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## **Ask the Experts: High-Risk Pools Kaiser Family Foundation July 15, 2008**

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**LARRY LEVITT:** This is Larry Levitt from kaisernetwork.org. Welcome to Ask the Experts, our regular interactive web show that provides in-depth discussion of current health policy issues and allows you to interact directly with the nation's top policy experts.

We have done a number of sessions recently, highlighting key elements of state and federal health reform proposals with many such proposals relying on private insurance as a primary mechanism for delivering health coverage. A major question that emerges is how to provide access to insurance for people with pre-existing health conditions.

Some approaches rely on greater regulation of the insurance industry, requiring insurers to take all comers and restricting their ability to charge higher premiums based on an individual's health status. Other proposals, most notably Senator John McCain's, calls for expanded use of so-called state high-risk pools to cover people with pre-existing conditions who are excluded from private insurance plans.

These high-risk pools have been around for over three decades with the first pool created in 1976 in Minnesota. Today they operate in over 30 states, give providing coverage to about 200,000 people, they have received only modest attention from the media and policy makers.

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Today, joined by a panel of state and federal policy experts, we are going to look more closely at how these pools work and at some of the promises and pitfalls to consider in expanding them as a part of a health reform package.

Karen Pollitz is a Research Professor at Georgetown University, where her focus is on the insurance market. Christina Nyquist is Managing Director of the Office of Policy and Representation at the Blue Cross Blue Shield Association. Dough Stratton is Executive Director of the Indiana High-Risk Pool and also Chair of the National Association of State Comprehensive Health Insurance Plans. And Lesley Cummings, joining us by phone from California, is Executive Director of the Managed Risk Medical Insurance Board or MRMIB, which runs that state's high-risk pool.

You can reach our panel of experts at any time during the show by e-mailing your questions to [ask@kaisernetwork.org](mailto:ask@kaisernetwork.org) and we will try to get to as many of your questions as we can. Thanks to all of you for joining us and Karen, let us start with you.

In the current non-group insurance market where people buy coverage on their own, in most states insurers are permitted to underwrite meaning exclude people based on health conditions or charge higher premiums. How effective do you think these state high-risk pools, which exist in over 30 states, have been at filling in the gaps in that market?

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**KAREN POLLITZ:** Well, they have not reached most of the people who are unable to pass medical underwriting. It is hard to know exactly how many people that may be but, AHP estimates that were just recently suggests that about 15-percent of applicants for underwritten policies are either turned down or charged a highly surcharged premium or have a rider imposed, any of which would make you eligible for a high-risk pool in most of the states.

But, when you look at the population of pools, maybe it is 1 to 2-percent of the individual market, in some states a percent of a percent. In work that I have done over the years with a number of patient groups who have tried through their call centers to refer uninsurable patients to the high-risk pools in their states, more than 90-percent of the time, people have not been able to get in for a variety of reasons.

**LARRY LEVITT:** And what are some of the reasons people cannot get into a high-risk pool?

**KAREN POLLITZ:** Well, a leading reason is that in every state that covers the uninsurable with their high-risk pool or offers coverage to the uninsurable, the very condition that made you uninsurable will be excluded as a pre-existing condition, usually for 6 to 12 months. That is a conversation stopper for most people. If you have been diagnosed with cancer, you cannot wait six months to start treatment. If you have diabetes, you cannot not manage your diabetes.

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**LARRY LEVITT:** So, people start coverage in a pool but there is an exclusion for that pre-existing condition.

**KAREN POLLITZ:** Right. So, that is a huge reason and another reason is that these pools are very expensive. All of them set their premiums at rates above those charged in the private market and in addition, the age rate, the average pool enrollee is about 50. And the average monthly premium when you look across all the pools is about \$600 a month for someone in a \$1,000 deductible policy action. So, they are very expensive.

And then finally, there are a range, depending on the programs that you look at, there are a range of other sort of eligibility restrictions. You have to have lived in state at least a year, you have to be a citizen, you have to have applied for Cobra and exhausted it, so forth. So, because of all of those layers of reasons, it can be very, very difficult to actually enroll.

**LARRY LEVITT:** You talk about a range of reasons, how with these over 30 states that have risk-pools, how homogeneous are they? Are they varied from state-to-state?

**KAREN POLLITZ:** Yes, they all vary from state-to-state, but these are common features, eligibility restrictions, high premiums, and pre-ex exclusions.

**LARRY LEVITT:** Christina, do you agree with Karen's assessment of how these pools are functioning now?

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**CHRISTINA NYQUIST:** Well, I think we think the high-risk pools have actually played a really valuable role in terms of helping many high-risk individuals, many thousands and thousands of high-risk individuals obtain coverage where they would not have otherwise been eligible for.

No system is perfect and the health insurance is very expensive because the health conditions are very expensive and if you look at the alternative for instance, some people look at guarantee issue and community rating, but if you look at states that have done this, for instance New York, the premiums can be extremely high and you see people paying premiums of between \$900 and \$1600 in the state of New York for health insurance.

So, while yes, some high-risk pool premiums are expensive, the alternative is expensive as well. It is also important to recognize that there are high-risk pools out there, depending on your situation and you can get high-risk pool coverage for \$300 a month in some states.

There is a wide spectrum and at the Association, what we are really interested in doing is improving high-risk pools and we think that one way to improve high-risk pools, is to have an infusion of federal funds into the high-risk pool community and that would make health insurance premiums more affordable for those individuals that are applying to high-risk pools.

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**LARRY LEVITT:** So, is your sense that there is more demand out there than can be satisfied now within the current pools or with current funding?

**CHRISTINA NYQUIST:** No, we think that the demand is largely being met in most states with the exception of I think California and Florida. We think the demand is being met, but we think that there would be more demand if the premiums were lower. So, for instance, obviously if you are only earning X amount per year, even if the high-risk pool gives you a fair premium, it is still too expensive for you. So, we are interested in additional subsidies as well.

**LARRY LEVITT:** From an insurance market perspective, how well are these pools at let us say keeping the non-group market, stabilizing the market or allowing a broader range of insurers to participate in that market? Is there sort of an insurance market stability role that the pools are playing or playing well or not so well?

**CHRISTINA NYQUIST:** Well, we think that the high-risk pools perform an important stop gap function. What is really important to recognize about health insurance is it is like any other insurance, it is important for people to buy the insurance before they actually need it. Because if everyone just waited until they needed insurance to purchase it, then insurance would not be affordable for anyone.

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And so, one of the reasons why we have insurance rules is because for someone who has been buying health insurance for five years from us and they bought coverage before they were sick and so on and so forth, it is not fair to make them pay a much higher rate for someone that actually waited until the last minute to buy insurance.

So, that is why we think the high-risk pool performs such an important function, is because for those individuals who find themselves in that situation, there is a stop gap mechanism. There is something to provide them coverage.

**LARRY LEVITT:** And do you have a sense, you talked about an infusion of money potentially helping, do you have a sense of how much would make a difference? What is an appropriate number to think about?

**CHRISTINA NYQUIST:** We are supportive of a 50-percent federal match for high-risk pool losses and we think that would help the states leverage their own funds to enhance high-risk pools.

**LARRY LEVITT:** And Karen, you have written some about that there is an existing federal grant program for high-risk pools, talk a little bit about that.

**KAREN POLLITZ:** There is an existing program. It was created in 2002 and it has been around for a couple of years. It has been a little intermittently funded by the congress. So, I think there have only been three grant awards since the

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program started. Like any Federal Grant Program, money is allocated according to formula that had a little politics behind it so, it is a small program, it is about \$75 million in assistance for all of the pools.

But, it is allocated unevenly. There are two pools out there. Christina mentioned a 50-percent match; there are two pools out there that are fully federally funded by the Federal Grant Program.

**LARRY LEVITT:** Where are they?

**KAREN POLLITZ:** New Hampshire—

**LARRY LEVITT:** Sorry to put you on the spot with—

[Laughter]

**KAREN POLLITZ:** New Hampshire is one, South Dakota or Iowa, it is another little pool. The funding formula is such that it can fund a very high proportion, even more than 100-percent proportion. Actually, of loses in pools if they are very tiny, if they only have a few hundred enrollees. And we do have a couple of pools that are that small. And interestingly, there are some loose requirements about how states can use this money.

But, there is actually no rule that says that the pools need to be enhanced with the money. And these two state pools continue to be expensive, continue to exclude pre-existing conditions and so forth.

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So, I would agree with Christina, additional funding is absolutely essential. It is not possible to peel off the most expensive layer of people who account for 80, 90-percent of all health care costs and expect states to fund these programs on a shoe string. It is going to be the whole shoe and then some. It is going to be a very expensive program to cover folks like this. And resource constraints are absolutely part of the problem that needs to be addresses.

But, I think we also need to look at what is the mission of the pools and is to be a source of funding for people who are turned away from private coverage? And therefore, to cover more uncompensated care that would otherwise occur when people are uninsured or sick. Or, is it to kind of stabilize the market?

And I think in many states, there is kind of a paradox going on and states may be trying to satisfy both of these and at some point they become mutually exclusive. It is hard to create a pool that does not look more attractive or that does not behave differently than the industry without the industry feeling like they are at sort of a competitive disadvantage and so often, state pools will decide to behave in ways that are similar to the private market, pre-ex'ing, charging higher premiums and so forth. And that is kind of regrettable that creates this problem.

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**LARRY LEVITT:** Doug, you actually run one of these things in Indiana, let me bring you in. First describe how the Indiana pool works, who gets in it, how is it financed, what kind of coverage it offers.

**DOUG STRATTON:** The program in Indiana is somewhat similar to the programs throughout the country that have high-risk programs. And I take a little bit of an issue with the fact that they are somewhat homogeneous other than what their missions are because as Karen mentioned, there are some that are almost exclusively funded through federal funds, there are some that are almost exclusively through state funds, there is others that the insurance industry plays a major role in terms of supporting the programs through appropriations and assessments.

And likewise, some of the other issues involving access, eligibility, residency requirements, it is the fact that those existed in each of the states. However, they vary drastically. Indiana, as an example, has a 90-day period of pre-existing conditions. There are others that have greater or lesser and in terms of how they actually operate, taking Indiana as an example, the mission for that program only dictates how the program operates.

And in a large measure, it is to be as safety net and provide health insurance coverage for people that cannot get in the commercial market because of the very issues we are talking

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about and that is the extraordinary high cost of these individuals.

When we look at how it is administered, who is eligible, I think virtually every administrator of every state would say we would like very much to be in a position that we could ease the access, we could make it more affordable. There are lots of premium subsidies going on right now including in the state of Indiana where we are actually finding funds to help offset the increased cost of premiums.

In terms of the population that is in these programs, I think it is really important to underscore the point that was just made; you have such a relatively small percentage of the population that has such an extraordinary impact on the overall health care cost of care in this country. And one of the things that I look at in terms of evaluating public policy kinds of initiatives in health care reform, is how do you best deal with that?

**LARRY LEVITT:** [Interposing] some examples of the kind [interposing].

**DOUG STRATTON:** An ideal example is the hemophilia population. As an example, there are approximately 54 participants in the Indiana program that have that disease diagnosis. That 54, in 2002, cost the program almost \$19 million, for 54 individuals. The point that I was driving at

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was, one of the things that I see is an enormous potential for the high-risk programs.

Not only the stability of the insurance market, generally, and finding access for people that need this kind of care, but, it represents a place where if adequately funded, and the kinds of resources are committed, it will have the opportunity to address high-cost cases like the hemophilia population and can have enormous impact on what I believe is the real underlying problem in health care today and that is the cost.

The example that I started off with, with the hemophilia population in 2002 costing \$19 million, we put a specifically designed disease management program in place. We were able to access 340B pricing which gives an enormous benefit in terms of pharmaceutical-

**LARRY LEVITT:** That is for community clinics, yes-

**DOUG STRATTON:** -Pharmaceutical kinds of services. We work directly with the treatment center. We brought the cost for that population down to something in the range of about nine million, a reduction of virtually 50-percent. It has sustained at that level, there is ever reason to believe that we will continue to do so.

There are other programs that going on throughout the country that are doing the same thing, taking a really high cost conditions and finding ways to provide better outcomes at

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an earlier opportunity, which will drive down those costs substantially and I think that is where the real future potential holds for these kinds of programs.

**LARRY LEVITT:** Christina and Karen talked about the potential for additional funding, in Indiana or other programs around the country, where do you see the need for that funding? What would that funding allow let us say your pool and other pools to do?

**DOUG STRATTON:** Well, the first thing it would need to do is it would need to subsidize or reduce the premiums because truly the cost is a significant impediment to a good number of people, keeping in mind that the people that most need this kind of extraordinary cost in care, are likely to be in a position where financially they have already been almost to the point of being devastated.

And so, the premiums, where it may be affordable to the people on this panel, are not going to be to someone who has had a serious disease condition for an extended period of time, it just simply will suck the resources out.

**LARRY LEVITT:** And how are the premiums set now in the Indiana pool?

**DOUG STRATTON:** The programs across the country are by and large modeled after the model program that the National Association of Insurance Commissioners did with the thought in mind, let us make these programs be something that really

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addresses this specific need, whether intended to be a panacea to cure all the problems.

The funding mechanism in large measure is based on a calculation that is originally done actually by determining what the insurance industry charges for that area and then adding a factor to that and in most instances, it is somewhere in the range of about 150-percent.

We are seeing more and more boards of these high-risk programs however, saying, you know what, if we do that we are going to lose the mission that we set. We are simply not going to serve the people that really need to be served and as a result, have deliberately said we can charge up to this amount, but we will not. We simply cannot in good conscious, continue to charge those rates.

**LARRY LEVITT:** Lesley Cummings from California, let me bring you in, California pool works a little differently from some of the typical pools around the country, can you describe some of those differences?

**LESLEY CUMMINGS:** Well, I think the biggest difference is that for most of our history, we have had to maintain a waiting list because we have not had sufficient funds to subsidize the losses in the pool. Additionally, because of that, our board has created a benefit cap of \$75,000 that allows us to serve more people but it really diminishes the

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value of the benefit to the person enrolled. And we have the lowest benefit cap in the country.

So, our struggle here has been to get adequate financing for the pool. I agree with Doug and basically everybody, that the cost of coverage here which is 125-percent of what the cost would be in the commercial market, is a barrier to people.

We did a survey and significant percentages of the people in our pool are actually fairly low income. They are 18-percent below \$2,000, 25-percent below \$40,000. They are paying a huge percentage of their income for this coverage, in the case of people with incomes under 20,000, 36-percent of their income for this coverage. So, that is our struggle here in California.

Now, because of this, our policy makers, as you know, advanced a major health care reform in this last year which unfortunately did not go all the way, but Governor Schwarzenegger proposed a totally different approach to having a high-risk pool.

In his proposal, which was, that there be guaranteed issuance, that there be rules about rating, and that there be an individual mandate. The purpose of that was to bring in enough healthy risk to offset the high-risk of people who had medically uninsurable conditions.

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**LARRY LEVITT:** Leslie, I did not plan it this way, but one of our first e-mail questions we have from the audience is about exactly this issue, about whether to compare the long-term financial viability for key stake holders for a high-risk insurance pool approach versus mandatory community rating.

And Christina, let me turn to you, you talked about this a little bit in states like New York that do have guarantee issue and community rating in the non-group market, how do you see the distinction between let us say relying on high-risk pools versus let us say moving the market more towards guaranteed access and community rating or eliminating health status rating.

**CHRISTINA NYQUIST:** Sure. Well, in a state that requires guaranteed issue, basically you have, let us say, your individual market subscribers or this pool, then if you have guarantee issue, your very high-risk individuals, essentially what you are saying is, we are going to have this pool of individual market subscribers be the source of subsidy for these very high-risk individuals. And that is how guarantee issue works.

With the high-risk pool, what essentially you are saying is, we have some very high-risk people and we need to take care of them. But, instead of just making our little pool of individual market subscribers subsidize as individuals, we are going to create a high-risk pool and we are going to pull

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broad subsidies from different sources, hopefully some from the federal government, some from tobacco taxes in some states, general revenues from the broader insurance pool, from assessments on self-funded plans.

And we are going to ask all those different broad based financiers to help subsidize this very high-risk individuals. That is the primary difference between guaranteed issue and the high-risk pool.

**LARRY LEVITT:** And Karen, how about from your perspective, how would you think about the distinction between let us say an insurance market reform approach versus relying on high-risk pools as a safety-

**KAREN POLLITZ:** Christina is right. One way or the other, a subsidy needs to be delivered and that is what insurance does. Even if you pluck off the top 15-percent of people, whoever remains in your individual market pool is involved in a cross-subsidy because some of them are not making claims and a few of them are.

So, I think there is no question that there needs to be a subsidy. I guess the question is how best to deliver that, is there a more efficient way and is there more politically palliative a way?

Either way could work. There is nothing wrong I think with the notion of high-risk pools and Doug and Christina are absolutely right, these pools do provide life-saving coverage

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to the people. I have a friend who is covered in the high-risk pool who is getting treatment for her cancer that just would not be happening otherwise. So, it is incredibly important that we find a way to do it.

But, I do think sometimes we get a little lost in the weeds and we lose track of sort of how the subsidies are actually working and we look for ways to sort of mask some of the cost or not pay attention to some of the cost or hope that some of them will not need to be subsidized in either market, in either approach. So, either way I think can work.

The one thing I would say about the pools and going back to this kind of notion that they have two missions, one is to be a safety net for the uninsurable and the other is to sort of find a way to stabilize the market.

That is absolutely a trade-off that is in the eye of the beholder and I think the way that pools have been governed traditionally in most states, they have taken a very kind of conservative approach and a very pro-industry approach to weighing decisions and deciding what can I do to cover more people and to make coverage more affordable and what can I do to make sure that the industry is not negatively impacted.

In my own state, I actually served on the board of the high-risk pool where I lived for a couple of years and that state took a kind of unique approach, at least for a while, they have since kind of gone back to the traditional way. But,

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first of all, they collected some very explicit data. In the state of Maryland, all carriers need to report regularly, quarterly, on how many applications they get, how many they deny, how many they charge more and so forth.

And, so you can see, how many uninsurable people were there in this state in April and then you can compare that to how many applied to the pool and when the pool was sort of being conservative on the side of how are we going to subsidize and they pre-ex'd and they had high premiums and high cost sharing and so forth, 1,200, 1,500 people a month were being denied coverage in the individual market and maybe 50 were coming to the pool.

They tried an experiment and relaxed all of those constraints and the industry folks said no, people will wait, they will wait until they get sick to buy coverage and they will not buy from us anymore and we said, well, let us just see. If they do, we will stop and so we relaxed all those things and all of the sudden, several hundred a month were coming to the pool. The applications in the individual market stayed steady, they never moved a blip, they never moved.

So, some of it I think when we sort of think about these different ways of subsidizing, we need to ask ourselves, are we about subsidizing or are we about protecting profitability of the industry and this notion of people waiting until they get sick I think is perhaps a little incorrect. It

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is absolutely true, you need to worry about selection, but, people do not wait until they get sick. People wait until they lose their coverage.

If people lose their job, they get divorced, they turn 19 and they lose their coverage and usually at that point they are in trouble with other reasons, they have trouble paying other bills and they have trouble paying for their medical care. The uninsured have trouble paying for their medical care.

So, it's not like these folks who need high-risk pool coverage waiting, you know, gaining the system, spending their trust fund on BMW's instead of participating in the insurance system, that is really not the problem that we are trying to address. We have a lot of uninsured people who are sick who just cannot afford, they just cannot afford to contribute much. They would be willing to contribute something but we cannot keep sort of piling these other penalties on them because it makes them go away.

And that is why there is not a waiting list in most other states. California is at least honest about it. They say this is all we have, rats, it is not enough and so there is a waiting list. There is not a waiting list in other states; they do not need a waiting list because people cannot come in.

**LARRY LEVITT:** They cannot come in because—

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**KAREN POLLITZ:** Because of all of these sort of other things that restrict the subsidy that needs to be out there. So, I just think we need to be more explicit about what the subsidy costs, if it is going to be in the private market, great, people are going to need more subsidies to help with that.

If it is going to be in a public program, fine, in some ways better, it is more accountable, but, let us be real about what the cost is and let us finance it, let us not kid ourselves and make some of it disappear off the balance sheets cause those are real people.

**LARRY LEVITT:** [Inaudible] Christina, would you see the trade-offs similarly to Karen?

**CHRISTINA NYQUIST:** No. [Laughter] Karen and I have worked many times together and I think we all have the same objective. We all want more people to have coverage and affordability is a challenge and the question is how do you maintain the balance to keep it affordable and the reason why we believe in high-risk pools, although we do think there needs to be additional funds and we would support enhancing the high-risk pools, we think that is a preferred approach to guaranteed issue because of the concern about adverse selection.

I know that is a wonky term, but essentially, the concern is that if individuals can buy coverage at any point in time, the old if you can wait until your house is burning to

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buy property insurance, then all property insurance would be much more expensive.

So, we think this is a good way to keep the prices manageable for the vast majority of people who are buying health insurance coverage. We are very supportive of laws like HIPAA, which basically say that if you lose your job and you need to buy coverage, that you cannot be pre-ex'd, the high-risk pool cannot pre-ex you, the high-risk pool would have to take you right away.

**LARRY LEVITT:** So the waiting periods we were talking about earlier would not apply to someone who is continuously insured, but someone who is buying insurance for the first time, they would not.

**CHRISTINA NYQUIST:** Right.

**LARRY LEVITT:** Or after a gap?

**CHRISTINA NYQUIST:** Right. Someone who is continuously insured would not face a pre-ex in a high-risk pool. If they are in a fall-back state, they would not face a pre-ex in the individual market. So, we are supportive of those types of provisions that protect those that are continuously insured and we want to continue to work at the Blues to enhance high-risk mechanisms so that they can face the affordability problem that we are having.

**KAREN POLLITZ:** Just a minor point, HIPAA eligible's are just a tiny subset of people who were continuously insured.

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You have to be continuously insured for a period of time, you have to have been coming out of a group policy and you have to have elected and exhausted Cobra.

In other states, you could have been continuously insured under an individual policy and come to the high-risk pool and still face a pre-ex. You can have come off the Medicaid program and come to the high-risk pool and still face a pre-ex. You can have come out of a group policy and not elected Cobra, just hoping to go straight into the pool, you cannot do it.

So, all I am saying is pay attention to the details. It is very easy in our system because the rules are so many and so complex for people to have a break in coverage. Almost 40-percent of our population will have at least a small break in coverage at some point over a three year period. It is hard not to.

**CHRISTNIA NYQUIST:** Once again, with regard to HIPAA, you can have a break in coverage up to 63 days and as long as your break in coverage is not more than 63 days, you are guaranteed access. And for those employers that do not have Cobra's coverage, they can bypass the Cobra requirement and go straight into the guaranteed mechanism and if that is the high-risk pool, it is the high-risk pool.

High-risk pools do vary as Doug mentioned earlier and there are high-risk pools that credit all prior coverage and

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there are some, for instance the state of Alabama, is completely focused on HIPAA eligible's. But, there are other high-risk pools that do credit all prior coverage.

**LARRY LEVITT:** I want to turn back to financing a bit, we have got a lot of questions about that for a health care discussion. And one just asked the panel is to talk about the varying financing approaches in the different states. Lesley, let me start with you in California, the state with the waiting list. You mentioned there being insufficient funding and that generating a need for a waiting list. How is the pool financed?

**LESLEY CUMMINGS:** In our state the pool is financed by state dollars, the subsidy is financed by state dollars. So, it is 63-percent is paid for by subscribers and the remainder is paid for by state dollars. That is unusual in the country. Most pools are financed with some variation of insurer fees or insurer fees with a tax credit, but that has not been the way here.

**LARRY LEVITT:** And, is there an annual discussion about how much state dollars to put into the pool?

**LESLEY CUMMINGS:** Actually, the source of the dollars that is used is tobacco tax dollars, which is a declining revenue source so, we will actually be getting less money next year than we have this year.

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**LARRY LEVITT:** And Doug, how about in Indiana, what is the financing source?

**DOUG STRATTON:** Similar to California, there is a premium that is charged that represents something in the range of about 51-percent of the total revenue that is necessary. The balance is made up 75-percent is picked up through the general appropriations by the state of Indiana and the balance then is assessed to the insurance industry on the basis of the same relativity that their premiums are to the total premiums in the state.

There is no tax credit that is given. Essentially, the state's perspective on that was that that is kind of the cost of doing business in the state of Indiana, you need to help fund and support these kinds of programs.

And I would like, if I could, for just a second to go back to an issue that was raised that I think really deserves some attention. And that is the issue of all the regulations and all the restrictions and requirements, not only with the high-risk programs but HIPAA and all of the other programs that have kind of formed the network and fabric, if you will, of the current health care system.

I think there is enormous problems and therefore opportunities in cleaning up some of this, making this process much more transparent, much smoother, working together much, much better.

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However, in doing so, in looking at this as objectively as I am able, and when I look at various policies from various organizations and parties, I try to look at what is the right solution, what should we be doing and how should we be doing it.

One of the concerns that I have today that has had an impact on that is this very issue of guaranteed issue versus a high-risk kind of program. I am concerned about messing with the industry right now, to be candid.

As I look at what is happening in the general economy and the problems that we have with the automobile industry and airline industry and lots of other industries, I think, you know what, if we start messing with health insurance industry and health care generally, there is the potential for lots of issue and that is not being an extremist.

But, as I thought about the policies and I thought about our discussion today, that issue became one of the things that I thought, you know, I think we need to be looking at incremental kinds of changes but it has to be done with the thought in mind, we have to start eliminating a lot of the barriers, a lot of the duplications, a lot of avoidable cost, administrative things and I think that would land itself along with the idea of finding programs we can really address the highest cost cases and do it with the focus of, if you find the

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best outcomes at the earliest time, you will bring real cost savings to the industry generally.

**LESLEY CUMMINGS:** -May weight in here?

**DOUG STRATTON:** Sure Lesley.

**LESLEY CUMMINGS:** Lesley from California. You know we viewed this, our Governor and the leadership and the legislature, viewed this really very differently here when we were contemplating health care reform. Everybody talks about the need to bring in subsidy when you are covering high-risk people but the mechanism that California looked to do that is to bring in low-risk people who are not now covered.

So, in the context of a comprehensive reform, our policy makers rejected the idea of a pool and said it is far, far better for medically uninsurable people to be able to get coverage like everybody else and you just have to make sure that you have a good risk mix in the market via the individual mandate for people to get coverage.

Another thing that I just wanted to mention is, in our pool, we had, in the last year that we did a fact book, 20-percent of our subscribers never filed a claim for anything in the year. And the bulk of our cost cluster around below \$5,000 per year. So, what this means is, these pools exist in an environment and the environment is specific to each state. And that environment is the rules of the individual market.

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Here in California, there are no rules, there is no specific rejection rate, no standard underwriting criteria, no rules about rating and you have to look at pools in that context.

**LARRY LEVITT:** Well, I am pretty sure we could probably stay here the rest of the hour in debate of comprehensive health reform and [laughter] community rating in every market. I have done that before, actually. [Laughter]

Let me turn back to some of the specifics of the pools, we had a question, and Doug talked about this earlier about case management or disease management within the pools. The question was whether high-risk pools have been having any success with these types of approaches or approaches to get the cost down.

And Lesley, let me stay with you, how would you characterize some of the approaches that the MRMIB pool in California have taken around managing high-cost cases?

**LESLEY CUMMINGS:** Well, the approaches that our pool takes, we are different in that we contract with several different plans and we rely on the disease management strategies of that particular plan. So, there is variation in the approaches used and that is way different than Doug, who is using one provider network or one plan so he can see exactly what is going on. So, I do not have the data on what happens plan-by-plan.

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**LARRY LEVITT:** And Doug in Indiana, the pool itself, are you taking an active role in putting in place programs to manage high-cost cases?

**DOUG STRATTON:** We are and in fact, we are the driver of that. We have designed them, we are in the process now of implementing another for AIDS and HIV. We have about 1,200 in our program and we go to the provider network that works in that area. We say if you would start off with a clean sheet of paper, what is the ideal, what is the gold standard in terms of providing care and where should we be investing our resources in terms of finding solutions and improving outcomes?

We then manage that ourselves. It is not turned over to a vendor. They are very driven on the basis of what our specific population and demographics needs are and that is what we will continue to do as we find other opportunities.

**LARRY LEVITT:** And how would you compare let us say what you do to what a typical private insurer might do in this area?

**DOUG STRATTON:** Well, I need to add, Indiana has a provision that was inserted in its statute about three years ago, that makes participation in disease management programs in the state mandatory. That was not without a lot of political debate and pushing and perceived by a lot of people as pretty draconian approach. I can tell you it has had an enormous impact.

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To require people in a program that is supported by public funds to do the things that need to be done to help take care of their care makes absolute sense to me and I do not have much reluctance at all of saying if you are in this program and you have one of those disease conditions, for example hemophilia or HIV positive, you have an obligation to help us with resources of this state and part of that is to adhere to the kinds of programs that we put in place.

In doing that, what we have essentially done is we have said, we are going to find exactly what needs to be done with this particular population and we are driven and directed by what is the best possible outcome and the best care we can provide and we generally believe that that is the least expensive overall, to do it right the first time.

**LARRY LEVITT:** We also had a number of questions about the actual benefits or terms of coverage in the pools and how it affects people with expensive illnesses, one from the Hemophilia Foundation about caps on coverage. The other asking about how pool coverage would serve the needs of someone with some traumatic brain injuries.

And Karen, you have looked a lot at the pools across states, what is your sense of how that coverage compared to let us say coverage in the private market deals with people with these very expensive illnesses which are the population it is covering?

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**KAREN POLLITZ:** Typically, high-risk pool coverage is far, far more comprehensive than what you would be able to buy in the private individual market. That coverage seems to decline every year. And certainly, there are exceptions, there are a few pools that drastically limit, for example, prescription coverage, mental health, not all pools cover maternity care, so, some of the benefit coverage weaknesses that you see in private industry will also appear in pools.

But, for the most part, I think the benefits are quite comprehensive. The one trend that has been growing in pools is that the cost sharing has been going up and because of this sort of trade-off, how can we make premiums affordable and still provide adequate coverage? Increasingly, you are seeing pools now that offer deductible options of \$5,000 a year, \$10,000 a year, there is one pool that has a \$25,000 a year limit on out-of-pocket max as one of the options.

If you have hemophilia, you need to factor that in because you are going to hit all those deductibles and maximums. So, in addition to the \$600 a month you are paying for your premium, you may be paying another \$25,000 out of pocket for the expenses. And that is hard. I think that is very hard for folks. The vast, vast majority of high-risk pool enrollees have a deductible of \$1,000 a year or higher that they are paying that.

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**LARRY LEVITT:** How about the benefit cap that Lesley talked about in California, the \$75,000 cap on benefits, is that a common-

**KAREN POLLITZ:** No, she is right, that is the lowest. That is the lowest one out there. I think Wyoming has, I cannot do this all from memory, at a couple hundred thousand dollars a year annual cap in one of their pool options. Mostly you do not see that in most cap options.

You do see lifetime limits in pools and most folks will not stay long enough to hit the lifetime limit but, and that is true in private coverage too. But, for select populations, hemophilia is certainly one, people with organ transplants who will consistently have claims in excess of \$100,000 a year. That is who gets hurt by those.

**LESLEY CUMMINGS:** Larry?

**LARRY LEVITT:** Yes, Lesley?

**LESLEY CUMMINGS:** So, what our board did was different than establishing high deductibles, an idea that is kind of an odd one for a population that you consider to be high-risk but, they provided a benefit cap so have a low deductible, it is \$500 but we have this benefit cap.

And I will tell you that a person from the Hemophilia Society in California came and talked to me and said we want to be able to get coverage through your pool but we cannot go there when you have a \$75,000 benefit cap and that benefit cap

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has kept us from getting any federal funds because the rule your coverage has to be like that this is available in the market and there is no coverage in California with that kind of a cap.

**LARRY LEVITT:** And is that something you have talked about revisiting, this balance between the deductible and a cap?

**LESLEY CUMMINGS:** We did. We had a big, long think about our benefit design about nine months ago and the board really wanted to lift the benefit cap but we realized that the people that would have to pay for it would be the subscribers because we are not getting anymore subsidy money and that would therefore make their coverage even less affordable to them than it is now.

So, the board did establish the \$500 deductible at that time, but decided that we had to wait to revisit the benefit cap until the day came that we got some additional subsidy dollars from somewhere.

**CHRISTINA NYQUIST:** The Association is supporting two initiatives—

**LESLEY CUMMINGS:** I am sorry?

**CHRISTINA NYQUIST:** [Interposing] I am sorry, I did not mean to interrupt, I thought you were finished.

**LESLEY CUMMINGS:** No, I am done.

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**CHRISTINA NYQUIST:** I was going to say, we are supporting two initiatives to try to address these issues. The first I have mentioned already which is a federal match for high-risk pools losses.

But, the second is what we call the percent of income tax credit and that is if an individual was going to a high-risk pool for instance and the high-risk pool premium that was quoted was above a certain threshold of their income, say more than 7-percent of their income or something like that, then they would qualify for special federal tax credit. So, people could feel comfortable that they are not going to face more than 7-percent of their income to be paid for the high-risk pool premiums.

**LARRY LEVITT:** And that would apply just to high-risk pool coverage?

**LESLEY CUMMINGS:** Well, I just would like to add that if that standard were adopted here, virtually our entire pool would get subsidized because you do not hit 7-percent of income until you reach \$60,000 a year for someone.

**CHRISTINA NYQUIST:** So, maybe that would be fine. I think the idea behind the percent of income tax credit is that there are people of moderate means who, when they are faced with a high-risk pool premium, it is very unaffordable even with all the back door subsidies that the high-risk pool has built into place.

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**LARRY LEVITT:** And we have a number of questions about this issue of affordability, one from an economist from South Carolina who also happens to be in the high-risk pool there who's premium for coverage for her alone is \$16,000 annually. And another from West Virginia from the office of the Insurance Commissioner asking if any states provide any subsidies for low income subscribers. Are any of you aware of states that do subsidize high-risk pool coverage?

**DOUG STRATTON:** Indiana does along with a growing number of states. I think, in fact, if you did a quick survey, you would probably find out of the 34 that are in operation today, probably at least 25 either are or in the process of putting something together to help subsidize those people that are least able to afford the care.

**LESLEY CUMMINGS:** I think a number of states use the availability of those federal grants to initiate a low-income subsidy program.

**KAREN POLLITZ:** And it is true, the number of programs has been growing. I was not aware it was that high but that is good news. In many states though, the low-income subsidy is a discount. It is not what you might typically think of, what I typically think of as a low-income subsidy. So, in many states, the subsidy is to take away the premium surcharge that Doug mentioned.

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Instead of charging a 150-percent of standard rates, they will just take it back to 100-percent which works out to about a one-third discount, which is something. But, if that brings your premium from \$1,000 a month down to \$600, and that subsidy is limited to people who are in poverty then obviously, that is not enough.

Doug, I think your program, I might be mistaken, I always mix up my states, but have you not also joined your Medicaid program and sort of found a way to subsidize some populations through Medicaid?

**DOUG CUMMINGS:** Yes, the state of Indiana has put a program in place this year, Healthy Indiana Program, specifically targeted and designed to help subsidize in a very substantial way, those that are unable to afford health care. And the concept is very innovative as far as I can see.

What they do is there has been an increase in the cigarette tax that funds this program as part of the administration's concept, the program funds are then used to promote programs that help smoking cessation kinds of initiatives. But, in addition, then siphons off a good portion of those funds to be used to pay premiums for anyone that is 200-percent or less than the federal poverty level.

**LARRY LEVITT:** Is that the full premium?

**DOUG CUMMINGS:** In most instances, it is, being applied to the full premium. In some instances, however, it can be up

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to 5-percent of what the annual income is for the family. But, that is a ceiling and what we are seeing in terms of the actual enrollment, a substantial percentage of the people are paying nothing. It is part of Medicaid extension program. There has been an enormous amount of energy and effort that went into that and it is having some real impact.

We are seeing substantial enrollment and we are getting the kind of impact that I think people are looking for and that is, we are actually taking a lot of people off the uninsured list that there is no way they could have afforded coverage under any other circumstances.

**KAREN POLLITZ:** And none of your enrollees are pre-ex'd either right?

**DOUG CUMMINGS:** That is correct.

**LARRY LEVITT:** And you are getting federal matching funds for that as part of the Medicare?

**DOUG CUMMINGS:** There is. As a result of it being part of a Medicaid state plan amendment, there is some additional funding that comes from the federal government. And those kinds of initiatives, what we are finding is, in a lot of states, they are starting to look at innovative ways to address the issues and I think we are starting to see some things come out those efforts that are really producing some sustainable results.

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**LARRY LEVITT:** I want to just sort of broaden the discussion a little bit, we had a question about, we have talked a lot about how do subsidize or the appropriate way to subsidize people in the non-group market and provide stability to that market. We also had a question about whether it is right to frame subsidies in this way. I will read the question.

We seem to be using high-risk pools to protect an individual insurance market when premiums are based on benefits are provided to a healthier population. Other nations, even if using private insurers are more effective in distributing risk equitably by basing contribution more on income levels than the actual real value of the benefits offered. Is there any reason that this concept would not work in the United States?

And Christina, let me start with you, is it your personal perspective, the Association's perspective, is it right for people to be paying different amounts based on their actual real risk, would it make more sense to move to a system where people are paying more based on income?

**CHRISTINA NYQUIST:** Well, I think what is really important to recognize is a couple of things. One of which, is a very important rule in the individual market and it is called guaranteed renewability which is once you actually buy individual market health insurance coverage, the insurer cannot cancel you because you get sick.

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So, when you actually look at our individual market pool, the health status is there is plenty of sick people in our individual market health insurance pool, but there are very sick people that purchase coverage before they got sick. So, I think if there is a real misperception that there are not sick people within the individual market coverage. There are very sick people within the individual market coverage, but they bought the coverage largely before they faced their illness.

To go back to the original question, the notion of guaranteed issue and community rating, it has been tried in states and it is not a magic solution to the cost problem. In New York, the community rated guarantee issue premium is between \$900 and \$1,600 per month for an individual. New Jersey, it is between \$1,200 and \$2,300 a month for an individual.

So, once again, cost is a problem and it is important for us to take hold of that. But, the concern with guaranteed issue is what happens if the lower risk individuals that are young and healthy, they say I am not going to buy coverage and once they leave, they take their subsidy with them and there is no one to subsidize the sicker individuals.

**LARRY LEVITT:** And do you think it would be more workable let us say, with an individual requirement to buy coverage like was proposed, Lesley talked about in California?

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**CHRISTINA NYQUIST:** The individual mandate is sort of an interesting question and the question we have is, many states for instance, require automobile insurance and have auto mandates and yet you still see double digit uninsured auto insured rates and so, we question whether or not just having an individual mandate would actually result in 100-percent coverage. Because you still have the affordability problem and just because the government is mandating it, doesn't mean that people are going to be able to buy it.

**LESLEY CUMMINGS:** Well, we do have a living example of this in Massachusetts and I think conventional wisdom is that they are doing a pretty good job of eliminating the uninsured there.

**CHRISTINA NYQUIST:** Well, a couple of things, one is, once again, Massachusetts has done some very innovative reforms. They build those reforms on a market that had been guarantee issue and community rated for eternity, it was not a new reform and so it did not create any market dislocations because of that.

Second of all, they still do not have an insurance rate that is zero. Certainly they have made progress in the first year but they do not have an uninsurance rate that is zero and what I think you were talking about was doing guaranteed issue in a new state without a history of guaranteed issue and whether or not that could be workable.

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**KAREN POLLITZ:** I just think it is important to separate out, there are two parts, two functions that are going on when we talk about subsidizing, literally, the majority of us in the United States only account for about 3-percent of all health care spending. For most of us, we spend a couple hundred bucks a year on health care and the majority of health care spending is accounted for by only 5-percent of the population.

So, either we spend a couple hundred bucks a year or a couple hundred thousand dollars a year. When you set premiums that being to reflect the actuarial value, you are saying explicitly, we are not going to do that or we are not going to do that completely. We are just going to say to the sick people, sorry, you are on your own for more of it.

All of us are parents. The year that our children were born, if we were priced actuarially, we would have paid for the delivery of that baby. That does not make sense. It does not make sense in terms of what people can afford practically, given what incomes are, and it does not make sense in terms of public health. We want people to be covered so they can go in and have their babies in a good health care setting. We want people with hemophilia to get their clotting factor.

So, whether it is through a public program that spreads it or through an insurance market, I think we expect that kind of cross subsidy and we need it. Otherwise, only Bill Gates

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could every afford to pay for his health insurance. None of the rest of us could when we are sick, when we need to use it.

The other subsidy is, when you sort of average health care cost, per capita spending is \$7,000 a year, that is more than a lot of families can spend, it is. So, we need additional subsidies based on ability to pay and the uninsured overwhelmingly, have very low incomes but even the median income in this country is only about \$45,000 so middle class families also need some help paying for health insurance that even has the kind of perfect cross-subsidization going on, in New York, in New Jersey.

What you do not see in the state of New York and New Jersey, but you do see in Massachusetts, at least for some of the population, is both parts, you see the cross subsidy so that we all sort of pay an average health expense and then you see additional income subsidies in Massachusetts at least for people up to the median income to help them afford that even premium and we really need to do both and as long as we keep doing one or the other, whether through a pool or through the market, it is going to work imperfectly.

**CHRISTINA NYQUIST:** I just wanted to make sure, clarify one thing and that is, in the individual market, when you first apply for coverage, you are underwritten and people evaluate your health status and then you are given a rate and when you apply if you are healthy, you get a tier one rate and you pay

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the standard. And if the next year, you then develop cancer, your rate does not go up because you developed cancer. You still have the tier one rate. That is the way individual market coverage generally works.

So, when we talk about health status rating and there are all these sort of yucky, horrible things to talk about, what we are really talking about is, we do not want to keep people from getting coverage but what we want to do, is not penalize the people that purchase coverage before they got sick. They are also struggling to buy health insurance coverage.

The money has to come from somewhere and once again, the reason why we have been very supportive of high-risk pools, is rather than say that those hundreds of millions of dollars to subsidize very high-risk individuals should just come from this little individual market pool.

What we are saying is, no, let us leave that little individual market pool alone and let us take broad subsidies from general revenues, tobacco taxes, all these other different sources and use those to subsidize a high-risk pool where individuals that are sick can get health insurance coverage and combined with a percent of income tax credit to make it affordable in the front end.

**LESLEY CUMMINGS:** Christina, I do not know what insurance market you are familiar with when you talk about

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guaranteed renewal, but, to my knowledge, there are no rules here in California about what a insurer could charge somebody even though they are renewing the product.

**CHRISTINA NYQUIST:** Once again, in the vast majority of states, the way the individual market works is, if you have health insurance coverage and you get sick and you are renewed, you do not get shifted into a different tier because you got sick. Now, there is always trend, which is applied to everyone. But, in terms of whether or not you were being charge more because you got sick, in the vast majority of markets that is not happening. And Blue Cross Blue Shield plans are not doing that.

**LARRY LEVITT:** Well, I am pretty sure we could spend a whole nother hour on this one as well. [Laughter]  
Unfortunately, we are coming to the end of this one. Let me just jump in with a clarification through the wonders of the internet. Someone from CMS wrote in to say that six of the CMS funded high-risk pools use their federal grants to provide low-income premium subsidies and others do so through state funding. So, a virtual panelist. [Laughter]

We are coming to the end of the hour. And, as I said at the start, Senator John McCain, the presumptive nominee for President from the Republican Party has featured high-risk pools as a major part of his health care reform plan.

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I want to close by asking all of you to talk about sort of comprehensive reform, market reform aside. What are the couple of things we could do now to improve high-risk pools, either at the state level or at the federal level. And Karen, let me start with you, what are some things that could be done to improve the function of these pools right now?

**KAREN POLLITZ:** Well, one very simple straightforward thing would be to just have more careful reporting on what goes on in the pools, how they operate. The High-Risk Pool Association actually publishes a terrific book every year that summarizes a lot of information about these programs, which is very useful.

And it would be helpful to have parallel information about how the individual market works that is sort of shedding risk into these pools, a lot more reporting about underwriting practices so we could get a better idea of who is out there, who needs help, and then we could evaluate how they are, how they are not.

More resources certainly is going to be an important way for these pools to be stronger. I think attention to the barriers of availability, affordability, and adequacy of coverage with particular attention to the pre-ex exclusions would help a number of people who would like to have avail themselves of help from these pools to be able to get in.

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And I think taking a look at pool governance is also important. Most of these decisions are made by, some are set in statue, but most are then made on a day-to-day basis by governing boards and when you look at who runs these pools in many states, the dominant interest represented on the board is the very insurance industry that gets taxed more if more people get in. So, I think we need to pay attention to that.

**LARRY LEVITT:** And Christina, you talked about the proposals for a federal matching funds for tax credits. What are a couple things you would like to see to improve the workings or the functioning of the pools right now?

**CHRISTINA NYQUIST:** Well, those two things I think are just really critical cause they both are addressing the cost problem on the back end for the high-risk pools so they can do things like make sure the offerings are market-based offerings and on the front ends to make sure the individuals can afford it based on their income.

And the third thing is just to make sure that pools are doing what Indiana has been doing, which is to pull the innovative case management disease management practices that have been developed in the employer based system, to make sure that those are being applied in the high-risk pool as well.

**LARRY LEVITT:** And Doug?

**DOUG STRATTON:** Well, I will go back to points that have been made throughout and that is in large measure, the

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issue was the cost of care. And as I look at and I think about what could we do to improve the circumstances, what can we do to improve operation of high-risk programs, whatever we could do to begin to take advantage of the resources that are available through a myriad of locations to find the best practices, to find the place that can focus on this very small percentage of the population.

And whether it is done through what currently is the design of a high-risk program or some other program, the logic that is behind the idea of focusing on this very small percentage of the population that so drive the cost, makes absolute sense and is probably the most important piece of finding how to deal with this cost piece.

**LARRY LEVITT:** And Lesley, we will close with you and I will ask you a slightly different question. With the failure of the health reform plan in California earlier this year, what should we expect over the next six months to a year in California and any debate there that might affect the running of the pool?

**LESLEY CUMMINGS:** Well, Governor Schwarzenegger remains committed to doing the big thing. As you may know, we have a terrible, terrible budget problem here so there are conversations going on between the administration and the legislature about what first steps can we take that would establish a good foundation for a long run and then we hope to

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return to the bigger issue when we are back on our feet financially?

**LARRY LEVITT:** I think we will leave it there. I am Larry Levitt and you have been watching kaisernetwork.org. Thanks to you for joining us, to our panel, and we will see you next time for Ask the Experts.

[END RECORDING]