State of Ohio
High-Risk Pool Feasibility Study

Prepared by

LEIF ASSOCIATES, INC.

ABOUT THIS STUDY

The Ohio Department of Insurance engaged Leif Associates, Inc., a health care actuarial firm, to conduct a study to determine whether a qualified high-risk pool is an appropriate mechanism for providing health coverage to federally eligible individuals and uninsured Ohioans.

High-risk pools are non-profit organizations that are created by state law to offer comprehensive health insurance to individuals who, in the absence of a statutory requirement for guaranteed access to individual health insurance coverage, would be unable to secure health insurance coverage because of their health status. This approach to covering uninsurable individuals has been adopted in one form or another by more than thirty states. In most states, high-risk pools also serve as the mechanism for providing coverage for federally eligible individuals and those eligible for the federal Health Coverage Tax Credit Program.

This study was paid for with a federal grant obtained by the Ohio Department of Insurance based on funding made available by Congress in the Trade Adjustment Assistance Reform Act of 2002 for implementation of qualified high-risk pools.

SUMMARY OF FINDINGS

The key findings of this study include the following:

- Based on the analysis described in this report, we believe that a high-risk pool is a viable option for the state of Ohio to provide coverage to people who have serious chronic health conditions.
- High-risk pools charge premium rates to participants that are high, and therefore a high-risk pool does not entirely solve the problem of the affordability of coverage for uninsurable individuals. It is a valuable mechanism for the portion of the uninsurable population that can afford the premiums, but the high cost of the high-risk pool coverage can present a barrier to others. As a result, many states have adopted discount programs to assist low-income participants.

<u>Current Environment and Predicted Enrollment</u>

- Approximately 1.3 million persons in Ohio are uninsured. A portion of the uninsured would be both eligible and willing to pay the premium for a federally qualified high-risk pool. It is likely that membership in a new high-risk pool in Ohio would number approximately 2,800 individuals in the first year, growing to approximately 13,000 individuals by the fifth year.

- It is expected that as many as 17,250 Ohio residents could eventually be enrolled in a high-risk pool.
- Approximately 1,800 individuals who are currently enrolled in open enrollment and HIPAA plans would likely move to the high-risk pool, since the rates would be lower and the benefits could be better.
- A high-risk pool could potentially reduce the number of uninsured persons in Ohio by over 15,000. Other than the 1,800 individuals currently enrolled in open enrollment or HIPAA-eligible plans, a high-risk pool would attract currently uninsured persons who have pre-existing health conditions, do not have access to employer-provided coverage, and are able to afford the higher than average premiums. The most likely candidates are retirees between the ages of 50 and 65 and self-employed individuals.
- Thirty states have used the NAIC Model Act for High-Risk Pools to establish high-risk pools.

Funding Analysis

- All high-risk pools lose money because premium rates are limited and the people being insured are high-risk individuals. Additional funding from some source is therefore required.
- The funding for a high-risk pool would need to come from a combination of premiums paid by participants and the additional funding source, since premiums would not be adequate to cover all the expenses of the program. A broad mix of additional funding sources would be beneficial, making the funding burden less detrimental to any one segment of the economy. Many other state high-risk pools rely on a broad mix of funding sources.
- Several high-risk pools partially fund net losses with state appropriations and from assessment of health insurers and reinsurers. One high-risk pool funds net losses through general state revenue, service charges on hospital admissions and outpatient surgeries, and assessment of health insurers and HMOs. Another high-risk pool funds net losses through assessments on health insurers and stop-loss carriers, and also receives additional funds from carriers with loss ratios less than 72%.
- Assuming that an Ohio high-risk pool would begin operations on January 1, 2006 and premiums are set at 150% of the standard market rate, the average monthly premium for participating individuals would be $476. The average monthly claims and administration costs combined would be $976, and this would result in a monthly shortfall of $503 per insured. By the fifth year of the program, the premium rate would grow to about $798 per month, the claims and administration costs combined would grow to $1,688, and the monthly shortfall would be $890 per participant.

- The high-risk pool shortfall would create an additional funding requirement of $20 million in the first year of the program. If this shortfall were to be funded through an assessment based on all individuals with commercial health coverage, including those in self-insured plans who purchase stop loss coverage, the annual assessment would be approximately $3 per insured life. If the shortfall were to be funded through a broad-based assessment shared evenly by insurers and hospitals, the assessment would be approximately $1 per insured life and 0.01% of hospital revenue. After five years, the shortfall would grow to $144 million. Using the same assumptions, the insurer and stop-loss assessment would be $19 per insured life per year. If the shortfall were to be funded through a broad-based assessment shared evenly by insurers and hospitals, the fifth year assessment would be approximately $10 per insured life and 0.06% of hospital revenue.
- Historically, no high-risk pools have gone insolvent, largely because of adequate oversight. The impact of future increasing costs could be minimized by limiting enrollment in the program, reducing benefits covered, or by increasing member cost-sharing. Some high-risk pools have experienced larger than expected losses requiring their Boards of Directors or state legislatures to take action to prevent funding mechanisms from being over-stressed.
- Over 180,000 individuals are covered in the current high-risk pools across the nation. Several of the pools have been in existence for over twenty years. A wealth of information and guidance is available from states that have high risk pools. Those states have used a variety of approaches to achieve unique goals influenced by each state's own particular budgetary situation, insurance market, and population demographics.

OVERVIEW OF THE REPORT

Using information provided by the largest health insurance carriers in Ohio, existing state high-risk pools, and publicly available sources, we have compiled a comprehensive report containing the following sections:

- Background Information. In this section, we provide a high level overview of the dilemma faced by uninsurable individuals, a summary of how Ohio has addressed that problem through its current open enrollment system, and a brief introduction to the high-risk pool concept.
- The Ohio Health Insurance Market. This section summarizes the various components of the Ohio health insurance market, including the uninsured, Medicaid and Medicare, employer-provided coverage, and individual health insurance plans. It includes the results of a survey of the largest Ohio carriers regarding their products and rates for both employers and individuals.

- Potential Impact of an Ohio High-Risk Pool. In this section, we provide the estimated enrollment, benefit structure, premium rates, and additional funding required for a potential Ohio high-risk pool. We include projections for a ten-year period and describe our methodology and assumptions.
- High-Risk Pools In Other States. In this section, we provide detailed information about common practices of high-risk pools in other states in the areas of plan operation, eligibility, administration, funding, and benefits, as well as guidelines provided by the NAIC model legislation and the requirements of federal HIPAA legislation for qualified high-risk pools.
- Key Implementation Considerations. This section outlines the many decisions that would have to be made if a high-risk pool were to be implemented in Ohio.

The cost and enrollment projections included in this study are estimates of future events based on many assumptions. To provide a framework for the projections, we have created a model that includes a range of assumptions. The attachments to the report include three assumption scenarios, which we have labeled Best Estimate, Less Conservative, and More Conservative. It is important to understand that while we believe we have used reasonable assumptions based on the information available to us, actual future results may be influenced by unforeseen events that we have not anticipated.

The results of this study will help Ohio policymakers evaluate the merits of a high-risk pool as an alternative to Ohio's current system for providing health coverage to citizens through an open enrollment system.

Without assistance from the individual insurance carriers in the State of Ohio, our analysis would not have been possible. We thank them for their cooperation.

THE DILEMMA OF UNINSURABLE INDIVIDUALS

One of the realities of the health insurance system in the United States is that it is a voluntary system. While there are various health insurance markets available to meet the needs of most people who wish to purchase health insurance, there still remain a few segments of the population who would like to be insured, but do not have access to coverage at prices they can afford.

The health insurance market is composed of two major segments:

- The group market provides health insurance plans to employers. Employers make the plans available to their employees who can choose whether or not to enroll themselves and their families. Employers generally pay a fairly substantial portion of the cost of the coverage. While an employer can set eligibility rules for participation, such as hours worked or employment status, group coverage cannot be denied to an employee or his/her dependents solely because of their health status.
- The individual market provides insurance plans to persons who wish to purchase coverage for themselves or their dependents directly from an insurance company. Persons seeking individual coverage are generally those who work for an employer that does not provide health insurance coverage, do not meet the eligibility requirements for their employer's plan, are self-employed or are not employed. Because of the voluntary nature of the health insurance market, individual health insurers require medical screening as part of the application process. They reserve the right to reject, rate-up, or impose exclusions for individuals who have pre-existing medical conditions.

In the absence of laws requiring insurers to provide individual coverage to persons with pre-existing medical conditions, those persons generally remain uninsured. This segment of the uninsured population is known as "uninsurable", to distinguish them from persons who have no insurance for reasons other than their health status. Uninsurable individuals have sought coverage, but have been unable to purchase it either because they have been rejected or they have been offered coverage at unaffordable rates. Because of their health conditions, uninsurable individuals are the portion of the uninsured population that most needs health insurance coverage. Their inability to secure coverage puts them and their families at considerable physical and financial risk.

CURRENT OHIO LAW

In order to address the problems of uninsurable individuals, over thirty states have implemented high-risk health insurance plans and provide some means of financial subsidies to help cover the cost of coverage. Other states, such as Ohio, have taken different approaches.

To make health insurance available to all Ohioans, the State uses an open enrollment system. The open enrollment system makes health insurance available to all Ohioans regardless of health status. There are three components of the open enrollment laws:

1. Ohio Revised Code §3923.58 applies to health insurance companies and MEWAs and requires them to accept individuals during an open enrollment period. The law became effective in 1993.
2. Ohio Revised Code §3923.581 applies to health insurance companies, health insuring corporations, and MEWAs and requires them to accept federally eligible individuals during an open enrollment period. A federally eligible individual is generally one who has at least 18 months of creditable coverage under a group health plan, is not currently eligible for group coverage, Medicare or Medicaid, does not have other health insurance coverage, and has exhausted any available COBRA coverage. This law became effective in 1997.
3. Ohio Revised Code §1751.15 requires health insuring corporations to hold an annual open enrollment period of not less than 30 days for individuals who are not federally eligible individuals at the time they apply for enrollment. This law also became effective in 1997.

The key provisions of Ohio Revised Code §3923.58 are as follows:

- Beginning in January of each year, health insurers and MEWAs who issue individual sickness and accident insurance policies must accept applicants for open enrollment coverage in the order in which they apply for coverage.
- Insurers must accept for open enrollment coverage individuals who are not eligible for coverage under any other private or public health benefits arrangement.
- The Ohio health care basic and standard plans, or substantially similar plans, must be offered to open enrollment applicants. Additional plans may also be offered if the insurer wishes to do so. They may establish a pre-existing conditions provision that excludes or limits coverage for up to twelve months for conditions manifested during the six months preceding the effective date of coverage. The use of specific networks of providers may be required.
- Premiums charged to individuals issued coverage during the open enrollment period may not exceed an amount that is two and one-half times the highest rate charged any other individual to whom similar copayments and deductibles are applied.
- The number of open enrollment individuals that an insurer is required to accept each year is limited to one-half percent of its total number of insured individuals in the state. Once that level of enrollment has been met, the

insurer can be relieved of its open enrollment requirements for the rest of the calendar year.

- Insurers are not required to accept applicants who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity. The effective date of benefits for open enrollment individuals can be as late as ninety days after their acceptance.

The key provisions of Ohio Revised Code §3923.581 are as follows:

- Beginning in January of each year, health insurers, health insuring corporations, and MEWAs who issue health benefit plans to individuals or non-employer groups must accept federally eligible individuals for open enrollment coverage in the order in which they apply.
- Pre-existing conditions provisions cannot be applied.
- The Ohio health care basic and standard plans, or substantially similar plans, must be offered to open enrollment applicants.
- Premiums charged to federally eligible individuals issued coverage during the open enrollment period may not exceed an amount that is two times the midpoint rate charged any other individual to whom similar copayments and deductibles are applied.
- The number of federally eligible open enrollment individuals that a carrier is required to accept each year is limited to one-half percent of its total number of insured individuals and non-employer groups in the state. Once that level of enrollment has been met, the insurer can be relieved of its open enrollment requirements for the rest of the calendar year unless all of the carriers have individually met the enrollment limit. In that event, carriers must again accept applicants.

Insurers may reinsure coverage of any individual or non-employer group acquired under §3923.58 or §3923.581 with the Open Enrollment Reinsurance Program. The program is funded through premiums and an assessment on each carrier that is required to provide open enrollment coverage. The assessments are apportioned among all carriers participating in the open enrollment reinsurance program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid by the carrier for open enrollment coverage and net of reinsurance premiums paid by the carrier for all other individual health benefit plans earned in the state during the year. The assessment of any carrier is limited to three percent of its Ohio premiums for health benefit plans covering individuals. Carriers may elect not to participate in the open enrollment reinsurance program if given approval by the Department of Insurance.

The key provisions of Ohio Revised Code §1751.15 are as follows:

- During the open enrollment period, Health Insuring Corporations must accept applicants and their dependents in the order in which they apply.
- The number of open enrollment individuals is limited to one percent of the health insuring corporation's total number of subscribers residing in the state or the health insuring corporation's capacity, whichever is less.
- Health insuring corporations are not required to accept applicants who are eligible for employer-sponsored coverage, continuation coverage, or Medicare.
- Health insuring corporations are not required to accept individuals who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity. Costs for organ transplants can generally be excluded for the first year of coverage.
- Rates for the open enrollment coverage must be filed with the Ohio Insurance Department and can be disapproved.

In addition to these open enrollment opportunities, some individuals are eligible for the federal Health Coverage Tax Credit (HCTC) Program. The HCTC program pays up to 65 percent of the cost of coverage for eligible Ohioans who have lost their jobs due to economic changes related to foreign trade issues or lost pension benefits due to a company bankruptcy. Eligible persons can secure coverage from certain private insurance plans that are qualified for the tax credit.

THE HIGH-RISK POOL CONCEPT

An alternative to the current Ohio open enrollment program is the establishment of a high-risk pool. High-risk pools are non-profit organizations that are created by state law to offer comprehensive health insurance to individuals who, in the absence of a statutory requirement for guaranteed access to individual health insurance coverage, would be unable to secure health insurance coverage because of their health status. This approach to covering uninsurable individuals has been adopted in one form or another by more than thirty states. In most states, they also serve as the mechanism for providing coverage for federally eligible individuals and those eligible for the federal Health Coverage Tax Credit Program.

A high-risk pool is an insurance program with its own health benefit plans, rates, administration, and management. Eligibility requirements determine who can enroll in the plan. The benefits are comprehensive and generally based on what is available through medically underwritten individual or employer-based coverage in the state.

Participants pay a premium rate that is established based on a formula included in state law. The premium is generally a multiple of the average individual health

insurance rate in the state, with a range that allows some flexibility to those who manage the plan. A typical high-risk pool rate is 125% to 200% of average medically underwritten individual health insurance rates, otherwise referred to as the standard risk rate.

Because the premium rates are high, a high-risk pool does not entirely solve the problem of the affordability of coverage for uninsurable individuals. It is a valuable mechanism for the portion of the uninsurable population that can afford the premiums, but the high cost of the coverage can present a barrier to others. As a result, many states have adopted discount programs to assist low-income participants.

Because high-risk pool participants are persons who have pre-existing health conditions, premium rates falling within the typical mandated ranges are not adequate to cover the cost of their health care and the administration of the program. As a result, a funding mechanism other than premium rates is necessary to cover the costs of the program. States have adopted a wide range of approaches to subsidizing their high-risk pools.

An appointed board of directors generally provides the management of high-risk pools. It is common for the board membership to be defined in law to ensure a balanced representation from the regulators, legislators, insurance carriers, medical professionals, and consumers. The board establishes the rules under which the plan operates and enters into contracts for the administration of the plan.

High-risk pools are a common concept across the country. From state to state, they tend to share some similarities but take on their own unique characteristics based on the insurance market, political climate, demographics, and economic conditions in the state in which they are formed. A state forming a new high-risk pool has many choices available in structuring the program. Because these programs have been in existence in other states for many years, there is much information available from which Ohio can draw to make good decisions about how a high-risk pool might best be structured to meet the needs of Ohio residents.

Later in this report, we provide specific details about how high-risk pools are structured in other states in order to provide a framework for examining an appropriate starting point for projecting the potential financial and operational implications of an Ohio high-risk pool.

FEDERAL GRANTS FOR HIGH-RISK POOLS

The Trade Adjustment Assistance Reform Act of 2002 included federal grant funding for federally-qualified high-risk pools. Congress appropriated funds for 2003 and 2004 to be used as follows:

1. $20 million in start up grants for states without high-risk pools. Grants of up to $1 million per state were available. Six states received start up grants.
2. $80 million in operational grants for existing qualified high-risk pools. Sixteen grants were awarded in each of the two years.

Congress has not yet approved an extension of the grant program for additional years, although such an extension is currently under consideration. The Senate Health, Education, Labor and Pensions Committee approved Senate Bill 288 in February 2005. The legislation would authorize $15 million for fiscal 2005 and 2006 for states establishing new high-risk pools. It would extend funding for states that already have high-risk pools by authorizing $75 million in operating grants for each of fiscal years 2005 through 2009.

THE UNINSURED IN OHIO

Recent studies show that the number of individuals without health insurance in the state of Ohio ranges from 1,247,200 to 1,359,000, or about 12% of the total population. Since most people over age 65 are on Medicare, studies of the uninsured often focus on the under age 65 population. In Ohio, approximately 13.6% of those under age 65 were uninsured in 2003. This represents an all-time high level of uninsured over a 17-year period that once dipped to 9.6% in 1989.

When stratified by age, the largest number of uninsured (455,200) is the group between 30 and 49 years of age, but the largest percentage without insurance (21.7%) is among the 19 to 29 year olds. Although Caucasians make up about 75% of the uninsured, racial and ethnic minorities are more likely to be without insurance (nearly 1 in 4 Hispanics and 1 in 6 Afro-Americans versus 1 in 9 Caucasians).

Individuals become uninsured for a variety of reasons. Of the approximately 1.3 million uninsured individuals in Ohio, it is estimated that 65% of them have incomes below 200% of Federal Poverty Level. Also, 21% of the uninsured in Ohio report that they have poor or fair health status.

Most uninsured Ohioans (82%) are in families where at least one person in the family works either full-time or part-time and 51% have family members who work full time all year. Smaller employers and the service and labor industries are less likely to offer health insurance coverage to their employees. Part-time workers are often ineligible for employee benefits. In addition, low-wage workers may find their employer-sponsored plans unaffordable. The percentage of all Ohioans covered by employer-sponsored health insurance has vacillated over the years from a high in 1989 of 71.3%, to a low of 64.1% in 1993.

Many low-income individuals, especially adults, cannot qualify for Medicaid through their state welfare systems. Throughout the country, more than 80% of all uninsured adults with incomes below 200% of the federal poverty level are ineligible for Medicaid and other public health insurance programs. Among those under age 65 and uninsured in Ohio, 871,000 or 65% are considered low-income and 474,000, or 35% earn more than 200% of the federal poverty level. Although low-income children in Ohio are generally eligible for Medicaid and the State Children's Health Insurance Program (SCHIP), it is estimated that between 40% and 50% of Ohio children who are uninsured are, in fact, low-income. Many of these children are potentially eligible for Medicaid or SCHIP.

MEDICAID AND MEDICARE

Approximately 1,173,670 people, or 10% of the population in Ohio, are on Medicaid. This compares with 13% throughout the United States. Of those Ohioans on Medicaid, nearly 55% are children ages 18 or under. This represents 21% of all children in the state.

Medicare covers more than 1.4 million people in Ohio, approximately 12% of the state's population. Of those on Medicare, approximately 10,000 are children and 161,000 are ages 19 to 64.

THE COMMERCIAL INSURANCE MARKET

The Ohio Department of Insurance provided us with 2003 market share data, which listed the five companies with the largest market share for individual, small group, and large group coverage for insurers as well as HICs (Health Insuring Corporations, or HMOs). In order to study the health insurance market in Ohio, we contacted the largest companies. Information requested consisted of individual and small group benefit designs for products currently sold, individual premium rate structures, and membership information for HIPAA enrollees, open enrollment enrollees, and membership by line of business. We also received loss ratio information for these enrollment categories.

The carriers with the largest employer-provided market share were:

- Community Insurance Company (Anthem)
- Medical Mutual of Ohio (MMO)
- United Healthcare
- Humana
- Aetna
- Kaiser Foundation Health Plan of Ohio
- Paramount (ProMedica)

These carriers represented 83% of the small group insurance market, 78% of the large group insurance market, 67% of the small group HIC market, and 74% of the large group HIC market.

In Ohio, around 64% of all residents (72% of adults ages 19 to 64) carry health insurance through their employers. This is higher than the national average of 54% and 64%, respectively. Approximately 67.4% of the private sector employers in Ohio offer health insurance. Ninety-seven percent of private employers with 50 or more employees offer coverage and 54.7% of small firms do. Total group premium for employee-only coverage in Ohio averages $3,087 per year (2002), approximately $100 less than the national average. Employers in Ohio contribute about 80.4% towards the employee-only premium with employees paying about $604 per year. Across the US, employees tend to pay a

lower percentage (17.7%) or $565 per year. Average group family premiums in Ohio are $8,163 per year, about $300 less than the US average. Employer contributions of 77.5% result in employee costs of $1,841, about $140 per year less than the national average.

The five largest writers of individual health coverage in Ohio insure 80% of the 244,000 Ohioans who have individual coverage. These carriers collectively account for 77% of the premium earned for individual coverage in the state in 2003. Because of ties between individual coverage and high-risk pools, our study focused on these five carriers:

- Community Insurance Company (Anthem)
- Golden Rule Insurance Company
- Medical Mutual of Ohio (MMO)
- Fortis Insurance Company (now named Assurant)
- American Community Mutual Insurance Company

The five largest HICs marketing individual coverage insure 98% of the 15,000 Ohioans with individual HIC coverage, which translates to 97% of the earned premium. The five carriers include:

- Kaiser Foundation Health Plan of Ohio
- UnitedHealthcare of Ohio Inc.
- The Health Plan
- Summacare Inc.
- Medical Health Insuring Corporation of Ohio

The information provided to us by the carriers allowed us to compare employer-provided coverage to individual coverage offered in Ohio. Our comparison showed that employer-provided products generally had the following characteristics when compared to individual products:

- Services covered as optional riders, such as maternity, mental health, and prescription drugs, in individual products are covered in the base medical plans for group coverage.
- Groups have the option of purchasing plans with significantly lower out-of-pocket maximums.
- Groups are generally presented with more plan design options than are individuals due to having less anti-selection risk with employer-provided coverage.
- Well child and other preventive services are more commonly found with lower copays in employer-provided coverage rather than being covered under the deductible and coinsurance of individual plans.
- Employers seeking coverage typically can obtain richer prescription drug benefits than individuals.

- Emergency room visits commonly have copays, such as $100, for group coverage, while individual products typically cover emergency room visits under deductible and coinsurance.
- Limitations on transplants that are common within individual policies are typically not as strict for employer-provided coverage.

Information from the carriers also provided an indication that the current open enrollment approach is not having a significant impact on reaching high-risk Ohio residents and HIPAA-eligible individuals. The individual insurance carriers reported total enrollment of that population of just under 1,800 individuals. We found the benefits and rate structures to be inconsistent and the rates to be widely disparate. The following table shows the number of open enrollment insureds and their average premium and claims in 2003. This information is from the Ohio Department of Insurance Annual Report of Ohio Health Insurance Business.

Type	***# Insured***	***Average Premium***	***Average Claims***
Non-Federally Eligible	934	$595	$632
Federally Eligible	863	$596	$692

The insurance market information obtained from the carriers enabled us to:

- Produce a recommended plan design for a potential high-risk pool
- Calculate the standard risk rate for individual plans
- Prepare different premium rate scenarios for a potential high-risk pool
- Create financial projections for a potential high-risk pool, and
- Study potential market migration and overall impacts to various markets if a high-risk pool is implemented in Ohio.

The potential impact of an Ohio high-risk pool is described in the next section.

EXPECTED DEMOGRAPHICS

High-risk pools have a demographic distribution that is not typical of the general population. There is a much greater prevalence of coverage for persons over age 50 than for younger ages. This likely results from early retirees whose former employers do not provide retiree health coverage.

Based on the actual demographics from several high-risk pools, we expect that an Ohio high-risk pool population would have the following demographic distribution by age and gender.

Distribution by Age and Gender			
Age Band	Male	Female	Total
0 - 19	4%	3%	7%
20 - 24	2%	1%	3%
25 - 29	2%	1%	3%
30 - 34	2%	1%	4%
35 - 39	3%	2%	6%
40 - 44	5%	3%	8%
45 - 49	6%	5%	11%
50 - 54	7%	8%	15%
55 - 59	8%	10%	18%
60 - 64	10%	16%	26%
Total	50%	50%	100%

It can be observed from the table above that a large percentage of the expected membership is made up of persons over the age of 50. These are likely to be early retirees who do not have employer-provided retiree health insurance coverage and are not yet eligible for Medicare benefits. Although the age for Social Security retirement benefit eligibility has begun to move beyond age 65, at this time age 65 remains as the starting date for Medicare eligibility.

Based on member counts by plan design for the state high-risk pools with deductibles similar to the ones we recommend for Ohio, the following table contains the expected distribution of membership by plan deductible option.

Distribution by Deductible	
Plan Deductible	Distribution of Members
$500	28%
$1,000	22%
$1,500	15%
$2,500	22%
$5,000	13%
Total	100%

PROPOSED BENEFIT STRUCTURE

All five of the largest Ohio individual insurance carriers offer statewide PPO plan designs with annual in-network deductibles ranging from $500 to $10,000 for an individual. Three of the companies also offer indemnity products with annual deductibles ranging from $500 to $10,000 per individual. Based on the plan designs of these individual health insurers, we developed a proposed plan design with comprehensive coverage and benefits consistent with those offered by the carriers.

We also compared the plan designs of all high-risk pools in existence in 2003 and 2004. The plan designs of the high-risk pools included deductibles similar to those offered in the commercial market in Ohio. There were, however, some notable differences between the two with regard to some specific services. These differences are common among high-risk pools and individual coverage in most states. The most important differences were for the following services:

- Maternity: The majority of high-risk pools cover maternity, while individual policies typically exclude maternity from base coverage and allow purchase of an optional rider. We recommend covering maternity.
- Skilled nursing: The maximum days of skilled nursing facility coverage is generally greater in the high-risk pools than the individual market in Ohio. We recommend implementing a 60-day per year maximum for skilled nursing facility care.
- Home health: The maximum home health coverage is generally greater in the high-risk pools than the individual market in Ohio. We recommend implementing a 100-visit per year maximum for home health care.
- Transplants: Transplant coverage for high-risk pools is typically less generous than that offered by individual carriers in Ohio. One Ohio individual carrier covers 100% of the transplant cost if the transplant takes place within contracted facilities. Several high-risk pools cover only a short list of types of transplants, and some have relatively low maximum transplant benefits. We recommend covering non-experimental transplants subject to the plan's

deductible and coinsurance with no specific in-network transplant maximum benefit.

- Pre-existing Conditions Exclusions: The pre-existing conditions look-back period established in the high-risk pools is six months or less (except in some states regarding maternity). The look-back period in the individual market in Ohio ranges from six to 24 months. The pre-existing conditions waiting period for most high-risk pools is six months (with some more and some less). The pre-existing conditions waiting period for the surveyed individual carriers in Ohio is twelve months. We recommend having a six-month look-back/six-month waiting period for pre-existing conditions for traditional pool participants and no pre-existing exclusions for federally eligible enrollees.
- Benefit maximums: Most high-risk pools have a lifetime benefit maximum of $1,000,000. A few high-risk pools have benefit maximums lower than $1,000,000. The individual carriers in Ohio have lifetime benefit maximums ranging from $2,500,000 to $8,000,000. We recommend implementing a high-risk pool lifetime benefit maximum of $1,000,000.

Our analysis also showed that several carriers are offering high deductible health plans that qualify as HSA-eligible (Health Savings Account) as individual or employer-provided products. Making high deductible plans qualified HSA designs may take little or no changes to the designs typically offered by high-risk pools due to their inherent high deductibles. There are, however, some nuances of the HSA qualification standards that would need to be studied closely if the Ohio high-risk pool were to implement such a product.

Due to the prevalence of PPO plans in the individual market in Ohio, and because of the significant cost savings a high-risk pool can obtain by using some managed care plans, we recommend offering a PPO plan rather than an indemnity design. Because of the limited individual enrollment in HMOs in Ohio and because a high-risk pool should have statewide coverage, we do not recommend implementing an HMO at the initial opening of the high-risk pool. Introducing HMO plans in limited geographic areas might be considered at a later time. We have included our recommendation for PPO plan designs in Attachment A.

EXPECTED PREMIUM RATES

Premium rates for high-risk pools are based on the standard risk rate offered in the state's individual market. The standard risk rate is calculated using the average rate charged by the largest carriers in the state that offer health benefit plans comparable to the policies issued by the high-risk pool. The largest carriers in the state's individual market are typically surveyed to determine their premium rates charged to an individual with "standard" health status. A high-risk pool must set its initial rates in the range of 125% to 150% of the standard risk

rate in order to be a federally qualified plan. Rates can be subsequently changed based on actual experience, but may not be more than 200% of the standard risk rate.

The following steps were taken to develop potential Ohio high-risk pool premium rates.

- The Ohio Department of Insurance provided a 2003 market share report. This report showed that Anthem, Fortis (Assurant), Golden Rule, MMO, and American Community had the greatest market share in Ohio's individual market.
- The individual rates and benefits used by these five companies were secured from the companies. After developing the recommended plan design as previously described, we analyzed the rates for each of the carriers' plan designs closest to each of the five recommended PPO designs.
- The carriers' plans were compared to the recommended plans to identify meaningful plan design differences. The actuarial value of the differences was determined, and appropriate adjustments were made to the current PPO rates for each carrier.
- For each of the recommended plan designs, the actuarially adjusted rates applicable in the Columbus, Ohio region were averaged among the five carriers to determine the standard risk rate for each age 0 through 64.
- The standard risk rate for each age was increased by 50% to determine the premium rate for each plan design based on the scenario of implementing rates equal to 150% of the standard risk rate.
- The rates were averaged into five-year age bands to simplify the rating structure.
- We determined that the average annual trend in the surveyed carriers rates is 13.9%. Using that trend rate, the current calculated rates were increased 13.9% in order to develop proposed rates effective January 1, 2006.
- A geographic analysis was performed to study how rates differ by county based on these five carriers' rates. We calculated average geographic rate relativities with the Columbus-area as the basis for the relativity. Based on information received from the carriers, we considered the Columbus-area to be Delaware, Fairfield, Franklin, Knox, Licking, Madison, Morrow, Pickaway, and Union counties. These counties were established as the 1.0 geographic factor, with other counties ranging from 1.00 to 1.20.

Based on demographic information and distribution by deductibles of multiple current high-risk pools, as well as census information by county for Ohio, we estimate that the average monthly PPO premium rate for an Ohio high-risk pool

population would be $458 per member for the first half of 2006. We expect that a semi-annual rate increase in July 2006 would result in an average premium rate of $476 per member per month overall for 2006. Results from the rate analysis can be found in Attachment B.

The projected $458 per month high-risk pool premium in the first half of 2006 represents a considerable savings from the average of $595 per month paid in 2003 by Ohio residents enrolled in the current open enrollment program.

As discussed earlier in this report, some states have premium subsidy programs to assist low-income participants. The subsidy programs take many forms but generally have discounts in the range of 20% to 50%. A discount program could be implemented in Ohio to promote affordability of the program and increase the membership, although a correspondingly higher level of external funding would be required.

ENROLLMENT ESTIMATES

Based on the experience of states with existing high-risk pools and based on Ohio's estimated population of approximately 11.5 million, it is expected that a high-risk pool in Ohio with typical eligibility rules, including coverage for federally eligible individuals, would grow over the first three years to enrollment in the range of 0.075% to 0.125% of population, or 9,000 to 16,000 participants. Assuming the average result of pools that have been formed in the last fifteen years, the likely Ohio participation will grow to about 11,000 individuals over the first three years of operation.

We based our monthly membership growth on the growth of the existing high-risk pools in their initial three years of operation and, for the well established pools, their growth in the most recent three years. From this information we determined that initially, program membership grows at a rate of about 4.7% per month. Once the plan is well established, membership typically grows at a rate of about 0.8% per month. Using these growth rates in our "best estimate" projection scenario and the basis of approximately 11,000 members as of January 1, 2009, we calculated the membership before and after that date.

Realizing that high-risk pools cannot grow at these growth rates indefinitely due to the limited population served, we analyzed the ultimate membership counts in existing high-risk pools based on a state's overall population. There was significant variation among the states, but the variations seemed to follow logical patterns, such as types of populations covered, when the programs were established versus economic fluctuations, and so forth. Based on the overall state population similarities, proximity to one another, and the assumption that Ohio would cover HIPAA-eligible individuals, we believe it would be reasonable to base a projected ultimate membership assumption for Ohio on what has

transpired in the well-established Illinois program, which has approximately 0.15% of the total Illinois population. For Ohio, 0.15% of a population of 11.5 million results in an ultimate high-risk pool population of 17,250.

There are approximately 1.3 million uninsured individuals in Ohio. While the estimated 17,250 persons that could ultimately be served by a high-risk pool seems like a very small percentage, it is important to remember a few facts:

- Approximately 65% of the uninsured in Ohio have incomes below 200% of the Federal Poverty Level (FPL). High-risk pools are generally structured to require participants to pay a premium that is 25% to 50% higher than individual insurance market rates. Therefore, a high-risk program does not meet the needs of low-income individuals for whom the premiums are unaffordable. This effectively reduces the target market for an Ohio high-risk pool to the other 35%, or about 455,000 uninsured individuals. A premium discount program would help to make high-risk pool coverage more affordable and therefore expand the number of low-income people who might take advantage of the program.

- An individual must have a pre-existing health condition in order to qualify for high-risk pool coverage. In Ohio, 21% of surveyed non-elderly uninsured individuals have reported that they are in poor or fair health status. So it is possible to conclude that the target market for a high-risk pool is about 21% of the 455,000 uninsured who fall above 200% of FPL, or 95,000 individuals.

- The projection of the ultimate Ohio high-risk pool population of 17,250 represents about 18% of the market that high-risk pools are intended to serve. This is a typical result, but can be influenced by the premium levels and promotional activities of the high-risk pool.

- There are currently 1,800 individuals who are insured under open enrollment policies and are paying rates that are on average higher than the projected high-risk pool rates. These individuals are likely to be the most financially able among the otherwise uninsurable population. A high-risk pool would be a more affordable replacement for the open enrollment program.

The table below summarizes the enrollment projections for a potential Ohio high-risk pool, assuming HIPAA-eligibles would be included in the pool and premiums would be set at 150% of the standard risk rate.

Enrollment Projections by Scenario Premium = 150% of the Standard Risk Rate			
Date	Less Conservative	Best Estimate	More Conservative
1/1/2006	755	2,150	3,503
1/1/2007	1,700	3,747	5,608
1/1/2008	3,830	6,532	8,979
1/1/2009	8,625	11,385	14,375
1/1/2010	8,941	12,546	17,187
1/1/2011	9,268	13,826	17,250
1/1/2012	9,607	15,236	17,250
1/1/2013	9,959	16,790	17,250
1/1/2014	10,323	17,250	17,250
1/1/2015	10,701	17,250	17,250
12/31/2015	11,060	17,250	17,250

The following table contains the assumptions used in developing the enrollment projections above.

Assumptions for Enrollment Projections by Scenario Premium = 150% of the Standard Risk Rate			
	Less Conservative	Best Estimate	More Conservative
Membership after 3 yrs (% of population)	0.075%	0.099%	0.125%
Monthly growth for initial 3 yrs	7.000%	4.700%	4.000%
Monthly growth thereafter	0.300%	0.800%	1.500%
Ultimate membership (% of population)	0.150%	0.150%	0.150%

Adjustments were made to the membership estimates of the 150% of standard risk rate scenario to reflect the estimated impact of higher or lower rates on enrollment, as shown below:

- 125% of the standard risk rate: 5% greater enrollment
- 175% of the standard risk rate: 5% less enrollment
- 200% of the standard risk rate: 10% less enrollment

FUND PROJECTIONS

We performed ten-year fund projections to model the expected size and future financial position of an Ohio high-risk pool. The fund projections consider the following program components:

- Enrollment
- Premiums
- Claims
- Administrative expenses
- Start-up costs
- Revenue from outside sources
- Interest income on fund balances, if any

Enrollment

Enrollment projections explained previously were used in our fund projections model.

Premiums

The average PPO premium for each person enrolled in the high-risk pool projected for the first half of 2006 is $458 PMPM under the best estimate scenario assuming premiums are equal to 150% of the standard rate. We assume that premiums will grow subsequent to January 2006 at the following semi-annual trend rates. The best estimate premium rate increase results in a second half of 2006 premium rate of $489 PMPM. The premium rate estimated overall for 2006 is $476 PMPM on average under the best estimate scenario. The best estimate trend annualized is 13.9%, the average annual trend for the surveyed carriers in the Ohio individual market.

Semi-Annual Premium Rate Increases by Scenario	
Scenario	Rate Increases
Less Conservative	8.1%
Best Estimate	6.7%
More Conservative	5.3%

Claims

The average incurred claims in 2003 for high-risk pools were $595.34 PMPM, based on pools established prior to 2003. The following table contains the annual claims trend assumed beyond 2003 by scenario. The best estimate equals the average annual trend for high-risk pools between 2001 and 2003. The 2006 claims are projected to be $931.68 PMPM according to the best estimate assumption.

Annual Claims Trend by Scenario	
Scenario	Trend
Less Conservative	13.1%
Best Estimate	16.1%
More Conservative	19.1%

Administrative expenses

Based on the administrative expenses for existing high-risk pools, we project the following administrative expenses per member per month in 2006, based on the number of members. We project that these rates will increase 5% annually after 2006.

Administrative Expenses PMPM in 2006	
Membership as of January 1	PMPM
<1,000	$66.37
1,000 – 10,000	$44.09
>10,000	$34.92

Start-up costs

The fund projections assume that implementation of the program would require a request-for-proposal process, for an estimated cost of $75,000, and half a year's salary for an executive director, for an estimated cost of $40,000. Start-up costs are estimated to total $115,000. Our projections held this amount consistent between the different scenarios.

These components are summarized in Attachment C. Pages of Attachment C progress through premium scenarios of 125%, 150%, 175%, and 200% of the standard risk rate. Each page summarizes the 10-year financial projections under the less conservative, best estimate, and more conservative scenarios.

Revenue from outside sources

To provide for the shortfall in fund balance, revenue in addition to premiums paid by enrolled members would need to be obtained. We have assumed that the additional revenue would be received initially on January 1, 2006 and each January 1 thereafter. Appropriate amount of notice to the payers of the additional revenue would need to be considered in determining the timing and frequency of the funding requests. We have also assumed that the minimum fund balance the program would want to maintain at any time is 10% of the prior year's claims. Our projection model solves for the amount of additional funding needed on January 1 of each year so that the ending fund balance as of December 31 of that year will equal 10% of the year's total claims.

Interest income

The following table contains the annual interest rate assumptions based on scenario.

Annual Interest by Scenario	
Scenario	Interest
Less Conservative	2.0%
Best Estimate	1.5%
More Conservative	1.0%

PROJECTED FUNDING IMPACTS

The revenue needed from outside sources based on the various scenarios is summarized in Attachment D. An estimated $19.9 million would be needed in the first year of the program, and this amount would grow to $144.2 million in the fifth year of the program. Although these amounts are substantial, they should be taken in the context of the mechanisms chosen to fund the high-risk pool's deficits.

As previously described, there are several methods of obtaining outside funding. The funding impact on any one entity is dependent on how the funding is spread between the payers. Attachment D displays the funding need spread among six payer scenarios:

- Scenario 1: Assessment per insured life per year, including stop loss carriers
- Scenario 2: Assessment per insured life per year, excluding stop loss carriers
- Scenario 3: Assessment as a % of premium
- Scenario 4: Assessment per hospital day
- Scenario 5: Assessment per $ of hospital revenue
- Scenario 6: Combined assessment based on Scenario 1 and Scenario 5 in equal shares.

Pages of Attachment D progress through premium scenarios of 125%, 150%, 175%, and 200% of the standard risk rate. Each page summarizes the funding need based on the less conservative, best estimate, and more conservative scenarios.

The estimated funding needed in 2006 is $19,909,830 based on best estimate assumptions and premium rates equal to 150% of the standard risk rate. The following table contains the funding impact in 2006 according to these six payer scenarios.

Funding Impact in 2006 Based on Best Estimate Assumptions and PPO Premium = 150% of SRR	
Funding Scenario	Funding Impact
1	$2.70 per year
2	$4.11 per year
3	0.12% of premium
4	$2.41 per hospital day
5	0.03% of hospital revenue
6	$1.35 per insured and 0.015% of hospital revenue

Based on the growth in high-risk pool participants and the growth in claims and costs, the high-risk pool's funding needs will grow predictably in future years. The next chart shows best estimated funding needs during the high-risk pool's first ten years of operation, and the corresponding impact of funding the high-risk pool through an assessment on insurers, or through an assessment on insurers and an assessment on hospitals.

Funding Need Based on Best Estimate Assumptions and PPO Premium = 150% of SRR		Funding Scenario 1 Assessment Per Insured Life	Funding Scenario 6 Assessment Shared Evenly by Scenarios 1 and 5	
Year	Total Funding Need	Per Year	Per Insured Life Per Year	% of Hospital Revenue
2006	$19,909,830	$2.70	$1.35	0.015%
2007	$37,234,752	$5.04	$2.52	0.024%
2008	$76,040,128	$10.27	$5.13	0.044%
2009	$114,358,006	$15.40	$7.70	0.058%
2010	$144,213,275	$19.38	$9.69	0.064%
2011	$186,721,729	$25.03	$12.51	0.072%
2012	$241,752,006	$32.32	$16.16	0.082%
2013	$302,361,870	$40.33	$20.16	0.089%
2014	$352,932,284	$46.95	$23.48	0.091%
2015	$414,417,020	$55.00	$27.50	0.094%

We have used premium equal to 150% of the standard risk rate in these examples; Attachment D includes other scenarios as well. The figures in the two tables above also assume:

- Annual growth rate of Ohio's insured population = 0.25%
- Annual increase in premiums in Ohio per insured person = 13.9%
- Annual increase in bed days in Ohio per insured person = 3.0%
- Annual increase in hospital revenue in Ohio per insured person = 13.9%

POPULATION AND MARKET IMPACTS

Implementing a high-risk pool in Ohio is expected to have the following population and market impacts:

- It is expected that as many as 17,250 Ohio residents could eventually be enrolled in a high-risk pool.
- Approximately 1,800 individuals who are currently enrolled in open enrollment and HIPAA plans would likely move to the high-risk pool, since the rates would be lower and the benefits could be better.
- The movement of the 1,800 open enrollment and HIPAA-eligibles would have little or no rate impact on the rest of the individual insurance market, since they represent less than 1% of the total individual lives insured.
- Because high-risk pool rates would be set at somewhere between 125% and 200% of standard risk rates, it is unlikely there would be any movement from existing individual coverage to the high-risk pool except for open enrollment coverage.
- Because an individual would not be eligible for the high-risk pool if they were eligible for employer-provided coverage, there would be no movement from the group insurance market to the high-risk pool. Current Ohio law prohibits employers from discriminating based on health status, so employer groups would not be allowed to move their "unhealthy" employees to the high-risk pool.
- Because an individual would not be eligible for the high-risk pool if they were eligible for Medicare or Medicaid, there would be no movement from those programs to the high-risk pool.
- A high-risk pool could potentially reduce the number of uninsured persons in Ohio by over 15,000. Other than the 1,800 currently enrolled open enrollment and HIPAA-eligible individuals, a high-risk pool would attract currently uninsured persons who have pre-existing health conditions, do not have access to employer-provided coverage, and are able to afford the higher than average premiums. The most likely candidates are retirees between the ages of 50 and 65 and self-employed individuals.

- A reduction in the number of uninsured individuals would be beneficial to the provider community since there would be less uncompensated care. It would potentially improve the health status of the 15,000 high-risk pool members who were previously uninsured because they would have access to affordable comprehensive care and preventive benefits.
- Participants in existing state and federal programs such as BCMH (Bureau for Children with Medical Handicaps) and ADAP (AIDS Drug Assistance Program) which provide limited health care services to persons with special needs might be eligible to receive comprehensive coverage from the high-risk pool. The same eligibility rules and premium rates would apply to these individuals as to other Ohio residents.

OTHER ITEMS FOR CONSIDERATION

High-risk pools are not the only approach used by states to address the issue of uninsurable individuals.

All carriers must guarantee issue all individual products in Maine, Massachusetts, New Jersey, New York, and Vermont. Blue Cross/Blue Shield plans must guarantee issue individual coverage all year long in the District of Columbia and the states of Michigan, North Carolina, Pennsylvania, Rhode Island, and Virginia.

Some states use a combination of high-risk pools and guarantee issue. For example:

- California requires carriers to guarantee issue two standardized plans to individuals who exhaust their high-risk pool benefits. Their high-risk pool lifetime maximum benefit is $750,000.
- Iowa requires carriers to guarantee issue a standard plan to any resident that has twelve months of consecutive coverage and has exhausted COBRA. Those without twelve months of coverage go to the state high-risk pool until they've completed twelve months.
- The high-risk pool is used only for federally eligible participants in the state of Alabama.
- In Washington, all carriers must guarantee issue all products to medically qualified individuals who score up to a certain level on a standardized health questionnaire. The questionnaire is designed to identify the eight percent of persons most expensive to treat, who are then eligible for the high-risk pool.

Idaho uses a high-risk reinsurance pool concept. Participating carriers underwrite and issue the individual high-risk pool policies and maintain the traditional insurer/enrollee relationship. The high-risk pool policies are ceded to the reinsurance pool, which serves as a risk spreading mechanism.

NAIC MODEL LAW AND HIPAA OVERVIEW

The National Association of Insurance Commissioners (NAIC) has developed and modified over time a model law for the establishment of high-risk pools. The purpose of model laws is to provide a uniform basis from which all states can deal with regulatory issues. However, the legislation that is ultimately enacted can be customized to fit the needs of individual states. The paragraphs below discuss the components of the NAIC "Model Health Plan For Uninsurable Individuals Act," as well as the actual practice of existing high-risk pools across the country on key operational and financial fundamentals.

The formation and operation of high-risk pools is also influenced by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law allows the states to use a qualified high-risk pool as an acceptable alternative mechanism for the guaranteed availability of individual coverage for federally eligible individuals. A qualified high-risk pool is defined as one that provides to all eligible individuals health insurance coverage that does not impose any pre-existing condition exclusion and provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Act.

PLAN OPERATION

The NAIC Model Act calls for a high-risk pool to be subject to the supervision and control of a board of directors. The board should consist of:

- The Director of Insurance or a designated representative who serves as an ex-officio member and will be the chairperson.
- An even number of members appointed by the Governor.
- At least two of the board members should be individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan.
- At least two board members should be representatives of insurers.
- A majority of the board should be composed of individuals who are not representatives of insurers or health care providers.

Board members should serve a three-year term after an initial phase-in period. Vacancies in the board should be filled by the Governor and could be removed from the board by the Governor for cause. Board members should not be compensated, but should be reimbursed for reasonable expenses incurred in the necessary performance of their duties. The board should make an annual report to the Governor that summarizes the activities of the plan, including key financial measures such as enrollment, premiums, administrative expenses and paid and incurred claims.

In actual practice, the number of board members for existing high-risk pools ranges from 3 to 17, including both voting and non-voting members, with an average of 9.5 members. The most common number of board members is 9 and 7, as 7 pools operate with 9 members and 7 pools operate with 7 members. In addition to 7 board members, the South Dakota high-risk pool also has a 15-member advisory board appointed by the governor.

There are a wide variety of board selection methods, but most of the boards are either totally or partially appointed by the state insurance commissioner, the governor or another public official. The California high-risk pool board, with 5 members, includes 3 appointed by the governor and 2 appointed by the legislature. In contrast to this, two states, Connecticut and Kansas have boards whose members are all elected by the high-risk pool membership.

Most state pools strive for board representation from the various stakeholders, including insurance carriers, insurance brokers, the insurance commissioner, health care providers, business owners, state legislators, high-ranking governmental officials and pool members. The Utah high-risk pool board includes representatives from 8 of these participating categories. A few of the boards are more heavily skewed towards one of the constituencies than the others. For example, 6 of the 7 Missouri high-risk pool board members are from the local insurance industry and in South Dakota, 5 of the 7 board members represent specific government agencies.

ELIGIBILITY

The NAIC Model Act defines the following individuals as being eligible for a high-risk pool:

- An individual person who is and continues to be a resident would be eligible if evidence is provided:

  (a) Of a notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

  (b) Of a refusal by an insurer to issue insurance except at a rate exceeding the plan rate.

- A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident would be eligible. Resident is defined in the NAIC Model Act as an individual who has been legally domiciled in the state for a period of at least 30 days, except that for a federally defined eligible individual, there is no 30-day requirement.
- Persons who can demonstrate the existence of any medical or health condition on a list of conditions promulgated by the board is eligible. The conditions on the list are known as presumptive conditions, and it is assumed

that the existence of such a condition would result in a rejection by health insurers. In this situation, the applicant is spared the time delay resulting from going through the process of getting an insurer rejection.

- Dependents of a person eligible for plan coverage would also be eligible.

The NAIC Model Act defines the following individuals as not being eligible for a high-risk pool:

- A person who has other coverage substantially similar to the high-risk pool coverage.
- A person eligible for Medicaid benefits.
- A person who terminated plan coverage less than 12 months ago, except if the person is a federally defined eligible individual.
- A person for whom a stated dollar amount of benefits has been paid by the plan.
- An inmate or resident of a public institution, except for a federally defined eligible individual.
- A person whose premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider. This restriction is important in order to prevent other government health programs from reducing their expenses by paying a high-risk pool premium that is less than current costs.

Most of the high-risk pools have patterned their eligibility requirements after the NAIC Model Act criteria. All of the high-risk pools require enrollees to be residents of their respective states and 13 of the 32 states impose residency requirements of one month to twelve months. Connecticut is unique in listing residency and age (between 19 and 65) as the only eligibility requirements for their high-risk pool.

Most of the states allow several ways for residents to qualify for high-risk pool eligibility. The most common criteria include: (1) rejection for health insurance by one (or sometimes two) insurer; (2) restrictive rider or pre-existing condition limitation; or (3) coverage at a rate exceeding the pool premium. Approximately 70% of the pools offer all three of these means for defining eligibility.

About half of the high-risk pools also offer a list of presumptive conditions that provide immediate eligibility for the pool. The lists range from one diagnosis (HIV) in Wisconsin to more than sixty conditions in states such as Alaska and Texas.

All but seven of the pools include federal eligibility under HIPAA as a means for pool eligibility, and for residents of Alabama, it is the only requirement.

A state's eligibility rules, premium levels, and length of time in operation will generally determine the number of individuals enrolled in its high-risk pool. The participation in existing high-risk pools averages 0.134% of the state's population. However, the participation ranges from 0.003% to .666% of the state's population. In absolute terms, the range is from 130 participants in Iowa to 33,700 in Minnesota.

At the low end of the range are Florida, whose pool has been closed to new members since 1991, and Iowa whose high-risk pool is made up of individuals satisfying a twelve-month continuation requirement for guarantee issue coverage, along with other states that do not use the high-risk pool for federally eligible individuals. At the high end of the range are Wisconsin, Nebraska, Montana, and Minnesota, which have all been in operation for over fifteen years. The majority of the states have participation ranging from 0.040% to 0.15% of the state's population. Those that cover federally eligible individuals and have been formed in the last 15 years have average participation of 0.099% of the state's population.

PLAN ADMINISTRATION

The NAIC Model Act sets out some guidelines for high-risk pools to follow in selecting a plan administrator and assigning duties. Specifically, the board should select an experienced, efficient, competitively priced and financially strong plan administrator through a competitive bidding process.

The duties of the plan administrator typically include the following:

- Determination of eligibility
- Payment of claims
- Premium billing
- Other duties as determined by the board

In addition to the plan administrator's functions, the cost for administering a high-risk pool might include some or all of the followings:

- Agent referral fees
- Actuarial services
- Accounting and auditor fees
- Assessment operations
- Bank charges
- Board of directors expenses
- Case management
- Disease management
- Executive director salary and expenses
- Legal expenses

- Marketing
- Office rent, equipment, and supplies
- Postage
- Printing
- Staff salary and expenses

Most of the high-risk pools utilize just one plan administrator, however New Hampshire and Alabama employ two and the California pool contracts with five different administrators. The types of organizations that provide plan administration services for high-risk pools include health plans, Blue Cross Blue Shield plans and third party administrators (TPAs). Of the 37 different administrators used by the pools, nearly 50% are local Blue Cross Blue Shield plans. Other local health plans represent 19% of the administrators and TPAs provide the rest of the administrative services. One TPA, Benefit Management, Inc. from Great Bend, Kansas, is the plan administrator for 4 different high-risk pools.

The average cost of administering a high-risk pool in 2003 was $411 per year per participant. This amount varied by the number of participants, with the smallest pools having the highest administration costs per participant and the largest having the lowest, as shown in the table below.

2003 Annual Administrative Expenses	
Number of Participants	Per Participant
Under 1,000	$688
1,000 to 9,999	$457
Over 10,000	$362
Total	$411

High-risk pools are not able to purchase reinsurance for large claims, since reinsurance carriers are not willing to take on such risk.

FUNDING OF THE PLAN

The funding for high-risk pools comes from a combination of premiums and additional revenue sources.

Premiums

The NAIC Model Act suggests premiums be structured and set in the following manner:

- Premium schedules should be based on age, sex and geographical location.
- The plan should determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to

individuals. A formula such as the average of the rates of the five largest carriers in the state with similar coverage is typically used.

- The standard risk rate should be established using reasonable actuarial techniques, and should reflect anticipated experience and expenses for the coverage.
- Initial rates for plan coverage should not be less than 125% to 150% of rates established as applicable for individual standard risks.
- In subsequent periods, rates should be established to provide fully for the expected cost of claims, expenses and other cost factors.
- However, in no event should plan rates exceed 200% of rates applicable to individual standard risks.

In actual practice, the rate structures used by the existing high-risk pools are quite varied. Only 21% of the high-risk pools follow the NAIC Model Act recommendation of basing premium schedules on age, sex and geographical location. Although all of the pools use age as a determinant, 6 pools use attained age and the rest use age bands. Gender is a criterion for 62% of the pools and only 24% of the states use area factors. Other criteria include tobacco use (28% of the pools) and HIPAA status (10% of the pools). Seven of the high-risk pools also offer benefit riders for an additional cost to cover services for pre-existing conditions, maternity, prescription drugs or chiropractic care.

High-risk pool rate caps generally range from 125% to 200% of a formula-based index of prevailing individual plan rates. Four pools follow the NAIC Model Act by imposing a cap of not less than 125% for initial rates and a maximum in subsequent periods of 150% or 200%, and three pools provide an over-all rate cap range of 125% to 150%. Of the 19 pools that have only a single rate cap, the most frequently utilized cap is 150% (seven pools), followed by 200% (six pools). Four high-risk pools have premium caps no more than 125% above comparable private coverage.

The Florida high-risk pool (which is closed to new entrants) caps their rates at 200% for low-risk individuals, 225% for medium-risk individuals and 250% for high-risk individuals. In addition, several pools provide different rate caps for different eligibility classes (medically-eligible or HIPAA-eligible) or for different types of plans. Two high-risk pools do not state a rate cap, but say their rates must be “reasonable,” based upon the benefits provided, risk experience and expenses of the plan.

A number of states also have a premium discount program available for lower income participants, because even with premium caps, the high-risk pools will be more expensive than comparable commercial coverage. Colorado, Connecticut, Montana, New Mexico, Oregon, Utah, Washington and Wisconsin offer rate

subsidies or lower out-of-pocket benefit costs to help eligible, low-income people afford the high-risk pool plans. The states use a variety of approaches to the rate subsidies, with some using just one discount amount and others using a sliding scale that varies by income level. The subsidies generally range from 20% to 50%, although a few fall outside this range.

In 2003, existing high-risk pool premiums averaged approximately $4,400 per year, or $366 per month per covered individual. The variation from state to state ranged from $2,000 per year in New Hampshire to $9,140 in Iowa. The majority of states have premiums that fall in the range of $3,000 to $6,000 per year. The premium levels are heavily influenced by the percentage of standard risk rates used by the state, as well as the type of coverage offered and the demographics of the population enrolled.

While on average the premium collected provides about 60% of the funding for high-risk pools, the states range from 25% of the funding from premium in New Hampshire to 78% in Alabama.

Additional Revenue

The NAIC Model Act suggests four alternatives for additional funding for high-risk pools.

(1) Assessment of health insurers based on their health insurance premiums written in the state

(2) Assessment of health insurers and reinsurers based on the number of persons they cover through primary, excess and stop loss insurance in the state

(3) A service charge on hospitals and surgical centers

(4) Appropriation of general revenue

In actual practice, states use different combinations of these funding sources from one year to the next, but are also creative in establishing different approaches. The high-risk pool founders realize that premiums collected from participants cover only about 60% of plan costs. How states manage to raise the rest of the required funding is an ongoing struggle for each high-risk pool and an ongoing debate within each state legislature.

Currently, 28 of the high-risk pools assess health insurers and HMOs for at least a portion of their funding. These assessments are generally based upon revenue and may involve a full or partial tax credit or no tax credit. The assessment may be only on health and disability insurers or may extend to stop loss carriers, re-insurers and third party claims administrators on a “per covered life” basis. An

assessment mechanism based on premium volume is currently used in Ohio in the Open Enrollment Reinsurance Program.

Another common approach is state fund allocations, including general revenue, state income taxes, premium taxes, state tobacco tax, tobacco settlement funds or other special state funds. At least ten of the high-risk pools receive a portion of their funding in this way.

Maryland's high-risk pool is currently funded by an assessment on hospitals. Kentucky assesses hospital admissions, as well as outpatient surgeries. West Virginia's pool, which will be operational in mid-2005, will also be funded by a hospital assessment. In addition, some of the pools also receive specially reduced billing rates from local providers.

The following table shows the prevalence of various funding mechanisms in states with high-risk pools. Some states show up more than once due to multiple approaches being used.

Funding Mechanism	*Number of States*	*States*
Assessment to insurance companies with full or partial tax credit	12	AL, AR, IN, IA, KS, MO, MT, NM, ND, SC, WI, WY
Assessment to insurance companies with no tax offset	10	AK, CT, FL, ID, IL, LA, MN, OK, TX, WA
Assessment to insurance carriers including stop loss and reinsurance carriers on a per covered lives basis	7	CO, IN, MS, NH, OR, SD, WA
Allocation from state funds, such as premium taxes, tobacco taxes, tobacco settlement funds, or general revenue	9	CA, CO, ID, IL, LA, KY, NE, SD, UT
Hospital surcharge or assessment	3	LA, MD, WV
Reduction of payments to health care providers	2	SD, WI
Excess loss ratio remittances	1	WA

Other unique funding sources over the years have included payments from an unclaimed property fund, deficit funding from the Department of Insurance, loans from the state board of investments, surplus Workers' Compensation Risk Pool funds and increases in licensing fees to pharmaceutical manufacturers/wholesalers/distributors.

The actual need for additional revenue by a high-risk pool is dependent on its level of enrollment, eligibility requirements, premium levels, plan designs, provider reimbursement levels, cost containment efforts, and program management. In calendar year 2003, the additional revenue required for the 181,000 participants in state high-risk pools totaled approximately $540 million, an average of about $3,000 per participant. The amount of additional funding needed in 2003 by the states ranged from nothing in South Dakota (a new plan in 2003) to over $90 million in Minnesota, which has over 33,000 participants and has been in operation since 1976.

BENEFITS

The NAIC Model Act includes two alternative approaches for defining high-risk pool benefits.

(1) The coverage must be consistent with comprehensive coverage for every eligible person who is not eligible for Medicare. This approach allows the state some flexibility in defining and periodically changing the benefits and exclusions.

(2) The coverage must be based on a list of benefits and exclusions listed in statute. This approach allows for some consistency in benefits between the high-risk pools in different states, but might be difficult to change over time as medical practice and prevailing benefit designs evolve.

Other benefit provisions of the NAIC Model Act require the following:

- In establishing the plan coverage, the board must take into consideration the levels of health insurance coverage provided in the state, as well as appropriate medical economic factors, and promulgate benefit levels that are generally reflective of health insurance coverage provided through a representative number of large employers in the state.
- Deductibles and coinsurance factors can be adjusted annually according to the Medical Component of the Consumer Price Index.
- The plan may use a pre-existing condition wait of six months for participants other than federally defined eligible individuals. The pre-ex period must be waived if satisfied under prior health coverage that was involuntarily terminated and application is made within 63 days.
- The plan must be the payer of last resort whenever any other benefit or source of payment is available. Benefits otherwise payable under plan coverage must be reduced by all amounts payable under any other health insurance coverage, including those payable by any state or federal program.

In addition, HIPAA requires that federally eligible individuals be given a choice of coverage including at least one plan that is comparable to comprehensive health insurance coverage offered in the individual market or that is comparable to a standard option of coverage available under the group or individual health insurance laws of the state.

The existing high-risk pools offer a variety of benefit plans, but there are some common themes. Plans tend to be PPO or indemnity in structure due to the need to provide coverage availability in all parts of a state, both urban and rural where HMO plans may not be available. Generally, the deductibles tend to be fairly high. Fifteen of the plans have a $500 deductible as their most generous plan, and nine start at a $1,000 deductible. The pools generally offer three to five different plan designs. Some of the states have started offering High Deductible Health Plans that are qualified for offering with a Health Savings Account. Twelve states also offer Medicare Supplement plans.

The high-risk pools provide a wide range of maximum dollar amounts for their benefit plans. Most of the pools have no annual maximum, but of the three that do (California, Louisiana and Utah), it ranges from $75,000 per year to $250,000 per year. In addition, Mississippi has an annual maximum of $100,000 for prescription drug benefits. Indiana has an unlimited lifetime benefit, Kentucky and Minnesota have no lifetime benefit maximum for one of their plan offerings and New Mexico has no maximum benefits, except for an annual maximum for preventive services and annual and lifetime maximums for transplant services. All other high-risk pools have lifetime benefit maximums that range from $350,000, for one of Wyoming's plans, to $2.8 million for another of Minnesota's plans. The most common lifetime maximum is $1 million, the limit for 19 of the 32 high-risk pools.

CLAIM COSTS AND LOSS RATIOS

Since the purpose of a high-risk pool is to provide coverage for persons who are high-risk, it is not an unexpected result that the participants' claims are much larger than those of a normal population. In fact, the average claim cost per high-risk participant nationwide in 2003 was about $7,144 per year or $595 per month. The claim costs for high-risk pools tend to fluctuate considerably from one year to the next, especially in the smaller pools, because of the catastrophic nature of certain very large claims experienced by this population.

High-risk pools also may exhibit higher than standard industry trends, especially during times when inpatient hospital costs are rapidly rising, as in the past few years. Inpatient hospital claims represent a greater portion of total claims for this population than for a typical population. While a health insurance carrier covering groups and individuals in the normal population might aim for a loss

ratio in the 75% to 85% range, high-risk pool loss ratios tend to vary based on the multiple of standard risk rate used in developing the pools rates and are generally over 120% ranging to as high as 300%.

SOLVENCY HISTORY

Because the funding approach used by most of the high-risk pools is an assessment mechanism, the pools are able to avoid insolvency. The plans project funding needs for a period and assess the entities that are mandated by law to provide the funding. The following list describes actions taken by a few of the high-risk pools:

- Florida: The only high-risk pool that has been closed is Florida. The Florida pool was closed for new enrollment in 1991 but is still operating to provide coverage for the 500 individuals who remain on the plan.

- Illinois: Since the inception of the Illinois high-risk pool in 1989, the pool was funded by state general revenue funds. In order to control the amount of state dollars needed, the number of eligible participants was capped. The cap has been increased a number of times, with the most recent increase to 5,950 participants. There was no need for a waiting list between January 1995 and September 2000, nor from April 2001 through April 2002. When the Illinois program became the alternative mechanism for HIPAA participants, that portion of the program was funded separately by assessments on health insurers with no cap on members.

- Indiana: This plan experienced significant losses in 2000 and 2001 after the state Department of Health moved more than 1,000 AIDS patients, hemophiliacs and others into the plan. The deficit caused by these very high cost patients raised the required carrier assessments to levels that exceeded the industry's premium tax credits. This resulted in considerable controversy with regard to the state's method of assessment on health insurers and reinsurers, particularly with regard to assessment on a per insured life basis versus amount of insurance premium charged. As of January 2005, the methodology for assessment was changed to return to a premium basis. The State will be directly responsible for funding 75% of net losses, while the other 25% will be assessed insurance carriers based on premiums charged.

- Maine: The high-risk pool ceased operation in 1995; the state moved to guarantee issue of individuals.

Historical assessments by the high-risk pools have fluctuated from year to year. Many factors affect the need for assessments, most importantly the number of individuals enrolled in the pool. In most states there have been changes in

funding mechanisms, insurance laws, and eligibility rules in recent years, which have all affected the need for funds. But no high-risk pool has become insolvent or had to terminate current members in order to avoid insolvency.

CONTROLLING COSTS IN HIGH-RISK POOLS

The existing high-risk pools use a variety of methods to control costs, including the following:

- Setting the premium rates at the highest level allowed by law. This has the dual effect of raising more premium revenue as well as exerting downward pressure on enrollment because of affordability. States generally have statutory rate caps set at 150% or 200% of standard risk rates. The NAIC Model Act prohibits rates above 200% of standard risk rate, making that level the maximum allowable for federally eligible enrollees.

- Limiting enrollment of non-federally eligible individuals. A few of the high-risk pools have a limit on the number of individuals they will cover. In this approach, as members drop out, new members are added, but only up to a predetermined number. High-risk pools are not allowed to limit the number of federally eligible members they will take, but the approach can be used for other applicants. As well as limiting overall costs of the pool, setting a maximum number of individuals to be covered by the pool at any given time allows the state to more easily predict funding needs. With this approach, the program could be required to operate within an annual budget. In the event of cost overruns, enrollment in the pool could be reduced.

- Limiting enrollment to only federally eligible individuals. In this approach, only federally eligible individuals are eligible for pool coverage. This approach is estimated to reduce the number of participants by 30% to 50%.

- Closing for new enrollment. As stated above, only the Florida high-risk pool is closed for new enrollment. This action was taken in 1991 when there were approximately 7,500 individuals in the plan. Current members were allowed to continue coverage and membership gradually dropped off to its current level of about 500.

- Limiting the amount of time an individual can be in the pool. In California, high-risk pool members are disenrolled after 36 continuous months of enrollment. They are then eligible for guarantee issue coverage that health plans in the individual insurance market are required to offer.

- Negotiating provider reimbursement rates or using a provider network. Where possible, states have negotiated favorable provider reimbursement

rates for the high-risk pool or are using existing provider networks with favorable fee schedules. Especially important for this population are hospital reimbursement arrangements using case rates or per diems as opposed to discounts off billed charges. Case rates for transplant patients are another important component in controlling costs.

- Increasing benefit cost sharing. Most of the high-risk pools are using PPO plans with fairly high deductibles. Generally, the lowest deductible available is $500, but a growing number have $1,000 deductibles as the most generous plan. The movement to higher deductibles has occurred over time and is expected to continue with high-risk pool coverage as well as the individual market in general.

- Limiting the amount of annual claim payment. In California, high-risk pool members are limited to $75,000 in benefits per year.

IMPACT OF HIGH-RISK POOLS ON UNINSURED RATES

It is difficult to identify a correlation between a state's high-risk pool membership and that state's uninsured rate. This is because the number of high-risk pool members is small in comparison to the number of uninsured. Notably, high-risk pool coverage is available only to a small subset of the uninsured population because it is targeted at uninsured people who have serious health conditions and ailments. In terms of reaching this subset of the uninsured, a high-risk pool is often the only available option.

A high-risk pool also has economic benefits for the health care system by bringing high-risk people into the ranks of the insured so their care can be managed, and medical providers are directly paid for their services. Properly managed care often reduces overall health care expenses, and direct payment of medical providers reduces the cost shifting that can occur with regard to uncompensated care.

If the State of Ohio were to move forward with the implementation of a high-risk pool, there are many decisions to be made concerning program operations and funding. The following is an outline of important issues to consider.

1. Plan Operation
    a. Board of Directors
        - Size: High-risk pools in other states range from 3 to 17.
        - Composition: Pools may consist of insurance carriers, insurance brokers, insurance commissioner, health care providers, business owners, state legislators, government officials, and pool members.
        - Selection methods: Appointment by government officials, election by members, etc.
        - Term of service
        - Voting rights: "All" versus "some" of the Board members having voting rights.
    b. Type of entity
        - Government, quasi-government entity, etc.
        - Operated out of a government department such as the Department of Insurance or outside of government with a salaried Executive Director
    c. Oversight
        - Department of Insurance
        - State auditor
        - Other state agency
        - External auditors
2. Eligibility
    a. Enrollment requirements regarding:
        - HIPAA eligibility
        - A health condition on a presumptive conditions list
        - Rejection from insurance carrier
        - Restrictive rider or pre-existing conditions limitation
        - Only coverage available is at a rate greater than the pool's premium
        - Medicare eligibility (Medicare supplement plans may be offered)
        - Alternative populations (e.g., ADAP participants)
    b. Reasons for being ineligible
3. Plan Administration
    a. Selection of an administrator

- RFP process

b. Type of administrator
   - Health plans
   - Blue Cross Blue Shield plans or
   - Third Party Administrators (TPAs)

c. Selection of a disease management and/or case management company

d. Availability and size of an agent referral fee

4. Funding of the Plan

   a. Premiums
      - Rating options
        1. By gender
        2. By smoking status
        3. By age bands (5 or 10 years)
        4. By geographic area
      - Initial % of standard risk rate (between 125% and 150%)
      - Maximum eventual % of standard risk rate (cannot be greater than 200%)
      - Implementation of a premium discount for low-income members
      - Composition of standard risk rate definition (3 to 5 carriers)
      - Frequency of changing premium rates
      - Would HIPAA-enrollees have a different % of standard risk rate than the rest of the pool?

   b. Other funding

      - State appropriation
        1. Unclaimed property funds
        2. Tobacco funds
      - General funds from state
      - Carrier assessments
        1. Based on number of lives covered
        2. Based on premiums earned
        3. To include or exclude stop loss carriers/reinsurance companies
        4. Offset by tax credits – premium tax or income tax
        5. Individual carriers with low rejection rates get discount on assessment
        6. Individual carriers with loss ratios below a set percentage are assessed the difference so that their net loss ratio equals the set percentage
      - Hospital-based
        1. $ fee per bed day

2. % fee of hospital bill
3. Government-payers (e.g., Medicaid and Medicare) excluded?
4. Does the patient or hospital pay this fee?

- Combination approach
- Timing of notice of funds needed
- Timing of collection of funds
- Entire pool to be funded by same source or different sources for HIPAA pool versus traditional pool
- Would the program cap membership to control the funding need?

5. Plan Designs Offered
    a. PPO, indemnity, and/or HMO
    b. Would different plan design options be available for the HIPAA pool versus the traditional pool?
    c. Would different plan design options (such as lower deductibles) be available for low-income participants?
    d. Range of deductibles offered, if applicable
    e. Coverage of services and exclusions
    f. Pre-existing conditions look back and waiting period (none for HIPAA-eligibles)
    g. Maximum benefits per year and/or per lifetime

Some additional considerations in starting up an Ohio high-risk pool are these:

- It will be necessary to do a preliminary assessment prior to the implementation of the high-risk pool in order to have funds available to cover the losses of the pool in its first year. The amount needed will depend on the statutory premium level and the timing of the assessment, but the best estimate scenario based on assumptions described in this report calls for a first year assessment of about $20 million.

- We encourage a thoughtful analysis of the timing and frequency of assessment notices and payments. The current practice of other states ranges from 30-day notice to 12-month notice. When notice has to be given far in advance, it is less likely that the assessment amounts will accurately reflect the plan's funding needs, so we encourage having the shortest notice period that is acceptable to the entities being assessed. Similarly, once notice has been given, payment should be due as soon as possible. Assessments more frequently than once a year will also result in more accurate and smaller assessments.

- A transition plan will need to be developed for the 1,800 individuals currently in open enrollment coverage. One approach would be to allow those individuals to stay in their current coverage if they so choose, although it is expected that most of them would want to move to the high-risk pool coverage assuming the rates are lower and the coverage is comparable. Concurrent with the implementation of the high-risk pool, the open enrollment process would be discontinued for new enrollees.

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ATTACHMENT A: RECOMMENDED PLAN DESIGNS

ATTACHMENT B: PROPOSED RATES

ATTACHMENT C: ENROLLMENT AND COST PROJECTIONS

ATTACHMENT D: FUNDING SCENARIO PROJECTIONS

Ohio High-Risk Pool

Recommended Plan Designs
Effective January 1, 2006

	Plan A	Plan B	Plan C	Plan D	Plan E
Deductible In-Network	$500	$1,000	$1,500	$2,500	$5,000
Deductible Out-of-Network	$1,000	$2,000	$3,000	$5,000	$10,000
Coinsurance In-Network	80%	80%	80%	80%	80%
Coinsurance Out -of-Network	60%	60%	60%	60%	60%
Out of Pocket Maximum In-Network (Includes Deductible)	$2,500	$3,000	$3,500	$4,500	$7,000
Out of Pocket Maximum Out-of-Network (Includes Deductible)	$5,000	$6,000	$7,000	$9,000	$14,000
Office Visits	Deductible and coinsurance				
Preventive	Deductible and coinsurance				
Well Child	Deductible and coinsurance				
Urgent Care	Deductible and coinsurance				
Emergency Room	$100 copay, then in-network deductible and coinsurance				
Inpatient	Deductible and coinsurance				
Outpatient	Deductible and coinsurance				
Prescription Drugs	$200 Rx deductible, then $15 copay generic, $30 copay preferred drugs, $45 copay non-preferred drugs				
Ambulance	Deductible and coinsurance				
Mental Health/Chemical Dependency	Inpatient: Deductible and coinsurance, 30 days maximum per year Outpatient: Deductible and 50% coinsurance, 20 visits maximum				
Durable Medical Equipment	Deductible and coinsurance				
Home Health	Deductible and coinsurance, up to 100 visits per year				
Hospice	Deductible and coinsurance				
Maternity/ Newborn	Deductible and coinsurance				
Chiropractic	Deductible and coinsurance, up to 12 visits per year				
Physical Therapy/ Occupational Therapy	Deductible and coinsurance with combined all therapies 40 visit maximum per year				
Speech Therapy	Deductible and coinsurance with combined all therapies 40 visit maximum per year				
Skilled Nursing Facility	Deductible and coinsurance, 60-daymaximum per year				
TMJ	Not covered				
Transplants	network				
Pre-existing Conditions	6-month lookback/6-month waiting period, none for HIPAA				
Lifetime Maximum	$1 million				

Ohio High-Risk Pool

Proposed Rates
Effective January 1, 2006

Base Rates

Age	$500 Deductible*		$1,000 Deductible*		$1,500 Deductible*		$2,500 Deductible*		$5,000 Deductible*	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0 - 19	$177.99	$177.99	$143.72	$143.72	$126.83	$126.83	$101.04	$101.04	$81.56	$81.56
20 - 24	$169.37	$338.58	$136.30	$284.18	$120.82	$251.88	$95.37	$196.07	$75.79	$115.22
25 - 29	$183.73	$400.76	$149.21	$339.28	$133.12	$301.99	$105.54	$236.90	$84.62	$141.45
30 - 34	$206.90	$400.50	$170.10	$337.31	$151.66	$301.39	$120.86	$239.15	$97.84	$162.04
35 - 39	$247.41	$407.65	$206.33	$342.75	$184.42	$307.11	$148.70	$246.87	$120.94	$188.20
40 - 44	$304.95	$443.49	$255.43	$374.37	$229.39	$336.56	$186.44	$273.85	$151.98	$222.67
45 - 49	$393.57	$495.41	$332.05	$422.43	$298.24	$380.78	$242.16	$311.88	$198.81	$259.48
50 - 54	$523.31	$571.66	$443.66	$493.40	$397.94	$444.95	$321.61	$365.99	$264.15	$304.85
55 - 59	$685.26	$668.25	$581.07	$580.22	$519.07	$525.36	$417.35	$433.80	$342.83	$362.54
60 - 64	$844.09	$765.91	$716.68	$668.70	$638.98	$605.86	$513.46	$499.70	$423.46	$419.24

* Deductibles displayed are applicable for in-network services. A separate deductible equal to two times the in-network deductible applies for out-of-network services.

County Factors

County	Area Factor	County	Area Factor	County	Area Factor	County	Area Factor	County	Area Factor
Adams	1.10	Darke	1.00	Hocking	1.00	Miami	1.05	Scioto	1.10
Allen	1.15	Defiance	1.10	Holmes	1.05	Monroe	1.05	Seneca	1.05
Ashland	1.00	Delaware	1.00	Huron	1.05	Montgomery	1.10	Shelby	1.05
Ashtabula	1.15	Erie	1.10	Jackson	1.10	Morgan	1.00	Stark	1.00
Athens	1.00	Fairfield	1.00	Jefferson	1.10	Morrow	1.00	Summit	1.10
Auglaize	1.10	Fayette	1.00	Knox	1.00	Muskingum	1.05	Trumbull	1.05
Belmont	1.10	Franklin	1.00	Lake	1.15	Noble	1.00	Tuscarawas	1.05
Brown	1.05	Fulton	1.10	Lawrence	1.10	Ottawa	1.10	Union	1.00
Butler	1.05	Gallia	1.10	Licking	1.00	Paulding	1.10	Van Wert	1.10
Carroll	1.05	Geauga	1.15	Logan	1.05	Perry	1.05	Vinton	1.10
Champaign	1.00	Greene	1.05	Lorain	1.15	Pickaway	1.00	Warren	1.00
Clark	1.05	Guernsey	1.00	Lucas	1.15	Pike	1.10	Washington	1.00
Clermont	1.05	Hamilton	1.05	Madison	1.00	Portage	1.10	Wayne	1.10
Clinton	1.05	Hancock	1.05	Mahoning	1.05	Preble	1.00	Williams	1.10
Columbiana	1.05	Hardin	1.10	Marion	1.05	Putnam	1.10	Wood	1.10
Coshocton	1.05	Harrison	1.05	Medina	1.10	Richland	1.00	Wyandot	1.05
Crawford	1.00	Henry	1.10	Meigs	1.00	Ross	1.05		
Cuyahoga	1.20	Highland	1.05	Mercer	1.10	Sandusky	1.10		

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 125% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	1,182	2,662	5,994	9,207	9,544
Premiums Earned					
- Total Dollars	$5,831,341	$15,352,825	$40,421,101	$72,042,257	$87,299,753
- Ave. PMPM	$411	$481	$562	$652	$762
Claims Incurred					
- Total Dollars	$12,214,047	$31,111,972	$79,249,306	$131,269,400	$153,899,533
- Ave. PMPM	$861	$974	$1,102	$1,188	$1,344
Administrative Expenses					
- Total Dollars	$941,196	$1,478,436	$3,496,208	$5,638,697	$6,137,327
- Ave. PMPM	$66	$46	$49	$51	$54
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($7,438,902)	($17,237,583)	($42,324,413)	($64,865,840)	($72,737,106)
- Ave. PMPM	($525)	($540)	($588)	($587)	($635)
Loss Ratios					
- Premiums=125% SRR	209%	203%	196%	182%	176%
- Premiums=SRR	262%	253%	245%	228%	220%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	2,949	5,141	8,961	12,503	13,778
Premiums Earned					
- Total Dollars	$14,039,044	$27,871,800	$55,334,055	$87,616,856	$109,973,843
- Ave. PMPM	$397	$452	$515	$584	$665
Claims Incurred					
- Total Dollars	$32,975,390	$66,730,737	$135,039,835	$212,661,125	$272,081,079
- Ave. PMPM	$932	$1,082	$1,256	$1,417	$1,646
Administrative Expenses					
- Total Dollars	$1,560,364	$2,855,743	$5,226,514	$6,065,516	$7,018,351
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($20,611,710)	($41,714,680)	($84,932,295)	($131,109,786)	($169,125,587)
- Ave. PMPM	($582)	($676)	($790)	($874)	($1,023)
Loss Ratios					
- Premiums=125% SRR	235%	239%	244%	243%	247%
- Premiums=SRR	294%	299%	305%	303%	309%

More Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	4,605	7,373	11,805	16,336	17,250
Premiums Earned					
- Total Dollars	$21,166,170	$37,581,482	$66,727,603	$102,207,339	$119,561,341
- Ave. PMPM	$383	$425	$471	$521	$578
Claims Incurred					
- Total Dollars	$55,582,451	$105,986,250	$202,097,695	$326,624,749	$406,902,679
- Ave. PMPM	$1,006	$1,198	$1,427	$1,666	$1,966
Administrative Expenses					
- Total Dollars	$2,436,338	$4,095,689	$6,885,196	$7,925,001	$8,786,639
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($36,967,619)	($72,500,457)	($142,255,289)	($232,342,411)	($296,127,976)
- Ave. PMPM	($669)	($819)	($1,004)	($1,185)	($1,431)
Loss Ratios					
- Premiums=125% SRR	263%	282%	303%	320%	340%
- Premiums=SRR	328%	353%	379%	399%	425%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 125% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	9,893	10,256	10,631	11,020	11,423
Premiums Earned					
- Total Dollars	$105,788,564	$128,193,035	$155,342,446	$188,241,704	$228,108,545
- Ave. PMPM	$891	$1,042	$1,218	$1,423	$1,664
Claims Incurred					
- Total Dollars	$180,430,978	$211,536,300	$248,004,011	$290,758,558	$340,883,757
- Ave. PMPM	$1,520	$1,719	$1,944	$2,199	$2,487
Administrative Expenses					
- Total Dollars	$6,680,050	$5,759,338	$6,268,637	$6,822,972	$7,426,327
- Ave. PMPM	$56	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($81,322,464)	($89,102,603)	($98,930,202)	($109,339,826)	($120,201,540)
- Ave. PMPM	($685)	($724)	($775)	($827)	($877)
Loss Ratios					
- Premiums=125% SRR	171%	165%	160%	154%	149%
- Premiums=SRR	213%	206%	200%	193%	187%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	15,184	16,705	17,250	17,250	17,250
Premiums Earned					
- Total Dollars	$138,035,611	$172,961,036	$203,285,071	$231,541,696	$263,725,992
- Ave. PMPM	$758	$863	$982	$1,119	$1,274
Claims Incurred					
- Total Dollars	$348,103,649	$444,326,337	$529,871,101	$615,180,349	$714,224,385
- Ave. PMPM	$1,911	$2,217	$2,560	$2,972	$3,450
Administrative Expenses					
- Total Dollars	$8,120,867	$9,380,976	$10,171,632	$10,680,214	$11,214,225
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($218,188,906)	($280,746,276)	($336,757,663)	($394,318,867)	($461,712,618)
- Ave. PMPM	($1,197)	($1,401)	($1,627)	($1,905)	($2,230)
Loss Ratios					
- Premiums=125% SRR	252%	257%	261%	266%	271%
- Premiums=SRR	315%	321%	326%	332%	339%

More Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	17,250	17,250	17,250	17,250	17,250
Premiums Earned					
- Total Dollars	$132,593,527	$147,046,222	$163,074,260	$180,849,354	$200,561,934
- Ave. PMPM	$641	$710	$788	$874	$969
Claims Incurred					
- Total Dollars	$484,621,090	$577,183,719	$687,425,809	$818,724,138	$975,100,449
- Ave. PMPM	$2,341	$2,788	$3,321	$3,955	$4,711
Administrative Expenses					
- Total Dollars	$9,225,971	$9,687,269	$10,171,632	$10,680,214	$11,214,225
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($361,253,534)	($439,824,766)	($534,523,181)	($648,554,998)	($785,752,740)
- Ave. PMPM	($1,745)	($2,125)	($2,582)	($3,133)	($3,796)
Loss Ratios					
- Premiums=125% SRR	365%	393%	422%	453%	486%
- Premiums=SRR	457%	491%	527%	566%	608%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 150% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	1,125	2,535	5,709	8,769	9,090
Premiums Earned					
- Total Dollars	$6,664,390	$17,546,086	$46,195,544	$82,334,008	$99,771,147
- Ave. PMPM	$493	$577	$674	$782	$915
Claims Incurred					
- Total Dollars	$11,632,426	$29,630,449	$75,475,530	$125,018,476	$146,570,984
- Ave. PMPM	$861	$974	$1,102	$1,188	$1,344
Administrative Expenses					
- Total Dollars	$896,377	$1,408,035	$3,329,722	$5,370,187	$5,845,073
- Ave. PMPM	$66	$46	$49	$51	$54
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($5,979,413)	($13,492,398)	($32,609,707)	($48,054,656)	($52,644,910)
- Ave. PMPM	($443)	($444)	($476)	($457)	($483)
Loss Ratios					
- Premiums=150% SRR	175%	169%	163%	152%	147%
- Premiums=SRR	262%	253%	245%	228%	220%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	2,809	4,896	8,534	11,908	13,122
Premiums Earned					
- Total Dollars	$16,044,621	$31,853,485	$63,238,920	$100,133,549	$125,684,392
- Ave. PMPM	$476	$542	$618	$701	$798
Claims Incurred					
- Total Dollars	$31,405,133	$63,553,082	$128,609,367	$202,534,405	$259,124,838
- Ave. PMPM	$932	$1,082	$1,256	$1,417	$1,646
Administrative Expenses					
- Total Dollars	$1,486,061	$2,719,755	$4,977,633	$5,776,682	$6,684,144
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($16,961,573)	($34,419,352)	($70,348,080)	($108,177,538)	($140,124,589)
- Ave. PMPM	($503)	($586)	($687)	($757)	($890)
Loss Ratios					
- Premiums=150% SRR	196%	200%	203%	202%	206%
- Premiums=SRR	294%	299%	305%	303%	309%

More Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	4,386	7,022	11,243	15,622	17,245
Premiums Earned					
- Total Dollars	$24,189,909	$42,950,265	$76,260,117	$117,299,703	$143,431,080
- Ave. PMPM	$460	$510	$565	$626	$693
Claims Incurred					
- Total Dollars	$52,935,668	$100,939,286	$192,473,996	$312,852,467	$406,812,356
- Ave. PMPM	$1,006	$1,198	$1,427	$1,669	$1,966
Administrative Expenses					
- Total Dollars	$2,320,322	$3,900,656	$6,557,329	$7,578,599	$8,783,965
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($31,181,081)	($61,889,677)	($122,771,208)	($203,131,362)	($272,165,240)
- Ave. PMPM	($592)	($734)	($910)	($1,084)	($1,315)
Loss Ratios					
- Premiums=150% SRR	219%	235%	252%	267%	284%
- Premiums=SRR	328%	353%	379%	400%	425%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 150% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	9,422	9,767	10,125	10,495	10,879
Premiums Earned					
- Total Dollars	$120,901,217	$146,506,326	$177,534,224	$215,133,376	$260,695,479
- Ave. PMPM	$1,069	$1,250	$1,461	$1,708	$1,997
Claims Incurred					
- Total Dollars	$171,839,027	$201,463,143	$236,194,297	$276,912,913	$324,651,197
- Ave. PMPM	$1,520	$1,719	$1,944	$2,199	$2,487
Administrative Expenses					
- Total Dollars	$6,361,953	$6,924,540	$7,536,877	$6,498,069	$7,072,693
- Ave. PMPM	$56	$59	$62	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($57,299,763)	($61,881,357)	($66,196,950)	($68,277,605)	($71,028,410)
- Ave. PMPM	($507)	($528)	($545)	($542)	($544)
Loss Ratios					
- Premiums=150% SRR	142%	138%	133%	129%	125%
- Premiums=SRR	213%	206%	200%	193%	187%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	14,461	15,936	17,165	17,250	17,250
Premiums Earned					
- Total Dollars	$157,754,984	$198,008,952	$242,781,640	$277,850,035	$316,471,190
- Ave. PMPM	$909	$1,035	$1,179	$1,342	$1,529
Claims Incurred					
- Total Dollars	$331,527,285	$424,159,806	$527,892,196	$615,180,349	$714,224,385
- Ave. PMPM	$1,911	$2,218	$2,563	$2,972	$3,450
Administrative Expenses					
- Total Dollars	$7,734,159	$8,949,122	$10,121,619	$10,680,214	$11,214,225
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($181,506,461)	($235,099,975)	($295,232,175)	($348,010,527)	($408,967,419)
- Ave. PMPM	($1,046)	($1,229)	($1,433)	($1,681)	($1,976)
Loss Ratios					
- Premiums=150% SRR	210%	214%	217%	221%	226%
- Premiums=SRR	315%	321%	326%	332%	339%

More Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	17,250	17,250	17,250	17,250	17,250
Premiums Earned					
- Total Dollars	$159,112,233	$176,455,466	$195,689,112	$217,019,225	$240,674,321
- Ave. PMPM	$769	$852	$945	$1,048	$1,163
Claims Incurred					
- Total Dollars	$484,621,090	$577,183,719	$687,425,809	$818,724,138	$975,100,449
- Ave. PMPM	$2,341	$2,788	$3,321	$3,955	$4,711
Administrative Expenses					
- Total Dollars	$9,225,971	$9,687,269	$10,171,632	$10,680,214	$11,214,225
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($334,734,828)	($410,415,521)	($501,908,329)	($612,385,127)	($745,640,353)
- Ave. PMPM	($1,617)	($1,983)	($2,425)	($2,958)	($3,602)
Loss Ratios					
- Premiums=150% SRR	305%	327%	351%	377%	405%
- Premiums=SRR	457%	491%	527%	566%	608%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 175% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	1,069	2,408	5,423	8,330	8,635
Premiums Earned					
- Total Dollars	$7,386,366	$19,446,912	$51,200,062	$91,253,525	$110,579,688
- Ave. PMPM	$576	$673	$787	$913	$1,067
Claims Incurred					
- Total Dollars	$11,050,805	$28,148,927	$71,701,753	$118,767,553	$139,242,435
- Ave. PMPM	$861	$974	$1,102	$1,188	$1,344
Administrative Expenses					
- Total Dollars	$851,559	$1,337,633	$3,163,236	$5,101,678	$5,552,819
- Ave. PMPM	$66	$46	$49	$51	$54
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($4,630,998)	($10,039,648)	($23,664,927)	($32,615,705)	($34,215,567)
- Ave. PMPM	($361)	($347)	($364)	($326)	($330)
Loss Ratios					
- Premiums=175% SRR	150%	145%	140%	130%	126%
- Premiums=SRR	262%	253%	245%	228%	220%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	2,669	4,651	8,107	11,312	12,466
Premiums Earned					
- Total Dollars	$17,782,789	$35,304,279	$70,089,803	$110,981,351	$139,300,201
- Ave. PMPM	$555	$633	$720	$818	$931
Claims Incurred					
- Total Dollars	$29,834,876	$60,375,428	$122,178,899	$192,407,685	$246,168,596
- Ave. PMPM	$932	$1,082	$1,256	$1,417	$1,646
Administrative Expenses					
- Total Dollars	$1,411,758	$2,583,767	$4,728,751	$5,487,848	$6,349,937
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($13,578,846)	($27,654,916)	($56,817,847)	($86,914,182)	($113,218,331)
- Ave. PMPM	($424)	($495)	($584)	($640)	($757)
Loss Ratios					
- Premiums=175% SRR	168%	171%	174%	173%	177%
- Premiums=SRR	294%	299%	305%	303%	309%

More Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	4,167	6,671	10,680	14,841	16,383
Premiums Earned					
- Total Dollars	$26,810,482	$47,603,211	$84,521,630	$130,007,171	$158,969,447
- Ave. PMPM	$536	$595	$659	$730	$809
Claims Incurred					
- Total Dollars	$50,288,884	$95,892,322	$182,850,296	$297,209,844	$386,471,738
- Ave. PMPM	$1,006	$1,198	$1,427	$1,669	$1,966
Administrative Expenses					
- Total Dollars	$2,204,306	$3,705,623	$6,229,463	$7,199,669	$8,344,767
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($25,797,708)	($51,994,734)	($104,558,129)	($174,402,341)	($235,847,057)
- Ave. PMPM	($516)	($650)	($816)	($979)	($1,200)
Loss Ratios					
- Premiums=175% SRR	188%	201%	216%	229%	243%
- Premiums=SRR	328%	353%	379%	400%	425%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 175% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	8,951	9,279	9,618	9,971	10,335
Premiums Earned					
- Total Dollars	$133,998,848	$162,377,845	$196,767,098	$238,439,492	$288,937,490
- Ave. PMPM	$1,247	$1,458	$1,705	$1,993	$2,330
Claims Incurred					
- Total Dollars	$163,247,075	$191,389,986	$224,384,582	$263,067,267	$308,418,637
- Ave. PMPM	$1,520	$1,719	$1,944	$2,199	$2,487
Administrative Expenses					
- Total Dollars	$6,043,855	$6,578,313	$7,160,033	$7,793,195	$6,719,058
- Ave. PMPM	$56	$59	$62	$65	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($35,292,082)	($35,590,454)	($34,777,517)	($32,420,970)	($26,200,206)
- Ave. PMPM	($329)	($320)	($301)	($271)	($211)
Loss Ratios					
- Premiums=175% SRR	122%	118%	114%	110%	107%
- Premiums=SRR	213%	206%	200%	193%	187%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	13,738	15,139	16,307	16,388	16,388
Premiums Earned					
- Total Dollars	$174,845,107	$219,459,922	$269,082,984	$307,950,456	$350,755,569
- Ave. PMPM	$1,061	$1,208	$1,375	$1,566	$1,784
Claims Incurred					
- Total Dollars	$314,950,921	$402,951,815	$501,497,587	$584,421,331	$678,513,166
- Ave. PMPM	$1,911	$2,218	$2,563	$2,972	$3,450
Administrative Expenses					
- Total Dollars	$7,347,451	$8,501,666	$9,615,538	$10,146,203	$10,653,514
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($147,453,265)	($191,993,559)	($242,030,140)	($286,617,079)	($338,411,110)
- Ave. PMPM	($894)	($1,057)	($1,237)	($1,457)	($1,721)
Loss Ratios					
- Premiums=175% SRR	180%	184%	186%	190%	193%
- Premiums=SRR	315%	321%	326%	332%	339%

More Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	16,388	16,388	16,388	16,388	16,388
Premiums Earned					
- Total Dollars	$176,349,391	$195,571,475	$216,888,766	$240,529,641	$266,747,372
- Ave. PMPM	$897	$995	$1,103	$1,223	$1,356
Claims Incurred					
- Total Dollars	$460,390,036	$548,324,533	$653,054,518	$777,787,931	$926,345,426
- Ave. PMPM	$2,341	$2,788	$3,321	$3,955	$4,711
Administrative Expenses					
- Total Dollars	$8,764,672	$9,202,906	$9,663,051	$10,146,203	$10,653,514
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($292,805,316)	($361,955,963)	($445,828,803)	($547,404,494)	($670,251,568)
- Ave. PMPM	($1,489)	($1,841)	($2,267)	($2,784)	($3,408)
Loss Ratios					
- Premiums=175% SRR	261%	280%	301%	323%	347%
- Premiums=SRR	457%	491%	527%	566%	608%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 200% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	1,013	2,281	5,138	7,892	8,181
Premiums Earned					
- Total Dollars	$7,997,268	$21,055,303	$55,434,653	$98,800,809	$119,725,376
- Ave. PMPM	$658	$769	$899	$1,043	$1,220
Claims Incurred					
- Total Dollars	$10,469,183	$26,667,404	$67,927,977	$112,516,629	$131,913,885
- Ave. PMPM	$861	$974	$1,102	$1,188	$1,344
Administrative Expenses					
- Total Dollars	$806,740	$1,267,231	$2,996,750	$4,833,169	$5,260,566
- Ave. PMPM	$66	$46	$49	$51	$54
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($3,393,655)	($6,879,332)	($15,490,073)	($18,548,988)	($17,449,075)
- Ave. PMPM	($279)	($251)	($251)	($196)	($178)
Loss Ratios					
- Premiums=200% SRR	131%	127%	123%	114%	110%
- Premiums=SRR	262%	253%	245%	228%	220%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	2,528	4,407	7,681	10,717	11,810
Premiums Earned					
- Total Dollars	$19,253,546	$38,224,182	$75,886,704	$120,160,259	$150,821,271
- Ave. PMPM	$635	$723	$823	$934	$1,064
Claims Incurred					
- Total Dollars	$28,264,620	$57,197,774	$115,748,430	$182,280,965	$233,212,354
- Ave. PMPM	$932	$1,082	$1,256	$1,417	$1,646
Administrative Expenses					
- Total Dollars	$1,337,455	$2,447,779	$4,479,869	$5,199,014	$6,015,729
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($10,463,529)	($21,421,371)	($44,341,596)	($67,319,719)	($88,406,813)
- Ave. PMPM	($345)	($405)	($481)	($523)	($624)
Loss Ratios					
- Premiums=200% SRR	147%	150%	153%	152%	155%
- Premiums=SRR	294%	299%	305%	303%	309%

More Conservative Scenario

	2006	2007	2008	2009	2010
Ave. Enrollment	3,947	6,320	10,118	14,060	15,520
Premiums Earned					
- Total Dollars	$29,027,891	$51,540,318	$91,512,141	$140,759,644	$172,117,296
- Ave. PMPM	$613	$680	$754	$834	$924
Claims Incurred					
- Total Dollars	$47,642,101	$90,845,358	$173,226,596	$281,567,220	$366,131,120
- Ave. PMPM	$1,006	$1,198	$1,427	$1,669	$1,966
Administrative Expenses					
- Total Dollars	$2,088,290	$3,510,590	$5,901,596	$6,820,739	$7,905,568
- Ave. PMPM	$44	$46	$49	$40	$42
- Start-up Costs	$115,000	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($20,817,500)	($42,815,629)	($87,616,052)	($147,628,315)	($201,919,392)
- Ave. PMPM	($439)	($565)	($722)	($875)	($1,084)
Loss Ratios					
- Premiums=200% SRR	164%	176%	189%	200%	213%
- Premiums=SRR	328%	353%	379%	400%	425%

Ohio High-Risk Pool

Enrollment and Cost Projections
Premiums: 200% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	8,480	8,790	9,112	9,446	9,791
Premiums Earned					
- Total Dollars	$145,081,460	$175,807,591	$213,041,069	$258,160,052	$312,834,575
- Ave. PMPM	$1,426	$1,667	$1,948	$2,278	$2,662
Claims Incurred					
- Total Dollars	$154,655,124	$181,316,829	$212,574,867	$249,221,621	$292,186,077
- Ave. PMPM	$1,520	$1,719	$1,944	$2,199	$2,487
Administrative Expenses					
- Total Dollars	$5,725,757	$6,232,086	$6,783,189	$7,383,027	$8,035,908
- Ave. PMPM	$56	$59	$62	$65	$68
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($15,299,422)	($11,741,323)	($6,316,988)	$1,555,404	$12,612,590
- Ave. PMPM	($150)	($111)	($58)	$14	$107
Loss Ratios					
- Premiums=200% SRR	107%	103%	100%	97%	93%
- Premiums=SRR	213%	206%	200%	193%	187%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	13,015	14,342	15,449	15,525	15,525
Premiums Earned					
- Total Dollars	$189,305,980	$237,610,743	$291,337,968	$333,420,043	$379,765,428
- Ave. PMPM	$1,212	$1,381	$1,572	$1,790	$2,038
Claims Incurred					
- Total Dollars	$298,374,557	$381,743,825	$475,102,977	$553,662,314	$642,801,947
- Ave. PMPM	$1,911	$2,218	$2,563	$2,972	$3,450
Administrative Expenses					
- Total Dollars	$6,960,743	$8,054,209	$9,109,457	$9,612,193	$10,092,802
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($116,029,319)	($152,187,292)	($192,874,466)	($229,854,464)	($273,129,320)
- Ave. PMPM	($743)	($884)	($1,040)	($1,234)	($1,466)
Loss Ratios					
- Premiums=200% SRR	158%	161%	163%	166%	169%
- Premiums=SRR	315%	321%	326%	332%	339%

More Conservative Scenario

	2011	2012	2013	2014	2015
Ave. Enrollment	15,525	15,525	15,525	15,525	15,525
Premiums Earned					
- Total Dollars	$190,934,679	$211,746,559	$234,826,934	$260,423,070	$288,809,185
- Ave. PMPM	$1,025	$1,137	$1,260	$1,398	$1,550
Claims Incurred					
- Total Dollars	$436,158,981	$519,465,347	$618,683,228	$736,851,725	$877,590,404
- Ave. PMPM	$2,341	$2,788	$3,321	$3,955	$4,711
Administrative Expenses					
- Total Dollars	$8,303,373	$8,718,542	$9,154,469	$9,612,193	$10,092,802
- Ave. PMPM	$45	$47	$49	$52	$54
- Start-up Costs	$0	$0	$0	$0	$0
Gain/Loss					
- Total Dollars	($253,527,675)	($316,437,329)	($393,010,763)	($486,040,847)	($598,874,021)
- Ave. PMPM	($1,361)	($1,699)	($2,110)	($2,609)	($3,215)
Loss Ratios					
- Premiums=200% SRR	228%	245%	263%	283%	304%
- Premiums=SRR	457%	491%	527%	566%	608%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 125% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$8,550,595	$18,858,416	$46,469,753	$69,081,556	$73,864,485
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$1.16	$2.55	$6.28	$9.31	$9.93
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$1.76	$3.88	$9.54	$14.15	$15.09
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.05%	0.10%	0.22%	0.28%	0.27%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$1.04	$2.21	$5.28	$7.60	$7.87
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.05%	0.07%	0.07%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$0.58	$1.28	$3.14	$4.65	$4.96
- Assessment per $ of Hosp Revenue	0.01%	0.01%	0.03%	0.03%	0.03%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$23,686,138	$44,628,487	$90,824,842	$137,475,531	$173,263,348
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$3.21	$6.04	$12.27	$18.52	$23.28
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$4.89	$9.19	$18.65	$28.16	$35.41
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.14%	0.24%	0.43%	0.56%	0.62%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$2.87	$5.23	$10.31	$15.12	$18.46
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.04%	0.06%	0.10%	0.14%	0.15%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$1.61	$3.02	$6.13	$9.26	$11.64
- Assessment per $ of Hosp Revenue	0.02%	0.03%	0.05%	0.07%	0.08%

More Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$42,264,940	$77,022,702	$150,858,353	$243,205,296	$302,168,818
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$5.74	$10.43	$20.37	$32.76	$40.60
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$8.72	$15.86	$30.98	$49.83	$61.75
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.26%	0.41%	0.71%	1.00%	1.09%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$5.12	$9.03	$17.13	$26.75	$32.19
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.06%	0.10%	0.17%	0.24%	0.27%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$2.87	$5.21	$10.19	$16.38	$20.30
- Assessment per $ of Hosp Revenue	0.03%	0.05%	0.09%	0.12%	0.13%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 125% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$82,681,007	$90,753,106	$100,916,913	$111,730,964	$123,079,347
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$11.08	$12.13	$13.46	$14.86	$16.33
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$16.85	$18.45	$20.47	$22.61	$24.84
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.26%	0.25%	0.24%	0.24%	0.23%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$8.53	$9.07	$9.76	$10.47	$11.17
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.06%	0.06%	0.06%	0.06%	0.06%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$5.54	$6.07	$6.73	$7.43	$8.17
- Assessment per $ of Hosp Revenue	0.03%	0.03%	0.03%	0.03%	0.03%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$223,469,935	$287,393,138	$341,777,915	$398,720,569	$466,795,697
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$29.95	$38.43	$45.58	$53.04	$61.95
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$45.55	$58.44	$69.32	$80.67	$94.21
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.70%	0.79%	0.82%	0.84%	0.86%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$23.05	$28.71	$33.07	$37.36	$42.36
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.17%	0.19%	0.20%	0.21%	0.21%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$14.98	$19.21	$22.79	$26.52	$30.97
- Assessment per $ of Hosp Revenue	0.09%	0.10%	0.10%	0.10%	0.11%

More Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$366,616,980	$446,168,269	$542,028,746	$657,438,811	$796,271,630
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$49.14	$59.65	$72.29	$87.46	$105.67
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$74.74	$90.72	$109.94	$133.02	$160.71
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	1.15%	1.23%	1.31%	1.39%	1.47%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$37.82	$44.57	$52.44	$61.60	$72.25
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.28%	0.30%	0.32%	0.34%	0.36%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$24.57	$29.83	$36.14	$43.73	$52.83
- Assessment per $ of Hosp Revenue	0.14%	0.15%	0.16%	0.17%	0.18%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 150% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$7,049,823	$15,066,845	$36,638,731	$52,197,653	$53,873,810
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$0.96	$2.04	$4.95	$7.03	$7.24
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$1.46	$3.10	$7.52	$10.69	$11.01
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.04%	0.08%	0.17%	0.21%	0.19%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$0.85	$1.77	$4.16	$5.74	$5.74
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.04%	0.05%	0.05%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$0.48	$1.02	$2.47	$3.52	$3.62
- Assessment per $ of Hosp Revenue	0.01%	0.01%	0.02%	0.03%	0.02%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$19,909,830	$37,234,752	$76,040,128	$114,358,006	$144,213,275
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$2.70	$5.04	$10.27	$15.40	$19.38
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$4.11	$7.67	$15.62	$23.43	$29.47
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.12%	0.20%	0.36%	0.47%	0.52%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$2.41	$4.37	$8.64	$12.58	$15.36
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.03%	0.05%	0.09%	0.12%	0.13%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$1.35	$2.52	$5.13	$7.70	$9.69
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.04%	0.06%	0.06%

More Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$36,246,189	$66,232,336	$131,028,095	$213,734,703	$279,686,935
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$4.92	$8.97	$17.69	$28.79	$37.58
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$7.48	$13.64	$26.91	$43.79	$57.16
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.22%	0.35%	0.61%	0.88%	1.00%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$4.39	$7.77	$14.88	$23.51	$29.79
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.05%	0.09%	0.15%	0.21%	0.25%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$2.46	$4.48	$8.85	$14.40	$18.79
- Assessment per $ of Hosp Revenue	0.03%	0.04%	0.08%	0.11%	0.12%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 150% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$58,781,690	$63,668,098	$68,350,900	$70,889,436	$74,174,724
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$7.88	$8.51	$9.12	$9.43	$9.84
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$11.98	$12.95	$13.86	$14.34	$14.97
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.18%	0.18%	0.16%	0.15%	0.14%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$6.06	$6.36	$6.61	$6.64	$6.73
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.05%	0.04%	0.04%	0.04%	0.03%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$3.94	$4.26	$4.56	$4.72	$4.92
- Assessment per $ of Hosp Revenue	0.02%	0.02%	0.02%	0.02%	0.02%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$186,721,729	$241,752,006	$302,361,870	$352,932,284	$414,417,020
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$25.03	$32.32	$40.33	$46.95	$55.00
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$38.06	$49.16	$61.33	$71.41	$83.64
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.59%	0.67%	0.73%	0.75%	0.77%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$19.26	$24.15	$29.25	$33.07	$37.60
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.14%	0.16%	0.18%	0.18%	0.19%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$12.51	$16.16	$20.16	$23.48	$27.50
- Assessment per $ of Hosp Revenue	0.07%	0.08%	0.09%	0.09%	0.09%

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$340,229,996	$416,895,074	$509,564,774	$621,436,265	$756,344,807
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$45.60	$55.74	$67.96	$82.67	$100.37
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$69.36	$84.77	$103.36	$125.73	$152.65
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	1.07%	1.15%	1.23%	1.31%	1.40%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$35.10	$41.65	$49.30	$58.23	$68.63
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.26%	0.28%	0.30%	0.32%	0.34%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$22.80	$27.87	$33.98	$41.34	$50.19
- Assessment per $ of Hosp Revenue	0.13%	0.14%	0.15%	0.16%	0.17%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 175% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$5,658,959	$11,564,629	$27,569,527	$36,673,180	$35,530,468
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$0.77	$1.57	$3.72	$4.94	$4.77
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$1.17	$2.38	$5.66	$7.51	$7.26
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.03%	0.06%	0.13%	0.15%	0.13%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$0.69	$1.36	$3.13	$4.03	$3.78
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.03%	0.04%	0.03%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$0.38	$0.78	$1.86	$2.47	$2.39
- Assessment per $ of Hosp Revenue	0.00%	0.01%	0.02%	0.02%	0.02%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$16,398,909	$30,367,874	$62,301,386	$92,897,589	$117,243,146
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$2.23	$4.11	$8.41	$12.51	$15.75
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$3.38	$6.25	$12.80	$19.03	$23.96
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.10%	0.16%	0.29%	0.38%	0.42%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$1.99	$3.56	$7.08	$10.22	$12.49
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.02%	0.04%	0.07%	0.09%	0.10%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$1.11	$2.06	$4.21	$6.26	$7.88
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.04%	0.05%	0.05%

More Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$30,628,600	$56,154,232	$112,462,489	$184,564,035	$243,097,744
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$4.16	$7.60	$15.19	$24.86	$32.67
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$6.32	$11.56	$23.10	$37.81	$49.68
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.19%	0.30%	0.53%	0.76%	0.87%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$3.71	$6.59	$12.77	$20.30	$25.89
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.05%	0.07%	0.13%	0.19%	0.21%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$2.08	$3.80	$7.59	$12.43	$16.33
- Assessment per $ of Hosp Revenue	0.02%	0.04%	0.06%	0.09%	0.11%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 175% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$36,878,587	$37,504,372	$37,086,137	$35,205,428	$29,574,357
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$4.94	$5.01	$4.95	$4.68	$3.92
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$7.52	$7.63	$7.52	$7.12	$5.97
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.12%	0.10%	0.09%	0.07%	0.05%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$3.80	$3.75	$3.59	$3.30	$2.68
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.03%	0.03%	0.02%	0.02%	0.01%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$2.47	$2.51	$2.47	$2.34	$1.96
- Assessment per $ of Hosp Revenue	0.01%	0.01%	0.01%	0.01%	0.01%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$152,584,201	$198,534,439	$249,071,494	$291,598,451	$343,936,427
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$20.45	$26.54	$33.22	$38.79	$45.64
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$31.10	$40.37	$50.52	$59.00	$69.41
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.48%	0.55%	0.60%	0.62%	0.64%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$15.74	$19.83	$24.10	$27.32	$31.21
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.12%	0.13%	0.15%	0.15%	0.16%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$10.23	$13.27	$16.61	$19.40	$22.82
- Assessment per $ of Hosp Revenue	0.06%	0.07%	0.07%	0.08%	0.08%

More Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$298,142,270	$368,240,786	$453,245,761	$556,162,033	$680,597,084
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$39.96	$49.23	$60.45	$73.99	$90.32
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$60.78	$74.88	$91.93	$112.53	$137.36
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.94%	1.01%	1.09%	1.18%	1.26%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$30.75	$36.79	$43.85	$52.11	$61.76
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.23%	0.25%	0.27%	0.29%	0.31%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$19.98	$24.62	$30.22	$36.99	$45.16
- Assessment per $ of Hosp Revenue	0.11%	0.12%	0.13%	0.14%	0.15%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 200% of Standard Risk Rate

Less Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$4,378,002	$8,351,768	$19,262,141	$22,508,138	$18,834,457
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$0.59	$1.13	$2.60	$3.03	$2.53
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$0.90	$1.72	$3.96	$4.61	$3.85
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.03%	0.04%	0.09%	0.09%	0.07%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$0.53	$0.98	$2.19	$2.48	$2.01
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.01%	0.01%	0.02%	0.02%	0.02%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$0.30	$0.57	$1.30	$1.52	$1.27
- Assessment per $ of Hosp Revenue	0.00%	0.01%	0.01%	0.01%	0.01%

Best Estimate Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$13,153,375	$24,027,853	$49,608,616	$73,094,278	$92,352,961
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$1.79	$3.25	$6.70	$9.85	$12.41
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$2.72	$4.95	$10.19	$14.97	$18.87
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.08%	0.13%	0.23%	0.30%	0.33%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$1.59	$2.82	$5.63	$8.04	$9.84
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.02%	0.03%	0.06%	0.07%	0.08%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$0.89	$1.63	$3.35	$4.92	$6.20
- Assessment per $ of Hosp Revenue	0.01%	0.02%	0.03%	0.04%	0.04%

More Conservative Scenario

	2006	2007	2008	2009	2010
Funding Need on Jan. 1	$25,412,171	$46,788,390	$95,161,536	$157,339,045	$208,888,009
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,368,075	7,386,496	7,404,962	7,423,474	7,442,033
- Assessment per Life per Year	$3.45	$6.33	$12.85	$21.19	$28.07
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,844,692	4,856,804	4,868,946	4,881,118	4,893,321
- Assessment per Life per Year	$5.25	$9.63	$19.54	$32.23	$42.69
Funding Scenario 3					
- Total Health Insurance Premium	$16,371,961,506	$18,694,283,315	$21,346,020,668	$24,373,900,335	$27,831,277,162
- Assessment as a % Premium	0.16%	0.25%	0.45%	0.65%	0.75%
Funding Scenario 4					
- Total Hospital Days	8,258,529	8,527,550	8,805,335	9,092,169	9,388,346
- Assessment per Hospital Day	$3.08	$5.49	$10.81	$17.30	$22.25
Funding Scenario 5					
- Total Hospital Revenue	$66,784,703,493	$76,257,946,722	$87,074,945,820	$99,426,309,197	$113,529,682,591
- Assessment per $ of Hosp Revenue	0.04%	0.06%	0.11%	0.16%	0.18%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$1.72	$3.17	$6.43	$10.60	$14.03
- Assessment per $ of Hosp Revenue	0.02%	0.03%	0.05%	0.08%	0.09%

Ohio High-Risk Pool

Funding Scenario Projections

Premiums: 200% of Standard Risk Rate

Less Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$16,971,695	$13,759,627	$8,752,661	$1,383,704	$0
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$2.27	$1.84	$1.17	$0.18	$0.00
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$3.46	$2.80	$1.78	$0.28	$0.00
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.05%	0.04%	0.02%	0.00%	0.00%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$1.75	$1.37	$0.85	$0.13	$0.00
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.01%	0.01%	0.01%	0.00%	0.00%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$1.14	$0.92	$0.58	$0.09	$0.00
- Assessment per $ of Hosp Revenue	0.01%	0.00%	0.00%	0.00%	0.00%

Best Estimate Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$121,057,352	$158,593,710	$199,799,254	$234,863,272	$278,693,701
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$16.23	$21.20	$26.65	$31.25	$36.98
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$24.68	$32.25	$40.53	$47.52	$56.25
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.38%	0.44%	0.48%	0.50%	0.52%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$12.49	$15.84	$19.33	$22.01	$25.29
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.09%	0.11%	0.12%	0.12%	0.13%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$8.11	$10.60	$13.32	$15.62	$18.49
- Assessment per $ of Hosp Revenue	0.05%	0.05%	0.06%	0.06%	0.06%

More Conservative Scenario

	2011	2012	2013	2014	2015
Funding Need on Jan. 1	$258,694,147	$322,513,817	$400,173,146	$494,488,056	$608,842,044
Funding Scenario 1					
- Total Insured Lives (Incl. Stop Loss)	7,460,638	7,479,290	7,497,988	7,516,733	7,535,525
- Assessment per Life per Year	$34.67	$43.12	$53.37	$65.78	$80.80
Funding Scenario 2					
- Total Insured Lives (Excl. Stop Loss)	4,905,554	4,917,818	4,930,113	4,942,438	4,954,794
- Assessment per Life per Year	$52.73	$65.58	$81.17	$100.05	$122.88
Funding Scenario 3					
- Total Health Insurance Premium	$31,779,074,250	$36,286,856,484	$41,434,056,359	$47,311,373,669	$54,022,373,745
- Assessment as a % Premium	0.81%	0.89%	0.97%	1.05%	1.13%
Funding Scenario 4					
- Total Hospital Days	9,694,172	10,009,959	10,336,034	10,672,730	11,020,394
- Assessment per Hospital Day	$26.69	$32.22	$38.72	$46.33	$55.25
Funding Scenario 5					
- Total Hospital Revenue	$129,633,584,242	$148,021,784,083	$169,018,304,100	$192,993,127,991	$220,368,720,714
- Assessment per $ of Hosp Revenue	0.20%	0.22%	0.24%	0.26%	0.28%
Funding Scenario 6: Combine Scen 1 & 5					
- Assessment per Life per Year	$17.34	$21.56	$26.69	$32.89	$40.40
- Assessment per $ of Hosp Revenue	0.10%	0.11%	0.12%	0.13%	0.14%