Washington State Health Insurance Pool

A Study of
Eligibility Standards for Pool Coverage

December 1, 2007

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Executive Summary

About This Study

Leif Associates, Inc., a health care actuarial consulting firm, was engaged by the Washington State Health Insurance Pool to perform a study of the pool's eligibility requirements. This study was initiated due to the passage in the 2007 legislative session of Senate Bill 5930, which contained the requirement stated below in RCW 48.41.100 (4):

> ***The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining the eight percent eligibility threshold, eligibility for Medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.***

Historical Information

- After the implementation of major insurance reforms in 1993, including guaranteed issue of individual health insurance, the individual market deteriorated and individual insurance was no longer available to new applicants in Washington.
- In 2000, a public policy group was formed to find a compromise position that would bring individual insurers back into the market. The group reached consensus regarding the use of a Standard Health Questionnaire that would allow rejection of the 8% most costly to treat applicants.
- Implementation of the new underwriting approach led to a re-opening of the individual insurance market in Washington. As of December 2006, there were approximately 264,000 lives covered in the Washington individual market by 72 individual carriers. The ten largest carriers cover approximately 98% of the lives.
- Subsequent to the 2000 implementation of the new individual insurance laws, WSHIP enrollment grew from about 1,000 lives to approximately 3,300 lives.

Key Findings

The Standard Health Questionnaire

- Washington is unique in its use of a standard health questionnaire. States without guarantee issue requirements allow individual carriers to determine their own medical underwriting criteria. Such was the case in Washington prior to the 1994 implementation of guarantee issue, when carriers rejected on average 15% to 20% of applicants for individual insurance.
- Implementation of the Standard Health Questionnaire with an 8% rejection threshold has led to higher rates in the individual market than if carriers could use their own underwriting criteria, because the rejection rate would likely be higher than 8%. For example, individual rates in Oregon, which uses a traditional medical underwriting approach, are approximately 17% lower on average than individual rates in Washington.
- High-risk pool rates are based on standard risk rates. If the rates for standard risks in the individual market are high, the high-risk pool rates will also be high. The high-risk pool rates in Washington are higher than in many other states. We looked at seven states and found

that WSHIP's rates were 16% higher than the average high-risk pool rate for comparable plans and multipliers.

- Because the WSHIP premiums are not adequate to cover the costs of the program, additional funding comes from the health insurance carrier assessments. The assessments have been in the range of $28 million to $38 million in the past three years. The assessments have added $0.81 to $1.06 per member per month to the cost of health insurance in Washington.

The 8% Rejection Threshold

- There were approximately 267,000 individuals in the individual market in Washington in 2006, including 2,400 in WSHIP's non-Medicare plans.
- The 8% most costly to treat of the 267,000 individuals had annual medical claims of at least $6,031 and total annual claims averaging $22,547. The total claims of these 21,360 persons were estimated to be $481 million in 2006.
- If the 8% threshold were decreased, it would affect the number of persons in the individual market and the cost of individual insurance. For example, a change to a 4% threshold would add 10,680 people to the individual market with insurance claim costs of about $64.5 million. Because these new entrants would be less healthy than the average individual, a rate increase for all individual insureds of about 10% would be required. The 10% rate increase would likely result in a loss of about 15,000 individuals who would drop coverage due to affordability issues. Thus there would be a net loss in the number insured and the costs would be higher for those who remained.
- If the 8% threshold were increased, it would also affect the number of persons insured and the cost of insurance. For example, a change to a 12% threshold would reduce the number of individuals in the individual market by 10,680, along with $35 million in claim costs. This would reduce overall costs for the individual insurance market by about 6%. A 6% decrease in cost could potentially bring an additional 8,300 individuals into the individual insurance market.

WSHIP Enrollment, Premium Levels, and Assessments

- In 2006, there were approximately 2,400 individuals enrolled in WSHIP's non-Medicare plans. This represents about 11% of the 21,360 individuals estimated to have health costs that exceed the 8% threshold. The average annual claim payment for the WSHIP enrollees was $16,748.
- If the 8% threshold were decreased, the number of WSHIP enrollees would decline but those remaining would have a much worse health profile. For example, a change to a 4% threshold would reduce the number of WSHIP enrollees from 2,400 to about 1,100, but their average annual claims would increase from $16,800 to about $27,000. WSHIP rates would be increased by the same 10% as required by the individual market.
- If the 8% threshold were increased, the number of WSHIP enrollees would increase and the overall health profile of WSHIP members would improve. For example, a change to a 12% threshold would increase the number of WSHIP enrollees from 2,400 to about 3,700. Average claims would be reduced from $16,800 to about $12,300. WSHIP rates would be decreased by the same 6% as required by the individual market.

- It appears that the threshold level does not have an appreciable effect on the amount of assessments required, due to the offsetting impacts of membership and average claims costs.

Publicly Sponsored WSHIP Enrollees

- Publicly sponsored enrollees account for approximately 23% of WSHIP's membership. These members have a slightly worse than average health profile, accounting for 26% of WSHIP's claims.
- There are three sponsoring organizations: Evergreen Health Insurance Program, Northwest Kidney Centers, and the Department of Social & Health Services.
- The members sponsored by the Evergreen Health Insurance Program are HIV/AIDS patients and make up about 20% of WSHIP's membership. Their medical claims are comparatively low while their pharmacy claims are quite high. Funding comes from a combination of state and federal funds. Federal funds come from the AIDS Drug Assistance Program (ADAP).
- Northwest Kidney Centers is a non-profit independent dialysis organization that sponsors about 35 WSHIP members with kidney failure. About 90% of the enrollees are Medicare-eligible. Medical claims per member per month are high compared to other WSHIP members, but the pharmacy claims are lower. Funding comes from both state and federal funds.
- The Department of Social & Health Services (DSHS) sponsors about 30 Medicaid-eligible WSHIP members, about half of whom have a diagnosis of HIV/AIDS. The cost of these enrollees is very high, averaging over $4,000 per member per month in 2006. In 2006, one of these enrollees met the $1 million WSHIP lifetime maximum.
- The overall impact of the publicly sponsored WSHIP enrollees in 2006 was to increase insurance company assessments by about $8.4 million. This translates to approximately $0.24 per member per month added to commercial insurance costs.
- We suggest that consideration be given to whether it is appropriate for publicly funded organizations and medical providers be allowed to enrollee members in WSHIP. Of the 33 other states with high-risk pools similar to WSHIP, over half prohibit or limit the payment of premiums by persons or organizations other than the enrollee and family members. The purpose of those restrictions is to prevent persons or organizations from benefiting financially or from shifting costs from public programs to the private sector.

More information about these topics can be found in the following sections of this report.

Background Information

The Washington State Health Insurance Pool (WSHIP) was created in 1987 by legislation known as the Washington State Health Insurance Coverage Access Act. The purpose of the legislation was to provide access to health insurance coverage to all residents of Washington who are denied health insurance. The intent, as stated in the law, was to provide a mechanism to ensure the availability of comprehensive health insurance to persons unable to obtain insurance coverage on either an individual or group basis directly under any health plan. By the end of 1993, WSHIP provided health insurance coverage to over 4,000 individuals.

In 1993, the Washington State legislature enacted the Washington Health Services Act. This law represented significant health insurance reform intended to guarantee universal access to health care for all Washington residents. It required defined health insurance benefits, caps on insurance premiums, and employer and individual mandates. The reforms were to be phased in gradually through 1999. However, many private health insurers pulled out of the state during the implementation period, leaving only a few insurers offering individual health insurance, some of whom closed their individual business to new applicants. Insurance rates began to rise rapidly. Portions of the law were repealed in 1995 but the guarantee issue requirements remained.

Many of WSHIP's enrollees left WSHIP beginning in 1994 and purchased coverage from individual carriers at significantly lower rates before these carriers closed their individual plans to new applicants. WSHIP enrollment fell 70%, from over 4,000 members at the end of 1993 to approximately 1,300 one year later. WSHIP enrollment dropped further over the next two years and then remained at around 800 members until 1999.

In 1999, new legislation was passed that allowed medical underwriting through the use of a Standard Health Questionnaire. According to the law, the questionnaire must provide for an objective evaluation of an individual's health status and be designed such that it is reasonably expected to identify the 8% of persons who are the most costly to treat. Applicants for individual insurance coverage who are not accepted by an insurer based on the results of the Standard Health Questionnaire are eligible for WSHIP.

As a result of the new legislation allowing insurance carriers to use medical underwriting and requiring the use of the Standard Health Questionnaire, WSHIP enrollment increased. Enrollment rose to over 1,000 by the end of 1999 and more than doubled during the following year. Subsequent membership has grown gradually and had reached nearly 3,400 in September 2007.

The complete statutory wording of WSHIP's eligibility requirements can be found in Appendix I.

The Rejection Threshold

Background

Before 1994 carriers marketing individual health insurance in the state of Washington could medically underwrite applicants. This means they could ask questions about the applicant's health conditions and choose to either accept or reject the individual for coverage, based on the carrier's own underwriting practices. Carriers could also exclude certain services or require waiting periods or exclusions for certain health conditions. Because carriers had their own medical underwriting criteria, they were able to define the risk profile they were willing to accept, which enabled them to achieve the rate level and profit margin they required from the individual market. Each carrier's desired risk profile for an individual policyholder was different, and this was reflected in the rate levels they charged. These provisions provided for competition in the market place as well as choice among many benefit plans for those who were accepted through a carrier's medical underwriting criteria.

In 1994, the health insurance reforms previously described became effective and significantly transformed the individual market. Among the various reforms, the ability of carriers to medically underwrite applicants was eliminated, so that any applicant must be accepted for coverage. Because a provision requiring individuals to purchase coverage was not implemented, individuals could come and go from the individual market as they needed health care services. This violated one of the basic principles of insurance, that insurance should be designed to provide coverage for unforeseen future events in order to provide funds to cover the cost of those events should they occur. The effect on the market was devastating. Within two years, most commercial carriers withdrew from doing business in Washington State. The locally domiciled carriers closed their individual business to new applicants.

Carriers had two significant financial incentives to close their individual lines of business and not accept new guarantee issue applicants. First, carriers could minimize losses that would occur from accepting new high-risk guarantee issue applicants. Second, they would protect their existing enrollees from higher future rate increases that would result from accepting the new high-risk applicants, thus hopefully maintaining affordable coverage for their existing policyholders.

History of the 8% Threshold

Because the individual insurance market in Washington had deteriorated and new individual applicants had few if any choices, state government officials and the insurance industry began talks in 1999 in an effort to find a compromise position that would improve the situation. A public policy group was formed by the House and Senate Health Care Committees with both Democratic and Republicans members. This group consisted of a variety of stakeholders, such as carriers, employers, providers and consumers. The size of the group ranged from 5 to 50 depending on the stage of the development process. There was no single advocacy group that had controlling power over the negotiations. The power between the groups was fairly evenly distributed, according to sources that were part of the group at that time.

The group identified certain principles which were considered essential for reaching a consensus, including the following:

- For carriers to reenter the individual market, they needed to have the ability to maintain a financially sound self-supporting individual block of business.
- In order to have a financially sound individual insurance market, the fundamental principles of insurance had to operate. One key principle was for the carriers to have a

mechanism to reasonably predict risk, through the application of medical underwriting for new applicants.

- Based on consumer advocacy group input, a consensus was reached on portability rules, preexisting conditions, and minimum benefit mandates.

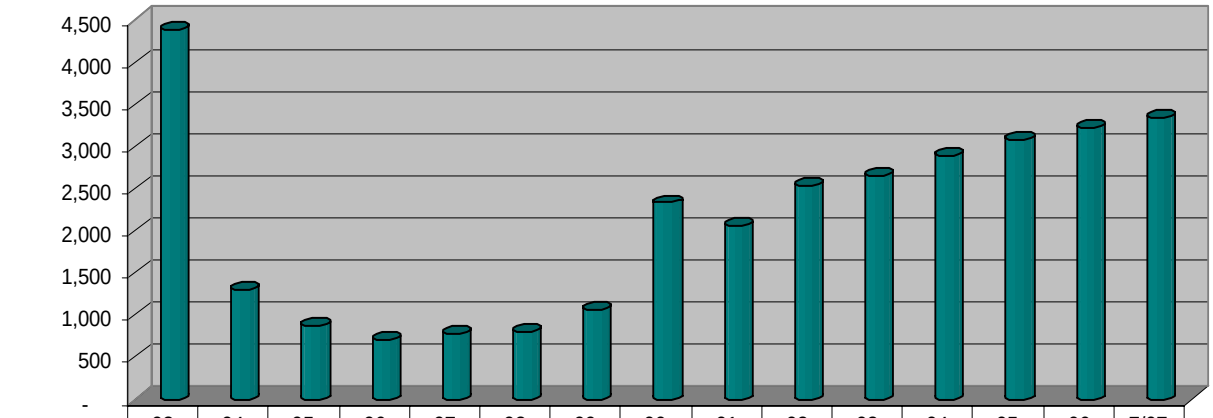
Carriers reported that prior to 1994 they had applicant rejection rates in the range of 15% to 20%. Through a process of negotiation, the public policy group reached consensus that an 8% rejection rate would be allowed. The methodology required the use of a Standard Health Questionnaire to identify the 8% of applicants that were the most costly to treat. All carriers would be required to use the same questionnaire and follow the same underwriting rules. To ensure carriers could not be arbitrary in their underwriting decisions, the Standard Health Questionnaire would use a point system based on specific diagnoses and conditions. The public policy group worked with consulting actuaries from Milliman USA (then known as Milliman & Robertson) for the initial development of the SHQ and point system. The new underwriting approach was implemented in 2000.

Applicants for individual coverage who were rejected by the individual carriers because they were part of the 8% most costly applicants would be able to secure coverage through WSHIP. In order to keep WSHIP relatively affordable, funding from sources in addition to premiums was required. This explicit subsidy comes from assessments on health insurance carriers. The result was and is an open market, where new products are continuing to emerge to satisfy the needs of individual consumers.

In December 2006, there were approximately 264,000 lives covered in the Washington individual market by 72 individual insurance carriers. The ten largest carriers cover approximately 98% of the lives.

Impact on WSHIP Enrollment

Implementation of the Standard Health Questionnaire with an 8% rejection threshold had, as expected, a significant impact on WSHIP enrollment. The table below shows WSHIP enrollment from 1993 through July 2007.



	93	94	95	96	97	98	99	00	01	02	03	04	05	06	7/07
Enrollment	4,387	1,307	862	712	766	808	1,065	2,333	2,062	2,532	2,652	2,889	3,087	3,226	3,348

It can be clearly seen from this chart how the WSHIP membership dropped dramatically when the reforms were implemented in 1994, remained low until 2000 when the Standard Health

Questionnaire was implemented, and has grown gradually since that time. However, the pool has not yet reached its pre-reform enrollment level.

In addition to comprehensive plans, WSHIP offers a plan that provides supplemental coverage for persons who are covered by Medicare, both over and under age 65. It should be noted that Medicare Supplement coverage is not subject to the guarantee issue rules and does not require use of the Standard Health Questionnaire. The WSHIP enrollment during the years when guarantee issue was in effect (1994 through 1999) was primarily made up of persons who were Medicare-eligible. Of the 3,348 members enrolled in WSHIP in July 2007, 902 were in plans designed for Medicare-eligible individuals.

Impact on Washington Individual Market Rates

Prior to the implementation of insurance reform in 1994, carriers rejected 15% to 20% of applicants for individual insurance and accepted some applicants with a rider either limiting or excluding coverage for a certain condition. Starting in 2000, the individual carriers were limited in their ability to reject individuals who would have been rejected in the absence of the Standard Health Questionnaire prior to 1994. Because of the mandatory 8% threshold, one could conclude that since 2000, carriers have been accepting a higher risk applicant than they were prior to the 1994 reforms. It follows that this resulted in higher rates than if the carriers were still rejecting 15% to 20% of the applicants.

The State of Washington is unique in its use of the Standard Health Questionnaire. States without guarantee issue requirements allow individual carriers to determine their own medical underwriting criteria and accept or reject applicants according to their own strategic objectives. In order to gauge whether individual rates in Washington are higher than in other states, we compared Washington rates to those in Oregon and Idaho. We chose these states because of their geographic proximity to Washington as well as the different models they employ to handle high-risk individuals.

Oregon has a traditional high-risk pool and no state laws requiring guarantee issue of individual coverage. Persons who have been refused individual health benefit coverage due to health reasons are eligible for the pool. In order to perform a comparison of the Washington individual market rates to those in Oregon, we secured the rates from the two largest individual carriers in each state. We selected a common benefit plan ($1,000 deductible with similar coinsurance) and blended the 2007 rates for the two largest carriers in each state using membership as the weight. We then compared the blended Oregon rates to the comparable rates in Washington. The comparison revealed that Oregon rates were lower than Washington rates at all ages, ranging from 6% to 27% lower at different ages. When weighted by the Washington population demographics, the Oregon individual rates are on average about 17% lower than Washington rates.

Idaho requires every individual carrier to guarantee issue to all individuals. They also have a high-risk pool, but unlike traditional risk pools, the Idaho pool is a reinsurance pool. Individuals are eligible for the high-risk reinsurance plans if they are HIPAA-eligible or if the carrier is unwilling to offer the individual coverage under one of their regular plans. The pool does not reimburse a carrier until the carrier has incurred an initial level of claims for an individual of $5,000 in a calendar year. The carrier is then responsible for 10% of the next $25,000 of benefit payments during a calendar year and the pool fully reinsures the remaining eligible claims expense. The relationship between the insurer and the enrollee is maintained by having the carriers underwrite the high-risk pool plans. In order to perform a comparison of the Washington individual market rates to those in Idaho, we followed a similar process as used with Oregon. We secured the rates from the two largest individual carriers in the state. We selected a common benefit plan ($1,000 deductible with similar coinsurance) and blended the 2007 rates for the two

carriers in each state using premium volume. We then compared the blended Idaho rates to the comparable rates in Washington. The comparison revealed that Idaho rates were higher than Washington rates at most ages, ranging from -1% to +21% at different ages. When weighted by the Washington population demographics, the Idaho individual rates are on average about 9% higher than Washington rates. The following table summarizes the individual rate comparison for the three states.

State	*Individual Market Structure*	*Individual Market Rates Compared to Washington*
Oregon	Medical Underwriting	-17%
Washington	Medical Underwriting with Standard Health Questionnaire and 8% Threshold	
Idaho	Guarantee Issue with Reinsurance Pool	+9%

There are many other factors that impact the level of individual rates in a state besides the market structure, such as geographic differences in provider reimbursement, provider practice patterns, demographic characteristics, and state insurance laws. We believe that the difference in market structure accounts for some portion of the difference in individual rates between the three states but it is not possible to determine how much is attributable to that factor.

Impact on WSHIP Rates

The typical way of developing high-risk pool rates is to first determine the average rate in the individual market for a standard risk individual and then multiply that standard risk rate by a factor greater than 1.00 to partially account for the higher expected cost of the high-risk individual. Because of this formula, if the individual market rates are high, the high-risk pool rates will follow.

The state of Washington uses this standard risk rate approach and a multiplier of 1.10 for most of its policyholders. The 1.10 multiplier is the minimum allowed by Washington law. The maximum allowed is 1.25 or 1.50, depending on the type of plan.

In order to determine how WSHIP's rates compare with other state high-risk pools, we compared the January 2007 WSHIP $1,000 deductible PPO rates to the rates of comparable plans of six other state high-risk pools. The six states we selected were Oregon, Idaho, Utah, Colorado, New Mexico and Nebraska. We chose these states because of their geographic proximity to Washington or because they are some of the older high-risk pools and we have a good knowledge of their rating practices.

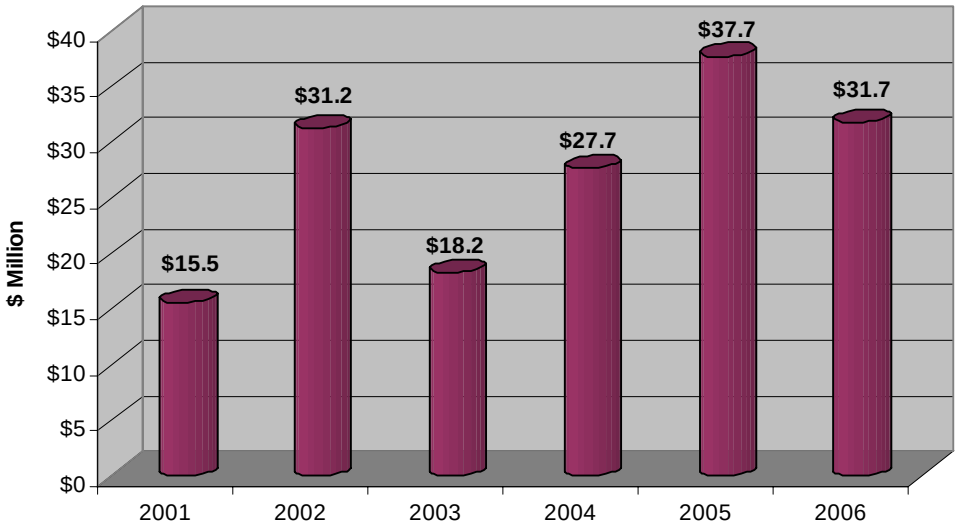
We calculated an average rate for a comparable plan design for each state and then normalized the rate to Washington's 110% standard risk rate multiplier. The following table shows how the rates compare to WSHIP's rates, with the WSHIP rate set at 100%.

State	*High-Risk Pool Rate Compared to WSHIP*
New Mexico	58%
Oregon	59%
Colorado	82%
Utah	89%
Idaho	95%
Washington	100%
Nebraska	119%
Average	86%

These rate relativities do not account for variances in different state trends, benefit mandates, administrative loads, regulatory requirements and the core operating structure of each pool. However, it can easily be seen that WSHIP's rates are at the high end of the range of rates for the comparison group. On average, WSHIP's rates are about 16% higher than the average rate for these seven high-risk pools.

Carrier Assessments

Because setting high-risk pool rates at a self-supporting rate level would result in unaffordable rates, the cost of the pools must be subsidized from another source. In Washington, that source is assessments on health insurance carriers. The history of carrier assessments for the past six years is shown in the following table.



Assessments on health insurance carriers are passed on to persons purchasing health insurance. In the past three years, the assessments have added between $0.81 and $1.06 per member per month to the cost of health insurance in Washington.

Changing The Threshold

The Theoretical Impact of Moving to a Different Threshold

It appears from our review that the choice of 8% as the rejection threshold was based on negotiations. It is approximately half way between the pre-1994 reform rejection ratio of 15% to 20% and the 1994 rejection ratio of 0%. The chosen rejection ratio impacts the rates and enrollment in the individual market as well as in WSHIP. In order to examine the 8% threshold, we have evaluated the potential impact of moving to a different threshold, either higher or lower. The following paragraphs describe the theoretical impacts of moving to a different threshold.

Individual Market Premium Levels and Enrollment

Increasing the rejection threshold to a higher percentage would result in fewer individuals being covered in the individual market because more applicants would be rejected for health reasons. The rates in the individual market would be lower, because the overall health status of individually insured persons would be improved. As a result, the loss of members due to higher rejection rates would be partially offset by new entrants into the individual market who previously could not afford the premium.

Reducing the rejection threshold to a lower percentage would result in more individuals being covered in the individual market because fewer applicants would be rejected for health reasons. The rates in the individual market would be higher, because the overall health status of individually insured persons would be worse. As a result, the increase in membership due to lower rejection rates would be partially offset by the loss of individual policyholders who could no longer afford the premium.

WSHIP Premium Levels and Enrollment

Increasing the rejection threshold to a higher percentage would result in more individuals being eligible for WSHIP because carriers would reject more applicants. The rates in the individual market would be lower, and because WSHIP rates are a multiple of individual market rates, the WSHIP rates would also be lower. As a result, WSHIP enrollment would grow.

Reducing the rejection threshold to a lower percentage would result in fewer individuals being eligible for WSHIP because individual carriers would reject fewer applicants. The rates in the individual market would be higher, and because WSHIP rates are a multiple of individual market rates, the WSHIP rates would also be higher. As a result, WSHIP enrollment would decline.

Assessments

The impact on carrier assessments from changing the underwriting threshold is not clear from a theoretical standpoint. While there would be fewer WSHIP enrollees with a lower threshold, those individuals would have higher average health care costs. Similarly, with a higher threshold, there would be more WSHIP enrollees with lower average health care costs. In both cases, the membership change and health care cost difference would be at least partially offsetting.

Estimates of the Financial Impact of Moving to a Different Threshold

We evaluated the impact of moving the current 8% threshold to alternate levels. The levels we chose were 4%, 6%, 10%, and 12%. The goal of the analysis was to estimate how a movement

to one of these alternate thresholds would impact membership and rates for the individual market and WSHIP, as well as carrier assessments.

Reden & Anders, the consulting firm performing the re-certification of the Standard Health Questionnaire for the period beginning April 1, 2008, provided information regarding individual market claims in 2006 for thresholds of 4%, 6%, 8%, 10%, and 12%.

Summary Information

The following table shows the estimated number of persons who met the various threshold levels in 2006, as well as the magnitude of their claims.

TABLE 1

Percent Threshold	*Dollar Threshold*	*Number of Persons*	*Estimated Average Total Costs Per Person*	*Total Costs for All Who Met Threshold*
4%	$11,066	10,680	$36,462	$389,413,000
6%	$7,909	16,020	$27,699	$443,736,000
8%	$6,031	21,360	$22,547	$481,602,000
10%	$4,760	26,700	$19,102	$510,010,000
12%	$3,884	32,040	$16,595	$531,688,000

The columns in the table above are defined as follows:

- The Percent Threshold is the percent of persons who were the most costly to treat. The current statutory threshold is 8%. The other thresholds were chosen to provide a range for analysis.
- The Dollar Threshold is the minimum total annual cost for a person who met the percent threshold. In other words, every person who reached the 8% most costly to treat threshold had medical costs of at least $6,031 during the year. Reden & Anders provided these amounts as determined from the re-certification study. This column shows that if the threshold were changed to 4%, a person reaching the threshold would have at least $11,026 in annual medical costs. At the 12% threshold, a person reaching the threshold would have at least $3,884 in annual medical costs.
- The Number of Persons meeting the threshold is simply the percent threshold times the total number of persons in the individual market. Based on the Office of the Insurance Commissioner's survey of the 2006 individual market, there were approximately 264,400 individuals covered by individual insurance in December 2006. Another 2,400 individuals were covered in WSHIP non-Medicare plans, for a total of 266,800 individual insured lives. We rounded to 267,000 for our calculations.
- The Estimated Average Total Costs Per Person includes a person's costs both above and below the threshold. Since the Reden & Anders study did not include trauma claims or pharmacy claims, we increased the amounts they provided by 15% to account for these two items.
- The Total Costs for All Who Met the Threshold is simply the number of persons who reached the threshold times the estimated average total costs per person.

Individual Market Premium Levels and Enrollment

The claims analyzed for this study were for persons currently insured either in the individual market or in WSHIP. Assuming that all currently insured individuals would retain coverage regardless of changes in cost, the potential impact of a change in the threshold on enrollment and costs is shown in the following table.

TABLE 2

Percent Threshold	*New Lives in Individual Market*	*Total Lives in Individual Market*	*Additional Health Care Costs in Individual Market*	*Additional Claims in Individual Market*	*Additional Claims PMPM*	*Potential Market Rate Adjustment*
4%	10,680	275,080	$92,189,000	$64,532,000	$19.55	+ 9.8%
6%	5,340	269,740	$37,865,000	$26,506,000	$8.19	+ 4.1%
8%	0	264,400	$0	$0	$0.00	0.0%
10%	(5,340)	259,060	($28,408,000)	($19,886,000)	($6.40)	- 3.2%
12%	(10,680)	253,720	($50,086,000)	($35,060,000)	($11.52)	- 5.8%

The table above shows how the rejection threshold influences the number of persons screened out of the individual market through use of the Standard Health Questionnaire. The table also provides some clues to the potential financial implications.

- The additional 10,680 people who would be included in the individual market if the threshold were reduced from 8% to 4% would have approximately $92 million in health care costs. Assuming that a typical individual plan design covers about 70% of health care costs, the additional claims in the market would be about $64.5 million. This translates to $19.55 per member per month for all 275,080 persons insured.
- If the threshold were raised from 8% to 12%, the 10,680 persons who would no longer be eligible for individual coverage would remove approximately $50 million in health care costs and $35 million in claims from the market, leading to a potential rate reduction of $11.52 per member per month for the remaining 253,720 persons in the individual market.
- There are two types of benefit plans available in the individual market. Comprehensive plans, which typically cover 80% of costs after a $500 or $1,000 deductible, have premiums averaging $250 to $350 per month. There has been recent membership growth in less generous plans with higher deductibles and premiums ranging from $125 to $250 per month. For purposes of calculating the potential market rate adjustment in the table above, we assumed an average current monthly rate of $200.
- According to a study performed by the Congressional Budget Office in 2005, the price elasticity of demand for individual health insurance is –0.57. For example, a 10% increase in insurance premiums is estimated to result in a 5.7% decrease in health insurance coverage. Thus, the potential decrease in total lives in the individual market as a result of reducing the threshold from 8% to 4% is expected to be approximately 5.6% of the 275,080 lives, or about 15,300 individuals who would presumably drop coverage and become uninsured. On the other hand, the potential rate reduction from increasing the threshold from 8% to 12% could potentially bring an additional 8,300 individuals into the insurance market.

WSHIP Premium Levels and Enrollment

Changing the threshold would also impact WSHIP's premium levels and enrollment. The following table shows the potential impact.

TABLE 3

Percent Threshold	*% of Eligibles Enrolled in WSHIP*	*Number of WSHIP Enrollees*	*Average Health Care Costs Per Person*	*Average Claims Per Person*	*Total WSHIP Claim Dollars*	*Average WSHIP Annual Premium*
4%	10.6%	1,133	$36,462	$27,084	$22,797,000	$6,376
6%	11.0%	1,758	$27,699	$20,575	$26,868,000	$6,048
8%	11.2%	2,400	$22,547	$16,748	$29,857,000	$5,808
10%	11.4%	3,055	$19,102	$14,189	$32,195,000	$5,622
12%	11.6%	3,718	$16,595	$12,327	$34,044,000	$5,474

The following paragraphs provide an explanation of the numbers in the table above.

- In 2006, there were approximately 2,400 individuals enrolled in WSHIP's non-Medicare plans. That represents 11.2% of the 21,360 individuals estimated to have health costs that exceed the 8% threshold.
- The percentage of those eligible who would enroll in WSHIP at different threshold levels was based on the current 11.2%, adjusted for the elasticity of demand impacts described above.
- The Average Health Care Costs Per Person are the same as those shown above in Table 1. The average claims per person of $16,748 for the 8% threshold category are the actual WSHIP average incurred claims for 2006. That amount represents 74.3% of average health care costs. The same percentage was used to determine the average claims per person in the other threshold categories.
- The Average WSHIP Annual Premium in 2006 for non-Medicare PPO coverage was $5,808. Since WSHIP rates are based on the standard market rates, the rate changes indicated for the various thresholds mirror the percent changes shown in Table 2 above.

Assessments

The impact of the various thresholds on WSHIP's 2006 assessments is shown in the following table.

TABLE 4

Percent Threshold	*WSHIP Annual Premium*	*WSHIP Annual Claims*	*WSHIP Annual Administrative Expenses*	*WSHIP Annual Losses*
4%	$7,225,000	$22,797,000	$1,102,000	$16,674,000
6%	$10,628,000	$26,868,000	$1,397,000	$17,637,000
8%	$13,939,000	$29,857,000	$1,701,000	$17,619,000
10%	$17,174,000	$32,195,000	$2,010,000	$17,031,000
12%	$20,352,000	$34,044,000	$2,323,000	$16,015,000

The numbers in the table above have been calculated as follows:

- The WSHIP Annual Premium is the average annual premium per person times the number of WSHIP enrollees from Table 3.

- The WSHIP Annual Claims are taken from Table 3.
- The WSHIP Annual Administrative Expenses for the 8% threshold category are based on the 2006 actual administrative costs per person times the number of WSHIP enrollees. For the other threshold categories, we assumed that 1/3 of the expenses are fixed and 2/3 varying with enrollment.
- The WSHIP Annual Losses column represents the amount of assessment that would be required to subsidize the program for non-Medicare eligible individuals at the various thresholds.

It appears that the threshold level does not have an appreciable effect on the amount of assessments required. With a lower threshold, there are fewer WSHIP enrollees but their health care costs are higher. With a higher threshold, there are more WSHIP enrollees but their health care costs are lower. These factors have an offsetting effect on the amount of subsidy needed. In Table 4 above, it can be seen that at both extremes the assessment amount is slightly lower than with the current 8% threshold approach.

Impact of Publicly Sponsored Enrollees

Washington statutes do not prohibit the payment of WSHIP premium on behalf of an insured by another person or organization. As of September 2007, there were 786 WSHIP members whose premiums were paid by publicly funded organizations. This represents about 23% of the total WSHIP membership. For purposes of this study, we are defining publicly sponsored enrollees as those sponsored by the Evergreen Health Insurance Program (EHIP), Northwest Kidney Centers (NKC), and the Department of Social & Health Services (DSHS).

In order to evaluate the impact of the publicly sponsored enrollees on WSHIP, we compared their claim data to that of other WSHIP members. We also looked at each of the sponsoring organizations separately. The following tables show the incurred claim experience for 2006 and the first half of 2007, with claims paid through September 2007 and an estimate of IBNR, in total and on a PMPM basis.

All WSHIP Enrollees

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	37,758	$18,250,241	$26,809,094	$22,740,496	$49,549,590	271.5%
	1H 2007	19,560	$9,489,165	$14,961,299	$11,818,032	$26,779,331	282.2%
PMPM	2006	37,758	$483	$710	$602	$1,312	271.5%
	1H 2007	19,560	$485	$765	$604	$1,369	282.2%

Publicly Sponsored Enrollees

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	8,830	$4,643,219	$4,663,484	$8,382,141	$13,045,626	281.0%
	1H 2007	4,625	$2,435,542	$2,133,150	$4,699,901	$6,833,051	280.6%
PMPM	2006	8,830	$526	$528	$848	$1,477	281.0%
	1H 2007	4,625	$527	$461	$1,016	$1,477	280.6%

All Other Enrollees

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	28,928	$13,607,022	$22,145,610	$14,358,355	$36,503,965	268.3%
	1H 2007	14,935	$7,053,623	$12,828,148	$7,118,131	$19,946,279	282.8%
PMPM	2006	28,928	$470	$766	$496	$1,262	268.3%
	1H 2007	14,935	$472	$859	$477	$1,336	282.8%

A few observations can be made from the tables above:

- While the publicly sponsored members represent approximately 23% of the members, they represent about 26% of the claims, indicating they have a slightly worse health profile than the other members.

- The publicly sponsored members have considerably lower medical claims per member per month but much greater pharmacy claims than the other members.
- The loss ratios of the publicly sponsored members are not substantially different than the other members, since their premium is higher. This could be due to their demographics or plan choices.

Sponsoring Organizations

Evergreen Health Insurance Program (EHIP)

To be eligible for this program, a person must be eligible for the Early Intervention Program (EIP), which serves people with low to moderate incomes who are living with HIV/AIDS in Washington State. Evergreen pays health insurance premiums for EIP-enrolled individuals for a variety of insurance plans, such as Medicare and individual or group policies, in addition to WSHIP.

Funding for the Evergreen Health Insurance Program comes from a combination of state and federal funds. The split between state and federal funds varies each year, with the federal funding ranging in recent years from 60% to 74% of total funding. In 2007, federal funding is 68% of total funding. The source of the federal funds is Title II of the Ryan White Comprehensive AIDS Resources Emergency Act, which funds the AIDS Drug Assistance Program (ADAP).

In September 2007, there were 723 WSHIP members sponsored by Evergreen. The following table shows the claims experience for 2006 and the first half of 2007. Claims are on an incurred basis with claims paid through September 2007 and include an estimate of IBNR.

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	7,795	$4,194,376	$2,572,309	$7,634,015	$10,206,323	243.3%
	1H 2007	4,167	$2,247,596	$1,611,270	$4,413,790	$6,025,060	268.1%
PMPM	2006	7,795	$538	$330	$979	$1,309	243.3%
	1H 2007	4,167	$539	$387	$1,059	$1,446	268.1%

This is the largest of the sponsoring organizations, accounting for about 20% of the total WSHIP membership. About 20% of the members are Medicare-eligible. Of the 80% that are not Medicare-eligible, most are in the $500 deductible PPO plan. The EHIP membership has grown at the rate of about 5 members per month over the past year, representing an annual growth rate of 9.5%. Medical claims per member per month are low compared to other WSHIP members, but the pharmacy claims are very high. The EHIP pharmacy claims represent more than a third of all WSHIP pharmacy claims.

Northwest Kidney Centers

Northwest Kidney Centers is a non-profit independent dialysis organization. They provide comprehensive treatment and support services for approximately 1,300 patients with kidney failure. Approximately 75% of their funding comes from Medicare's End-Stage Renal Disease Program. The balance comes from private insurance, Medicaid, Washington State's Kidney Disease Program, patient resources, and donations. The Kidney Disease Program is a state-funded program that helps low-income residents with the costs for treatment of end stage renal disease.

In September 2007, there were 36 WSHIP members sponsored by Northwest Kidney Centers. The following table shows the claims experience for 2006 and the first half of 2007. Claims are on an incurred basis with claims paid through September 2007 and include an estimate of IBNR.

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	500	$157,659	$470,699	$170,462	$641,161	406.7%
	1H 2007	235	$79,659	$201,253	$98,734	$299,987	376.6%
PMPM	2006	500	$315	$941	$341	$1,282	406.7%
	1H 2007	235	$339	$856	$420	$1,277	376.6%

This sponsoring organization accounts for only about 1% of the total WSHIP membership. The membership is declining, with September 2007 having 12% fewer enrollees than a year prior. Almost 90% of the enrollees are Medicare-eligible, which accounts for the lower than average premium. Medical claims per member per month are high compared to other WSHIP members, but the pharmacy claims are lower.

Department of Social & Health Services (DSHS)

The Department of Social and Health Services is the third sponsoring public entity. DSHS has a program called the Health Insurance Premium Plan (HIPP). Persons who are covered by WSHIP but are also eligible for Medicaid can apply for this program. DSHS performs an evaluation of the expected costs for the person if they were enrolled in the Medicaid fee-for-service program. This amount is compared to the WSHIP premium plus any other out-of-pocket costs such as deductibles, copays, and coinsurance for the WSHIP plan. If the costs to purchase the WSHIP coverage are less than the expected Medicaid claim payments, DSHS will pay the WSHIP premium for the member. Medicaid is funded by a combination of federal and state funds in approximately equal shares.

The following table shows the claims experience for 2006 and the first half of 2007 for the DSHS enrollees. Claims are on an incurred basis with claims paid through September 2007 and include an estimate of IBNR.

	Period	*Member Months*	*Premium*	*Medical Claims*	*Pharmacy Claims*	*Total Claims*	*Loss Ratio*
Total	2006	535	$291,184	$1,620,477	$577,665	$2,198,142	754.9%
	1H 2007	223	$108,287	$320,627	$187,377	$508,004	469.1%
PMPM	2006	535	$544	$3,029	$1,080	$4,109	754.9%
	1H 2007	223	$486	$1,438	$840	$2,278	469.1%

Approximately half of the DSHS enrollees have a diagnosis of HIV/AIDS, while the rest have a variety of serious health conditions. The claim data shown above is distorted by the fact that one DSHS member met the $1 million lifetime maximum in 2006. The number of DSHS enrollees has declined over the last few years. In January 2005, there were 59 enrollees. The enrollment has declined to 27 enrollees in September 2007. Only about 30% of the enrollees are Medicare-eligible. Of the 70% that are not Medicare-eligible, most are in the $500 deductible PPO plan.

Impact on WSHIP and the Insurance Market

Since WSHIP is primarily funded by assessments on insurance carriers, the losses experienced due to publicly sponsored enrollees is borne by the commercial insurance market. The table below shows the WSHIP financial results, with and without these enrollees.

		2006 Actual	*Without Publicly Sponsored Enrollees*
Revenue	Earned premium	$18,250,241	$13,607,022
	Excess loss ratio receipts	$717,409	$717,409
	Federal grant awards	$2,432,464	$2,432,464
	Investment income	$404,148	$404,148
	Total revenue	$21,804,262	$17,161,043
Expenses	Medical incurred claims	$26,809,094	$22,145,610
	Pharmacy incurred claims	$22,740,496	$14,358,355
	Administrative costs	$2,196,666	$2,196,666
	Total expenses	$51,746,256	$38,700,631
Net Loss		$29,941,994	$21,539,588

The comparison above indicates that publicly sponsored enrollees added approximately $8.4 million to WSHIP losses in 2006, which is about 28% of total losses. The losses are assessed to insurance carriers and passed through to insurance consumers. In 2006, there were 35.3 million member months of commercial coverage (counting stop loss lives at 1/10 as required by law). The $8.4 million in publicly sponsored enrollee cost added approximately $0.24 per member per month to commercial insurance costs.

There are 33 other states with high-risk pools similar to WSHIP. Nineteen of those states (58%) prohibit or limit the payment of premiums by persons or organizations other than the enrollee and family members. The purpose of those restrictions is to prevent persons or organizations (such as health care providers or government agencies) from benefiting financially or shifting costs from public programs to the private sector.

It should be considered whether the Northwest Kidney Centers program should be allowed to pay the premium for patients who use their services, since their investment in the premium provides a significant financial return to their organization. It should also be considered whether DSHS should be allowed to choose whether to enroll a Medicaid-eligible member in Medicaid or pay WSHIP premium. Paying the WSHIP premium for a Medicaid-eligible person results in a shift of Medicaid costs to the commercial insurance market and also results in a loss of matching federal funds.

Impact on State Budget

The impact on the state budget for the three organizations that sponsor WSHIP enrollees is noted below:

- **Evergreen Health Insurance Program**. It is clear from the analysis of EHIP's claims shown above that the medical claims of AIDS patients ($387 per month in the first half of 2007) are much more like those of a normal population than the typical WSHIP enrollee ($765 per month). The high cost of an AIDS patient comes from the cost of drugs, which average over $1,000 per month. The AIDS Drug Assistance Program (ADAP) provides funds to cover drugs for low-income AIDS patients.

The ADAP program provides funding to cover AIDS drugs for persons at or below 300% of the Federal Poverty Level (FPL). It provides funding for persons with or without insurance.

- **For persons with insurance**, the program helps pay copay costs for medications on the ADAP formulary, with copays ranging from $0 to $20. The program also covers annual deductibles up to $500 and costs during pre-existing condition period for certain services. Clients must go to providers and labs that contract with ADAP.
- **For persons without insurance**, the program helps pay for prescription costs for medications on the ADAP formulary, with a copay ranging from $0 to $70 depending on income. The program also pays for limited HIV-related provider visits and tests for certain services. Clients must go to providers and labs that contract with ADAP.

In 2006, the EHIP program paid approximately $4.2 million in premiums to WSHIP. The individuals they sponsored received $10.2 million in health care, a difference of $6 million. If the EHIP program were not allowed to pay the premiums for WSHIP members, the members could potentially have been in the ADAP program without insurance and received direct payment of their care from the program. The $6 million difference would be shared between state and federal funding. Assuming 70% federal funding, the additional cost to the state would be 30% of $6 million, or $1.8 million, if drugs were purchased at WSHIP's price levels. The increased cost to the state would likely be less than $1.8 million due to the fact that the ADAP program can purchase AIDS drugs at 340B price levels, which WSHIP cannot. 340B drug pricing is significantly lower than commercial contract drug pricing.

- **Northwest Kidney Centers**. In 2006, Northwest Kidney Centers paid $158,000 in premium to WSHIP. The individuals they sponsored received $641,000 in health care, a difference of about $483,000. Northwest Kidney Centers receives funding from the state's Kidney Disease Program, which helps low-income residents with the costs of kidney disease. The Department of Social & Health Services administers this program for persons with gross income at or below 200% of FPL. Presumably, in the absence of being able to sponsor individuals in WSHIP, the additional cost to the state for these patients would be approximately $483,000 per year, if the state's provider contracts were comparable to WSHIP's.

- **Department of Social & Health Services**. In 2006, DSHS paid $291,000 in premium to WSHIP. The individuals they sponsored received $2.2 million in health care services, a difference of $1.9 million. These individuals were eligible for Medicaid. If they had been in Medicaid, the additional cost would have been shared between state and federal funding in approximately equal share. The additional cost to the state would have been approximately $950,000, if the state's provider contracts were comparable to WSHIP's.

While the purchase of insurance with state and federal funds by these programs allows their funds to go further, the question remains as to whether spreading the high cost of care for low income individuals for whom public programs are available across the entire health insurance market in Washington is an effective and appropriate strategy.

Appendix I. WSHIP Eligibility Requirements

For informational purposes, what follows is a copy of the WSHIP eligibility for coverage provisions, which can be found at RCW 48.41.100.

(1) The following persons who are residents of this state are eligible for pool coverage:

(a) Any person who provides evidence of a carrier's decision not to accept him or her for enrollment in an individual health benefit plan as defined in RCW 48.43.005 based upon, and within ninety days of the receipt of, the results of the standard health questionnaire designated by the board and administered by health carriers under RCW 48.43.018;

(b) Any person who continues to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator pursuant to subsection (3) of this section;

(c) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool; and

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(b) Any person on whose behalf the pool has paid out one million dollars in benefits;

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(d) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(d) of this section.

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier had been offering an individual

health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in a pool plan pursuant to subsection (1)(c) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(c) of this section, but may continue to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator. The pool administrator shall offer to administer the questionnaire to each person no longer eligible for coverage under subsection (1)(c) of this section within thirty days of determining that he or she is no longer eligible;

(b) Losing eligibility for pool coverage under this subsection (3) does not affect a person's eligibility for pool coverage under subsection (1)(a), (b), or (d) of this section; and

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool.

Appendix II. Sources and Contributors

Sources

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Appendix III. Glossary of Terms and Concepts

DSHS — Department of Social & Health Services.

EHIP — Evergreen Health Insurance Program

EIP — Early Intervention Program

IBNR — Incurred but not reported. The value of the unpaid portion of incurred claims includes (1) unreported claims; (2) reported but unprocessed claims; and (3) processed but unpaid claims. When analyzing claims that were incurred in a recent period, typically it is appropriate to apply an IBNR adjustment to paid claims in order to account for claims that have not been received or processed yet.

Incurred Claims — The value of all amounts paid or payable under a health benefit plan during a defined period.

Member Months — The total sum of the number of months enrolled by each person in a population. For example, if one person was enrolled for four months and another person was enrolled for five months, they would represent a total of nine member months. This unit is the divisor of per member per month (PMPM) calculations.

NKC — Northwest Kidney Center

PMPM — Per member per month. This is a standard measurement in the health care industry that describes dollars pertaining on average to one member for one month.

SHQ — Standard Health Questionnaire. This questionnaire must generally be completed by anyone applying for individual coverage in Washington State.

Trend — A measure of a rate of change, over time, of the elements affecting costs. Claim cost trend is generally composed of unit cost trend and utilization trend. An increasing unit cost trend can be caused by an increase in the price of a particular service or by replacing a relatively inexpensive service with a more expensive one. Utilization trend is a change in the number of services performed, days spent in a facility, or a visits to a provider.

Unit Cost — The average cost of a single service performed, a day spent in a facility, or a visit to a provider.

Utilization — A count of services performed, days spent in a facility, or visits to a provider.

WSHIP — Washington State Health Insurance Pool