2009 Fall National Meeting
Washington, DC
HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Wednesday, September 23, 2009
8:30 – 10:00 a.m.
Gaylord Convention Center—Maryland Ballroom A—Ballroom Level

Sandy Praeger, Chair	Kansas
Joel Ario, Vice Chair	Pennsylvania
Marcy Morrison	Colorado
Kevin McCarty	Florida
Michael T. McRaith	Illinois
Carol Cutter	Indiana
Ralph S. Tyler III	Maryland
Monica Lindeen	Montana
Morris J. Chavez	New Mexico
Kim Holland	Oklahoma
Kent Michie	Utah
Paulette Thabault	Vermont
Jane L. Cline	West Virginia

AGENDA

1. **Roll Call**

2. **NASCHIP Discussion and Presentation on State High Risk Pools and Health Care Reform** – *Vernita Bridges-McMurtrey (Missouri risk pool) and Richard Popper (Maryland risk pool)* (15 minutes)

3. **Consider Adoption of 2010 Charges**—*Commissioner Praeger (KS)* (10 minutes)

4. **Legislative Update**—*Brian Webb (NAIC) and Josh Goldberg (NAIC)* (15 minutes)

5. **Health Care Reform Update and Discussion**—*Commissioner Praeger (KS)* (15 minutes)

6. **Briefing on Wisconsin Autism Law**—*Commissioner Dilweg (WI)* (10 minutes)

7. **Consider Adoption of Committee Task Force Reports** –
   - Regulatory Framework Task Force—*Commissioner Kipper (NV)* (10 minutes)
   - Senior Issues Task Force—*Commissioner McCarty/Mary Beth Senkewicz (FL)* (10 minutes)

8. **Consider Adoption of Accident and Health Working Group of the Life and Health Actuarial Task Force**—*Steve Ostlund (AL)* (5 minutes)

9. **Any Other Matters Brought Before the Committee** (5 minutes)

10. Adjournment

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NASCHIP Health Reform Transition Proposal

Vernita McMurtrey & Richard Popper

September 23, 2009

35 States have High Risk Pools

- Currently offer comprehensive coverage to those denied individual coverage, or who have HIPAA or Health Coverage Tax Credit (HCTC) guaranteed-issue coverage
  - 28% of risk pool enrollment due to HIPAA eligibility
- Most premiums set at 110 to 150% of standard underwritten market rates. Premiums only cover 54% of plan costs.
- Pools expend $2 billion in annual claims costs for 200,000 plan participants
- Funded by insurance carrier assessments, hospital assessments, special or general fund revenues
- 12 risk pools discount premiums based on income
- 9 new state risk pools established in past 10 years
- Average household income of participants: $41,000

Risk Pools – Background Info

- Today, risk pools function like “special needs plans” for individuals who are cannot obtain coverage in the private market
- Benefits provided by state risk pools are much more extensive than what is available in the individual market.
  - For example, in one state, typical private coverage in the individual market limits pharmacy benefits to $500 annually whereas coverage through the state risk pool covers $100,000 in annual pharmacy benefits. For individuals with health conditions who rely on medications that can cost thousands of dollars a month, the risk pool’s slightly higher premium is a bargain when you consider that the pool only charges a $20 to $30 co-payment for these expensive drugs. Coverage for the drugs may not be available in the private market. If it is, the cost-sharing can be as much as half of the cost of the drug.
  - Some risk pools also provide supplemental Medicare coverage that helps seniors with very high out-of-pocket costs, such as the Part D “donut hole” (the senior pays only a modest co-pay).

Proposal

- **Summary**
  - Provide at least $6 billion in new annual federal funding to state high risk pools to provide health insurance coverage to hundreds of thousands of vulnerable Americans during the transition period between enactment and implementation of health reforms
  - New grants would operate similar to the subsidies proposed in the major health reform mechanisms in the House and Senate legislation, except the grants would provide subsidies both to make premiums more affordable and to cover the high losses incurred by state risk pools (risk pools pay out more in claims than they take in revenues)

Risk Pool's Federal Reform Proposal

- Problem addressed by proposal:
  - Health insurance reforms (guaranteed issue, no pre-ex, etc.) go into effect 2010 but subsidies and coverage requirements don't take effect until 2013
  - Americans with poor health status cannot be denied a policy from 2010+ but products currently available likely won't meet their needs (e.g., annual drug benefit = $500)
  - Policies with better coverage may be too expensive until subsidies are available

Proposal

- 1.3 million (3%) uninsured Americans report they are in poor health
  - Option 1
    - Double risk pool enrollment (to approx. 400,000 individuals) with $800 million to $2 billion in annual new federal funding
  - Option 2
    - Quadruple risk pool enrollment (to approx. 800,000 individuals with $6 billion in annual new federal funding

Proposal

- New “Interim High Risk Coverage Expansion Grants” could be used by state risk pools to:
  - Re-open closed risk pools or those with a current waiting list risk pools, including Florida, California, and Illinois;
  - Reduce premiums in other available risk pools, either through across the board rate reductions, and/or the establishment or expansion of income subsidy programs for limited income pool members; or
  - Expand coverage to individuals accessing care through risk pools by reducing deductibles, copay/coinsurance requirements, pre-existing condition exclusion periods, and increasing annual benefit limitations on prescription drug or medical care.

Proposal

- Grants could be allocated according to a formula that takes into account:
  - The number of uninsured in each state
  - The percentage of uninsured in state
  - state pool enrollment
  - state pool losses
- Grant funds could be allocated in FY10 and FY11 regardless of prior plan losses. However, it may make sense to allocate 50% of grants for FY12 based on FY10 losses, and 75% of grants for FY13 could be allocated based on FY11 losses.

Proposal

- For states without high risk pools, the funding formula could take into account the number of HIPAA-eligible individuals in lieu of state pool enrollment and losses.
- As a condition for receipt of grant funds, a “maintenance of effort” requirement could be imposed on plan assessment formulas, based on annual assessment levels in place for the pool’s 2009 fiscal year.

Proposal

- With additional federal subsidies, risk pools can also reduce their premiums to provide more affordable health coverage to certain groups not addressed in the recent American Recovery & Reinvestment Act, including:
  - Unemployed uninsurable individuals, who are not eligible for the new federal COBRA subsidy because of when they lost their job, the break up or bankruptcy of employer, or health plan
  - Uninsurable individuals whose current employer does not offer coverage or are self employed;
  - Chronically ill uninsurable individuals currently unable to afford pool coverage due to the cost of premiums and limited state subsidies; and,
  - Individuals on Social Security disability during their two-year waiting period for Medicare eligibility.

Proposal

- In addition to expanding coverage to those most in need of health insurance, Interim High Risk Coverage Expansion Grants would:
  - Reduce the uncompensated care cost that high risk uninsured individuals impose directly on both health care providers, and indirectly on insured individuals through provider cost shifting
  - Allow a greater number of high risk pool uninsured individuals to receive cost saving preventive and chronic disease treatment care starting in 2010, rather than later in 2013 and 2014 when proposed market reforms and subsidies begin to be implemented
  - Maintain the affordability of individual market rates, since individual rates are significantly lower in states with state high risk pools compared to states without such pools.

Proposal

- Expanded risk pool funding is warranted in part because of the lack of funding for covering federally mandated HIPAA-eligibles, who are 28% of risk pool members.
  - Congress has never provided full funding to states for covering HIPAA-eligible individuals which Congress mandated in 1996.
  - As a result, most state high risk pools have had to dedicate existing funding to cover HIPAA-eligible individuals, limiting the resources available to provide coverage to other individuals with medical conditions that make them uninsurable in the private market.
  - Furthermore, individuals who have lost coverage because their company has gone out of business cannot take advantage of subsidies for COBRA continuation coverage.

Proposal

- Proposal appears to have some support from President Obama:
  - **"Immediately offers new, low-cost coverage through a national 'high risk' pool to protect people with pre-existing conditions from financial ruin until the new Exchange is created.** For those Americans who cannot get insurance coverage today because of a pre-existing condition, the President's plan will immediately make available coverage without a mark-up due to their health condition. This policy will offer protection against financial ruin until a wider array of choices become available in the new exchange in 2013."

Source: http://www.whitehouse.gov/issues/health_care/plan/

Proposal

- Proposal appears to have some support from Senate Finance:
  - ***"High Risk Pools*****.** In 2010, the proposal would increase funding for state high risk pools, so long as the funds are not used to replace current premium assessments and are not distributed to high risk pools that have a waiting list."

Source: Senate Finance Committee, "Framework for Comprehensive Health Reform"

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