STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

JOE MANCHIN III
Governor

JANE L. CLINE
Insurance Commissioner

April 8, 2009

The Honorable Early Ray Tomblin
Senate President and Lieutenant Governor
Bldg 1, Rm 227M
Charleston, WV 25305

The Honorable Richard Thompson
Speaker of the House
Bldg 1, Room 228M
Charleston, WV 25305

Dear President Tomblin & Speaker Thompson:

We respectfully submit the attached "Financing Options for AccessWV, January 2009", as the report to the Legislature required by §33-48-2 (j) of the Model Health Plan for Uninsurable Individuals Act.

The financials of AccessWV continue to be solid. The program ended Calendar Year 2008 with a period surplus of almost $2.8 million and carry-over funds of $11.1 million. With the hospital assessment methodology that is in place, AccessWV expects a surplus of $2.5 million in 2009 and ample carry-over funds into 2010. The AccessWV Board of Directors reviewed year-end financials at its March 2009 meeting and acted to reduce the FY2010 hospital assessment by one half.

A permanent source of financing will be needed for the risk pool, should it begin to operate at a deficit. Based on current projections, the pool is expected to operate with a surplus through 2013. However, the Board of Directors is ever cognizant that the financial situation of AccessWV may change dramatically, if members start to present with catastrophic expenses.

The Board proposes to return to the Legislature in January 2010 with an updated financial report and recommendations for continued financing.

Thank you for your attention and support of West Virginia's high risk pool.

Sincerely,

Jane L. Cline, Insurance Commissioner
Chair, AccessWV Board of Directors

Sincerely,

Nancy Maleček, Acting Director
AccessWV

JLC/NM/ew

attachment

cc: The Honorable Joe Manchin III, Governor
Virgil T. Helton, Cabinet Secretary, Department of Revenue
Aaron Allred, Legislative Services Manager

Summary
Report to the Legislature on Financing Options
AccessWV Board of Directors

Background

The "Model Health Plan for Uninsurable Individuals Act" of 2004 provided for hospital assessments to finance West Virginia's high risk pool (known as "AccessWV"). It also required the Board of Directors to report to the Legislature in January 2006 on alternative funding mechanisms. Since then, the Board has reported to the Legislature annually. In its previous three reports, the Board recommended continuation of the hospital assessment until financing from this source is no longer adequate to cover the Plan's operating needs. Historically, AccessWV has operated with a surplus. The Board noted that "a permanent source of funding at an increased level should be identified before AccessWV begins to operate at a deficit" and pledged to return to the Legislature with recommendations for a permanent sourcing of financing when this occurs. The Board continues to report to the Legislature annually on the financial status of AccessWV.

Plan Performance in 2008

Enrollment. AccessWV continued its pattern of steady, gradual growth during 2008, netting a 30 percent enrollment increase for the year. As of December, the program had 568 policyholders (representing 652 members). Since its inception in 2005, the risk pool has served almost 1,100 West Virginians who had no other recourse for coverage at the time of their enrollment in the pool.

Members include those unable to obtain coverage in the private, individual market because of pre-existing medical conditions as well as persons with guaranteed access to coverage through the federal Health Insurance Portability and Accountability Act (HIPAA). The latter, despite their right to coverage, often face excessively high rates in the private market if they have health issues. AccessWV is also a state qualified plan for the Federal Health Coverage Tax Credit (HCTC) program.

AccessWV members suffer from such serious conditions as diabetes, cancer, psychosis, and heart failure. While the covered population is small relative to the State's population, AccessWV provides a critical service to these West Virginians, who might otherwise go without necessary health care or add to the burden of uncompensated care in the State. The major deterrent to enrollment growth is the costliness of the premiums relative to the incomes of West Virginians who might qualify for the program. By law, AccessWV must set premiums at 125-150 percent of the standard market rate.

Program Highlights. Significant actions were undertaken in 2008 to make program more affordable.

- Premiums for most rating categories were reduced in January. These reductions benefited some 85 percent of the policyholders. Since then, premiums have been held steady, and there will have been no change in premiums for at least 18 months (through June 2009) and possibly longer.
- A more affordable "higher deductible" product was introduced effective January 2009. Premiums for this coverage are, on average, 22 percent below the premiums on the previous least expensive product.
- The Board continues to explore the feasibility of a premium subsidy program for members in financial need.

To strengthen outreach to the target population, the Board authorized a one-time referral fee of $50 to agents who assist with AccessWV applications (effective April 2008). In addition, the prior authorization requirement imposed on out-of-state services in July 2007 resulted in a significant shift of claims payments to West Virginia hospitals. This had a favorable impact on Plan costs as well as a beneficial impact on WV facilities, which saw increased revenues from AccessWV.

Financial Results. To date, AccessWV's financial experience has been more favorable than anticipated. The Plan ended 2008 with a period surplus of $2.8 million and carry-over funds of $11.1 million. The 2008 policy loss ratio was 76%. These results are due mainly to lower than anticipated medical and pharmaceutical claims costs.

Revenue Sources. In 2008 AccessWV was supported through member premiums ($3,522,623), hospital assessments ($2,069,545) and interest ($269,825) constituting 60 percent, 35 percent and 5 percent of total revenues respectively. As of December 2008, policyholders were paying an average monthly premium of $574 with 23

percent paying in excess of $700. To hold down premiums, 54 percent of policyholders selected the least expensive product available ($2,000 medical/$1,000 pharmacy deductible).

The hospital assessment is authorized for "an amount not to exceed a maximum of twenty-five percent above the one tenth of one percent" assessed on hospitals to support the Health Care Authority. The assessment was taken at the maximum in 2008. While federal funding was available in 2008, AccessWV did not have an operating loss in FY 2007. As a result, the program was not eligible to compete for federal funding.

Financial Plan: 2009-2013

Assuming that external financing of $2.2-$2.5 million will be available each year, the **Financial Plan: 2009-2013** shows AccessWV operating with a period surplus through 2013. The size of the surplus will decline slowly. Ending funds available will continue to be substantial.

Financial Plan: 2009 - 2013

	2008	2009	2010	2011	2012	2013
Revenues	$5,861,993	$6,853,073	$7,983,685	$8,941,050	$9,738,156	$10,526,111
Expenses	$3,066,439	$4,323,660	$5,428,001	$7,171,631	$8,667,918	$10,262,067
Period Surplus/(Deficit)	$2,795,554	$2,529,413	$2,555,685	$1,769,419	$1,070,238	$264,044
Ending Funds Available	$11,114,530	$13,643,943	$16,199,628	$17,969,047	$19,039,285	$19,303,328

Enrollment projections in the Financial Plan are conservative and are based on the pool's experience to date and the current program design. Enrollment is expected to eventually taper off. The ultimate capacity of the program is unknown due to uncertainties surrounding the total size of the eligible population and the potential impact of any future programmatic changes. Enrollment projections are shown below.

Year Ending	Dec '08	Dec '09	Dec '10	Dec '11	Dec '12	Dec '13
# Policyholders	568 *(act)*	718	827	905	960	1,001

As the pool continues to add enrollment and accumulate claims experience, the projections will become even more credible and will provide a more accurate base for determining the long-term financing needs of the program. The Financial Plan continues to be updated regularly. Current financial projections show significant improvement over past projections owing mainly to lower than expected claims costs.

The Board continues to grapple with the challenge of making the program more affordable to the many "high risk" West Virginians. As the Board implements additional strategies to reach out to the target population, enrollment may increase beyond that shown in these projections. In this situation, a period deficit may occur before 2013 and the ending funds may decline substantially. The financial projections could also change significantly if the pool experiences a shift in its enrollment towards persons with more costly, catastrophic illnesses. To date, no members have reached their lifetime or annual medical benefit maximums.

Conclusions and Recommendations

The Board is cognizant of the work being done by the Legislature and Governor's Office to address the broader issue of the uninsured in the State. The Board fully supports the development of a comprehensive program for the State that takes into account the special needs of its medically vulnerable constituency. ***The high risk pool has proven a viable and successful mechanism for addressing the health coverage needs of medically uninsurable West Virginians.***

Options for Alternative Financing

Approaches used in other states to cover deficits faced by high risk pools include:

- Insurer assessments, which may include reinsurers, third party administrators and/or Medicaid carriers (29 states)
- State general funds, tax credits or other state sources (15 states)
- Provider assessments (2 states, including WV)
- Miscellaneous other sources (3 states)

Some states use more than one mechanism, thus the counts shown exceed the 34 risk pools operating in 2008. Each approach has pro's and con's. No one mechanism is ideal, and states with risk pools continue to explore different financing approaches.

Guiding Principles

- The financing mechanism for the risk pool should spread costs as broadly as possible.
- The funding mechanism should be secure and not depend on a yearly appropriation process.
- If necessary, consideration should be given to using a blend of sources to spread costs broadly.

Underlying Philosophy

- The high risk pool can play a vital role in the State's overall strategy for increasing health insurance levels. As such, financing for the pool should be as broad-based as possible so that the burden is widely distributed.
- Ideally, financing would come from an allocation of state funds.
- Cognizant of the many demands on state monies, the Board recognizes that an alternative source of funding may continue to be necessary.

Conclusions and Recommendations

- While recognizing the current, favorable financial position, the Board notes that there is no guarantee that AccessWV's favorable financial results will continue. The situation could change dramatically, if members start to present with catastrophic expenses.

- The Board continues to support an operating plan that limits expenditures to the funding level that has been available historically. This includes:
    - *Limiting enrollment to the number of participants that can be supported*
    - *Amending benefits as necessary*

- The hospital assessment remains the financing mechanism of choice, until financing from this source is no longer adequate to cover the Plan's operating needs.

- Given the funds available at the end of 2008, the Board reviewed updated financials at its March 2009 meeting, and acted to reduce the FY2010 hospital assessment by one half.

- The Board is highly committed to carrying out the mission of the high risk pool to provide an insurance safety net to medically vulnerable West Virginians. The Board strongly supports using part of the reserves available at the end of 2008 to support a premium subsidy program for members in financial need and is actively exploring this option.

- A permanent source of funding at an increased level will be needed should it appear as if AccessWV will start to operate at a deficit. At that time, the Board will return to the Legislature with a determination of the amount of financing needed and with recommendations for the permanent source of this financing. Meanwhile, the Board will continue to report to the Legislature annually on the financial status of the Plan.

Financing Options for AccessWV

January 2009

Presentation by the Board of Directors to the
West Virginia State Legislature

Background

Enabling Legislation	**Article 48 "Model Health Plan for Uninsurable Individuals Act" enacted July 2004**
Provision for External Financing	**Hospital assessments**
Legislative Mandate to Board	**Study and recommend alternative funding mechanisms to the Legislature in January 2006**
Previous Board Recommendations	• ***Continue hospital assessment as interim funding source*** • ***Provide update to Legislature each January*** • ***Identify permanent source of funding before AccessWV operates at a deficit***
January 2009	***Situation:*** **Risk pool in sound financial condition** ***Board Recommendations:*** • **Explore using reserves for "low income" subsidies** • **Assess whether 2009 hospital assessment is needed**

Current Status of AccessWV

Milestones

Operations Began	July 2005
First Effective Date of Coverage	August 2005
Enrollment as of December 08	568 policyholders representing 652 members
Rate of Growth in 2008	• 30% increase over 12/07 • 11 policies per month (net)
Persons Served Since Inception	About 1,100

Eligible Populations

- Medically uninsurable persons
- Persons with guaranteed access to coverage through the Health Insurance Portability and Accountability Act (HIPAA)
- Persons eligible for the Health Coverage Tax Credit (HCTC)

End of Year Enrollment

	Dec 05	Dec 06	Dec 07	Dec 08
# Policies	96	298	436	568
# Members	***102***	***345***	***497***	***652***

- Enrollment growth has been gradual but steady. As of Dec 08, the pool is serving over 650 members.

- A risk pool makes coverage ***available,*** but in itself does not address the ***affordability*** of coverage. Many eligible persons find the pool unaffordable.

- Program promotional activities include:
  - One-time agent referral fee of $50 *(implemented April 2008.)*
  - Notification by insurance carriers at the time of coverage denial.
  - Public appearances by the Executive Director, Insurance Commissioner and Insurance Commission staff.
  - Distribution of program materials through stakeholder groups (providers, aging organizations, legislators, etc.) who have contact with the target population.

Financial Results: Calendar Year 2008

Total Accrued Revenue	**$5,861,993**
Premiums	$3,522,623
Assessments	$2,069,545
Interest	$269,825
Total Incurred Expenses	**$3,066,439**
Medical Claims	$1,956,754
Pharmacy Claims	$722,267
Administration	$387,419
Beginning Funds Available	**$8,318,976**
Period Surplus (Deficit)	***$2,795,554***
Ending Funds Available	***$11,114,530***

- The financial picture at the end of 2008 continues to be favorable.

- AccessWV finishes its third full-year of operation with a period surplus of almost $2.8 million and projected carry-over funds of $ 11.1 million.

- The policy loss ratio (claims ÷ premiums) was 76 percent. Member premiums were 115 percent of total incurred expenses.

Financing to Date

Year	Member Premiums	Hospital Assessments	Federal Funding	All Sources
2004		$1,502,426	$1,000,000	$2,502,426
2005	$199,164	$1,658,025	$0	$1,857,189
2006	$1,406,486	$1,763,598	$0	$3,170,084
2007	$2,678,523	$1,899,164	$0	$4,577,687
2008	$3,522,623	$2,069,545	$0	$5,592,168
Total	**$7,806,796**	**$8,892,758**	**$1,000,000**	**$17,699,554**

- AccessWV has received $17.7 million from member premiums, hospital assessments and federal funding.
- Hospitals are assessed at 0.025 % of gross revenues.
- Federal funding provided $1M for start-up. There has been no additional funding.

Premiums

Statutory requirement	125-150% of standard market
Premium level set by Board	130% of standard market
Average monthly premium *(12/08)*	$574
Policyholders paying monthly premiums of $700+ *(12/08)*	23%
Policyholders selecting plan with highest deductibles: $2,000 medical/$1,000 drugs *(12/08)*	54 %

- Policyholders are paying significant premiums for coverage in AccessWV.

- Despite their high levels, premiums collected by risk pools are generally not adequate to cover costs, owing to the extraordinary medical needs of the members.

Potential for Future Federal Funding

Period	Appropriation	Status of AccessWV
FFY 06	Funds ($75 M) available for State FY 05	Not eligible—not operational in FY 05
FFY 07	***No funds appropriated for State FY 06***	
FFY 08	Funds ($49 M) appropriated for State FY 07	Not eligible--no operational loss in FY 07
FFY 09	$49 M included in Former President Bush's budget for State FY 08; no appropriation finalized as yet.	Operational loss of $51,000 in FY 08; may have opportunity to apply for funding.
FFY 10	?	Unknown

- The "State High Risk Pool Funding Extension Act of 2006" authorizes high risk pool funding through FFY 2010.

- Pools with operational losses qualify for grants to offset losses and for bonus awards to be used for member benefits (reduced premiums, disease management, etc.).

- AccessWV did not have an operating loss in FY 07 but has a small loss for FY 08.

Enrollment Projections: CY 09 – CY 13

Policyholders*

2008	2009	2010	2011	2012	2013
568 *(actual)*	718	827	905	960	1,001

* Does not reflect dependents on family policies.

- Enrollment projections in the Financial Plan continue the steady, gradual growth experienced by the pool and also reflect the current program design.
- Cost of coverage has been the major deterrent to enrollment growth.
- Enrollment could increase as the Board implements additional strategies to enhance affordability.
- Ultimate enrollment is an unknown due to the uncertainty of the total size of the eligible market.

Significant Board Actions in 2008

Strategies to Increase Enrollment	
Affordability	• Premium reduction in 1/08 for 85 percent of membership. • No premium increase through 6/09 and possibly longer. • More affordable "higher deductible" coverage plan launched for 1/09 with significantly lower premiums. • "Low income" premium subsidies under consideration.
Outreach	• Referral fee of $50 to encourage agents to assist with applications.
Strategies to Influence Revenue Flow	
Use of In-State Facilities	• Significant shift in percent of hospital claims dollars to in-state facilities (78 percent of total in FY 08) after requiring prior authorization for out-of-state services.

Highlights from the Five Year Financial Plan: CY 09 – CY13

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
External Financing *	$2,069,545	$2,152,000	$2,238,000	$2,328,000	$2,421,000	$2,518,00
Period Surplus (Deficit)	$2,795,554	$2,529,413	$2,555,685	$1,769,419	$1,070,238	$264,044
Ending Funds	$11,114,530	$13,643,943	$16,199,628	$17,969,047	19,039,285	$19,303,328

* at the level afforded by the current hospital assessment

- Based on enrollment and utilization experience to date, AccessWV will continue to operate with a surplus and will have substantial carry-over funds through 2013. The size of the surplus will decline fairly steadily. The Plan will not experience a deficit through 2013.

- The Financial Plan assumes external financing at the level afforded by the current hospital assessment.

- Current projections are more favorable than past projections, owing to lower than expected claims costs. There is no guarantee that results will continue to be favorable. The situation could change dramatically, if members start to present with catastrophic expenses. The Board continues to monitor financial performance closely.

- Additional enrollment and utilization experience will lead to even more credible projections and a more accurate determination of the long-term financing needs of the program.

Financing Sources Used by Other States with High Risk Pools

- Assessments on insurers with or without tax credits
- Expansion of insurer assessments to include reinsurers and/or TPA's
- Assessments on providers
- General revenues or other state sources
- Miscellaneous other sources

- States use a variety of financing sources based on their unique situations. A blend of sources may be used.
- The majority of states with pools (29 out of 34) use an insurer assessment of some kind.
- A number of pools receive direct or indirect state support.
- States continue to explore different financing approaches.

Major Considerations for a Financing Option

- Who benefits from the risk pool?
- Who pays under the financing option?
- Does the approach cover the deficit adequately?
- Is the financing stable from year to year?
- Can the approach be implemented easily?

Who Benefits from the Risk Pool?

Stakeholder Group	*Potential Benefit*
Members	Do not have to bear the financial consequence of going uninsured; can receive needed care.
Insurers	Do not have to take risk of insuring persons with health issues.
Hospitals	Increased utilization; better collections.
Physicians and other providers	Increased utilization; better collections.
Pharmacies & pharmaceutical companies	More business and profits.
Employers that buy health insurance	Lower premiums due to less cost shifting to cover uncompensated care; attractive alternative for employees with portability rights.
Self-insured employers	Lower costs due to less cost shifting to cover uncompensated care; attractive alternative for employees with portability rights.
Persons with health insurance	Lower premiums due to less cost shifting to cover uncompensated care.
Persons who use the health care system	Lower charges due to better collections and less cost shifting.
Society as a whole	Members of society who have been dealt bad health are taken care of—a societal good.
State government	Fewer "spend down" enrollees for Medicaid; satisfied citizenry.

- Many segments of society benefit from the high risk pool.

Who Pays under the Financing Option?

How the Financing Options Work

Option	How It Works
Assessment on Insurers	• Insurers are assessed to cover pool losses in proportion to the amount of health insurance premiums written in state. *Alternative:* Insurers are assessed based on number of covered lives. • A tax credit may be granted.
Assessment on insurers, reinsurers and/or TPA's	• Assessment is usually levied per covered life instead of as % of premiums. • *In some cases*, the reinsurer assessment may be based on a fraction of covered lives.
Hospital assessments	• Hospitals may be assessed based on gross revenues. *Alternative:* Assessment may be added as a charge to patient bills.
Premium increases	• Premiums are increased to cover costs.
Appropriation from state revenues or other state source	• Legislature appropriates funds annually. *Alternative:* Legislature allows ongoing draw from specified source.

Who Pays under the Financing Option?

Option	Who Pays	Who Does Not Pay	Policy Arguments
Assessment on Insurers	Commercial insurers and their insureds (employers and individuals)	Self-insured employers; general public	***Pro**: Carriers are in business to provide coverage and should be assessed if they choose to deny coverage to some people.* ***Con**: Assuming pass-through to insureds, assessment is not broad enough since the self-funded population does not share costs.*
Assessment on insurers with tax credit	General public for full or partial tax credit Commercial insurers and their insureds (employers and individuals) for non-creditable portion	Self-insured employers for non-creditable portion	***Pro**: Tax offset draws on state general revenues spreading the cost among the general population.*
Assessment on insurers, reinsurers and possibly TPA's	All insured employers and persons	Persons without insurance, on public programs or otherwise exempt.	***Pro**: Assuming a pass-through, assessment is spread broadly among those with private insurance coverage.*
Hospital assessments	Payers to whom the hospital passes down the cost. Payers may include carriers, their insureds and self-pay individuals.	Hospital users to whom the hospital does not pass down the cost (public payers in WV). Non-users	***Pro:** With pass-through, risk is spread broadly among privately insured population and more broadly, if public payers are included.*
Premium Increases	Insureds in the high risk pool	Everyone not in high risk pool	***Con**: Does not allow society to share burden of caring for those who have been dealt poor health.* ***Con:** Would lead to severe adverse selection.*
State sources	Taxpayers	No one exempt	***Pro**: Spreads cost broadly through society.* ***Con:** Gives preference to one segment of the population when others may also be deserving.*

Is the Financing Adequate, Stable and Easy to Implement?

Mechanism	Adequacy	Stability	Ease of Implementation
Assessment on Insurers	Depends upon how is assessment is collected (whether keyed to losses or collected in advance). With the latter, there could be a shortfall.	Yes	Varies
Assessment on insurers with tax credit	Depends upon how is assessment is collected (whether keyed to losses or collected in advance). With the latter, there could be a shortfall.	Only if tax credit is kept in force.	Requires change to tax code
Assessment on insurers, reinsurers and possibly TPA's	Depends upon how is assessment is collected (whether keyed to losses or collected in advance). With the latter, there could be a shortfall.	Yes	Requires data on reinsurers and TPA'S. Data may not be available.
Hospital assessments	Shortfall if assessment does not cover loss.	Yes	Yes, if added on to an existing assessment.
Premium Increases	Yes, but may need to be very large.	Yes, but may lead to severe adverse selection thus jeopardizing the viability of the pool.	Yes
State sources	Varies	Varies, but prone to changeability as state political climate changes.	Yes

West Virginia Specifics		
Mechanism	**Key Facts**	**Considerations**
Assessment on Insurers	• 50% of group market is self-funded. • Commercial insurers pay 3% premium taxes. Premium taxes go into state general revenues. • Blue Cross and HMO's do not pay premium or state corporate income taxes.	Assessing insurers, if there was no pass-through to insureds, would place the cost on those companies that benefit from medical underwriting. Assessing insurers that currently do not pay a premium tax (Blue Cross and HMO's) might not create an undue burden. An insurer-only assessment would miss the 50% of the group market that is self-insured.
Assessment on insurers, reinsurers and possibly TPA's	• Reinsurers do not pay premium taxes. The Offices of the Insurance Commissioner does not collect data on reinsurer operations in WV. • The Offices of the Insurance Commissioner collects data on TPA operations in WV.	While this approach would extend the financing burden to all insureds (those with commercial insurance as well as the self-insured), implementation would be difficult because of the lack of data on reinsurers. There may be data on which to base a TPA assessment.
Hospital assessments	• The WV Health Care Authority only reviews rates for commercial payers (30% of the payer universe). • There is no explicit pass-through in the rate-setting process. • Through 12/08, WV hospitals have received about 40 percent of all medical claims dollars paid by AccessWV.	While there is no explicit pass-through, assessments are absorbed in the hospital budgets. Over time they may be passed on to commercial payers. If hospitals pass through assessments to all payers, the cost burden would be spread most broadly. Even without a pass-through to public payers, this is a way to reach the self-insured. While WV hospitals have not yet benefited significantly from claims payments by AccessWV, they are expected to do so over time.
Premium Increases	• Would likely price almost everyone out of the pool.	This would depress enrollment and result in a very unhealthy pool.
State sources	• To date, initiatives to increase insurance levels have not tapped state resources. WV did not elect to spend tobacco settlement funds for this purpose.	State funds might be allocated if the high risk pool were viewed as an essential component of an overall state strategy to increase health insurance levels. A state source ensures costs are spread broadly.

Conclusions and Board Recommendations

Preamble

- The Board recognizes the work being done by the Legislature and Governor's Office to address the broader issue of the uninsured in the State.

- The Board fully supports the development of a comprehensive program for the State that takes into account the special needs of the risk pool's medically vulnerable constituency.

- The high risk pool has proven a viable and successful mechanism for addressing the health coverage needs of medically uninsurable West Virginians.

Conclusions and Board Recommendations

Guiding Principles

- The financing mechanism should spread costs as broadly as possible.
- The financing mechanism should be secure and not depend on a yearly appropriation process.
- If necessary, consideration should be given to using a blend of sources to spread costs broadly.

Underlying Philosophy

- The high risk pool stands to make a vital contribution to the State's overall strategy for increasing health insurance levels. As such, financing for the pool should be as broad based as possible so that the cost burden is distributed widely.
- Ideally, financing would come from an allocation of state funds.
- Cognizant of the many demands on state monies, the Board recognizes that an alternative source of funding continues to be necessary at this time.

Conclusions and Recommendations

- There is no guarantee that AccessWV's favorable financial results will continue. The situation could change dramatically, if members start to present with catastrophic expenses.

- The Board continues to support an operating plan that limits expenditures to the approved funding level, including:
    - *limiting enrollment to the number of participants that can be supported*
    - *amending benefits as necessary*

- The hospital assessment remains the financing mechanism of choice, until financing from this source is no longer adequate to cover the Plan's operating needs.

- Given the substantial funds available at the end of '08, the Board, at its March '09 meeting, will determine whether the hospital assessment is needed, after updated financials are reviewed.

- The Board strongly supports using part of the reserves to support a premium subsidy program for members in financial need.

- A permanent source of funding at an increased level will be needed when AccessWV starts to operate at a deficit. At that time, the Board will return to the Legislature with a determination of the amount of financing needed and recommendations for permanent financing. The Board will continue to report to the Legislature annually on the financial status of the Plan.