ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7391 SENATE HEALTH EDUCATION & SOCIAL SERVICES

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

HIAA has long-supported state uninsurable risk-pools. These risk pools are included as one of the components in our program of "Financing Health Care for All Americans." Uninsurable risk pools address accessible health coverage to those who are otherwise considered medically uninsurable. However, we have serious concerns with a number of the provisions contained in SB-74, which will result in underfunding of the program, inappropriate accessibility to the program. We strongly encourage the committee's consideration and adoption of proposed amendments reflecting the issues discussed below.

During the 1990 Alaska legislative session, then-Senator Coghill sponsored SB-304 and the Senate Labor and Commerce Committee agreed to a committee substitute for the original bill -- CSSSSB-304. The committee substitute was a result of an agreement emanating from negotiations between all interested parties. However, the amendments were provided too late for the bill to complete its journey through the legislative process last year. We encourage the committee to amend SB-74 to duplicate the previously agreed-upon version of CSSSSB-304.

Individuals with severe preexisting conditions may be ineligible to purchase insurance from the private insurance industry. A number of states have enacted uninsurable risk pools to address this need. Historical data of the loss ratios of the "mature" (longest operating) risk pools are:

Connecticut - 200 percent

Florida - Exceeded 200 percent in 1990

Indiana - Close to 200 percent in the last several years

Minnesota - Exceeded 200 percent over the last three years

North Dakota - Over 200 percent in 1986-87 and exceeded 175 percent in 1989

Wisconsin - Was the best controlled, but its loss ratio is now moving over 150 percent

These figures indicate the absolute requirement that additional funding is going to be required to cover the claim losses due to the adverse experience of the uninsurable risk pools. We strongly encourage general fund appropriations be allocated to cover these losses. However, if the committee keeps the current assessment on health insurance companies doing business in Alaska, on a pro rata earned premium basis, we strongly encourage the allowance of a credit against premium taxes imposed against disability insurers. Suggested wording of a new section of the bill to accomplish this purpose would include the following language as AS 21.09.210 (j):

> A member of the Comprehensive Disability Insurance Association created in AS21.55.010 may credit against a premium tax imposed against disability insurance premiums under this section, an amount equal to an assessment against the member under AS21.55.220(d). Any portion of the credit allowed in this subsection that cannot be taken in a tax year without reducing taxable premiums below zero may be

carried forward and credited in successive years until the credit is exhausted.

A new subparagraph should be added to Section 21.55.060 on page 3. The present paragraph should be designated as sub paragraph (a). A new subparagraph (b) should be added to read:

A member of the Association is entitled to receive a credit against taxes levied by the state on disability insurance premiums as provided in AS21.09.210(j).

The 1990 CSSSSB-304 legislation allowed for such a credit by the inclusion of the above-referenced language.

Most states with uninsurable risk pools either have the losses covered by a broad-based funding mechanism, i.e., general funding, dedicated taxes or allow a premium tax offset as mentioned above. Examples of dedicated taxes imposed by other state uninsurable risk pools include: California -- funding from cigarette and tobacco products surtax fund; Colorado -- funding by imposing a $2.00-4.00 charge on state taxpayers whose federal income tax return indicates an adjusted gross income in excess of $15,000; Louisiana -- funded by a $2.00 service charge on each admitted hospital day and $1.00 charge for admittance to an ambulatory surgery center. Fees are paid by all private payers as a medical expense; Maine -- assessment on all revenues of hospitals in the state.

An adequate premium must be charged to the insured, reflecting the increased risk that will be borne due to their

preexisting medical condition. SB-74, as proposed, permits a maximum premium of 125 percent of the average of five Association members' standard premiums for similar-type benefits. CSSSSB-304 (1990) included a 150 percent premium based on the average of an estimate of five Association members' standard premium for like-type benefits. It is our understanding that Senator Coghill and the group of interested parties had further agreed that the premium would be raised to 175-200 percent of standard risk. Most state insurance risk pool plans allow premiums greater than 125 percent. Therefore, we strongly encourage the committee to increase the premiums to 200 percent of the average of five Association members' plans. Even with a 200 percent premium, the claims experience of these uninsurable individuals will be inadequate to cover all the claims losses.

Deductibles are a mechanism to reduce the cost of the insurance policy premium to the purchaser. CSSSSB-304 called for two alternative deductibles: $1,000 and $5,000. SB-74 has substantially reduced deductibles -- $200, $500 and $1,000. Today, the average private sector deductible for standard policies is considerably higher than $200. In addition, many state uninsurable pools have deductibles substantially greater than those proposed in SB-74. We request the committee consider increasing the deductible to a more appropriate level such as those proposed in last year's CSSSSB-304.

Unlike CSSSSB-304, SB-74 includes Medicare-eligible persons within the uninsurable risk pool, allowing the pool to act as a Medicare supplement plan. We oppose this inclusion, as the

purpose of the uninsurable risk pool is to provide coverage for those without any insurance. People covered under Medicare have coverage and are also eligible to purchase Medicare supplement insurance. Medicare supplement policies are available in Alaska. Congress included in the Omnibus Budget Reconciliation Act of 1990 -- P.L.101-508 -- that Medicare supplementary policies meet specific National Association of Insurance Commissioners (NAIC) standards. The NAIC is actively working on the development of the ten variations which will be before the NAIC for adoption later this year. Therefore, we do not see the need for inclusion of Medicare supplement coverage within the uninsurable risk pool and urge the committee to remove that provision which is 21.55.100(b) on page 3. CSSSSB-304 did not include Medicare supplementary insurance within the uninsurable risk pool.

SB-74 requires a lifetime maximum of $1 million per individual. This coverage is higher than many of the state uninsurable risk pool programs. To further make the pool premium more affordable, we suggest reducing the policy lifetime maximum to $500,000 similar to the amount contained within CSSSSB-304.

CSSSSB-304 allowed for a preexisting exclusion of 12 months. However, SB-74 allows only 3 months for such an exclusion. It is necessary to collect an adequate premium over a period of time in order to cover the losses for expected claims, as for people with preexisting conditions. Therefore, a three-month preexisting exclusion is an inadequate amount of time and will lead to further losses for the pool, especially as the premium charge will be inadequate to cover all claims incurred. Therefore, we

strongly encourage the committee to amend the 3-month preexisting time limit to 12 months.

Section 21.55.220 allows an employer who has one or more eligible persons enrolled in a state plan to pay for the premiums of that person. We are concerned that such a provision will allow employers to "dump" higher risk employees into a state pool which is available only for individuals who are medically uninsurable, i.e., those who have been declined health insurance. The purpose of the uninsurable risk pool is not to reduce the cost of an employer's overall premium for their employees -- by their eliminating a higher risk employee from the group -- but to provide access to health insurance to medically uninsurable individuals. HIAA recognizes that some small employers have been declined insurance because one or more of the employees have proven to be uninsurable. However, SB-242 will preclude that from occurring, and all employees of an employer will be covered. Therefore, provisions in SB-242 negate the need to find high-risk employees an alterative to their group plan. Employers should not be encouraged nor given the opportunity to "dump" higher risk employees into a state uninsurable risk pool.

Section 21.55.300 in SB-74 does not include a listing of persons who are ineligible for coverage, as does Section 21.55.300(b) in CSSSSB-304. It is imperative to list those persons who would not be eligible for coverage, i.e., a person who at the time of application is eligible for medical assistance; a person who terminated coverage under the chapter in the previous 12 months; or that a person on whose behalf the pool

has paid out the maximum lifetime benefits; or for persons who are inmates of public institutions; or persons whose benefits are duplicated under public programs.

The purpose of insurance is to provide coverage for some unexpected, future event. Allowing applicants to pay retroactively for coverage back to when their previous contract was terminated is a violation of the principle of insurance. Coverage should be based on a prospective, not a retrospective basis. Therefore, we strongly encourage Section 21.55.330(b) to be deleted. HIAA is very willing to work with the committee in developing a workable, affordable, uninsurable risk pool that will be to the benefit of Alaskan medically uninsurable residents. Participation by health insurers is required in the uninsurable risk pool, as a privilege of doing business in Alaska. Insurance companies want to support and participate in the risk pool. However, the absence of a broad-based financing mechanism or a premium tax offset for the claims-incurred losses to pay the residual losses will result in a failed system with severe financial implications to the insurers licensed in Alaska.

We thank the committee for its consideration of incorporating the provisions of CSSSSB-304 into SB-74.

THOMAS A. TURNER, CLU

INSURANCE AND EMPLOYEE BENEFITS

Senator J. Kerttula
P.O. Box V
Juneau, AK 99811

March 10, 1992

Re: SB 74

MAR 13 1992

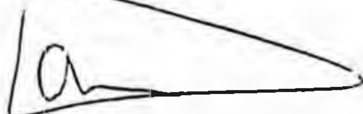
Dear Senator Kerttula:

As the chairman of the Southern Alaska Life Underwriters Association Legislative Committee, I am writing to advise you of our strong support for your bill number 74. In reviewing all of the health insurance related submitted this session, yours offers the potential to benefit the greatest number of Alaskans. Unfortunately, most of these Alaskans do not have a well funded lobbying effort. Self employed individuals, small business owners and employees and their families make up this group. The one thing that they all have in common is one or more medical problems which deny them access to comprehensible medical coverage. These people fall through the cracks because they either make too much money or have too large a net worth to qualify for Medicaid.

We also support your legislation because it provides for a fiscally responsible mechanism to guarantee these Alaskans coverage. It is not a socialized all intrusive plan, as some have proposed, but a solid first step in meeting the needs of most Alaskans who desire adequate medical care.

Members of our organization will continue to be in contact with you throughout the session, and hope that we can assist you in getting this legislation passed.

Sincerely,



Thomas A. Turner, CLU
Chairman, Legislative Committee
Southern Alaska Life Underwriters
TT/jm

cc: Senator Virginia Collins

1400 WEST BENSON SUITE 350 ANCHORAGE, ALASKA 99503 (907)257-5216 FAX (907)279-5016

Ernest B. Meloche, MD
Fellow of the American Board of Emergency Physicians
Emergency Department Medical Director
Ketchikan General Hospital
3100 Tongass Avenue
Ketchikan, Alaska, 99901

March 27, 1992

Senator Jay Kerttula
PO Box V
Juneau, Alaska, 99811

Dear Senator Kerttula,

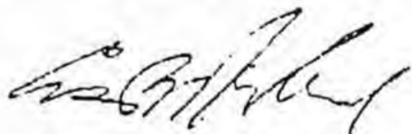
I strongly support Senate Bill 74, the bill which provides high risk health insurance for those people found to be uninsurable. I am a practicing emergency physician in Ketchikan, Alaska, as well as the medical director for Ketchikan General Hospital Emergency Department. In my practice I have witnessed again and again the tragic situation of people who have been denied health insurance.

Many people in this category are responsible, working individuals who are excellent neighbors and citizens of our state, yet who have been afflicted with any of a wide number of diseases which create claims on a health insurance policy. The unavailability of insurance for individuals with medical conditions within the state of Alaska has forced patients of mine to leave Alaska. Others have been driven into bankruptcy and are living w-ll below the poverty line simply trying to keep up with the costs of their illnesses.

The insurance industry insists that they can not accept such high risk individuals. While such a decision makes financial sense for a profit making company, we must ask ourselves if this is how we wish to treat our neighbors when they fall into such unfortunate circumstances. Senate Bill 74 creates a mechanism whereby such people would be allowed to act responsibly and purchase their insurance like anyone else, admittedly at a slightly higher rate. This is fully acceptable.

It is not acceptable to deny health care protection to those who need it most. Senate Bill 74 is an excellent step toward a responsible Alaskan health care policy. It is important for Senate Bill 74 to pass as soon as possible, since more Alaskans are finding themselves affected by this problem daily. If I can be of any assistance in this matter please feel free to contact me directly. Thank you for your efforts on behalf of those to whom this legislation will be literally life-saving.

Sincerely,



Ernest B. Meloche, MD,

BALDWIN FINANCIAL CONCEPTS

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FAX COVER SHEET

SENT TO: Senator Arliss Sturgulewski

COMPANY:

FAX# 465-3810 DATE 4/3/92

FROM: Leona Baldwin

TOTAL NUMBER OF PAGES INCLUDING COVER

COMMENTS: There are currently thousands of Alaskans who cannot obtain medical insurance coverage at any cost due to current or pre-existing medical conditions. The ability to obtain medical coverage is a right no one should be denied.

Please report Senate Bill 74 out of Committee.

Sincerely
Leona Baldwin, CLU, ChFC

If total number of pages received differ from number sent, or if theres was a transmission problem please call.
Thank You.

Consulting Services, Inc.

C. Keith Powell, ASA, MAAA
Consulting Actuary

10-22
10-29

September 28, 1990

Office of the Director
Department of Insurance
Juneau, Alaska 99811

Dear Sir:

I was recently asked to make a presentation to an actuarial meeting on the subject of state pools for people who are uninsurable for health coverages. The larger topic of the meeting was national health insurance, and I was asked specifically to examine the possibility that these state pools (now existing or in the process of implementation in 23 states) may be a backdoor approach to national health insurance.

The survey that I did in preparation for this presentation developed some interesting information on the financial results under those pools, different approaches to funding used by the various states, eligibility requirements, etc.

As the consulting actuary who reviews the pool rates for the Indiana DOI, I have often wished that I had such information available; so I thought you or a member of your staff might be interested in the financial results of these pools.

I am enclosing a summary of these financial results, as well as a copy of my presentation. If you or a member of your staff would like to discuss this material, feel free to contact me. I can usually be reached at 502-245-1459 on Monday through Thursday, or by mail at the address below.

Sincerely yours,

C. Keith Powell

C. Keith Powell, ASA, MAAA
Consulting Actuary

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STATE POOLS FOR THE UNINSURABLE.

As of 1989 thirteen states had in place relatively mature (operational for two years or more) state pools offering health insurance coverage for residents who can not otherwise get health insurance. Counting the states with newer programs, some authorized but still in the process of becoming active, the total is now 23 states whose populations represent over 50% of the people in this country. This is about four times the number of such pools in force five years ago - a very rapid and surprisingly little publicized development. The ongoing, and worsening, problem of the lack of availability of private sector coverage for large segments of the population seems to be a major force driving this growth of state sponsored pools.

I would like to share with you the results of a recent survey of these programs that I have completed. While I am rambling through the survey results, you might want to keep in mind the following radical thoughts, not original with me:

(i) With the growth of these pools, we might be seeing a form of national health insurance growing right before our eyes.

(ii) Of the approaches to national health insurance with any chance of implementation, this might be the one that is most favorable to the private insurance industry.

Now, to the results of the survey.

(1) Eligibility Requirements.

It is difficult to generalize about eligibility requirements, but the most common one is an individual's status as uninsurable for reasons of health. There are other requirements in several states, and the type of proof of eligibility based on the status of uninsurable for reasons of health varies considerably by state.

(2) Financial Results.

If you look at 1989 results for the thirteen relatively mature plans, there was $68 million of collected premiums and $112 million of paid claims, for a paid loss ratio of 165%. The administrative cost of $9 million was about 8% of claims. If you take out two large states (Connecticut and Minnesota) that are atypical in certain important respects, the "loss ratio" drops from the 165% above to about 139%. Of the remaining eleven states, seven show loss ratios in the 125% to 150% range.

I think that this loss ratio range of 125% to 150% is about where

it should be. This is my conclusion based on looking at commutation functions for health insurance claims and making some guesses about antiselection in the bigger claims. It is also borne out as order of magnitude reasonable by conversion experience, experience on some Blue Cross plans that are not underwritten, and some social insurance experience.

When you look at details, results are, as you would expect, all over the place for reasons such as rate of growth, position in the rating cycle, etc. Within the eleven more normal plans, the paid loss ratios for 1989 range from a low of 72% to a high of 172%.

The low loss ratio of 72% was from Washington, a very fast growing plan that had $122,000 of collected premium in 1988 and $2,065,000 in 1989. Under these conditions a paid claims / collected premium loss ratio understates incurred claim / earned premium experience due to the claims reporting and processing lag and to the failure of collected premiums to reflect the fact that some of the collected premiums are not fully earned. The Washington plan also has a six month / six month preexisting condition exclusion. In the presence of such fast growth, a great deal of the experience will still be driven by the pre-ex period and as such the loss ratios will be considerably lower than ultimate experience should show.

The Iowa plan, with its loss ratio of 112%, is another very fast growth case.

The high loss ratio of 172% for 1989 comes from right here in Indiana. This resulted from some very special circumstances. The Indiana plan tried to get approval for an incredibly large rate increase to be effective 7/1/89. The DOI challenged the rate increase all over the place, and it was finally approved under the Indiana deemer provision effective 12/1/89. The effect of this delay contributed to the high loss ratio in Indiana for 1989. Just as a footnote to this story, as some of the Indiana participants might know, the incredibly high set of rates was rescinded in 1990 and the state plan agreed to make partial refunds of the excessive portion of the premiums.

Again, the purpose of this detail is to present an argument that most of the plans tend to have cash loss ratios in the range of 125% to 150%. As you might expect, the results by state are all over the place due to such factors are rate of growth, the pre-existing condition exclusion provisions, and the plan position in its rating cycle.

On additional thought bridging design and pricing is that there is surprisingly little exclusive provider design in these plans. This could be the one angle that could really contribute to bringing

down the loss ratios somewhat. It should be possible to get some excellent discounts from hospital and physician providers by promising them these very high using populations.

(3) Funding Mechanism.

Premiums are most often set at 125% to 150% of the some version of an average price for underwritten products in the state. This price reason pops up for many reasons.

At the low end of the 125% to 150% range, it is probably a friendly gesture to the insurance industry to try to keep the price above 125% of the average hot selling underwritten rate. By keeping the rate 25% over the average selling rate for underwritten products, it is safe to assume that there will be little or no loss of private sector underwritten business to the pools. Notice that but for this point of wanting to protect the private sector you could logically justify holding the pool rate below 125% of the average selling rate for an underwritten product. Recall that the underwritten rates generally target 50% to 70% loss ratios, so a pool rate based on 125% of the average underwritten selling rate means that the pool is allocating twice as high a percent of premium to benefit costs as the private sector product does.

If you go much higher than this range of 125% to 150% of the average underwritten selling rate a look at claims distributions and almost any reasonable guesses about antiselection show that the product will be priced well above "reasonable" for a very large portion of the people needing the product. This would discourage purchase of pool products by not only a large number of the people who need it but also by the very people who do not tend to contribute large losses to the pool.

The linkage between this 125% to 150% and the emerging loss ratios of 125% to 150% mentioned earlier is very tenuous. There actually might be a little bit of a linkage, but it is pretty far out there and it is probably best to think of them as unrelated concepts.

Remaining costs (in addition to premiums) are usually paid by either (i) the insurance industry in the state or (ii) local health care providers, and there is often some kind of tax offset that ultimately brings it to roost on general revenues.

(4) National Health Insurance Implications.

In 1989, 13 states (representing roughly 20% of the U. S. population) paid $112,000,000 in health benefit costs to providers, $9,000,000 for administration mainly to the insurance industry, for a total cost of $121,000,000. This was offset by $68,000,000 in premiums collected, for a net cost of $53,000,000. With all kinds

of caveats, extrapolating that to the entire U. S. would have cost less than $300,000,000. These numbers relate to programs that are almost exclusively freedom of choice arrangements that have made very little effort to get the savings from exclusive provider arrangements; and proper use of exclusive provider arrangements could introduce an element of savings. Again, with still more caveats, it had no direct impact on the federal deficit.

Note how nicely these pools dovetail with existing public and private health insurance programs.

Medicare and Medicaid are the major social insurance programs in this country. Medicare people generally do not need the pool benefits because the Medicare program itself is so comprehensive. Medicaid people generally already have some kind of half way decent benefits. They are not as generous as those in the state pools, but then Medicaid people generally pay nothing for their benefits.

I am going to try to summarize the value of this concept of national health insurance to the insurance industry, at the risk of getting up on the soap box.

Over the last half century the private health insurance industry has proved itself totally incapable of providing significant medical expense benefits on an individual basis to people with serious health problems, in spite of the fact that these people beg for our products and are willing to pay almost anything asked for the benefits. At least for freedom of choice insurers there is no reason to believe that this is changing, and in fact the problem seems to be worsening each year health care costs grow faster than other costs. While this is a very serious indictment of our industry, it does point out that the people that we are losing to these pools are the very people that we could not handle anyway. In fact, the payments that the health insurance industry receives to administer the benefits for these people probably exceeds aggregate premiums that the industry could collect from them for meaningful medical expense benefits; and absent state legislation making the cost fall directly on insurers, it comes without underwriting losses or significant financial risks.

These pools leave with the health industry the very people that the health insurance most wants and takes the people that they do not want.

With caveats, I would like to suggest that this may be the feasible approach to national health that is kindest to the health insurance industry.

Uninsurable Pool Data

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Connecticut					
1983	3134889	3442223	272550	109.80%	7.92%
1984	3473145	4454451	315450	128.25%	7.08%
1985	3285762	4579461	276379	139.37%	6.04%
1986	3532941	4203833	246156	118.99%	5.86%
1987	3186476	6663081	337235	209.11%	5.06%
1988	3460337	7293434	412942	210.77%	5.66%
1989	4495872	10438000	567826	232.17%	5.44%

Comment - These results may not be typical due to the presence of a Blue Cross plan in the process of being phased out.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Florida					
1983	23759	0	0	0.00%	ERR
1984	505798	141430	69114	27.96%	48.87%
1985	1107581	774174	103946	69.90%	13.43%
1986	1770171	1686195	184889	95.26%	10.96%
1987	2858173	3963710	357017	138.68%	9.01%
1988	5294446	8581468	1134991	162.08%	13.23%
1989	12443960	17425025	2810723	140.03%	16.13%
Indiana					
1983	2352179	217878	56512	9.26%	25.94%
1984	6356995	6843691	256462	107.66%	3.75%
1985	7505144	9518759	253524	126.83%	2.66%
1986	7197774	11552494	443791	160.50%	3.84%
1987	6301707	11564602	459462	183.52%	3.97%
1988	5607908	9640519	500643	171.91%	5.19%
1989	6210701	10690610	670565	172.13%	6.27%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Iowa					
1987	164995	56725	16560	34.38%	29.19%
1988	1008691	1249159	82560	123.84%	6.61%
1989	2876251	3232227	339660	112.38%	10.51%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

Minnesota 1976 @ 15%

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Maine					
1988	15179	0	33960	0.00%	ERR
1989	228189	290179	81265	127.17%	28.01%
Minnesota					
1983	4082351	6981967	383741	171.03%	5.50%
1984	6413829	9761835	665100	152.20%	6.81%
1985	9492438	13324992	984514	140.37%	7.39%
1986	10772454	18913879	904886	175.58%	4.78%
1987	11407281	21893358	928773	191.92%	4.24%
1988	14197219	27098596	1340562	190.87%	4.95%
1989	18459482	38373578	2115892	207.88%	5.51%
Montana					
1987	9870	0	9759	0.00%	ERR
1988	97026	65374	14675	67.38%	22.45%
1989	316276	395050	24523	124.91%	6.21%
Nebraska					
1986	8414	0	11558	0.00%	ERR
1987	458857	443238	14600	96.60%	3.29%
1988	1221792	1808813	57097	148.05%	3.16%
1989	2572213	4088816	128223	158.96%	3.14%
New Mexico					
1988	233053	127399	103475	54.67%	81.22%
1989	1222400	1565229	157945	128.05%	10.09%
North Dakota					
1983	138666	345918	25305	249.46%	7.32%
1984	455874	1058694	35904	232.23%	3.39%
1985	894701	1704988	56756	190.57%	3.33%
1986	1321991	2863886	108756	216.63%	3.80%
1987	1626970	3389229	174130	208.32%	5.14%
1988	1937903	3340441	234984	172.37%	7.03%
1989	2261638	3691487	278007	163.22%	7.53%
Tennessee					
1987	556763	17450	0	3.13%	0.00%
1988	3236204	2807338	317930	86.75%	11.32%
1989	8433944	10212644	623744	121.09%	6.11%

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Washington	Earned	Incurred			
1988	124260	74121	78575	59.65%	106.01%
1989	1940334	2543839	204221	131.10%	8.03%
Wisconsin					
1983	1232352	2463703	156964	199.92%	6.37%
1984	2079996	3104604	196338	149.26%	6.32%
1985	2600586	3265492	210646	125.57%	6.45%
1986	2856286	3336087	284500	116.80%	8.53%
1987	2959861	3956056	366245	133.66%	9.26%
1988	4056671	5518189	906550	136.03%	16.43%
1989	6676614	9754103	885383	146.09%	9.08%

Comment - Participating insurers are not permitted any kind of credit against premium or income taxes.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Total					
1983	10964196	13451689	895072	122.69%	6.65%
1984	19285637	25364705	1538368	131.52%	6.06%
1985	24886212	33167866	1885765	133.28%	5.69%
1986	27460031	42556374	2184536	154.98%	5.13%
1987	29530953	51947449	2663781	175.91%	5.13%
1988	40490689	67604851	5218944	166.96%	7.72%
1989	68137874	112700787	8887977	165.40%	7.89%
Total - Minus Connecticut and Minnesota					
1983	3746956	3027499	238781	80.80%	7.89%
1984	9398663	11148419	557818	118.62%	5.00%
1985	12108012	15263413	624872	126.06%	4.09%
1986	13154636	19438662	1033494	147.77%	5.32%
1987	14937196	23391010	1397773	156.60%	5.98%
1988	22833133	33212821	3465440	145.46%	10.43%
1989	45182520	63889209	6204259	141.40%	9.71%

U520

United States General Accounting Office

GAO

Briefing Report to the Committee on Labor and Human Resources, U.S. Senate

April 1988

HEALTH INSURANCE

Risk Pools for the Medically Uninsurable

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Human Resources Division

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April 13, 1988

The Honorable Edward M. Kennedy, Chairman
The Honorable Orrin G. Hatch, Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

This report responds to your March 23, 1987, request concerning state-administered health insurance risk pool programs. You asked that we determine the programs' characteristics, enrollment, and financial experience; the characteristics of the persons they insure; and their success in meeting expectations. We agreed with your offices to focus on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the other nine states that have more recently enacted risk pool legislation. We obtained oral comments on this report from the Department of Health and Human Services and have incorporated them where appropriate.

Risk pool programs provide health insurance to individuals who cannot obtain it because their health conditions make them unacceptable risks to private insurers. The programs provide comprehensive insurance coverage similar to that of employer-sponsored group health plans. Costs to the insured are relatively high because of generally large deductibles and premiums that are usually 25 to 50 percent more than those paid by individuals with private health insurance.

Despite high premiums, the programs require a subsidy. Two states subsidize their risk pools directly from state revenue, while most of the 15 states that have enacted risk pool legislation assess risk pool deficits against insurers doing business in the state. In the majority of these states, however, insurers may credit their full share of risk pool deficits against state premium or corporate income taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as financing the risk pool from general revenues.

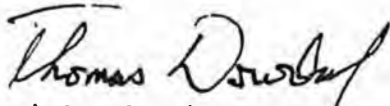
The six programs we reviewed have consistently operated at a loss, paying an average of $1.60 in claims for each dollar of premium income in 1986. According to estimates prepared by the Health Care Financing Administration (HCFA), private insurers nationally paid $0.87 in claims per dollar of premium income during that year.

The six programs insured about 20,000 individuals. Middle-aged individuals appear most likely to enroll in risk pools. Enrollees incur higher medical expenses than the general population. The data available indicate that their expenses are higher for treatment of heart conditions, cancer, and diabetes specifically. Insurance industry and advocacy group officials believe that risk pools can also help finance the cost of treating patients with acquired immunodeficiency syndrome (AIDS). State officials expressed concern that AIDS patients could increase program costs, but did not know the extent to which persons infected with the virus that causes AIDS have enrolled in risk pools.

The six states we reviewed have not determined the extent to which persons who cannot obtain insurance because of poor health are enrolling in risk pools. State officials generally believe, however, that their programs are not serving all eligible individuals.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in this report and other interested parties.

If you have any questions, please call me on (202) 275-6195.



for Michael Zimmerman
Senior Associate Director

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
BLS	Bureau of Labor Statistics
GAO	General Accounting Office
HCFA	Health Care Financing Administration

CORRECTION

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TO ASSURE LEGIBILITY

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ABBREVIATIONS

AIDS acquired immunodeficiency syndrome

BLS Bureau of Labor Statistics

GAO General Accounting Office

HCFA Health Care Financing Administration

HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE

INTRODUCTION

About 63 percent of the population is covered by health insurance that is related to employment, normally a group insurance plan. Persons not covered by a group plan may purchase an individual plan. When writing an individual policy, insurance companies normally obtain information on the individual's medical condition to assess the risks involved in providing coverage. Occasionally companies either refuse to provide coverage to, or limit coverage for, persons who have chronic medical conditions that are costly to treat. These persons are commonly referred to as the medically uninsurable.

An estimated 37 million Americans lack health insurance coverage. Researchers believe that from 1 to 2 million of these persons cannot obtain insurance because of medical conditions that make them unacceptable risks to private insurers. Researchers also believe that this group is growing because (1) an increasingly competitive insurance market has led insurers to adopt more restrictive health insurance standards; (2) increasing health care costs, and resulting increased insurance premiums, have discouraged some employers from providing group health insurance as an employee benefit; and (3) advances in diagnostic testing have enabled insurers to identify individuals who have potentially costly illnesses.

In the past, Blue Cross and Blue Shield Plans have been a source of insurance for the medically uninsurable. During the 1930s, when the plans pioneered health insurance, all group and individual subscribers paid a uniform rate regardless of their health status. Enrollment in the plans was open to all, and individuals who were at risk of incurring high medical costs benefited because their premiums were subsidized by lower risk individuals. Commercial companies entered the field in the 1940's, and a competitive for-profit health insurance industry developed.

In this competitive environment, Blue Cross and Blue Shield Plans began to base premiums for large group policies wholly or partly on the group's health experience, rather than on the experience of all their subscribers. Therefore, the plans had fewer lower risk individual subscribers to subsidize health care costs for high-risk individuals. Not all Blue Cross and Blue Shield Plans continue to offer individual insurance coverage without regard to health status, referred to as open enrollment. As of October 1987, Plans in 11 states and the District of Columbia offered open enrollment. Appendix I lists the states in which Plans offer open enrollment.

To help the medically uninsurable, 15 states have passed legislation establishing health insurance risk pool programs.[1] Typically, the states create associations to operate the programs and require all insurers doing business in the state to be members. The associations offer insurance to eligible individuals and establish premiums. If premiums do not cover expenses, deficits are generally shared among association members. Table 1 shows the states that have enacted legislation, and the effective dates.

Table 1: Effective Dates of Risk Pool Authorizing Legislation[a]

State	Effective date
Connecticut	Apr. 1976
Minnesota	July 1976
Wisconsin	Jan. 1981
North Dakota	July 1981
Indiana	Sept. 1981
Florida	July 1982
Montana	July 1985
Tennessee	July 1986
Nebraska	Sept. 198[illegible]
Iowa	Jan. 1987
New Mexico	Apr. 1987
Washington	May 1987
Illinois	Apr. 1987
Maine	Sept. 1987
Oregon	Sept. 1987

[a]Rhode Island established a risk pool in 1975. However, Blue Cross and Blue Shield of Rhode Island offers open enrollment. According to a state official, no more than 10 or 12 persons have been enrolled in the risk pool at any time. Because of its small size, we did not examine the Rhode Island program.

In addition, according to a study conducted by the Intergovernmental Health Policy Project, legislatures in 12 states considered, but did not enact, legislation authorizing a risk pool during 1987. Appendix II lists these states.

OBJECTIVES, SCOPE, AND METHODOLOGY

On March 23, 1987, the Chairman and the Ranking Minority Member of the Senate Committee on Labor and Human Resources asked us to obtain information on health insurance risk pools. In later discussions with their offices, we agreed to obtain information on

[1]Blue Cross and Blue Shield Plans in the 15 states with risk pools we examined do not offer open enrollment.

-- the programs' characteristics, including eligibility requirements, covered medical services, deductibles, and coinsurance requirements;

-- the programs' experience concerning enrollment, premium income, claims expenses, and subsidy requirements;

-- enrolles' characteristics, including age, gender, primary illness, and the types and costs of medical services they have received; and

-- the extent to which the programs have met the expectations that led to their creation.

As agreed with the Senators' offices, our review focused on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the nine other states that have more recently established risk pools.

In the six states, we spoke with and obtained and reviewed appropriate documentation from (1) risk pool program administrators, (2) officials of state insurance departments, and (3) representatives of private groups interested in the programs. For the other nine states, we interviewed and obtained documents from program administrators. We also interviewed representatives of national organizations interested in risk pools. Appendix III lists the groups and organizations we contacted.

To obtain information on program characteristics, we analyzed authorizing legislation, reviewed program administrative policies and procedures, and examined risk pool insurance policies. We compared program characteristics to data on employer-sponsored group insurance plans reported by the Bureau of Labor Statistics (BLS) in its June 1987 Survey of Employee Benefits in Large and Medium Firms, 1986. We discussed program characteristics with program administrators, state insurance department officials, and representatives of private groups interested in risk pools to obtain their views of how program characteristics affect program operations.

To obtain information on the programs' enrollment and financial experience, we analyzed program financial and operating reports prepared by program administrators and state insurance departments. We also discussed enrollment and financial trends with these officials.

To obtain information on the insured, we analyzed reports prepared by program administrators and state insurance departments,

and interviewed program administrators, risk pool association representatives, and state insurance officials. Except for Wisconsin, which surveyed risk pool enrollees in 1982, 1984, and 1986, limited information on the characteristics of the insured was available. Moreover, the results of Wisconsin's surveys may not accurately represent the characteristics of enrollees in that state's risk pool because many of those surveyed did not respond, and state officials did not analyze the characteristics of nonrespondents to determine whether differences existed between them and respondents.

To obtain information on how well the programs have met the expectations that led to their creation, we examined authorizing legislation and reviewed legislative histories and program evaluations where available. We also discussed the programs' effectiveness with program administrators, state insurance officials, and representatives of private groups interested in risk pools.

Our fieldwork was conducted between April and November 1987 in accordance with generally accepted government auditing standards. We obtained oral comments from the Department of Health and Human Services, and have revised the report to reflect these comments where appropriate.

RISK POOL PROGRAM CHARACTERISTICS

Risk pools provide health insurance that is comprehensive, but costly, to persons who can afford, but have difficulty obtaining, health insurance. Risk pool insurance covers a broad range of health services comparable to those covered through group health insurance plans offered by large and medium-sized employers.

Deductibles, or the covered medical expenses an enrollee pays before the plan pays, are usually higher under risk pool insurance than under typical group plans. Further, premiums charged for risk pool insurance are norm[illegible] 2[illegible] to 50 percent higher than rates private insurers charge [illegible] individual policy. The premiums that risk pools charge d[illegible] over claims expenses. Risk pool operating losses are generally shared among private insurers doing business in the state. Most states, however, allow insurers to offset these losses through state tax credits.

Risk Pool Management

The organizational structures of the 15 state risk pools are essentially the same. The risk pool is operated by an association consisting of health insurance providers doing business in the state, including commercial health insurance companies and Blue Cross and Blue Shield Plans. Twelve states also require health maintenance organizations to be association members. While

legislation in six states provides for self-insured organizations[2] to be association members, U.S. district courts have held that, under the provisions of the Employee Retirement Income Security Act of 1974, employers with self-insured health plans are exempt from state insurance regulation and therefore cannot be required to participate in a risk pool.

The risk pool association manages the program through its governing body, which generally includes health insurance industry officials, state government officials, and consumer representatives. The association recommends premium rates and changes in program benefits within the framework of authorizing legislation. The association contracts with an insurance company to administer the program, issue policies, collect premiums, process claims, and maintain financial records.

State insurance departments oversee program operations--they review and approve program operating plans, premium rates, and changes in program benefits. The departments also review program performance.

Eligibility Requirements

To be eligible for risk pool enrollment, individuals must normally have been rejected for health insurance by one or more insurers. Ten states also grant eligibility to persons who either hold or have been offered a policy with premiums higher than risk pool premiums. Eleven states permit enrollment if an individual was offered a policy that excluded coverage of specific medical conditions. Seven states allow applicants with specified diseases--such as cancer, acquired immunodeficiency syndrome (AIDS), or juvenile diabetes--that generally make it difficult to obtain insurance to enroll without meeting other requirements. Table 2 summarizes the eligibility requirements of the various state programs.

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[2]Self-insured organizations directly bear the risk and cost of providing health care coverage rather than purchasing coverage from an insurance company.

Table 2: Eligibility Requirements for State Risk Pool Programs[a]

State	Individuals are eligible if they: Are refused coverage by (number of insurers)	Are offered limited coverage by other insurers	Are offered high premiums by other insurers	Suffer from specified diseases
Florida	Two	Yes	Yes	No
Illinois	One	No	Yes	Yes
Indiana	Two	Yes	Yes	Yes
Iowa	One	Yes	Yes	Yes
Minnesota	One	Yes	Yes	Yes
Montana	Two	Yes	No	No
Nebraska	One	Yes	Yes	Yes
New Mexico	One	Yes	Yes	No
North Dakota	One	Yes	No	No
Oregon	One	No	No	Yes
Tennessee	One	Yes	Yes	Yes
Washington	One	Yes	Yes	No
Wisconsin	One	Yes	Yes	No

[a]Connecticut and Maine do not have these eligibility requirements.

Insurance Benefits

Risk pool insurance covers a comprehensive range of medical services and is comparable to the coverage that large and medium-sized employers make available through their group health plans. Table 3 provides examples of medical services typically covered or excluded under risk pool insurance policies.

Table 3: Medical Services Typically Covered or Excluded Under Risk Pool Insurance Policies

Covered	Excluded
Hospital services	Experimental treatments
Physician services in-hospital and out-of-hospital	Cosmetic treatments
Prostheses	Eyeglasses and hearing aids
Durable medical equipment	Dental care
Physical therapy	Routine physical examinations
Oral surgery	Expenses payable under other insurance or under government programs
	Custodial care

The programs also protect enrollees from extraordinary medical costs by limiting the out-of-pocket expenses that they must pay during the year. Table 4 shows the out-of-pocket medical expense limits under the state risk pool programs.

Table 4: Out-of-Pocket Medical Expense Limits of State Risk Pool Programs

State	Out-of-pocket limit	
	Individual	Family
Connecticut	$2,000	$4,000
Florida[a]	2,500	5,000
Illinois	1,500	3,000
Indiana[a]	1,000	2,000
Iowa[a]	1,500	3,000
Maine	1,500	3,000
Minnesota	3,000	b
Montana	5,000	b
Nebraska	5,000	b
New Mexico[a]	1,500	2,500
North Dakota	3,000	b
Oregon	c	c
Tennessee[a]	1,500	2,000
Washington[a]	1,500	3,500
Wisconsin	2,000	4,000

[a]The program also offers a higher out-of-pocket limit at a reduced premium.

[b]Limit on out-of-pocket medical expenses is applied "per covered person." No family limit is provided.

[c]As of January 1988, Oregon had not established an out-of-pocket expense limit for its program.

Cost-Sharing and Benefit Limitation Provisions

Risk pool insurance policies contain a number of cost sharing and benefit limitation provisions. These features, which are traditional mechanisms that have long been used in the insurance industry, include

-- deductibles, or the amount of covered medical expenses, either for a calendar year or per hospital admission, an enrollee must pay before the plan provides coverage;

-- coinsurance, or the fixed percentage or amount of covered medical expenses an enrollee must pay after satisfying deductible requirements;

-- waiting periods during which expenses to treat medical conditions diagnosed before the policy was issued, referred to as preexisting conditions, are not covered; and

-- limitations on the maximum amount of medical expenses that will be paid during the enrollee's lifetime.

Cost Sharing Provisions

Risk pool deductibles for medical expenses are generally higher than deductibles under the group health plans that large and medium-sized employers offer. According to risk pool officials, high deductibles discourage unnecessary use of medical services and help control costs. With one exception, Wisconsin, the programs allow enrollees to select from among two or more deductible amounts. BLS found that group health plans covering 78 percent of employees at large and medium-sized firms have medical expense deductibles of $150 or less and that plans covering 93 percent of the employees have deductibles of $200 or less. Table 5 shows the range of medical expense deductible amounts under state risk pool programs.

Table 5: Deductible Amounts for State Risk Pool Programs

State	Medical expense deductibles for an individual	
	Lowest	Highest
Connecticut	$400	$1,500
Florida	1,000	2,000
Illinois	250	1,000
Indiana	200	1,000
Iowa	500	1,000
Maine	500	1,000
Minnesota	500	1,000
Montana	500	1,000
Nebraska	250	1,000
New Mexico	500	1,000
North Dakota	150	1,000
Oregon	a	a
Tennessee	500	2,000
Washington	500	1,000
Wisconsin	1,000	1,000

[a]As of January 1988, Oregon had not established a deductible for its program.

Risk pool coinsurance requirements were generally comparable to those required under group health plans that large and medium-sized employers offer. Thirteen of the 15 states require enrollees to pay 20 percent of covered medical expenses after meeting

deductible requirements. Nebraska requires a 10-percent coinsurance payment, and, as of January 1988, Oregon had not established a coinsurance percentage. BLS found that group health plans covering 86 percent of employees at large and medium-sized firms also contained a 20-percent coinsurance feature.

Benefit Limitation Provisions

Risk pool insurance policies exclude preexisting medical conditions from coverage for a period of time. Preexisting conditions are those that have been diagnosed or treated during a specified period before the effective date of the policy--referred to as the condition period. Costs of treating preexisting conditions are not covered for a period after the effective date of the policy--referred to as the waiting period. Insurers have traditionally used waiting periods for preexisting conditions to prevent persons in poor health from purchasing insurance only when they plan to seek treatment.

Nine programs will waive or reduce the preexisting condition waiting period if the individual had other insurance in force before enrolling. Two of these states require enrollees requesting a waiver to pay a 10-percent premium surcharge. One state will also reduce the waiting period for enrollees who pay a surcharge, whether they had other insurance or not.

Thirteen state risk pool programs limit the maximum amount in benefits payable during an enrollee's lifetime. The limits were generally similar to those of the group health plans that large and medium-sized employers offer. BLS found that group health plans covering about 43 percent of the employees at large and medium-sized firms were covered by a plan that limited lifetime benefits to $500,000 or less.

Table 6 shows the benefit limitation provisions of the state risk pool programs.

Table 6: Benefit Limitation Provisions of State Risk Pool Programs

State	Preexisting condition provisions: Condition period (months)	Waiting period (months)	Waiver provision	Maximum lifetime benefit
Connecticut	6	12	a	$1,000,000
Florida	6	6	None	500,000
Illinois	6	6	b,c	500,000
Indiana	6	6	None	None
Iowa	6	6	b	250,000
Maine	3	3	a,b	500,000
Minnesota	3	6	a	250,000
Montana	60	12	b	250,000
Nebraska	6	6	d	500,000
New Mexico	6	6	b	None
North Dakota	3	6	b	250,000
Oregon	6	6	d	1,000,000
Tennessee	6	6	None	500,000
Washington	6	6	b	500,000
Wisconsin	6	6	None	500,000

[a]Waiting period may be waived or reduced under certain limited circumstances.

[b]Waiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool.

[c]Waiting period will be reduced if the applicant also pays a premium surcharge.

[d]Waiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool and pays a 10-percent premium surcharge.

Cost-Containment Provisions

Private insurers have included a number of cost-containment features in their health insurance policies. In general, these features discourage individuals from seeking unnecessary medical treatment or encourage them to use less costly treatment alternatives. BLS surveyed large and medium-sized firms to determine whether their health plans included any of nine common

cost-containment measures.[3] BLS found that 68 percent of the employees at large and medium-sized firms were covered by a plan that included at least one of the nine cost-containment features.

Like private insurers, risk pool programs include cost-containment features in their insurance policies. Eight of the state programs have implemented one or more of the provisions covered in the BLS survey. The most common provision, a requirement that decisions to hospitalize enrollees be reviewed by the program administrator, has been adopted by seven states. Three states require enrollees to obtain a second opinion before nonemergency surgery, three states require enrollees to use generic rather than more expensive brand-name drugs, and three states require that routine laboratory tests before hospitalization be performed on an outpatient basis.

Risk Pool Premiums

The basis for setting risk pool insurance premiums is normally prescribed in authorizing legislation. Premiums are usually established based on the rates charged for private health insurance in the state and vary based on age and, sometimes, sex and geographic area. The legislation generally provides for premiums to be adequate to cover anticipated claims expenses, but it limits rates to a multiple of the rates charged by private insurers. Legislation in 12 states provides for multiples between 125 and 150 percent. Three states provide for higher multiple limits, including Montana, which provides a 400-percent limit. Program administrators in the six states we reviewed survey private insurers to determine the average rates they charge for health insurance as a basis for setting risk pool rates. Table 7 shows the rate limits and examples of premiums charged in the six states reviewed.

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[3]The cost containment measures covered in the BLS survey included (1) incentives to encourage a second surgical opinion before nonemergency surgery, (2) incentives to encourage use of outpatient surgery, (3) incentives to use generic rather than more expensive brand-name drugs, (4) limits on reimbursement for nonemergency weekend hospital admissions, (5) separate deductibles for hospital admissions, (6) incentives to have routine laboratory tests done on an outpatient basis before hospitalization, (7) higher payment for delivery at a birthing center, (8) incentives to audit the hospital's statement, and (9) preadmission certification requirements.

Table 7: Rate Limits and Examples of Annual Premium Rates Charged by State Risk Pool Programs

State	Rate limit[a] (percent)	1987 annual premium rates for coverage with a $1,000 medical expense deductible for a 40-year-old Male	40-year-old Female	55-year-old Male	55-year-old Female
Connecticut	150	$1,156	$1,538	$2,077	$2,486
Florida	200	1,924	1,924	3,153	3,153
Indiana	150	1,162	1,597	2,130	2,363
Minnesota	125	641	641	999	999
North Dakota	135	945	945	1,383	1,383
Wisconsin	150	996	1,320	1,784	1,660

[a]Based on rates charged for private health insurance in the state.

Financing Program Deficits

Risk pool authorizing legislation generally prescribes how program operating deficits will be financed. In 12 of the 15 states, deficits are shared among risk pool association members through assessments voted by the association's governing body. These states distribute assessments in proportion to each member's share of total premium income[4] in the state except in Connecticut, which assesses members according to their share of total claims paid, and in Washington, which assesses members according to their share of total health insurance subscribers. Maine plans to finance deficits through a tax on hospital revenues, while Illinois will subsidize its risk pool from general revenues. Tennessee will provide up to $2 million a year from general revenues to cover deficits, with any remaining deficits made up from assessments to association members. Oregon assessed association members for startup costs, but state legislation does not address how operating deficits will be financed.

Nine of the 12 states that assess deficits against association members allow them to credit the assessments against their state taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as subsidizing risk pool losses from general revenues. In the other three states, assessments are considered a cost of doing business that the state insurance department may consider when approving rates the companies propose for their health insurance plans.

[4]Premium income is the revenue an insurer earns from the sale of insurance.

As stated earlier, legislation in six states provides for self-insured organizations to be risk pool association members. The courts, however, have held that because employers with self-insured health plans are exempt from state insurance regulation under the Employee Retirement Income Security Act of 1974, they cannot be required to participate in risk pools.

Insurance industry officials and program administrators in the states we reviewed believed that exempting self-insured organizations from risk pool participation can unfairly increase the burden on persons who obtain private insurance from risk pool association members. Even in states where tax credits relieve insurers from subsidizing risk pools, officials were concerned because of the possibility of the tax credit being repealed. Minnesota, for example, repealed its tax credit provision in 1987.

RISK POOL ENROLLMENT AND FINANCIAL EXPERIENCE

In five of the six programs we reviewed, enrollment has increased since 1983. For the six programs, total enrollment increased 48 percent to 20,545 persons. However, the Minnesota risk pool, with 10,842 insured, has 53 percent of the six-state total.

The risk pools in the six states have consistently operated at a loss. In 1986 the programs paid an average of $1.60 in claims for each dollar of premium income. According to estimates prepared by HCFA, private insurers nationally paid about $0.87 in claims per dollar of premium income during the same period. To date, however, assessments to risk pool association members in the three states that do not permit tax credits have been modest when compared to the total volume of insurance business in the states.

State officials have found that often a conflict exists between the objectives of (1) increasing enrollment by enhancing the attractiveness of the risk pool plan and (2) reducing deficits through higher premiums or reduced coverage.

Enrollment

Enrollment in risk pool programs has increased since 1983, but growth in the programs has not been uniform. Between the end of 1983 (the first year all six were offering policies) and the end of 1986, the number of insured grew from 13,842 to 20,545.[5] About half of the insured at the end of 1986 were in Minnesota. Two newer programs, those in Florida and North Dakota, experienced

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[5]The number of policies in force is virtually equivalent to the number of insured persons, according to program officials, since almost all risk pool policies are for individuals rather than families.

significant percentage growth, but from a low base. Table 8 summarizes the number of policies in force at the end of 1983 and 1986.

Table 8: Risk Pool Insurance Policies in Force as of December 31, 1983, and December 31, 1986

State	Policies in force as of December 31, 1983	Policies in force as of December 31, 1986	Change (percent)
Connecticut	3,419	2,315	-32
Florida	49	1,036	2,014
Indiana	2,288	2,998	31
Minnesota	6,043	10,842	79
North Dakota	245	1,279	422
Wisconsin	1,798	2,075	15
Total	13,842	20,545	48

Because of turnover in the enrollee population, the number insured through risk pools has been greater than indicated by the table. Excluding North Dakota, for which data were not readily available, there were about 23,000 policies written and in force during the 3-year period in addition to the 19,266 policies in force on December 31, 1986.

Wisconsin was the only state that has surveyed former enrollees to determine why they had canceled their policies. In 1982 Wisconsin surveyed 562 former enrollees and received responses from 208, or about 37 percent of those surveyed. About 23 percent canceled because they could not afford the insurance premiums. The other cancellations resulted from enrollees obtaining group health insurance coverage, becoming eligible for Medicare, dying, or moving out of the state.

Fiscal Experience

Risk pools in the six states we reviewed have consistently operated at a loss. The six programs incurred an aggregate net operating loss of about $18.1 million in 1986--about three times the 1983 level. Minnesota, with by far the largest enrollment, experienced the greatest loss, $9,024,228 in 1986. Table 9 compares program operating results for calendar years 1983 and 1986.

Table 9: Comparison of Risk Pool Deficits for Calendar Years 1983 and 1986

State	Deficit or (surplus) 1983	1986	Change (percent)
Connecticut	$508,721	$885,375	74
Florida	(6,276)[a]	681,157	b
Indiana	177,657	5,160,982	2,805
Minnesota	3,972,634	9,024,228	127
North Dakota	230,896	1,633,219	607
Wisconsin	1,609,052	678,806	-58
Total	$6,492,684	$18,063,767	178

[a]The Florida risk pool was in operation only during the last 4 months of 1983 and, according to program officials, had a surplus primarily because of the 12-month waiting period for coverage of preexisting medical conditions.

[b]Percentage change not calculated.

From calendar year 1983 to calendar year 1986, premium income for the six programs increased by 178 percent, while claims expense increased by 190 percent. Meanwhile, the loss ratio--the ratio of claims expenses to premium income--increased from $1.54 in claims per dollar of income in 1983 to $1.60 in 1986. In comparison, the loss ratio for health insurers nationally, according to HCFA estimates, was $0.87 per dollar of premium income during 1986. Table 10 shows the loss ratios for the six states for calendar years 1983-86.

Table 10: Risk Pool Loss Ratios for Calendar Years 1983-86

State	Claims paid per dollar of premium income 1983	1984	1985	1986
Connecticut	$1.10	$1.28	$1.39	$1.19
Florida	a	0.28	1.79	1.25
Indiana	0.83	1.56	1.30	1.70
Minnesota	1.87	1.65	1.49	1.76
North Dakota	2.49	2.32	1.91	2.17
Wisconsin	3.02	2.07	1.35	1.19

[a]The Florida risk pool was in operation only during the last 4 months of 1983 and, according to the pool's audited financial statements, did not incur claims expense during the period.

Administrative Expenses

Risk pools in the six states we reviewed reimburse the company that administers their programs for expenses incurred in issuing policies, processing claims, and paying benefits. This reimbursement, however, is generally subject to limits. Three states reimburse the program administrator for reasonable costs incurred, but Minnesota and North Dakota limit the reimbursement to 12.5 percent of claims expenses. Indiana and Wisconsin pay the administrator a basic monthly fee plus additional fees related to the volume of activities, such as processing insurance applications and insurance claims. Florida, which has the highest rate of administrative expenses, reimburses the administrator for all direct costs incurred, pays a monthly fee for indirect costs, and additional activity-related fees. Administrative expenses ranged from about 3.7 percent of claims expenses in Connecticut and Indiana to about 14.9 percent of claims in Florida.

Assessments

Risk pool association members share in operating losses through assessments voted by the association's governing board. Because the association normally maintains a cash reserve, assessments are not necessarily equal to operating losses for any given year. Table 11 shows the 1986 assessments in the six states.

Table 11: Assessments Levied on Members of State Risk Pool Associations--1986

State	Assessment
Connecticut	$1,490,387
Florida	0
Indiana	4,683,662
Minnesota	9,054,432
North Dakota	1,509,780
Wisconsin	750,000
Total	$17,488,261

Despite concerns expressed that risk pool losses will significantly increase insurance costs, assessments to date have been modest compared to the total volume of insurance business in the states. For the three states that did not permit tax credits, risk pool assessments represented less than 1 percent of the total volume of premium income in those states.

Program Features That Have Affected Operations

Officials in the six states have adjusted program requirements and benefits to achieve two sometimes conflicting objectives--increasing enrollment and controlling costs. Efforts to make the programs more attractive to potential enrollees, mainly involving improved benefits, tend to increase operating losses. Program officials have found that, in particular, reductions in and waivers of preexisting condition waiting periods contribute to increased program losses. However, when program administrators have attempted to control costs through premium increases and benefit restrictions, enrollment has either decreased or increased at a lower rate.

State program officials have not made a detailed analysis of how various changes have affected program operations. According to officials, many factors affect the operations of a risk pool, and it is difficult to isolate the impact of a change or event from the impact of the other factors. Nonetheless, program officials told us that the programs' enrollment history and fiscal experience can provide insight into the impact policy changes are likely to have on program operations.

Efforts to Increase Enrollment

Minnesota has the largest enrollment of the six risk pool programs reviewed, and that enrollment has grown steadily since 1983. Minnesota law limits risk pool premium rates to 125 percent of comparable private insurance rates. However, despite significant loss increases, the state insurance department has not authorized an increase in premium rates since 1985 even though the law would have permitted it. As a result, the program has the lowest premium rates of the six programs reviewed.

Wisconsin has taken several steps to boost enrollment. In 1985 it implemented a program, financed by state revenues, to subsidize risk pool premiums for low-income individuals. Persons with a household income of less than $16,500 are eligible for the premium subsidy, which varies with income. Table 12 shows the percentage of premium subsidies and the number of policyholders assisted as of December 31, 1986.

Table 12: Subsidy Percentage by Income and Number of Persons Assisted by the Wisconsin Program

Household income	Subsidy as a percentage of premium	Number of policies
Under $9,000	33.3	253
$9,000-$11,999	29.0	151
$12,000-$14,999	23.0	138
$15,000-$16,499	17.0	57
Total		599

Participants in this program represented about 29 percent of risk pool enrollees as of December 31, 1986. Wisconsin officials estimated that $433,000 was spent for premium subsidies in 1987. In 1988, the state will introduce a program to also subsidize deductibles for low-income individuals.

Provisions to waive the waiting period for coverage of preexisting medical conditions have proven costly. In 1983, Indiana authorized a waiver for enrollees who paid a 10-percent premium surcharge. Losses increased sharply during 1983 and 1984, and program officials attributed the increase to the waiver provision. Similarly, North Dakota introduced a waiver in 1985 to attract enrollment. According to North Dakota officials, the additional revenue gained from the 50-percent premium surcharge did not cover the sharp increase in claims expenses. The state has since terminated this waiver provision.

Efforts to Control Costs

The Connecticut program experienced sharply increased losses in part due to court action that required the program to provide unlimited coverage for mental and nervous conditions. To moderate losses, Connecticut increased premiums and doubled both deductibles and out-of-pocket expense limits for enrollees in 1985. Enrollment declined by about 20 percent between December 31, 1984, and December 31, 1985. Program officials identified the changes as a major factor in the enrollment decline. The state's robust economy and federal legislation extending health benefits to laid-off workers also contributed to the decline, according to the officials.

In 1983, Wisconsin took various steps to reduce risk pool losses. It raised the limit on risk pool premiums from 130 to 150 percent of comparable private premiums, extended the waiting period for coverage of preexisting medical conditions from 30 days to 6 months, and increased the enrollee's liability for out-of-pocket medical expenses from $1,500 to $2,000. Growth in program participation has been modest, despite the previously noted premium subsidies provided to low-income enrollees.

To reduce losses that occurred as a result of waiving the waiting period for coverage of preexisting medical conditions, Indiana increased base premiums significantly and, in January 1986, increased the waiver surcharge from 10 to 25 percent. Despite this action, losses continued to increase. Program officials believe that the higher premiums resulted in only those with the most costly health conditions enrolling or continuing their enrollment. Average claims paid per policyholder were $3,713 in 1986, the highest of the six programs reviewed. Program officials believe that enrollees paid the higher premiums and the 25-percent waiver surcharge because they had an immediate need for medical care. Indiana has since eliminated the waiver provision.

ENROLLEE CHARACTERISTICS

Risk pool enrollees are most likely to be middle aged. The limited data available suggest that enrollees incur higher medical costs generally and incur higher costs for heart and circulatory diseases, cancer, and diabetes specifically than does the population at large. State officials are concerned about, but have little information on, the potential cost impact on their programs concerning the treatment of AIDS patients.

Researchers who have studied risk pools believe that from 0.5 to 1 percent of the population is medically uninsurable. Their estimates, however, are rough approximations, not supported by detailed research on the size and demographic makeup of this population.

Demographics of Risk Pool Enrollees

Risk pool enrollees are more likely to be between the ages of 40 and 64 than the general population. Five of the six states reviewed maintained data on the age and sex of enrollees. Table 13 compares the age distribution of enrollees in the five states as of December 31, 1986, to that of the U.S. population in 1986. About 54 percent of the enrollees in these states were females, compared to about 52 percent of the national population.

Table 13: Comparison of Age Distribution of Risk Pool Enrollees to the National Population as of December 31, 1986[a]

Age category	Percent distribution: Risk pool enrollees	Percent distribution: National population
Under 30	22	47
30-39	14	16
40-49	15	11
50-59	26	9
60-64	19	5
Over 64	4	12

[a]The Census Bureau does not publish age distribution estimates for individual states for age categories comparable to those the risk pools maintain. Analysis of Census Bureau state-level data shows that differences between age distribution in the five states and the nation are not significant.

Insurance officials described various factors that influence the makeup of risk pool enrollment. First, women are less likely to participate in the labor force than men and are more likely to depend on their spouse for access to employer-sponsored group insurance plans; and as a result, women are at greater risk of losing access to group insurance because of divorce or death of a spouse. Second, middle-aged workers who lose coverage under group plans because of layoffs or terminations are more likely than younger workers to be in poor health and to experience difficulty in obtaining commercial health insurance. Finally, large numbers of persons 65 and older may not be enrolled because they are generally covered by Medicare.

Wisconsin has conducted periodic surveys to obtain demographic information on its program enrollees. In 1986, Wisconsin surveyed 1,919 enrollees and received responses from 1,101, or about 57 percent. The results of this survey may not accurately represent the characteristics of all enrollees in that state, but do provide information on the respondents. Wisconsin found that

-- 61 percent were not employed, and 13 percent were employed part time; and

-- 88 percent of those who were employed worked for firms employing 25 or fewer people--firms less likely to provide group health insurance.

Cost and Nature of Medical Services Used

The six states we reviewed did not gather consistent data on the health care costs risk pool enrollees incur. Available information on medical expense reimbursements made to enrollees, however, indicates that the costs they incur are higher than those of the average person. Table 14 presents 1986 claims expenses per policyholder, based on the average number of policies outstanding for the year in the six states. The states did not maintain consistent data on claims expenses per insured person, and these figures may slightly overstate average annual expenses for an individual to the extent that more than one person was insured under a policy.

Table 14: Average 1986 Claims Expenses per Policyholder for State Risk Pool Programs

State	Average claims expense per policyholder
Connecticut	$1,742
Florida	2,504
Indiana	3,713
Minnesota	1,804
North Dakota	2,495
Wisconsin	1,555

As the table shows, average claims expense per policyholder, not including deductible and coinsurance expenses paid by the policyholder, varied considerably. The weighted average for the six states was $2,140. In comparison, according to estimates prepared by the Department of Health and Human Services, per capita health care expenses, including deductible and coinsurance payments, averaged about $1,620 nationally in 1986.

Three states have gathered information on the conditions that enrollees suffer from, and one state has gathered information on the conditions that made it difficult for them to obtain insurance in the private market. The company that administers the Florida, Indiana, and Wisconsin programs summarizes claims expenses by the health conditions that led enrollees to seek treatment. These data indicate that enrollees in these states incur more expenses for the

treatment of heart and circulatory diseases, cancer, and diabetes than national averages for all persons the company insures. Table 15 shows the data from the three states.

Table 15: Comparison of 1986 Claims Expenses Incurred, by Medical Condition, for Three State Risk Pool Programs, to Company's 1986 Average Claims Expense

	Percent of claims expenses paid			
Medical condition	Company average	Florida	Indiana	Wisconsin
Heart and circulatory diseases	12	12	15	23
Cancer	7	15	18	13
Abdominal conditions	10	18	10	7
Diabetes	1	5	3	6
Blood disease	1	5	1	5
All other	69	45	53	45

In its periodic surveys, Wisconsin asks enrollees about the health conditions that prevented them from obtaining private insurance. In 1986, about 22 percent of those who responded reported that heart-related diseases prevented them from obtaining insurance. About 11 percent cited hypertension; 14 percent, diabetes; and 9 percent, cancer.

Impact of AIDS on Risk Pool Programs

Both insurance industry and advocacy group officials have indicated that risk pools can help finance the cost of treating AIDS patients. The president of the Health Insurance Association of America, for example, has written that no institution by itself can bear the burden of "the alarming medical bill for AIDS." Likewise, the executive director of the Gay Men's Health Crisis, an organization interested in AIDS-related health care issues, has acknowledged that insurance companies have legitimate concerns about the catastrophic cost of treating AIDS patients. Both have endorsed risk pools as part of the solution to the problem of financing AIDS care.

Program officials in the six states reviewed expressed concern about the potential impact of AIDS-related costs on their risk pool program. None of the states limit coverage of AIDS, and four states--Indiana, Iowa, Minnesota, and Nebraska--specifically make individuals diagnosed with AIDS eligible for their programs. None of the states, however, had studied whether individuals likely to develop AIDS were enrolled in their programs or whether enrollees were being treated for the disease. In two states, officials noted that the types of medical services being provided certain enrollees appeared to be consistent with an AIDS diagnosis.

HAVE THE PROGRAMS MET EXPECTATIONS?

The six states we reviewed have not formally assessed risk pool program performance. Risk pool legislation emerged in response to a perception that opportunities to purchase health insurance were decreasing for persons with serious health problems. According to state officials and insurance industry representatives, the legislation generally was a compromise response to other approaches that would have required all insurers to offer open enrollment. Legislators concluded that the risk pool would distribute the burden of persons with chronic or costly medical conditions among insurers more equitably. Legislation authorizing the risk pools did not establish specific goals but rather contained general statements about assisting the medically uninsurable. Legislative histories of the programs generally offered limited insight into what legislators expected the programs to accomplish.

The information that would be needed to evaluate program performance generally has not been developed. Officials in the six states reviewed have not estimated the size of the medically uninsurable population in their states. Consequently, program officials do not know what portion of this population their programs serve. Further, the states generally do not compile information on the makeup of the enrollee population. As a result, program officials do not know which population segments find the programs most attractive or, more importantly, which segments to target in order to bring coverage to those in need. Officials in the six states reviewed generally believe that their programs are not serving all the medically uninsurable in their states.

SUMMARY

Risk pools provide subsidized health insurance to that segment of the uninsured population that cannot obtain it because of poor health. The six programs that we reviewed have assisted a limited number of persons. As of February 1988, conclusive evidence to show that risk pools are or are not effective, and data that would allow comparison of risk pools to other mechanisms for financing health care for the uninsured, had not been developed.

STATES IN WHICH BLUE CROSS AND BLUE SHIELD PLANS OFFER OPEN ENROLLMENT

District of Columbia
Maryland
Massachusetts
Michigan
New Hampshire
New Jersey
New York
North Carolina
Pennsylvania
Rhode Island
Vermont
Virginia

STATES THAT CONSIDERED, BUT DID NOT ENACT, LEGISLATION AUTHORIZING A RISK POOL DURING 1987

Alaska
California
Georgia
Mississippi
Missouri
New York
Ohio
South Carolina
South Dakota
Texas
Vermont
West Virginia

PRIVATE GROUPS AND ORGANIZATIONS CONTACTED TO OBTAIN INFORMATION ON RISK POOLS

American Diabetes Association
Washington, D.C.

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

Center for Health Affairs
Chevy Chase, Maryland

Communicating for Agriculture
Minneapolis, Minnesota

Employee Benefits Research Institute
Washington, D.C.

Health Insurance Association of America
Washington, D.C.

Intergovernmental Health Policy Project
Georgetown University
Washington, D.C.

National Association of Insurance Commissioners
Kansas City, Kansas

National Governors' Association
Washington, D.C.

National Health Policy Forum
George Washington University
Washington, D.C.

The Center for Study of Social Policy
Washington, D.C.

Urban Institute
Washington, D.C.

Washington Business Group on Health
Washington, D.C.

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Insurers Weeding Out the Sick

Even in large group plans, those with problems can lose coverage

By Gina Kolata
New York Times

New York

In a new practice, some health insurance companies are starting to divide the sick from the well, even in large groups that were once a bastion of security in a tumultuous industry.

Families in large groups had always felt that if they had been part of the group for at least six months or a year, their medical costs would be covered and their premiums would remain stable. But now, some insurance companies are drastically raising rates for sick people, and even for people they think may become sick.

The result, said Dr. Norman Daniels, an ethicist at Tufts University who is an expert on health insurance, is that "no one in this country with private health insurance coverage who is in any kind of group plan is free from the kind of uncertainty that competition is producing."

One Family's Story

No one knows how common it is for insurance companies to raise the rates for the sick in large groups, which usually consist of employees at big corporations or members of special-interest organizations. But the experience of Kathleen Renshaw of Leucadia, Calif., and others shows that the problem, once thought to be limited to small groups, is spreading to large groups as well.

Renshaw finally admitted defeat in her struggle to keep group health insurance for her family when the annual premium reached $16,000 a year. Her problem is her 8-year-old daughter, Marisa, an exuberant child who swims on a team and takes singing lessons.

But Marisa has only one kidney, and it does not fully function. She needs regular checkups and may face kidney failure in the future. When the family's insurance company learned of the problem, which doctors discovered when Marisa was 3, it began doubling the family's health insurance premiums each year, the maximum increase allowed by California law.

Finally, the family could no longer pay, and no other company would insure them. Along with Marisa, Renshaw, her husband, William Harvey, and their 4-year-old daughter, Kirsten, who has no medical problems, were out in the cold.

Renshaw and Harvey never thought they would be without health insurance. They both have jobs, they bought group health insurance through the alumni association at the University of California at San Diego, and they always paid their premiums.

"I thought that when you pay insurance, the insurance companies will pay for you when you get sick," Renshaw said.

'Spiral of Exclusion'

Donald Light, a sociologist who is professor of health policy at the University of Medicine and Dentistry of New Jersey, said the family's experience is "a tragic example of the spiral of exclusion that is spreading through the entire health care industry."

Light said the practice of raising rates for people who are sick or have pre-existing conditions began in small groups, like self-insured small businesses, in the mid- to late 1980s. Although it is still most common in small groups, he said, it is spreading to larger and larger groups. The group Renshaw and Harvey joined has thousands of families.

Donald B. White, a spokesman for the Health Insurance Association of America, which represents commercial insurance companies, said that what happened to Renshaw's family is unacceptable. He said it is because of cases like hers that "we and everyone else are proposing reforms that would change the laws so that could not happen again."

White said most problems are with small groups, so the insurance association has proposed legislation to change that market. It wants federal laws to guarantee that high-risk people in small groups can buy insurance at a cost that is no more than 50 percent more than the average premium.

Legislation

Senator Lloyd Bentsen, D-Texas, has introduced a bill in Congress that would prevent the exclusion of sicker people from health insurance coverage sold to small businesses and would prevent small groups from canceling policies of sicker people.

But these remedies do not address the situation Renshaw and Harvey faced because they were not insured with a small group.

Through a catastrophic health insurance plan of the California Children Services, Marisa is now covered for major problems with her kidney, but nothing else.

And Renshaw said this coverage is available only if a family of four has an income of $40,000 or less. But if Renshaw, now a substitute teacher, gets a full-time teaching job, which she has been seeking, the family would be disqualified. In that case, she said, "our next option is a divorce."

STAYING AHEAD *Jane Bryant Quinn*

Having Health Insurance Is No Guarantee of Coverage

Americans who have health insurance may complacently ignore the terrors of the people without.

But there's a mounting risk your health insurer will fail, leaving you with unpayable bills. The toll is cutting across every kind of medical-payment group.

■ According to Standard & Poor's, 121 life and health insurance companies went broke in the past three years.

■ Blue Cross and Blue Shield of Charleston, W.Va., collapsed in 1990, leaving some $41 million in unpaid bills.

■ At least 131 Health Maintenance Organizations failed between 1988 and 1990, says Jon Christianson, a professor in the School of Public Health, University of Minnesota.

■ Unknown numbers of multiple employer welfare arrangements have gone broke, often through fraud. MEWAs sign up small companies that can't afford coverage from the major insurers. Some MEWAs are legitimate, but others collect premiums and then skip.

So serious is the carnage that, in some states, doctors and hospitals require their patients to agree, in writing, to pay any bill that their insurer defaults on.

When looking for a sound insurance company, all you can go by is its safety rating. You want an A+ from A.M. Best and AAA from at least one of the other major rating firms — Moody's, Standard & Poor's or Duff and Phelps. S&P also passes out "q" ratings for insurers it hasn't examined in full — the highest being BBBq. Such a company might be an AAA had S&P examined its books.

No rating system covers HMOs. A.M. Best doesn't rate the Blues, either, although a few are rated by S&P. To get the current financial statement of any Blue plan, call its public information department or your state's insurance commission. Look to see if it's making or losing money.

With MEWAs, the sign of a high-risk plan is lower monthly premiums than the competition offers. Employers shouldn't buy into a MEWA without asking their state insurance commission if the plan is licensed for sale there and whether there have been any complaints. Avoid new MEWAs.

> *The sign of a high-risk plan is lower monthly premiums than the competition offers*

If your insurer fails, leaving you with unpaid bills, you might be caught by one of the following safety nets:

■ "Hold-harmless" clauses. These stop doctors and hospitals from dunning individuals for bills that should have been paid by their medical-service plans. All federally qualified HMOs have them, as do HMOs in 33 states. Some states also require them of the Blues and of regular insurance plans. Some doctors ignore hold-harmless clauses and bill their patients anyway (ask your state insurance department if you have to pay). If you sign an agreement to pay when you enter a hospital you might, in some states, lose the protection of a hold-harmless clause.

■ State guaranty funds. All the states — the only exception being the District of Columbia — now provide guaranty funds for individual policies. They cover up to $100,000 of medical expenses (more in some states) for insurers licensed to sell in the state. Most group-health plans aren't included, however, nor are MEWAs. Eighteen funds now cover the Blues; seven cover HMOs.

In general, the funds guarantee (up to the dollar limits of state law) all your back bills, all your current bills, and all future bills until you find another insurer or your policy comes up for renewal, which may be anytime from tomorrow to 12 months. Starting from the time your insurer failed, you have to pay premiums to the guaranty fund, perhaps at a higher rate than you paid before.

■ Insurance-agent liability. If your agent sold you a policy from a company not licensed in your state, the agent may be liable for any bills the company defaults on. Pennsylvania, which is vigorously pursuing MEWA cases, has collected more than $70,000 from agents on behalf of consumers, says Linda Wells, chief counsel for the state insurance department. Some states hold agents liable if they knew or should have known that the company was insolvent, says Washington, D.C., attorney Gregory Luce.

If you work for a big company whose insurer fails, the chances are good that your employer will cover your bills. Smaller companies, however, may not be able to afford it. Sometimes doctors and hospitals don't bill patients whose insurers collapse, but that's not a sure thing, either. You have to get lucky, which is no way to run a health-insurance system.

// Health Benefits Letter #18

...covering state, federal and private-sector developments in health benefits reform

Blues Release New Health Insurance Reform Proposal

In testimony before the House Ways and Means Committee, Bernard Tresnowski, President of the Blue Cross Blue Shield Association, presented a new health reform proposal that, he said, had been unanimously approved by his board of directors just days before. He said,"we must create a new insurance environment — patterned on the Blue Cross and Blue Shield organization's historic practices."

The proposal would eliminate most existing health insurance companies by allowing tax deductions only for benefits purchased from "qualified carriers." To become qualified, an insurer would have to meet federally imposed standards that would include the use of participating provider arrangements and managed care techniques. "Under our approach, we would stop rewarding insurance companies that are principally claims processors and medical underwriters," Mr. Tresnowski told the committee.

He said qualified carriers, "must demonstrate proven records of managing health care costs effectively, including a capacity to perform utilization management, selective provider contracting and uniform billing and data collection."

Mr. Tresnowski said this emphasis on managed care, combined with with reform of the medical malpractice system would control health care costs better than regulatory approaches could.

For assuring universal coverage, Mr. Tresnowski proposed requiring small employers to offer, but not pay for, employee coverage. Those who do not fund coverage "would be subject to an assessment which would be significantly less than the cost of contributing to coverage."

Employees would be required to "accept" the coverage, and be required to pay for it unless their employer could be persuaded to pick up the tab.

Mr. Tresnowski does not directly discuss the cost impact on individual employees, except to say "substantial tax subsidies" would be made available to low income employees, and "most employees" would have most of their premium paid by their

(Please turn to page 2)

Twenty-five States Now Have Enacted High Risk Pools

Twenty-five states have enacted insurance pools for their high risk populations. According to information compiled by Communicating for Agriculture (CA) these pools (also known as "Comprehensive Health Insurance Plans" or CHIPs) enroll 76,873 people (see charts on pages 4 and 5).

The pools are intended to provide subsidized coverage to individuals with existing medical conditions who are unable to obtain insurance in the private market. They typically provide major medical benefits with substantial deductibles and copayments. They also charge from 125% to 400% of the standard premium for similar benefits within the state. At these rates the pools are clearly not intended to help people of limited means, but are aimed at those with financial resources who are otherwise uninsurable.

While the pools do not cover large numbers of people, they have an effect well in excess of raw enrollment figures because of the high use of services by those who are enrolled. According to the most recent available numbers, the seventeen state pools which have been active long enough to pay claims, pay over $185 million per year for 67,972 enrollees - an average payment of $2,726.30. For this coverage enrollees pay premiums averaging $1,583.24 per person per year. The difference is made up for by any one of several subsidy approaches.

NAIC Model Revisions

How to subsidize the pools for losses in excess of premium income has been the biggest issue of contention for those states that have not yet adopted a pool. The National Association of Insurance Commissioners

(Please turn to page 4)

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High Risk Pools in 25 States

(Continued from page 1)

(NAIC) has had a working group of regulators, chaired by South Dakota's Director of Insurance Mary Jane Cleary, looking into this and several other issues for the past two years. This working group is about to release a revised model act for public comment with the hope that it will be adopted at the December NAIC meeting in Houston.

Other issues considered by the NAIC group were benefit structure, pool administration, and whether group plans should be allowed to refer high-risk employees to the pool. Discussion of each of these issues follows.

Financing

States have adopted a wide range of financing mechanisms for their high-risk pools. Nearly all of the early ones were viewed as industry-based residual market mechanisms that were organized, operated and financed by the health insurance industry. The industry was assessed for any excess losses but could take the assessments as a credit against their premium tax obligation.

More recently pools have been seen as public programs, usually with broad-based boards of directors and broad-based funding. Several are now financed through general revenues, others use dedicated taxes on tobacco or hospital services. The new NAIC model act references all the available financing mechanisms without recommending reliance on any one of them. Director Cleary says the model lays out the following funding sources:

- Premiums from enrollees
- Health insurer assessments with full or partial tax offsets
- Per capita assessments on insurers and reinsurers

High Risk Pools - Financial Experience

	Enrollment	Premiums Collected	Per Person Premium	Claims Paid	Per Person Claims
CA	8,901	n/a	n/a	n/a	n/a
CO	n/a	n/a	n/a	n/a	n/a
CT	2,200	$ 4,495,872	$ 2,043.58	$ 10,438,000	$ 4,744.55
FL	5,934	$ 12,443,960	$ 2,097.06	$ 17,425,025	$ 2,936.47
GA	n/a	n/a	n/a	n/a	n/a
IL	4,370	$ 11,951,968	$ 2,735.00	$ 24,138,119	$ 5,523.60
IN	3,080	$ 8,376,736	$ 2,719.72	$ 16,978,462	$ 5,512.49
IA	1,971	$ 4,574,013	$ 2,320.66	$ 5,053,843	$ 2,564.10
LA	n/a	n/a	n/a	n/a	n/a
ME	400	$ 515,525	$ 1,288.81	$ 1,154,193	$ 2,885.48
MN	25,272	$ 25,734,981	$ 1,018.32	$ 49,469,692	$ 1,957.49
MS	n/a	n/a	n/a	n/a	n/a
MO	n/a	n/a	n/a	n/a	n/a
MT	304	$ 629,463	$ 2,070.60	$ 569,834	$ 1,874.45
NE	2,904	$ 4,422,717	$ 1,522.97	$ 6,760,239	$ 2,327.91
ND	1,303	$ 2,571,307	$ 1,973.37	$ 4,312,535	$ 3,309.70
NM	1,656	$ 2,854,825	$ 1,723.93	$ 4,205,865	$ 2,539.77
OR	1,211	$ 1,332,469	$ 1,100.30	$ 1,132,952	$ 935.55
SC	1,072	$ 1,636,144	$ 1,526.25	$ 1,794,927	$ 1,674.37
TN	4,121	$ 10,775,374	$ 2,614.75	$17,121,200	$ 4,154.62
TX	n/a	n/a	n/a	n/a	n/a
UT	n/a	n/a	n/a	n/a	n/a
WA	2,793	$ 4,718,231	$ 1,689.31	$ 7,186,956	$ 2,573.20
WI	9,287	$ 10,561,456	$ 1,137.23	$ 17,569,449	$ 1,891.83
WY	94	$ 20,690	$ 220.11	$ 548	$ 5.83
	76,873	$107,615,731	$ 1,583.24	$185,311,839	$ 2,726.30

NOTES: All figures are year end 1990 except, CT and Fl (1989), OR (6/90), and WY (4/91). Per capita averages exclude California enrollment. Source, Communicating for Agriculture

High Risk Pools - General Information						
	Effective Date	Pre-X Waiting Period	Premium Cap	Funding Source	Tax Offset	Plan Administrator
CA	1991	90 Days	125%	Tobacco Tax	n/a	BCBS
CO	1991	6 Months	175%	Income Tax Surcharge	n/a	BCBS
CT	1976	12 Months	150%	Insurer Assessment	No	Travelers
FL	1983	12 Months	300%	Insurer Assessment	No	BCBS
GA	note 1	6 Months	150%	General Revenue	n/a	n/a
IL	1989	6 Months	135%	General Revenue	n/a	Mutual of Omaha
IN	1982	6 Months	150%	Insurer Assessment	Yes	ASGC, Inc.
IA	1987	6 Months	150%	Insurer Assessment	Partial	Mutual of Omaha
LA	1992	6 Months	200%	Lottery & Hospital Tax	n/a	n/a
ME	1988	90 Days	150%	Hospital Tax	n/a	Mutual of Omaha
MN	1976	6 Months	125%	Insurer Assessment	No	BCBS
MS	1992	12 Months	175%	note 2	No	n/a
MO	1991	12 Months	200%	Insurer Assessment	Yes	BCBS
MT	1987	12 Months	400%	Insurer Assessment	Yes	BCBS
NE	1986	6 Months	165%	Insurer Assessment	Yes	BCBS
NM	1988	6 Months	150%	Insurer Assessment	Partial	BCBS
ND	1981	6 Months	135%	Insurer Assessment	Yes	BCBS
OR	1990	6 Months	150%	note 2	No	BCBS
SC	1990	6 Months	300%	Insurer Assessment	Yes	BCBS
TN	1987	6 Months	150%	Gen'l Rev. & Insur. Assmt.	No	BCBS
TX	note 1	6 Months	200%	Insurer Assessment	Yes	BCBS
UT	1991	6 Months	200%	General Revenue	n/a	BCBS
WA	1988	6 Months	150%	Insurer Assessment	Yes	Mutual of Omaha
WI	1981	6 Months	150%	Insurer Assessment	No	Mutual of Omaha
WY	1991	6 Months	200%	Insurer Assessment	Partial	BCBS

NOTES: (1) Effective dates in GA and TX depend upon additional legislative action. (2) MS and OR both assess payers, including reinsurers and TPAs, on a per capita basis. Source, Communicating for Agriculture

High Risk Pools in 25 States

(Continued from previous page)

- Hospital fees on admissions or outpatient services when paid by a third party
- General revenues
- Dedicated revenues from alcohol and tobacco taxes, per-employee payroll taxes, income tax surcharges, and state lottery proceeds.

Each of these approaches is in effect somewhere. Which approach is most acceptable depends on the political and economic status of the particular state.

Administration

As public financing becomes more prevalent, so does public administration of the pool. The new model will suggest that board members be appointed by the insurance commissioner in those states where the commissioner is elected, or by the governor in states where the commissioner is appointed. In either case the board should have a majority of public members and should be chaired by the insurance commissioner.

The pool boards will continue to select an insurer or other entity to perform administrative services for the pool.

Benefits

Generally, covered benefits in the existing pools are very comprehensive. They are structured as major medical programs with high deductibles and copayments. Deductibles range from $200 to $2,000 for individuals and stop-loss levels may be as high as $5,000.

Most pools give enrollees a choice of coverage options and set premiums according to the level of coverage

(Please turn to page 6)

High Risk Pools in 25 States

(Continued from page 5)

chosen. Maximum lifetime benefits may be as low as $250,000 or as high as $1 million.

The NAIC working group had two concerns about benefits. One was whether to include benefits that are mandated for inclusion in private insurance contracts, and the other concern was on how to encourage the use of managed care and other cost containment programs. The revised model continues to reference a major medical approach to benefits but suggests that the final decisions on benefit structure and cost controls should be left to the board.

Enrollment

Several states have had problems with employer groups "dumping" their high-risk employees into the pool as a way of lowering the cost of coverage for the rest of the group, or of making the whole group insurable when it otherwise would not be.

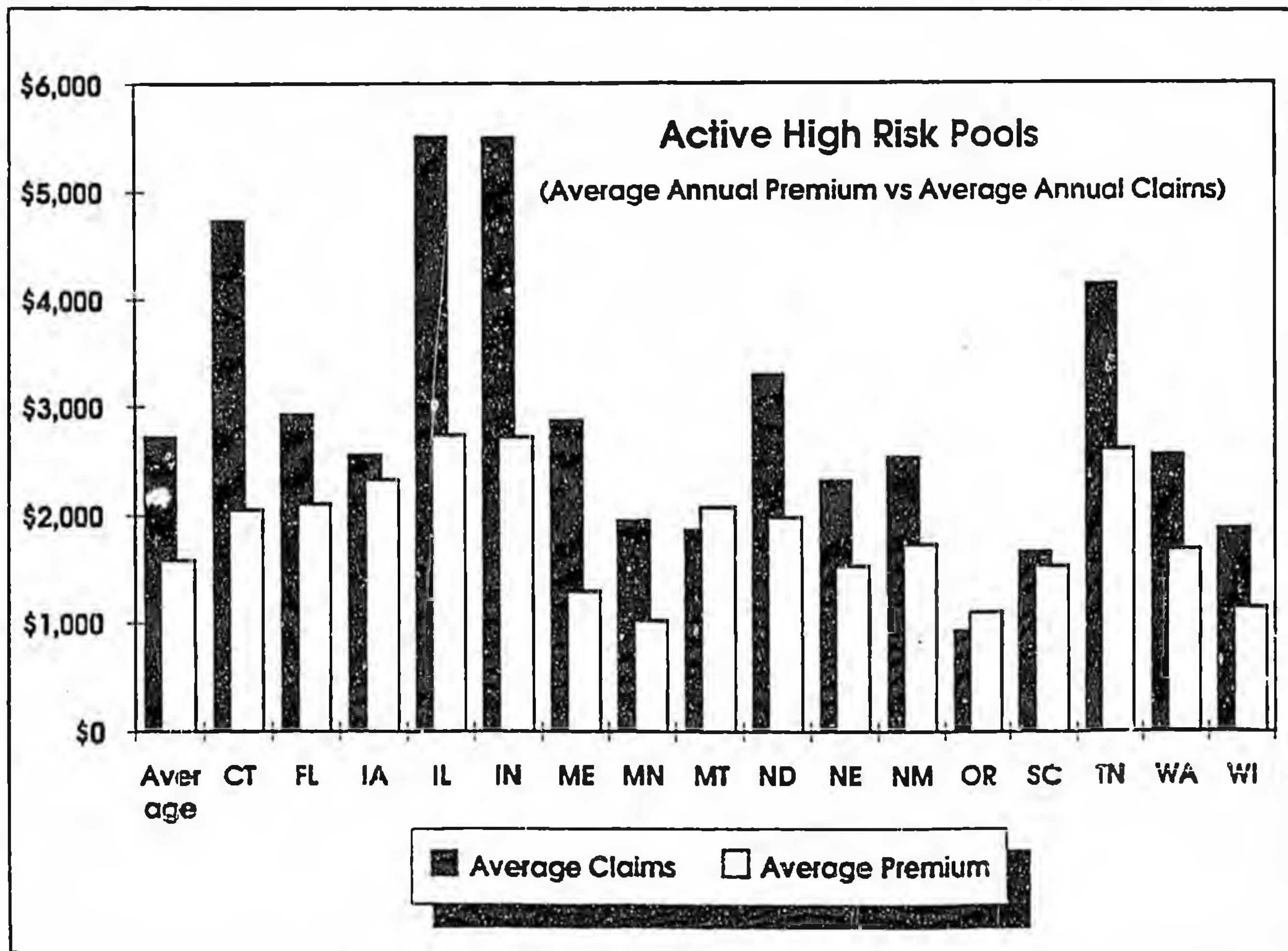
Some people maintain that this use of a pool is a legitimate strategy for simultaneously covering people with medical conditions, and making small group coverage more affordable for standard-risk employer groups.

Most states enacted pools only for individuals, and did not anticipate this use by employers. The administrators in several of these states are alarmed that pool enrollment (and pool losses) has exceeded projections because of this use by employers.

Director Cleary said the new model will include language taken from the California legislation which prohibits dumping. The language calls it an unfair trade practice for insurers, employers or agents to refer someone to the pool for the purpose of separating them from employment-based coverage.

The adoption of the new NAIC model in December is likely to renew efforts to enact pools in those states that have come close to adopting them in the past. Notable among these states are Ohio, North Carolina, Oklahoma, New Hampshire and Arizona. Director Cleary said that in her own state of South Dakota a pool bill is likely to pass next year, but it will need to have funding other than straight general revenues or the governor will veto it.

The report from Communicating for Agriculture is available for $24 by calling 612-854-9005



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SB
75

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 75

Revision Date: 12/11/91
Title: Reimbursement of Scholarship Loans
Sponsor: Senator Kerttula
Requestor: (S)HESS

Department Affected: Education
BRU: Postsecondary Education Commission
Component: Student Loan Corporation
COMPONENT SERIAL NO. 0 2 1 8

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING: (Thousands of Dollars)

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

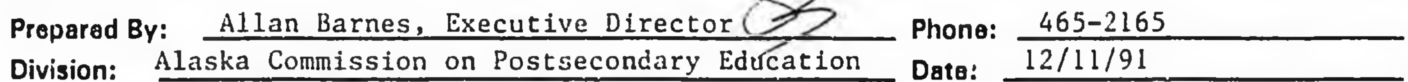
POSITIONS:

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: NONE

ANALYSIS: (Attach a separate page if necessary.)

Fiscal impact occurs in year 2000-2001 (see attached).



Prepared By: Allan Barnes, Executive Director
Phone: 465-2165
Division: Alaska Commission on Postsecondary Education
Date: 12/11/91

Approved by Commissioner:
Agency: **Date:**

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/7/91

SB75

Analysis of Fiscal Impact

Fiscal Impact

Year	Cost	Year	Cost
1991-92	None	2001-02	6,615.7
1992-93	None	2002-03	8,041.5
1993-94	None	2003-04	9,111.1
1994-95	None	2004-05	9,557.7
1995-96	None	2005-06	9,798.8
1996-97	None	2006-07	9,982.7
1997-98	None	2007-08	10,115.1
1998-99	None	2008-09	10,229.0
1999-00	2,726.4	2009-10	10,337.7
2000-01	5,049.7	2010-11	10,446.9

Assumptions

1. Forgiveness amounts are based on a loan demand which allows for a 1% increase from 1993-94 through 2003-04.

2. Interest is included as part of total indebtedness allowable for forgiveness.

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 75

Revision Date:
Department Affected: Education
Title: Reimbursement of Scholarship Loans
BRU: Postsecondary Education
Component: Student Loan Corporation
Sponsor: Kerttula
Requestor: (S)HES
COMPONENT SERIAL NO. 0 2 1 8

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

Fiscal impact occurs in year 1999-2000. (See attached.)

Prepared By: Jane Byers Maynard, Executive Director
Phone: 465-2165
Division: Alaska Commission on Postsecondary Education
Date: February 6, 1991

Approved by Commissioner:
Agency:
Date:

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

SB 75

Analysis of Fiscal Impact

Fiscal Impact

Year	Cost	Year	Cost
1991-92	None	2001-02	6,615.7
1992-93	None	2002-03	8,095.9
1993-94	None	2003-04	9,042.9
1994-95	None	2004-05	9,212.5
1995-96	None	2005-06	9,211.6
1996-97	None	2006-07	9,181.3
1997-98	None	2007-08	9,121.5
1998-99	None	2008-09	9,110.4
1999-00	2,726.4	2009-10	9,152.8
2000-01	5,049.7	2010-11	9,222.4

Assumptions

1. Forgiveness amounts are based on a loan demand which allows for a 1% increase from 1993-94 through 2003-04.

2. Interest is included as part of total indebtedness allowable for forgiveness.

#4311T

Alaska State Legislature

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO: Senator Arliss Sturgulewski, Chair
Senate HESS Committee

FROM: Senator Jay Kerttula

SUBJ: Senate Bill 75 --
Student Loan Rebate

DATE: January 30, 1991

Jay
Thank you

I would appreciate your scheduling Senate Bill 75, relating to a rebate program for the Alaska Student Loans.

Senate Bill 75 is a redraft of Senate Bill 121, which I drafted last session to reinstate the student loan forgiveness program. Senate Bill 75 is worded in terms of a "rebate", rather than "forgiveness" due to an opinion of the attorneys for the Alaska Student Loan Corporation. I have attached a copy of that opinion for your information.

The loan rebate program under Senate Bill 75 would work in the same fashion as the former student loan forgiveness program, 10 percent of the loan would be rebated to a student after he or she lives in Alaska for one year after graduation, 20 percent for two years, 30 percent for three years, etc.

As you are aware, the student loan forgiveness provision was an integral part of the student loan program since its inception. Loan rebate or forgiveness serves a very basic function -- encouraging Alaska's young people to return to the state after graduation. We cannot afford to continue to lose the talents and energy of these young people.

I appreciate your consideration of this request. I have attached some general and specific background information which was issued by the Student Loan Corporation in 1986.

JK:kh

(1) Jay wants to exclude part-time. may need to be specifically excluded.

SENATE BILL NO. 75

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91
Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to reimbursement of scholarship loans; and providing for an effective**
2 **date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 14.43.120 is amended by adding new subsections to read:
5 (s) A portion of a loan shall be reimbursed to the borrower by the state if, after
6 completion of the course of study for which the loan was granted, the borrower is a resident of
7 the state and has fully repaid the entire principal and interest due on the loan. The portion of
8 the loan that shall be reimbursed by the state is based on the length of the borrower's residence
9 in the state after completion of the course of study for which the loan was granted and on the
10 following percentages of the principal amount of the loan plus interest up to a total of 50 percent
11 of the total indebtedness:
12 (1) at least two, but less than three years residence in the state, 10 percent;
13 (2) at least three, but less than four years residence in the state, an additional 10
14 percent;

1 (3) at least four, but less than five years residence in the state, an additional 10
2 percent;
3 (4) at least five, but less than six years residence in the state, an additional 10
4 percent;
5 (5) six years or more residence in the state, an additional 10 percent.
6 (t) Reimbursement under (s) of this section is subject to appropriation by the legislature.
7 Money obtained from the sale of bonds by the Student Loan Corporation under AS 14.42.220
8 may not be appropriated for the reimbursement of loans.
9 * **Sec. 2.** This Act applies to principal and interest due on a loan entered into on or after July 1, 1987,
10 that is unpaid as of the effective date of this Act.
11 * **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

ALASKA STUDENT LOAN CORPORATION

STEVE COWPER, GOVERNOR

P.O BOX FP
JUNEAU, ALASKA 99811-0599
PHONE: (907) 465-2854

Senate Bill No. 75

The members of the Commission on Postsecondary Education endorse the concept of restoring loan forgiveness. The provisions of SB 75 to provide for a rebate of funds subject to legislative appropriation are in keeping with Alaska Student Loan Corporation Bond Counsel criteria.

Jane Byers Maynard
Executive Director

05-E34LH

Kathy

STEVE COWPER, GOVERNOR

JAN 1 ? 1990

ALASKA COMMISSION ON POSTSECONDARY EDUCATION

P O BOX FP
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M E M O R A N D U M

TO: The Honorable Jay Kerttula
Alaska State Senate

FROM: Jane Byers Maynard, Executive Director
Alaska Commission on Postsecondary Education

SUBJECT: Senate Bill 121

DATE: January 11, 1990

Enclosed at your request is fiscal impact information for Senate Bill 121. This information is an update of the costs provided to you last session in the attached February 21, 1989 memo from Dr. Phipps.

Based on the attached position paper submitted last year by the bond counsel for the Alaska Student Loan Corporation, Mr. Kenneth Vassar, it is still assumed that forgiveness would be in the form of a rebate as discussed by counsel. I have asked Mr. Vassar, however, to review his opinion to determine if any other administrative options are available in light of our obligations to bondholders. He will be happy to do so.

Costs associated with the bill have been revised to reflect a more realistic loan growth rate and default rate scenario over the next several years as detailed in assumptions 3 and 4 below.

Assumptions

1. Forgiveness would take the form of a rebate.

2. The intent of SB 121 is to provide forgiveness retroactively to loans made after the previous forgiveness provisions were repealed in 1987.

3. Loan growth is assumed to:

   a. stabilize 1989-90 through 1992-93;
   b. increase by 1.5% 1993-94 through 1996-97; and
   c. increase by 3% from 1997-98 on.

4. Loan default rates are assumed as follows:

   a. 17.3% 1987-88;
   b. 18.7% 1988-89;
   c. 18.7% 1989-90 through 1990-91;

The Honorable Jay Kerttula
January 11, 1990
Page 2

d. 15.0% 1991-92 through 1992-93;
e. 14.0% 1993-94 through 1994-95;
f. 13.0% 1995-96 through 1996-97; and
g. 12.5% 1997-98 on.

Fiscal Impact

Year	Cost	Year	Cost
1987-88	None	1999-00	1,803,450
1988-89	None	2000-01	3,313,017
1989-90	None	2001-02	4,518,639
1990-91	None	2002-03	5,664,843
1991-92	None	2003-04	6,567,063
1992-93	None	2004-05	7,000,168
1993-94	None	2005-06	7,293,504
1994-95	None	2006-07	7,508,067
1995-96	None	2007-08	7,678,401
1996-97	None	2008-09	7,826,589
1997-98	None	2009-10	8,007,259
1998-99	None	2010-11	8,212,509

It would be my pleasure to meet with you to discuss this information at your convenience.

Attachments

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TO: Ron Phipps
Alaska Student Loan Corporation
FROM: Kenneth E. Vassar
RE: SB 121
DATE: February 17, 1989

POSITION PAPER

Senate Bill No. 121

Senate Bill No. 121 would add payment forgiveness provisions to the current student loan program.

We note that the language of the bill is cast in terms of the State paying a portion of the borrower's loan. One interpretation of this language would be that the borrower would be liable for full payment of his or her loan but would be entitled to expect reimbursement from the State for a portion of the amount paid. However, similar language used to establish the previous forgiveness program led to an interpretation that the borrower simply did not have to repay the portion that was to be paid by the State. The latter interpretation creates difficulties as discussed below to the extent that the legislation affects loans already made at the time of passage.

Generally, legislation cannot be enacted to impair contract rights of others. One issue that arises with respect to SB 121 is the effect this legislation would have on loans that have already been pledged as security under the indenture for the bonds issued by the Corporation in 1988. If the legislation is interpreted to mean that the borrower does not have to repay the portion to be paid by the State, then SB 121 would impair the bondholders' contract rights by reducing the individual borrower's obligation to make payment on the loan. Such an impairment of the security for the bonds cannot be intentionally accomplished without first obtaining the consent of the bondholders. Although payments could be made by the State on behalf of the borrowers, such payments would be subject to annual appropriation and, therefore, would not avoid the impairment concerns expressed above.

SB 121 could be clarified so that it would clearly create a rebate program rather than a forgiveness program (that is, the borrower would continue to make full payments to the Corporation of the entire amount due on the loan for the entire term of the loan and the State would thereafter appropriate money to repay the borrower for a portion of those payments). Under such a program, the impairment concerns discussed above would not arise. However, it would have to be abundantly clear that (1) the borrower remains liable for making full payment of the amount owed without regard to any such rebate provisions, (2) the rebate would occur only after the borrower has made full payment on all amounts due on the loan for the life of the loan, and (3) neither the borrower nor the State would have any recourse to the Corporation's assets in connection with the rebate program.

Even if SB 121 is applied purely prospectively (that is, only with respect to loans made after passage of the bill), it should be noted that its provisions would affect the Corporation's ability to issue bonds to finance the loan program. This is because of the coverage ratio required to be met pursuant to the indenture before further bonds of the Corporation can be issued. Any reduction in revenues as a result of non-payment by borrowers (or the State on their behalf) would reduce the coverage ratio at some time in the future and would thereby make it more difficult for the Corporation to issue bonds in the future and become self-sustaining.

Again, we would not encounter this problem if the legislation were clarified to create a rebate program rather than a payment forgiveness program. A separate program that would reimburse or rebate qualifying students for payments made on their student loans (with the students continuing to make payment to repay their loans) would have no adverse impact on the Corporation's coverage ratios. This alternative would require that the State appropriate the money necessary to reimburse or rebate the student borrowers from sources other than assets pledged under the indenture.

As a final note, if the retroactivity provisions of Section 2 of the bill remain in the bill, we would suggest that they be clarified. The intent of this Section we would guess to be to provide forgiveness retroactively to loans made after the previous forgiveness provisions were repealed; however, by making this legislation applicable to any loan remaining unpaid as of the effective date, Section 2 appears to include loans that were made under the old forgiveness program. This could lead to double forgiveness, which we would guess is not the intent.

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April 18, 1989

Ron Phipps
Alaska Student Loan Corporation
400 Willoughby Avenue
P.O. Box FP
Juneau, Alaska 99811

Dear Dr. Phipps:

You have requested our opinion with respect to the validity of a legislative attempt to retroactively modify the terms of student loans that were financed under the Alaska Student Loan Program and that were pledged to secure an issue of the Alaska Student Loan Corporation bonds.

The contract clause, found within Article I, Section 10, of the United States Constitution, prohibits states from enacting laws which impair the obligation of contracts. However, this prohibition is not absolute. An impairment may be constitutional if it is reasonable and necessary to serve an important public interest, it is necessary for the achievement of that public interest, and it is a reasonable impairment of the contract appropriate to the public purpose justifying the legislation. United States Trust Co. v. New Jersey, 431 U.S. 1 (1977).

In this case, it cannot be doubted, either upon principle or authority, that enactment of Senate Bill 121 ("SB 121") would impair the obligation of the Corporation under its 1988 indenture. Enactment of this legislation would effectively extinguish individual borrowers' obligations to make payments on loans which have been pledged as security under the subject indenture. This impairment is not cured by SB 121 requiring the State to make payments on behalf of the borrowers. An exchange of debtors, which is fundamentally a substitution of security, with rare exception, requires a petition to be submitted to a court of equity if not provided for within the indenture or trust instrument. See, Rievman v. Burlington Northern R. Co., 618 F. Supp 592 (D.C.N.Y. 1985) (which summarizes case law on the ability of an indenture trustee to substitute security without bondholder consent).

Hence, the only remaining question is whether SB 121 is "reasonable and necessary" to serve an important public purpose so as to conclude that impairment of contract is constitutional.

The obvious intent of SB 121 is to encourage graduates to return to the State. This is an important purpose; however, it is doubtful that providing partial loan forgiveness is reasonable and necessary to accomplish this goal. Additionally, the effect of enacting SB 121 is mere conjecture; no data has been compiled which concludes that a forgiveness clause will cause the return of graduates. Moreover, based on case law, this purpose would not meet the "reasonable and necessary" tests outlined above.

In the recent case of United States Trust Co. v. New Jersey, supra, the Court held that New York and New Jersey violated the contract clause by enacting legislation to allow the port authority to use port income to subsidize rail passenger transportation in violation of a previous statutory covenant to private bondholders. The rationale provided was that the state had agreed to certain terms that the bondholders might have relied upon and the public interest in improved rail services could be pursued without violating their contract rights. The Court further stated that impairment of bond contracts by a state or state agency would rarely be sustained, especially where the state's self interest is at stake.

The only time in this century that alteration of a municipal bond contract has been sustained by the United States Supreme Court was in in Faitoute Iron & Steel Co. v. City of Ashbury Park, 316 U.S. 502 (1942). That case involved the New Jersey Municipal Finance Act, which provided that a bankrupt local government could be placed in receivership by a state agency. A plan for the composition of creditors' claims was required to be approved by the agency, the municipality, and 85% of the creditors. The plan would be binding on non-consenting creditors after a state court conducted a hearing and found that the municipality could not otherwise pay off its creditors and that the plan was in the best interest of all creditors.

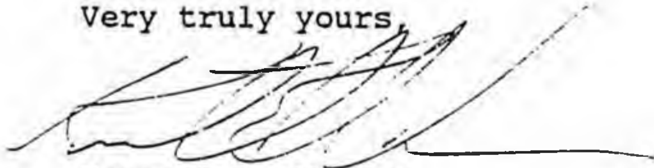
Under the specific composition plan at issue in Faitoute, the holders of revenue bonds received new securities bearing lower interest rates and later maturity dates. The Court rejected contract clause objections because the old bonds represented only theoretical rights; as a practical matter the

city could not raise its taxes enough to pay off its creditors under the old contract terms. Further, the Court found that the composition plan was adopted with the purpose and effect of protecting the creditors, as evidenced by their more than 85% approval.

The Faitoute case is to be distinguished from the case at hand. No one has suggested here that the State has acted for the purpose of benefiting the bondholders and there is no serious contention that the value of the bonds will be enhanced by SB 121. Moreover, SB 121 does not require bondholder consent prior to it enactment and implementation.

Based on the foregoing, it is our opinion that enactment of SB 121 would fail constitutional challenge pursuant to the contract clause prohibition of impairment of obligation.

Very truly yours,



Kenneth E. Vassar

KEV:cm

ALASKA STUDENT LOAN

Background and Discussion Materials

January 1986

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INTRODUCTION

The Alaska Student Loan Program is one of the most successful programs offered by the State of Alaska. Its purpose is to provide low-interest loans to Alaskans wishing to pursue education and training at a postsecondary level. The program has grown from serving just over 1,000 Alaskans in 1971-72, to the current 1985-86 level of serving over 16,000 Alaskans. The true impact of this program is considerable, that is, the financial assistance, not only to the individual, but to the individual's family; the expanded educational opportunities afforded the citizens of the state; the societal benefits of having a more highly trained and educated citizenry; and the benefits to the state and the local communities of having educational institutions and resources available to meet current and future demands. All of these are related, either directly or indirectly, to the availability of student loans. Alaska has chosen to invest in the education of its people. Through these loans, which are in large part repayable to the state, Alaska has committed itself to providing opportunities and access to all those residents seeking postsecondary education. The value of this commitment is undeniable, but the program has now expanded to the point of placing a significant annual demand upon the state treasury and creating the need for greatly increased state staffing.

In the academic loan years of 1983-84, 1984-85, and again this year, 1985-86, loan demand has outstripped available funds, and thousands of applicants have been turned away. The state is rapidly approaching the time when some difficult decisions must be made concerning the future of the student loan program. For the first time, borrowers in 1986-87 must contribute at least $500 from a non-state-loan source toward their eligible loan expenses. This alone will not solve the demand/availability problem, but it is an indication of the types of changes and alternatives which must be explored if the program is to be preserved for future Alaskan students.

LEGISLATIVE HISTORY

The current student loan program was created by the 1971 Alaska State Legislature, however, it was based upon a program which originated in 1968. The 1968 Alaska State Legislature established a program of Scholarship Loans (Senate Bill 378). These loans were for undergraduate students studying in Alaska at an accredited institution. The student could borrow up to $500 per year for up to four years. The loans were non-interest-bearing and could be used only to meet the costs of books, tuition, and required fees (excluding room and board). If the student lived in Alaska after ceasing study, the loans were forgiven at a rate of $500 of loan indebtedness for each six months spent in Alaska.

This program was amended by the 1970 Alaska State Legislature after a good deal of debate (based upon the bill number for the adopted legislation - FCCS SCS CSHB599). Loans now were for up to $750; could be used at any accredited college or university, could be used for books, tuition, room and board, and required fees; and were eligible for forgiveness at a rate of $750 of loan indebtedness for each full year spent in Alaska. The loans were still restricted to undergraduate students and were still non-interest-bearing.

In 1971, the Alaska State Legislature once again looked at student loans and passed CSHB415 (Finance) am S. This bill created the true framework for the present student loan program. Under the 1971 program, student loans could be obtained for undergraduate study, graduate study, and career education programs. Undergraduate students and career education students could borrow up to $2,500 per year and graduate students could borrow up to $5,000 per year. Students could borrow for up to six years of study. Loans were to bear interest at a rate of 5 percent and could be used for books, tuition, room and board, and required fees. Forgiveness was limited to 40 percent of the total borrowed (plus interest), and was accrued in 10 percent increments for each year of employment in Alaska after the grace year.

The loan program experienced minor amendments on a number of occasions, but remained relatively unchanged until the 1976 Alaska State Legislative Session. During that session, FCCSSB70 passed. Under this bill, the undergraduate and career education borrowing maximum was raised to $3,000 per year, but the $5,000 per year maximum for graduate students was maintained.

Subsequently legislatures continued to make relatively minor adjustments to the program, and then in 1981, the last major change occurred. The 1981 Legislature passed FCCSSB120, which raised the borrowing maximums to $6,000 per year for undergraduate and career education students and to $7,000 per year for graduate students. The bill also raised the amount of loan forgiveness up to 50 percent of the total borrowed (including interest), and provided that this forgiveness be accrued in 10 percent increments for each year of residence in Alaska after the grace year. Loans under this program could be obtained for up to five years for either undergraduate or graduate study or up to eight years of combined study. This is the program currently being administered by the state.

PROGRAM DESCRIPTION

PURPOSES

1. To provide Alaskans with access to postsecondary educational resources through low-interest loans to students.
2. To encourage an educated citizenry through initial access to education and training and through inducements to utilize that education and training in Alaska.

TERMS

1. Undergraduates and vocational students may borrow up to $6,000 per year of full-time study.
2. Graduate students may borrow up to $7,000 per year of full-time study.
3. Students may borrow for up to 5 years of undergraduate study, or up to 5 years of graduate study, but for not more than 8 years combined.
4. A student must be a two-year Alaska resident to borrow and must maintain full-time study in good standing to continue borrowing Alaska student loans.
5. Loans may be used for attendance at any approved institution.
6. Proceeds from loans may only be used for the costs of tuition and fees, room and board, and books and supplies.
7. Loan repayment begins one year after the student ceases to be a full-time student (except for approved periods of deferment).
8. Repayment is over a 10-year period with provision for extending to 15 years if necessary.
9. Interest charged on the loans is 5%.
10. No loan will exceed the cost of tuition and fees, room and board, and books and supplies less $500, or the loan maximums, whichever is lower.

FORGIVENESS

If, upon completion of the program of study for which the loan was granted, the borrower resides in Alaska, a portion of the loan, plus interest, shall be forgiven by the State. That portion, for up to a total of 50%, shall accrue as follows:

1. 2-3 years residence in the state, 10%
2. 3-4 years residence in the state, an additional 10%
3. 4-5 years residence in the state, an additional 10%
4. 5-6 years residence in the state, an additional 10%
5. Over 6 years residence in the state, a final 10%.

This residence must be continuous and must begin within one year of completion of program.

REPAYMENT SCHEDULE

IF YOUR STUDENT LOANS TOTAL:	YOUR MONTHLY PAYMENT FOR 120 MONTHS (10 YRS.) WOULD BE:	TOTAL TO BE REPAID:		
		5% Interest	Principal	Total
$1,000.00	$ 10.61	$ 273.20	$1,000.00	$ 1,273.20
2,000.00	21.21	545.20	2,000.00	2,545.20
3,000.00	31.83	818.40	3,000.00	3,818.40
4,000.00	42.43	1,091.60	4,000.00	5,091.60
5,000.00	53.06	1,363.60	5,000.00	6,363.60
6,000.00	63.64	1,636.80	6,000.00	7,636.80
7,000.00	74.25	1,910.00	7,000.00	8,910.00
8,000.00	84.95	2,182.00	8,000.00	10,182.00
9,000.00	95.46	2,455.20	9,000.00	11,455.20
10,000.00	106.07	2,728.40	10,000.00	12,728.40
15,000.00	159.10	4,092.00	15,000.00	19,092.00
20,000.00	212.13	5,455.60	20,000.00	25,455.60
25,000.00	265.16	6,819.20	25,000.00	31,819.20
30,000.00	318.20	8,184.00	30,000.00	38,184.00
35,000.00	371.23	9,547.60	35,000.00	44,547.60
40,000.00	424.26	10,911.20	40,000.00	50,911.20
45,000.00	477.29	12,274.80	45,000.00	57,274.80
50,000.00	530.33	13,639.60	50,000.00	63,639.60

TABLE 1
STUDENT FINANCIAL AID ADMINISTRATION
STATE STUDENT LOAN ACTIVITY
Projected to 1990-91

Year	Loan Awards	% Change	Loan Volume	% Change	Average Loan	Loan Collections	General Fund	Loan Forgiveness	Repayment* Accounts	Defaul** Rate
1971-72	1,081	--	$ 1,603,158	--	$1,483	$ -0-	$ 1,500,000	$ -0-	$ -0-	N.A.
1972-73	1,748	61.8	2,870,384	79.0	1,642	-0-	2,952,900	-0-	-0-	N.A.
1973-74	1,665	(5.0)	2,986,176	4.0	1,793	-0-	2,952,900	-0-	-0-	N.A
1974-75	1,457	(12.5)	2,659,807	(10.9)	1,826	235,476	3,105,600	703	1,625	80.0
1975-76	1,719	18.0	3,382,997	27.2	1,968	465,530	3,791,500	44,233	2,153	44.6
1976-77	1,921	11.8	3,850,507	13.8	2,004	1,141,461	3,550,900	64,746	2,775	24.9
1977-78	2,265	17.9	4,604,167	19.6	2,033	1,191,851	2,006,100	314,306	3,470	22.3
1978-79	2,795	23.4	6,416,402	39.4	2,296	1,391,643	3,600,000	445,985	4,289	19.3
1979-80	3,918	40.2	9,373,949	46.1	2,393	1,603,436	8,130,000	409,501	5,301	14.5
1980-81	6,460	64.9	15,957,717	70.2	2,475	2,225,388	12,821,127	555,494	7,196	11.2
1981-82	9,898	70.3	40,559,499	154.2	4,098	2,779,900	37,701,000	785,769	10,683	9.2
1982-83	13,058	31.9	55,007,395	35.6	4,213	4,609,051	52,000,000	(846,028)	15,669	9.1
1983-84	14,785	13.2	62,912,316	14.4	4,255	6,410,124	60,000,000	1,171,239	21,771	13.5
1984-85	17,173	16.2	75,075,883	19.3	4,372	9,572,795	60,000,000	1,664,612	27,886	12.4
1965-86*	16,130*	(6.1)	80,675,498*	7.5	5,002*	6,867,737*	63,600,000	1,190,263*	36,341*	14.3*
Projections										
1986-87	18,431	N.A.	81,557,175	N.A.	4,425	15,985,103	63,572,072	2,839,506	46,280	
1987-88	18,950	2.8	86,222,500	5.7	4,550	19,352,145	64,870,355	3,421,624	55,123	
1988-89	19,325	1.5	90,441,000	5.0	4,680	22,762,094	65,678,906	4,011,160	63,380	
1989-90	21,493	11.7	103,381,330	14.3	4,810	26,189,108	75,192,222	4,603,646	72,557	
1990-91	23,373	8.7	115,696,350	11.9	4,950	30,104,760	83,591,590	5,280,612	82,765	

1300 app. 6 mm short

*Repayment account totals and default rate are for June 30 of each year. All 1985-86 data are as of January 24, 1986.

1-24-86

1985-86 ALASKA STUDENT LOANS

PROGRAM STATUS (January 24, 1986)

Student Level	Number	Amount	Average Loan
Freshman	4,325	$20,819,066	$4,814
Sophomore	3,009	14,629,396	4,862
Junior	2,275	11,282,137	4,959
Senior	2,252	10,818,533	4,804
Vocational	3,019	15,696,602	5,199
Undergraduate	14,880	$73,245,734	$4,922
Graduate	1,250	7,429,764	5,944
TOTAL	16,130	$80,675,498	$5,022

AVAILABLE FUNDS

FY86 Appropriation	$63,600,000	
FY85 Carry-forward	3,352,877	
Federal Receipts (GSL)	225,000	
	$67,177,877	Sub-total
Estimated Receipts	11,879,790	
	$79,057,667	Total
Vocational Set-Aside	$15,811,533	
Collegiate	$63,246,134	

IN-STATE/OUT-OF-STATE ATTENDANCE BY LEVEL (January 24, 1986)

Student Level	Alaska	%	Out-of-State	%
Freshman	2,250	52.0	2,075	48.0
Sophomore	1,459	48.5	1,550	51.5
Junior	1,027	45.1	1,248	54.9
Senior	1,000	44.4	1,252	55.6
Vocational	2,285	75.7	734	24.3
Undergraduate	8,021	53.9	6,859	46.1
Graduate	252	20.2	998	79.8
TOTAL	8,273	51.3	7,857	48.7

PERCENT IN-STATE PREVIOUS YEARS

Year	Undergraduate	Graduate	All Loans
1978-79	35.1	12.0	32.3
1979-80	36.1	12.3	33.3
1980-81	45.3	17.9	42.3
1981-82	47.3	23.8	45.0
1982-83	53.1	23.4	50.4
1983-84	53.3	21.9	50.5
1984-85	56.7	21.7	54.0
1985-86 (1-24-86)	53.9	20.2	51.3