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TO: Joint Standing Committee on Insurance and Financial Services

FROM: Karynlee Harrington, Executive Director, Dirigo Health Agency

CC: Trish Riley, Director of Governor's Office of Health Policy and Finance
Dr. Robert McAfee, Chair of the Dirigo Health Agency Board of Directors

DATE: January 8, 2008

RE: P.L. of 2003, Chapter 469, Section 6971 4.

On behalf of the Dirigo Board of Directors, I am pleased to present this report to the Joint Standing Committee on Insurance and Financial Services as required by Chapter 469 of the Public Laws of 2003, Section 6971, 4. The Dirigo Legislation passed in 2003 required that after 3 years of operation, the Dirigo Health Agency (DHA) compare the trend for two data elements – (1) average premium rates, and (2) the rate of uninsured individuals – in Maine and the 31 states that had established a statewide high-risk pool as of July 1, 2003.¹

The legislation required that DHA submit legislation to establish a statewide high-risk pool consistent with the characteristics of high-risk pools operating in other states if the trend for both of those data elements exceeds the trend in the high-risk pool states.

DHA has completed the analysis required by law and has determined that, because both criteria were not met, DHA is not required to submit high risk pool legislation.

Trend in Uninsured Rate

The rate of employer sponsored insurance (ESI) has been declining across the United States.² As people lose ESI, they could become uninsured, enroll in Medicaid, or enroll in the individual market.

Figure 1 shows the trend from 2004 to 2006 – i.e., the percentage point change in coverage – for those four coverage categories (ESI, uninsured, Medicaid, individual market) in Maine, the US, and the 31 high risk pool states. The data is from the US Census Department as reported at the Kaiser Family Foundation's statehealthfacts.org web-site. Only changes that are statistically significant are included; blank cells means there was no statistical change.

¹ 24-A MRSA 6971(4)

² www.statehealthfacts.kff.org

Figure 1 shows that the rate of uninsured in the US increased by 1.0% from 2004 to 2006, while Maine's rate of uninsured during this time period stayed statistically unchanged. Among the 31 high risk pool states, the average change in uninsured rate was an increase of 0.9%, with eight states' rate increasing, one state's decreasing, and 22 states' staying statistically unchanged. From 2004-2006 Maine's uninsured trend was lower than the average of the high risk pool states.

Trend in Average Premiums

The only source we could find to compare individual market premiums is an annual survey done by America's Health Insurance Plans (AHIP), an industry trade group.

The data provided in the annual survey is problematic for several reasons. First, AHIP's report notes that "the data on premiums by state are more uncertain than the national averages reported elsewhere in this report. This is because the response level in many states was relatively small, both in terms of the number of policies in the data and in terms of the variety of companies reporting data in the state."³ That means that differences between the states – and differences in the same state from one year to the next – could be influenced by sample sizes.

AHIP's report also notes that differences in premiums are influenced by a "variety of factors, including premium rating and underwriting rules, differences in health care costs, demographics, and consumer benefit preferences."⁴ In other words, it is not possible to make apples to apples comparison between premiums in different states using data reported in the AHIP report because the benefits people are purchasing vary state to state. Additionally, because spending on health care services – which is the biggest driver of health insurance premiums – varies significantly from one state to another,⁵ it is not possible to assess the extent to which differences in premiums between the states are attributable to insurance regulation versus other factors.

To address the benefits design issue we asked the Bureau of Insurance to query insurance chiefs in all the states through the National Association of Insurance Commissioners to assist by requesting that the 31 high risk pool states send data on individual market premiums and benefit design that we could use in lieu of the AHIP data. Only two states sent a response that included any information on benefits design, and most states responding indicated that they did not collect such data.

Another source that has been used before the committee is e-healthinsurance.com. Unfortunately this is not a reliable source for premiums because medical underwriting is done in the 31 states with high risk pools, making it impossible to get a true quote on-line (i.e., one that shows the actual premiums people pay after underwriting).

We thus relied on the AHIP data, which is shown in Figure 2. We include the 5 states with guaranteed issue in addition to the 31 high risk pool states. The high risk pool states are sorted by the third column, which shows the change in premium from 2004 to 2006.

Figure 2 also includes individual market enrollment and high risk pool enrollment and premiums, which will allow comparisons of: (1) premiums paid in high risk pools versus the individual market, as well as changes in individual market versus high risk pool premiums;⁶ and (2) the number of people in the individual market for each person in high risk pools.

³ America's Health Insurance Plans. "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits." December 2007.

⁴ *Ibid.*

⁵ Figure 3 shows federal data on per capita health care spending in each of the 50 states.

⁶ As with the AHIP data, though, the benefits may differ between the individual market and high risk pool plans, making apples to apples comparisons impossible.

Changes in Individual Market Premiums

The data shows that individual market premiums tend to be higher in guarantee issue states than in the high risk pool states, but as noted in the AHIP report, this could be driven by a range of factors, one of which is that – as shown in Figure 3 – spending on health care services (which is the biggest driver of health insurance premiums) is higher in the Northeast than in other parts of the nation.

As far as the trend in individual market premiums, the AHIP reports indicate that 15 of the 31 high risk pool states had increases from 2004 to 2006, from a low of 5% in Kansas to a high of 70% in New Mexico; while 13 states had decreases, from -47% in Wisconsin to -2% in Wyoming; three states did not have sufficient data. As noted above, it is not clear to what extent these changes are driven by differences in sample size and/or differences in plan designs from one year to the next.

Overall, the average change in premiums among the high risk pool states was an increase of 2%; the median change was an increase of 6%.

The AHIP report did not include 2004 data for Maine, so we instead look to insurance company Rule 945 filings with Maine's Bureau of Insurance. It is important to note that we are uncertain if this is a fair methodological comparison. We do not know how AHIP collected its data so cannot assure that this is an "apples to apples" comparison. That said, according to those state filings, the average Anthem premium increased 38% from 2004 (\$146) to 2006 (\$202), while the average Mega premium decreased 5% from 2004 (\$175) to 2006 (\$166). Anthem and Mega comprised 81% and 16% of the individual market, respectively, at the end of 2006.

This suggests that the trend in the individual market premium was higher in Maine than in most high risk pool states, but, as noted above, it is impossible to state this conclusively without adjusting premiums for benefit design to ensure apples to apples comparisons, and data to make such an adjustment are not available.

High Risk Pool Premiums

Importantly, individual market rates in states with high risk pools exclude the cost of the sickest – those who have left the individual market and are covered in the high risk pool. In guarantee issue states, those costs are included in individual market rates. Thus to make a fairer comparison, we should examine the rate increases for people in the high risk pool as well.

In the majority of the high risk pool states, high risk pool premiums increased significantly more than individual market premiums: while the average individual market increase was 2%, the average high risk pool increase was 11%. This is in addition to the fact that high risk pool premiums are higher than individual market premiums to begin with: in all but two states,⁷ 2006 average high risk pool premiums were from 1.5 to 4.8 times higher than average 2006 individual market premiums; the median was 2.4 times higher.

⁷ In New Mexico, the average high risk pool premium is slightly less than the average individual market premium because New Mexico has one of the highest PMPM assessments (which finance the pool's losses, which in turn reduces the need for high risk pool premium) of the 31 states, and because New Mexico is the only state to assess premiums collected by managed care organizations for services provided to Medicaid enrollees. In Idaho, the average high risk pool premium is slightly less than the average individual market premium because: (1) Idaho has the lowest PMPM high risk pool claims (\$294 whereas the second lowest is \$522 and the median is \$743) and (2) a premium tax finances a significant portion of the pool's losses, which, in turn reduces the need for high risk pool premium.

Finally, on average, there are about 50 - 60 people in the individual market for every person in a high risk pool, ranging from a low of 12 people in Minnesota (which has the oldest and one of the largest high risk pools in the US) and a high of 296 in California.⁸

Conclusion

The Dirigo Legislation passed in 2003 required that after 3 years of operation, the Dirigo Health Agency (DHA) compare the trend for two data elements – (1) average premium rates, and (2) the rate of uninsured individuals -- in Maine and the 31 states that had established a statewide high-risk pool as of July 1, 2003.

1. Average premiums in Maine may have increased more than in the high risk pool states, but it is impossible to state this conclusively without adjustments for benefit design.
2. The uninsured rate trended upwards in the high risk pool states, but it remained unchanged in Maine.

Because both criteria were not met, DHA is not submitting high risk pool legislation.

⁸ The median and average ratios of individual market enrollment to high risk pool enrollment are 62 and 48, respectively. This excludes Florida, whose high risk pool has been closed to new enrollment since 1991 and thus is a severe outlier whose inclusion would skew the average.