medicare plan's main appeal is apparently to disabled individuals covered by Medicare. The total enrollment on the Medicare plan this January was only 130, so these percentages are based on very small numbers.

TABLE 1

Washington State Health Insurance Pool Demographic Analysis
January 31, 1990 Enrollment

Non-Medicare Plans

	WSHIP Enrollees			Standard Commercial Population		
Age	Male	Female	Total	Male	Female	Total
0-19	.081	.055	.136	.166	.166	.332
20-29	.077	.034	.111	.100	.093	.193
30-39	.091	.056	.147	.102	.102	.204
40-44	.060	.042	.102	.040	.041	.081
45-49	.052	.055	.107	.028	.031	.059
50-54	.054	.057	.111	.026	.029	.055
55-59	.060	.082	.142	.020	.023	.043
60-64	.053	.085	.138	.012	.014	.026
65+	.003	.003	.006	.003	.004	.007
Total	.531	.469	1.000	.497	.503	1.000

Medicare Plan

Age	WSHIP Enrollees
20-29	.046
30-39	.185
40-49	.269
50-59	.231
60-64	.146
65-69	.100
70-74	.008
75+	.015
Total	1.000

Table 2 shows the persistency of these plans; thus far, the persistency is fairly high. Overall, over 80% of the policies sold were still in force on January 31 of this year. For issues from the third quarter 1988 through the second quarter 1989, or those that had to buy a rate increase on July 1, 1989, about 75% of policies are still in force. The policies issued since the third quarter 1989 have not yet had any rate increases. Persistency is slightly better for the $1,000 deductible plan than for the $500 deductible plan at all durations, and persistency on the Medicare plan is slightly better, but similar to, persistency on the non-Medicare plans.

TABLE 2

Washington State Health Insurance Pool Persistency Analysis

Non-Medicare								
	$500 Ded. Plan		$1,000 Ded. Plan		Total		Medicare	
Quarter of Issue	Issues	% Inforce 1/31/90	Issues	% Inforce 1/31/90	Issues	% Inforce 1/31/90	Issues	% Inforce 1/31/90
3 Q 88	73	73	25	76	98	73	15	87
4 Q 88	208	71	90	71	298	71	19	63
1 Q 89	342	74	111	77	453	74	34	88
2 Q 89	347	76	145	77	492	76	32	84
3 Q 89	307	86	122	92	429	88	32	84
4 Q 89	259	92	110	98	369	93	18	94
1 Q 90*	85	96	24	100	109	97	4	100
Total	1,621	80	627	83	2,248	81	154	84

* includes only January, 1990 issues

I guess my general reaction would be that it appears to me that the majority of purchasers are really looking for fairly permanent protection, and the policy for the most part is not being used for short term or stop-gap protection. In terms of the mix of business by policy, about 67% of the in force policies are on the $500 deductible plan, about 27% on the $1,000 deductible, and about 6% on the Medicare.

The claims experience (Table 3) shows that experience has deteriorated from a 56% loss ratio in 1988 to a loss ratio of about 116% in 1989. The 1988 loss ratio is complete, but it's based on only 1,053 enrollee months, which is comparable to having a year's experience on an 88-member, or perhaps a 35-40 employee group, which obviously is not very credible. The month to month variation in loss ratios in 1988 is further evidence that there's very little credibility there. The 1989 experience is far more credible, and is comparable to having perhaps a 500-600 employee group for a year. The fourth quarter 1989 incurred claim estimates are still a little soft. We did have claims run out through February of this year, so the estimates are starting to zero in fairly well. The loss ratio for the pool since inception is about 112%. Since rates were built using a 75% target loss ratio, and included a 1.5 morbidity factor, this is roughly consistent with 225% of standard morbidity. The 1989 overall loss ratio of 116% is more like 230% of standard morbidity, and the 125% loss ratio in the second half 1989 is close to 250% of standard morbidity. The experience has worsened somewhat, although the number of enrollees was very small in 1988 and we would anticipate that the impact of fairly sizable deductibles would cause experience to deteriorate somewhat throughout the year in 1989. However, we do have a wearing-off of pre-existing conditions clauses on a sizable portion of the enrollment starting in late 1989, and that's probably contributing to poorer experience. From the experience of other states and looking at the trend in loss ratios, it would be reasonable to assume that things could still get far worse, but it does appear

that current morbidity levels are running somewhere around 250% of typical commercial morbidity levels.

TABLE 3

Washington State Health Insurance Pool Claims Experience Analysis

Month	Exposure	Earned Px (000)	Incurred Claims (000)	Loss Ratio
7/88	38	4	8	2.00
8/88	41	5	8	1.60
9/88	95	11	1	.09
10/88	189	22	3	.14
11/88	296	34	32	.94
12/88	394	46	16	.35
1/89	534	64	111	1.73
2/89	689	83	46	.55
3/89	841	101	116	1.15
4/89	984	119	83	.70
5/89	1,153	139	114	.82
6/89	1,290	155	168	1.08
7/89	1,370	198	144	.73
8/89	1,441	208	245	1.18
9/89	1,576	228	367	1.61
10/89	1,685	244	291	1.19
11/89	1,762	255	268	1.05
12/89	1,875	271	433	1.60
Quarter				
3 Q 88	174	20	17	.85
4 Q 88	879	102	51	.50
1 Q 89	2,064	248	273	1.10
2 Q 89	3,427	413	365	.88
3 Q 89	4,387	634	756	1.19
4 Q 89	5,322	770	992	1.29
Year				
1988	1,053	122	68	.56
1989	15,200	2,065	2,386	1.16

Looking at the big picture, i.e., solving the problem of 31 million uninsureds in the U.S. (or 37 million), high risk pools are making a fairly small contribution. For example, in the state of Washington, it's estimated that we have approximately 600,000 uninsureds, and we're approaching the second anniversary of having a high risk pool with a little over 2,000 insureds in the pool. I think even with aggressive projections regarding the growth of the pool, it's probably unrealistic to think that we'll ever achieve much more

than 1-2% of the uninsured population in pool enrollment. Furthermore, relative to the number of individuals covered, the price tag -- whether it's being paid by the state, by carriers, or by providers -- is quite high, and the losses per enrollee per month can be very high, with sizable losses occurring even with relatively modest enrollment. However, high risk pools are providing coverage to a segment of the population that has money to afford coverage but simply can't find it. As such, they probably are serving a useful function.

MR. LARRY M. GORSKI: While I'm not the actuary for the Illinois program, I have been involved with it over the last year and a half. Our program started in April of last year. We have about 4,500 enrollees over a 10-month period of time, so that's a pretty quick enrollment in our state. The one interesting fact is that in Illinois, the deficit is picked up directly by the state, as opposed to an assessment process, with or without a tax offset. So the state picks up the deficit directly. It's actually appropriated before the beginning of each fiscal year, so it's a somewhat different process in Illinois.

I have three questions. One provision that's been very controversial in Illinois is the buy-down, in which the pre-existing provision can be reduced and/or eliminated by the payment of an additional premium. I think that provision was in Indiana at one time, and I'm not sure about Washington. I'd like to have a few comments on that.

I was surprised about the comments concerning persistency. It had been my understanding that, generally, persistency had been very poor with the other health pools, and we have been anticipating the same thing. We don't have enough experience really to make a determination, but the general feeling is that persistency was low and I was surprised to hear the comments in that area.

Third, an issue that has come up, and has not yet been addressed, is that while premiums for the program are based on industry premiums and averaging, and a percentage increase over that, since the actual composition of the pool is essentially uninsurable people, you would think that their risk profile would be somewhat similar. Thus, their expectation of loss might be somewhat independent of demographic characteristics, so there was some question as to whether a rate scale based on age and sex made any sense for this kind of population. Claim cost curves should be somewhat flatter, one would think, and there was some argument that premiums should be unisex, and maybe uni-age also. I wonder if that question had come up in other states.

MS. DUDLEY: I'll answer a couple of them quickly, and I have a question for you, Larry. As I recall, the Illinois law established a budget appropriation for the program. How did the first-year's experience turn out in relation to that budget figure, and what happens if it exceeds the amount that's been appropriated?

MR. GORSKI: Our first year is not yet complete. The way we went about it is that we were asked to estimate the cost for the first year of the program based on our expectation of enrollment. We came up with a number which was less than what was willing to be appropriated, so we had to set a cap on enrollment. So we said that, based on our appropriation, we feel we can enroll 4,000 people. As the year has progressed, the 4,000 people did not enter as soon as we anticipated. We then said that perhaps we could

enroll a few more, because the impact of pre-existing would defer those costs. We have always been up front about this, and would say that those costs would appear in the out year; but this year, our cost would be somewhat less based on 4,000, so we said 4,500. At this point we probably have about 1,000-1,500 applications to get into the program; we have exceeded our enrollment in one sense, because we've exceeded the cap in terms of applications, but we have capped total enrollment at 4,500.

MS. DUDLEY: I was interested as that law passed about how it was going to work. To answer your pre-existing question as it related to Indiana, originally when the ICHIA pool first began in 1982, there was a pre-existing condition buy-out option for a six-month pre-existing condition clause. Initially, that premium was a 10% extra premium. At some point in about 1985, when there was an analysis done, the realization was made that a high percentage of the losses were coming from those people. People were literally stopping by at the ICHIA office and purchasing a policy on their way to the hospital -- the pre-existing extra premium was raised to 25%. When losses continued to mount and another analysis was done in 1988, coupled with the reexamination of the law and what the board could do to really get a handle on it, they eliminated the pre-existing condition as an option for Indiana. However, during the legislative interim study committee process in which the board was presenting its proposals, the board got the very strong signal that the legislature felt that pre-existing condition waiver was an important one. So, while the law was amended to make the standard pre-existing condition period 12 months, there is another buy-out possible. It's a 15% premium, and again, it is anticipated that that will drive claims up. In addition, the law was also amended to provide that the pre-existing condition clause does not apply in the case where a member is coming to ICHIA directly from another insurance mechanism, where they are leaving that mechanism through no fault of their own. That's the Indiana answer.

MR. MASSINGILL: In Washington State, an individual cannot buyout of the pre-existing clause. I think Washington, perhaps because of being one of the later pools, learned from the mistakes of some of the other states in that respect. I don't have any specific comments regarding the persistency issue other than in the particular experience of our state. We do know that approximately 75% of the policies did purchase a rate increase of roughly 25%, and have persisted in the one year timeframe. I hesitate to make too broad a conclusion beyond that. On the third point, the unisex and uni-age question, in Washington, the board was allowed to have rates that varied by age and by sex. It was my recommendation to the board that we have rates varying by age and sex, and they adopted that proposal. I guess we never considered anything other than doing that.

MR. D.W. MORAN: Just one last comment on the persistency issue, and also the age-sex issue. My observation of these pools is that most of the enrollment tend to be chronic conditions, rather than the tails on high-cost catastrophic events, or anticipations of high-cost catastrophic events, so you anticipate somewhat greater persistency along those lines. That also has some implications for age and sex, because there are some age/sex correlations with both the incidence and the cost differentiations. I think that age would be a much more important factor than sex in varying rates in this situation.

MR. MASSINGILL: I see one problem if rates vary by age and sex. The law requires that you rate as a percentage of standard risk or standard population risk, so, if you do choose to use age, it would be my interpretation that you're not allowed to modify the slope to try to reflect chronic or other conditions that individuals would have.

MS. DUDLEY: I didn't give the Indiana answer to your age and sex question. Indiana's rates are based on age, sex and five geographic areas in the state that cluster around the four major cities and a regional area.

MR. GORSKI: I just want to follow up on one point. Illinois' rates are also based on age, sex and geography. The point is that certain people, in viewing the pool, had anticipated a much smaller slope in the claim cost curves. It was their view that the rates should not be done in that fashion, but in fact, they are.

MR. RONALD E. BACHMAN: While it may not be a direct concern, I was wondering if anybody has tried to analyze using the 75% loss ratio assumption? I guess that's sort of an industry standard for a small group, but has anybody analyzed the actual cost of the implementation of these plans, i.e., considering their board costs, advertising costs, and the expenses which the administrating companies are charging?

MR. MASSINGILL: In the state of Washington, the board is working on a volunteer basis, so there's no cost for the board. They do pay their actuary; the total administrative costs for Mutual of Omaha, the plan administrator, were about 14% of the premium.

MS. DUDLEY: In Indiana, the board also operates at no salary. The Indiana plan was administered by Mutual of Omaha until about a year ago, and then there was a rebidding process, and Blue Cross and Blue Shield of Indiana became the administrator. We did an analysis for the legislative hearing and did administrative expense ratios to claims paid. For 1984 that ratio was 3.4%; for 1985, it was 4.3%; for 1986, it was 3.7%; and for 1987, it was 4.3%.

MR. BACHMAN: My second question is: in order to minimize the number of people who would have to enter a high risk pool, is anybody in any state doing anything to encourage people to have high-deductible catastrophic coverage before they have the problem, so that they do at least have an insured solution to financial ruin that might otherwise occur? Are there any tax incentives, or any other approaches that might be appropriate?

MR. D.W. MORAN: There doesn't seem to be a lot of action on that dimension at the state level. There's some discussion of attacking pre-existings, or restrictions on medical underwriting, a little bit more directly. No one is mandating a very narrow, high-corridor product, to my knowledge.

MR. BACHMAN: And finally going back to address the analysis of the enrollment of those pools a little bit more, are they people who have in fact been involuntary canceled by insurance carriers? Are they people who never had coverage and thought they could move mountains because they were young and healthy, and all of a sudden they had a

problem and now they can't get insurance after the fact? What's the makeup of the people in these groups?

MS. DUDLEY: The Indiana data experience analysis that was done prior to the legislative hearing indicated that a heavy percentage of our members are females in the 60-64 age range. They are people who have lost their coverage either through divorce, death of their spouse, unavailability or unemployment kinds of situations. We did have a number of people, and this was responded to by a change in the law, who were attracted by a very benefit-rich ICHIA policy, but were covered by (generally) a self-funded plan with some pretty extensive internal limitations. They were attempting to drop their coverage and come to ICHIA. That's one of the reasons that the language change was made. In looking at the kinds of health conditions that people have in Indiana who are in the high risk pool, the first most frequent is heart and circulatory; second is cancer; third is diabetes. We do pay for the standard, medically-acceptable, medically-necessary, transplants. There's a lot of that mix in there. Washington may have had other experiences.

MR. MASSINGILL: Well, our demographics are certainly skewed towards the high ages, up very close to age 65. I have not seen any analysis done of the reasons for people enrolling. I think the reasons that were mentioned here are probably the same types of reasons. The largest two age/sex population cells are females ages 60-64, and females ages 55-59.

MR. HARRY L. SUTTON, JR.: I'm on a steering committee right now reviewing the Minnesota program. The major issues are focused on trying to control health care costs because, similar to Indiana, the legislation permits unlimited free choice of provider and doesn't permit the Blues, who do the administration, to negotiate fees or limit where individuals can go for high cost procedures. I'd like to give just two seconds worth of information, but I want to ask my question first in case I forget it. The question is whether you have any real data showing what the value of the pre-existing is worth for this kind of population? In Minnesota, there's a lot of pressure to get rid of the pre-existing. Recent legislation has said that anybody who is left high and dry because their HMO goes bankrupt can move into the high risk pool without pre-existing. Farmland Industries has created unemployment for 2500 employees in southern Minnesota, and the legislature wants to allow all those people to join the high risk pool with no pre-existing. Thus, the legislature's local social policy is to expand the use of this pool for people who somehow lose their insurance, even though they might have COBRA or something.

Our pool is bigger; it's 15,000 people, with about $20 million deficit in 1989, the loss ratio was 192% of a 125% pro-forma premium in 1988. It will be much higher because the former insurance commissioner refused to let the rates go up very much. Three years ago the tax base was changed. It came out of premium taxes, so indirectly it was out of state general revenues, because it was a deductible from premium taxes. It was charged against the Blues and HMOs, who were out of it before, and there is no deduction from premium taxes or profits or anything else. Roughly, the HMOs pay half the tax, the Blues pay a quarter of the tax, and the insurers pay the rest. It started at 0.4% or 0.5% of premium, and now it's up over 1.0% and rising rapidly, particularly if

we bring in these big populations. The HMO industry, and I presume the Blues, are greatly disturbed because they're paying the bulk of the tax. I am interested, because the legislature is trying to push away the pre-existing. We also have very high turnover, indicating that people come in for a year or two and, once they get a big illness or surgery covered, they tend to drop out. We're studying to find out if they come back later. We just don't know that question, and there's no preventing them from signing up more than once.

MS. DUDLEY: I found your comment about the sentiment in the legislature in Minnesota moving away from pre-existing interesting. I studied the various risk pools; Minnesota, which was one of the earliest, was one we looked at frequently. The political climate in Minnesota that we saw from a distance of 600 miles certainly appeared to be far more socially liberal than what we were seeing in Indiana, but you've just articulated a different mood. When we went back to the Indiana General Assembly in 1989 seeking those changes that the board felt necessary to operate the fund more prudently, among them was getting the authority to use cost containment. Now that the administrator in Indiana is Blue Cross-Blue Shield of Indiana, the provider networks of Blue Cross are extended to the ICHIA members. By contract with the providers, anyone that Blue Cross and Blue Shield administers is subject to the same conditions. In addition, the pool is negotiating its own networks of some specialty providers with whom they appear to do a great deal of business. The statement of the General Assembly in Indiana was very clearly that they wanted Indiana to return to the pre-existing condition waiver opportunity. It was not mandated by the law. We were successful in convincing them that that was not necessary, that the board heard their message, and would take action to do it because the existing law provided them with that opportunity. But a more politically conservative state was telling us to go back to it, and Indiana pays it ultimately directly, because in Indiana it is a tax credit and not a deduction. So I found your comment very interesting. I can put you in contact with people who can get you the information you were asking about our experience with the pre-existing condition.

MR. MASSINGILL: Obviously, with no option, we don't have any experience per se on the effect of not having the pre-existing. The pre-existing is waived where prior coverage existed in the State of Washington, and that's on approximately 5% of the policies. With 2200 policies, that is roughly 100 policies which have a waiver of the pre-existing.

MR. ROBERT C. BENEDICT: In the political evolution of these risk pools, was there discussion of broader-based funding beyond insurance companies, HMOs, etc., and if there was, why did that not succeed?

MS. DUDLEY: As I said, I was not around when the original bill in Indiana passed in 1981. There was an intent that it be broad-based, in that everyone who offered a plan should participate, but obviously Federal law preempted that. There really has not been much discussion in Indiana as it relates to other ways of spreading the base, but it's important that you understand the political and the fiscal climate of Indiana. It is very fiscally conservative, and it is fiscally, a very healthy state because of that conservatism. Our governors for the last 15-20 years, regardless of political party, have been extremely resistant to look at anything that would cause a general tax increase. So, to look at funding a pool of this sort by broadening the base and taking it directly out of the

general fund, as Illinois did, would not likely be adoptable in Indiana for a number of years. That's my personal opinion.

MR. BENEDICT: No discussion of a cigarette tax, a gas tax, alcohol tax, anything like that?

MS. DUDLEY: No, although those taxes in Indiana are dedicated to some pretty specific, and in some instances, health-based, kinds of things. In recent years, the no-tax-increase political base on which people have run has included gasoline, alcohol, and cigarette taxes, and those are dedicated. There's a real resistance, at least in our state, to expand those things to which they are dedicated.

MR. MASSINGILL: Bob, I think that in some states the cost is being paid by the state. I believe that the plan that just passed in Maine is actually going to be paid by providers through a hospital tax of some sort. So there is some variation from state to state as far as the degree to which costs are being paid by health carriers versus the state versus the providers.

MR. D.W. MORAN: I think that the generic politics of this is that most dedicated taxes tend, whether at the federal or state level, to attempt to match the revenue source with some perception of where the problem comes from in the first place. Given that the perception in the high risk world is that the problem of uninsurability is a characteristic of the insurance market, then some combination of the people who are either in the insurance market or beneficiaries of the proceeds of the insurance market ought to finance it. Once you get out into the larger world, as Harry Sutton was suggesting, as these things tend to migrate in the direction of more unemployed people and that sort of thing, I think the focus of attention will turn to employer tax bases. I'd be really surprised if they ever got, in a generic way, towards population tax bases, particularly ones that have been viewed as regressive to the low income population as cigarette, tobacco, or alcohol taxes.

MR. JOSEPH W. MORAN: I was rather disturbed at the initial presentations with respect to the Indiana and Washington State programs. They made no mention whatsoever of the management of the provider network which would seem to me to be the heart of managing the program. Ms. Dudley, you did mention something about provider networks; is this part of the responsibility of the administering agency, to select the providers, negotiate with providers, define underwriting utilization review standards, etc. or who does it?

MS. DUDLEY: Indiana's initial law, enacted in 1981 did not allow that to happen.

MR. J.W. MORAN: It forbid it?

MS. DUDLEY: Yes.

MR. J.W. MORAN: Even though the HMOs were subsidizing?

MS. DUDLEY: Yes. It very specifically gave the members certain rights and free access was one of them. You must also keep in mind again the political climate. HMOs are not that active in Indiana, or were not at that time, which may in part explain why that was an omission from the original act. In the amendment in 1989, that was one of the authorities that the board sought. The current language now provides that the board has the authority to utilize cost containment mechanisms that are generally available, or are being applied in the insurance industry at large, subject to the adoption of the board and the approval of the insurance commissioner. In Indiana that means the administrator, who today is Blue Cross and Blue Shield of Indiana, is very actively pursuing developing individual networks for ICHIA members in some highly concentrated geographic areas, as well as some very specialized provider communities. Lots of home health agencies deal with many of the ICHIA members who are chronically ill, and there was an attempt to develop some relationships with those people, separate and apart from the Blue Cross networks. The Blue Cross contract with its providers in Indiana extends those prices negotiated to all of the accounts that are administered by Blue Cross and Blue Shield of Indiana, so automatically ICHIA got the benefits. There are other cost containment mechanisms that are in the process of being suggested to the board and adopted. They always had the opportunity to request second surgical opinions and such, and they had developed a list where they did in certain circumstances, and didn't in others. Did I answer your question?

MR. J.W. MORAN: Yes. Do you perceive that Indiana has lagged seriously behind other states in terms of the degree of use of provider networks and utilization controls on their risk pools?

MS. DUDLEY: I think a fair answer to your question might be prior to 1989, yes, because they didn't have the statutory authority to do so. While there might have been some frustration in this regard, there was no movement made in that direction because it was legally impossible. They're trying to catch up, now, clearly.

MR. MASSINGILL: In Washington I would characterize the level of managed health care as being, at best, moderately managed. That's probably an exaggeration. I would characterize the provider reimbursement as being straight fee-for-service. There's been no provider negotiations for other than fee-for-service, and so it's, at best, a moderately managed fee-for-service plan which, as you're saying, is a very costly one.

MS. DUDLEY: Let me also add that once the law changed in 1989 and Blue Cross and Blue Shield of Indiana began being the ICHIA administrator, their phones were ringing off the hook with complaints from individuals who had been members for three, four or five years, who were accustomed to the claim submitted being the claim that was paid. It was a real learning curve for them to understand that they were now in an environment where there was going to be managed care. They didn't like it a lot, and many of them went to their legislators. Fortunately, we had already covered that base with the legislators. The legislators understood that for ICHIA to remain fiscally viable, it had to begin using the mechanisms that the insurance industry and the HMOs in the state were actively using to hold down claims costs. But there was a real uproar, and the ICHIA administrator had to add additional lines because they had angry claimants on the phone constantly; hopefully, we'll derive the benefits ultimately in a fiscal sense.

MS. JOAN P. OGDEN: Utah has just adopted legislation which will provide for a similar kind of pool. They are going to be administering it through a staff model delivery system using health centers as the staff model system. They are also going to be providing an alternate choice of traditional comprehensive major medical high deductible. My question is, has any state experienced this sort of thing? I'm going to have to do the rating for this. The second question is that Utah also has funded this from the general fund to an amount of $3 million each year. The question here is their intent to limit enrollment by disease type; has any other state approached that?

MS. DUDLEY: Good luck, Joan.

MR. D.W. MORAN: It's a mystery.

MR. SUTTON: I'd like to catch up on a couple of the earlier questions; first of all, Minnesota and managed care. About 70% of the enrollment in our high risk pool is from rural areas where there's very little chance at the moment of doing managed care. It doesn't mean that the Blues couldn't have used their limited discounts through their network if the law permitted it. In the 1989 legislative session, the insurance commissioner had circulated proposals for a payroll tax of $.50 a month per employee. The big employers who were self insured and weren't paying anything, of course, were attacked frontally. Everything got into a mess, and the commissioner wrote to every member of the ICHIA program saying that the big employers wanted to raise premiums, and take away their choice of provider. They all called the legislature and the governor vetoed any bill that came out of there. There was a bill that came out trying to manage the care, but there were so many complaints that he vetoed the bill. This year, they can't get by abortions, so nothing will happen.

MS. DUDLEY: Political reality plays a great deal in what ultimately comes out. In answer to a previous question about broadening the base, an employee payroll tax in Indiana would probably face exactly the same kind of reaction that it got in Minnesota. The employer community, and particularly the small employer community, is a very effective lobby base, and would do lots of things to try to prevent the bill's passage, or to secure its veto should it pass. While the ideal may be running in this direction, many of the things that ultimately result are compromises that result from the political reality.