NORTH CAROLINA HEALTH INSURANCE RISK POOL

ANNUAL REPORT OF THE EXECUTIVE DIRECTOR

TO THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE PRESIDENT PRO TEMPORE OF THE SENATE, THE COMMISSIONER OF INSURANCE, THE JOINT LEGISLATIVE HEALTH CARE OVERSIGHT COMMITTEE AND THE COMMITTEE ON EMPLOYEE HOSPITAL AND MEDICAL BENEFITS AS REQUIRED BY G.S. 58-50-180

April 30, 2009

BACKGROUND:

North Carolina 2007 Session Law 532 (House Bill 265), enacted by the 2007 General Assembly, required the establishment of a non-profit entity known as the North Carolina Health Insurance Risk Pool ("Pool"). The purpose of the Pool is to:

- Provide access to quality non-group health care coverage to individuals whose health and or medical history qualifies them as "high-risk", at a price that is lower than that charged to high-risk individuals by commercial health insurers;
- Function as an acceptable alternative mechanism under the federal Health Insurance Portability and Availability Act of 1996, for eligible individuals and their dependents; and
- Serve as one form of qualified coverage that is available to individuals who are eligible for the tax credit for health insurance costs under the Trade Adjustment Assistance Reform Act of 2002, section 35 of the Internal Revenue Code of 1986, and their dependents.

H.B. 265 provided for State funds for Inclusive Health to pay for a portion of its start-up and ongoing operating costs. The law sets out detailed requirements relating to the governance, establishment and operations of the Pool. It also contained an annual reporting requirement for the Pool's Executive Director which reads as follows:

"§ 58-50-180. Risk Pool established; board of directors; plan of operation.

(g) The Executive Director shall make an annual report to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the Commissioner, the Joint Legislative Health Care Oversight Committee, and the Committee on Employee Hospital and Medical Benefits. The report shall summarize the activities of the Pool in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses."

There is a separate provision of law which requires the Board of Directors of the Pool to submit to the General Assembly an annual report. That report which is specified in G.S. 58-50-255 was submitted on March 1, 2009 to the General Assembly. It dealt with pool financing, estimates of individuals and costs, and methods for providing a premium subsidy. Accordingly, this report will be confined to the topics specified in G.S. 58-50-180.

REQUIRED DISCUSSION:

1. Benefit Plan Enrollment

Enrollment has grown at a gradually increasing rate since the Pool first started accepting applications on October 20, 2008. As of April 15, 2009, the Pool had exactly 1,000 enrollees. An enrollment graph showing this trend is included in Attachment A.

As a new program, the Pool's enrollment growth has been closely tied to growing public awareness and familiarity with this new coverage option. The Pool's target audience includes a combination of citizens who may be paying very high premium rates in order to maintain coverage that they badly need given their health care costs, and those who decided that they cannot afford those high rates. Given the high cost and need for coverage, these individuals rely heavily on word-of-mouth information from trusted sources such as health care providers and health insurance agents. As a result, the outreach and marketing process has employed a grassroots approach to these trusted sources of information to reach those who can use the Pool's coverage.

Chief among these are the state's 13,000 licensed health insurance brokers and agents, the health care provider community and the community health charities serving our target audience. The Pool has worked with all of these key groups to spread the word. Pool staff have addressed health insurance agents across the state at monthly chapter meetings which has led to almost 500 agent assisted application submissions thus far. As part of recontracting the MedCost provider network at Medicare rates, the Pool has solicited patient referrals from the 103 hospitals and 26,000 providers who have thus far chosen to participate with the Pool. Community health charities have featured the Pool on their websites and sent informational mailings to their members.

The Pool has enjoyed free media coverage in the press and on television and radio across the state fueled by the attention to health insurance for the unemployed and health reform in general. The Pool's kickoff on January 1st and "Covering the Uninsured Week" in March spurred media and public interest in the Pool. In addition, the Pool developed and ran public service announcements and ads on television and radio in the Triangle to test out the effectiveness of this medium for possible use statewide.

The eligibility details of those who have enrolled in the Pool are included in Attachment B entitled "Monthly Membership by Eligibility Group." It compares total enrollment by the three major eligibility groups through which individuals may qualify for Pool enrollment including "High Risk", "HIPAA" or "HCTC". "High Risk" includes anyone who qualifies due to a denial or exclusion of coverage, a premium that is higher than the Pool's premium, or because they have one of the 45 diagnoses which qualify for automatic eligibility. "HIPAA" includes those who have exhausted COBRA who have turned to the Pool for coverage, and "HCTC" includes trade displaced individuals who qualify for the Health Coverage Tax Credit.

The major early surprise is that 56% of the first quarter's enrollees qualified by virtue of their HIPAA status. This matches the recent experience of other state risk pools and may be a symptom of the economic downturn and the slow job market where some of these individuals may have otherwise found employment and group coverage. High Risk eligibles make up 41% of the total and HCTC just 3%. North Carolina has one of the largest per capita distributions of trade displaced workers from textiles and furniture in the country. Enrollment of this group has historically been very low nationwide despite the 65% premium subsidy furnished by the IRS. With the subsidy increasing to 80% on May 1st due to the federal stimulus package changes, there may be an increase in uptake among these laid off workers.

"Monthly Membership by Plan" in Attachment C compares enrollment by the 3 Plan Types offered by the Pool based on statute. Plan A and Plan B are PPOs with $1,000 and $2,500 deductibles respectively. Plan C is a High Deductible Health Plan with a $5,000 deductible with which members can choose to include a Health Savings Account. First quarter 2009 plan choices reflect a price sensitivity and bias toward lower premium rates over better benefit coverage. The most popular plan choice was Plan C, the highest deductible health plan, followed by Plan B which is the second lowest premium with a $2500 deductible. The $1000 deductible Plan A attracted only 17% of total enrollees thus far.

We recognize the continuing challenge of raising public awareness and reaching those who may most need our help. In fact, the Pool has requested two changes to the law that have been introduced in HB 1391 to make this more possible. The first will allow the Board to provide premium subsidies if funds are available for this purpose and the Board deems it fiscally prudent to do so. The recent reauthorization of federal risk pool funding for this purpose will provide an opportunity for the Board to consider premium subsidies. The second is an extension to twelve months after the date that enrollment into the Pool first begins during which those who enroll can reduce their pre-existing condition waiting period from twelve months to six months. This change would extend the current deadline of June 30, 2009 for getting the 6 month versus the 12 month waiting period for another 6 months.

Experience has shown that awareness raising leading to a person actually enrolling is a multi-step process that takes time to reach fruition. Even for a subsidized health insurance option like Inclusive Health, it can require multiple messages and repeat exposures from trusted sources to result in enrollment. We therefore expect to continue these strong outreach efforts in new and creative ways in the next year.

2. Net Written and Earned Premiums

The Pool started enrolling members on October 20, 2008 for the first time. The first month's premium is required at the time that an individual submits their enrollment application to the Pool. For subsequent months of coverage premium payment is due prior to the first of the coverage month for which the premium is being paid. Each member's premium is based on their age, gender and smoker status.

Through March 31, 2009 the Pool had total written premiums of $1,088,034 and earned premiums of $758,646.

3. Expense of Administration

Year-to-date administrative expenses through March 31, 2009 totaled $695,400. They are included in the Income and Expense Report in Attachment C. The major expense item was outside contractual expenses of $431,847, including $159,011 paid to the Pool's third party administrator, and $115,776 in advertising and marketing expenses to publicize the Pool. Legal, financial accounting, and actuarial services were also prominent among those covered by this category. In addition, personnel expenses totaled $217,162. These included salary, benefits, and travel costs.

All of the Pool's administrative expenses over the last year were covered by a Federal start-up grant of $850,000 which ended on March 31, 2009. Federal funds were tapped first before any State funds were utilized.

4. Paid and Incurred Losses

Total paid claim costs through the first quarter of active coverage were $370,755. 71% of this total was comprised of prescription drug claims costs. There is less lag time on the use of and payment for prescription drugs especially for a high cost population on numerous prescription drugs. So while we do not expect prescription drugs to continue to comprise this high a percentage of total claims, they are clearly a claims and cost management challenge for a high risk pool. We will be paying special attention to opportunities to reduce the unit price and to maximize the cost effective utilization of prescription medications in the months ahead.

SUMMARY OF POOL ACTIVITIES TO DATE:

The Pool Work Plan in Attachment D summarizes the significant milestones accomplished to date as well as the key tasks that need to be done in the year ahead. Key milestones include the following: (1) the selection of CoreSource, Inc. of Charlotte as the plan administrator in June 2008; (2) the approval of the Pool's policy forms, application, and premium rates by the North Carolina Department of Insurance in September, 2008; (3) the start of enrollment in October, 2008; and (4) the beginning of coverage on January 1, 2009. The Pool's enabling statute had set January 1, 2009 as the deadline for commencing enrollment in the Pool.

In addition, the Pool was approved in September by the Centers for Medicare and Medicaid Services as the HIPAA State Alternative Mechanism for enrollment by individuals who are exhausting their COBRA coverage. This has proven to be a particularly valuable designation with the economic downturn for individuals exhausting their COBRA coverage. The Pool was also certified by the North Carolina Employment Security Commission as a state qualified plan for displaced workers eligible for the health premium subsidy under the 2002 Trade Adjustment Assistance Act. Finally, the Pool has achieved a participation rate of 98% among the 26,000 MedCost network providers at the Medicare rate required by HB 265.

During the next year, the Pool will continue its outreach efforts aimed at raising public awareness and growing Pool enrollment. We will be focused on managing the accessibility, cost and utilization of health plan benefits. This will involve evaluating provider cost containment, quality and utilization management programs and changing or upgrading them as necessary. It will also involve reviewing the benefit designs and premiums in light of ongoing experience and making any changes necessary on January 1, 2010.